THE MANY FACES OF MENTAL HEALTH: THE INTERSECTION OF MEDICALIZATION AND IGNORANCE MANAGEMENT IN PSYCHOTHERAPY

by

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Abstract

Despite psychotherapy being an increasingly popular mental health treatment, how practitioners of psychotherapy conceptualize mental health remains poorly understood. Using a grounded theory approach, I conducted 15 semi-structured interviews to elucidate how medical doctor psychotherapists and clinical psychologists in Ontario enact mental health. Practitioners were found to alternate between four enactments of mental health—restoration, enhancement, management, and stabilization—attempting to downplay patients' expectations for therapy. Practitioners can then better achieve promised therapeutic outcomes, helping them appear competent rather than ignorant and ineffective. Practitioners have also medicalized—attached medical understandings to—emotional management and social support, re-positioning these practices as medical interventions. Ignorance management and medicalization can be at cross-purposes. Medical understandings are increasingly spread by promising patients a "happier, healthier you", expectations that practitioners may not be able to achieve. Ambitious definitions of mental health can thus be paradoxical, simultaneously improving and undermining the reputation of practitioners and psychotherapy.

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Chapter 1

Introduction

According to the Centre for Addiction and Mental Health and Canadian Mental Health Association, Canada is in the midst of a mental health crisis (CAMH 2022; CMHA 2023). But can we convincingly declare a "mental health crisis" or "epidemic" without knowing what "mental health" is? Does "mental health" mean that you are not experiencing significant and prolonged sadness (APA 2022)? Or does it mean something more, like regularly experiencing happiness (Kahneman, Diener, and Schwarz 1999) or feeling that your life is meaningful (Frankl 1946)? Divergent definitions of mental health abound, amongst members of the public (Keyes et al. 2021; Ryff 1989), academics (see Huta and Waterman 2014 for a review), and health care agencies (e.g., PHAC 2006; WHO 2018). While there are overlaps, there are also important differences that lead to different conclusions, muddying the water for policymakers, professionals, patients, and broader society (Koushede et al. 2019).

My thesis provides insights into this problem. I do not explore how practitioners "know" or conceptualize mental health at a theoretical level, nor do I seek to adjudicate between different theories and present a definitive definition of "mental health"—if such a single, universal definition can even exist (see Leonardi 2018). Instead, following Mol's (2002) approach, I focus on how mental health is 'enacted'—i.e., how practitioners "do mental health" in their everyday clinical practice. Under this approach, "mental health" is best understood as an object acted upon by a set of practices, in contrast to

more traditional approaches that view mental health as a state of being, collection of resources, and/or cluster of dispositions (e.g., Seligman 2011).

Given my background in both psychology and sociology, I elected to examine the practice of psychotherapy. Previous research examining the everyday clinical practices of mental health professionals has typically lumped psychotherapy and pharmacotherapy together (e.g., Brown 1987; Halpin 2016; Smith 2014; Whooley 2010), assuming a common understanding of mental health across both treatment modalities. Flick (2021:231) however argues that psychotherapy should not be conjoined with pharmacotherapy. Rather, psychotherapy must be regarded as a separate occupation, possessing its own professional jurisdiction predicated upon its own body of expert knowledge and set of skills (Abbott 2014[1988]). Enactments of mental health in psychotherapy may thus diverge from those discussed in more pharmacotherapy-focused studies, reflecting the unique "profession" of psychotherapy.

To explore the practice of psychotherapy, I conducted interviews with two groups of practitioners in Ontario: clinical psychologists (CPs)—who have completed an accredited graduate program culminating in a PhD dissertation and year-long clinical internship—and MD psychotherapists—who have complete medical school, residency, and a year-long fellowship in medical psychotherapy. Clinical psychologists are the main private practitioners of psychotherapy in Ontario, while MD psychotherapists are one of the larger groups of practitioners in the public system (Ali 2001; Kurdyak et al. 2020). I chose to conduct my research in Ontario because 1) the province has the greatest number of MD psychotherapists, and 2) I had existing relationships with several mental health professionals in the province which facilitated recruitment.

My investigation focuses on three questions. First, *how* is mental health enacted through interventions (i.e., how change is achieved) and goals (i.e., how change is evaluated)? Second, *why* do practitioners employ these specific interventions and goals? Third, *what* are the broader social consequences of practitioners using these specific interventions and goals?

1.1 Summary of Findings

Following these three lines of inquiry, my thesis makes three primary arguments. First, I argue that there are four ways practitioners enact mental health: 1) restoration, through which practitioners aim to eliminate the patient's symptoms and restore "normal" functioning; 2) enhancement, which aims to optimize the patient's well-being; 3) management, which aims to maintain the gains made in therapy; and 4) stabilization, which aims to stop the patient from getting worse.

Second, I connect these various enactments of mental health to professional ignorance. I argue that the reason why practitioners use these different understandings of mental health is to manage ignorance, hoping to maintain professional authority and decrease the risk of the patient dropping out of therapy prematurely. Specifically, practitioners employ a *downplay-achieve* ignorance management strategy. Practitioners *downplay* therapeutic goals, using the different enactments of mental health to get patients to set "realistic" goals. Practitioners then strive to *achieve* these downplayed goals using an eclectic mix of interventions, "proving" to patients that the practitioner is competent and that psychotherapy is an effective treatment.

Third, I argue that practitioners have ascribed a medical, healing function to the interventions they use in psychotherapy, linking these practices to proper management of

mental health. Previously non-medical actions are 'medicalized' (Conrad 1975), causing broader society to view these techniques as medical in nature and understand them using a medical framework. Rather than looking at how a problem is medicalized by being "treated" with a medical intervention (Conrad 2007), I instead examine the process through which the "medical intervention" itself comes to be viewed as expert, medical practice. I propose that medicalization in psychotherapy progresses through the re-definition of problems (Conrad and Schneider 1992; Jutel 2011) and the *re-definition of solutions*, causing everyday emotions management techniques and social support to become viewed as medical concepts (Hochschild 1983; Thoits 1985).

Overall, findings were generally consistent across MDs and CPs, with the commonalities greatly outnumbering any dissimilarities. Though their professional education differs—medical school versus graduate school in clinical psychology—the training and practice of psychotherapy for both professional groups is remarkably similar. MDs and CPs use many of the same manuals, textbooks, worksheets, scales, and other psychotherapy-related resources, while conferences and professional development courses often bring together practitioners from a variety of professional backgrounds. Flick (2021:231) goes so far as to argue that psychotherapy represents a distinct profession, suggesting that health care professionals should be grouped by the treatment modality they employ instead of their professional background. For these reasons, in the rest of the thesis, my results combine the interview data from both professions and it can be assumed that I did not find any noticeable differences unless otherwise specified.

1.1.1 Intended Contributions

By examining how mental health is enacted in psychotherapy, this thesis helps advance several areas of sociological theory. The first body of literature I aim to contribute to is research on society's and medicine's changing definitions of "health". Medicine is increasingly orienting towards the optimization of health, aiming to make people "better than well" instead of simply alleviating disease (e.g., Clarke et al. 2010; Conrad 2007; Rose 2007). I provide insights into this re-definition of health, exploring whether practitioners of psychotherapy display the same focus on optimization that has been observed in other areas of medicine. I find that practitioners show an ambivalent attitude towards this understanding of health, sometimes engaging in enhancement-oriented practices while at other times practitioners are highly critical of and constrain enhancement. Practitioners also report enacting and orienting towards other understandings of mental health, like wanting to stabilize patients and stop them from getting worse. These enactments of health can greatly diverge from more enhancement-oriented practices, further highlighting practitioners' complex relationship with "health as optimization".

Another sociological literature my project contributes to is the management and production of ignorance. Ignorance—an absence or limitation of knowledge—can be regarded as undesirable, a threat to professional authority that must be minimized to maintain credibility (Whooley 2019:18). However, ignorance can have many positive functions for professions, particularly when it is not evenly distributed, giving one group access to special information while excluding others (Abbott 2014; Proctor and Schiebinger 2008). For instance, within the interaction of psychotherapy, the lopsided distribution of ignorance is used by practitioners to gain and maintain authority over

patients (Moore and Tumin 1949). I examine the strategies practitioners use to manage and produce ignorance in psychotherapy, contrasting the practice's shorter timeframe and one-on-one interaction structure against the ignorance management strategies used by professionals when they engage with the broader public through publications, press releases, and policy decisions (Whooley 2019). I argue that in psychotherapy, practitioners prioritize "realistic" promises and aims, wanting to increase the likelihood of patients' believing that their therapeutic goals have been achieved rather than leaving disappointed.

The final literature to which my thesis contributes is medicalization theory (Conrad 1975, 2007). Medicalization theory has typically focused on problems (Jutel 2011; Showalter 2019), showing how deviance comes to be re-defined as disease—e.g., the re-definition of juvenile delinquency as hyperactivity (Conrad and Schneider 1992)—or how previously non-medical problems come to be treated with medical interventions—e.g., the growing trend of using selective serotonin reuptake inhibitors (SSRIs) and other pharmaceutical to "cure" shyness (Scott 2006). Through these pathways, medical frameworks and language are applied to "problems in living" (Szasz 1961), expanding the jurisdictions of the health care professions. Instead of focusing on how problems come to be viewed as medical, my project examines how previously non-medical solutions come to be viewed as medical and re-defined as "treatments" or "interventions". The methods, tools, and techniques practitioners use to enact mental health are not intrinsically medical. Rather, practitioners appropriate many existing concepts and practices by assigning them a mental health management function, encouraging patients and the public to view these acts as medical ones. I argue that is

another important but often overlooked pathway through which medical understandings and professional authority expand into everyday life.

1.1.2 Structure of the Thesis

In this introductory chapter, I provide an overview of psychotherapy, explaining how the practice operates and situating it in broader society. I also review the literatures and theoretical frameworks which guided this project. Chapter 2 covers methodology, where I explain my data collection and analysis procedures. In Chapters 3, 4, and 5, I report my findings. Chapter 3 explains how practitioners enact mental health. I outline four key enactments of mental health: restoration, enhancement, management, and stabilization, showing how practitioners understand mental health as a changeable and multifaceted concept. In Chapter 4, I explain how practitioners use the various enactments of mental health to manage ignorance through a downplay-achieve strategy. Practitioners report changing the therapeutic goals they set with the patient over the course of treatment, altering their aims in an effort to make therapy seem successful, thereby maintaining their professional authority and the patient's motivation.

In Chapter 5, I introduce the concept of medicalization through the re-definition of solutions, showing how medical understandings can be extended by ascribing a healing, health-promoting function to a procedure or substance. I apply this framework to psychotherapy to demonstrate how the practice medicalizes everyday life, specifically by re-defining emotion management and social support as medical, mental health interventions. Finally, in Chapter 6, I discuss how the definitions of mental health used by practitioners have different implications for ignorance management and medicalization. While the aims of these two processes can align, they can also conflict,

resulting in practitioners implementing compromises that partially constrain both ignorance management and medicalization.

1.2 What is Psychotherapy?

The practice of psychotherapy typically centres around the transformation of meaning and selfhood (Avdi and Georgaca 2007:160; Guilfoyle 2002), seeking to alter how the patient acts, feels, and thinks. Mental health practitioners present psychotherapy as a therapeutic, health-promoting interaction between patient and practitioner (e.g., Beck 2011) while critics view the practice as a coercive socio-political enterprise that seeks to produce specific types of citizens (Szasz 1974:213). Although mental health practitioners elucidate the processes involved in psychotherapy, the goals of therapy are less clearly stated (Flick 2021:235). Specifically, the normative ideal of a "mentally healthy person" constructed through psychotherapy is often left implicit, helping the concept avoid evaluation (Sadler 2005:452).

I take a social constructionist approach to mental health and illness (e.g., Conrad 2007; Horwitz 2002), understanding "mental health" as a socially contingent concept open to re-definition across time and place. My analysis uncovers this implicit ideal of "mental health"—as enacted in psychotherapy—thereby enabling a better understanding of its social power and consequences. For instance, previous research has found that our idea of "mental health" exerts a powerful normative influence on our everyday activities, pushing people to orient towards and align their lifestyles with what it means to be a "mentally healthy person" (e.g., Pepping et al. 2016). The influence of this unspoken ideal has grown alongside the practice of psychotherapy over the past several decades in a self-reinforcing loop, whereby the greater importance of health increases the demand

for treatment, while expanding treatment makes health a greater focal point in our everyday lives (e.g., Furedi 2003; Lasch 1979; Wright 2015). A critical examination of how mental health is enacted in psychotherapy is thus needed to better understand this growing social phenomena.

For much of its history, psychotherapy only had a small, elite clientele-base. During the psychoanalysis heyday of the 1950s and '60s, only 2% of Americans reported consulting a psychiatrist or psychologist at any point *in their lives* (Gurin, Veroff, and Feld 1960 as cited in Kadushin 1969:4), with the dominant Freudian approaches primarily appealing to people who were white, wealthy, educated, and Jewish (Kadushin 1969; Scull 2015:324). Since the decline of Freudian approaches in 1980s and '90s (Luhrmann 2000), the practice of psychotherapy has greatly expanded, with recent U.S. data estimating that roughly 10% of the population received psychotherapy *within the past year* (Terlizzi and Norris 2021). This expansion can be partly attributed to numerous concerns of a "mental health crisis" or "epidemic of mental illness" (*cf.* Horwitz and Wakefield 2007; Rose 2018), with several governments implementing programs to improve the accessibility of psychotherapy (e.g., Australia's Better Access Initiative).

Most notably, the United Kingdom has witnessed a large growth in the prevalence of psychotherapy over the past decade thanks to the Improving Access to Psychological Therapies (IAPT) programme implemented in 2008 (Marks 2017; Pickersgill 2019a). This programme provides funding to train more mental health practitioners in psychotherapy and increased the number of public-funded psychological services available (NHS England n.d.). Similar changes have also been implemented in Ontario, the focus of my study. In 2018, the Ontario Provincial Government began piloting the

IAPT-inspired Ontario Structured Psychotherapy Program, extending the Ontario Health Insurance Plan (OHIP) to a select number of private practitioners of psychotherapy (AFHTO 2021). The province also began training more general practitioners and family doctors in psychotherapy (e.g., TeleCBT 2018), designating these non-psychiatrist physicians the title and right to practice as an MD Psychotherapist (MDPAC n.d.).

In Ontario, the *Regulated Health Professions Act, 1991* (RHPA) restricts the practice of the "controlled act of psychotherapy" to six professional colleges: social workers, nurses, occupational therapists, registered psychotherapists, physicians, and psychologists. The "controlled act of psychotherapy" is a subset of the more general "psychotherapy" and can be distinguished according to five elements: 1) it involves the treatment of an individual; 2) it employs a psychotherapy technique; 3) the practitioner and individual have a therapeutic relationship; 4) the individual has a serious mental disorder; and 5) the disorder might seriously impair the individual's judgement, behaviour, or social functioning (CRPO n.d.). Importantly, these legal definitions allow practitioners to use a variety of techniques and theoretical orientations (CNO 2022), making both the controlled and uncontrolled versions of psychotherapy umbrella terms that encompass a heterogeneous set of practices (Marks 2017:6).

1.2.1 Conceptualizing and Enacting Mental Health

Currently, both in Ontario (Hunsley, Ronson, and Cohen 2013) and many Western jurisdictions (Marks 2012), behavioural conditioning and/or sustained talk are the most popular forms of psychotherapy. For instance, psychoanalysis seeks to produce lasting change in the patient's personality by identifying areas of 'resistance'—i.e., oppositional behaviour—and then revealing the underlying, repressed emotional conflicts

(Alexander 1948:275–76). In contrast, cognitive behavioural therapy (CBT) emphasizes the importance of correcting 'cognitive distortions'. For instance, assuming a future situation will produce the worst possible outcome instead of less severe and more probable outcomes (Beck 2011:202). Practitioners hope to alter the patient's distressing emotions and behaviours by altering the patient's dysfunctional interpretations of events as well as the inverse, changing the patient's behavioural patterns to alter their problematic thoughts. CBT shares this approaches with many other prominent types of therapy including Dialectical Behavioral Therapy (DBT), Rational Emotive Behavioral Therapy (REBT), and Acceptance and Commitment Therapy (ACT) (Dimeff and Linehan 2001; Ellis and Dryden 2007; Hayes, Strosahl, and Wilson 2011).

Some aspects of psychotherapy are better articulated than others. Practitioners clearly define the mechanism of action, such as the aforementioned 'resistance' in psychoanalysis and 'cognitive distortions' in CBT. The method of treatment is also explicitly stated and described. CBT frequently employs techniques such as behavioural activation, which involves scheduling and regularly engaging in pleasurable activities (Greenberger and Padesky 2015:201), and thought records, a series of steps through which patients can evaluate their emotions and thoughts to produce less distressing ones (Beck 2011:214–18; Greenberger and Padesky 2015).

By contrast, the goals of treatment are usually vague or unstated (Flick 2021:235; Luhrmann 2000). For example, influential clinical psychologist Judith Beck (2011)—who is also the daughter of CBT founder Aaron Beck—outlines the goal of CBT as "correcting thinking errors" (p. 158). She explains what a "thinking error" is by providing a typology of common errors with examples (ibid:202). However, in her description, it is

not clear how or when a professional can tell that a thinking error has been sufficiently "corrected". Other end goals of Beck's approach are similarly opaque, like whether thoughts should be realistic or optimistic, and what type of thoughts need to be corrected. While pathology is defined, health is not. My project aims to address this uncertainty and uncover how practitioners enact "mental health" in psychotherapy, improving our understanding of this important yet elusive concept.

1.3 Research Questions and Objectives

Practitioners' understandings of mental health in psychotherapy are ambiguous. This thesis examines this ambiguity by asking: How do mental health practitioners enact "mental health" in psychotherapy? I attend to three aspects in particular. 1) The setting of therapeutic goals, i.e., what do practitioners aim for? 2) Intervention techniques, i.e., how do practitioners attempt to realize these aims? And 3) the use of clinical assessments, i.e., how do practitioners judge whether they have successfully realized their aims?

I employed a grounded theory approach (Charmaz 2014) in my interviews with clinical psychologists and MD psychotherapists, analyzing my participants' accounts to better understand how they enact mental health in their day-to-day work (Mol 2002). Grounded theory studies have a specific relationship to existing literature. Following grounded theory protocols, I use "sensitizing concepts" as a loose frame to guide my interviews and analysis, examining my findings in relation to existing theories (Blumer 1986:147–48; Charmaz 2014:30). Further following grounded theory, I do not engage in specific hypothesis testing. Rather, I focus on developing novel analytic concepts that inductively emerge (ibid:31), using my findings to critique and refine prior research.

In the following sections, I detail the literature and theoretical frameworks that guide my project. First, I look at work on medicalization (Conrad 1975; Zola 1972) and diagnosis (Brown 1990; Jutel 2009). Definitions of "health" and "illness" are powerful social tools that facilitate the expansion of medical understandings and professional authority by re-defining previously non-medical problems as medical ones (Foucault 1967; Illich 1976; Szasz 1961). Second, I look at how definitions of health are changing over time, focusing on research on medicalization (Conrad 2007), biomedicalization (Clarke et al. 2010), and the expansion of the life sciences in everyday life (Rose 2007). Due to factors including the pharmaceutical industry, professional interests, and consumer demand, health has increasingly oriented towards optimization and becoming "better than well" (ibid:98). Finally, I look at the ignorance literature, outlining the ignorance management and production strategies professions use to appear in control of the problems they seek to solve (Borup et al. 2006; Proctor and Schiebinger 2008; Whooley 2019).

1.4 Constructing Problems: Expanding Medical and Professional Jurisdictions

Medicalization can be broadly understood as the expansionary process by which "something becomes defined as medical" (Conrad and Slodden 2013:62). Medicalization theory typically examines how non-medical problems come to be re-defined, described, and/or treated as medical problems, bringing an increasing range of everyday life "under medical dominion, influence and supervision" (Zola 1983:295). Regarding mental health, medicalization has typically centered around the pathologization of deviant behaviour (Conrad and Schneider 1992), whereby moral issues are transformed into medical symptoms and diseases (Olafsdottir 2010). For example, in his classic case study, Conrad

(1975) describes how disruptive, delinquent behaviour in children was recast as hyperkinesis (and later attention deficit hyperactivity disorder [ADHD]). Instead of being seen as "bad" children in need of discipline, those labeled with the new disorder were now seen as "sick" children in need of treatment (Conrad and Schneider 1992:145–70).

According to Conrad (2007:5), definition is the key to medicalization. It is through re-definition that physicians, pharmaceutical companies, consumers, and third-party payers influence society's perceptions of problems, resulting in previously non-medical issues being understood as disorders and/or treated with medical interventions (Conrad 2005). Like illness, health is also open to redefinition, allowing conditions previously considered "normal" to be recast as "problematic" and requiring intervention (Barker 2014; Clarke et al. 2003; Conrad 2005). The enactments of mental health and mental illness in psychotherapy play a key role in this definitional process, spreading medical understandings and language to everyday experiences (e.g., Lindholm and Wickström 2020).

Medicalization theory builds on the related concepts of 'professionalization' (Conrad 2007:12; Flick 2021) and 'medical imperialism' (Illich 1976). Whereas medicalization focuses on how aspects of everyday life come to be understood as medical problems, professionalization is concerned with how aspects of everyday life come to be understood as professional problems under "expert control" (Conrad 1975). Through redefinition, issues are framed as complex, requiring the supposedly more capable hands of professionals to be properly managed and/or resolved. This process attempts to establish a professional monopoly that valorizes expert opinion while dismissing lay debate and discussion (Abbott 2014:71–72). In addition to transforming lay problems into

professional ones, professions are also thought to act imperialistically by attempting to expanding and infringe on the jurisdictions of other professions (Abbott 2014; Strong 1979). For example, psychiatry redefined "madness" as a medical problem rather than a spiritual or legal one, positioning physicians as the "appropriate" experts while trying to push clergy members and lawyers aside (Abbott 2014:292–325; Foucault 1967:216–22; Rimke and Hunt 2002).

Definitions of "illness" and "health" sit at the intersection of the sociology of medicine and sociology of professions (e.g., Abbott 2014; Freidson 1988). The application of a medical lens to an issue typically places it within medicine's purview via their claim to a unique expertise regarding medical matters (Rose 2018; Whooley 2013). If successful, this redefinition process grants healthcare professionals sizable jurisdiction over the subsequent framing of the issue, the development of potential solutions, and control over individuals deemed to be "disordered". The concepts of professionalization and medical imperialism provide the context for medicalization, exploring which groups get to create the labels of illness and health, as well as how said group use these labels to claim and maintain professional jurisdiction over new and established problems.

Though medicalization and professionalization often overlap, they can be distinct processes. For instance, people regularly use clinical language and diagnostic labels from the DSM to understand their everyday emotional experiences, describing themselves as anxious, depressed, or OCD [obsessive-compulsive disorder]. Despite adopting this medicalized perspective, these individuals do not often seek out professional help (Bröer and Besseling 2017; Lindholm and Wickström 2020). Emotional problems have thus been redefined as a medical problem (i.e., medicalization) but *not* a professional one (i.e.,

professionalization). Likewise, thanks to the ever-expanding self-help movement, people increasingly incorporate health-promoting medical practices into their daily lives outside the direct supervision of healthcare professionals (Barker 2014; Rimke 2000; Rose 2007:64). Medicalization and professionalization are important concepts, outlining how medical and professional understandings of health and illness spread, often in tandem but not always.

A final area of research connected to the construction of health and illness is the sociology of diagnosis (e.g., Brown 1990; Jutel 2009, 2011; Rosenberg 2002). Diagnosis, both as a label and action, is an incredibly powerful social tool (Rosenberg 2002), warranting its own theoretical framework (Brown 1990; Jutel 2009). Jutel (2009) argues that "medical authority and medicalisation both enable, and are enabled by, diagnosis" (p. 280), pointing out the unspoken importance of diagnosis in earlier work on medicalization and professionalization. For example, Zola (1972) argued that the labels of "healthy" and "ill" are the key rhetorical tools that enable medicalization, allowing medical understandings to be applied to "an ever increasing part of human existence" (p. 487). Freidson (1988) meanwhile argued that "where illness is the ubiquitous label for deviance in an age, the profession that is custodian of the label is ascendent" (p. 244), highlighting the fundamental link between diagnosis and professional authority.

In sum, Jutel's framework further stresses the importance of classification—via specific codified diagnoses and the general label of "illness"—in spreading medical and professional understandings. Diagnosis acts as a boundary between health and illness, allowing the society to categorize "sick patients" from "healthy people". However, this boundary is socially constructed and malleable. Professionals and advocacy groups can

construct new diagnoses or alter existing clinical entities to expand—and sometimes contract—medical understandings, transforming "health" into "illness" and vice versa (Jutel 2009). The construct and enactment of these "health" classification systems have profound impacts on professional organization, society's understandings of issues, and the solutions lay people and professionals use to resolve said issues (Bowker and Star 2000).

1.4.1 Clinical Enactments of Health and Illness

Research from medicalization, professionalization, and the sociology of diagnosis highlights the central role of formal diagnoses in the re-definition of problems at the conceptual level (Showalter 2019). But do formal diagnoses play an equally important role in everyday clinical interactions? Here findings are mixed. Previous studies have argued that mental health professionals are generally ambivalent towards the DSM and its powerful diagnostic framework (e.g., Callard 2014; Chew-Graham et al. 2002; Kokanovic, Bendelow, and Philip 2013; Pickersgill 2014). Psychiatrists report engaging in diagnostic 'workarounds' (Koehne et al. 2013; Whooley 2010), playing fast and loose with diagnostic criteria or even "evading a formal diagnosis" (Brown 1987:40). These studies also report examples where psychiatrists normalize patients' experiences, telling patients that their emotion are a reasonable, non-pathological response and that they are only applying a formal diagnosis to secure treatment access and/or insurance reimbursement (Brown 1987; Chew-Graham et al. 2002; Whooley 2010). Smith (2014) argues that these critiques and workarounds constitute a 'passive resistance' to medicalization, suggesting that diagnosis may not be as powerful a tool for proliferating

medical understandings and professional authority as theorists claim. Or it may be a powerful tool that practitioners are often unwilling to make full use of.

Claims about the DSM's irrelevance to clinical practice have been challenged and may be overstated. Even though practitioners do not place their full support behind the DSM and regularly critique the manual, practitioners continue to use DSM diagnoses with the majority their patients. Rather than working *around* the DSM, practitioners might be best thought of as working *within* the framework (Halpin 2016), albeit with some discontent. Furthermore, though practitioners may attempt to undermine the DSM, these efforts do not undermine the importance of diagnosis itself. According to Pickersgill (2023), practitioners frequently question the specifics of the DSM's diagnostic framework in an effort to produce more refined diagnostic entities, thereby challenging the current iteration of the DSM while simultaneously underscoring the necessity of having a formal classification system to understand mental/emotional problems. The use of diagnostic labels in clinical practice is a contested topic, demonstrating the need for further research to improve our understanding of how of mental health and mental illness are enacted through treatment practices like psychotherapy.

Clear tensions exist between the various theoretical accounts and different empirical studies. My project is well-positioned to examine these issues by bringing a unique perspective. First, previous research has largely focused on psychiatric perspectives and practices, with psychiatrists making up the entire sample (e.g., Brown 1987; Smith 2014; Whooley 2010), or a sizable portion of it (e.g., Halpin 2016; Pickersgill 2019b, 2023). In contrast, my study explores if and how formal diagnoses are used by clinical psychologists and MD psychotherapists. The former professional group

has received some attention in the literature (e.g., Craciun 2018; Flick 2021; Halpin 2016) while the latter has received none at all. Though psychiatrists dominated the provision of mental health treatments in earlier eras (Abbott 2014; Scull 2015; Whooley 2019), the majority of mental health assessments and treatments are now administered by non-psychiatric health professionals (Chew-Graham 2010; Goleman 1985; Rose 2018). The actions and opinions of non-psychiatric practitioners, coming from different professional and theoretical backgrounds, are thus increasingly important to understand.

Second, I restrict my focus to psychotherapy. The studies discussed above (e.g., Brown 1987; Halpin 2016; Smith 2014; Whooley 2010) combined psychotherapy and pharmacotherapy, assuming diagnosis plays the same role in both practices. In contrast to these approaches, Flick (2021) argues that the practice of psychotherapy has a sufficiently distinct set of knowledge and skills to be considered its own profession. This study thus seeks to provide insights and understandings unique to psychotherapy that may be pushed out by pharmacotherapy. Finally, my work focuses not on the application of a medical intervention to a problem (Conrad 2007:5), but on the medical intervention itself. Medicalization theory typically analyzes the social construction of *problems* (Showalter 2019), but does not explore the social construction of *solutions*—i.e., how everyday actions are ascribed medical understandings and healing functions.

In sum, clinical psychologists and MD psychotherapists are not psychiatrists. Psychotherapy is not pharmacotherapy. And solutions are not problems. My project analyzes areas that typically go overlooked in medicalization and professionalization research, arguing that clinical psychologists' and MD psychotherapists' enactments of mental illness in psychotherapy differ from previous research. Specifically, I find that

while DSM categories are used by practitioners, mental illness is predominately treated as a biopsychosocial feedback loop that is less constrained by the specific disorder criteria articulated in the DSM. Furthermore, I argue that through psychotherapy, practitioners medicalize emotion management and social support, re-defining everyday emotional and social actions as medical solutions that should be engaged in under the supervision of mental health professionals.

1.5 The Optimization and Enhancement of Health

The second literature which informs my project is research on how definitions of health are changing over time. Specifically, I look at how patients, health care professionals, and governments increasingly aim to enhance health and promote well-being rather than simply eliminating illness and disease. Biomedicalization theory (Clarke et al. 2003, 2010) builds on medicalization (Conrad 2007), arguing that since the mid-1980s American medicine has been drastically reconstructed. The modern medicalization processes, as described by Conrad (1975), accurately characterized medicine in the United States for the half century or so from the 1940s to the 1990s (Clarke et al. 2010:43-58). However, in the decades since, medicine has undergone gradual but significant postmodern transformations at the organizational, economic, and technoscientific levels. These key changes include the rise of transnational healthcare corporations, direct-to-consumer advertising, managed care, evidence-based medicine, and biostatistics, as well as the reframing of the ideal patient as a responsible, educated, self-advocating consumer.

Clarke and colleagues largely attribute the shift from medicalization to biomedicalization to the explosion of technoscientific developments in medicine and

broader political-economic transformations. These shifts have altered the production, distribution, and consumption of medical information; how bodies and identities are constructed; and how "health" is conceptualized (ibid:xiv-xv). While earlier eras of medicine typically focused on normalization (i.e., managing and eliminating disease), in the era of biomedicalization medical professionals and the public increasingly also strive for "optimization and enhancement" (ibid). For example, testosterone is increasingly administered to middle-aged and elderly men to enhance their "manly" characteristics, by supposedly slowing the aging process and "promot[ing] strength, vitality, and [sexual] potency" (Rothman and Rothman 2004:132). Testosterone replacement therapy targets "physical sub-efficiency" (Conrad 2007:29), showing the shift in focus of treatments from life-*threatening* diseases to life-*limiting* conditions (Clarke et al. 2010:243).

Conrad (2005) proposes a similar theoretical framework to Clarke and colleagues, noting that our definitions of health have been reconstructed, increasingly orientated towards social and biomedical "enhancements". New techniques, drugs, and genetic modifications increasingly commodify health itself instead of illness by seeking to push human capabilities beyond what many see as the "normal" range. However, in contrast to Clarke and colleagues, Conrad argues these changes are an extension of the medicalization process rather than a novel, qualitatively different phenomenon.

Conrad (2007:133-145) connects the shift in how we conceptualize health with the broader professional, commercial, and institutional shifts to medicalization. Physicians and health care professionals still play a key role in medicalization, deciding who has access to the healthcare system through the provision of diagnoses and administration of treatments. However, these professional groups do not have the same

influence over our definitions of health and illness as they did during the "golden age of doctoring" (McKinlay and Marceau 2002). Since the 1980s, medical authority has weakened, both at the level of individual physician autonomy and for the profession as a whole (Starr 2017:511). Conceptualizations of health are increasingly driven by extraprofessional engines, specifically the biotechnology industry, patient-consumers, and the corporatization of medical care (Conrad 2005). The groups facilitate medical expansion through market expansion (Conrad and Leiter 2004), buying and selling a growing number of medical solutions that offer the promise of self-improvement (Conrad 2005, 2007:70–96; Conrad and Potter 2004).

Alongside medicalization and biomedicalization theory, changing definitions of health have been a key focus in research on the construction of the self. Rose (2001, 2007) describes the transformation from wanting to avoid illness to wanting to optimize well-being as a new 'will to health' (ibid:64), a "highly problematic obligation" to be happy and live well (Rose 2018:197). Like Conrad and Clarke, Rose (2007) partially attributes this shift to growing consumer demand spurred on by extensive marketing from the biotechnology industry. Thanks to technoscientific advancements, biology is no longer seen as fixed, now being reformulated as manipulable and improvable (Rose and Novas 2005:5). New potentialities are envisioned and capitalized upon, selling the hope and means of creating a better, healthier self (Novas 2006).

While patient-consumers and corporations play an important role, Rose (2001:17-18) also attributes these changes in our understandings of health to the biopolitical efforts of liberal, democratic governments. The older public hygiene and illness screening movements that entailed heavy government involvement have been replaced by "health

promotion", encouraging individuals to manage and surveil their own health (Armstrong 1995). The production of health is increasingly offloaded from the state on to the individual, making the public largely responsible for their own well-being and quality of life (Rose 2007). Led on by the hope of self-actualization (Rose 2006:147), citizens are encouraged to take an active role, engaging in self-techniques to govern and care for themselves (Rose and Novas 2005:16–17). Governments thus act through a more hands-off manner, using the combination of hope and health to shape the public's moral beliefs about how life should be lived, consequently shaping their behaviour (Rose 1999).

Despite disagreeing about specific causes and precise outcomes, biomedicalization, medicalization, and research on the construction of the self all converge on the twin notions that our conceptualizations of health and goals of medical treatment have changed. According to these bodies of research, patients, governments, and the health care industry increasingly want to expand the boundaries of health, shifting our focus from surviving to thriving.

1.5.1 How is Mental Health Enacted in Psychotherapy?

Building on this work, I explore whether practitioners of psychotherapy display the same focus on optimization that is being observed in other areas of medicine. Psychotherapy presents a useful case for examining the intersection of health, technology, and economics as discussed in biomedicalization (Clarke et al. 2003, 2010), medicalization (Conrad 2007), and the influence of the life sciences on personhood (Rose 2001, 2007). The practice of psychotherapy may diverge from the trend of orienting towards optimization, with practitioners aiming for the older goal of restoring mental health instead of trying to enhance it. I argue there are two main reasons as to why the

practice of psychotherapy may differ: 1) the current lack of biomedical technologies integrated into widespread clinical practice, and 2) financial pressures by governments and insurance companies to reduce costs.

To the first point, psychotherapy exists as a somewhat anachronistic, biopsychosocial treatment in a predominately biomedical era (Clarke et al. 2003, 2010; Pickersgill 2019a). Brain scans, genetics testing, and other biomedical technologies have not been incorporated into regular psychotherapeutic diagnosis or treatment, although there are efforts to change this (Andreasen 1988; Falkai, Schmitt, and Andreasen 2018; Halpin 2022b; Savitz, Rauch, and Drevets 2013). To my knowledge, previous research on enhancement has largely overlooked psychotherapy, instead focusing on other areas of medicine where biomedical interventions and technologies have had more significant impacts on practice (see Clarke et al. 2010; Conrad 2007). Though practitioners of psychotherapy regularly talk about "enhancing" patient agency (Williams and Levitt 2007), emotional awareness (Lane et al. 2022), self-esteem (Shechtman 1993), and other patient outcomes, it is unclear whether their use of "enhancement" is consistent with the use of the term in medical sociology. By "enhance", practitioners may simply mean "to improve", wanting to make the patient well and not "better than well".

The second reason psychotherapy is a useful case for examining the emergence of enhancement-oriented treatments is because economic considerations have shaped and continue to shape the practice (Pickersgill 2019), in turn shaping enactments of mental health and mental illness. Pharmacotherapy is a significantly faster alternative to psychotherapy. Practitioners can increase their income by seeing more patients within the same time frame (Chew-Graham 2010; Smith 2014), while governments and private

insurers can reduce costs by paying for a small number of consultations rather than a large number of therapy sessions (Luhrmann 2000; Maturo 2010). Health care professionals and payers both have a financial incentive to restrict the availability of psychotherapy, striving to manage and maintain cost parity between the two treatment modalities (Conrad 2005).

These financial concerns exert a heavy pressure on psychotherapy, altering the practice in significant ways. Most notable is the decline of Freudian-inspired approaches during the era of biomedicalization (Hayes and Hofmann 2017) and the rise of cognitive-behavioural therapies (Marks 2012). In addition to not adapting well to the new epistemological standards of measurement and quantification (Abbott 2014:205–6; Craciun 2018), Freudian approaches were seen as too inefficient (Whooley 2019:169). Psychoanalysis is a time and financially intensive therapy, necessitating numerous sessions per week over the course of several years (Luhrmann 2000). By comparison, CBT is designed to have a limited time course of twelve sessions or so (Dryden and Still 2018:xi), although in practice treatment can go longer. Some practitioners continue to use Freudian therapies, although even these formerly long-duration approaches are frequently modified to conform to current demands by governments and insurers to reduce costs (Smith 2019:8). For instance, practitioners increasingly use brief psychodynamic therapy designed to last the 8-to-16-week course typical of CBT (Warren 1998).

Given these economic constraints, several scholars (Flick 2021:239; Pickersgill 2019) have questioned whether current approaches to psychotherapy seek to enhance mental health (e.g., Seligman 2011), or simply restore it (e.g., Hofmann et al. 2012). Though the positive psychology movement rife with talk of enhancement has become

influential in public, governmental, and academic spheres (Ahmed 2010; Cabanas and Illouz 2019), its integration into clinical practice is thought to be comparatively muted (Jankowski et al. 2020; Seligman and Peterson 2003). With their shorter, more limited time courses, CBT and brief psychodynamic therapy have far less time to develop the patient's personality, as classic psychoanalysis and humanistic therapy sought to do (Alexander 1948:275; Rogers 1961), and so may opt for less lofty treatment outcomes.

My study provides inductive insights to address these tensions by exploring which understandings of mental health dominate in psychotherapy, and to understand what role, if any, is played by ideas of optimizing health. Specifically, I argue that practitioners enact four definitions of mental health in psychotherapy: 1) restoration, which aims to eliminate symptoms and restore "normal" functioning; 2) enhancement, which aims to optimize the patient's well-being; 3) management, which aims to maintain the gains made in therapy; and 4) stabilization, which aims to stop the patient from getting worse.

1.6 How Professions Produce and Manage Ignorance

The third literature which informs my project is research on the management of ignorance, specifically looking at how ignorance is used by health care professionals. Ignorance is fundamentally tethered to knowledge (Ungar 2008), "knowledge" here referring to thoughts and beliefs about our physical, social, and internal worlds. These beliefs are socially constructed and structured by one's social position (Berger and Luckmann 1966; Merton 1937). Ignorance is generally seen as the flip side of knowledge, representing an absence or limitation of knowledge (Gross 2010:68). Given that knowledge is socially constructed, limitations to knowledge (i.e., ignorance) are

socially constructed as well (Smithson 1985). These limitations, though omnipresent in our lives, remain poorly understood (Proctor and Schiebinger 2008).

Ignorance is typically conceptualized as a complex and multifaceted topic, manifesting in many forms across people, objects, and time (Whooley 2019:218–19). Part of the reason for this complexity is that our attention is selective (Zerubavel 2015), consequently making our construction of knowledge/ignorance selective as well. As Kleinman and Suryanarayanan (2013) argue, "the production of knowledge is always matched by the corresponding production of ignorance". By looking at an object one way we potentially ignore other manners of looking, often creating blind spots where some perspectives are left to languish in ignorance (Proctor and Schiebinger 2008).

Ignorance is an important topic of study because it is a powerful social resource and mechanism of social control (Creager 2021; Owens 2022). Ignorance can be used to motivate, with gaps in knowledge spurring on new investigations to overcome our current ignorance (Berlyne 1954; Loewenstein 1994; Popper 2005[1959]). Ignorance can also be used to mobilize and coordinate social actors, with claims-makers commodifying promises of new knowledge to secure the attention and support of the public, governments, and corporations (Hedgecoe and Martin 2003; van Lente 1993, 2012).

In other situations, ignorance can have the opposite effect, instead being used to mollify and dissuade action. Knowledge producers can manipulate ignorance by controlling the framing of issues, strategically promoting certain questions and ways of knowing while dismissing knowledge created about different issues or through different means (Kleinman and Suryanarayanan 2013). For example, physicians regularly prioritize "evidence-based" knowledge produced randomized controlled trials while

discrediting knowledge produced through patients' own experiences and patient communities (Barker 2008; Whelan 2007). Alternatively, knowledge may be produced and then intentionally suppressed, like the tobacco industry burying their own research that showed a link between tobacco consumption and cancer (McGoey 2014; Pinto 2017). In both instances, unwanted, potentially damaging knowledge can be obscured, lessening or removing the impetus to take action. The status quo is thus maintained, protecting the resources and reputations of select groups (Creager 2021; McGoey 2012).

Professions are intimately familiar with the potential risks and benefits of ignorance, with both professional bodies and individual practitioners understanding the importance of producing and managing ignorance. Ignorance can be unevenly distributed across knowers, with some possessing more ignorance than others (Proctor and Schiebinger 2008). Professions have historically fought to produce and maintain such inequalities of knowledge/ignorance, establishing their jurisdictions by claiming to be comparatively less ignorant about an issue than the public or other professions (Abbott 2014). The socially recognized authority of professions rests upon their claims of possessing a unique specialized knowledge (Whooley and Barker 2021), encouraging professions to zealously guard their trade secrets to ensure the continued existence of their profession (Freidson 1988:338).

Promises of knowledge however create requirements (van Lente 2000), in turn creating vulnerabilities should the promisor not adequately meet expectations (van Lente 2012). Ungar (2008) argues that "role incumbents are expected to have mastered knowledge relevant to their role". In the case of health care professions and professionals, they are expected to be able to identify problems (i.e., diagnosis), predict how the

problem will progress (i.e., prognosis), and offer an effective solution (i.e., treatment) (Wray and Loo 2015). When practitioners and professions are thought to not have delivered on these promises, they are often seen as ignorant (Whooley 2019), potentially losing the trust of patients and the public (Harris 2012; Parsons 1951b; Sztompka 2007).

Given the risks associated with being labeled as "ignorant", professional organizations, institutions, and practitioners engage in a variety of strategies to manage public perceptions and downplay their ignorance (Whooley and Barker 2021). When faulted for not possessing sufficient knowledge about a topic (Ungar 2008), health care professionals may attempt to redirect ignorance away from themselves by blaming the medical condition itself (Timmermans and Buchbinder 2010). The disease and/or treatment at hand may be framed as complex, making the production of knowledge a slow and difficult task (Whooley 2019:219). In such cases, knowledge might be promised in the future, a "mere matter of marching", to offset anxiety created by our abundant ignorance in the present (Brown and Michael 2003). Or the object may be said to be so complex that it is unknowable. New knowledge about the object cannot be produced simply because it exists outside our understanding and methods (Kleinman and Suryanarayanan 2013). This type of ignorance is framed as permanent rather than transient (Whooley 2019:219), while any efforts to reduce it are seen as a fool's errand.

In sum, ignorance is a widespread phenomenon, existing wherever there is knowledge (Smithson 1985). Like knowledge, ignorance is a powerful resource with a wide range of uses and important social consequences, both beneficial and harmful. Ignorance is particularly useful for professions and practitioners, who employ various

ignorance management and production strategies to assert their competence, develop trust, and maintain their professional jurisdictions.

1.6.1 How do Practitioners use Ignorance in Psychotherapy?

In contrast to the studies discussed above, my project examines ignorance management and production at the micro or interactional level. This is not an investigation of how researchers, corporations, professions, regulatory agencies, or advocacy groups use ignorance in the public and scientific arenas to advance their interests. Rather, I look at how practitioners manage and produce ignorance one-on-one with a patient in therapy. Agreeing with previous work (Conrad and Kern 1986; Halfmann 2012; Halpin 2022a), I argue that medicalization manifests differently at the micro/interactional and macro/conceptual levels, and that ignorance management does as well (Whooley and Barker 2021).

Perceptions of ignorance differ according to one's positioning relative to a problem and the fulfillment of expectations, with the individuals closest to an issue being the most likely to be confronted by limitations of knowledge and uncertainty (Borup et al. 2006; MacKenzie 1993). In addition to differences of degree, practitioners also face differences in the kinds of ignorance they encounter. Ignorance can belong to collectivities, reflecting "limitations of current knowledge" (Fox 2013[1957]:208), or it can belong to individuals, reflecting their "incomplete or imperfect mastery of available knowledge" (ibid). Conceptual claims-makers must negotiate the former, collective type of ignorance. Practitioners however must deal with both collective and individual ignorance, evaluating "Do I know enough to treat this case?" and "Does the field know enough to act effectively?" (Light 1979). Unlike the management of conceptual

ignorance about mental health and illness (see Whooley 2019), practitioners of psychotherapy are not arguing about abstract concepts or making far off promises to the masses. Instead, they are promising "tangible" results within 8 to 16 weeks to a specific individual.

Given the different positioning and different pressures, practitioners may consequently view ignorance differently and use different strategies compared to conceptual claims-makers. E.g., how do practitioners win over patients, i.e., the "key actors" (Hedgecoe and Martin 2003) or "necessary allies" (Borup et al. 2006), and mobilize their support? How do practitioners create "tangible improvements" to demonstrate their mastery over mental health and fulfill the patient's expectations for therapy? Do practitioners offload present ignorance onto the future by promising better treatments on the horizon, or do they prefer to deal with ignorance in the here-and-now?

My project investigates these questions by exploring how ignorance is managed at the micro, interactional level in psychotherapy, drawing on interview data with practitioners rather than a content analysis of academic papers (Whooley 2019). Within the ignorance studies literature, interactional ignorance management has been largely overlooked (Whooley and Barker 2021). The topic has received some attention in medical sociology, however much of the focus has been on how physicians manage the uncertainties surrounding diagnosis, not treatment practices (e.g., Pilnick and Zayts 2014; Rafalovich 2005; Timmermans and Buchbinder 2010). Whereas diagnosis promises an explanation, treatment promises an outcome: better health. Littlejohn and Kimport (2017) did look at the prescription of contraceptives as a "treatment", however their focus was restricted to the management of physician and medical ignorance regarding adverse

effects, not treatment effectiveness. This thesis offers a new perspective, connecting ignorance studies to research on how professionals manage medical uncertainty within the patient-practitioner interaction. Furthermore, I focus on how practitioners manage perceptions of treatment effectiveness and "mental health" (i.e., promised outcomes) to make themselves appear competent to secure the patient's trust. Specifically, I explore how practitioners use complexity and uncertainty to set lowered expectations, hoping to reduce later ignorance produced through patient expectation-outcome incongruities.

Understanding how ignorance is managed within the patient-practitioner interaction is needed to further our understanding of the healthcare system and professions. Parsons (1951b) argues that "therapeutic success is not possible unless the patient can be brought to trust his physician" (p. 313). Trust is greatly influenced by patients' belief that the professional is competent (Harris 2012; Sztompka 2007)—i.e., capable of making them "healthy". Ignorance management, alongside definitions of health, thus lie at the heart of health care. According to Parsons (1951b:310-22), due to the comparatively long-lasting and intimate patient-practitioner relationship in psychotherapy, the practice is the clearest demonstration of the prototypical trust-building practices that underlie all health care interactions (Underman 2020). The importance of trust-related concepts like "rapport", "bedside manner", and the "art of medicine" (DiMatteo 1979; Dobkin 2020; Weissmann et al. 2006) are particularly pronounced in psychotherapy, with mental health practitioners and researchers building an immense literature emphasizing the central importance of the "therapeutic alliance" to the practice (e.g., Elvins and Green 2008; Horvath and Luborsky 1993; Leach 2005; Martin, Garske, and Davis 2000).

My examination of psychotherapy is well positioned to provide new insights into the role of trust and ignorance management in health care. Specifically, I argue that at the interactional level practitioners employ a downplay-achieve strategy, contrasting this approach against the ignorance management strategies used by mental health professionals at the conceptual level (Whooley 2019). Practitioners encourage patients to adopt comparatively less ambitious definitions of mental health, thereby setting patients' expectations of therapy low. Practitioners then draw on a wide range of interventions in an effort to achieve these goals and fulfill their promises, decreasing the likelihood of the practitioner appearing ignorant and the patient terminating therapy prematurely.

1.7 Conclusion

Psychotherapy is a growing practice, with both governments and members of the public increasingly positioning the practice as a solution to mental health problems. Despite the rising popularity of the practice, practitioners' aims are not clearly articulated and the ways they enact mental health remain poorly understood. This thesis employs a grounded theory approach to addresses these issues, focusing on three main topics. First, my research is "sensitized" (Blumer 1986:147–48; Charmaz 2014:30) by research on medicalization (Conrad 1975), medical imperialism (Illich 1976), and diagnosis (Brown 1990; Jutel 2009), looking at how practitioners expand medical understandings and professional jurisdictions through the re-definition of solutions in addition to the re-definition of problems. Second, I consider work on medicalization (Conrad 2007), biomedicalization (Clarke et al. 2010), and the role of the life sciences on the construction of the self (Rose 2007), examining the extent to which practitioners aim to enhance patients and make them "better than well". Third, I look at research on ignorance

(Gross 2010; Proctor and Schiebinger 2008; Smithson 1985), expectations (Borup et al. 2006; Brown and Michael 2003; van Lente 2000, 2012), and professions' use of ignorance (Whooley 2019; Whooley and Barker 2021), exploring the strategies practitioners employ in therapy sessions to manage their ignorance and retain the trust of patients.

In the following chapter I provide a more in-depth explanation of grounded theory, explaining how this methodological approach informed my data collection and analysis.

Chapter 2

Data Collection and Methodology

In this chapter I outline and explain my approach to data collection and analysis. I begin by describing my sample, recruitment process, and how I recorded data. I then go through my interview guide and the major topics of inquiry. I justify my use of semi-structured interviews, with this more flexible approach facilitating my exploration of how practitioners understand and enact "mental health". Afterwards, I provide a rationale for my sample of medical psychotherapists and clinical psychologists. Sampling across these two professions, their wide range of mental disorders, and different schools of therapy provided variation that facilitated the development of theoretical concepts. Finally, I provide a brief overview of grounded theory and explain how I integrated this approach into my data analysis and coding processes. Throughout the chapter I engage with the strengths and limitations of my methodological choices, exploring their implications for this project and the conclusions I make in Chapters 3 through 6.

2.1 Overview of Methods, Recruitment, and Sample

I conducted 15 in-depth, semi-structured interviews with eight MD psychotherapists (MDs) and seven clinical psychologists (CPs) from Ontario. This sample size was selected as it provided the opportunity to engage in the iterative data collection process that characterizes grounded theory, allowing me to collect data, form analytic categories based on said data, and then test the accuracy of these categories through further data collection (Charmaz 2014:15). This sample size thus enables

theoretical abstraction while balancing both the time constraints a master's thesis project and the challenges of recruiting from difficult to access professional groups.

The interviews lasted between 30 and 60 minutes. Interviews were digitally recorded using Audacity. Interviews were transcribed using A.I. transcription (Otter.ai) and then manually verified through accuracy checking. Transcripts were complemented by memos I wrote during and shortly after the interviews, where I recorded my initial response to the conversations and key takeaways (Charmaz 2014). Four interviews (one MD and three CPs) were conducted in-person at the practitioners' office, while the remaining 11 (seven MDs and four CPs) were conducted online via Microsoft Teams. Eleven practitioners (four MDs and all seven CPs) worked in or around the National Capital Region—where I was located—and were given the choice of conducting the interview in-person or online. The other four practitioners (all MDs) came from a variety of urban and rural regions in Southern Ontario and so all five interviews were conducted via Teams.

Thirteen participants were recruited through 'network sampling' (Heckathorn and Cameron 2017), contacting these participants through their social networks. I had pre-existing personal and/or professional relationships with five participants (two MDs and three CPs), all in the National Capital Region. These practitioners passed on my contact information and connected me to an additional eight participants (six MDs and two CPs). I also sent out a general call for participants through the Ottawa Academy of Psychology, an association of clinical psychologists in the Ottawa area. An email containing a short description of the study and my contact information was sent to all members on the Ottawa Academy of Psychology email list, however this recruitment effort received no

responses. I then "cold called" six CPs (three women and three men) in the National Capital Region whose contact information I found online when looking for psychologists in the Ottawa area. I sent these CPs an email inviting them to participate in my study, providing a short description of the study and my contact information. Of the six, two (both men) agreed to participate while another forwarded my message on to other practitioners in their office, although I did not receive any further interest from this office.

Regarding sample demographics, 11 practitioners were women (eight MDs and 3 CPs), and four were men (all CPs). Fourteen practitioners were white—one of whom was Jewish and predominately worked with Jewish patients—and one was East Asian. Thirteen practitioners (seven MDs and six CPs) were anglophone and two (one MD and one CP) were francophone, although both of their practices were bilingual. Practitioners varied greatly in terms of years of experience. Two MDs I interviewed had only been in independent practice for a little over six moths—one had previously worked as an emergency physician for 12 years and the other had experience working as a family doctor. The least experienced CP meanwhile had only been in independent practice for around two years. Several MDs and CPs were at the opposite end of their careers, having practiced psychotherapy for nearly three decades or more. One practitioner I spoke with was even in the process of winding down their practice in preparation for retirement. In terms of theoretical orientation, cognitive-behavioural therapy (CBT) was the most well-represented school of therapy by a significant margin, with nine practitioners (six MDs and three CPs) primarily employing or identifying with a cognitive-behavioural approach. Two CPs identified as emotion-focused therapists (EFT), one CP with ego state

therapy (a branch of psychodynamic therapy), one CP with existentialist therapy, one MD with family systems therapy, and one MD with interpersonal therapy (IPT).

Pseudonyms are used with the data to protect the anonymity of the participants, while potentially identifying information has been removed. This study was granted ethics approval by the Dalhousie Research Ethics Board (#2022-6317).

2.2 Focus of the Interviews

The interview schedule was largely the same for both CPs and MDs, with minor wording changes to match the practitioner's background (see Appendix A for the initial interview schedule and Appendix B for the version in use at study completion). At the start of each interview, I reminded practitioners to respect patient anonymity at all times during the interview and informed them that they could refuse to answer any questions or discuss any topics they were not comfortable with. In accordance with their comfort level, some practitioners choose to remain more abstract to not disclose specific details about their patients. However, the majority were forthcoming, outlining the actual exposure hierarchies, thought records, etc. they had used with the patient, making sure to not disclose the patient's name or other identifiable information.

I began the interview by asking practitioners to walk me through a recent case of theirs to get a better idea of their day-to-day work. As recommended by Weiss (1995), I asked practitioners to provide concrete and specific examples where possible, rather than generalized, abstract answers. Here practitioners typically began with a general introduction, telling me about the patient populations they work with (e.g., adult, child, teen), the types of problems and disorders they usually see (e.g., anxiety, depression, PTSD), and the school(s) of therapy they use (e.g., CBT, ACT, EFT). Practitioners and I

then focused in on a patient or two, with practitioners describing the specific issues and techniques that characterised that treatment effort. For example, Joyce, a clinical psychologist, recounted her use of exposure therapy—consisting of psychoeducation, an exposure ladder, and modelling appropriate reactions to feared stimuli—to help a child patient overcome a phobia of extreme weather events that was stopping the child from going outside anytime the sky was overcast.

The first 20 to 30 minutes of the interviews were spent going through these specific case studies. My questions during this section typically focused on four topics. First, I often sought to elicit a more precise explanation of therapeutic techniques to obtain a better idea of what these techniques actually look like in practice (e.g., “I’m not really familiar with [technique]. Can you walk me through it?”). Second, I inquired about the specific goals or desire outcomes practitioners set with the patient (e.g., “Do you remember any of the specific goals this patient had?”). Third, I asked about the metrics and methods they used to monitor treatment progress (e.g., “What kind of tips you off to that [change or outcome]? Is that just like a general feeling you get?”). And fourth, I sought to better understand how practitioners adjust their treatment plans in response to changes in the patient's condition (e.g., “How did you shift your approach towards the end of therapy once the patient started to improve [in a certain area]?”).

The final section of the interviews typically lasted 10 to 15 minutes and was centred around more abstract topics. Here, I asked practitioners how they defined and conceptualized “mental health”. Practitioners could define it in relation to their own life or their patients’ lives, as the opposite of mental illness or a separate concept altogether—whatever they saw fit. I prompted practitioners if they responded with generic terms like

"well-being" or "resilience", asking them to clarify what exactly these concepts look like in practice. I then asked participants how they thought their definition of mental health compared to that of other mental health professionals, looking to identify what they believed to be shared themes central to mental health, as well as what elements of mental health they believed to be more distinctive and overlooked. Finally, I usually ended the interviews by opening the floor to practitioners, asking them if there were any topics they would like to discuss more in-depth, or perhaps a topic they would like to bring up that we did not cover. Issues mentioned by practitioners were diverse and included criticism of the DSM, certain schools of psychotherapy, manualized approaches to psychotherapy, the harms of pharmacotherapy, the lack of availability of psychotherapy, the pathologization of normal emotions, and discrimination against religious patients.

2.3 Interviews as a Choice of Method

The central goal of this study is to examine how practitioners of psychotherapy enact "mental health". I focus on the perspectives of mental health practitioners because their understandings and opinions are highly consequential. The practices and definitions practitioners endorse have important social ramifications, shaping public understandings of mental health (Wright 2020), of mental illness (Armstrong 1980; Canguilhem 1978:149), and exerting a normative influence on the everyday activities people engage in to better align with the ideal of a "mentally healthy person" (e.g., Dlugonski, Joyce, and Motl 2012). Furthermore, psychotherapy is a growing industry (Pickersgill 2019a; Terlizzi and Norris 2021), meaning the influence of practitioners might increase for the foreseeable future. A critical examination of practitioners' enactments of "mental health" and psychotherapy is thus important and timely.

I use semi-structured interviews as a method of data collection because qualitative interviews aim to understand the "observations of others" (Weiss 1995:1), giving the researcher the opportunity to understand the perspective or life-world of the participant (Kvale 1996). Human attention and memory are selective (e.g., Proctor and Schiebinger 2008; Zerubavel 2015). Practitioners' retellings of the cases they have worked on is constrained by the events and aspects of the environment that they attend to, encode, and retain. Though many of the intricacies of past actions and interactions are lost thanks to these biases (Alshenqeeti 2014), what remains can be incredibly revealing, highlighting the goals, activities, and outcomes practitioners believe are worth attending to and remembering. Rather than observing therapy sessions and imposing my own judgements, interviews help me listen to what practitioners *themselves* think is important, telling the story of mental health and psychotherapy in their own words and voices (Berg 2007:96).

Another advantage of qualitative interviewing lies in the type of data that is produced. Interview data tends to be more rich in detail and naturalistic compared to data produced through quantitative, experimental methods (e.g., Alshenqeeti 2014; Rubin and Rubin 2011), addressing some of the shortcomings of past investigations into practitioners' understandings of mental health (e.g., Broverman et al. 1970; Phillips and Gilroy 1985). Interviews thus increase practitioners' influence over my inquiry and data, helping me better explore how practitioners understand 1) mental health and mental illness, 2) the purpose and aims of psychotherapy, and 3) the techniques they use.

I employed semi-structured interviewing because this approach gave me and my participants greater flexibility (Gubrium and Holstein 2002). By having a general schedule to guide the interview, I was able to direct the conversation to specific topics

relevant to the aim of my study, ensuring I could collect relevant data (Berg 2007:39). For example, I could focus our conversations more on treatment instead of discussing diagnosis (e.g., Whooley 2010). At the same time, this approach allowed practitioners and me to pursue topics that emerged over the course of the interview (Rubin and Rubin 2011:88). For instance, interviews with emotion-focused therapists were able to focus more on the importance of social relationships while interviews with cognitive-behaviour therapists might focus more on the importance of thought records.

My use of semi-structured interviews also gave practitioners greater leeway to guide the conversation, helping the data reflect their experiences and knowledge rather than my pre-existing assumptions (Charmaz 2014:56–57). The most prominent example of this was practitioners' problematization of happiness and normalization of anxiety. This was a recurring theme that practitioners were passionate about and would discuss at length. Given the sociological literatures on our changing definitions of mental health (e.g., Clarke et al. 2010; Conrad 2007; Rose 2007) and the medicalization of everyday emotions (Horwitz and Wakefield 2007, 2012; Rose 2018), this was not an area of inquiry I anticipated when initially designing my interview guide. However, the flexibility of semi-structured interviews gave practitioners the opportunity to challenge my assumptions and better organize the discussion around topics they ascribed central importance to. In sum, I chose to employ semi-structured interviews as this methodology provided many advantages in helping me understand how practitioners themselves conceptualize and enact "mental health" in psychotherapy.

2.4 Choice of Sample

I sampled CPs and MDs to contrast how mental health is enacted across and within two disciplinary groups that practice psychotherapy. The health professions are not a unified, monolithic entity (Mol 2002:3–4), nor are their understandings of disease. Professional views of disease are shaped by professional practices (Foucault 1975). Consequently, the divergence of practices across and within professional groups can cause enactments of disease to diverge (Mol 2002:46–47). Given this variability in understandings of disease, enactments of mental health may vary with professional groups and their corresponding clinical practices. By speaking with both CPs and MDs, I was able to investigate variation and similarity in understandings of mental health across these professional backgrounds and training (i.e., medicine and psychology).

The inclusion of MDs in my sample provided additional unique lines of investigation. First, MD psychotherapy represents an emerging, non-psychiatrist perspective on mental health that also originates from medicine. Obtaining non-psychiatric understandings of mental health is important as primary care physicians are frequently people's first point of contact with mental health services. These physicians are currently involved in or responsible for the majority of mental health treatment (Chew-Graham 2010; Frances 2013:101–3). MD psychotherapy is primarily composed of physicians who have worked as primary care physicians (MDPAC n.d.), so the inclusion of this professional group has the added utility of providing insights into how primary care physicians think about mental health.

Second, MD psychotherapy is a comparatively newer professional group than clinical psychology (Baker and Benjamin Jr. 2000), only gaining recognition from the

Ontario Medical Association in 1996 (MDPAC n.d.). MD psychotherapy presents a unique perspective that has been overlooked by previous sociological research that predominantly focuses on psychiatrists (e.g., Abbott 2014; Brown 1987; Luhrmann 2000; Smith 2014; Whooley 2010, 2019). MDs might construct a distinct definition of mental health in an attempt to distinguish themselves from other groups that practice psychotherapy (Abbott 2014:81–83). Or, if MDs and CPs have similar orientations, this might evidence broader, systemic mechanisms that are shaping definitions of health. In sum, the inclusion of this profession in my sample offered many potential benefits.

I chose to include CPs in my sample because like MDs they represent a growing non-psychiatric perspective on mental health. Clinical psychology formally emerged in the wake of World War II (Baker and Benjamin Jr. 2000), and so represents a much more established professional group than the comparatively inchoate specialty of MD psychotherapy. Like MD psychotherapists, CPs are one of the few professional groups that both only practice psychotherapy and have the legal power of diagnosis in Ontario. Though MD psychotherapists can legally prescribe, the ones I spoke to did not, preferring to leave the management of medications to psychiatrists and/or family doctors (Jackson et al. 2014). These professional similarities and differences make clinical psychology an interesting contrast for MD psychotherapy. Second, I was previously a graduate student in clinical psychology and am well acquainted with the field. This background facilitated my integration into the world of my CP participants, enabling me to speak with them as novice or student rather than an outsider. It also accelerated the recruitment process.

In many respects my sample is a ‘convenience sample’ (e.g., Etikan 2016), selecting participants based on their availability and accessibility. That said, I made a

conscious effort to engage in 'theoretical sampling' as recommended in grounded theory (Charmaz 2014). In contrast to probabilistic sampling which seeks to generalize findings by obtaining a representative sample, theoretical sampling selects participants with the aim of further developing and refining analytical categories (ibid:192).

A key element of theoretical sampling is "discovering variation" (ibid: 207), looking for "negative cases" and "puzzling findings" (ibid:198-201) that could challenge and flesh out my emerging theoretical framework. Searching for variation also helps improve the credibility of my findings, with the inclusion of diverse conditions increasing the scope and generality of my framework (Charmaz and Thornberg 2021; Glaser and Strauss 1967). Two key themes which emerged after analyzing my first five interviews was the therapeutic pluralism that appeared to characterize both practitioners' 1) methods of intervention and 2) understandings of mental health. To this end, I contacted practitioners who worked with different disorders and/or had different theoretical backgrounds, hoping that these differences in methods and diagnosis would grant me further theoretical insights into practitioners' enactments of mental health.

My sample covered practitioners who worked with a wide range of DSM-5-TR disorders, including major depressive (MDD), generalized anxiety (GAD), obsessive compulsive (OCD), binge eating (BED), dissociative identity (DID), adjustment, post-traumatic stress (PTSD), borderline personality (BPD), and specific phobia. Common comorbid problems like substance use, work-related burnout, abuse/interpersonal violence, and suicide were also regularly discussed. Practitioners meanwhile represented a diverse range of therapies, notably cognitive behavioural (CBT), acceptance and

commitment (ACT), dialectical behavioural (DBT), interpersonal (IPT), emotion-focused (EFT), family systems, and ego-state (a form of psychodynamic therapy).

Importantly, many practitioners identified as being fully or partially "eclectic" or "integrative", incorporating techniques from different schools of therapy into their treatment approach. I thus also sought to speak both with practitioners who were highly eclectic and practitioners who instead tended to stick to a single school of therapy. In sum, I examined a variety of therapies for a variety of disorders. This approach enabled me to better understand how flexible practitioners' conceptualizations and enactments of mental health in psychotherapy are, and how practitioners can use this flexibility to benefit themselves—as individual clinicians—and their profession.

2.5 Grounded Theory: Coding and Analysis

I analyzed my data using grounded theory (Charmaz 2014), a systematic yet flexible inductive method for data collection and analysis. Originally formulated by Glaser and Strauss (1967), grounded theory is rooted in symbolic interactionism (e.g., Blumer 1986), assuming that reality is constructed through interactions and that people are reflexive, active agents (Charmaz 2014:9). This approach was further influenced by social constructionism (e.g., Berger and Luckmann 1966), emphasizing the subjectivity of both participants and the researcher (Charmaz 2000, 2014:13–14).

Grounded theory uses an iterative approach, where data is collected and analyzed simultaneously, allowing me to adapt my lines of inquiry to test the accuracy of emergent themes in future data. I conducted batches of two to three interviews, transcribing and coding them before integrating this information into my ongoing theorizing. I would also

refine and focus my codes with each transcript, using 80 unique codes on the first transcript down to around 40 unique codes per transcript on the final five transcripts.

As recommended by Charmaz (2014:113), I began with an initial detailed coding. Using NVivo, I went through my data line-by-line to note the processes, events, and meanings that participants discussed. This initial effort produced 155 codes, e.g., "attitude towards self", "avoidance of distress", "interrupting feedback loop", "motivation/willpower". I then went through a second round of 'selective coding', amalgamating the codes based on key, shared themes in *focused codes* (Charmaz and Thornberg 2021). For instance, my codes "physiological awareness", "memory", and "internal monitoring" became one group called "introspection", while "client as own therapist", "maintenance of gains", and "resilience" became "management model of health". After the second round, I was left with 40 unique focused codes.

Finally, I identified clusters by attending to the relations between focused codes (Charmaz and Thornberg 2021), particularly looking for groups of three to five focused codes that displayed high interconnectivity. For instance, I connected the "stabilization", "harmful coping skills", "crisis", and "regression" focused codes together as a cluster of co-occurring and overlapping themes. I constructed clusters based on my usage of codes and language (Wittgenstein 1953). Specifically, I went through my coding looking for codes that commonly overlapped (i.e., two or more codes applied to the same utterance) or appeared in succession (i.e., two or more codes frequently preceding or succeeding each other). I then plotted these connections and clusters through 'diagramming' (Charmaz 2014:221–23; Clarke and Friese 2007) to visualize and advance my analytical framework. I based my diagrams on graph theory given my previous experience using the

approach to analyze social networks (e.g., Barnes and Harary 1983) and brain connectivity (e.g., Farahani, Karwowski, and Lighthall 2019). In my approach, focused codes acted as nodes while the co-occurrence of codes was used to generate edges (see Appendix D for simplified example diagram). I use these clusters as the basis for my analyses presented in Chapters 3 to 6.

2.6 Conclusion

I conducted 15 semi-structured interviews with clinical psychologists and MD psychotherapists practicing in Ontario. These interviews covered a wide range of therapeutic schools and mental disorders. I employed grounded theory to guide my data collection and analysis processes. My choice of sample, data collection method, and analytical framework carry strengths but also limitations. In the upcoming chapters (Chapter 3 to Chapter 6), I present my findings, showing how they advance sociological theory and our understanding of psychotherapy.

Chapter 3

Health and Optimization: The Many Faces of Mental Health

In this chapter I explore how practitioners "do mental health", focusing on how practitioners attempt to produce changes in the patient's condition and evaluate when change has been successfully achieved. I look at the varied interventions and criteria practitioners use, arguing that practitioners do not have a single, rigid enactment of mental health. Rather, practitioners enacted four definitions: 1) restoration, 2) enhancement, 3) management, and 4) stabilization. I argue that practitioners take an instrumentalist approach, switching between different definitions of mental health over the course of therapy to ensure that patients believe that therapy is on track to achieve its intended goals, a topic I explore more fully in Chapter 4.

I go through the four models of mental health practitioners use in psychotherapy. I begin with the restoration model, which aims to eliminate the patient's symptoms and restore "normal" functioning. I present theoretical understandings of this model and contrast them with practitioners' understandings. I then draw on Fromm (1941) to highlight how practitioners can both act as agents of social control (Parsons 1951b:247; Szasz 1961) and actively encourage deviance (Goffman 1961). Second, I outline the enhancement model, which aims to optimize the patient's well-being, again contrasting theoretical and practical understandings. Though themes of optimization and enhancement appear in therapy, practitioners were outwardly against this aim, positioning distress as an unavoidable part of life. Third, I explain the management model, which aims to maintain the gains made in therapy. Here practitioners add a temporal dimension to mental health, focusing on the patient's susceptibility to imagined future symptoms

and possible recurrences of mental illness. Finally, I introduce a new concept: the stabilization model. The stabilization model attempts to stop the current situation from further deteriorating and is used widely in health care. I finish this chapter by looking at how practitioners employ this model in therapy.

3.1 Restoration and the Negative Model

For many practitioners, the aim of psychotherapy is to resolve the patient's mental illness. But how do practitioners know when they have successfully realized this aim? One set of outcomes practitioners use to orient themselves is the restorative model of mental health—also known as the negative, medical, or traditional model—which sees "health" as the absence of symptoms (e.g., Bichat 1801; Comte 1858; Freidson 1988:246). This approach equates mental health with restoring patients to normality, "normal" here having two potential meanings. First, "normal" can be defined from the 'standpoint of society', referring to the individual's ability to "fulfill the social role he is to take in that given society" (Fromm 1941:159). Second, we can view health or normality as the well-being of the individual (ibid). Rather than judging "normal" in reference to conformity to societal norms, this second perspective judges "normal" from the 'standpoint of the individual', emphasizing the patient's sense of self and individuality. In the following sections, I explore how practitioners employ both understandings of normality in psychotherapy. I begin by outlining how practitioners emphasize the restoration of societal norms, before discussing the restoration of individual norms to help patients "get back to the way they were" (Sasha, MD). I conclude by showing how practitioners value both perspectives, seeing both individual and societal normality as integral to mental health.

Under Fromm's first understanding of normality—from the standpoint of society—health care acts as a mechanism of social control. Practitioners understand health as the condition in which the patient is able to successfully fulfill their previous social roles and conform to broader normative expectations (Owen 1993; Parsons 1951a; Szasz 1974), thereby "participat[ing] in the reproduction of society" (Fromm 1941:159) and contribution to the stability of the social system.

Practitioners regularly enact this understanding of mental health, striving to help patients return to normality by "reclaim[ing] their lives and functioning" (Dorianne, CP). In psychotherapy, practitioners largely focus on three domains of functioning: "day-to-day, socially, [and] occupationally" (Julie, MD). Of the three domains, daily functioning appears to play the most central role in psychotherapy, acting as a key metric of success. "Metric" is the operant word here, as practitioners' understandings of daily functioning is deeply intertwined with their use of scales—both subjective and standardized—that operationalize mental health as an alleviation of subjective distress and reduction in the severity of symptoms:

> They'll have a lowered distress. So often using the subjective units of distress scale [SUDS], 0 to 10 scale. And they're reporting less activation, thinking about this particular thought or belief that is problematic for them… So throughout, from phase one on, the subjective units of distress scale is a constant I measure, have them report on that. Sometimes in session as we're doing the cognitive work they'll report that. I also have them describe their mood every beginning of the session, I asked them to rate the average mood 0 to 10 in the past week. And so throughout I do that. I also have some questionnaires that I've had them fill out throughout therapy, the Post Traumatic Stress Disorder Checklist-Five (PCL-5) is one instrument that we use. And the patient health questionnaire (PHQ-9). And the WHODAS 2.0 [World Health Organization Disability Assessment Schedule]. (Dorianne, CP)

"Quick and dirty" (Peyton, MD) subjective measures—divorced from categorical DSM diagnoses—are regularly employed by all participants, providing practitioners with real-time feedback to ascertain whether the current treatment approach is working. Patients are asked to make a holistic and *quantitative* assessment of their mental health, reducing their current circumstances and sensations to a single, easily digestible number (Armstrong 2011; Armstrong et al. 2007; Maturo, Moretti, and Mori 2016).

Standardized, "objective" measures also ask patients to quantify their feelings, thoughts, and actions, however, through a more comprehensive evaluation. Clinical scales might assess specific DSM-5-TR disorders, e.g., the PHQ-9 measures symptoms of MDD while the PCL-5 assess symptoms of PTSD. Alternatively, these scales might look at specific areas of functioning. For instance, the activities of daily living [ADLs], e.g., "Are they showering? Brushing their teeth? Are they eating?", and the instrumental activities of daily living [IADLs], e.g., "Are they able to go to the bank?" (Julie, MD). These scales are both qualitative and quantitative. For instance, the PHQ-9 scores patients along a continuum from 0 to 29 while also using categorical cut-offs, e.g., 0 to 4 is the normal, non-clinical average (Kocalevent, Hinz, and Brähler 2013), 5 to 9 is mild depression, 10 to 14 is moderate depression, and so on.

Through these scales, practitioners' case conceptualizations draw on DSM criteria while also incorporating external frameworks, producing a much more expansive understanding of health and illness. Through subjective and standardized metrics, practitioners understand mental heath as a condition of 1) minimal emotional distress, 2) the capacity to engage in self-care, and 3) the ability to perform tasks at the level of a competent, independent adult. Only once the patient can sufficiently "self-regulate" in

these three respects will the practitioner view the patient as restored or "rehabilitated" (Goffman 1961:71).

Occupational functioning is another common goal in therapy, especially when attending therapy is mandated by the patient's insurance. Success here is operationalized through concrete actions, specifically, the patient's ability to get back to work—or school—and reliably perform necessary occupational roles:

> So I had a 20 something year old patient who works as a nurse in the neonatal intensive care unit at one of the major [town] hospitals. And she is off work, completely off work, felt to be due to stress leave from work… And then the next week, we asked, "What do you miss most about work?". She said, "My friends, my colleagues there, I really miss them. We would always have breaks and coffee". And I said, "What about maybe meeting them for coffee in the lobby of the hospital during their break? Do you think you could do that? Because then you'd have to go in the door of that hospital". And so that worked. That actually worked. And then I said, "Well how about the next week go for coffee in your guys' lounge, the nurses' lounge. Which is right where you work". And then actually what happened is she realized she loved it there because she could see all the babies she was working with on all this. She actually could totally separate that terror that she had from work. Like, immediately. It was very obvious that this was not the source of her fear, or her anxiety or anything. So then I said, well, how about you try a four hour shift? Can you get permission to do that? And I actually called her family doctor and I said, "I'm going to try to get her back to work. I know, you took her off. But let's just see if we can try her back to work". And it worked very well. We got her to eight-hour shifts, and then immediately because of the nurses shortage, they were booking her really, really heavily. And that's when another problem showed up. She would actually become sick, either with PMS or with something, and it would always be something. And she would fail on, I would say, 20% of her shifts. (Tracey, MD)

Treatment goals for this patient centred around their occupational functioning, with a partial return to work indicating therapeutic success while missing shifts indicated regression. Practitioners also understand work as an important part of mental health, offering patients a potential source of meaning, pleasure, self-esteem/mastery, and socialization. Work is thought to provide structure to patients' lives, interrupting the

cycle of avoidance and "cocooning" (Dorianne, CP) by getting the patient out of the house, as well as stopping patients from "navel gazing" (Peyton, MD) that can trigger the cycle of rumination. This is not to say all types of work are promoted uncritically. Practitioners do encourage patients to leave their jobs in some circumstances, however it is with the expectation that the patient will find another meaningful activity—paid or volunteer—to occupy their time.

Occupational functioning is where the influence and constrains of external agents and institutions can most readily be observed. Practitioners act as 'street-level bureaucrats' (Lipsky 1976), implementing policies of the public Ontario Disability Support Program [ODSP] and private insurance—typically offered through the patient's employer—that aim to return patients to work (Wynne and McAnaney 2004). Alongside governments and insurance companies, the issue of disability brings practitioners in to contact, and sometimes conflict, with other healthcare professionals like primary care physicians. For example, Tracey's patient was on ODSP and so efforts to return the patient to work had to be negotiated with the patient's family physician who had placed them on ODSP. Ultimately, practitioners' valorization of occupational functioning as a central component of "mental health" is, in part, a reflection of these agents and institutions. Practitioners directly impose this work-focused enactment of mental health on patients through psychotherapy, while institutions impose it indirectly by dictating the conditions that constrain the financial resources available to patients and practitioners.

Social functioning is a third area of focus. When queried about how they understood mental health, almost every practitioner stated that having social relations was an important goal in itself. Humans are understood as social animals, having an innate

need to socialize and connect (e.g., Aristotle 1813; Maslow 1943). This need to connect with somebody is so central to our well-being that that "somebody could include a dog… it doesn't always have to be a human" (Marie-Pierre, CP). Establishing good relationships is of paramount importance. According to practitioners, patients share this view, often coming to therapy in search of bettering or repairing social relations with family, close friends, and valued others:

> His obsessions were all about that he might miss something important to do with his house, that there would be a disaster in his house. So it would be things like missing that the roof was leaking, or missing the left water running… And then his compulsions were things like checking the attic again and again for water damage, hours would be taken up with this check. Or checking to make sure water wasn't running, all those sorts of things. Or going into his children's room and organizing their closets or organizing books in their room to very specific specifications… His relationship was strained with his wife. He was afraid he was exposing his children to just the distress of the whole thing. So it really gotten out of hand in that sense. (Eugene, CP)

In everyday interactions, family and friends are distressed by the patient's dysfunction and violation of social norms, positioning the patient as deviant. Patients may come agree with this evaluation and believe that their situation has "gotten out of hand", providing an impetus to enter and complete therapy. Alternatively, valued others may coerce the patient into therapy, forcing their transformation from civilian to patient (Goffman 1961:136). Employers may threaten to fire patients unless the patient agrees to enter therapy. Spouses may threaten to leave and take the children. Friends may threaten to cut-off contact. Interested parties invoke the patient's responsibility to not threaten the well-being of those around them through their disordered behaviour, ultimately pressuring the individual into treatment (ibid:141).

Practitioners here aim to restore social functioning, working on relationships directly through social skills training or offering couples counselling. But many of the other therapeutic techniques practitioners are trained in are internal and self-focused. Practitioners must then sell patients on this type of work, presenting it as "a U-turn. So turning inward… you do a little bit of work inside, and then that often will help in terms of coming back out again" (Bethany, MD). Through this rhetoric, the internal world of thoughts and emotions is wedded to the external world of interpersonal relations.

In sum, practitioners often aim to transform the patient into a "normal" and "functional" person, who is able to "to form and maintain affectionate relationships with others, to perform in the social roles usually played in their culture… as well as manage other emotions such as sadness" (Joanie, MD, quoting Bhugra, Till, and Sartorius 2013). Mentally healthy people find and keep jobs, make and maintain relationships, take care of themselves and their households, and can regulate their concentration and mood. When the restoration of role functioning is emphasized, psychotherapy can act as a mechanism of social control, returning deviant people to functional positions within society (Goffman 1961; Parsons 1951b).

3.1.1 Normality According to Whom?

Alongside the societal view of restoration that emphasizes functioning, practitioners also seek to restore "normality" as viewed from the from the standpoint of the individual (Fromm 1941:159). When patients start therapy, practitioners typically try to understand "what kind of person do they [the patient] want to be? And what did they do that violated their own perceptions of themselves? … How do you live up to those values in life?" (Roderick, CP). Illness here is seen as a 'biographical disruption' (Bury

1982), 'loss of self' (Charmaz 1983), or 'frustration of expectancies of [one's] normal life pattern' (Parsons 1951b:298), with many patients supposedly entering psychotherapy because they want to regain their "old self" or recover their "premorbid personality" (Peyton, MD). Practitioners' focus is thus not on society's prospects for the individual, but the individual's prospects for themselves.

Normality from the standpoint of the individual plays an important role in treatment, often being incorporated into practitioners' enactments of mental health and judgements of therapeutic effectiveness. Though in the earlier example Tracey aimed to get the patient back to work, with another patient Tracey recounted how they were completely ambivalent to occupational functioning and societal-focused normality:

> I've had a couple of patients on stress leave. And this one was in work for a major telecom company in customer service. So literally her job was people pleasing. And she was being evaluated all the time. Every interaction the customer had to rate a rate or on a scale of one to five stars. Brutal! And they were increasing the expectations, they actually expected these people to have dual calls going at the same time. Like what the heck? How on earth can you do that? Definitely a toxic workplace, no question… I decided to try it, this was also an experiment. And then I tried it with other patients and it really worked. So this is cool, this is a thing. So the idea was, "You can't please everyone". We know that. But I took it a step further and say "We can't, nor should we ever aim to please *anyone*". You can't please anyone. And that is like a bombshell of a thought and makes you sound like a total jerk… So "You can't please anyone" is actually one of the healthiest thoughts that you can have. So going back to your question, does that mean you leave a workplace or that you leave relationships? Not necessarily, what you do is you show up as the person you need to be, and then the rest is not up to you.

In this second example, Tracey prioritizes individual-focused health and normality. By promoting the maxim "You can't nor should you aim to please anyone", practitioners are telling patients to reject the role expectations placed upon them by others, showing a disdain for societal-focused normality. In its place, patients are encouraged to focus on

their own well-being, to "be the person I need to be, so authenticity" (Tracey, MD) rather than "the person he believes he is expected to be" (Fromm 1941:160). A similar phenomenon also occurs with respect to interpersonal relationships. Scott, a clinical psychologist, described how at the end of therapy with a patient who broke off contact with a family member, the patient "could have stayed [in the relationship with his brother], he could have done whatever. It just so happened it worked like that at the end". Again, practitioners emphasize the individual's interests, not society's.

In these instances, practitioners largely disregard occupational and social functioning in favour of "authenticity", where not being your true, authentic self is seen as a deficit state ('self-actualization' meanwhile is understood as going above and beyond the normal, authentic state; see Chapter 3.2). In such instances, psychotherapy cannot be understood as a method of social control as it weakens the ties between self and society, engendering a 'civic apathy' (Goffman 1961:165) in patients by promoting an indifference to conformity and shame (ibid:169). Practitioners can promote some rule-breaking and deviance in an effort to have patients express their "authentic" needs, thereby differentiating themselves from their expected social role (Bourdieu 1979).

Health from the standpoint of the individual also manifests in the subjective and standardized scales practitioners use to evaluate treatment progress. By using these measures to evaluate treatment effectiveness, I argue that practitioners are also tacitly enacting a "mental health" that is predominately centred on individual well-being instead of successful role functioning. Subjective measures privilege the patient's own feelings and perception of personal progress, rather than acting as an outside assessment of their role functioning. Most standardized scales also include questions which inquire about the

patient's levels of positive and negative emotions—e.g., "In the past month, how much were you bothered by strong negative feelings such as fear, horror, anger, guilt, or shame?" (PCL-5)—as well as about the patient's perception of themselves—e.g., "Over the last 2 weeks, how often have you been bothered by feeling bad about yourself, or that you are a failure or have let yourself down?" (PHQ-9). Furthermore, while population norms exist for these scales, allowing health and illness to be defined in relation to broader society, practitioners tend to compare the patient's current scores against their past scores to track personal change over the course of treatment. Again, the patient themselves is used by practitioners as the primary yardstick for health.

The aim of individual-focused health can be most readily observed by the presence of patients in psychotherapy who, according to practitioners, are not outwardly dysfunctional in terms of social or occupational roles:

> So I had a complex patient, young woman, come in. And her problem list in my mind was anxiety, OCD, body dysmorphia, anorexia, depression, could be bipolar, she may have had a manic episode. Yeah, and it was a lot. And she had never had professional help before. The fact that she had a job, friends, she wasn't estranged from her family. Like the fact that she was even functioning as well as she was, an incredible testament to how hard she's been working, and how much she's been trying to cope with all of that. And so in talking to her, we kind of went over, where and all of these things have been long standing. None of it's kind of new. (Julie, MD)

In cases like the one described by Julie, these patients cannot be restored to previous social and occupational roles because they have never left them. Practitioners recognize that patients can have "a mental health problem and there are lots of other elements of their life that are totally intact" (Eugene, CP). There is no serious interpersonal role dysfunctional that others detect, rather the problem is felt internally—i.e., the patient evaluating their own sense of self and well-being. This is a central theme for

practitioners, who note that mental health should be defined "not by others seeing you as functional, but you feeling that way" (Joyce, CP). Health and normality from the standpoint of the individual clearly exert a powerful influence over the practice of psychotherapy, influencing both patients' motivations for seeking treatment and practitioners' enactments of mental health. According to practitioners, restoring the patient's social functioning is important, but so is restoring the patient's authentic self and personal sense of well-being.

Individual and societal understandings of normality are further complicated as these different ideas of restoration can be in conflict, such that individuals may be required to sacrifice their individual health in order to conform to their normative role obligations (Fromm 1941:160). This dilemma commonly rears its head in psychotherapy and is one that practitioners are intimately familiar with:

> So one of the things I really love is that he's [Gabor Mate, an influential Canadian family physician] now talking about this sense of authenticity versus attachment. And so in order to survive, we have to be able to attach. And so what I see, mental illness is where people couldn't attach for whatever reason… the other thing that we have another need for is authenticity… they have to shut down their authenticity in order to attach. So mental health for me is what got covered over right? It's like your essence got covered over. That's how I see it. We start to have these personas in the world to in order to be in the world and then they can be real extreme. (Bethany, MD)

Acceptable functioning is understood as an important goal. But it is not practitioners' only goal, nor the most important one. In contrast to Fromm, who saw an inherent contradiction between the two "normalities", Parsons (1949:387, 1951b:26) argued that societal interests need not interfere with the satisfaction of individual goals. Conflict can arise from time to time, but generally both forms of normality can peacefully coexist.

Practitioners tend to align with Parsons over Fromm, arguing that mental health consists of "both aspects… attachment and authenticity" (Bethany, MD), or "function and feeling" (Marie-Pierre, CP). Practitioners attempt to integrate both understandings of normality into psychotherapy. At one moment practitioners might advocate for the restoration of social role functioning, while the next they might encourage deviance from role expectations, instead aiming to restore the patient's sense of self. Psychotherapy can act as a method of social control in certain instances, but this is not practitioners' primary goal when they enact the restorative model of health. Rather, they flexibly use both understandings of normality to meet the demands placed upon them by broader society—which asks practitioners to curtail deviance—and individual patients—who ask practitioners to restore their sense of self.

3.2 Enhancement and the Positive Model

The second model of health present in psychotherapy is the *enhancement* or *positive model*. Through this model, health care no longer seeks to simply "sustain health or repair the body" (Clarke et al. 2010:xxiv) by "arrest[ing] the abnormality, and re-establish[ing] the natural vital norm" (Rose 2007:17). Instead the aim becomes the "optimization and enhancement" (Clarke et al. 2010:xiv–xv) of life by "improv[ing] almost any capacity of the human body or soul" (Rose 2007:82). Definitions of health are extended beyond the traditional poles into new territory with new norms about what it means to be "healthy". Here, interventions are centered around promoting positive well-being and overcoming conditions seen as life-limiting rather than life-threatening (Clarke et al. 2010:243). The contemporary focus on enhancement is intimately entwined with the advancement and proliferation of biomedical technologies. These technologies aim to

free humans from the constraints imposed by nature and give us "biological control", increasingly opening the human mind/body to modification and perfectibility (Clarke et al. 2010:108; Rose 2007:17).

Though conceptually separate, in practice restoration and enhancement can blur together, rendering it difficult to distinguish whether treatment has moved the patient back to normality or whether it has gone above and beyond that mark (Clarke et al. 2010:xxiv). Practitioners work around this problem by employing positive enactments of mental health alongside negative ones, noting the importance of "positive experiences and good functioning as well. So both, a decrease, absence of symptoms and an improved quality of life" (Dorianne, CP). With this conceptual quandary in mind, I argue there are three areas where practitioners' attempts at enhancement are most readily apparent: 1) mood and emotions, 2) sense of meaning, and 3) interpersonal abilities. Instead of simply restoring the patient to normality, in these three areas practitioners often define therapeutic success as having the patient improve upon their pre-morbid quality of life.

Practitioners can promote a positive model of health through mindfulness—"focusing the mind on whatever is happening in the present" (Tegan, MD)—and other methods of introspection. Through these efforts, practitioners hope to help patients attain a new range of pleasurable emotions and experiences:

> I always use this analogy, depending on the age of people they might not relate to it. But in cameras, the aperture on a camera, it shrinks down or increases to change the depth of field. And so I think sometimes, both individuals and in general, we think that people just block out the unpleasant emotion. But it doesn't work that way. It's like the aperture on the camera, so the more unpleasant emotion you're blocking out, the smaller your emotional range gets… Part of learning to tolerate the unpleasant emotion is so we can create more space for the pleasant emotion. I can give you an example, another client I worked with who had DID [Dissociative Identity Disorder, previously known as Multiple Personality Disorder] and depression went out for dinner with some friends. And

> they came back into the next session and they were like, “I went out for dinner and I had a dessert after dinner that I've had 10 times before. And it's never tasted so good as it did that time. That was the best dessert I've ever had”. And it was because they were more connected to their sensory information. They are more connected to their emotions and they’re actually able to experience it, that joy of that moment. Whereas they'd always been disconnected and they had gone and eaten the food, it had been okay. But that's a concrete example that has always stuck with me since they reported that. I've had a client in session as they start to ground and start to talk about how rich the colors are. Just how vibrant the colors are. Meanwhile, they're walking around through life and even they'll have the experience visual in this muted range right? So that's about adding the richness back into life, about finding a way to experience the pleasant and enjoyable things in life. Not just about, “Let's get rid of the unpleasant stuff”. (Rodger, CP)

Mindfulness and introspection are not just seen as methods of alleviating distress and anxiety. They can also function as a means of helping patients optimize their everyday lives, enhancing the levels of pleasure and enjoyment they obtain from simple actions, such as having a dessert or a cup of coffee. For the patient described by Rodger, psychotherapy has created new sensory and emotional possibilities, allowing the patient to experience the world in a way they had never felt before. Unlike subjective and standardized scales which are only concerned with the frequency/severity of negative emotions, here positive emotions—assessed via subjective report—are positioned as the aim patients and practitioners strive to realize. Their emergence and augmentation is taken as evidence that treatment has been successful.

Positive emotions act as a powerful goal in therapy. Rodger continues on, explaining that therapy can open patients up to “the things that bring us joy, or excite us, or give us a sense of purpose… eventually that becomes a motivator” that keeps the patient engaged in therapy. Pleasure and happiness have long been presented as highly desirable feeling-states in the Western hedonistic tradition, from Democritus through to Bentham and now positive psychology. Therapy entices patients with these sensations,

promising a means of achieving this elusive goal we have been socialized into greatly valuing (Ahmed 2010; Cabanas and Illouz 2019). Practitioners make use of this "promise of happiness" to sell patients on therapy, persuading them not to discontinue and to adhere to professional recommendations, dangling the carrot in front to ensure that patients remain motivated throughout.

A similar phenomenon plays out with respect to meaning. In contrast to the hedonistic tradition, the Western eudaimonstic tradition emphasizes the importance of "living well" (Deci and Ryan 2006:2). "Living well" is a multifaceted concept, but across modern theories (e.g., Keyes 2005; Ryff 2014; Seligman 2011), a recurring, central theme is the idea of meaning or purpose—having a "*why* to live for" (Nietzche as quoted in Frankl 2006[1946]:76). Practitioners do use meaning in an effort to restore patients and establish a buffer against negative experiences, but they also see this intervention as a means to augment patients' quality of life:

> Are you feeling like your life is enhanced, more meaningful, more valuable? I check in with that constantly, right? What's still missing? What do we need to continue to think about and work on and improve and grow? (Roderick, CP)

The ideas of meaning, purpose, and personal growth have a long history in psychotherapy, dating back to Jung's concept of 'individuation' (Rusu 2019) and Maslow's (1943) 'self-actualization'—i.e., becoming "everything that one is capable of becoming". This enhancement, eudaimonstic-oriented approach is common amongst practitioners as self-improvement, much like happiness, is greatly sought after goals in Western society (Foucault 1979; Rose 2007). Therapy is presented as an important method of helping patients achieve self-actualization, realizing an optimized state that remains only as a potentiality for the average person (Maslow 1943; Rose 2007:23).

Practitioners offer this reward to patients to motivate their engagement in therapy, regularly asking the patient whether they believe they have achieved this aim or are on track to achieve it. Again, the positive, enhancement model acts as a carrot that can tap into powerful wellsprings of motivation, helping practitioners secure the patient's engagement in therapy.

The third form of optimization present in psychotherapy focuses on socializing and social skills, with practitioners helping patients practice "assertiveness", "validation", and "compassion". The DEAR [Describe, Express, Assert, Reinforce] MAN [Mindful, Appear confident, Negotiate] GIVE [Gentle, Interested, Validate, Easy manner] FAST [Fair, Apology-free, Stick to values, Truthfulness] mnemonic from DBT was the most frequently discussed tool, with practitioners using this approach in an effort to help patients develop strong interpersonal skills. Validation was also highly lauded by many practitioners, supposedly being the "secret sauce for relationships" (Cassandra, MD). Interpersonal skills are a common therapeutic goal, with practitioners not only looking to mend damaged relationships or resolve social skills deficits, but also to enhance the patient's interpersonal effectiveness:

> Once we'd hit double digits of sessions, like session 10 and 11, we switched gears a little bit because he'd gotten such a good response from his anxiety standpoint and getting a bit more active and out of the house. The next goal that he really wanted to tackle was assertive communication. So how to better set his own boundaries and limits, and communicate what his wants and needs were in an effective way with other people. He was somebody who was still volunteering quite heavily with a mental health organization within [town]. So he did a lot of their organizing, and he was out on the board, and all of that stuff. So he wanted some new skills, to better play that role and be a bit more assertive in those situations. So we went through an assertiveness workflow together, and learned a lot about that, about effective communication. And that was kind of how we ended it off. (Tegan, MD)

Tegan starts with a negative model, aiming to quell the patient's anxiety and help them reclaim their life. Towards the end of therapy (the standard course of CBT is 12 ± 4 sessions), a positive model is put into effect and the attention of patient and practitioner switches to the development of "effective communication". The patient has been successfully restored and the original aim fulfilled. But the prescribed number of sessions has not been reached. The enhancement model thus enters, with the practitioner offering the patient an even greater level of social functioning provided the patient remains in therapy and under the practitioner's gaze. The practitioner's income is thus maintained without having to overcome the challenges of starting over and establishing rapport with a new patient.

For practitioners, enhancement and restoration are not conflicting, mutually exclusive enactments of mental health. Rather, they can be used to complement each other to ensure that patients do not discontinue therapy prematurely. These models act as moving goalposts. When patients first come into therapy, restoration that targets life-threatening issues is prioritized over enhancement that targets life-limiting issues. At this point in the therapeutic process, enhancement may be a remote, unrealistic ambition that would only disincentivize patients. In contrast, goals relating to restoration are seen as more attainable and less likely to resulting in disappointment. Practitioners work with patients to establish an initial framework which outlines what is and isn't possible in therapy. This outline can easily be redrawn if the patient starts to show significant progress, with practitioners introducing a new set of more enhancement-related goals. This strategy ensures that practitioners can always position a new goal just ahead on the horizon to entice patients, helping to maintain patients' effort and engagement. These

new goals are potentially infinite (Merton 1957:191), ensuring therapy always seem desirable and that the need for practitioners' services is never fully obviated.

3.2.1 Anti-Enhancement Trends: Distress as Normal

While certain elements of psychotherapy are consistent with the health optimization trend described by Clarke, Conrad, and Rose, other elements diverge. Notably, 1) enhancement and customization in psychotherapy are not new practices, and 2) despite employing enhancement-oriented techniques, practitioners also endorsed strong, anti-enhancement beliefs. Like Clarke and colleagues (2003:181–82), Rose (2007) argues that enhancement is not new. What is novel about contemporary optimization practices is the focus on *customization*, aiming to fulfill "desires that can appear trivial, narcissistic, or irrational, shaped… by the market and consumer culture" rather than traditional societal or individual understanding of normality (p. 20).

The types of enhancement techniques employed by practitioners emphasize customization. However, these techniques are not novel, instead being largely consistent with the older ideas of growth and self-actualization (Ryff 2014:11). These concepts were first used by clinical practitioners in the 1940s, '50s, and '60s to describe "the person who would emerge if therapy were maximally successful" (Rogers 1961:183). For Carl Rogers (ibid:187-188), optimal mental health consisted of being open to experience and living in the moment, captured by the contemporary practice of mindfulness. For Karen Horney (1950:15), it entailed having self-knowledge and being true to oneself, seen in the practitioners' emphasis on authenticity and "be[ing] aware of their own needs" (Rodger, CP). For Erich Fromm (1949:84), it involved experiencing oneself as an embodied, intentional actor, aligning with the contemporary focus on "intentionality… find meaning

in everything they do" (Roderick, CP) and helping patients no longer "live in autopilot" (Cassandra, MD).

Self-actualization and growth lean very heavily into customization, and were critiqued at the time for fostering a narcissistic preoccupation with individual development and expression (Lasch 1979:218). For instance, in Maslow's (1943) hierarchy, the first four needs are universal and normality-centric while the need for self-actualization at the top is incredibly individualized. Becoming "everything that one is capable of becoming" is left up to the individual to define and realize, customizing their ideal self. The "modern" trend of individualistic customization then is not really modern, at least in psychotherapy. Rather, these enhancement, customization-oriented clinical practices can be understood as a continuation of older ones, whose origins predate the shift towards optimization observed in other areas of medicine.

Psychotherapy may have been an early adopter of this trend because of its unique position compared to other treatment practices. For the average practitioner, the practice of psychotherapy has had little direct contact with biomedical technologies. Many practitioners base their understandings of mental illness, emotions, and behaviour in the brain, however, these practitioners have not yet incorporated brain scans, genetics tests, etc. into their everyday clinical diagnostic or treatment approaches. Instead the practice pursues enhancement through more traditional methods (Rose 2007:20), seeking to discipline the mind and body (Foucault 1979). Psychotherapy had thus already incorporated means of striving for customization into practice prior to the "age of biological control" (Rose 2007:16) brought about by advancements in biomedical technology.

Secondly, though practitioners employed positive models in certain aspects of their work, in other areas they were vehemently opposed to this perspective. One of the topics most commonly brought up by practitioners, which was also the issue they were the most animated about, was that negative emotions are completely normal:

> So let's talk about anxiety. When someone comes in and says, “I have anxiety”, I bristle. I really dislike that concept. Because you're a human being, of course you have anxiety. It's like saying, “I have a nose” right? But people say it like “I have a mental illness”. The fact that I experience anxiety means something is wrong with me. And I hear that idea too much. I want to normalize the spectrum of all this stuff with people… I think one of the most important things I do is normalize the experience of human emotions. Mental health to me isn't about not experiencing anxiety. It's about recognizing that it's okay to experience anxiety, and how to manage it, and be resilient about that anxiety in the moment. So the normalization of human emotions is the most important thing to me when I think about this stuff. (Roderick, CP)

Practitioners regularly condemn patients’ individual-focused understandings of mental health that equate well-being with always being happy and never experiencing distress. Such goals are dismissed as “unrealistic” (Julie, MD) or “delusional” (Tracey, MD), noting that “you cannot be 100% content and 100% calm. I'm sorry but those people are on drugs okay” (Sasha, MD). Practitioners take the view that negative emotions can be perfectly acceptable in day-to-day life. Rather than seeking to optimize patients’ emotional experiences and produce happy, positive people (Cabanas and Illouz 2019), practitioners thus instead look to normalize these internal experiences by “telling people that there's actually nothing wrong with them” (Cassandra, MD). In some cases, practitioners even go so far as to praise the emotions seen by patients as pathological:

> Negative emotions are not necessarily bad. So for instance if someone's really angry, that doesn't mean you don't have good mental health. Maybe the appropriate response is for you to be angry and if you're not angry about that, then you're not allowing yourself to express yourself right? (Joanie, MD)

Practitioners possess a very different view of good mental health compared to the positive psychology and happiness economic movements. Happiness is approached with ambivalence. On the one hand, this emotion is generally a pleasant experience that can be used to motivate patients in therapy. On the other, happiness should be problematized, as it is an unattainable, unrealistic ideal that can produce severe disappointment. According to practitioners, when this aim is internalized patients tend to medicalize their everyday emotions, coming to understand anger, sadness, and anxiety as problematic and necessitating professional intervention. Ultimately, practitioners make selective use of enhancement, restricting the positive model of health to certain patients, points in treatment, and/or issues that the practitioner believes can be feasibly achieved within the confines of therapy.

3.3 The Management Model: Maintaining Treatment Gains

The third definition of mental health practitioners employ is the *management model* (Parsons 1975:262), also known as secondary prevention (Ades 2001; Greene 2007:205). Under this approach, the patient exists in a no-man's land between health and illness. They are not seen as actively sick, displaying only marginal symptoms and dysfunction (Halpin 2021; Rosenberg 2002), yet are still thought to need professional and/or self-led interventions to manage their health and minimize the risk of becoming more fully sick in the future (Rose 2007:10). This approach adds a temporal dimension to health, viewing it as a precarious, potentially transient state (Esquirol 1838:98).

Unlike primary prevention and surveillance medicine which target entire populations (Armstrong 1995), management is more narrow in scope, targeting only individuals who have entered therapy. Furthermore, instead of hoping to catch and

prevent the onset of disease, management aims to “maintain therapeutic gains” and stop the patient from becoming sick *again*:

> If things are going well for clients, I usually think about maintenance of gains. Maintenance is really thinking in CBT terms for a second. But it's a very common thing I think about too. Like, let's explore what went well, and how do you keep that up? That's a very important question to think about too. And when things get hard, how are you going to deal with that?... That's one way I deal with future things. The other way I think about it is I never terminate with clients, ever. I'm lucky I'm in private practice, I don't have any sort of external forces that tell me I must end relationships with clients. My relationship with clients always end with “When you want some more support with something, I'm here”. (Roderick, CP)

Like enhancement, we see the sequential ordering and prioritization of models. Restoration typically comes before management. Once “things are going well” and the patient has sufficiently recovered, then practitioners can start shifting into a more management focused approach. But rather than restoring or enhancing in the patient’s life in the here-and-now, management focuses on the future, hoping to prevent patients who have been mentally ill from falling back into poor mental health.

Health is understood as a temporary state that must be constantly maintained. Patients are told that they must “recognize that you're vulnerable to falling into this trap” (Eugene, CP) because they have been sick before, casting mental illness as both current disease and future risk factor (Armstrong 2011:411). Patients are also encouraged to adhere to the regime prescribed by the practitioner to properly manage their risk and forestall severe dysfunction (Parsons 1975:259). To this end, practitioners look to provide patients with a coping skills “toolkit” and to foster “resilience”, enabling the patient to recover and adapt to future stressors they encounter when outside of the practitioner’s care (Ungar 2021:2).

For practitioners, the future-oriented management model functions through a mix of professional (Armstrong 1995) and self-surveillance (Rose 2007). Several clinical psychologists like Roderick discussed how patients would remain "under my umbrella" (Marie-Pierre, CP) once they had completed the original course of therapy, offering follow-up sessions even years later. Once a patient undergoes therapy, practitioners look to keep that patient within their sphere of influence, medicalizing their life in perpetuity. Even MD practitioners, for whom the number of sessions for each patient is restricted by OHIP, typically offer 'booster sessions' to their patients in order to monitor whether their mental illness has re-emerged and/or if the patient has additional therapeutic goals they would like to pursue (Beck 2011:348–50). Invoking concepts like "risk", "vulnerability", and "susceptibility" dissolves the distinction between health and illness, providing practitioners with a justification for continuing therapy and professional surveillance even in the absence of severe mental illness (Armstrong 1995).

Self-surveillance meanwhile is promoted through the rhetoric of autonomy and independence. This approach shifts the burden of monitoring and care off the practitioner and onto the patient (Armstrong 1995; Rose 2007), rather than onto the patient's support network as found with other conditions (e.g., Charmaz 1983; Halpin 2021). Patients were deemed ready for self-management when they had "become their own therapist" (Beck 2011:30), a common goal for practitioners:

> Are they starting to feel like their own therapist. Which is one that we don't write that down as a goal. But we've talked about that are they comfortable now if they have different things, changes in their life, that they can use some of these tools that they learned to apply them in the future. So how do we know we're done? You can just tell when people in session, I can just sort of reflect back and say, "So what do you think would help now?" and they're starting to get it. They start laughing because they say, "I'm becoming my own therapist, I know the answer". (Peyton, MD)

Several practitioners referenced the idea using Beck's "own therapist" language, while others phrased it as developing an "inner therapist", being able to access their "adult self", or for child patients, having the parents act as therapist in absentia. Consistent with Rose's (2007) discussion of biological citizenship and the management of genetic susceptibilities, practitioners involve patients in a psychological citizenship and the management of psychopathology susceptibilities. Proper management and citizenship necessitate "continuous training, life-long learning… constantly to improve oneself, to monitor our health, to manage our risk" (p. 154). Under this management model of health, patients are considered healthy and ready to "graduate" from therapy only after they have ""insightfully" come to take… the hospital's view" (Goffman 1961:154–55), or in this case, the practitioner's view. The patient must come to see themselves and the world through the eyes of the therapist, reproducing practitioners' professional surveillance outside the confines of psychotherapy. The "client as their own therapist" ideal thus facilitates the medicalization and therapization processes (Lanas and Brunila 2019), strengthening the legitimacy of the psy-disciplines and therapeutic culture (Furedi 2003; Rose 1998:156; Wright 2008).

Importantly, the management model can blur with enhancement (Rose 2007). The patient is no longer a lay person but a practitioner-lite, "enhanced" with new skills and expertise in the form of a familiarity with clinical terminology and intimate knowledge of therapeutic interventions (Collins and Evans 2008). Practitioners achieve this management-enhancement through in-session instruction, where patients watch how the practitioners thinks, acts, and addresses the patient's problems. Patients are then

encouraged to internalize and mimic this behaviour. In-session efforts are supplemented by referring patients to external community resources, relevant books and websites, allowing patients to further immerse themselves in the world of mental health.

Practitioners argue that they do not want patients to be dependent on them long-term. Instead, practitioners see their role more as a facilitator, enhancing patients with the skills and knowledge required to access their own, internal resources, ideally obviating the need for professional assistance. That said, practitioners also note that the "things that were working are going to break down over time, the coping mechanisms" (Roderick, CP), demonstrating how many practitioners never truly remove themselves from the picture. MDs and CPs alike are often ready to bring patients back into therapy should any mental health problems return in the future (exceptions do occur when the patient is seen as an "unmotivated" or "bad" patient that practitioners are happy to be rid of). In sum, the management model offers practitioners another way through which to enact mental health. Management builds on restoration, wanting to help patients maintain the gains they have made in therapy into the future, predominately through self-surveillance and the internalization of the therapist's worldview. However, practitioners never fully make themselves irrelevant, always emphasizing the usefulness and availability of future sessions for when—not if—mental illness inevitably returns.

3.4 The Stabilization Mode: Stopping Further Deterioration

The fourth enactment of mental health practitioners employ in psychotherapy is the *stabilization model*. Stabilization is a minimalist approach to health, aiming to halt or slow further exacerbations of the patient's condition. This interruption is precarious and

must be continually worked on, preventing patient and practitioner from focusing on restoration:

> I once talked to a psychiatrist friend of mine, brilliant, brilliant man. He studied epidemiology and he said one of the problems we have in medicine, and psychology kind of follows that model, is that we think people always have to be getting better. So it always has to be a line like that [motions in an upward, diagonal line]. And what we don't look at is whether people aren't getting worse. So sometimes the work that I do is about, it's actually about not people always getting better, *but about people not getting worse* [emphasis added]. Some of the people I work with, they have so many complex issues… I've been at this for over twenty years now, well over 20 years. I'm not naive like I used to be, that I'm going to fix everybody or everybody's going to get completely better. If people can manage their symptoms more effectively and just not end up in crisis after crisis, I sort of see that as real progress. (Marie-Pierre, CP)

The goal of this model is simply to 'stop the bleeding' and 'minimize losses'. Like restoration, stabilization seeks to reduce the patient's dysfunction. However, the patient is still noticeably dysfunctional rather than "restored", and practitioners importantly consider that dysfunctional state a success. The aims of restoration, enhancement, or management are far off luxuries when patients are on the cusp of "getting worse" and potentially dying in the immediate future. In such instances, practitioner do not define "health" by the absence of symptoms or the adequate performance of roles, but by the absence of aggravations.

The stabilization model features prominently in the mental health field. Per Ontario's *Mental Health* Act, physicians can detain patients for up to 72 hours if the patient is seen to be a risk of causing "serious harm" to themselves or others. The aim of "forming" patients is not to restore but to stabilize[1], to keep the patient alive and

[1] Although the opposite effect is often achieved (e.g., Chung, Ryan, and Large 2016; Jordan and McNiel 2020)

relatively unharmed for the time being. The distinction between stabilization and restoration also appears in the Freudian-era idea of "pills and skills" whose logic was used to justify the combination of psychotropic drugs and psychotherapy. Pills were meant to stabilize and prepare the patient for talk therapy, alleviating the most extreme symptoms. The skills taught in psychotherapy meanwhile were meant to more fully restore functioning (Luhrmann 2000).

Similar stabilization approaches exist within the broader healthcare system, for instance, in the use of antibiotics to combat pulmonary exacerbations caused by lung infections for patients with cystic fibrosis. Antibiotics can put an end to these exacerbations, helping to secure a basic level of lung functioning and preventing death by pulmonary insufficiency (O'Sullivan and Freedman 2009). However, the greater set of symptoms and dysfunction that accompanies cystic fibrosis remains and is not targeted as therapeutic goal (Sanders et al. 2017).

3.4.1 Stabilization in Psychotherapy

Returning to psychotherapy, stabilization is most commonly used 1) for patients with past and/or present trauma and 2) when faced with the issues of suicidality, hospitalization, dissociation, and drug use, linking these severe outcomes to adverse life events. When faced with complex patients who "just have chronic suicidal ideation" (Peyton, MD), stabilization is seen as the most realistic aim. The risk of suicide and self-harm commands practitioners' attention, forcing treatment to prioritize present outcomes to ensure the patient does not sustain life-threatening injuries. The stabilization model can be employed long-term like in the manner described by Marie-Pierre, where the typical length of treatment for patients with complex problems is "five to seven years" (Rodger,

CP). Alternatively, stabilization can be used by practitioners as a stopgap, keeping patients alive until more expert, intensive therapy can be brought to bear:

> Those are not the things that we as CBTers, we shouldn't really be touching. I don't think personally, like major abuse, major incest. I'll get them comfortable. I'll get them at least understanding thoughts. But then if they're going to have flashbacks and all that, I step back, no, I think you really shouldn't. I think I'm here to guide you, to be a stepping stone to get you to a true trauma specialist. (Sasha, MD)

Here practitioners invoke their "boundaries of competence" to define realistic and unrealistic goals for therapy. Restoring patients with major trauma is framed as a difficult, if not impossible goal for CBT-oriented practitioners not trained to deal with severe trauma. Instead, this "complex" task and these "complex" patients are said to require a more specialized, expert practitioner knowledgeable about trauma processing, shuffling the burden off one practitioner and on to another (Seim 2017, 2022).

Practitioners admit their ignorance and limit their own role, simultaneously asserting the competence of the practice by flourishing the promise of more effective, less ignorant others in front of patients. Stabilization may be the only aim in the present moment, but by engaging in therapy and putting the effort in, the opportunity to pursue the more desirable aims of restoration, enhancement, and management may present themselves down the line. Basic therapy that just attempts to stop the patient from getting worse may lack the glamour of the other models. But it can maintain its appeal by being sold as a "stepping stone" (Sasha, MD) to more advanced aims and the better quality of life they offer.

Like restoration, enhancement, and management, practitioners' enactment of the stabilization model of health is *selective*—employed with certain patients at certain points

in therapy—and *complementary*—adding to rather than excluding other enactments of mental health. Practitioners are happy to focus on stabilization, management, enhancement, or restoration, flexibly drawing on whichever enactment of mental health they believe is needed in the moment for the patient. "Mental health" is so controversial and difficult to define for health care professionals (e.g., Manwell et al. 2015) because there is no single definition that practitioners consistently employ. Instead, this concept should be viewed as fluid and contextual, requiring a pluralistic, "many definitions" approach (Leonardi 2018) to fully capture the multifaceted ways in which practitioners "do mental health".

3.5 Conclusion

In this chapter I outlined four models of health practitioners use in psychotherapy: 1) restoration, which aims to eliminate the patient's symptoms and restore "normal" functioning; 2) enhancement, which aims to optimize the patient's well-being; 3) management, which aims to maintain the gains made in therapy; and 4) stabilization, which aims to stop the patient from getting worse. Practitioners flexibly alternate between different enactments of mental health across time and patients, ensuring that treatment goals are always seen by the patient as achievable given their current situation. Psychotherapy then *can be* a mechanism of social control in certain contexts with certain patients, but in other situations the practice can have the opposite effect. The same is true for enhancement and customization. Psychotherapy can aim to make patients "better than well" (Rose 2007:98), while other times it has very different goals, like simply wanting to stop patients "from not getting worse" (Marie-Pierre, CP).

In the next chapter, I propose that practitioners flexibly use these different enactments of mental health in an attempt to manage ignorance, downplaying therapeutic goals and then using an eclectic array of interventions to achieve these goals.

Chapter 4

Managing Ignorance by Managing Mental Health

In this section I take an ignorance studies approach, arguing that practitioners use the many faces of mental health to manage ignorance, thereby presenting themselves to patients as knowledgeable and competent professionals. Through this impression management (Goffman 1959), practitioners strive to maintain professional authority and decrease the risk of patients dropping out of therapy prematurely. Though "ignorance" is traditionally assigned negative connotations (Proctor and Schiebinger 2008), I do not use the term in a pejorative sense to judge practitioners as incompetent and challenge their professional authority. Rather, I view ignorance as an inevitable, fundamental component of professional life (see Abbott 2014; Freidson 1988; Whooley and Barker 2021), and merely seek to describe and analyze how practitioners of psychotherapy interact with ignorance in their day-to-day work.

I begin by outlining the downplay-achieve strategy (discussed above), showing how practitioners use the different definitions of mental health to make patients set downplayed, "realistic" goals. I then explore how practitioners eclectically draw on a mix of therapies to achieve said goals, striving to fulfill the promise of "mental health". Fundamental to the downplay-achieve strategy is the operationalization of goals and outcomes. I highlight several benefits of this approach. Next, I argue that patients' expectations of what therapy should look like can also make practitioners appear ignorant if they fail to conform. This acts as a countervailing force, limiting practitioners' use of the achieve strategy by discouraging eclecticism. Finally, I argue practitioners are concerned with managing patients' perceptions of ignorance and presenting themselves

as competent mental health professionals because trust is necessary to secure the patient's motivation. According to practitioners, without motivation, therapy will not function. Therapeutic failure in turn increases the likelihood of patients discontinuing prematurely, lowering practitioners' esteem and income while potentially hurting the reputation of the profession as a whole. Ignorance and trust are thus powerful social resources central to the success of psychotherapy, needing to be managed by practitioners to expand medical understandings and maintain professional authority.

Importantly, practitioners' actions and decisions are influenced by a variety of factors in addition to ignorance. Notably, a suffering-focused analysis (see Wilkinson 2001) would emphasis health care professionals' deep motivation to alleviate their patients' suffering (Arbore, Katz, and Johnson 2016). Practitioners' attempts to achieve downplayed therapeutic goals may be in part motivated by this desire, wanting to offer any solace they can to reduce the patient's pain and their own empathetic suffering. In this chapter however, I restrict my analysis to ignorance management, exploring the personal competence and professional authority related benefits that practitioners accrue through the careful construction of therapeutic goals and "progress".

4.1 Therapeutic Goals and Outcomes

In psychotherapy, treatment is flexibly pursued through various means to various ends (i.e., restoration, enhancement, management, and stabilization). Resultingly, practitioners enactments of mental health appear inconsistent over time and across patients. What then is the aim of practitioners? I argue that practitioners seek to manage ignorance and present themselves as competent professionals.

Ignorance, simply put, is a limitation or absence of current knowledge (Gross 2010:68). Traditionally ignorance is regarded as an undesirable threat to professional authority that must be minimized to maintain credibility in the public arena (Whooley 2019:18). However, ignorance can have many positive functions, particularly when it is not evenly distributed (Proctor and Schiebinger 2008). In psychotherapy, the lopsided distribution of ignorance is used by practitioners to distinguish themselves from patients and other professions, helping practitioners gain and maintain authority over the domain of mental health (Abbott 2014:292–326; Moore and Tumin 1949). To this end, ignorance must be actively produced through selective attention to create knowledge about one topic while leaving others shrouded in mystery (i.e., privileging issues) and selective disclosure to stop certain people from knowing certain things (i.e., privileging people; Proctor and Schiebinger 2008). Ultimately, practitioners are often ambivalent towards ignorance, wanting to produce or reduce ignorance depending on the situation.

I argue that practitioners attempt to produce ignorance and manage patients' perceptions of their competence through a downplay-achieve strategy. "Downplay" refers to practitioners providing patients with new frameworks through which to judge their current status (Goffman 1952), alternating between the four models of health to set expectations low yet still motivate the patient. "Achieve" refers to practitioners' eclectic use of interventions to realize the promises they establish. According to practitioners, promises or "goals" are necessary to motivate patients and convince them that therapy can provide what they want/need. However, these promises are also a source of potential ignorance (van Lente 2000), as discrepancies between promised therapeutic goals and

actual outcomes are a serious threat to practitioners' professional authority and the patient's motivation (Borup et al. 2006:291).

Should treatment fail to adequately deliver the promised outcomes established by the dyad, patients may feel disappointed and terminate therapy prematurely, sometimes even by "ghosting" (Sasha, MD) the practitioner. Premature discontinuation is deeply undesirable for practitioners, potentially harming their self-esteem, reputation, and income. Practitioners are faced with the task of creating desirable yet feasible goals, using the downplay-achieve strategy to attract patients into therapy *and* keep them there.

The downplay strategy is fundamentally ingrained in psychotherapy. Practitioners are intimately aware of the importance of downplaying, outwardly praising the power of this technique: "There's a lot to be said for lowering expectations. And there's a lot to be said for dropping unrealistic expectations" (Tracey, MD). "Realistic" is a common buzzword used by practitioners to lower patients' goals for therapy:

> So setting more realistic goals, and then breaking it down. And so I'll say, "What's bothering you out of the things that I told you I could help with in terms of talking therapy? Which ones bother you the most? And which ones do you think you can realistically work towards? Which ones are you ready to work towards?" (Julie, MD)

Practitioners attempt to set the boundaries of reality by distinguishing between "realistic goals" and the patient's initial, "unrealistic" expectations, constructing therapy as a this-worldly practice with a limited scope and effectiveness rather than a magical panacea. Practitioners aim to downplay the patient's initial desires, offering new replacement goals that are presented as a compromise between what the patient wants and what is actually possible in therapy (Goffman 1952). The construction of therapeutic goals is always selective and heavily regulated by practitioners, never wanting to make promises they

cannot keep. Practitioners are also faced with the countervailing onus of giving patients something to strive towards to maintain their engagement in therapy. The aims of therapy must be meticulously managed, ensuring desirable goals are always on the proximate horizon but not positioned so far away as to be discouraging. Practitioners' judicious use of the downplay strategy is understood as a key method of achieving these aims.

The downplay mechanism is also built into to several treatment models, described in terms of "phases" of treatment. For PTSD, practitioners outlined a three-stage model of "stabilization, memory processing, and reclaiming of life functioning" (Dorianne, CP). Practitioners begin with the simplest aim: stopping patients from getting worse. Then they gradually transition to the more ambitious aim of restoration. Or recall the CBT-style approach employed by Tegan in Chapter 3.2, where the initial aim of therapy was to restore the patient by alleviating their panic attacks and driving anxiety. Once achieved, the dyad switched to a new, more ambitious aim: the enhancement of social skills. Practitioners downplay in an effort to start goals low, challenging patients' incoming expectations for therapy to mitigate the risk of future disappointment. The carrot remains to direct and motivate, but it is placed just barely out of reach. Once practitioners are confident that forward progress has been made or is forthcoming, then the goalposts can be moved and a new model of health can enter play.

Change in therapy is not linear however, nor is progress guaranteed. Therapy is "bumpy", filled with "ups and downs" (Roderick, CP). Downplaying then is not a one-and-done strategy. Practitioners must regularly review their goals, bouncing between models and goals when regression inevitably occurs:

> He was able to return to work in very modified duties, like not at all to the level he was working. But it was getting him out of the house. But actually, the work

> was so below his skills that it became depressing for him to be in that position. So it was quite triggering, the loss this profession that he was very proud of and became very depressed. And had issues in the workplace and had to go off on leave again. And was even hospitalized at some point for suicidal ideation. Yeah, so it came to that level. So was hospitalized, got him back, lifted depression again. (Dorianne, CP)

Dorianne initially focuses on restoration until the patient takes a turn for the worse. Reclaiming the patient's pre-morbid life and returning to work become overly ambitious and unlikely goals, resulting in Dorianne 'shifting the object' of knowledge (Whooley 2019:227) by re-orienting away from restoration and towards the stabilization framework instead. Again, goals are downplayed, kept within the range practitioners judge to be feasible. When a dramatic shift occurs, practitioners do not redouble their efforts, striving to attain the original aim. Their efforts are instead directed towards "reassessing" the patient's condition and reformulating therapeutic goals. Rather than bringing the patient up, the boundaries of success are brought down to mirror the patient's shift, with this new framework hopefully maintaining the appearance of competence and the patient's trust.

Herein lies the advantage of the downplay strategy, being used to increase patient ignorance while decreasing how ignorant the practitioner looks. It also highlights the strategy's dependence on the many faces of mental health. Proctor and Schiebinger (2008) argue that "[i]gnorance is a product of inattention" (p. 7). Practitioners make use inattention by flexibly switching between different metrics of success—i.e., the many faces of mental health—and selectively sharing information about specific outcomes. Though these techniques make patients more knowledgeable about their progress towards *current goals*, they simultaneously make patients more ignorant about their progress towards *earlier expectations* by not collecting or disclosing this set of outcome data.

The inattention and consequent lack of knowledge regarding past promises can make it more difficult for the patient to judge whether therapy has fulfilled their initial expectations. Perceptions of practitioner ignorance that can result from discrepancies between expectations and outcomes are thus obscured, helping practitioners appear competent and maintain their professional authority. For instance, if the patient is not back at work, the practitioner can instead focus on and celebrate that the patient is not actively suicidal. Or if the patient's relationship with their partner and child is still troubled, the practitioner can emphasize significant improvements in the patient's mood, sleep, and energy levels—as indicated by their GAD-7 and PHQ-9 scores. By encouraging patients to restrict their focus to their progress towards a specific set of goals, practitioners make patients ignorant about any changes, or lack of change, in other areas. The patient's selective ignorance about goals and outcomes helps practitioners laud successes while masking regression and failure, making the practitioner appear competent and their approach to psychotherapy appear effective, thereby maintaining the patient's motivation.

4.1.1 Eclecticism in Psychotherapy

The *achieve* strategy is most evident in practitioners' eclectic use of interventions. Lowering expectations is advantageous, but some change in the patient's condition must still occur to establish psychotherapy as a useful practice and the practitioner as a competent professional. According to practitioners, effecting change is not an easy task, as therapy is messy and patients are heterogenous, requiring practitioners "to have different ways of working with people and different symptoms or challenges" (Rodger, CP). Through this view, practitioners manage ignorance by 'deflecting blame' off the

knower and onto to the object to be known (Whooley 2019:225), attributing failure to the supposed complexity of mental illness. Practitioners often attempt to work around this perceived complexity through innovation—i.e., bringing in new therapeutic techniques—continually stressing that what works with one patient may not work for another.

Practitioners also use innovation to manage ignorance by critiquing and defying "standardized", "manualized", or "evidence-based" approaches. Manualized therapies are regimented, prescribing a specific set of therapeutic interventions that practitioners can use and outlining the expected progression of therapy across sessions (see Beck 2011:354). Though endorsed by many professional bodies, manualized treatments were regularly criticized by practitioners for lacking the flexibility and comprehensiveness necessary to help "real" patients:

> CBT is the gold standard for many things, and individual models because of course a lot of the research is done on adhering to your models. But I'm always mindful of the people that are in the studies, you have to have exclusionary criteria for the studies. A lot of times you can be in the study for CBT, but you have to have unipolar depression that hasn't been present for more than 6 months, not been any medications, haven't done therapy. And I'm thinking, "Well of course it's going to work! That makes sense because they've just excluded all the people that I actually see!"… The people that have tried two or three different medications, or the people that have had a course of psychotherapy, or the people who have recurrent traumas. So there's that. It's just when we say evidence-based, sometimes the people in front of you are the ones that are actually excluded from any trials. So you don't actually have the evidence right? (Joanie, MD)

Fox (2013[1957]) argues that ignorance can be collective, representing "limitations of current [professional] knowledge", or individual, representing "incomplete or imperfect mastery of available knowledge" (p. 208). The existence of a second form of ignorance creates additional possibilities alongside additional demands. As seen with Joanie, practitioners can offload ignorance onto the collective and re-assert their competency by

critiquing manualized approaches (Parker 2005). These critiques also present treatment as a complex "art" rather than a simple, routinized practice (see Malterud 1995), creating a space where individual practitioners can flaunt their expertise and autonomy in an effort to distinguish themselves from "less skilled" therapists that adhere to the basic, manualized protocols (Brown 1987; Whooley 2010). During the interviews, several practitioners levied this critique at social workers who practice psychotherapy.

In line with previous research (Hunsley and Lefbvre 1990; Warner 1991), the majority of practitioners I interviewed identified as being "eclectic" or "integrative". These practitioners regularly deviated from manualized approaches by incorporating ideas and methods from different schools of therapy in their practice. Practitioners stressed that "if something's not working, you find something that does work" (Cassandra, MD). Why a technique does or doesn't work can still be an interesting question to practitioners. Not because it reveals some fundamental truth about the "mind-brain" (Eugene, CP) but because it can point practitioners in the direction of other effective interventions. Overall, practitioners came across as instrumentalist in their approach, prizing pragmatism and effectiveness over tradition or ideological purity. If a technique helps achieve therapeutic goals, it is a valuable tool, theory be damned.

Eclecticism should not be overstated though. Practitioners definitely displayed preferences for certain techniques and schools. They often endorsed a particular underlying theoretical model supporting a specific school of therapy or explanation for mental illness. Likewise, they typically open therapy with their favourite, tried and true methods. However, I did not encounter a single practitioner who rigidly adhered to a single school of therapy or manualized treatment. Even practitioners who primarily

identify with a single school acknowledged that they regularly blended the odd technique or two from other approaches into their practice. The ideologies are there, but in practice they do not quite hold their weight.

In sum, pragmatic and achievement-focused is the best way to describe practitioners' approach to therapy, with practitioners very rarely employing one single style of intervention. Practitioners happily adopt an innovative, eclectic stance that prioritizes their ability to realize therapeutic goals, even if it means deviating from the established, professionally prescribed means of treatment (Merton 1957:196). They employ multiple interventions in succession, until one helps the patient achieve their therapeutic goals. Sometimes practitioners even employ multiple techniques at once in a results-focused "throw everything at the wall and see what sticks" strategy. A single method used in isolation has a sizable amount of uncertainty in terms of whether it will help the patient successfully realize their goals. With multiple methods, used either in succession or simultaneously, only one needs to work for therapy to be labeled "successful". Practitioners thus attempt to disguise their ignorance by counting their hits and ignoring their misses. According to practitioners, mental health problems are complex and so it should not matter whether it was the 2nd, 5th, or even 10th intervention that finally worked. What matters is that the desired result was achieved! Achievement through adaptability is constantly at the forefront of practitioners' therapeutic decisions, using this central strategy to maintain the perception that they are competent and therapy is effective.

4.2 The Importance of Operationalizing Therapeutic Goals

Managing therapeutic goals and outcomes is a central task, with practitioners wanting to minimize the ignorance ascribed to them and maximize the patient's motivation. A key technique that facilitates the downplay-achieve strategy is the operationalization of goals. Practitioners emphasize the importance of constructing goals that are SMART [**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound]. The abstract desires patients often present with must be transformed, broken down into concrete operational definitions.

The operationalization of these goals has several ignorance management functions. First, designing goals in concrete language allows practitioners to evaluate their feasibility, informing them whether the goal is worth pursuing. "Worth pursuing" in this context meaning that practitioners expect the patient to make noticeable progress within a reasonable time frame. Second, this process of aims reconstruction gives the practitioner the opportunity to shift the patients' aspirations downward. Practitioners can lessen the risk of disappointment by reframing and reducing an overly ambitious goal, using "realistic" and similar terms to sell patients on these new goals. Or, rather than redefining the goal, practitioners can replace it. Practitioners regularly shift the patient's attention and reorient therapy towards less disappointment-inducing goals, negotiating through the "We can't do that, but we can do this" form described earlier by Julie. Either way, downplaying produces new goals that practitioners see as more achievable.

Finally, concrete goals can help reduce disappointment by acting as a *sensing technology*, "making that which is imperceptible into something that we can perceive" (Robbins et al. 2021:1106). Operationalizing goals and progress through tools like

standardized scales is a particularly powerful method of maintaining motivation later in therapy. Practitioners might "show" patients the changes in their scores over the course of therapy to create a sense of progress, "proving" that therapy is working and that the patient is getting better. The combination of operationalization and downplaying here can be particularly effective as 1) the threshold of evidence required to demonstrate of positive change is comparatively low, and 2) achievements are more clearly legible to the patient (Robbins et al. 2021). Practitioners can 'appeal to exemplars' (Whooley 2019:223-24) by pointing to the patient's PHQ-9 score, showing how it has dropped from a 22 (severe) to a 12 (moderate). Or they can highlight how the patient has been able to return to work two days a week with modified duties. Downplaying and operationalization help practitioners guide patients' attention, redefining big wins and small wins alike as progress and presenting these changes as evidence of the practitioner's competence.

Though practitioners can use operationalization to produce ignorance through selective attention (Proctor and Schiebinger 2008), this technique can backfire. In these instances, practitioners attempt to produce ignorance and preserve motivation through selective disclosure, hiding any regression or lack of demonstrable progress:

> But see some people, their [Patient Health Questionnaire-9] score doesn't change very much, so I don't push that really like stupendously. So that they don't feel like they haven't changed… But then I'll get them to kind of see the numbers gradually but I won't necessarily put it on the graph because like the difference will be like a tiny, tiny difference. But there will have been some progression you know. (Sasha, MD)

Information is taken but not given, with Sasha producing an unequal distribution of ignorance by concealing outcome data from the patient (Proctor and Schiebinger 2008:8–

9). Therapeutic results are readily shared with the patient when they affirm the practitioner's competence and effectiveness of psychotherapy. But when results paint a more negative picture that could lead to disappointment, outcome data is obscured. Through this strategy, practitioners hope to prevent a loss of patient motivation and trust that could occur if the patient was confronted by the lack of easily observable progress. Ignorance is thus managed through the selective disclosure of information, with practitioners attempting to maintain their professional authority and keep the patient in the medical encounter by influencing the perceived effectiveness of the treatment.

4.3 The Three-Legged Stool: Reconciling Expectations of Therapy

Ignorance and motivation are not only dependent upon prescribed goals, but also upon prescribed means (Merton 1938; 1957). Practitioners can be made to look ignorant 1) if patient outcomes fail to conform to the patient's expectations, or 2) the practice itself fails to conform to expectations. According to practitioners, patients often have idiosyncratic views of what therapy should look like, a unique mélange derived from representations of therapy in the media, past personal experiences, experiences of friends and family, and personal preferences regarding interpersonal communication styles. Professional bodies, researchers, and government prescribe rough boundaries of acceptable interventions. Though practitioners are well aware of these prescriptions, patients generally are not, leaving practitioners to reconcile any discrepancies:

> If that conversation gets shut down, and it's not a direction people want to go, I'll shift gears. I can really easily shift to very straight CBT kind of work, or people want to talk about childhood history, which I think has value too. All these things have value in their own right. So I try to adapt and be the therapist that my clients want me to be. Sometimes people just want you to listen and not say a word. And those are always odd. But I'm happy to be that person... I think about this one client all the time when I say that, where I literally saw him for three years and I

> barely said a word. Every other week, bi-weekly. And he would regularly say how valuable my advice was. My advice! He wouldn't just say the time I spent with him. I never gave him a word of advice! But his experience of it was coming out with advice about life. It was very, very interesting to watch… Listening, just being a sounding board so he can bounce ideas off of. But even then, if I if I tried to reflect on anything, even sort of basic listening, active listening skills, he just kept going, whatever was own his mind, there was no pausing to have a conversation. But he found it extremely valuable. (Roderick, CP)

Patient and practitioner views can collide. According to practitioners, the two parties attempt to negotiate a compromise. The initial agreement is continually re-negotiated over the course of therapy, while also being refined through trial-and-error. The degree to which treatment plans reflect the patient's demands is hotly contested. Jutel (2011) agrees with practitioners, presenting this negotiation as a "cooperative interaction" that "made sense within our respective clinical and lived experiences" (p. 13). Other authors however have framed this interaction more as a battle (e.g., Timmermans and Buchbinder 2010), where practitioners selectively disclose the risks/benefits of procedures (shuster 2019), or fail to even mention the existence of alternative procedures (Entwistle et al. 2006).

For clinical psychologists, the difference of opinion can be worked out in the initial intake, where practitioner and patient assess "fit". If fit is poor, with patients wanting to work on a problem and/or use a therapeutic approach the practitioner is not comfortable with, they are usually referred on to practitioners who are more familiar with that disorder and/or problem. For MD psychotherapists however, neither patients nor the public healthcare system have the resources to properly engage in selective allocation:

> I do CBT. Because of the group I'm affiliated with, people are weeded out appropriately so it minimizes the practice. Because it's mainly online we're not doing as much dissociation or as much trauma work. Obviously people slip through this process… we're not supposed to do anyone who is acutely suicidal, but having said that I think probably 33% of my patients have some sort of our

> more suicidal ideation… a lot of trauma and personality disorders sneak through too. (Peyton, MD)

The public healthcare system attempts to create "good fit" by appropriately matching patients with practitioners. According to MD psychotherapists though, this filtering process regularly breaks down, in part because patient demand far outstrips the availability of OHIP-covered therapists. Patients can thus be assigned to practitioners who have little experience with their problem and/or desired approach, leaving the patient with the unfortunate choice of sticking it out with this therapist or terminating. This professional arrangement makes strain resulting from conflicting ideas about therapy a more common issue for MDs than their psychologist counterparts.

Patients' pre-existing expectations can also affect practitioners' ignorance in that they constrain the achieve strategy. Patients might have faith in a specific approach and may be highly skeptical of others, leaving practitioners the option of 1) adapting to the patient's wants, or 2) prioritizing techniques they believe to be the most effective. If a patient comes in with panic attacks and wants Freudian psychoanalysis, practitioners are likely to be frustrated, as the recommended treatment is a combination of exposure and psychoeducation about the panic cycle. Likewise, if the patient is wed to CBT, then practitioners' efforts to incorporate an eclectic mix of techniques from ACT, DBT, or IPT may not be welcomed. Patients' preferred treatment methods can act as a countervailing force. The practitioner is caught between attributions of ignorance produced by discrepancies between actual and expected therapeutic *means*, and attributions of ignorance from discrepancies between actual and expected therapeutic *outcomes*.

Practitioners are caught at the intersection of scientific evidence and individual, idiosyncratic experience (Whelan 2009). Many attempt to negotiate this cost-benefit

trade-off through the concept of the 'three-legged stool' (Peterson et al. 2016), which consists of "what the person wants, what is evidence-based, and what the therapist has actually trained in" (Joanie, MD). On the first leg, adapting to the patient's vision of therapy can help minimize strain produced by discrepancies between the actual therapy sessions and the patient's interpretation of therapy. On the next leg, prescribed 'evidence-based' methods promise to reduce disappointment as these interventions have a documented track record of achieving therapeutic goals. On the third leg, practitioners face their "boundaries of competence". Presumably, practitioners are more effective at achieving therapeutic goals when using interventions they are trained and practiced in.

Again flexibility, not ideological purity, was found to be the primary aim for the practitioners I interviewed. They were happy to mix-and-match, bouncing between conformity to established approaches when patients were amenable to more practitioner-envisioned therapy, and conformity to patient-envisioned therapy when patients were more insistent *and* the approach appeared to be working. Serious strain and disappointment can emerge however when the patient's version does not work. As one more psychodynamically-inclined practitioner revealed, "a lot of soldiers I work with… they think I'm just completely a flake" (Marie-Pierre, CP). These patients want to talk about the "here-and-now"—i.e., about their current problems—not their early-life experiences. Practitioners may entertain that approach for a while. But if practitioners are unable to convincingly instill a sense of progress using the patient's preferred approach, practitioners will likely try to convince patients that other methods can be helpful if given the chance, even if it is not what the patient had initially envisioned.

In sum, according to practitioners, innovation via eclecticism can serve as an excellent ignorance management strategy. Using a variety of methods sequentially or synchronously helps practitioners better realize patient goals. Professionally prescribed methods have sizable amounts of uncertainty due their questionable success rates (e.g., Frances 2013). Variation within a single approach and/or across different schools of therapy helps practitioners cope with this uncertainty and adjust their practices to compensate. However, eclecticism can clash with patients' expectations of what therapy should look like. Practitioners are forced to balance what they want, what the patient wants, and what the research recommends, striving to minimize disappointment that risks increasing the ignorance attributed to the practitioner. Both the means and goals of therapy are regulated by expectations, meaning deviation from either threatens to paint the practitioner as incompetent and undermine their professional authority.

4.4 The Role of Trust and Motivation

I argue practitioners are particularly concerned with increasing patient ignorance while managing how ignorant they appear to the patient as these factors are believed to affect trust and motivation (see also Craciun 2018:991). Practitioners understand psychotherapy not as something that is done to the patient, but as something the patient does. In contrast to Parsons's (1951a) formulation of the sick role, patients in psychotherapy are thought to have the ability to "pull themselves together" and become healthy (Jutel 2011:35–36). As highlighted by a practitioner interviewed by Craciun (2018), "[t]he main problem with therapy isn't ... the actual intervention, it's getting people to do it." (p. 982). Motivation and willpower are understood as invaluable resources in psychotherapy:

> He was a really receptive learner… He was so organized. So he, you know, he really, really made a good effort to kind of keep on top of all of that stuff. So that I think was a big part of his success too. (Tegan, MD)

Patients who "buy-in", make a "good effort", and show "an adaptability and willingness to learn and change" (Tegan, MD) are deemed to be 'suitable' for psychotherapy (Brown 1987, 1990). For them, therapy is predicted to be fast and effective. In contrast, patients who display "rigidity", who are "at a stage in [their] life where [they] didn't really want to change" (Sasha, MD), or for whom "mental illness, depression, anxiety becomes an identity" (Roderick, CP) are understood as problematic and challenging. When engagement and a willingness to change are absent, therapeutic success is thought take longer, if it arrives at all. A good practitioner must then "be a good salesperson" (Marie-Piere, CP), capable of winning the patient over and mobilizing their effort. In sum, 1) practitioners see motivation as central to psychotherapy, and 2) motivation is thought to be greatly influenced by the patient's perception that the practitioner is competent enough to successfully realize the patient's mental health expectations. Motivation and ignorance are thus deeply intertwined, giving ignorance management a central place in psychotherapy as well.

This is not to suggest that psychotherapy is a placebo that only works because patients want it to. For practitioners, the belief that psychotherapy is effective is important, but only insofar as belief motivates effort. A willingness to invest effort in the absence of belief can still produce positive results. At the heart of the CBT model is the "cognitive triangle", a framework that argues there is a reciprocal relationship between our thought, feelings, and behaviours. Techniques like thought records use the typical pathway, acting on patients' thoughts to change their feelings and behaviours.

Alternatively, practitioners can use patients' behaviours to change their thoughts and feelings, essentially asking the patient to act as if they were not sick and "just start doing things" (Cassandra, MD). According to practitioners, if you "decide to do it" treatment can succeed, even if your "gut" still harbours doubts about the effectiveness of the practice. Ultimately, practitioners see a fundamental link between effort and success in therapy. Belief in the practice and practitioner are incredibly helpful in mobilizing effort, but it is not always necessary for the practice to function.

4.5 Conclusion

In conclusion, practitioners are acutely aware of and concerned with patients' attributions of ignorance. Health professionals must manage ignorance at the conceptual level, convincing the public and governments of their competency to justify their professional authority (e.g., Abbott 2014; Whooley 2019). I demonstrate that health professionals must also manage ignorance within the patient-practitioner interaction, shifting the focus of research on ignorance management from public discourse to practice (Whooley and Barker 2021). Health care interactions are replete with uncertainty and ignorance (e.g., Pilnick and Zayts 2014; Rafalovich 2005; Timmermans and Buchbinder 2010). Practitioners seek to control the creation of expected outcomes and perceptions of treatment effectiveness in order to appear competent, hopefully securing the patient's trust and preventing premature discontinuation. Through successful ignorance management, patients are kept in therapy longer, remaining enmeshed in medical frameworks and under the practitioner's supervision.

Practitioners employ a variety of ignorance management strategies, seeking to selectively alter the patient's ignorance to ensure the practice, profession, and practitioner

themselves are seen as competent and effective. I argue that the primary strategy practitioners employ is a downplay-achieve approach. Practitioners use the many models of health to establish downplayed therapeutic goals, flexibly alternating between different definitions to accommodate changes in the patient's condition and ensure goals are always "realistic". Practitioners then attempt to fulfill these promised outcomes, eclectically using interventions to increase the likelihood of the patient achieving their goals. A key step in the downplay-achieve strategy is the operationalization of goals and outcomes in concrete, measurable terms.

A second source of ignorance in therapy is the discrepancy between practitioners' method and patients' expectations of therapy. Like therapeutic goals, therapeutic means must be managed to not appear ignorant. Patients' expectations here restrict the types of techniques practitioners can employ without appearing ignorant, limiting practitioners' ability to achieve promised outcomes. Practitioners are left balancing three potentially conflicting demands: what the patient wants, what the practitioner wants, and what the evidence recommends. If ignorance—as indicated by strain and disappointment—abound, then patients are unlikely to feel motivated, reducing the likelihood of therapeutic success and increasing the likelihood of premature discontinuation, outcomes no practitioner wants.

In the following chapter (Chapter 5), I outline how psychotherapy medicalizes everyday problems and practices. In the final chapter (Chapter 6), I integrate these themes of ignorance management and medicalization, discussing how these two processes interact and conflict.

Chapter 5

Medicalization Through the Re-Definition of Problems and Solutions

In this chapter, I examine how psychotherapy medicalizes everyday life. "Medicalization" is often implicitly equated with "overmedicalization" (Conrad, Mackie, and Mehrotra 2010) and assumed to have critical, negative connotations (e.g., Strong 1979; Whalen and Henker 1977). Like with "ignorance", I do not use the term "medicalization" as a negative judgement, nor do I seek to ascertain whether a given problem or practice is "truly" medical. Instead, I aim to analyze the process by which problems and solutions become understood as mental illness and psychotherapeutic interventions, respectively. In the first part of this chapter, I argue that practitioners have an ambivalent attitude towards the DSM's view of mental illness, using DSM diagnostic labels yet preferring to treat mental illness as a biopsychosocial feedback loop—an active, multifaceted, self-maintaining process. Here, definitions of "illness" remain loosely coupled to the official language of the mental health professions, which allows practitioners to medicalize problems outside of the issues contained in the DSM.

In the second part of this chapter, I outline an often-overlooked form of medicalization: medicalization via the re-definition of solutions, "solutions" referring to practices or substances that come to be understood as medical treatments. I develop this concept by contrasting it against existing approaches that predominately emphasize medicalization via the re-definition of problems and deviance. I then briefly outline historic examples of this process—the medicalization of the opium poppy and the demedicalization of honey—to demonstrate how the re-definition of solutions facilitates the expansion of medical language and the jurisdiction of health professionals. Next, I

apply this lens to examine the practice of psychotherapy. I propose that practitioners ascribed a medical, healing function to lay 'emotion management techniques' and social support (Hochschild 1979, 1983:24; Thoits 1985). Drawing on Thoits's emotion management techniques, I detail the parallels with practitioners' intervention methods, showing how practitioners are bringing everyday emotional management techniques under the purview and expertise of mental health professionals. I finish by connecting psychotherapy's medicalization of emotion management techniques and social support to the broader medicalization of emotions, showing how medicalization through the re-definition of solutions must be examined alongside medicalization through the re-definition of problems to fully gauge the extent and nature of this process.

5.1 Medicalization Through the Re-Definition of Problems

Medicalization can broadly be understood as the process by which "something becomes defined as medical" (Conrad and Slodden 2013:62). Professionalization (Conrad 2007:12) or medical imperialism (Illich 1976), meanwhile is the process whereby problems and/or practices are re-defined and brought under the jurisdiction of a profession. The construction and application of formal diagnoses is central to the re-definition of an issue as a medical and/or professional problem. Research from the sociology of medicine (Freidson 1988[1970]:244; Jutel 2009; Rosenberg 2002), the sociology of professions (Abbott 2014[1988]:52–55), and even Hippocrates himself (2005:183) all stress the importance of diagnosis in establishing the authority of health care practices, practitioners, and professions.

Consistent with this research, practitioners I spoke with also emphasized the importance of diagnosis in psychotherapy. Psychotherapy typically begins with

practitioners collecting information through past medical records, various questionnaires, and a series of over the phone and in-person intake interviews to get "an idea of what [the patient] is coming in for" (Bethany, MD). This mass of information is then organized through "case conceptualization" or "formulation", in which practitioners attempt construct a coherent picture of 1) who the patient is, 2) what their problem is (i.e., a diagnosis), and 3) how treatment should proceed. The transformation of "problems in living" (Szasz 1961) into formal, codified medical diagnoses is thus a key first step that practitioners use to help structure and inform the planned course of treatment.

Throughout the interviews, participants and I discussed patients diagnosed with a variety of DSM-5-TR mental disorders, including major depressive, obsessive compulsive, binge eating, dissociative identity, adjustment, post-traumatic stress, and specific phobia, as well as corollary issues such as substance use, work-related burnout, abusive relationships, and suicide. Practitioners assign every patient at least one DSM diagnostic label to justify treatment, reinforcing the central role of the "psychiatric Bible" and formal diagnosis in medicalizing patients' presenting problems (Halpin 2016; Pickersgill 2023). However, "[k]nowing how categories are defined does not tell us how health professionals use a category" (Halpin 2022a:8), with practitioners enacting the same diagnosis in potentially very different ways (Mol 2002).

Though problems were invariably transformed into DSM disorders, practitioners harboured an ambivalent attitude towards this practice and framework. Agreeing with Balint (1964:40), practitioners recognized the importance of a shared, concise diagnostic framework and its ability to coordinate mental health professionals. But, consistent with previous investigations of psychiatric diagnostic practices (Brown 1987; Whooley 2010),

this framework is also positioned as peripheral to professional work. Practitioners use the DSM while simultaneously challenging its categorical framework through criticism, ridicule, and efforts to restrict the manual's influence (Pickersgill 2023):

> We need a classification system so we can be talking about the same thing at the same time, some of the time. But we shouldn't fool ourselves that the categorization system works. (Eugene, CP)

In place of the DSM's framework, practitioners prefer to approach mental illness as if it were a "feedback loop", "cycle", "cascade", "spiral", or "corkscrew". In other words, as an active, self-maintaining process that tends to progressively get worse. Eugene continued on, outlining how this understanding can be used to guide therapy:

> I mean theoretically, OCD is just a feedback loop right? It's a feedback loop. It's very much like becoming afraid of a dog, except you've become afraid of the thought, a theme of thought. And then you're doing all these safety seeking behaviors, which we call compulsions in OCD, or avoidance behaviors. And that becomes this feedback loop that strengthens the belief. Like I have to do something about this thought I'm afraid of… Very hyper vigilant to the thoughts of a specific theme. And then of course, you can't stop thinking about it. Bunch of your behaviors related to those thoughts. So once you become aware of that feedback loop, you can just interrupt it. That's what exposure response is doing really… you just stop it from becoming this self-reinforcing thing.

This understanding of mental illness as a feedback loop is nothing new, appearing in both psychology and sociology. Prominent acceptance and commitment therapist (ACT) Russ Harris (2008) has argued that mental illness is a "vicious cycle" in which problematic thoughts beget problematic emotions, which beget problematic behaviours, and so on. Although this understanding does exist in the literature, it does not seem to be explicitly taught to practitioners, hence the diversity of terms they employed to describe this phenomenon. Feedback loops also feature prominently in sociological theories of

deviance and mental illness, notably in Parsons's (1951b:173) "vicious circle" and Becker's (1963:37) "deviant cycle".

DSM diagnoses only capture a part of how practitioners enact mental illness, with the biopsychosocial feedback loop helping decouple case conceptualization from DSM categories. Specific disorders are used as a rough guide to facilitate practitioners understanding of patients' problems. However, practitioners regularly question the manual's clinical utility, paralleling critiques raised in the literature (e.g., Frances and Nardo 2013; Zimmerman et al. 2015). Eugene went on to explain the difficulties of integrating DSM categories into therapy:

> OCD can look like 1000 different things. And the function of the compulsions can be radically different in two people who fit into that category. It's still useful to be able to say they're both stuck in that OCD loop. But you can't stop there, you have to map it in the person who's in front of you… It's the same treatment in the sense that it's some version of CBT with exposure therapy. But you have to know what fear you're supposed to face or what compulsion you're supposed to stop. And that is mapping the problem and that is different in each person.

Case conceptualizations are tailored to the individual, not the disorder. DSM disorders however still play an important role, functioning as a second-level framework. Practitioners note that certain disorders are associated with certain prognoses (e.g., suicide risk in BPD but not OCD), and that certain types of therapy tend to work better for certain problems (e.g., CBT typically works well for anxiety but not trauma). The feedback loop meanwhile functions as a third-order, overarching framework that transcends DSM categories by creating a core common to all disorders and therapies.

Focusing solely on formal diagnostic criteria risks underestimating the full extent of the medicalization facilitated by the practice of psychotherapy, overlooking aspects of everyday life that practitioners pathologize through their more comprehensive case

conceptualizations. The biopsychosocial feedback loop and this multilayered understanding of mental illness facilitates medicalization, providing practitioners with a framework that helps extend their enactments of mental illness beyond the confines of the DSM. From the biopsychosocial feedback loop perspective, the emotional, psychological, and social worlds all potentially contribute to the feedback loop and so must be monitored. This overarching understanding of mental illness is thus seen as giving practitioners license to bring vast swaths of everyday life under a psychomedical framework and their professional purview.

The biopsychosocial feedback loop means that practitioners frequently medicalize the social world, positioning social norms, roles, and relationships as key stressors that can initiate and maintain the feedback loop. Practitioners partially individualize and internalize these social dynamics through the concepts of shame and guilt, "the moral emotions" (Scott, CP), which arise when the individual believes that they have failed to uphold role obligations, transgressed social rules, or violated the trust of another (Turner 2010:135). Shame and guilt are then linked to mental illness (e.g., Kim, Thibodeau, and Jorgensen 2011), completing the medicalization pathway by re-defining these social phenomenon as precipitating and/or perpetuating factors (Carr and McNulty 2016:811).

In addition to medicalization via the labelling and re-definition of problems, practitioners also medicalize by administering treatment. Conrad (2007) argues that medicalization can occur when "a problem is defined in medical terms … or "treated" with a medical intervention" (p. 5). Practitioners regularly utilize this second method, administering psychotherapy to treat a variety of "problems in living" (Szasz 1961):

> I don't know if this is just my patient mix, but what I'm finding a lot of it is trying to navigate people who are struggling in their relationships. They might not

> necessarily have a mental health diagnosis that would fit DSM criteria, but they're in a lot of distress because they're having a hard time relating to other people in their lives. Their wives, their kids, what have you. So that's been I think something that's surprising to me, that I can't always put a diagnosis on somebody. But it's obvious that somebody is struggling and having functional impairment because of troubles in their personal relationship. (Tegan, MD)

Tegan notes how medical-professional language and understandings, specifically the DSM, can lag behind medical-professional practice. According to practitioners, many of their patients are "distressed", have past or ongoing relational trauma, are experiencing work-related burnout, all of which are problems that exist outside of the formal DSM categories. Practitioners can attempt to stretch DSM diagnoses to cover these issues, which is often done to secure private insurance or OHIP coverage and ensure the patient is able to access psychotherapy. As highlighted by Tegan though, even when a DSM diagnosis is not readily forthcoming, medicalization persists through the application of a medical treatment (i.e., psychotherapy) to the problem. In doing so, practitioners reinforce the belief that these types of problems are best "solved" through medical interventions administered by health care professionals. Again, social dynamics are positioned as medical problems that should be under the jurisdiction of health care professionals. In sum, thanks to the biopsychosocial feedback loop, practitioners are encouraged to engage with social processes, re-defining and treating these social problems as putative causes or expressions of mental illness that require the supervision of a mental health professional.

5.2 Medicalization Through the Re-Definition of Solutions

In this section, I extend medicalization theory to the re-definition of solutions. Rather than looking at how re-definition and/or the application of a medical treatment can

transform a previously non-medical issue into a "medical problem", my analysis focuses on how an intervention that previously was not seen as medical in nature is transformed into a "medical intervention"—i.e., a treatment or therapy. I argue that focusing on the re-definition of problems limits the applicability of medicalization theory by overlooking how medicalization can "shape ideas about illness *and healing* [emphasis added]" (Barker 2014:168). By considering how previously non-medical practices and substances come to be understood as medical solutions, I enable medicalization theory to better explore the proliferation of health care professions into everyday life.

Accounts of medicalization have predominately focused on the re-definition of problems (Showalter 2019), showing how criminality, deviance, badness, and "problems in living" come to be understood through formal diagnoses and the label of 'illness' (e.g., Conrad and Schneider 1992; Rimke and Hunt 2002; Szasz 1961). Other medicalization pathways exist, for instance a problem can be medicalized when it is treated with medical interventions like pharmaceuticals (see Abraham 2010). For example, stimulants were used in clinical practice to treat behavioural problems for decades prior to the emergence of "hyperkinetic impulse disorder" (Conrad 1975). Hyperactive behaviour was initially brought under the supervision of physicians and medicalized through the professional administration of treatment, with the construction of a diagnosis only coming later.

Although medicalization through the re-definition and/or application of medical interventions to problems is an incredibly important form of medicalization, the emphasis on "problems" misses other crucial ways medical and professional understandings are applied to new objects. While traditional medicalization theory and pharmaceuticalization question whether diseases and disorders are inherently "medical", we can also ask

whether interventions are inherently "medical" or whether their medical nature is also socially constructed. In this chapter, I take the latter position, arguing that the "something" (Conrad and Slodden 2013:62) being re-defined through medical language might not be a problem but a solution. For instance, returning to hyperkinesis, rather than examining the creation of the disorder as Conrad (1975) did, my approach would instead question how stimulants become medicalized—i.e., understood as a medical substance to be administered to sick or disordered persons under the authority of physicians.

Like diagnostic frameworks and the construction of problems, treatment frameworks and the construction of solutions are central to the expansion of medical jurisdiction. Though in theory these two types of professional work are conjoined, in practice diagnosis and treatment frameworks can diverge (Abbott 2014:56). For participants in my study, treatment did not have a strict one-to-one correspondence to diagnosis (e.g., always using treatment A for disorder X but treatment B for disorder Y). Instead, treatment plans were only partially prescribed by DSM categories (see also Brown 1987), with practitioners also orienting their treatment decisions around the feedback loop. Treatments (i.e., solutions) can thus diverge from diagnoses (i.e., problems; Whalen and Henker 1977), opening new ways for the health care professions to spread medical understandings and expand their professional jurisdictions.

By focusing on medicalization via the re-definition of solutions, we can explore these pathways, looking at "medical interventions" and their histories. I argue that the medical profession has expanded by medicalizing procedures and substances that were previously lay, everyday activities or under jurisdiction of a different profession. For example, when the opium poppy (*Papaver somniferum*) first saw use in the Neolithic

period (*c.* 5,000 BCE) in Western Europe, it was used for cooking, as a recreational intoxicant, in religious ceremonies, and as an aphrodisiac (Kritikos and Papadaki 1967; Merrillees 1962:292). According to Counsell (2008), there is "no indication of any medicinal application at this time" (p. 197). It was not until the Bronze Age (*c.* 3,300-1,200 BCE) the plant first saw uses in medicine (Rudgley 1993:28). This medicalization process accelerated during the 17th-century with the invention of laudanum (Kramer 1979), followed by morphine and heroin in the 18th-century, (Conrad and Schneider 1992:120–21; Lindesmith 1965:129–30), and eventually OxyContin, Fentanyl, and others in the late 20th and early 21st-centuries (Currie and Hannes 2021).

While the poppy moved from non-medical to medical, the history of honey evidences the opposite process. Indeed, "the use of honey as [a] … health agent is much older than the history of medicine itself" (Kuropatnicki, Kłósek, and Kucharzewski 2018), with the first written record dating back to Egypt *c.* 5,500 BCE. Honey continued to play a pivotal role in medicine following the Arab conquest in the 7th century (Perho 1995), and only began to fall out of favour in the first half of the 19th century as the Ottomans imported modern European-style health care (Derr 2021; Shefer-Mossensohn 2014). This de-medicalization was further cemented in the 1950s and '60s by the new emphasis on biomedicine and laboratory science (Baker 1978:220). Honey was once the prize jewel of ancient Egyptian medicine (Nunn 202:148), whereas today it has largely been dismissed to complementary and alternative medicines, showing how far this former wonder drug has fallen. Accordingly, I argue that one way we can conceptualize medicalization is in relation to what is defined as a medical intervention—with medicine

re-defining everyday problems *and* everyday solutions. In the remainder of this chapter, I discuss how psychotherapy re-defines lay practices as medical interventions.

5.3 The Medicalization of Everyday Life in Psychotherapy

I begin by examining two areas that have perhaps experienced the greatest medicalization in psychotherapy: emotion management and social support (Thoits 1985). Building on medicalization through the re-definition of problems, medicalization through the re-definition of solutions has enabled practitioners to permeate emotion management and social support with mental health connotations (Furedi 2003; Wright 2015). I connect lay emotion management and social support to the various intervention methods practitioners use, demonstrating how these previously non-medical and non-professional practices have been placed at the heart of psychotherapy and fundamentally linked to the management of mental health. I then explore the broader societal consequences of this medicalization and professionalization effort. I conclude by discussing how the framework introduced at the start of the chapter—medicalization via the re-definition of solutions—opened the way for this investigation and in-depth understanding.

5.3.1 Emotion Work and Management

Emotion management has been so thoroughly medicalized and incorporated into psychotherapy that the two practices are often believed to be synonymous. Practitioners encourage patients to understand their thoughts, feelings, and bodies through a medical framework, simultaneously positioning mental health professionals as the knowledgeable (i.e., non-ignorant) and rightful authority on emotion management. Meanwhile, the emotion management techniques devised by family, friends, and the individual themselves are discredited as ineffective or problematized as actively harmful. Through

this practice, practitioners attempt to fortify their treatment and jurisdictional claims while concurrently eliminating non-medical use of these techniques. I begin by explaining Thoits's (1985) emotion management framework to show how many of the lay techniques she articulates are analogous to the intervention methods practitioners employ in psychotherapy. I then breakdown how practitioners and the larger mental health research complex extends their language and expertise over these activities.

Building on Hochschild's (1979, 1983) study of emotional systems, Thoits (1985) proposes a framework of everyday 'emotion management techniques' that individuals use to bring their emotions into conformity with normative feeling rules. Thoits's framework is based on research from non-mental health related samples—namely university students, flight attendants, and bill collectors (see Hochschild 1983)—and the concept of emotion management can be traced back to etiquette books popularized throughout the 18th, 19th, and early 20th-century (Elias 1978[1939]; Lakoff 1975; Wouters 1995). Despite these non-medical origins, Thoits (1985) notes that "different schools of therapy advocate techniques that correspond broadly to major types of emotion work described here" (p. 242). Over time, mental health practitioners have ascribed a medical function to these techniques by incorporating them into clinical practice, repositioning techniques that manage *emotions* (i.e., non-medical) as techniques that manage *mental health* (i.e., medical; Béjar 2014; Hochschild 1983:192). I next outline Thoits's (1985) emotional management techniques, demonstrating the clear parallels between said techniques and the "medical interventions" employed by practitioners of psychotherapy.

Thoits (1985) proposes six emotion management techniques: 1) the behavioural manipulation of situational cues, 2) cognitive manipulation of situational cues, 3)

behavioural manipulation of physiological sensations, 4) cognitive manipulation of physiological sensations, 5) behavioural manipulation of expressive gestures, and 6) cognitive manipulation of cultural labels. The first technique, the cognitive manipulation of situational cues, is when external circumstances are "reinterpreted to seem less threatening or problematic" (Thoits 1985:234). Here, Thoits provides the examples of devaluing one's initial goals and distracting oneself from the perceived problem. The manipulation or reinterpretation of external situations pervades common CBT tools like thought records and behavioural experiments. Themes of reinterpretation also appear in acceptance and self-compassion work, as well as in concepts like "internal locus of control" and "circle of control":

> If you go on stress leave and you find, "You know what? I'm realizing is my job actually doesn't matter. It's just to fund the rest of my life". So then maybe the minutiae of all those stressors can just roll off my back more easily. If I can say, "I don't care, I'm just here to earn a living", then I can go home and make the rest of my life more meaningful right? (Roderick, CP)

Roderick encourages their patient to reassess and devalue their initial goal, "insightfully" realizing that their job "actually doesn't matter". Practitioners regularly seek to bring the patient's ambitions in-line with their resources and ability, hopefully alleviating strain by reducing the demands patients place on themselves. Even the distraction method mentioned by Thoits is borrowed by practitioners, who encourage patients to use "healthy distractions" (Cassandra, MD) like exercise or socializing to improve their mental health.

The parallels between Thoits's cognitive manipulation of situational cues to manage emotions and practitioners' clinical interventions are even more obvious in an example Thoits provides, quoting one of Hochschild's interviewees:

> I try to remember that if he's drinking too much, he's probably scared of flying. I think to myself, “he's like a little child”. Really, that's what he is. And when I see him that way, I don't get mad that he's yelling at me. He's like a child yelling at me then. (Hochschild 1983:55)

This same exact strategy is employed by practitioners:

> I give the example of someone in a checkout line in the grocery store, somebody's having a really bad day and they are losing it. Like the person in front of them has 13 items, not 12. And they're mean to the cashier, the cashier did nothing wrong. Someone peed in their cornflakes. This is terrible. I can tell you that there's nothing that that cashier can do to make that person's experience a five star. Nothing… So that person was having a bad day. That person was probably bullied all their life. That person probably had terrible co-workers. Maybe was sick, maybe was being pressured to show up at work, maybe had four different places to go. Or just as generally miserable because that's all they know. They're wearing their “I'm miserable” glasses. (Tracey, MD)

In both situations, the problematic behaviour of another person is reinterpreted. However, Hochschild’s example seeks to manage emotions while Tracey’s seeks to manage mental health. As I suggest, clinicians are largely using a re-packaging of lay techniques that, as seen in Thoits (1985) and Hochschild’s (1979, 1983) work, have no intrinsic association with medicine, psychotherapy, or mental health. By using these techniques in therapy for decades, mental health professionals have re-defined previously non-medical techniques that manage emotions (Wouters 1995) as medical techniques that manage mental health, allowing medical and professional understandings to proliferate.

The next technique outlined by Thoits (1985) is the behavioural manipulation of situational cues, i.e., when individuals “actively avoid or leave the situation, replace certain situational features with others, or construct entirely new situations” (p. 234). This technique has clear parallels to practitioners’ encouragement of action and criticism of

avoidance. Most practitioners mentioned that they have supported or even pushed patients to leave problematic situations, finding new jobs, new relationships, etc.:

> The first goal was to get her parents out of her house or her out and give her some way to extricate. So she had moved away from out east and come to Ontario to get away from her parents as a teenager like 17-18. But then her parents, as an adult, because they were feeling unwell and wanted her to look after them. And the other sister completely cut them off, wouldn't even talk to them. So they followed her to the same town. And actually, she's a pleaser. Her parents moved in with her even though they're abusive, with her husband whose already there. And they [the patient and her husband] actually had to move to the basement… We worked on that every session, getting her to work through boundaries and to discuss with her parents that really long-term it wasn't okay to stay here. We had her helping her parents looking for appropriate living, nursing homes, retirement homes. (Peyton, MD)

Though internal, cognitive changes are seen as the bread-and-butter of psychotherapy, practitioners are quite willing to use external action to manage the patient's mental health. Sometimes reappraisal is deemed insufficient, with practitioners instead coaching patients on how to make concrete, situational changes. However, these actions and external changes promoted in therapy are to be understood through a psychomedical framework, where patients are told to always stop and consider whether a behaviour or course of action will improve their mental health or exacerbate their mental illness.

The third technique is the behavioural manipulation of physiological sensations, which can be produced through "drugs, alcohol, coffee, cigarettes, deep breathing, or exercise" (Thoits 1985:235). Again, through psychotherapy, practitioners assign medical understandings to the use of these everyday substances and activities:

> The social activity and even the relationship towards alcohol. The value that you have towards that, it's bonding, there's a social connection. And I'm never gonna give it up completely that social connection with friends. But I need to stop doing it when it's not connecting me to people. And so again, what value do you have in alcohol? It's a social connector, social lubricant. But if I started using it in ways

> that are isolating. If I'm drinking alone in my house, well, that's not how I value it, it's actually against my values to drink that way. (Roderick, CP)

Initially, Roderick's patient ascribed social, leisure, and emotion management functions to drinking alcohol. Over the course of treatment however, the emotion management and leisure uses are pushed aside, ideally becoming dissociated from this activity/substance while a medical, mental health related function is added. Rather than thinking about whether alcohol makes them feel good (i.e., emotion-centred usage), the patient is encouraged to consider how their drinking affects their mental health in terms of living in align with personal "values" (i.e., authenticity). The social function is allowed and even encouraged to remain because social relations are assigned a therapeutic purpose in psychotherapy, with practitioners teaching patients that good social support and positive social interactions are healing. The final two items mentioned by Thoits—deep breathing and exercise—have been particularly medicalized in psychotherapy. Practitioners regularly prescribe these activities to patients in an effort to interrupt the feedback loop, stressing how important deep breathing and exercise are for mental health.

The same pattern holds for Thoits's final three emotion management techniques, whereupon being integrated into therapy their medical function becomes increasingly dominant while non-medical functions are diminished or even overwritten. For example, the fourth technique, the cognitive manipulation of physiological sensations, involves "rescan[ning] bodily sensations for those associated with an appropriate state" (ibid:235). Practitioners from all schools of therapy stress the importance of this technique and the need to help patients "learn how to know what they're feeling… [and become] aware of

themselves" (Rodger, CP). In the professional context of psychotherapy, this introspective, internal monitoring is formalized as "emotional processing":

> There's four or five step process of emotional processing. So one, you have to be able to label. Once you can label it, you got to tolerate it. Or sometimes you got to tolerate before label… Once you can tolerate, then it's about exploring and differentiating. So, "Oh, this is shame". But this isn't shame like that shame. This is like shame when that happened, like you forgot to feed your kids or something. There's shame when like your dad points at you shame. It's not just shame, a little bit of fear here too, right? So really exploring. (Scott, CP)

Practitioners coach patients on what emotional labels to use, making use of tools like an "emotions wheel"—a visual graphic which lists and links different emotional states to a specific colour and/or design pattern (e.g., sad is blue and anger is red). Alternatively, practitioners might facilitate emotional processing by 'reflecting back' (Craciun 2018). Practitioners can point out the patient's facial expressions, body tension, and other external signs of distress while simultaneously asking patients to reflect on what emotions they are experiencing in that moment, using the dyadic interaction of psychotherapy to teach patients how to simultaneously explore and manage their internal states (Reddy 2001). Crucially, by engaging in this activity in the context of psychotherapy, practitioners ascribe a medical function to emotional processing, encouraging patients to associate the monitoring of internal sensations with their mental health, attaching medical meanings where there previously may have been none.

The penultimate technique, the behavioural manipulation of expressive gestures, involves using our outward expressive gestures (i.e., 'surface acting') to manipulate our internal feelings (i.e., 'deep acting'). This technique is commonly used in acting, where the individuals pretends and behaves "as if" their outward displays were authentic in an

attempt to convince their internal feelings to follow suit (Hochschild 1983:42). The exact same language is used by practitioners with their 'acting as if' technique:

> People can restructure their beliefs and rewrite them. But they're not going to believe it. Intellectually they can say, "Yes, I think this is a better rule, assumption, or belief". But in their gut, they don't believe it. So by 'acting as if', you say, "What would a person do, what would I do, if I believe this?". I would apply for this job. I would spend an hour on my presentation and no more. I would clean half the house and not the whole house. And then you just start doing those things. And then you after you do those things, the experience of doing them and realizing that the world doesn't fall apart if my house is not perfectly clean, it helps people to start believing their new restructure belief… Fake it 'till you make it. That's got a big bad rap to it, but it works. But I'd say 'acting as if', it's actually like *a CBT technique* [emphasis added]. (Cassandra, MD)

Practitioners again appropriate an everyday emotional management technique that, according to Hochschild (1983), originated with actors, not practitioners. However, as Cassandra asserts, 'acting as if' is now "a CBT technique", becoming medicalized by being re-defined as a putative solution that can improve patients' mental health.

Finally, the sixth technique described by Thoits is the cognitive manipulation of cultural labels, which involves relabeling one's experiences "transforming a nonnormative feeling into a normative one" (1985:235). Practitioners enforce normative feeling rules (Hochschild 1979; Thoits 1985), telling patients that certain kinds of events should produce certain kinds of emotions. A common example used by practitioners is that someone violating your trust should lead to sadness and/or anger, not numbness and dissociation. Manipulation of cultural labels is also incredibly prominent in practitioners' efforts to normalize distress and negative emotions (see Chapter 3.2.1). Through these efforts, feelings and emotions become intimately connected to mental health, turning emotion management techniques into mental health management techniques.

In sum, the intervention methods that practitioners use in psychotherapy to manage mental health overlap greatly with techniques individuals use in their everyday lives to manage emotions. Therapy might be more than these lay strategies, but it nonetheless heavily borrows from them. As I argue, these solutions that were previously thought of as regulating emotions are increasingly thought of as regulating mental health. A healing, health-related function has been added to these activities, justifying practitioners' jurisdictional claims and activities in these areas. This re-definition that equates emotion management techniques with mental health management techniques also promotes the view that emotional problems are best treated by practitioners of psychotherapy, showing how the construction of problems and solutions intertwine to facilitate the proliferation of medical frameworks and professional authority.

5.3.2 The Discovery of Social Support

In addition to these six techniques, Thoits identifies social support as a resource that greatly influences the success of emotion management efforts. Good social relations are understood as a mediating factor between emotional management techniques and outcomes. Practitioners also place a premium on social support and positive social relations, monitoring the patient's existing support networks and teaching patients how to strengthen said networks to improve their mental health:

> It's also looking at those important spheres around them. In many cases, of course, that's like that family or the caregiver network. And so for, that particular individual, is that support network around them equipped in some way to support as well?... That's what I'm really looking at all the time as best I can. (Joyce, CP)

In contrast to Thoits, practitioners present social support as an intervention in itself, a technique that can be used to manage emotions and mental health. Social relations with

friends, family, and even the practitioner—known as the "therapeutic alliance"—are regularly employed in psychotherapy in an effort to break the feedback loop of mental illness. Socializing and turning to valued others for support are enlisted into the therapy as a form of treatment, assigning a health-related function to acts that typically have social functions. Patients and practitioners thus come to associate these activities with mental health outcomes and medical language.

Like with emotion management techniques, Thoits makes the connection between lay social support used to manage emotions and the professional mental health management in psychotherapy, referring to the practice as "the purchase of social support" (p. 241). By emphasizing medicalization through the re-definition of solutions, I argue that psychotherapy can be viewed as the *medicalization of social support*, not merely its professionalization or commodification (though these remain important elements connected to medicalization).

The term "social support" itself provides an excellent demonstration of the power of medicalization via the construction of solutions. The concept of "social support" was once used in several fields, both inside and outside of medicine. However, psychotherapy and other medical practices have re-defined the term, stripping away the older non-medical uses and making the medical definition dominant. Searching "social support" on Google Scholar for results prior to 1960 reveals how multifaceted this concept once was. In this period, "social support" was used in mental health research with the same connotation we assign it today (e.g., Klonoff et al. 1960). But the term was also used in sociology to refer to the public's interest in scientific research (Merton 1938); in political science to refer to people's level of support for government policies (Young 1952); in

social psychology, where it was used to explore attitudinal change on social issues (Hardy 1957); and in industrial/organizational research to examine how relations among colleagues impact productivity (Blau 1960).

In stark contrast, when searching "social support" and looking at recent decades, one is greeted with pages upon pages of articles from psychologists, sociologists, epidemiologists, and all manner of health professionals who define social support as a health-promoting activity and resource (e.g., Cunningham and Barbee 2000; French et al. 2010; Gottlieb and Bergen 2010; House, Umberson, and Landis 1988; Taylor 2011). The medical definition of social support has triumphed. Usage of the term has been restricted to health-promotion while non-medical understandings have gradually been pruned away.

Practitioners and researchers have also increasingly professionalized the idea of social support (e.g., Wright 2015), which further helps medicalize the concept. Most notable here is the work by mental health researchers in the 'help-seeking' literature which broadly examines 1) who individuals turn to for assistance when faced with problems in living, and 2) the factors which influence these help-seeking decisions. Despite finding that individuals typically address their problems through informal help-seeking (i.e., friends, family, and colleagues) (Narikiyo and Kameoka 1992) or self-reliance (Gulliver, Griffiths, and Christensen 2010), researchers regularly problematize these choices, arguing that "people do not receive the sort of help they need from their informal supports" (Rickwood et al. 2005). In the place of supposedly "deficient" self-reliance and informal social support, researchers and clinicians advocate that individuals should seek out formal social support from mental health professionals.

Social support is placed in a medical framework by being connected to mental health, as well as a professional framework, where people are told that their social relations and interactions should ideally be monitored by a mental health professional (Abbott 2014:293). Once placed in this framework, the help or social support-seeking behaviours the patient had learnt prior to therapeutic supervision—along with many emotion management techniques—are discredited. In their place, patients are encouraged to insightfully adopt practitioner-provided social support and the practitioner-taught "coping toolkit". Older, non-medical understandings of social support and emotion management are thus abandoned and/or transformed into mental health interventions couched in a psychomedical, therapeutic language (Klein and Mills 2017).

Practitioners have already begun to reap the rewards of the medicalization and professionalization of social support. While several practitioners noted that older patients—particularly men—tended to be skeptical and "resistant" to psychotherapy, younger patients generally showed the opposite proclivity:

> I'm seeing a lot of younger people are coming in with this idea that therapy is valuable. And so they walk away, no matter what we do, the time we spent together was valuable. Because that's their pre-existing notion, it's valuable to talk to someone. (Roderick, CP)

By medicalizing and professionalizing social support, individuals come to believe that professionally administered psychotherapy is inherently beneficial for their well-being. Talking about your emotions with a friend is replaced by talking about your mental health with a practitioner, realizing the aim of many 'help-seeking' researchers and increasing the demand for psychotherapy. As noted by Roderick, these efforts have also created a self-reinforcing cycle where the belief that talking to a practitioner is helpful increases

the likelihood that therapy is successful, confirming and strengthening the medicalized understanding of "social support". Medicalization begets medicalization.

5.4 Conclusion

In this chapter, I outlined how practitioners enact the DSM in psychotherapy. Practitioners do employ DSM categories and labels, however, they also understand mental illness as a biopsychosocial feedback loop, using both frameworks in the case conceptualization process. This understanding is used to re-define patients' social and emotional problems and justifying practitioners' surveillance of these areas, facilitating the medicalization of problems beyond those articulated in the DSM.

I then introduced a modified understanding of medicalization: medicalization through the re-definition of solutions. This approach emphasizes that medical language and frameworks can spread through the re-definition of solutions in addition to the redefinition of problems that sociologists typically focus on (e.g., Conrad 2007; Foucault 1967; Jutel 2011). The great majority of interventions employed by practitioners are the same or similar to the many unnamed emotion management techniques and resources individuals employ in everyday life (Hochschild 1983; Thoits 1985). By incorporating these techniques into psychotherapy, practitioners connect these activities to the framework of mental health and claim them as their own.

Through this process, professional jurisdictions and medical understandings are expanded, with the ascribed mental health-related functions pushing aside other, non-medical uses. In conclusion, this expanded definition of medicalization, including the construction of both problems and solutions, offers new insights into the processes of medicalization and demedicalization, enabling researchers to better understand how the

medical profession affects language and broader societal understandings. In the next chapter, I examine how medicalization and ignorance management interact in the practice of psychotherapy, exploring how these forces should be understood as existing within a system of interrelated processes rather than in isolation.

Chapter 6

Discussion

In this thesis, I employed a grounded theory approach to analyze 15 semi-structured interviews with MD psychotherapists and clinical psychologists. These interviews covered a range of DSM-5-TR disorders (including major depressive, obsessive compulsive, binge eating, dissociative identity, post-traumatic stress, and specific phobia), and represented a diverse range of therapeutic schools, notably cognitive behavioural (CBT), acceptance and commitment (ACT), dialectical behavioural (DBT), interpersonal (IPT), emotion-focused (EFT), family systems, and ego-state.

In Chapter 3, I argued that practitioners primarily employ four enactments of mental health: 1) stabilization, 2) restoration, 3) enhancement, and 4) maintenance. In Chapter 4, I connected practitioners' intervention methods to their enactments of mental health, showing how practitioners vary their means and ends in an effort to manage ignorance through a downplay-achieve strategy. In Chapter 5, I argued that practitioners act on mental illness as if it is a biopsychosocial feedback loop, facilitating medicalization through the re-definition of problems. I then introduced the concept of medicalization through the re-definition of solutions and apply this framework to psychotherapy, showing how the practice has medicalized everyday activities, notably emotion management and social support.

In this final chapter, I connect these threads, proposing that practitioners' understandings of mental health play a central role in medicalization and ignorance management. I explain how practitioners strive to balance these two key professional demands.

6.1 Balancing Ignorance and Expansion

Practitioners must be seen as agentic and not "procedural dupes" (Garfinkel, 1967), intentionally engaging with issues like medicalization (Halpin 2022a; Pilgrim, Rogers, and Gabe 2010; Smith 2019; Whooley 2010) and ignorance management (e.g., Brown 1987; Fox 2013; Luhrmann 2000). I found that practitioners frequently showed an awareness (and dislike) of certain forms of medicalization, making concerted efforts to normalize everyday emotions like anger and anxiety. Regarding ignorance management, practitioners were acutely aware of both individual and collective ignorance, recognizing the threat patient skepticism poses to their professional authority and noting the importance of convincing them of therapy's effectiveness. Despite not using these terms, medicalization and ignorance are fundamental components of psychotherapy that I suspect ever practitioner is intimately familiar with.

Medicalization and ignorance management can function in concert. In the "stage" or "phase" model of therapy, practitioners typically begin by focusing on stabilization, setting expectations for therapy comparatively low. Once patients have achieved "success" within this framework of mental health, practitioners typically progress to the next framework: restoration. If restoration is largely successful, then health can be re-defined as optimization, in the form of enhancement and management (Rose 2007). According to practitioners, this graduated approach helps them to keep disappointment and accusations of ignorance low, thereby maintaining their professional authority. More complex goals that pose a greater risk of disappointment are not introduced immediately but only after more basic ones have been achieved. By gradually rolling out more

ambitious aims, practitioners can better "prove" that the patient is getting better and that psychotherapy works, fostering a sense of progress that keeps the patient motivated.

This graduated re-definition of mental health also facilitates medicalization, with practitioners moving the goalposts to offer an ever-expanding array of services and interventions. Once the patient has been stabilized, health is re-defined as restoration, creating a new need for professional assistance. Following restoration, health is re-defined as enhancement and/or management, selling patients on the idea that they can always be healthier, happier, and have better relationships. Practitioners take advantage of the "ambiguously defined notions of what it means to be healed… trap[ping] individuals in an ongoing disease-therapy cycle" (Barker 2014). At each stage, new understandings of mental health are enacted, bringing more and more aspects of everyday life under a medial framework and practitioners' professional purview.

The relationship between medicalization and ignorance is not always harmonious though. The two can act as countervailing forces, with practitioners attempting to negotiate the often-conflicting aims of maximizing medicalization and minimizing ignorance. Treating mental illness as a biopsychosocial feedback loop partially divorced from DSM diagnoses helps practitioners re-define problems in living as medical problems (Szasz 1960) and everyday practices like social support as medical solutions (see Chapter 5). But, by laying claim to such a broad range of problems and solutions, practitioners increase their risk of being seen as ignorant, as many cannot be experts across all three biopsychosocial domains. Ignorance can undermine authority (Abbott 2014), meaning overly expansive medicalization may have the opposite effect and

weaken professional jurisdiction over a problem/solution rather than strengthening it (Whooley 2019).

In the case of psychotherapy, several practitioners noted that patients often came in wanting relationship advice and couples counselling. Practitioners frequently chose *not* to focus on such social matters in therapy, rejecting medicalization by deeming these aspects of everyday life to be too far outside their training and scope of practice. By using their 'boundaries of competence' and the 'three-legged stool' (Peterson et al. 2016) to manage ignorance, practitioners simultaneously hinder medicalization. The potential medicalization and jurisdictional expansion offered by the biopsychosocial feedback loop is only partially realized, being limited by practitioners' concerns regarding their competence and abilities. Ignorance management here is used to support past medicalization and strengthen existing professional jurisdictions, while keeping further medicalization in check (at least for the moment). Practitioners thus attempt to balance the two processes, wanting to promote but also maintain their professional authority.

This countervailing effect can also be seen in practitioners outward distain for enhancement-related aims. As outlined by several theorists (e.g., Clarke et al. 2010; Conrad 2007; Rose 2007), optimization facilitates medicalization by re-conceptualizing health as "perfectibility", an unobtainable ideal that people can endlessly pursue as they are perpetually positioned as "not truly healthy" or "at risk". Whereas historic medicalization was generally restricted to the more severe forms of mental illness like schizophrenia and catatonic depression (Shorter and Fink 2018), the enhancement model facilitates the medicalization of everyday adversity (Horwitz and Wakefield 2007, 2012).

The medicalization of life-limiting conditions—notably distress and anxiety—was generally not welcomed by the practitioners I spoke to for two main reasons. First, the medicalization of comparatively basic problems can undermine practitioners' efforts to position psychotherapy as a skillful "art" (Sasha, MD) that solves complex problems. Patients with more minor, routinized problems were disparagingly nicknamed the "walking worried" (Peyton, MD), with practitioners believing that these patients take valuable time and resources away from "real" cases. This was a particular bugbear for MD psychotherapists, who argued that dealing with such trivialities threatened their "moral and ethical obligation" (Julie, MD) to provide services to the broader taxpaying public that often struggle to access mental health services (CAMH 2022).

Goals like enhancement and alleviating life-limiting problems are often seen as "trivial, narcissistic, or irrational" (Rose 2007:20), degrading practitioners' expertise and the supposed skill required to properly practice psychotherapy. Repeated rejections of the medicalization of comparatively minor, less skill-intensive problems can manage ignorance through 'retrenchment' (Abbott 2014:288; Whooley 2019:228). Practitioners fall back to the more severe forms of mental illness where their expertise can be put more fully on display, emphasizing the solemn importance of psychotherapy and reinforcing practitioners' claims to a socially valuable yet esoteric ability (Becker 1993; Seim 2022).

The second way in which ignorance management conflicts with enhancement-driven medicalization is the challenge enhancement poses to practitioners' downplay-achieve strategy. By practitioners' own admission, they cannot ensure that patients will never face adversity or experience trauma. They cannot ensure that patients will always feel happy and never anxious. Even when it comes to major depressive disorder, the

"bread and butter" of mental health treatment, clinical studies show only around a 50% improvement rate for psychotherapy (placebo response rates sit just behind at 30% or so). Practitioners generally felt hopeful yet limited in terms of their therapeutic effectiveness. The grandiose promises generated by enhancement-centric definitions of mental health were seen by practitioners as aims they could not possibly hope to live up to, and so had to be discouraged (see Chapter 3.2.1). Again, practitioners fight back against some forms of medicalization in an attempt to manage the ignorance patients ascribe to them, wanting to lower patients' expectations and restrict treatment to problems where therapeutic success is deemed feasible. This way practitioners can achieve the aims the dyad sets in therapy, encouraging the patient to view psychotherapy and practitioners as an effective.

6.2 Positioning Practitioners

The ambivalent relationship between medicalization and ignorance management is further complicated by practitioners' place among mental health institutions. While enterprising practitioners have been involved in the medicalization of life-limiting conditions (Scott 2006), medicalization through the re-definition of problems has largely been attributed to the pharmaceutical industry, the public, the media, governments (Abraham 2010; Conrad 2005; Olafsdottir 2010), researchers, and policymakers (Horwitz and Wakefield 2007; Rose 2018). For these groups, medicalization predominately operates through a hype-disappointment strategy (Brown and Michael 2003; Whooley 2019). 'Hype' is generated through claims-making, defining a problem and then bringing attention to it by emphasizing its severity (Hilgartner and Bosk 1988). These groups will often promise a solution to the problem they have constructed, positioning their plan or product as the much-needed cure. Hype offloads present-day ignorance on the future,

known as ‘time work’ (Whooley 2019). Time work here has two important impacts: 1) it makes the current lack of knowledge appear as a transient rather than fundamental state, and 2) it separates the claims-maker from past or contemporary failures.

Promises however are expected to be kept, imposing requirements on the claims-maker generating the hype (van Lente 2000). Requirements that go unfulfilled typically lead to ‘disappointment’ and “reveal” the ignorance of the claims-makers (Borup et al. 2006:291). To manage this exacerbated ignorance and separate themselves from the disappointment they produced, claims-makers often attempt to generate hype about a new problem and/or solution, causing the cycle to begin anew (Whooley 2019).

Claims-makers that employ the hype-disappointment strategy are typically distanced from the actual implementation of the solution (Borup et al. 2006:292). Practitioners in contrast are at the “coal face”, being burdened with the task of actually having to realize the promised solutions. The hype-generating medicalization efforts of the promissory groups impose ignorance on practitioners by creating a discrepancy between public expectations and the actual state of practitioners’ knowledge. Practitioners retaliate by regularly denouncing this medicalization both in private and in public (e.g., Francis 2013, Harris 2008). Due to their positioning, the aims and interests of these institutions diverge, coming to a head over optimization-centric medicalization.

This difference in positioning is key to understanding the divergence in ignorance management strategies (Brown and Michael 2003:16). Deferring ignorance via time work is comparatively easy for conceptual claims-makers. Their promises occur on the longer timescale of decades, and they are more removed from the in-practice implementation of promised diagnostic and treatment innovations. The practitioners I interviewed, dealing

with interactional ignorance management, had no such luxuries. Any promises about treatment effectiveness quickly come to bear, the time span instead being measured in weeks and months. This temporal proximity between intervention and outcome limits practitioners' ability to assign and challenge casualty like conceptual claims-makers can (e.g., Shanks, Pearson, and Dickinson 1989).

Failure to uphold expectations also occurs in a relatively more obvious manner in therapy. At the conceptual level, the effects of policy changes, technological innovations, etc. are more separated from individual experience (Mills 1959), typically being measured using group or population-level statistics. For instance, in psychotherapy research, the efficacy of an intervention is evaluated by comparing the outcomes of a treatment group against a control group and seeing if the difference is statistically significant and/or there is a meaningful effect size. This complexity and ambiguity gives conceptual claims-makers greater leeway to obscure ignorance by manipulating information on outcomes (Henry 2021) and casting doubt on claimed causal links (Kleinman and Suryanarayanan 2013).

In contrast, at the interactional level (i.e., in clinical practice), the effectiveness of interventions is more straightforward and salient, being evaluated not through inferential statistics but by the patient's individual testimony. While there is some wiggle room for practitioners to play up the success of therapy—recall Sasha selectively graphing changes in the patient's PHQ-9 scores in Chapter 4.2—practitioners' ability to negotiate ignorance is limited by patients' demands for changes in their condition that they can see and feel.

Alongside these differences in means, there are differences in goals. Disappointment is undesirable in health care interactions as trust is central to the success

of treatment (Parsons 1951b:313). This is particularly the case in psychotherapy. As practitioners emphasized, the practice's effectiveness depends on the patient's effort, which in turn depends on their trust. I argue that this is why practitioners employ the downplay-achieve strategy instead of the hype-disappointment approach characteristic of conceptual claims-makers (Brown and Michael 2003). Trust is influenced by predictability and competence (Harris 2012; Sztompka 2007). Even preschool-aged children will stop trusting someone who has been wrong and unreliable in past interactions (Brosseau-Liard, Cassels, and Birch 2014; Kushnir and Koenig 2017). To develop and maintain patients' trust, practitioners must consistently "honour their obligations" (Thompson, Adams, and Niven 2015:137–38) across interactions.

Hype can generate an initial surge of willpower that motivates the patient to engage with therapy. However, if promised outcomes are not achieved, disappointment will occur and trust in the practitioner will be severely damaged. Patient motivation produced through hype might quickly dry up, increasing the likelihood of therapeutic failure and premature discontinuation. In contrast, the downplay-achieve strategy aims to maintain a steady stream of motivation throughout the course of treatment, ideally decreasing the risk of patients dropping out. As I argue, when ignorance, trust, and motivation are managed correctly, practitioners secure their professional authority, income, reputation, and sense of self-esteem. When managed incorrectly, these desirable outcomes are threatened or even lost, ensuring ignorance is always at the forefront of practitioners' minds. In sum, practitioners exist in a different environment and face different challenges than conceptual claims-makers, consequently employing different strategies to manage ignorance and maintain their professional authority.

6.2.1 Private and Public Funding

The interplay between medicalization and ignorance is also affected by payment model. In both the private and public markets, third-party insurers and governments can facilitate medicalization by covering the cost of certain types of care, reinforcing the idea that the problems in question should be dealt with through medical means. However, managed care organizations and governments can also constrain medicalization by not providing coverage for certain treatments and issues, limiting the type and extent of services offered in an effort to cut costs (Conrad 2005:10). While cost cutting is emphasized in both private insurance and public funding, these restrictions are thought to more seriously dominate public models, allowing private psychotherapy to engage in greater optimization-driven medicalization (Flick 2021; Pickersgill 2019a).

I did not find this to be the case however, largely because of an ignorance management strategy that acted as a counterbalance: establishing boundaries of competence. A recurring theme amongst the publicly funded MD psychotherapists I interviewed was that they were supposed provide treatment to as many patients as possible, 'shuffling the burden' of more complex issues—namely trauma and personality disorders—to more specialized therapists who had the time and resources to work with the patient for years (Seim 2017, 2022). MD psychotherapists often sought to get ahead of their ignorance by openly acknowledging gaps in their knowledge, using this third leg of the stool to push more complex and challenging cases that carry a greater risk of disappointment and appearing ignorant onto psychologists and psychiatrists.

Privately funded clinical psychologists are generally able to provide therapy for much longer than their publicly funded MD counterparts, in theory providing more

opportunities for optimization-oriented treatment (i.e., enhancement and management). In practice however, this extended duration of therapy did not translate into greater medicalization. Privately funded clinical psychologists can work with patients for longer, but this additional time is often spent on ignorance management. Many of the clinical psychologists I spoke to tend to take on patients with more complex problems, requiring them to shift their evaluation framework and lower their standards of mental health. In the face of these challenging patients and problems, practitioners often view stabilization or the restoration of basic functioning as success. Enhancement and management can come into play, but sometimes only after years of therapy. In contrast, by preferentially treating simpler issues that are more routinized and involve less potential for ignorance, MD psychotherapists can move comparatively quickly from model to model. Medicalization via optimization (i.e., enhancement and management) can thus be achieved, even with the shorter 12 to 16-week treatment window provided by OHIP.

In sum, practitioners use the different enactments of mental health in an effort to maintain their professional authority and integrity by balancing both medicalization and ignorance management. This balancing act is affected by institutional factors, particularly whether practitioners are in private practice or covered under public OHIP funding, further complicating how mental health is enacted, with whom, and at which points in time.

6.3 Contributions

Psychotherapy is an increasingly popular mental health intervention amongst both the public and policymakers (Pickersgill 2019a). By obtaining an in-depth look at 1) the types of problems practitioners encounter, 2) the types of goals they set in therapy, and 3)

how they evaluate patient progress, this thesis aims to improve our understanding of this growing phenomenon and how its practitioners define mental health. This study makes five key contributions to theory.

First, practitioners employ several different enactments of mental health and a variety of intervention techniques. We should not read too far into any single model or intervention and assert that psychotherapy seeks to make people rational (Foucault 1967) or that it is always a mechanism of social control (Parsons 1951b:141). Restoration is a common goal for practitioners and psychotherapy can undoubtedly have social control functions. But only sometimes (see also Strong, 1979)! Other times practitioners even go so far as to encourage deviance, either by prioritizing individual-focused health (Fromm 1941:159) and/or by fostering a sense of civic apathy in the patient (Goffman 1961:165).

Second, I introduce the *stabilization model of health*, through which practitioners' aim to "stop patients from getting worse". Though health care professionals are typically envisioned as wanting to help patients get better, that goal may not also be feasible given the patient's current condition. Instead of helping the patient return to work, be happier, or "become their own therapist", practitioners may preoccupy themselves with keeping the patient alive and out of the hospital. Stabilization appears in wide array of health care settings beyond psychotherapy, complementing the traditional trio of the negative, positive, and preventative models used in medicine.

Third, I demonstrate how practitioners employ a *downplay-achieve strategy* to manage patients' perceptions of ignorance, hoping to maintain their professional authority and prevent premature discontinuation. Practitioners draw on the many models of health to tailor therapeutic aims to the patient, while simultaneously drawing on an

eclectic array of interventions to increase the likelihood that said aims are attained. This study further identifies factors, such as the timescale of promises and the types of ignorance present in therapy, which cause practitioners' ignorance management approach to diverge from researchers, policymakers, and other more publicity-facing professionals (e.g., Borup et al. 2006; Whooley 2019).

Fourth, I outline how medicalization can occur through the *re-definition of solutions* in addition to the re-definition of problems (Conrad 1975; 2005). Medicalization theory has traditionally focused on problems (Showalter 2019), looking at how deviance comes to be described in a medical language and brought under the supervision of health care professionals through the construction of formal diagnoses and/or the application of a medical intervention to treat the problem (Conrad and Schneider 1992). In contrast, my framework focuses on solutions—i.e., how practices and substances are transformed into "medical treatments" administered by or under the direction of a health care professional. This framework highlights how "medical interventions" are also socially constructed, allowing the health care professions to medicalize and extend their professional authority over substances and practices by ascribing healing functions to them. This approach opens new understandings into the spread of medical language and the jurisdiction of health care professions. Psychotherapy in particular has medicalized many everyday emotion management techniques by re-positioning them as expert, health-promoting practices. Notably, emotion management and social support have become so thoroughly medicalized by psychotherapy that they are now synonymous with the professional management of mental health.

Fifth, this study shows how practitioners' enactments of "health" connect medicalization and ignorance management. These two processes can be complementary, such as in the stage model of psychotherapy. Here, practitioners gradually progress from stabilization to restoration to optimization, continually allowing new problems to be medicalized while also preserving professional authority by ensuring new goals are only introduced once the practitioner believes they are "realistic"—i.e., possible for the practitioner to achieve.

At other times, medicalization and ignorance management can be at odds, acting as countervailing forces that practitioners attempt to balance. More ambitious, optimization-oriented definitions of "health" re-define life-limiting problems as conditions that warrant medical intervention and/or supervision (Armstrong 1995; Clarke et al. 2010; Rose 2007), enabling practitioners to expand their professional jurisdiction and keep patients in therapy longer. However, these more ambitious promises of a "healthier you" create more demanding standards that practitioners are then expected to achieve. Medicalization and jurisdictional expansion can increase the risk of practitioners appearing ignorant, undermining their authority and causing premature discontinuation. Practitioners may consequently push back against medicalization in certain areas, notably the pathologization of "normal anxiety" and the desire to be perpetually happy. These expectations are thought to be unachievable and setting them as therapeutic goals would make the practitioner look ignorant and their techniques ineffective. Practitioners frequently discourage understandings of "mental health" that include such expectations in an effort to maintain their existing authority, even if it comes at the cost of limiting further medicalization and professional expansion.

Ultimately, “mental health”, as enacted in psychotherapy, cannot be adequately captured through a single, universal definition. Rather, to properly accommodate the different needs and contexts in which “mental health” is enacted (Mol 2002), “mental health” should be understood as a flexible, malleable concept. Practitioners employ a pluralistic approach with “many potential definitions” (Leonardi 2018), tailoring the mental health framework they employ to specific patients at specific points in time. This approach enables practitioners to exercise agency when expanding and/or maintaining their professional authority, seeking to ensure that psychotherapy and the services of mental health professionals continue to be in demand.

6.4 Limitations and Future Directions

A key limitation of this study arises from my use of interviews as a method of data collection. What people say they do does not necessarily correspond to what they actually do (Jerolmack and Khan 2014; LaPiere 1934), with practitioners potentially presenting themselves not as how they act, but rather as how they believe the ideal clinician should act (Edwards 1953). Social desirability and impression management did somewhat bias my interviews. When I first asked practitioners to walk me through a past case of theirs, every story was one of success rather than failure. However, once participant-interviewer rapport was better established, many practitioners did open up and discuss instances where they felt they had failed, or even where patients had discontinued prematurely. Practitioners do selectively present information in interviews, but they were also quite forthcoming at times, willing to critique psychotherapy as a practice, critique their professions, and even critique themselves.

An ethnographic investigation of psychotherapy could help overcome this limitation (see Craciun 2018; Luhrmann 2000). However, ethnography imposes additional hurdles, both logistically—i.e., gaining access to these sites—and ethically—i.e., direct observation could be seen as overly intrusive, hindering therapeutic rapport and positive treatment outcomes. These obstacles would be challenging to overcome given the time constraints of a master's project. There still can be a relatively highly correspondence between people's attitudes and actions (Ajzen and Fishbein 1977; Vaisey 2014), which can be further improved by asking practitioners about past decisions and specific cases to discourage more idealized-type responses (Weiss 1995). Ultimately, participant testimony can serve as a valid and useful source of data (Lamont and Swidler 2014; Tavory 2020), with interviews providing important insights into how practitioners themselves understand and enact "mental health" (Berg 2007; Kvale 1996).

Several limitations also arise from my choice of sample. My sample was non-representative, selected through a mix of convenience and theoretical sampling, and cannot be generalized to CPs and MDs in Ontario or other jurisdictions. Intra-professional variability is highly debated. A long-standing body of clinical research has emphasized the existence of 'common factors' (Laska, Gurman, and Wampold 2013; Rosenzweig 1936) central to all major branches of psychotherapy and healthcare professional-patient interactions (Parsons 1951b:310-22). Others have however argued that there exists sizable within-profession heterogeneity (e.g., Pickersgill 2012), pointing to the existence of several hundred variations of psychotherapy (MacLennan 1996). While professional groups favour certain types of psychotherapy over others (Hunsley et al. 2013), these groups do not typically restrict their members' practice to a single type.

Instead, members can usually practice whichever type(s) of psychotherapy they wish. As a result, practitioners in Canada often identify as "eclectic", combining different therapies in a somewhat idiosyncratic manner (Hunsley and Lefebvre 1990; Warner 1991).

Furthermore, my sample was restricted to MD psychotherapists and clinical psychologists, excluding other professional groups who practice psychotherapy (i.e., social workers, nurse practitioners, occupational therapists, psychiatrists, and registered psychotherapists). The "controlled act of psychotherapy" in Ontario has a pluralistic distribution currently spread across six professional colleges. The controlled act is itself a subset of the broader category of psychotherapy, which in turn is a subset of counselling, a practice anyone can claim (Buckingham n.d.). These different professional groups may have different understandings of mental illness, mental health, and psychotherapy given each group has different training, modes of payment, clientele, and so on, which can all influence their enactments of health (*cf.* Flick 2021). For instance, several MD psychotherapists contrasted their own eclectic approach against what they saw as a much more manualized, protocol-based approach employed by social workers. If true, then the downplay-achieve strategy may be limited to certain practitioners in certain professions, rather than being applicable to the practice of psychotherapy as a whole.

A second limitation caused by my choice of sample is my exclusion of firsthand patient perspectives. Practitioners' understandings are incredibly important as practitioners greatly shape the methods and aims of psychotherapy. However, they are only one piece of the puzzle. Throughout this paper, I have discussed patients' goals, their motivation, their understanding of thoughts and emotions, etc. Crucially, these are not patients' actual understandings but merely practitioners' interpretations of patients'

perspectives. These interpretations should be viewed with a fair amount of skepticism, as existing research indicates that practitioners are somewhat poor at predicting patients' perceptions of psychotherapy and its outcomes (Hatfield et al. 2010; Ionita and Fitzpatrick 2014). Patients may have different understandings of mental health and their therapeutic aims might diverge, simply agreeing with practitioners' operationalization of goals in order to please them (Parsons 1951a:458). A parallel investigation based on patient accounts could be of great value, providing a contrast to compare patient and practitioner understandings of the practice and mental health.

6.5 Conclusion

Psychotherapy is an increasingly popular treatment for mental health problems (Pickersgill 2019; Terlizzi and Norris 2021). Despite the growing prevalence and influence of this practice, several aspects remain poorly understood (Flick 2021), particularly its understanding of mental health (Sadler 2005). Through 15 semi-structured interviews, I sought to elucidate how two groups of practitioners—MD psychotherapists and clinical psychologists—conceptualize mental health in psychotherapy. Initially, I intended to construct a definitional framework comparable to those proposed by Seligman (Peterson and Seligman 2004; Seligman 2011), Keyes (2002, 2005), and Jahoda (1958). Over the course of the interviews, I quickly discovered that practitioners did not view mental health in this way. There was no single enactment applicable to all patients at all points in time. Sometimes mental health is equated with positive enhancement, like being happy, finding life meaningful, and having good social relations. Other times mental health is instead produced by helping patients regain their daily functioning and return to work. Ultimately, psychotherapy revealed itself to be an

incredibly complex and contingent practice, without universal understandings of mental health, nor universal interventions to promote mental health.

Not only is the practice of psychotherapy a worthwhile object of study in its own right, it also offers insight into broader areas of sociological inquiry, notably ignorance management and medicalization theory. Psychotherapy extends medical understandings into everyday life by associating various problems and solutions with mental health, re-positioning them as "mental illnesses" or "mental health interventions". Regarding ignorance management, psychotherapy clearly demonstrates the prototypical trust-building practice fundamental to all health professional-patient interactions (Parsons 1951b:310-22). Captured by concepts like "bedside manner" and the "art of medicine" (Dobkin 2020), psychotherapy is structured around a comparatively long-lasting and intimate relationship between the patient and practitioner, bringing the issues of trust, ignorance, and professional authority to the forefront.

In closing, the practice of psychotherapy offers many potential insights for researchers in sociology. This study acts as an early step towards a sociology of psychotherapy (Flick 2021; Owen 1993), establishing an overview of practitioners' key methods of intervention and enactments of mental health, as well as how these elements affect the interrelated processes of medicalization and ignorance management.

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Appendix A

Initial Interview Guide

Reminder: confidentiality + free not to answer any questions, let me know and we can always move on

Practices

1. What patient populations or issues do you typically work with?

2. Without revealing any identifying information about any of your patients, can you walk me through some recent presenting problems that you've helped treat?

    2.1. What goals did you set?

3. How did you decide which goals or issues you were going to prioritize?

4. How did you monitor progress towards these goals?

    4.1. How do you know when the patient was better?

    4.2. How do you know when the patient is getting worse?

5. What happens when you and a patient disagree regarding the goals of therapy?

    5.1. What happens when you and patient disagree about whether to stop treatment?

6. How do you define mental health?

    6.1. How do you think your definition compares to that of other practitioners?

Closing Details

1. How long have you been practicing psychotherapy?
2. For MDs - Before psychotherapy, what specialty did you practice/train in?
3. How would you characterize your style of therapy?

Appendix B

Final Interview Guide

Reminder: confidentiality + free not to answer any questions, let me know and we can always move on

1. Without revealing any identifying information about any of your patients, can you walk me through a recent presenting problem that you've helped treat? (to help get a better idea of your day-to-day work)
    1.1. What goals did you set?

2. How did you decide which goals or issues you were going to prioritize?

3. How did you monitor progress towards these goals?
    3.1. Did the patient get worse at any point (regress)? How did you know?
        3.1.1. How did you respond to this negative change?

4. How have you helped patients with interpersonal problems, either at work or with family, friends?
    4.1. Have you ever advised or helped patients leave problematic social relations or arrangements?

5. How do you define mental health?
    5.1. How do you think your definition compares to that of other practitioners?
        5.1.1. Do you talk much with other practitioners about the techniques, tricks that you use or they use in therapy?

6. Are there any important topics or issues that you would like to bring up that we didn't cover?

Appendix C

Example Thought Record

Situation	Moods	Automatic Thoughts	Evidence That Supports the Hot Thought	Evidence That Does Not Support the Hot Thought	Alternative / Balanced Thought	Re-Rate Moods Now

Appendix D

Simplified Coding Diagram (lines with different dash types represent different clusters)