Embodied Expertise: The Science and Affect of Psychotherapy

by

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List of Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
APsA	American Psychoanalytic Association
BDI	Beck Depression Inventory
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioral Therapy
DBT	Dialectical Behavioral Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, fourth edition, revised
GAD	Generalized Anxiety Disorder
NIMH	National Institute of Mental Health
NOS	Not Otherwise Specified (e.g. anxiety, not otherwise specified)
OCD	Obsessive Compulsive Disorder
PHQ-9	Patient Health Questionnaire 9
PTSD	Post Traumatic Stress Disorder
RADS	Reynolds Adolescent Depression Scale
SAMHSA	Substance Abuse and Mental Health Services Administration
SUDS	Subjective Units of Distress Scale

Introduction. *Psychotherapeutic technologies and mastery of selves*

       A late September Friday at the University Psychiatric Clinic was a study in contrasts for residents training in talk therapeutic interventions. They started off in the psychodynamic core class by learning how to use patients' dreams in the therapeutic process. A classical object of inquiry in psychoanalysis, dreams presented trainees with great difficulty: how were they to decode their significance to the patient? And, more importantly, how would they use them in treatment? This was precisely the conundrum that a fourth year resident faced when a patient working through questions of childhood abuse brought up a suggestive but opaque dream early on. Terry, the experienced psychoanalyst and psychiatrist who trained residents in this therapy, told them to "treat the dream as a portal to the [patient's] problems." To the experienced observer, such "portals" can reveal pieces of the larger puzzle of "who the patient is." Addressing the residents' unease, Terry reassured them that "we can never interpret a dream until the patient can arrive at the interpretation themselves." At this point in their training, residents had heard these related themes repeatedly: that everything is an opportunity for learning about patients' problems, but that they can't just be told what is wrong, needing to gain such insight themselves. These less than specific therapy lessons were complemented by two others: that therapists' own affective reactions were essential sources of knowledge about the patient, and that the therapeutic relationship was their primary lens into the roots of their patients' problems.

The following two hours in the mentorship on cognitive behavioral therapy couldn't have been more different. There, guided by Robert, an experienced psychologist and CBT practitioner, residents discussed cognitive strategies by which patients can modify their thoughts. Therapy here was not an exploratory mission in which patients' recollections were to be treated as "portals" into their problems. Insight into the past was replaced by interventions in the present. This became especially clear in a training video prepared by the Beck Institute for Cognitive Behavior Therapy[1]. Judith Beck, an experienced and renowned clinician, guided Deanne, a young African-American woman, through several CBT techniques. Deanne had been suffering from depression for several months, and her current situation worsened her condition. She craved her independence, but lived with, and cared for her aging mother, who returned her help by babysitting her young children. "The thoughts that you have," Judith told Deanne, "are making you feel sad. You can't stop the thoughts from getting into your head, but once they're there, you can do things to change those thoughts... evaluate them critically and think about 'how true are they?' Or, if it's a picture going through your mind, then you can try to change the picture." They discussed just such a "picture thought": when she felt particularly hopeless, Deanne imagined herself alone looking out the window of her empty and desolate childhood apartment. This daydream was frightening: could she ever escape the past? Could she assert her independence and build a happy, full life? Judith proposed that Deanne fight back such discouraging imaginings by reconstructing them in her mind: could she fill the apartment with furniture? Envision her children on the bed, jumping up and down?

Judith did not wait for Deanne to arrive at some "understanding" of how her past influenced her present. Rather, she took Deanne's affectively charged daydream of her

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[1] The Beck Institute for Cognitive Behavioral Therapy is the foremost training organization for CBT in this country, started by Aaron Beck, one of the originators of cognitive therapy. His daughter, Judith Beck, is also a well-known CBT practitioner and holds a leadership role at the Institute.

childhood home, and transformed it such that it would better fit her expectations of what her life should be. The patient acknowledged that the modified "picture thought" would make her feel "better," but her problem remained: should she move out, leaving her mother, and giving up the financial security of that arrangement? To tackle this problem, Judith told Deanne that "sometimes when you have to make a decision, it would be helpful to look at say, what are the advantages […] and the disadvantages […]. I think that if you put [those] down on paper, it may then help you […]." Deanne had no trouble coming up with the pros and cons of moving out, leading Judith to remark that even though her "depression score is a 41"[2] she "can think about this clear-headed!" The video ended with Judith reiterating that, through cognitive behavioral therapy, Deanne will learn that changing her thoughts will help change her emotions, and thus lessen her depression. For residents, the message was widely divergent from that of two hours prior: in CBT, they would assume a directive role, and their interventions (based on written exercises and measures) would help them identify and treat patients' specific problems.

That day at the Psychiatric Clinic, along with many others I spent observing and talking to trainees and experienced psychotherapists, offered me a window into a world of talk therapy pulled between two opposing forces: that of psychoanalytic psychotherapy, and its rivals, the "evidence-based" interventions (e.g. CBT, but also, dialectical behavioral therapy and interpersonal therapy). These "ideologies" (Strauss et al. 1964) present mental health workers and their patients with an essential dilemma: is well-being the result of insight into the roots of emotional and relational problems, or is it achieved by calibrating thoughts and behaviors such that they translate into positive emotions[3]? This dissertation examines the therapeutic practices

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[2] This score is the result of a questionnaire called the Beck Depression Inventory. The BDI assesses the severity of symptoms associated with depression in the DSM-IV-TR. A score between 29 and 63 denotes severe depression.

[3] This dissertation focuses on talk therapy while acknowledging that psychopharmacology dominates the field of mental health. Others have completed excellent histories and ethnographies of pharmacological psychiatry (e.g.

that make up these distinct approaches, their consequences for the professionals that enact them, and their implications for how we understand what it means to be a 'normal' human being. In the microcosm of a psychiatry residency program, I learned about the modes of thinking, feeling and doing that amount to clinicians' embodied therapeutic "habitus," to borrow a term from Bourdieu (1977). Yet I also came to believe that there are several dimensions that set expert practices in these two orientations apart. Over the following chapters, I will show that psychoanalytic psychotherapists come to embody an expertise I call *affective-relational* that transforms practitioners' emotions and relational abilities into epistemic tools. Psychodynamic clinicians focus on patients' memories of "developmental" events, and their impact on the therapeutic relationship, as they attempt to reconstruct the history of their problems. In contrast, therapists working with cognitive and behavioral techniques[4] approximate the *techno-scientific* expertise of scientists working in laboratories. They make extensive use of inscriptions (such as manuals, forms, "homework"), and quantification (for example, measures of depression and anxiety) as they attempt to delimit their patients' issues into problems that can be addressed with targeted interventions. These expertises thus draw on distinct epistemic tools, and construct different objects of knowledge (e.g. the past in psychoanalysis, and the symptom in "evidence-based" therapies).

My discussion of affect, inscriptions and temporality as defining elements of psychotherapeutic expertise is both empirically and theoretically motivated. Empirically, using a grounded theory approach, I found affect and temporality to be important themes in my data.

Healy 1997; Luhrmann 2000), so I choose to focus on a less well traveled comparison of talk therapies. I delve further into a justification of my choice in the Case Selection section of this Introduction (on p. 29).

[4] The experienced practitioners that trained residents in dialectical behavioral and interpersonal psychotherapy (the other two "evidence-based" therapies) repeatedly described their interventions as behavioral, concerned with change not psychodynamic understanding. I will then sometimes describe all the "evidence-based" therapies as cognitive and behavioral (to be distinguished from the singular, cognitive behavioral therapy which refers to CBT interventions). I also use the terms "evidence-based" and "empirically-supported" in quotation marks, to acknowledge their contested status in the field of talk therapy.

Affect emerged as a dominant concern in the professional space of psychotherapy, both as an object of intervention, and as an intrinsic element of pursuing this line of work. Psychotherapy is, at its most basic, aimed at soothing patients' affective difficulties, and clinicians who participated in this study spoke of empathy, giving patients hope, as well as becoming proficient at observing, normalizing and reflecting patients' emotions[5]. Clinicians were also concerned with finding something to like about their clients, and with controlling their own emotional reactions to the often painful, and sometimes disturbing stories they heard. Moreover, upon closer examination of psychodynamic therapists' discussion of what they think about as they do their work, I found that feelings became veritable epistemic tools in their practices. Largely ignored in scholarship on expertise, I decided to pursue this line of analysis in the dissertation. I attend to these issues at greater length in chapter three.

Temporality was similarly dominant in my data. Participants in this study were explicit about the importance of time as a boundary that sustains the therapeutic frame. Time was also an essential point of differentiation that practitioners of "evidence-based" therapies invoked when discussing what set their treatments apart from psychoanalytic ones. I discuss these themes in chapter two. But there was an additional temporal element that only emerged upon closer examination of the data: the temporality of therapeutic interventions. As I show in chapter four, whereas psychoanalytic therapists focus developmentally, cognitive and behavioral practitioners construct their interventions around "precipitating" events. This, I argue, has implications for how their respective patients come to think of themselves and their problems.

My focus on inscriptions was largely theoretically informed. Scholars in social studies of science have long recognized the importance of inscriptions and quantification in the making of scientific facts (e.g. Latour and Woolgar 1979; Latour 1999, 2005). Moreover, quantification

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[5] These latter skills form the core of a separate paper.

has emerged as an important practice in constructing and asserting trust, institutional legitimacy, and objectivity (e.g. Porter 1995; Espeland and Stevens 2005). Yet research in the sociology of professions and work has paid less attention to such practices. Approaching psychotherapy as an exercise in "social knowledge making" (Camic, Gross and Lamont 2011), I hoped to uncover the relevance of such practices in this field. A round of theoretically informed coding revealed that inscriptions are not only essential to psychotherapeutic expertise, but they play distinct roles in the psychoanalytic and "evidence-based" orientations. My findings indicate that inscription is consequential for these professionals' jurisdictional and autonomy claims.

Yet my focus on these three aspects of psychotherapeutic work obscures some of its other relevant dimensions. Confidentiality concerns precluded me from observing enough therapy sessions to provide an informed commentary on the conversational techniques that therapists use to motivate and treat patients[6]. My discussion of how patients themselves influence therapists' practices is similarly limited. Moreover, while recognizing its role as an essential and influential "inscription" in the world of mental health, I am less concerned with how practitioners make use of the DSM, given recent works that do just that (e.g. Luhrmann 2000; Whooley 2010). Lastly, I also set aside discussions of pharmacology despite its importance to residents' work. It too has received increased attention in the literature (the works of Healy, Metzl and Lakoff have been especially informative) (see also footnote 12). Nevertheless, the expert practices I examine in the following chapters prove essential to therapists' claims to professional jurisdiction, autonomy and credibility, as well as to their impact on the larger social world. As such, they carry both professional and social consequences.

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[6] An excellent edited volume published in 2008 attempts to do just this with psychoanalytic psychotherapy: *Conversation Analysis and Psychotherapy,* edited by Anssi Perakyla, Charles Antaki, Sanna Vehvilainen, and Ivan Leudar.

As residents and other trainees learned about different therapeutic procedures, they also inadvertently participated in ongoing conflicts regarding the social organization of the profession. As such, the expert practices they came to adopt, and that form the core of this dissertation, have both professional and social implications. Professionally, these practices take place in a larger context that favors particular kinds of knowledge: the quantified, 'scientific,' standardizable, and impersonal knowledge (cf. Porter 1995) of the "evidence-based" approaches. These therapies are becoming increasingly successful jurisdictionally, sidelining the dominant psychoanalytic orientation. We see this in the spatio-temporal environments of therapeutic practice (the subject of chapter two), the way clinicians communicate with insurance companies (discussed in chapter three), and how they treat their patients' problems (examined in chapters two, three and four). Yet as they assert a more dominant position in the field of medicine, psychotherapists in the cognitive and behavioral orientations are also ceding some of their autonomy. Unlike their psychoanalytic colleagues practicing in private offices away from the prying eyes (and forms) of insurance companies, these therapists are embedded in systems of expertise that link them to the psychological laboratory, insurance panels, the journals that distribute research articles asserting their efficacy, and publishing houses producing their manuals. Some of these links are no different from those connecting psychoanalytic practitioners to a body of knowledge that precedes them. But, in treatment, psychodynamic therapists tend to rely more on an experienced gut instinct and clinical wisdom. In contrast, cognitive and behavioral therapists' approach is more dependent on the knowledge and tools produced by the other actors they are linked to in the psychological and medical system of expertise. This relative loss of autonomy has an important upside: it generates legitimacy. Unlike their psychoanalytic colleagues who draw credibility in therapy sessions from their

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experienced and intensive self-reflexivity, cognitive and behavioral clinicians rely on a battery of tools that signal their institutional connections. Theirs is an organizationally vetted legitimacy.

The main contribution that this dissertation makes to studies of professions and occupations is to empirically demonstrate the interplay between jurisdiction and autonomy. First, I show that these two essential traits of professions can, in particular institutional conditions, be at odds rather than complementary. Thus, my data indicates that maintaining autonomy can detract from a group's ability to succeed in contests of jurisdiction (this has been the case with psychoanalysis). This finding provides additional specificity to debates over the fate of the medical profession in the aftermath of managed care. Second, and more broadly, I argue that jurisdiction, autonomy, and authority cannot be solely explained through macro-level analyses [e.g. about "abstract" knowledge (Abbott 1988), or ties to the state (Freidson 1970)], but must also be viewed through the lens of professional practice. It is in practice that experts sustain their status when their authority is in doubt. Moreover, expert practices render professions' claims to a particular jurisdictional territory credible. Lastly, in practice, professionals negotiate the various epistemic, social, economic and other institutional pressures that influence their work.

The larger payoff of this analysis is to show that expertise is imbued with a moral authority that bears important social consequences, and is naturalized as epistemic credibility. We live in a "disenchanted" world (Weber [1919]1958, p.117) where experts and the knowledge they produce have assumed a dominant role (Bell 1973; Giddens 1990, 1991; Beck 1992; Drucker 1993; Stehr 1994; Brint 1994; Knorr Cetina 2001). This dominance appears as the 'natural' consequence of experts' extensive technical, abstract knowledge, and long years of training. Moral authority is tied obliquely to "professional codes of ethics," those long lists of

rules that trainees learn early on, and don't revisit unless something goes wrong. Yet such

authority is much more prevalent than these codes would lead us to believe. Expert knowledge,

by virtue of its claims to "truthfulness," ability to solve problems, and speak in authoritative

"facts," demands that we make decisions about how to live according to its dictums. What and

how we eat and drink, how we sleep, exercise, work, make love, raise children, educate them, or

care for those in need are all domains open to expert intervention. We accept experts' "advice"

because we trust their knowledge, a knowledge which we are under-qualified to judge[7]. We thus

mirror their faith in their expertise[8].

The influence that experts wield in our society by virtue of this technical, abstract

knowledge has been the subject of a wealth of scholarly works. Previous studies have elaborated

the ways in which such influence is manifested in domains ranging from everyday life to policy

making (see e.g. Jasanoff 1990; Rose 1990, 1996; Brint 1994; Porter 1995; Gieryn 1999;

Hilgartner 2000). This study offers a somewhat different approach to understanding the moral

authority of expertise, by focusing on knowledge-on-the-ground (see also, Anspach 1993;

Timmermans 1999, 2006; Lakoff 2005a, 2005b). I attend to psychological experts' embodied

practices and show them at work, applying the various knowledges they draw on. I argue that

these practices change those who come within their purview. Specifically, I suggest that

psychoanalytic expertise promotes a notion of well-being that emphasizes affect, and a historical

view of self focused on formative relationships. In contrast, cognitive and behavioral therapeutic

practices foster selves constructed out of fragments—thoughts, behaviors, feelings—which can

be modified and measured through targeted techniques. Well-being is achieved in series of

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[7] Some argue that making such judgments is getting easier with the advent of the internet and sites such as webmd, but the internet can also function as yet another platform for the dissemination of "expert advice."

[8] Conflicts abound, and the rise of health social movements is one arena in which the hegemony of medical knowledge is being increasingly contested (Epstein 1996; Brown and Zavestosky 2004; Best 2012).

interventions, as people become increasingly proficient at recognizing and controlling ill-functioning internal processes. These models of self reverberate beyond the therapy room.

In their insistence on the individual as the locus of change, all therapeutic interventions downplay the role of structural and cultural forces in shaping who we are, and limiting our ability to fully control our destinies. As such, both therapeutic orientations reify particular aspects of selfhood: the past, the unconscious and memory in psychoanalytic practices, and the executive power of the mind in the "evidence-based" therapies. Western European and American cultures have keenly felt the influence of psychoanalysis, from 'blaming' the family—especially the mother—for who we are and how we fail, to the psychologism that runs through workplaces, classrooms, and the media (Hale 1995; Zaretsky 2004). Cognitive and behavioral therapies' commitment to change in the present deepens our problematic cultural commitment to an already prevalent individualism. Though they seem to offer liberation from the past, fostering a sense of possibility, they close off the kind of generational continuity that, for better or worse, has fueled our understanding of who we are, at least for the last century.

Cognitive and behavioral tools that encourage measurement and fragmentation exercise a growing influence amplified by a larger cultural matrix that values the kinds of people and data they produce. Examples range from the classroom, as teachers' and students' abilities are increasingly understood by various measures (cf. Porter 1995), to the world of sports, where athletic performance is deconstructed and quantified (Eder 2012). Quantification is also rising in visibility as a tool by which people seek to improve their lives. For instance, the *Quantified Self* movement is made up of members from all over the world who attempt to attain "self knowledge

through numbers."[9] Such knowledge is then used to improve one's life: to lose weight, sleep better, be more efficient, less stressed, happier.

Thus, the therapeutic techniques that residents and other mental health workers learn matter beyond the therapy room. Choices about whether to talk about patients' dreams, or help them decrease their depression scores by modifying "picture thoughts," reverberate in the larger social world through the models of self they promote. In the clinical hour, as those choices turn into practical considerations about what kind of therapy is "best suited" to patients' problems, their moral weight is obscured, thus becoming naturalized as epistemic credibility. This dissertation examines expert practices in an attempt to clarify their social significance.

In sum, the close examination of therapeutic expert practices provided in the following chapters (especially two, three and four) makes several contributions of interest to sociological audiences. First, my elaboration of a typology of expertise that distinguishes affective-relational from techno-scientific practices specifies how emotions and temporality can serve as knowledge tools. These are essential to creating the "social knowledge" Camic, Gross and Lamont (2011) recently called attention to, and a potential line of differentiation from those scientific practices rendered in the detailed laboratory ethnographies of Latour (with Woolgar 1979, 1999), Collins (1974) and Knorr Cetina (1999). Second, my findings contribute to the professions and occupations literature by disentangling professional jurisdiction from autonomy. I show that the two do not presuppose each other, but can characterize related segments of a profession to varying degrees. Moreover, I argue that maintaining autonomy can hurt a profession in its attempts at preserving its jurisdiction. I also illustrate a form of knowledge—affective-relational—that may be increasingly valuable in our society as it reorients towards a service economy (Gorman and Sandefur 2011). Third, and most importantly, I argue that

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[9] Information gathered from the Quantified Self website, http://quantifiedself.com/. First accessed in April 2012.

psychotherapeutic expert practices are one of the essential "technologies" for building selves, and shaping our ideas about 'normality,' and 'goodness' (cf. Foucault 1977, 1988; Rose 1990, 1996). In the following pages, I will define key terms and situate the empirical analysis in the field of previous scholarship. I follow this with a justification of my case selection, and a description of my methods and data. I conclude with an overview of chapters one through four.

Expertise and the professions

Two perspectives dominate the scholarship on expertise: one views it as a relational attribution by one group onto another. Another, rooted in sociological and anthropological studies of scientific work, characterizes it as a practical achievement. Both are relevant to the concerns of this study, and I discuss each in turn. The sociological literature on professions and occupations takes expertise to be the property of groups with more or less organized ways (e.g. credentialing) of controlling claims to expert status, and its accompanying economic and social rewards (Parsons 1951; Larson 1977; Starr 1982; Brint 1994; Chambliss 1996). From this perspective, expertise amounts to a social status validated by multiple institutional relations: between the profession and the state (which grants it the ability to determine its membership and work), training institutions (as they help set and enforce credentialing standards), and sectors of the market (Freidson 1970; Larson 1977; Brint 1994). For example, adopting a somewhat cumbersome, Parsonian definition, Rose (1996, p.86, italics in original) argued that expertise is "a particular kind of social *authority*, characteristically deployed around *problems*, exercising a certain *diagnostic* gaze, grounded in a claim to *truth*, asserting technical *efficacy*, and avowing *humane* ethical virtues." Like others writing in this tradition, Rose (1996) seemed to conflate experts' epistemic practices, with their professional standing. Thus, expertise was not only "technical efficacy" "deployed [diagnostically] around problems" but also an "ethical"

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orientation, and "social authority." While "ethics" and "authority" sparked these scholars'

interest (e.g. Parsons 1951), they were largely silent on the topic of what experts' "technical

efficacy" entailed. The content of expert work as the technical mastery of 'complex,' 'abstract'

knowledge remained, in this literature, secondary.

When they did take knowledge as an object of study, scholars of professions were mostly

interested in its social organization, and its role in ordering the "system of professions" (Abbott

1988). For example, Strauss et al. (1964) showed how distinct psychiatric ideologies (i.e.

somatic, therapeutic, and milieu) impacted the distribution of roles in the hospital wards, and the

social organization of treatment. Knowledge—as ideology—determined whether psychiatrists

prescribed medications, spent time talking with patients, or transformed the ward into a surrogate

family. This in turn impacted how doctors, psychologists, social workers, nurses and aides

interacted with each other, shaping the status hierarchy in the hospital. Practitioners' actions

were constrained not only by their ideological commitments, but also by an organization (the

hospital) with strong ties to an influential psychoanalytic institute representing the dominant

therapeutic system of the time (ibid.).

Focusing on the social organization of professions, Abbott (1988) argued that professions

and occupations must be understood as parts of a system organized by the logic of jurisdictions.

Jurisdiction—the connection between a profession and its work—is based on a profession's

"abstract knowledge" (ibid.). The 'right' level of "abstraction," Abbott argued, is time and space

specific, and achieving it is the ticket to jurisdictional security, at least temporarily (ibid.). Yet

how one could determine whether a profession's knowledge had reached this level of abstraction

was hard to tell: in Abbott's (1988) examples, we know this to be the case because a profession

came to occupy a high status in a particular field. Thus, according to his theoretical model,

psychoanalysis dominated the "personal problems jurisdiction" (ibid.) because it proposed an appropriately abstract system of therapy, and knowledge about the self. How do we know the psychoanalytic system of knowledge had reached the right level of abstraction? Because, Abbott (1988) seems to argue, it won jurisdictional contests with other mental health practitioners (e.g. neurologists, psychiatrists, other talk therapies). This somewhat circular argument rests on an assumption about the 'right' level of abstraction that is difficult to test: 'rightness' is in the eye of the beholder. Nevertheless, Abbott (1988) proposed more empirically satisfying ways to determine how and why a profession retains, even temporarily, jurisdictional dominance. He argued that jurisdictions are contested in the public sphere, in the legal domain, and in the workplace. I focus on therapists' work practices (and, mention briefly in the conclusion, the media attention accorded cognitive and behavioral techniques), and contend that the "techno-scientific" approach of the "evidence-based" therapies is increasingly gaining the jurisdictional ground that, for much of the twentieth century, belonged to their psychoanalytic counterparts. Their techniques lend themselves to measurable results, and link clinicians to the psychological laboratory—the locus of scientific credibility and authority (cf. Latour and Woolgar 1979; Gieryn 2002, 2006; Henke and Gieryn 2008). These are essential for its culturally powerful claims to scientific legitimacy.

Viewing expertise as a status attained by successfully navigating particular institutional arrangements, early writers in the sociology of professions focused on the social processes by which it was acquired (Becker et al. 1961; Coser 1979; Light 1980; Haas and Shaffir 1982). They showed how medical students, faced with an avalanche of knowledge, "gamed" the system by mainly studying for tests (Becker et al. 1961). Quickly grasping the applied nature of medical knowledge—to be distinguished from the laboratory-bound sectors of professions (Freidson

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1970; Abbott 1988)—they relished opportunities for gaining clinical experience, and increased

responsibility for patient care (Becker et al. 1961). Haas and Shaffir (1982) shed light on the

"props" that helped medical students develop a doctorly identity (e.g. the white coat, a

stethoscope), while Smith and Kleinman (1989) showed how they distanced themselves

emotionally from the reality of the decaying or sexualized human body. Other scholars

illustrated the "sociological ambivalence" (Merton and Barber 1976), and uncertainty (Fox 1957)

that residents faced as they undertook the paradoxical task of "learning [how to doctor] through

being" a doctor (Coser 1979, p. 103; Light 1980). Relationships were central to their personal

and professional development, and, for psychiatric residents, supervision was essential to

acquiring substantive knowledge, and a self-reflexivity typical of then-dominant psychoanalytic

approaches (Coser 1979; Light 1980; Luhrmann 2000). These novices' efforts were not in vain

as they were awarded entry into the privileged profession of medicine.

This dissertation also sheds light on the 'sociological ambivalence' that psychiatry

residents face as they learn how to work psychodynamically in a medical world that has grown

increasingly unreceptive to that approach. In chapter three, I show that this ambivalence is

especially apparent in the inscription practices residents take up as part of their medical duties.

But this discussion will be secondary to my examination of the "field of practices" (Schatzki

2001) that make up the opposing talk therapeutic ideologies battling for jurisdiction over mental

illness today: psychoanalytic and "evidence-based." Previous studies did little to illuminate the

"epistemic machineries" (Knorr Cetina 1999) by which trainees and experienced practitioners

learn about illness, and intervene into its development (Berg and Casper 1995; but see

Timmermans 1999, 2006; Lakoff 2005a, 2005b). This project takes such epistemic practices as

its primary focus and adds to existing understandings of expertise an illustration of practices that

emphasize affective and relational knowledge. Cognizant that institutional dynamics make

particular kinds of expertise more credible and authoritative in different historical periods (I give

an overview of these dynamics in the field of psychotherapy in chapter one), I shed light on the

practices by which therapists in psychoanalytic and "evidence-based" orientations come to know

and treat their patients' problems. I distinguish between the affective-relational expertise of the

former and the techno-scientific orientation of the latter, and propose that these practices have

significant professional and social implications. Professionally, they shape therapists' claims to

jurisdiction and autonomy, while socially they wield a moral authority that translates into distinct

notions of what it means to be a well-functioning person.

In recent years, sociologists have become increasingly attentive to expert practices (the

second dominant perspective in scholarship on expertise), particularly in two domains: studies

of medical work, and social studies of science. Medical sociologists adopted a mostly critical

stance towards those they studied. Research on doctor-patient interaction illustrated the

variegated ways in which power distorts those relationships, with sometimes negative

consequences for patients (Heritage and Maynard 2006). Light (1980), Brown (1987), and

Whooley (2010) have shed light on the haphazard ways in which practitioners apply *Diagnostic

and Statistical Manual of Mental Health* (DSM) categories, which in turn has implications for

how they understand their patients' problems, and craft their solutions. When they examined

medical practices, scholars have tended to emphasize their "technoscientific content," and the

relations of power and control they solidify (Berg and Casper 1995). For example, Timmermans

(1999) demonstrated how cardiopulmonary resuscitation, an essential medical technology,

shapes not only what doctors and nurses do and how they do it, but has larger implications for

how we think of, and treat death in our society. Other ethnographic studies of medical work

have shown the uneven bases of diagnostic and treatment decisions. Anspach's (1993) research

in neonatal intensive care depicted the often conflictual relationships between nurses and doctors

as they made life and death decisions (see also, Chambliss 1996). The former relied on direct

interactions with babies, and observations of the relations between parents and children, whereas

the latter counted primarily on their technical knowledge, and ability to diagnose and asses the

viability of a cure. Nurses and doctors were differently equipped to make highly consequential

decisions, because of their positions in the "ecology of knowledge" of the unit. Their

orientations intersected in ways that privileged the opinion of the higher status experts: doctors.

By emphasizing what is at stake in medical professionals' epistemic practices—the lives of

newborns (Anspach 1993), people's lives and deaths (Timmermans 1999), and how people

understand and treat mental illness (Lakoff 2005a, 2005b)—these scholars shed light on the

moral authority of expertise.

This research also illuminated gaps within professional bodies of abstract knowledge, and

between professional knowledge and its practical application. Such critiques, along with

structural changes in the world of medicine, have led some scholars to proclaim the waning

power of the medical profession. The proletarianization (i.e. medical professionals moving from

self-employment to wage labor), and deprofessionalization (i.e. professions are losing control

over their work, and, hence their autonomy) theses (Haug 1988; Ritzer and Walczak 1988;

Hafferty and Light 1995; Leicht and Fennell 1997; McKinlay and Marceau 2002) both hint at

professionals' loss of autonomy. Such concerns have been particularly important over the last

three decades, as managed care has risen to the forefront of medical practice, and insurance

companies have assumed a greater role in treatment decisions (Mechanic and McAlpine 2010).

Though its position as an ideal-typical profession has been waning, medicine maintains its

preeminence in our society, as doctors hold "the ultimate trump card, […] expertise that may keep patients alive" (Timmermans and Oh 2010, p.98).

I seek to unpack one instantiation of this expertise by focusing on psychotherapeutic work. As some scholars have argued (Timmermans and Berg 2003; Timmermans and Kolker 2004), we cannot grasp the effect of large scale changes, such as managed care, and evidence-based medicine, only from a macro institutional perspective. I shed light on questions of professional autonomy and jurisdiction by comparing the expert practices of psychoanalytic psychotherapists with those of their counterparts in the newer, "evidence-based" therapies. In chapter three, I show that the inscription practices of psychoanalytic clinicians serve to maintain their autonomy from the mental health care system, while also reaffirming their increasing loss of jurisdiction. In contrast, cognitive and behavioral therapists' work with inscriptions and measures embeds them in systems of expertise, connecting therapy rooms to laboratories, hospitals, and insurance companies. Though their autonomy may be more limited, they make stronger claims to institutional legitimacy, and thus wield higher professional capital in the field of mental health.

My focus on expertise as a practical accomplishment was deeply influenced by a second body of literature: science and technology studies. Sociologists and anthropologists of science have provided a wealth of "thick descriptions" (Geertz 1973) showing that the successful creation of knowledge, and application of rules and techniques depends on scientists' embodied practices (Polanyi 1962; Garfinkel, Lynch and Livingston 1981; Lynch, Livingston and Garfinkel 1983; Pickering 1992; Knorr Cetina 1999). In the introduction to the edited volume *Science as Practice and Culture*, Pickering (1992, p.2) argued that scholars needed to study "what scientists actually do," along with "studying scientific culture, meaning the field of

resources that practice operates in and on."[10] Latour (1987, 1999; Latour and Woolgar 1979), Collins (1974), and Knorr Cetina (1999) have been among the first to establish the motifs of this research: attention to practice rather than professional norms, the interrelation of science and technology instead of the separation of formal knowledge and its application, and the importance of space (and to a lesser degree, time) as a boundary that both legitimates and constitutes scientific work. For example, Latour and Woolgar (1979) compared the scientific laboratory to a "system of inscription" that "black boxed" scientific facts, allowing them to traverse spatial and temporal boundaries (see also, Latour 1999). Knorr Cetina's (1999) comparative research of high energy physics experiments, and molecular biology laboratories, illuminated the "practices of creating and warranting knowledge" characteristic of these particular scientific cultures (p. 246). She focused on what she called the "machineries of knowledge construction" (ibid., p. 3), a category in which she includes not only modes of thinking, but also scientists' bodies, their inscription apparatuses, and the objects they use in their work (e.g. the detector, the laboratory bench). Relationships between people and things are essential to the knowledge-making process, as detectors in HEP experiments were imbued with agency by their not-always-in-control human masters (ibid.). Moreover, the body of the molecular biologist becomes a primary "technical device in the production of science" (p.119). This dissertation is similarly concerned with embodied practices, showing that the spatio-temporal environments of psychotherapy foster the embodied dispositions that make up a therapeutic habitus: the ability to withstand intense emotions, to communicate empathy, to skillfully observe people's emotions, to listen and process information according to one's therapeutic specialty. But I also show that private offices and

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[10] Sewell (1999) on the other hand considered practices to be part and parcel of culture rather than a separate component. In other words, culture is not simply a set of ideas and norms, but it contains within it the practical ways in which people interact with those norms and ideas, changing them in the process. However we approach this concept, it is enough to note here that ideas and practices go hand in hand.

longer temporal frameworks foster an affective-relational expertise, while the uniformly muted offices of cognitive behavioral therapists, along with the shorter time spans of their treatments, lend themselves to techno-scientific expert practices.

When scholars in this tradition followed knowledge outside the laboratory, they noted the prevalence of expertise as personal, embodied ways of knowing which challenged the primacy of the scientific method. Most often, scientists' "technical" expertise (Collins and Evans 2007) clashed with the embodied knowledge practices of non-scientists on issues with policy ramifications (e.g. Wynne 1989; Epstein 1996; Scott 1998; Marlor 2010). Thus, experts ignored Cumbrian farmers' practical knowledge of raising sheep in the aftermath of Chernobyl, to the detriment of the latter (Wynne 1989, 1993). In contrast, Epstein (1996) demonstrated that, at crucial moments in the process of making sense of what would be known as "AIDS," activists influenced scientific decisions by claiming a form of *experiential* knowledge not available to researchers in their labs. Their "lay expertise" (ibid.) approximates what Scott (1998) called "metis," the kind of particularistic, idiosyncratic process of knowing that emerges out of personal experience. Taken together, these studies, along with laboratory ethnographies, made two especially important points: first, all knowledge is constituted through embodied practices, and, second, the legitimacy of "expertise" is contextual.

Embodiment is also one of the key themes in this dissertation. Drawing on a number of studies that focus on the process of *knowing* (e.g., Polanyi 1962; Latour and Woolgar 1979; Knorr Cetina 1999; Acord 2010; Pagis 2010), I approach expert practices as "*ensembles of patterned activities* […] by which human beings confront and structure the situated tasks with which they are engaged" (Camic, Gross and Lamont 2011, p.7, italics in the original). Repetitive engagement in such "patterned activities" gives rise to a particular embodied dispositions that

make up the expert "habitus" (Bourdieu 1977). Put thus, expertise is not the sole property of professional groups, but can exist outside professions and occupations (e.g. Wynne 1989; Epstein 1996; Scott 1998). I focus on the kind of institutionally legitimated expert practices that have been the focus of scholars of professions, primarily due to the moral authority that, I argue, becomes naturalized in such work. Psychotherapeutic expertise is thus akin to the "specialist" practices that Collins and Evans (2007) distinguished from "ubiquitous" (e.g., speaking a native language) and "meta" (e.g., making judgments about experts and their knowledge) expertises.

Though scholars focused on practice, and expertise in particular, acknowledge the central role of the body in getting things done, their discussion of embodiment ends there (but see, Knorr Cetina 1999; Boyer 2005a). For example, in his introduction to the agenda-setting edited volume proclaiming the "practice turn" in theory (Schatzki, Knorr Cetina, and von Savigny 2001), Schatzki (p.17) argued that "practice theory's embrace of embodied understanding is rooted in the realization that the body is the meeting point both of mind and activity and of individual activity and social manifold." I use embodiment both in this general sense—recognizing the centrality of the body to achieving and performing the kind of practical understanding the 'habitus' requires—as well as in a more particular sense. As I show in chapter two, the spatial positioning of bodies in the therapy room is indicative of the power distribution characteristic of this profession. In chapter three, I discuss the epistemic value of psychoanalytic therapists' affective reactions, as well as the embodied ways by which clinicians in both orientations 'model' particular affective dispositions to their patients. My work adds further depth to understandings of expertise by shedding light on these affective dimensions of work. Without this, and the additional elaboration of temporality in expert work (that I discuss below, and at further length in chapters two and four), we have only a limited understanding of the tools by

which professionals can assert authority in interactions with clients when it is most vulnerable to contestation (Parsons 1951).

Experts' epistemic assurance—their trust in their knowledge—is a performance that depends on a well-calibrated emotional display. Such displays must also demonstrate a mastery of time: there are more or less appropriate times for experts to assert their knowledge (Zerubavel 1979, 1982), a knowledge which can colonize the affective and temporal orientations of their interlocutors. In an especially stark example, think of the doctor communicating a deadly diagnosis to an unexpecting patient whose affective life and temporal anticipation are suddenly transformed. Differently distressing are divorce lawyers' efforts to adjust their clients' affective and temporal expectations of the process, and of their soon-to-be former spouses (Sarat and Felstiner 1995). I turn next to a brief discussion of emotions and temporality in the literature, and clarify my own contributions.

Emotions, time, and expert practices

Scholars that approached expertise as a special status legitimated by institutional arrangements, tended to treat affect as a professional tool for establishing ethical uprightness, and gain patients' trust. Thus, Parsons (1951) argued that a stance of "affective neutrality" was necessary for doctors to skillfully fulfill their duties. Drawing on psychoanalytic ideas of the time, he proposed that this attitude would make possible patients' disclosure, and insulate doctors against the difficulties of working with dying and decaying human bodies (ibid.). Later, Lief and Fox (1963) argued that it was in fact a "detached concern" that more appropriately characterized doctors' emotions at work, as it allowed them to properly manage the sociological ambivalence created by the institutional norms of "affective neutrality" and "affectivity" (i.e. caring for patients). For both Parsons (1951) and Lief and Fox (1963), feelings are key to

establishing trust between doctors and patients. Similarly, Shapin (2004) has argued that

technical expertise is not enough of a basis to foster such trusting relations. After all, most

people are not qualified to evaluate their doctor's or lawyer's knowledge. Shapin pointed out

that "[t]he cardiologist has to care about *your* heart as well as to know a lot about hearts" (2004,

p.48). Thus, she needs to express enough "concern" for the patient to inspire trust. At the same

time, she could not be so involved so as to be unable to make the sometimes painful decisions of

inflicting pain on the patient for his or her betterment. This means that "at a practical level, the

evaluation of expertise contains within it a moral evaluation" (ibid.), which depends, partially, on

the feelings that professionals are able to communicate to their clients, and the affective

responses they foster on their part. By these accounts, experts' affect facilitates clients' trust,

making room for the application of their expert knowledge. Emotions are secondary to

professionals' 'actual' skills, playing a supportive role in their expert toolkit.

   Though Barley (1996) declared the "technician," "a person whose work revolves around

instruments and who requires training in a science or technology" (p.409), as the ideal typical

expert of the new, computer-centric economy, service occupations continue to rely on

"emotional labor" (Hochschild 1979, 1983). The technicization of service occupations does not

have to be at odds with the relational and affective labor that care workers have traditionally

provided those who purchase their services. Hochschild's (1979, 1983) groundbreaking studies

put emotions on the map for studies of work, and many of her followers have detailed the skillful

ways in which workers from government offices to nursing homes repressed or called up

context-specific emotions (Lopez 2006; Mastracci, Newman and Guy 2006). This research has

shown the gendered, unequal, and sometimes alienating dimensions of emotional labor

(Hochschild 1983; Leidner 1993, 1999; Folbre and Nelson 2000; England 2005). But despite the

theoretical framework set forth by Hochschild (1979, 1983), and the field's exciting empirical findings, there has been little crossover between this research and that on professions and expert work. Perhaps this is due to the distinct status of professionals and service workers, or, more importantly, to the assumption that expert practices driven by technical, abstract knowledge are devoid of affectivity. This dissertation builds on recent research that suggests otherwise, and argues that emotions are not solely relevant to professionals' client interactions, but are veritable epistemic tools in the process of working on diagnosis, inference, and treatment (Abbott 1988).

Few researchers have examined the role of affect in scientific work, an arena that has usually been depicted as anathema to emotionality. Parker and Hackett (2012) have shown that affective ties between scientists turned into an attenuated sense of collective effervescence which enhanced their creativity. Knorr Cetina (2001) has argued that all knowledge practices have an affective and "relational" underpinning. Similar to Parker and Hackett (2012), she focused on non-routine epistemic practices, which, she argued "best epitomize epistemic practice" (p.188). When they encounter new work, or problems in their ongoing endeavors, experts turn to "relational resources" such as "taking the role or perspective of the other; making an emotional investment (taking an interest) in the other; and exhibiting moral solidarity and altruistic behavior that serves the other person" (p.189). This, Knorr Cetina (2001) argued, is the case whether the "other" is another person or a thing (in her example, a protein). The affective investments that scientists make in the relationships they build with other "actants"—to use actor network theorists' term for human and non-human participants in social action (Law 1992; Latour 2005)—are essential to their epistemic practices (Knorr Cetina 2001). These studies enhance our understanding of how affect and expertise are connected, by showing that emotions are intrinsic to the relationships experts form with other experts, or with their "objects" of

knowledge, whatever they may be. I show that practitioners of psychoanalytic psychotherapy

resort to an affective understanding of their patients' relational problems that reflects and

exceeds the empathy discussed in these studies.

Two other scholars have granted emotions such a role. Halpern (2001) underscored the

importance of a "gut instinct" with which doctors can understand their patients' symptoms and

responses to medical treatments. Luhrmann (2000) pointed out that psychiatry residents being

trained in psychodynamic psychotherapy learn a form of "double-entry bookkeeping" to account

for their own and their patients' emotions, needs and desires. This allows them to "take

themselves out of the equation," and better understand their patients (Luhrmann 2000, pp. 63-76;

see also Light 1980). They partially achieve such insight through their supervisory relationships,

as experienced analysts "supply the support the residents need to become free of anxieties so that

strongly embedded dispositions or internal conflicts will not interfere with their relationships

with their patients" (Coser 1979, p.90). I build on these studies, and show that psychodynamic

therapists' affective approach results in a highly local and idiosyncratic form of expertise that

stands in contrast to cognitive and behavioral clinicians' techno-scientific methods. Affective-

relational expertise allows psychodynamic therapists to adopt a more historical and

developmental approach to the problem of mental illness (cf. Luhrmann 2000). Yet their

efficacy is difficult to quantify, making theirs a tenuous position in today's medical world

focused on "evidence-based" interventions.

Emotions are essential to the embodied practices that make up expertise (Luhrmann

2000; Knorr Cetina 2001), and can function as veritable sources of knowledge in expert practices

concerned with the making of "social knowledge." Thus, the psychodynamic clinician relies on

her affective experiences, and her self-awareness, to understand her patients' difficulties as they

manifest themselves in the therapeutic relationship. In other words, psychodynamic therapists' knowledge of their patients' problems is the result of an intra and intersubjective process. It is a personal journey of discovery for patient and therapist, in which the therapist's affective experiences serve as a guiding light. This is a distinct epistemic project compared to that of cognitive and behavioral practitioners. Their knowledge of mental illness is the result of a methodical process of specifying, delimiting, and measuring affective, cognitive and behavioral states. Though they too rely on their affective reactions to communicate empathy, most of their interventions are designed to eschew practitioners' subjectivity.

One other element is essential to constituting affective-relational and techno-scientific practices: time. Durkheim ([1912]1995) and Sorokin and Merton (1937) established early on that time is a "social fact" worthy of sociological attention. They illuminated the cultural meanings embedded in seemingly natural social rhythms (ibid., also, Bergmann 1992). This early problematizing of calendrical or clock time led to a wealth of studies about the various temporal structures that organize people's lives (e.g. Goffman 1959; Roth 1963; Douglas 1966; Thompson 1967; Zerubavel 1979, 1982; Hochschild 1997, 2003) and how they experienced such structures (e.g. Schwartz 1974; Auyero 2011). For example, Zerubavel (1982) showed that schedules and calendars shape our experiences, and condition our social identities. He asserted that we organize our lives around particular "temporal maps" that help us navigate the intricacies of privacy, observability and legitimacy (ibid.).

"Practice is inseparable from temporality," Bourdieu argued, not only "because it is immersed entirely in the current of time," but also "because it plays strategically with time, and especially with tempo" (1977, p.81). Tempo, rhythm, and directionality make up the "temporal structure" of practice, thus "constituting" its meaning (ibid.). Scholars have shown how

communities of experts construct particular professional identities around different temporalities (e.g. Zerubavel 1979; Traweek 1988; Fine 1990). Dubinskas (1988) provided an especially insightful analysis of time in managerial and scientific work. His distinction between "planning" and "developmental" time pinpointed the sources of conflict and mismatch between these two cultures as they came together in the increasingly commercialized space of university research. Thus, whereas managers' temporal perspectives tended to emphasize closed-ended projects with finite goals and limited financial investments, scientists' view of themselves and their knowledge as continuously growing made for more open-ended perspectives of work[11]. Dubinskas (1988) showed that these distinct temporal orientations—the rhythms and tempos of managerial and scientific work—made for different, albeit similarly high status professional cultures.

Similarly, the temporal organization of psychotherapy shapes clinicians' expert practices. Thus, the longer, more open-ended temporal frames of psychodynamic treatments make possible the kinds of affective-relational expertise typical of this approach. The work of identifying one's affective reactions, and locating their roots in the therapeutic interaction takes time. Some of the residents referred to this as "psychodynamic time," to be distinguished from the shorter, more limited time-spans of cognitive and behavioral (and pharmacological for that matter) interventions. Psychodynamic time not only signified a distinct length of treatment (and, as I show in chapter two, session frequency), but also a more flexible approach to using the 45 minutes of the therapy session. Therapy time in a psychodynamic treatment was for reflection, feeling, and understanding. In contrast, time in the "evidence-based" therapies was "active" and "agenda" driven. It revolved around exercises and techniques aimed at fostering change in the

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[11] This is in keeping with Knorr Cetina's (2001, pp.190-4) argument that objects knowledge have an unfolding character never acquiring a "thing-like" status. In other words, problems are never fully resolved, phenomena never fully explained, and this open-ended character of knowledge creates "structures of desire" that underpin the relational dynamics she posits as foundational to epistemic practice.

immediate future. Cognitive and behavioral therapists' techno-scientific practices eschewed affective understanding in favor of targeted techniques and limited temporal frames.

Fine (1990) linked organizational time and occupational identity by focusing on restaurant kitchens. He showed that "rush time" was not only significant because of what it could demonstrate about one's ability as a chef, but also because it was accompanied by an affective shift vis-à-vis down time. As restaurant workers negotiated issues of synchronization, tempo and rhythm, their affective experiences changed from boredom to excitement or anger. In contrast, professionals' cool detachment during moments of crisis can betray their "guilty knowledge"— that 'profane' familiarity with disease, death, and immoral behavior (Hughes 1958). Hughes (1958) argued that a professional "may see the present in longer perspective than [...] the layman," thus gaining a better understanding of a problem's past and future (ibid., p.83). Such an understanding can distort experts' affective reactions: having seen and dealt with many "emergencies" (whereas the client may have little experience with such events) tempers practitioners' emotional reactions. "In time of crisis," Hughes (1958, p.83) argues, "detachment appears the most perilous deviation of all, the one least to be tolerated." Such detachment makes "the professional mind" seem "as a perversion of the common sense of what is urgent and less urgent" (ibid.). Be it that they experience excitement, boredom, or calm, professionals' affective reactions are temporally organized, and, as Hughes (1958) argues, morally charged. In psychotherapy, clinicians have harnessed their ability to withstand intense emotions and take a longer perspective on their patients' problems into a professional strength. It is a source of credibility, and a basis of authority.

Psychotherapeutic practices take place within temporal bounds that both imbue them with a sense of the sacred, and grant clinicians professional authority. Within the time frame of

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psychotherapy, clinicians control the emotional demands of their work—they are, to borrow a phrase from Orzechowicz (2008), "privileged emotion managers." Moreover, as I show in chapter two, in the therapy room, during the clinical hour, therapists' vision is hegemonic. Within these spatio-temporal contexts, clinicians determine what counts as relevant knowledge about patients' problems, and how patients conform to the demands of psychotherapy. Yet focusing solely on the temporal frames of expert work obscures the possibility that time may function as an epistemic tool that, in the hands of psychotherapists, can shape our ideas of what it means to be a well-functioning human being. In chapter four, I return to the issue of temporality, and link it to a discussion of narrative self-identity. I argue there that clinicians in psychodynamic and "evidence-based" therapies provide patients with distinct temporal tools for ordering and imbuing meaning into the events that make up the identity-narratives they inevitably construct as they "confess" (Foucault 1978) their troubles. Psychoanalytic practitioners focus on the "developmental" time of their patients' problems, seeking insight into the affective mechanisms by which the past manifests itself in the present. In contrast, "evidence-based" practitioners' techno-scientific expertise revolves around cognitive and behavioral interventions into "precipitating events"—those moments that hasten patients' mental and emotional crises. Though recognizing the historical development of their patients' most intractable problems, these clinicians eschew the historicizing attempts of their analytic counterparts in favor of change and present-oriented interventions. This analysis demonstrates that the making of "social knowledge," focused on understanding human beings and the "aggregate or collective units—the groups, networks, markets, organizations, and so on—where these human agents are situated" (Camic, Gross and Lamont 2011, p.3), depends in part on the temporality of the epistemic practices it entails. In addition, the affective dimension of such

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practices can serve as an important source of insight into people's histories, motivations, and emotional lives.

In sum, this dissertation shows that expertise in psychoanalytic psychotherapy presumes the use of clinicians' affective and relational skills in the service of treatment. Here, knowledge is individual and idiosyncratic, a kind of particularistic wisdom that comes with intense and prolonged self-reflection. Emerging out of a clinically-oriented culture, psychoanalysis has been increasingly sidelined by its laboratory-bound competitors adopting cognitive and behavioral approaches. I argue that practitioners of these "evidence-based" therapies embody an expertise that approximates a techno-scientific ideal dependent on the creative application of standardized tools and treatment protocols. Quantification, classification, and routinization make up the core of these approaches, placing practitioners within institutional systems that combine epistemic with economic concerns in (presently) successful ways. In contrast to affective-relational practices that draw on emotions as sources of knowledge, techno-scientific approaches relegate emotions to a secondary, supportive role. Therapeutic practices in these orientations differ along one additional dimension: temporality. Psychodynamic psychotherapists work with expansive and open temporal frames, seeking to identify significant "developmental" events in their patients' pasts. In contrast, adopters of the "evidence-based" specialties emphasize the time-limited nature of their treatments, and work on producing change by intervening into "precipitating" events. Therapists in these two (sometimes overlapping) "epistemic cultures" (Knorr Cetina 1999) are caught in a jurisdictional struggle over mental illness and health, the consequences of which exceed the boundaries of their profession.

This dissertation makes several contributions to the literatures on expertise, professions, and the psychological sciences. First, I elaborate a typology of expert practices that illuminates

the affective and temporal dimensions of knowledge work. By taking up a profession engaged in the application of knowledge about human beings, this is also a contribution to the newer studies of "social knowledge making" (Camic, Gross and Lamont 2011). Second, I argue that approaching expertise as a practical achievement has implications for our understanding of professional autonomy and jurisdiction. I show that these two essential attributes are not by necessity linked, but can characterize different segments of the same profession to varying degrees. Moreover, I argue that practices aimed at sustaining a profession's autonomy can undermine its attempts at maintaining jurisdiction. Third, I shed light on a set of psychological practices—that of the "evidence-based" therapies—that have received little scholarly attention. These modalities have challenged psychoanalytic dominance in the field of talk therapy. My findings suggest that we are seeing the rise of a model of selfhood that circumvents the historicity promoted by psychoanalysts, in favor of fragmentation, specification and change.

Case selection

Psychotherapy presents a unique case for extending theoretical understandings of professional expertise for two reasons: the contested status of its knowledge, and the power of this professional field. Talk therapy has faced critiques from inside and outside of medicine. The most damning include lack of precise diagnostic schemes (Light 1980; Brown 1987; Whooley 2010), or consensus around the causes and treatments of mental disorder (Healy 1997; Lakoff 2005b). Questions around psychiatrists' status as "real" doctors—an anxiety that rears its head among psychiatry residents [see e.g. American Psychiatric Association's guide (2007) for residents]—reinforce the status of mental health workers as standing somehow outside the bounds of legitimate medicine. Some academic observers have even questioned the skills that psychotherapists claim to have (e.g. Goffman 1961; Light 1980; cf. Brint 1994), while patients'

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accounts of "bad therapists" flood the web whenever an article about psychotherapeutic practice surfaces in the news.

And yet, despite such forceful criticisms that seem to cut to the very core of the field, psychotherapy and the groups it includes (psychiatrists, psychologists, social workers), still thrive, exercising a great deal of influence in modern society (Foucault 1978, 2006; Rose 1985, 1990, 1996; Giddens 1991; Hacking 1995). Mental health professionals are centrally located in what Foucault (1988, p.18) has termed "technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality." One of the most powerful such technologies has been the confession, an act through which the "speaking subject" seeks to attain some ultimate truth by narrating her deepest fears and desires (Foucault 1978). To Foucault (1978), the act of confessing is an essential trait of modern Western civilization, a mode of interaction that has infiltrated a whole series of relationships (e.g. familial, medical, educational, legal) (also, Rose 1996). A defining element of the confession is that it "unfolds within a power relationship," in which the listener "intervenes in order to judge, punish, forgive, console, and reconcile" (ibid., pp. 61-2). As some of the most important authoritative interlocutors in this confessional system, therapists are veritable 'technologists of the self,' furthering the project that scholars have attributed to the psychological sciences: the making of the modern self.

Historical studies have thus illustrated the emergence of a "personal problems jurisdiction" (Abbott 1988) and a "soul" that could be studied and controlled (Hacking 1995, 1998). They have chronicled psychology's rise to domination over people's everyday lives

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(Giddens 1991; Rose 1999), and the influence of psychoanalytic thought on our conceptions of

the self (Wain 1999; Roudinesco 2001). In other words, the psychological sciences have shaped

not only how we think of deviant ways of being, but also how we understand what it means to be

normal (Rose 1990; Lunbeck 1994; Hacking 1995, 1998). Over the past three decades, new,

"evidence-based" therapeutic orientations have risen to dominance in the field of mental health[12],

challenging longstanding psychoanalytic ideas, and proposing distinct models for what it means

to be a well-functioning human being. Differences between psychoanalytic and "evidence-

based" approaches to mental illness range from conceptualization to treatment.

Though psychoanalytic theory has departed from Freud's early drive model of mental

illness (Liff 1992), its principle mode of application continues to rely on engagements between

patients and therapists focused on the former's discussion of their affective and relational

difficulties. Despite differences between varying schools of psychoanalysis (e.g. Freudian,

object relations, self-psychology, Lacanian), psychodynamic therapy is based on the theory that

people come to develop mental health problems due to unresolved traumas, and the

accompanying negative affect that they push out of consciousness (Eagle and Wolitzky 1992;

Liff 1992). Acts of "trying to hide certain memories, ideas and desires from himself or herself"

(Eagle and Wolitzky 1992, p.113) escape patients' immediate consciousness, and are difficult to

identify and reverse. They do, nonetheless, come to the surface in relationships, and the one

between therapist and patient is psychodynamic practitioners' ultimate tool (Jacobs 1991;

Chodorow 1999). It is within this unique relationship that therapists can learn about their

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[12] Interview data lead me to believe that the practices I associate with techno-scientific expertise are characteristic of psychopharmacology as well. While pyschopharmacology dealt the most powerful blow to psychoanalysis beginning in the 1960s (Light 1980; Luhrmann 2000; Lakoff 2005a, 2005b; Strand 2011) I choose to focus on talk therapists for two reasons: first, we know less about the practical ways in which therapists enroll "talk" to claim legitimate jurisdiction over the problems of everyday life. Second, unlike pharmaceuticals, which have long played an important role in physicians' expert tool kits, granting them a ready-made symbol of authority, talk is a less powerful legitimating tool. Interview data lead me to believe that the practices I associate with techno-scientific expertise are characteristic of psychopharmacology as well.

patients' problems, and provide alternative models of being while calling patients' attention to the patterns they are (re)enacting (Jacobs 1991; Chodorow 1999; Liff 1992). Here, "everything's analyzable" as one of my interviewees put it, and the ultimate goal is to develop patients' ability for insightful introspection and self-awareness (Liff 1992; Chodorow 1999).

Cognitive behavioral therapy (CBT), the paradigmatic "evidence-based" intervention, relies on distinct assumptions about mental illness and its causes. CBT, a hybrid of the cognitive approach championed by Albert Ellis and Aaron Beck[13] (1967, 1976, 1979) and behavioral interventions, is aimed at changing patients' maladaptive thought patterns through targeted techniques. From the inception of the field, Beck touted the testability of his propositions, and the "systematic experiments" (1976, p. 4) that had demonstrated the efficacy of his techniques (see also, e.g. Clark and A. Beck 1999). This orientation attributes emotional distress to "fundamental cognitive errors in seeing the world" (Arnkoff and Glass 1992, p. 662) that can be corrected with the help of discrete cognitive tools and behavioral exercises (see also, A. Beck 1976). Linking behaviors and emotions to cognitions, Judith Beck, Aaron Beck's daughter and a renowned cognitive therapist herself, stated that the cognitive model "hypothesizes that people's emotions and behaviors are influenced by their perception of events" (1995, p.14). As I observed it, CBT therapists combined the cognitive and behavioral models, aiming to change not only thoughts but also behaviors to help patients feel better. The practitioner of CBT (similar to DBT or interpersonal therapy—two other "evidence-based" approaches) is thus less interested in gaining (and granting) insight into the relational roots of patients' emotional distress. Rather, as

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[13] The 'invention' of cognitive therapy is a contested issue in the field. Two important figures share claims to this innovation: Aaron Beck, whose writings I will return to throughout this manuscript, and Albert Ellis (I discuss these further on p. 55). Ellis's techniques were seen as somewhat eccentric in the training program where I completed my fieldwork, though his approach bears many similarities to that championed by Beck through the Beck Institute for Cognitive Behavioral Therapy. In future research, I will attempt to better understand the conflict that led to Beck's and Ellis's nearly independent lines of work even after they discovered their similar passion for cognition.

A. Beck (1976, p.3) succinctly put it: "the therapist helps a patient unravel his distortions in thinking and […] learn alternative, more realistic ways to formulate his experiences."

I return to a history of these interventions in the next chapter, and detail their workings in chapters two through four. First, I examine the spatio-temporal dimensions of these therapists' work, showing that they rely on the therapy office and session time as boundaries that distinguish their work from the kind of help family or friends can provide. Within these environments, clinicians are authoritative figures whose embodied expertise serves to medicalize patients' everyday problems. Chapters three and four illustrate therapists' approaches to Axis I (with a focus on depression and anxiety), and Axis II (personality) diagnoses—the most important sets of problems therapists identify from the range included in the *Diagnostic and Statistical Manual of Mental Disorders* (see also, Whooley 2010). In those chapters, I show that therapists employ distinct epistemic tools to make sense of, and treat their patients' problems, and that their interventions have different temporal orientations. These orientations translate, I argue, into divergent notions of what it means to be a well-functioning human being. Lastly, I suggest that affective-relational and techno-scientific expert practices lend themselves to divergent forms of knowledge: idiosyncratic, particularistic and deep on the one hand, and calculable, rationalized and standardized on the other. Within the field of mental health, these approaches, and the knowledge they produce, have translated into the increased sidelining of psychoanalytic practitioners, in favor of their "evidence-based" counterparts.

Methods and data

I conducted 18 months of ethnographic observations in the Psychiatry Residency program of a large public university. Unlike residents training in psychiatry in the 1950s, 60s and 70s (Strauss et al. 1964; Bucher 1965; Coser 1979; Light 1980), those participating in the

program at the time of my research (2009-2011) faced a very different professional field. For them, a private practice focused on psychoanalytic work was a thing of the past. While many of the program's graduates entered academic psychiatry (about 35% of those finishing between 2001 and 2010), close to 30% took jobs with private care facilities (e.g. group practices of varying sizes, and health management organizations). For most, work after the residency consisted of pharmacology sessions ranging from 15 to 30 minutes per patient. Few started smaller private practices, and I had a chance to talk with some about what prompted their decision. Most did so to pursue more talk therapy: they enjoyed the process and liked spending more time with their patients. But, as a psychiatrist in the beginning of her career told me, things were complicated financially, and temporally: she could make more money seeing three to four patients in an hour. Blocking off one hour increments for talk therapy patients didn't work with the 15 minute slots she had allotted to her medication patients. Since prescribing most psychiatric medications is their exclusive jurisdiction, psychiatrists face multiple pressures to practice their specialty.

Psychiatric training in this and other programs still offer a good deal of talk therapy instruction. During their third and fourth years, residents in the program I observed saw patients on an outpatient basis, both for pharmacology and talk therapy. The bulk of their time was taken up with prescribing medications, but they also had a chance to treat patients psychodynamically, or by applying one of the empirically supported approaches. Psychologists and social workers also received some of their training in cognitive and behavioral techniques alongside psychiatry residents. I observed conversations and interactions during mentorships (meetings combining didactics with case discussions), group supervision sessions (meetings in which participants— novices and experienced therapists—discuss particularly challenging cases), and therapy sessions

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with adults and children (amounting to approximately 360 hours of observations). I took notes on interactions in (1) cognitive behavioral therapy for anxiety, (2) cognitive behavioral therapy for depression, (3) interpersonal therapy, (4) dialectical behavioral therapy, (5) couples and marriage therapy, and (6) psychodynamic psychotherapy. Whereas the first five mentorships (considered to be "evidence-based") met for 6 month rotations, the psychodynamic core class met year round. It is worth noting that of all the training settings I observed, only one was led by psychiatrists who also practiced psychoanalysis. Instructors in all the others were either social workers or psychologists. This too is reflective of psychiatry's move away from psychotherapy.

I observed therapy sessions in cognitive behavioral therapy, psychodynamic psychotherapy, and couples and marriage therapy. I had the opportunity to witness a CBT treatment with a young man that lasted nearly 6 months, as well as other, shorter treatments, two with male adolescents, and one with a young mother and her son who was diagnosed with Attention Deficit and Hyperactivity Disorder. I also observed, along with residents and other trainees, cognitive and behavioral therapy sessions in depression and anxiety, as well as sessions with couples seeking help with their marital problems. Lastly, I took notes on the videotaped psychodynamic psychotherapy sessions conducted by one of the instructors of the psychodynamic core class. In addition to illuminating therapeutic ability and knowledge, these sessions made clear the degree of control that novices could wield over their own feelings of insecurity and inadequacy in highly emotional circumstances. I gained a deep appreciation for the skill necessary to get someone to open up about their problems, reign in intense feelings, and motivate people to do the things that they are most afraid of. I also came to learn about the emotional toll that this line of work can take on those who choose it as their profession. One resident told her colleagues that she would always feel the need to get on a treadmill and run for

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an hour on Thursday evenings after seeing a particularly challenging patient. That was her therapy session.[14]

I complemented my ethnographic observations with in-depth interviews. I talked at length with 60 practicing psychotherapists ranging in level of training (including 31 psychologists, 22 social workers, and seven psychiatrists), and years of experience (from six months to more than 30 years). Most of my respondents practiced either psychodynamic psychotherapy or cognitive behavioral therapy, but some also specialized in psychoanalysis, dialectical behavioral therapy, or family therapy. Whereas 25 participants practiced psychodynamic therapy, 21 ascribed to "evidence-based" techniques, and 14 described their work as eclectic, or practiced both orientations as part of their training. My interviewees worked in a variety of settings but some patterns were apparent: 68 percent of psychodynamic psychotherapists had private practices, whereas only 19 percent of the "evidence-based" therapists did (most worked either in group practices, or at university affiliated mental health clinics). Interviews lasted between one and three hours and covered four topics: professional history, what a typical therapy session looks like, what therapists think about and how they feel when they interact with patients, and whether and how their professional knowledge has been relevant in their personal lives. These narratives are helpful for understanding how therapists experience their work, and their insights form the bases of many of the arguments I make here.

I began my ethnographic observations by taking hand-written notes that I would later transcribe, jogging my memory for details that I had inevitably left out in the moment. When it became evident that my use of a computer would not be disruptive of the meetings, I began

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[14] Unlike residents training at earlier times (e.g. Strauss et al. 1964; Bucher 1965; Light 1980), participants in this study were not obligated or even strongly advised (in the public fora I observed) to undertake their own therapy. This is partly a function of the decreased emphasis on psychoanalytic practice in their post-training careers, and their own decreasing interest in psychodynamic therapy. Nevertheless, as I show in the empirical section of the paper, instructors in psychodynamic therapy insisted on self-awareness as an essential element of doing therapy.

taking typed notes that I would revisit at the end of every day, to correct and fill-in missing details. This provided me with richer data on ongoing conversations, as well as other relevant details about what therapists did and said during clinical sessions. I uploaded word documents with these data, and my transcribed interviews, into NVivo 9, a qualitative data analysis software. I used the program in three rounds of coding. First, I conducted a targeted reading of a limited number of observations and interviews to identify the dominant themes in my field notes. Using these inductively identified themes, I then conducted an exhaustive coding of my ethnographic observations, generating other codes in the process. The resulting coding scheme contained upwards of 100 themes, which I then classified, in a third round of targeted coding, into five general categories: boundaries, therapist self-presentation, time/space/money, embodiment and emotions, and expert techniques. With these codes, I returned to my interviews and completed a final round of targeted analytic coding.

The organization of the dissertation

I start with a historical chapter that contextualizes the mental health field as we find it today. Drawing on secondary sources, I show that psychoanalytic approaches emerged out of clinical work with patients, whereas "evidence-based" therapies had their roots in laboratory-based research. Similar historical circumstances aided the rise of these therapies, as they found their footing in wars starting with World War I. I show that 'scientism' and professional legitimacy were always a concern in the American mental health field. This translated into pushing out lay practitioners (primarily religious representatives and non-M.D.s), and focusing on preventative methods that would increase jurisdiction over the problems of everyday life. This chapter contextualizes my argument that, in the transition from psychoanalytic to "evidence-based" interventions into mental health we are witnessing a concurrent transformation

of what counts as legitimate knowledge about the soul. Introspection and intensive clinical

observations are being replaced by inscription and measurement.

In chapter two, I begin to illustrate the epistemically-specific ways in which therapists

practice their craft. The chapter focuses on the spatio-temporal environments of therapeutic

work, and illuminates their essential function as boundaries that set this expertise apart, and

denote its authority. Moreover, I contend that such environments reflect the social organization

of the profession (i.e. the increasingly central position of cognitive and behavioral therapists), as

well as serving epistemic functions. Within the spaces and times of psychotherapy, practitioners

develop a therapeutic habitus in which the epistemic underpinnings of professional organization

become objectified (cf. Bourdieu 1977, p.57). Chapters three and four are concerned with how

practitioners of these two treatment ideologies respond to similar problems. In chapter three I

focus on their responses to depression and anxiety (two of the most common diagnoses they

assign today), while in chapter four I illustrate their distinct methods for approaching some of the

most challenging patients they see, those believed to suffer from personality disorders. I tease

out the ways of thinking, feeling, and doing that characterize affective-relational expertise, and

contrast them to the embodied techno-scientific practices of their "empirically-supported"

counterparts.

In chapter three I show that all therapists learn to tolerate intense emotions and practice a

form of affective asceticism that allows them to focus on their patients. Psychoanalytic

therapists also rely on their emotions as a source of knowledge in diagnosing and treating

patients' problems. These clinicians make use of their affective reactions as epistemic tools by

treating them as indicators of how patients themselves may be feeling (especially when they may

not be aware of such feelings), or of their interpersonal troubles (therapists' emotions are also

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thought to mirror those of significant others with whom the patient may be having difficulties). I illustrate cognitive behavioral therapists' reliance on measures, research and evidence, formal diagnosis, and inscription. Chapter four shows that, while psychoanalytic and "evidence-based" therapists agree on the developmental nature of their patients' personality disorders, they adopt treatments that emphasize distinct temporalities. Psychodynamic psychotherapists focus on "developmental" events to help patients gain insight into how their past impacts their present emotional and relational difficulties. Dialectical behavioral therapists emphasize instead the concrete skills and tools that patients can adopt to manage "precipitating events," those moments which may hasten an emotional crisis. In this chapter, I explicitly link therapists' temporal "technologies" to distinct models of selfhood. These therapeutic techniques shape patients' sense of "inner time" (Garfinkel 1967), the historicizing work people do in the process of constructing meaningful self-narratives.

The chapters detail my approach to expertise as a set of embodied practices that depend not only on technical, abstract knowledge, but also on affect and temporality. My findings have implications for how we understand debates about the credibility of different kinds of expertise, as well as about professional autonomy and jurisdiction. The two kinds of expertise that I describe in this dissertation are not mutually exclusive. In practice, many therapists work— imperfectly in the eyes of those whose allegiance is strong with one side or the other—with techniques from both. They, along with others (e.g. teachers, doctors, chefs, art authenticators) who make use of affective, relational, and techno-scientific tools, are bricoleurs. Arguably, the two forms of knowledge typical of these expert practices are complementary, and can work in tandem. The idiosyncratic knowledge resulting from affective-relational approaches can be a stepping stone to making generalizable claims about larger groups or phenomena. The

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anthropologist who becomes close to an informant, eventually tests the information through pattern-finding analytics. Likewise, the scientist forming an "empathic" relationship with the protein she studied (Knorr Cetina 2001) eventually transforms and 'sanitizes' her observations such that they could be published in scientific journals with little interest in such 'extraneous' information. As Latour and Woolgar (1979) showed, only the inscription tools of techno-science—sustained by generous economic resources—make possible the transformation of particularistic knowledge into generalizable "fact" and, ultimately, "truth." Techno-science forms a powerful machinery that occupies a dominant position in our society.

Conclusion

The beginning decades of the twentieth century marked the transition from a "social trustee" model of expertise in which professionals considered themselves keepers of socially valuable knowledge, to "expert" professionalism emphasizing the technical and complex nature of their knowledge and skills without its social implications[15] (Brint 1994). "Expert knowledge," Brint (1994, p.8) notes, "has enjoyed a virtually unquestioned legitimacy in American culture." Many scholars of the professions consider this technical, complex, abstract, esoteric knowledge to be the core of professional power (e.g. Parsons 1951; Abbott 1988, 1991). Yet this emphasis on complex, abstract knowledge motivated them to attend to the cognitive aspects of professional work, to the detriment of its practical dimensions. Without such understanding, we have only a limited picture of how practitioners assert legitimate expertise and authority in interactions with clients when it is most vulnerable to contestation (Parsons 1951), how they create and apply the abstract knowledge that forms the basis of their jurisdictional claims, or how large scale changes (such as managed care) impact professional work and autonomy. Moreover, this focus on

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[15] An excellent example of this re-orientation can be found in the prosperous, economically optimistic, and utterly libertarian Silicon Valley (Packer 2013).

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knowledge and cognition has led scholars of professions to largely ignore the role of affect and temporality in expert work. These prove to be essential to therapists' knowledgeable practices, and their professional status. Lastly, emotions and time are essential in shaping the moral authority of therapists' epistemic practices.

Though it isn't hard to imagine other professional spheres where techno-science dominates (in fact, the opposite is true: it's difficult to imagine places where it does not), it is more difficult to see the workings of affective-relational expertise in other spheres. Alongside psychotherapy, there are a variety of arenas of professional practice where some form of affective and relational knowledge is relevant, such as teaching (Edwards 2010), coaching (Chambliss 1988), management and leadership (Goleman 1995), and art dealing and authentication (Cohen 2012). All of these expertises rely on technical knowledge, as well as on an embodied "gut instinct," that is part affective *bodily hexis* (Bourdieu 1977), and part relational skills. And while we have developed an extensive understanding of techno-scientific expertise, we have paid less attention to the relevance of embodied affective knowledge to expert work.

As "engineers of the soul" (Rose 1990), experts in the psychological sciences play an essential role of how we think of what it means to be a well-functioning human being. From the family, to education, to intimate relationships, they have shaped how modern individuals think of themselves as both psychological and social beings (Rose 1990; Giddens 1991; Illouz 2008). Yet as I detail the embodied practices that front line workers perform in their interactions with some of the most afflicted members of our society, we come to see that there is not one unified "self" that the psych sciences promote. The historical, affective, and self-reflexive model of psychoanalytic practitioners has come under attack from two formidable opponents. In the mid-twentieth century, pharmacological interventions reduced the mind and soul to biology and

neurochemistry. Being a well-functioning person from this perspective depends on the right brain chemistry achieved with the help of complex cocktails of psychiatric drugs, a goal more elusive than it initially appeared. This dissertation is more concerned with the "evidence-based" talk therapies. The self in their perspective is made up of more or less malleable components— thoughts, emotions and behaviors—that can be changed with the aid of targeted techniques. Fragmentation, specification and measurement make possible self-adjustment through 'scientific' tools. This project begins to illuminate how the engineering of selves happens in clinicians' therapy rooms. These are important grounds for naturalizing the moral authority of expertise, disguising it in technical choices about how to diagnose and treat mental illness.

Chapter 1. *The psychological sciences in historical perspective*

It wasn't at all clear, at the turn of the 20th century, that the psychological sciences would achieve the (however embattled) prominence they currently enjoy. A little more than a hundred years ago, a "personal problems jurisdiction" hadn't yet been defined, much less become the territory of any specified body of "experts" (Abbott 1988). Yet today it is nearly common knowledge that, for help with 'personal problems,' one can turn to a select yet diverse group of professionals called "psychotherapists" (i.e. clinical psychologists, psychiatric social workers, psychiatrists who have partially resisted the pull of pharmacology). Therapies have proliferated into the hundreds (Hale 1995), easing and, arguably, creating modern anxieties, and shaping modern selves. My focus in this dissertation is on two competing approaches that dominate the field: psychoanalytic therapy, and cognitive and behavioral interventions. In this chapter, I provide a brief (and thus necessarily superficial) history of the psychological sciences, and discuss the institutional contexts that shape psychotherapeutic work today.

The historical events[16] that facilitated psychological experts' dominance over "personal problems" (Abbott 1988), and the "normal" (Lunbeck 1994), were dramatic. Train accidents, churches and religious zealots, wars, and acrimonious professional conflicts shaped the development of the mental health field as we know it today. Throughout, jurisdictional battles raged: between neurologists and psychiatrists, psychiatrists and lay practitioners, somatic

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[16] I focus on the peculiarly American story of the psychological sciences, cognizant of the different institutional configurations that characterize the psychological scene in Europe and elsewhere. What sets the US apart, as I will show in the following pages, are the drive towards professionalization by the 'psy' practitioners, and their relative eclecticism.

psychiatry and psychoanalytic psychiatry, and, more recently, between pharmacological approaches, laboratory psychology, and psychoanalysis. At times, other therapeutic orientations emerged and dominated the scene temporarily (e.g. Gestalt therapy, Rogersian therapy, milieu therapy, behaviorism), but always in the shadow of the big two: biologism and psychoanalysis. Over the last half century, a third set of important players has emerged: the cognitive and behavioral therapies. The history I lay out over the next pages begins to detail the jurisdictional struggles that have defined the field of mental health.

I show that an initial period of conflict between neurologists and psychiatrists (both similarly new professions in the nineteenth century) was followed by the growing power of psychiatry and its ally, psychoanalysis. The influence of psychoanalysis grew, partly because it discredited grass roots 'mind cure' movements, partly due to its affiliation with the medical settings where psychiatrists trained, and partially because it marginalized practitioners of psychoanalysis who did not have a medical doctor degree. Yet the middle decades of the twentieth century signaled a sea change for the field: critiques of its system of abstract knowledge grew increasingly loud and potent (not least because of its less than desirable rate of success in treating patients). In addition, psychiatric medications were showing initial signs of efficacy, and research into the effectiveness of psychoanalytic techniques began to lag behind other interventions (including the growing behaviorist orientation, and the incipient cognitive one). In a world of medicine increasingly concerned with scientific evidence, this very last factor proved to be psychoanalysis' Achilles heel. Chapters two, three and four of this dissertation depict the expert practices of psychoanalytic therapists as they increasingly turned away from claims to 'science' (dominant in the field's early years), and oriented towards the

intersubjective space of the therapeutic encounter (Weiner 1995; Zaretsky 2004). But it took

nearly a century for these developments to take place.

Early struggles in an emerging field

Nineteenth century Americans relied primarily on family and friends to deal with the

problems of everyday living (Abbott 1988). Only in serious circumstances would they turn to

clergymen, doctors or lawyers. Yet these professionals were not especially well-equipped to

tackle most of the problems they were confronted with, possessing limited specialized

knowledge. Larger social changes made their interventions untenable (ibid.). As the industrial

revolution set in motion the reorganization of work, families, communities, and cities,

widespread problems with "nerves" came to afflict individuals struggling to adapt to new,

distinctly modern, identities (Abbott 1988; Zaretsky 2004). In this context, a group of

professionals emerged to deal with "American nervousness": neurologists (Abbott 1988). Their

claim to jurisdiction was contested from the start. The clergy had hereto assumed dominance by

lending people their sympathy and understanding, and helping those dealing with more complex

issues enroll the services of other qualified professionals (e.g. doctors, bankers). Neurology

successfully claimed the "personal problems" jurisdiction by asserting a scientific approach

(ibid). Its rise (similar to that of psychology and psychotherapy later) had its roots in war

(Blustein 1981; Abbott 1988). After the Civil War, when neurologists treated soldiers suffering

from "gunshot wounds of the nerves" (Blustein 1981, p.242), they brought their organic focus to

other nervous diseases. They adopted a "holistic inference system," considering all aspects of

"bodily function" relevant to diagnosis and treatment (Abbott 1988, p.288). Yet despite the fact

that they "styled themselves as scientists above all" (Blustein 1981, p.242), it was to no avail:

their patients suffered from too broad an array of illnesses, and their treatments failed more often

than proved useful. Soon, they struggled to maintain jurisdiction against a second, stronger group: psychiatrists. But before those battles would be set in motion, neurologists and psychiatrists briefly joined together against a growing set of talk therapeutic treatments.

"Psychotherapy" as a field only began developing in the first two decades of the twentieth century (Caplan 2001). "Prevailing neurological theory," Caplan (2001) pointed out, "held that mental states were merely concomitants of physical states," making psychotherapy "at best superfluous, and, at worst, thoroughly misguided" (pp.3-4). Yet a cluster of nervous conditions, and a series of religious movements focused on providing emotional relief through talk, transformed "psychotherapy" into a valid alternative to neurologists' somatic interventions (ibid.). Psychotherapy, Caplan (2001) argued, started with a recognition by railway surgeons working in the late 1800s that people who survived train accidents without any obvious physical injury nevertheless came to display a variety of somatic symptoms (e.g. partial paralysis, headaches). After psychological explanations for such symptoms became increasingly accepted (partly under the influence of research by Jean-Martin Charcot on "male hysteria"), American railway surgeons turned to the rest cure and "suggestive therapeutics" for treatment (ibid., p.34). Their interventions consisted of a combination of isolation, and advice "directing the patient's mind away from hurtful suggestions" (ibid.). The seeds of talk therapy were planted.

The rise of "neurasthenia," a catchall category that included somatic symptoms, as well as others we would currently associate with depression and anxiety, was a second catalyzing moment in the history of psychotherapy in the US (Caplan 2001). The unwieldy disease category came from within the field of neurology itself, and forced these practitioners to emphasize the role of "rapport" in identifying a growing battery of symptoms. At a time when "the focus of healing, especially among elite, laboratory-trained physicians, shifted away from

the patient and toward his diseased body," neurasthenia presented neurologists with a seemingly insurmountable challenge (Caplan 2001, p.43). They turned to the doctor-patient relationship to uncover symptoms (if not treat them) and thus made possible a temporary opening towards non-somatic interventions (ibid.). Nevertheless, they continued treating the varied conditions captured by this diagnosis with established practices: hydrotherapy, diet, electroshock, medication, and rest (ibid.).

The mind cure and Emmanuel movements proved to be the most important engines for psychiatrists' and neurologists' recognition that talk therapy was not something they would willingly give up to lay practitioners (Caplan 2001). More than their methods, it was talk therapies' popularity that led these professionals to re-consider their staunchly somatic approach (ibid.). Mary Baker Eddy was one of the best known proponents of the mind cure, and it was she who gave it a religious, Christian Scientific bend (Abbott 1988; Caplan 2001). Though wildly successful initially, the link to religion led to a backlash from medical men who took their malpractice complaints to the courts (Caplan 2001). The rise of a "New Thought" movement that drew on some of the tenets of the mind cure—such as emphasizing suggestion—without its religious underpinnings, made talk therapies more palatable to neurologists and psychiatrists (Abbott 1988; Caplan 2001). Later, the Emmanuel movement gained even greater visibility and legitimacy, primarily because it claimed to draw on religion *and* science. The movement started in an Episcopalian church in Boston, quickly enlisting the backing of prominent neurologists of the time, and gaining enormous popularity at the height of worries about "neurasthenia." But as the movement's reputation grew, medical practitioners felt their jurisdiction threatened, and withdrew their support, claiming instead that psychotherapy could not be administered by "nonmedically trained professionals" (Caplan 2001, pp.132-3). Just as psychoanalysis (in the

US) would become the sole territory of medical doctors, psychiatry and neurology pushed out "lay" talk therapists, and secured professional jurisdiction through the courts, and in the public sphere (Abbott 1988). Yet this greater opening toward talk therapy would ultimately work against neurologists who would lose their jurisdiction to psychiatrists. The early 1900s were fertile ground for the makings of psychiatry as a legitimate profession with jurisdiction not only over those deemed insane, but everyday "personal problems" as well.

In nineteenth century America, psychiatry resided in the asylum (Abbott 1988; Lunbeck 1994). Drawing on a French tradition initiated by Philippe Pinel in the 1700s (Deutsch 1949), American asylum keepers sought to apply a "moral therapy, which promised complete cures under the properly detailed regimentation of activities, the emotions, and the environment of the insane" (Abbott 1988, p.294). Their interventions, just like those of their neurologist counterparts, also failed. The ranks of the hospitalized swelled, and, despite the extreme methods psychiatrists sometimes adopted—such as hydrotherapy, dental and gynecological surgery (Abbott 1988; Lunbeck 1994; Scull 2004)—their patients didn't seem to get better. Their efforts proving less than successful, psychiatrists adopted a twofold strategy focused on prevention, and the regulation of everyday life. Prevention helped reorient psychiatrists away from a focus on the somatic *treatments* they employed in asylums, to the social *causes* of mental illness. In addition, World War I afforded psychiatry increased visibility as doctors screened soldiers for combat suitability, and dealt with shell shock (Abbott 1988).

Prevention thus opened the door for psychiatry's greater incursions into the problems of everyday life. This, Lunbeck (1994) argues, was the strategy adopted by an entrepreneurial and motivated group of psychiatrists from Boston who sought to increase the standing of their profession. Dismayed with the failure of their "alienist" predecessors—those keepers of asylums

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where no cures could be found—psychiatrists in the early twentieth century reoriented their field from an exclusive focus on the "insane" to its complement, the "normal" (ibid.). Psychiatric inroads into everyday life began with treatments of syphilis, and mental testing that distinguished between the "feebleminded" and the "normal" (Danziger 1990; Lunbeck 1994; on 'intelligence' testing see also Carson 2007). These two paths converged in psychiatrists' adoption of "psychopathy" as a catch-all term for problems of the "personality" (Lunbeck 1994). This, Lunbeck argued (1994, p.69), "was an important means by which the discipline effected the shift from the necessarily limited psychiatry of the abnormal to a psychiatry of normality." In contrast to the "symptom," which "was relatively rare," the personality was both ubiquitous and pliable (because it was thought to be separate from "the core of the self") (ibid.). Its presumably gendered nature made it a further platform for inquiry and intervention into the everyday lives of women more than men. Though in more recent decades psychiatry has given up the lofty goal of changing personalities, the traces of its early aspirations can still be felt in psychoanalysis. There, "character change" continues to be, as some of my staunchly psychoanalytic interviewees put it, the ultimate goal of treatment.

Psychoanalysis and psychotherapy take off in the US

As jurisdictional struggles between neurology and psychiatry continued into the early decades of the 1900, psychoanalysis offered a way out of the stalemate. Its "explicit theories about psychic mechanism" helped separate physical from psychological illnesses, and fostered a final split between these professional rivals (Abbott 1988, p.305). But more than settling jurisdictional disputes, psychoanalysis was to become a legitimate treatment modality in its own right with a firm institutional footing in universities, hospitals, and training institutes. Freud gave his lectures at Clark University in 1909, and his ideas started to gain wide applicability

during World War I (Hale 1995). At the time, instances of shell shock were overwhelmingly treated through hypnosis, electroshock, rest, or suggestion, but some psychoanalytic explanations infiltrated these practices: references to "catharsis and trauma, conflict between instinctual wishes and social constraints, repression, dreams, unconscious mental processes" came to dominate war time articles about the mental illnesses that afflicted soldiers (Hale 1995, p.21). The end of the war brought forth the advent of training Institutes in the US and Europe, illuminating the struggles of routinizing and professionalizing what started as a charismatic movement around Freud (Zaretsky 2004).

Institutes proliferated to accommodate disagreements over theory, technique, and membership. Despite this constant splitting, these organizations provided psychoanalysis with an educational basis upon which to claim its professionalism[17] (Hale 1995; Zaretsky 2004). By granting admission and membership in training institutes only to M.D.s, psychoanalysis quickly became entwined with mainstream psychiatry in the US (ibid.). Thus, the institutes were central to bringing psychoanalysis and psychiatry together in a relationship that would gain full force in the 1940s, 50s and 60s (ibid.). Yet by the time the contested question of "lay" analysts was settled in 1988 as a result of a lawsuit (Hale 1995; Wallerstein 1998; Zaretsky 2004), psychoanalysis was already losing ground to pharmacological approaches (Luhrmann 2000), and to the increasingly visible cognitive and behavioral therapies. The lawsuit granted psychologists and psychiatric social workers full membership into the American Psychoanalytic Association, and the right to practice analysis as fully credentialed professionals (ibid.). Before 1988, sympathetic psychiatrists had trained social workers and psychologists (who would practice as

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[17] APsA has currently accredited 30 Institutes nationwide, while others operate outside its auspices (this was the case with one of the training organizations in the city where I conducted my fieldwork, the one I describe below as the Association). It has a total of 3070 members, 57% male, and 43% female. Data obtained from personal communication with Dean Stein, executive director of the American Psychoanalytic Association.

"lay" analysts), and faced severe repercussions when found out. But despite this settlement of professional jurisdiction, the American Psychoanalytic Association's membership continues to be dominated by psychiatrists: 69% are certified MDs or DOs (doctor of osteopathy), whereas only 22% have psychology degrees, and 7% are psychiatric social workers[18].

The draw of psychoanalysis as a system of knowledge and practice was rooted in its original method for understanding and shaping the newly developing "extrafamilial identities" that would become the hallmark of the twentieth century (Zaretsky 2004). Its epistemic value accorded it full jurisdiction over the problems of everyday life (Abbott 1988). Freud had argued that each individual's "personality" was characterized by its own unique psychic life, a life that could be known through the analytic process (Zaretsky 2004). This, Zaretsky (2004) asserts, was in keeping with the modern move toward individualism and self-determination. Freud's theory of the unconscious made the "modern" person into "a unique individual, the product of a highly specific and localized history, driven by a complex set of motivations that could not be understood except in the context of a genuinely personal, nonreproducible inner world" (Zaretsky 2004, p.38). This focus on specific identities would not only provide the engine that powered the increasing "psychologization" of social life, but also an "empty consumerism" that drove the corporate boom of the second industrial revolution (Rose 1996; Zaretsky 2004, p.11).

Institutionally, as a talk therapy technique, psychoanalysis had to conquer not only the medical realm of psychiatry, but also the non-medical one of religiously tinged psychotherapies that had captured Americans' imagination (and their wallets) in the early 1900s (Abbott 1988; Caplan 2001; Zaretsky 2004). Its (mutually beneficial) alliance with psychiatry was due to three

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[18] An additional 2% have either MA/MS degrees, or are classified as "other." I obtained these statistics through personal communication with Dean Stein, the Executive Director of the American Psychoanalytic Association. If data from an accredited Institute in the city where I conducted my fieldwork is correct, DOs make up a very small percentage of the total MD population.

interrelated reasons: first, psychoanalysis provided a sophisticated theoretical model of the etiology and treatment of mental illness; second, it made a convincing case for the scientism of its theories and methods; and third, it could draw on a powerful clientele, holding the promise of high remuneration and status for practitioners (Abbott 1988; Hale 1995; Zaretsky 2004). Psychoanalysis came to dominate the field of talk therapy by the end of the 1950s, solidifying not only its grip over mental health, but also aiding the spread of talk therapy. As with any dominant paradigm, it came under attack, particularly regarding its scientism. First, researchers failed to conduct the kinds of research studies that would prove its efficacy (Hale 1995). Second, as notions of scientific knowledge changed to emphasize instruments, quantification, and inscriptions, psychoanalysts' clinical knowledge came to seem increasingly idiosyncratic and subjective (Zaretsky 2004).

Despite its early presence in the US, psychotherapy (with a psychoanalytic bent) only caught on during World War II. Psychologists and social workers became the primary purveyors of "psychoanalytic psychotherapy"—to be distinguished from psychoanalysis, which remained the proper territory of MDs until the late 1980s (Herman 1995; Wallerstein 1998). Yet while social workers had a direct interest in clinical practice—one often blocked by psychiatrists (Abbott 1988; Lunbeck 1994; Caplan 2001)—this was not actually the case for psychology, which was chiefly a "laboratory science" at the time (Capshew 1992, 1999). Although "today therapeutic proficiency is considered psychology's most important contribution to human understanding, happiness, and peace" (Herman 1995, p.3), this is a relatively recent development. In fact, the "experimental" division of psychology entered the war with higher status and promise, but it was its clinical arm that came to define psychological practice after World War II (when the PsyD was also established as a formal program) (Herman 1995).

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During World War II, experimental psychologists and their counterparts in sociology were busy waging psychological warfare (by boosting American morale while shaking that of the enemy), managing internments camps, and tracking public opinion (Herman 1995). In contrast, clinical "experts" engaged directly with soldiers focused on their readiness for and responses to war. Clinicians were recruited not only from amongst psychiatrists, but also psychologists and social workers, whose limited exposure to such work was remedied by crash courses in screening and treating emotional disorders (ibid.). Screening efforts were both too great a success and a failure: psychological experts identified a staggering number of potential soldiers as unfit for combat—nearly 2 million, or about 12% of recruits—but their diagnoses varied widely, as no two clinicians agreed on what was wrong with a given recruit (ibid.). For these reasons, psychiatrists, psychologists and social workers began focusing on "prevention," leading to a wide-scale "normalizing" effort that would legitimize psychotherapeutic interventions (ibid.). Similar to the earlier project of the Boston psychiatrists who sought to gain jurisdiction over 'normality' (Lunbeck 1994), these efforts helped reorient the psychological sciences towards "producing mental health" rather than intervening at the point of illness (Herman 1995, p.98). Needless to say, this expanded the psychological sciences' jurisdiction and professional status.

While wartime adjustments necessarily placed psychotherapeutic practice at odds with the strict demands of psychoanalysis (e.g. long treatments, frequent sessions, deep emotional engagement), psychoanalytic ideas infiltrated clinical work. Thus, Herman (1995, p.115) argued, "the ultimate point of psychotherapy was to untangle the knots tying previous psychological patterns to current psychological reactions," a goal shaped by psychoanalytic ideas. Despite the fact that such "uncovering" work was made nearly impossible by the

conditions of war, clinicians hung to it as a mark of professionalism. After all, the more

common sense treatments they prescribed for soldiers—sleep, rest, proper nutrition—made little

use of their special "psychological" expertise (ibid., p.116). Post war developments further

affirmed the growing power and jurisdiction of psychological experts, and the public trust that

they commanded. The National Mental Health Act of 1946 led to the creation of the National

Institutes of Mental Health, as well as to a wealth of federal funding for psychological research.

Psychology departments around the country took up the training of clinical psychologists, a

branch which "soared to unprecedented heights of visibility, authority and political importance"

after World War II (Herman 1995, p.21).

Psychologists, laboratories, and "evidence-based" therapies

Despite developments in its clinical arm, academic psychology never shed its identity as

a laboratory science. Today, the "scientist-practitioner" model predominates, and the laboratory

is still considered the locus of psychological expertise (Capshew 1992, 1999). Experimental

psychology has its roots in the mid-19th century, when practitioners began transitioning from

"introspection" to "instrument-based" research methods (Coon 1993). The laboratory was

essential to psychology's professionalization and its differentiation from philosophy (Danziger

1990; Capshew 1992, 1999; Coon 1993). It fostered the emergence of what Coon (1993, p.777)

called "brass-instrument psychology," and facilitated a turn from individual descriptive data to

collective measures (Danziger 1990; Coon 1993). Driven by a desire to have their discipline

considered a 'proper' science, psychologists took up the new practice of turning "psychological

attributes" into numbers[19] (Danziger 1990; Porter 1995). This was, Danziger (1990, p.148)

argued, necessary for the future of the discipline, given its weak theoretical grounds, and the

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[19] More dangerously, in Danziger's (1990) telling, psychology today displays a veritable "methodolatry"—a worship of statistical methods.

elusive object of study that motivated its pursuits: human consciousness. As they solidified their professional standing, psychologists' "mechanical objectivity"—lent by instruments, machines, and numbers, replaced the more idiosyncratic expert practices and skills required, for example, to assess student progress (Porter 1995). In addition, quantification and measurement facilitated the institutional connections psychologists formed, particularly with educators, the military, and private industry, connections that at once increased their visibility and constrained their research (Danziger 1990).

It was out of the "scientist-practitioner" model that the "evidence-based" psychotherapies emerged.[20] "Behavioral techniques," Rose (1999, p.233) argued, "have associated themselves with the sterile atmosphere of the laboratory, the rigour of experimental methods and advanced statistical techniques and the objectivity and neutrality of the white-coated psychologist." Behavioral research first became known in the 1920s and 30s through Ivan Pavlov's work on classical conditioning, and John Watson's applications of these theories and methods (Glass and Arnkoff 1992; Herman 1995; Rose 1999). In the 1940s and 50s, "learning theory" and its focus on consequences had gained broader attention, when Hans Eysenk, a British psychologist, published works on its application to the treatment of psychological disorders (Glass and Arnkoff 1992). In the US, B.F. Skinner's research on "operant conditioning" tied behavior to reinforcement, and inspired therapeutic interventions with children and adults, particularly those who were institutionalized (ibid.). The 1960s saw the emergence of a spate of professional organizations and journals, all focused on behavioral interventions with patients otherwise

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[20] These therapies did not provide the only alternatives to psychoanalytic treatments of mental illness. Another notable and influential approach was "client centered therapy," originated by Carl Rogers. Rogers and his followers focused therapists' stance of acceptance of patients' feelings (a position that also became one of the central tenets of DBT). Thus, "if the therapist accepts, recognizes and clarifies the feelings expressed by the client, there will be movement from negative feelings to positive ones, followed by insight and positive actions which are initiated by the client" (Zimring and Raskin 1992, p.630). Though this orientation gained a foothold among clinical psychologists and psychiatric social workers, it did not find many proponents in psychiatry. Nevertheless, it continues to gain adherents, and some of its tenets influence the work of practitioners of other therapies as well.

deemed difficult to treat (ibid.). Though behaviorism has lost its initial appeal, some of its interventions have been co-opted by therapeutic approaches employed today (such as cognitive and dialectical). Exposure treatments for phobias and social skills training are only a few of the offshoots of behaviorism that practitioners in the cognitive, dialectical, and interpersonal therapies incorporate into their approaches. But behaviorism alone was not enough to push the "evidence-based" therapies to national prominence. It was its alliance with the newer therapies that did so.

The works of Albert Ellis and Aaron Beck were foundational to cognitive therapy, while Marsha Linehan pioneered dialectical behavioral therapy. Throughout, these practitioners, like their behaviorist contemporaries and predecessors, emphasized the *empirical* bases upon which they formulated their interventions, and the *science* that backed their approaches (Beck 1967; Arnkoff and Glass 1992; Glass and Arnkoff 1992; Bloch and Beck 2004). Ellis and Beck both trained as psychoanalysts before elaborating cognitive theories, testing them, and putting them into practice with patients (Bloch and Beck 2004; Halasz and Ellis 2004). Ellis, a psychologist, grew disenchanted with his patients' seeming lack of progress in often lengthy psychoanalytic treatments (Halasz and Ellis 2004). His personal experiences with applying "rational" thinking to negative circumstances that were out of his control spurred him to look at different therapeutic interventions (Arnkoff and Glass 1992; Halasz and Ellis 2004). On these bases, Ellis elaborated "rational emotive therapy" which focused on the effect of people's thinking on their feelings (ibid.). Aaron Beck would arrive at a similar theory around the same time.

Beck was a psychiatrist who trained in psychoanalysis as its professional dominance was rising (Bloch and Beck 2004). In his telling, he sought to demonstrate the efficacy of psychoanalysis in treating depression, but none of the empirical studies he conducted backed up

his hypotheses (ibid.). Increasingly disillusioned with the treatment, he began asking patients to sit up (rather than lay on the couch) to better observe their "non-verbal communication," and focus on their self-perceptions (ibid.). Patients, Beck noted, markedly improved within ten or twelve sessions (ibid.). Concluding that "psychoanalysis was a faith-based therapy" (ibid., p.858), Beck turned increasingly to empirical research on cognitive interventions. His theories, similar to Ellis's, focused on people's "cognitive error[s] in seeing the world" (Arnkoff and Glass 1992, p.662). Yet unlike Ellis, whose emphasis was on "whether [beliefs] are rational," Beck's cognitive therapy stressed "whether beliefs and thoughts are realistic" (ibid.). Nevertheless, these approaches merged to influence treatment and efficacy research in nearly all the major diagnoses, from anxiety and depression, to personality and phobias.

Marsha Linehan's trajectory to founding Dialectical Behavioral Therapy was both personal and professional. In a recent New York Times article, Linehan detailed her early struggles with severe mental illness, struggles that brought her to the Institute of Living in Hartford, CT (Carey 2011b). Her self-harming behavior was treated with all available interventions, ranging from medication, to analytic therapy, and even electroshock (ibid.). After three years of institutionalization, Linehan found better help and inner-strength by relying on her Catholic faith (ibid.). Though she continued to fight mental illness, she pursued a doctorate in psychology, and began a career as one of the most recognized psychologists to impact therapeutic interventions with suicidal patients. Dialectical behavioral therapy was founded on the dual concepts of "radical acceptance" and the need to change (ibid., Linehan 1993), while some of its techniques (e.g. "mindfulness") have been broadly adopted by practitioners in other specializations. The focus of DBT is behavioral transformation by "teaching the client self-

change skills" in the context of a "collaborative," empathetic relationship (Glass and Arnkoff 1992, p.610).

These therapies (and others, such as interpersonal psychotherapy) bear the imprint of laboratory-based scientific knowledge. For example, as I show in chapter three, practitioners make extensive use of quantification and measurement, mirroring psychology's overall orientation towards "instrument-based" (Carson 1999) knowledge. Thus, patients learn to measure their anxiety or depression on a "Subjective Units of Distress Scale" or SUDS, classifying the intensity of their states from 0 to 10, or 0 to 100. This foregoes the lengthy discussions of feelings, dreams, and relationships characteristic of psychoanalytic interventions. Numbers stand in for subjective experience, and serve to connect psychotherapeutic practitioners to other institutional actors, most importantly health insurance companies. In the world of managed care, an improved score on a "depression scale" is equated to mental health, and decreased need for therapeutic services. One could argue that clinical psychologists, psychiatric social workers, and psychiatrists have become prisoners of the system that their laboratory-based colleagues helped create: a system in which measures and averages are more telling than patients' subjective experiences, and experts' fine-tuned skills (cf. Danziger 1990).

Psychoanalytic decline

Psychoanalytic practitioners are finding themselves increasingly 'outside' medicine and its institutions. As the Cold War set in, the power of psychoanalysis reached unprecedented heights, while fostering a culture of depoliticization, and little self-examination and self-criticism among practitioners (Zaretsky 2004, pp.289-93). This coincided with the rise of "ego psychology," a theoretical strand developing out of psychoanalytic theory that emphasized the role of the ego as "the agent of reason and control" (Zaretsky 2004, p.278). The theory was

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explicitly formulated with the laboratory in mind, aiming to test and systematize Freudian ideas (Hale 1995, p.232; Zaretsky 2004). Yet difficulties with achieving these goals became quickly apparent: the distance between clinical observation and theory was nearly unbridgeable, as clear notions of "confirming" evidence lacked, and psychoanalytic "constructs" were difficult to quantify (Hale 1995, pp. 240-41). As "evidence-based" medicine became the dominant force in the field, psychoanalysis found itself increasingly on the margins of the psychiatric departments it had once dominated (Zaretsky 2004).

At the same time as it was failing in the lab, cultural criticisms mounted from the anti-psychiatry movement, and from social movements catalyzed by identity politics. The works of R.D. Laing (1971), Thomas Szasz (1970, 1974), and even Goffman (1961) and Foucault (1965) were received as damning critiques of psychiatry generally, and psychoanalysis implicitly (and sometimes explicitly) (Hale 1995; Zaretsky 2004). As the feminist movement gained momentum, so did critiques of psychoanalytic theories of sexual development (ibid.). An important source of change came from psychologists and social workers who sought accreditation as psychoanalysts, forcing the profession to accept more women into its ranks. Taken together, these cultural and structural changes informed another shift in psychoanalytic practice and theory. Ego psychology receded into the background, while a more phenomenological perspective emerged (ibid.). Today, unconscious "drives" are no longer the primary focus of psychoanalytic treatments (though I heard Terry talk to residents about them several times during my observations). Instead, emphasis is placed on the "objects" (significant others) and relationships in a patient's life. The therapist becomes, in this formulation, a "participant-observer," shedding her 'analytic mask,' and being "as much a participant in the interaction as is the patient" (Eagle and Wolitzky 1992, p. 134). I encountered this view among

my interviewees as well. They often spoke of how they communicated affectively with their patients even as they sat silently in their chairs. One of the residents I interviewed poignantly recalled the moment in which he realized that the therapeutic relationship is significant to patients in ways that force clinicians to shed the emotional distance typical of medical doctors. This, he thought, forced residents to depart from their medical knowledge, examine their own affective reactions, and consider how they may be relevant to treatment. I argue that this epistemic project makes up psychoanalytic practitioners' affective-relational expertise. Using emotions as epistemic tools and seeking insight into the patient's past through the therapeutic relationship are landmarks of psychodynamic therapists' practices.

Yet these developments were not neutral to the standing of psychoanalysis. Zaretsky (2004, p. 339) decried the "weak identity of American psychoanalysis," both from a theoretical and institutional standpoint. Furthermore, the field's institutional losses were perhaps nowhere more apparent than where it had been formerly dominant: psychiatry. Psychiatry's distancing from psychoanalysis was marked by a return to biology. The most prominent (and controversial) development has been the growth of psychopharmacology in the post-World War II years (Healy 1997). In the 1950s, three drugs entered the psychiatric scene: an anti-psychotic, an anti-depressant, and lithium (Healy 1997; Lakoff 2005b). These opened the door for radical changes, the first of which was a transfer of patients from mental hospitals to community mental health centers (ibid.). Initially, psychiatric drugs were tightly wedded to talk therapeutic practice (Healy 1997; Metzl 2003; Lakoff 2005b). Psychiatrists contemplated hybrid treatments, discussing the effects of medications on the transference, and hoping patients would become better participants in psychoanalytic treatments (Metzl 2003). But legislative and economic conditions shifted this short-lived collaborative tone: the passage, in 1962, of legislation

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requiring safety and efficacy testing for new medications made questions of "disease specificity" even more pressing for psychiatry (Lakoff 2005b). This led to the development of standardized questionnaires and diagnostic interviews which culminated in the *Diagnostic and Statistical Manual of Mental Disorders III*, an edition that shed its previous analytic diagnoses, and focused principally on standardization, categorization, and empirical evidence (Healy 1997; Lakoff 2005b; Strand 2011). The DSM is now the foremost diagnostic manual in the US, and its ubiquity has coincided with the spread of pharmacological, as well as cognitive and behavioral interventions.

The financial impetus towards greater reliance on psychiatric drugs came from pharmaceutical companies (Healy 1997). As a series of epidemiological studies conducted in the 1960s proclaimed the widespread presence of depression in both hospitalized and non-hospitalized individuals, the American Psychiatric Association campaigned to make practitioners aware of the diagnosis (Healy 1997, pp.229-230). The pharmaceutical industry took heed, and began developing "anti-depressants," and, with time, other drugs, helping construct mental illnesses in the process (ibid.). In addition, the onset of managed care changed psychiatry: doctors are primarily reimbursed for prescribing medications in sessions that last between five and thirty minutes, thus having an additional "incentive" to turn away from talk therapeutic techniques (Healy 1997; Luhrmann 2000; Lakoff 2005b). The enormous professional and lay popularity of psychiatric drugs has radically changed the ways in which we think of mental illness and those who suffer from it. Yet this development hasn't completely rendered the psychotherapies obsolete, as most psychiatry departments continue to offer training in psychoanalytic psychotherapy, as well as cognitive and behavioral methods. Nevertheless, psychoanalytic training has been transformed, as fewer and fewer residents choose to enter

institutes and formally take up psychoanalysis. I turn next to a discussion of how these changes played out in my field site.

The University Clinic and Psychoanalytic Institutes in Midwest City

I spent approximately 350 hours at the psychiatric outpatient clinic[21] of a public university with an extensive and prestigious medical system. The clinic is located on the outskirts of the city, in a new building that only got quiet on Friday afternoons. A large bright lobby welcomed patients as they waited for their pharmacological or talk therapy appointments. Pamphlets containing information about various mental conditions and their treatments were strewn on tables. In this airy, almost cheerful space, mental illness was not a hidden, stigmatized condition, but a problem like any other. The clinic hosted psychiatrists, psychologists, social workers and psychiatric nurses, contributing to three different activities: research, patient care, and training. I spent my time with psychiatrists, psychologists and social workers training under the auspices of the psychiatry department. I focused specifically on their initiation in talk therapeutic techniques: cognitive behavioral, dialectical behavioral, interpersonal therapy, and psychodynamic psychotherapy.

The trajectory of the psychiatry department at Midwestern Public University followed that of the field as a whole: first it was dominated by neurologists, next by psychoanalysts, and now, by pharmacologists. It started in the late 1800s as the Department of Nervous Diseases and Electrotherapy, led by a neurologist whose chairship came to an end in the 1920s when the Department of Neurology split off from what formally became the Department of Psychiatry. Reflecting its orientation at the time, psychiatry was focused on institutionalization and somatic treatments. Psychotherapy only gained popularity amongst physicians around World War II, a

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[21] This brief history and overview of my field site is indebted to multiple conversations with historians, psychiatrists and psychologists affiliated with the University, some of whom are central actors in this story. I am precluded from identifying them, but am heavily indebted to their individual kindness and collective knowledge.

time when formal, extensive psychotherapeutic training began at Public University as well. This training was facilitated by a Veterans' Readjustment Program aimed at providing support to soldiers returning from war, and their families[22]. In the 1940s, the size of the residency at University Psychiatry increased, and residents began to receive psychoanalytic training. Through the 1950s and 60s the reputation of the program as a psychoanalytic center grew. A majority of residents undertook formal training in psychoanalysis, consisting of lectures, a personal analysis, treating patients analytically, and supervision. In the 1970s, the third chair of the Department of Psychiatry faced a program akin to a psychoanalytic institute. Reflecting a sea change in attitudes towards psychoanalysis, he made two important changes that would disrupt this legacy: first, he emphasized research, supporting aggressive hiring in this area. Second, he required that all full time faculty work full time for the university, an arrangement that excluded the many analysts on the rosters who served as supervisors for residents, but otherwise led private practices in the city. This dealt a serious blow to psychoanalytic training in the residency program. In addition, a growing interest in behavioral interventions and research began to draw residents away from psychoanalysis.

The Anxiety Disorders Program began in 1972 as a research study examining how patients suffering from various phobias responded to in vivo exposure treatments. As it publicized its behavioral interventions, the program started to receive more requests for treatment. In the late 1970s it garnered local media attention for its "research-based" exposure treatments, and this too increased its popularity. Patient referrals grew, and the kinds of problems they presented with broadened beyond phobias. In 1981 it attracted slightly fewer than 100 patients; in 2008 that number was above 450. As the program grew, so did its role in

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[22] Working with veterans remains a significant part of residents' training. During my time there, they often presented cases of former soldiers struggling to re-adjust to the demands (and relative boredoms) of civilian life.

psychotherapeutic training for residents and other mental health workers. Its graduates have included not only researchers and local therapists, but also psychiatrists and psychologists who would go on to restructure therapeutic training across the University.

This restructuring picked up full steam in the late 1990s with the energetic interventions of one of these graduates, a well-respected psychologist[23]. Jeremy reappears in the following chapters as one of the instructors that led the CBT for anxiety mentorship. But he played another major role in the history of therapy training at the University Psychiatric Clinic: as director of education, he championed the formal introduction of CBT, DBT, and IPT into the curriculum, first in the form of brief lectures, and later as mentorships. He was instrumental to re-structuring the residency such that it would accommodate more time for trainees to learn, in Jeremy's cautious phrasing, the "so-called evidence-based or empirically-supported therapies." Jeremy praised the American Psychiatric Association for "helping us in their residency education standards because they wanted more meaningful training in other forms of psychotherapy, empirically-supported psychotherapy, so this system gained acceptance in part because it helped us with our accreditation." Jeremy believes that there continues to be an imbalance between psychodynamic and "evidence-based" therapeutic training in the curriculum. He told me that "the amount of psychodynamic training" was "out of proportion" with other psycho-social therapies, as "[residents] had seminars specifically related to [psychoanalytic theory]," they took on psychodynamic cases, and had a supervisor. This, he thought, was the kind of "training that is required to really learn a therapy." To reach this "gold standard," the program needed to include one-on-one supervision based on videotaped sessions. This remains a work in progress.

All residents rotate through at least one of the "evidence-based" therapies. These interventions appeal to many of them, due to the shorter term focus, and the emphasis on targeted

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[23] I draw here on an interview I conducted with Jeremy a few months into my fieldwork.

interventions that, some believed, are easier to use during medication management sessions.

Perhaps most importantly, these therapies speak the scientific language medicine has adopted.

Their clinicians emerge out of "scientist-practitioner" programs in which therapeutic

interventions are carried out as part of research projects. This was especially evident in the

Anxiety Disorders Program's mission, published in 1981:

> The primary goal of the program is to establish a population of patients with anxiety disorders suitable for the conduct of research into the nature, mechanism and treatment of anxiety disorders. Secondary goals [...] include providing high quality diagnostic and treatment services, training of research personnel, disseminating authoritative information about Anxiety Disorders, and maintaining a financially solvent program.[24]

The primary goal here is research, not treatment. Though this may be an especially stark

statement of the emphasis that drives "evidence-based" therapies, it isn't necessarily unusual. I

mentioned earlier that Beck, from the very beginnings of cognitive therapy, touted the empirical

studies demonstrating the efficacy of his interventions. Moreover, a focus on research is not

atypical for top-tier universities where tenure decisions are based on publication record. Jeremy

told me that if he and other clinicians devoted themselves solely to training, supervision, and

clinical practice, they would commit "career suicide" because they would have no time left for

research and publishing. The implication is that devotion to clinical work is devalued in a

system that emphasizes the "*scientist*-practitioner" model. This reinforces the "techno-

scientific" approach that most clinicians in these orientations come to embody. In the clinical

room, therapists resemble researchers in laboratories as they measure patients' distress, fill out

forms, and conduct exercises that entail extensive inscription practices. These practices also

make such interventions seem more concrete (though there is nothing concrete about

distinguishing between a cognition and an emotion—see e.g. Reddy 2001). For this reason, and

their relatively contained nature, many residents preferred cognitive and behavioral treatments.

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[24] Excerpt from PowerPoint presentation assembled by the current director of the Anxiety Disorders Program.

Psychoanalytic training, in contrast, has lost much of its draw. One or two out of 10 to 12 entering residents every year consider undertaking formal training in psychoanalysis as they progress through the program. Residents begin receiving instruction in the tenets of psychoanalysis in their second year (when they are also encouraged to take on patients for psychodynamic treatment). During their third and fourth years they see anywhere from one to five psychodynamic patients, receive one hour of supervision per week from an experienced psychoanalyst affiliated with the Institute, and attend a weekly, hour long didactic and group supervision meeting (which I observed over the course of my 18 months with the program). Residents can also participate in other lectures and case discussion events organized by the Institute. Yet during my time in the program, one of the consistent complaints that they voiced was their difficulty with psychoanalytic theory. Their concerns extended from concepts to the therapy room. Unlike pharmacology, and cognitive and behavioral therapies, psychoanalysis relied on an abstract system of knowledge that residents had difficulty grasping intuitively. Yet by their fourth years, most were able to present and discuss cases in psychoanalytic terms. For the majority, this would be their last direct engagement with this kind of therapy, while for a small minority it would be the beginning of a new career.[25]

The psychoanalytic scene. Though the city had benefited from the existence of a psychoanalytic organization as early as the 1930s, conflicts over who should be allowed to practice psychoanalysis—an especially American concern, as Zaretsky (2004) and Hale (1995) point out—led to its losing accreditation from the American Psychoanalytic Association. A formal,

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[25] According to residency statistics, 43% of residents who had entered the program between 2001 and 2009 and graduated, moved into academic careers. 20% entered the public sector (i.e. hospitals), while 36% went on to private sector jobs in Health Management Organizations or, in very few cases, private practice. I interviewed three recent graduates of the program, one of whom had already begun psychoanalytic training at the Institute, while another was going to do so within two years of my exiting the field.

accredited Institute was established only in 1965, after functioning as a training center for

psychiatrists since 1957. Psychoanalytically inclined psychologists and social workers chafed

against the rigid bounds set by APsA, and continued organizing, conducting meetings and

training with sympathetic psychiatrists. They formed an alternative training organization (I will

call it the "Association") in 1988. This, according to its mission statement, is an "egalitarian"

and "gender sensitive" institution, dedicated to the advancement of non-MDs and women.

Unlike the Institute, the Association is not formally accredited by the American Psychoanalytic

Association. Paradoxically, its beginnings coincide with a significant victory by psychologists

who sued the American Psychoanalytic and the International Psychoanalytic Association for

discriminatory and monopolistic practices (Wallerstein 1998).

      The co-existence of these two organizations—the Institute and Association—makes for a

vibrant psychoanalytic scene in a relatively small city, yet little overlap between them has led to

some acrimony and competition. Nevertheless, I met several young therapists—social workers

and psychologists—who attended events at both. Conversely, I met no young psychiatrists who

trained with the Association, probably due to the ongoing relationship between the University's

psychiatry department and the Institute. Analysts affiliated with the Institute (46% of whom

have an MD degree, compared to less than 8% of the Association's members[26]) continue to

dominate residents' psychodynamic training. I have interviewed members of both the Institute

and the Association, and the themes I identify in the following chapters hold true for all. My

goal was not a within-group comparison; rather I hoped to identify similarities and differences

with the "evidence-based" therapies that currently present psychoanalytically inclined therapists

their greatest challenge. An essential arena for these professional struggles, and the structural

environment that shapes therapists' embodied practices is economics, and I turn to this next.

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[26] Percentages obtained from listed membership on the Institute's and the Organization's respective websites.

Money and mental health

Mental health is big business. The NIMH places the cost of mental health services in 2006 at $57.5 billion dollars, or an average of $1,591 per person living in the US.[27] The Centers for Disease Control and Prevention cite a World Health Organization study that ranks the burden of depression third worldwide, while anxiety disorders are "the most common class of mental disorders present in the general population" in the US, and cost $42.3 billion in the 1990s.[28] The amounts--reflecting both the costs of treatment, and the lost earnings that result from mental illness--are staggering.

Among participants in this study, the issue of money was paramount: how much to charge patients, how to enforce payment, how to deal with insurance companies, and how to manage it all in private offices versus group practices versus clinics. Issues related to insurance payments were perhaps most common, as therapists struggled with whether to participate in insurance plans, how to manage the necessary paperwork, and how to treat patients in ways that would be feasible under insurance companies' regimes. Practitioners at the University Psychiatric Clinic made few such choices; embedded in the medical system, they were inevitably dependent on insurance payments. Though I was told of a patient who needed long term care stretching over multiple years and paid out of pocket, such cases were rare. The overwhelming majority of patients at the Clinic were insured. Therapists there (and those in group practices) benefited from the services of a large administrative staff that handled billing questions. Clinicians working in group practices were similarly dependent on insurance companies. They too relied on assigning DSM diagnoses—useful both for reimbursement and for treatment purposes—and on targeted, time-limited interventions. In fact, of 21 interviewees that identified

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[27] Information retrieved on 4.30.2013 from: http://www.nimh.nih.gov/statistics/4COST_AM2006.shtml
[28] Information retrieved on 4.30.2013 from: http://www.cdc.gov/mentalhealth/basics/burden.htm

with the "evidence-based" interventions, only four worked in private practices. The majority were affiliated either with the University Clinic, or group practices. These organizational arrangements reinforce the techno-scientific orientation of cognitive and behavioral therapists.

Their psychoanalytic counterparts exercised greater independence in financial matters. A majority (68%) worked in private offices, while the rest were in group practices (including those who are still in training). The former had the greatest flexibility and independence, and were most likely to bill patients directly (of the 12 interviewees who did not accept insurance, only two declared an eclectic orientation—the rest were either psychoanalysts or psychodynamic therapists). One of my interviewees told me that he is "not an employee" of insurance companies, and this reflects the attitude of many who opted out of the insurance system. Third party payers were seen as not only interfering with treatment—in the most immediate way by forcing practitioners to assign DSM diagnoses which ran counter to their way of thinking about patients—but also as setting below-market fees. This is not entirely wrong: some of the psychoanalytic practitioners I spoke with charged $180-$190 for a session, whereas fees set by insurance companies stayed well below $100, depending on the provider's education and experience. Higher pay and less paperwork were the two motives invoked by those participants in this study who considered exiting clinics and group practices for private practice. Therapists in private practice billed patients directly and received payments in the form of a check or cash once a month (or, as was the case of a young therapist trying to establish a private practice, every week). At times, they provided their patients with an insurance reimbursement form to submit to their insurance company. The few practitioners who accepted insurance payments, and those who provided their patients with insurance reimbursement slips, made use of the DSM. While psychodynamic therapists generally refrained from discussing a diagnosis with their patients,

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they did so when providing them with a bill. But even clinicians who used the DSM for these purposes were critical of the manual.

The exchange of money is an essential element of professional practice and status (Freidson 1970). In psychotherapy, the fee is a necessary (though not sufficient) element of the "frame" (a concept I discuss in the next chapter): the spatio-temporal-economic arrangements regulating interactions between therapist and patient. The frame allows therapists to set their work apart from the kinds of help and advice patients could receive from family and friends. Some psychoanalytic therapists assign it further symbolic value: how much patients are willing to pay (when therapists agree to a sliding scale), whether they pay on time, whether they are too concerned with payment, are all to be discussed as a part of the therapeutic process. This is, of course, in line with the greater analytic stance that, as one of my interviewees put it, "everything's analyzable." In contrast, cognitive and behavioral practitioners participating in this study, tending to work in practices where they are not directly engaged with billing, were less likely to think and talk about the symbolic meaning that money acquires in their practice. They are firmly rooted within the scientific-financial networks of current medicine.

Money also matters for therapists' expert practices, and I have hinted above at one way in which it does so. Therapists who accept insurance payments, and those who provide insurance reimbursement slips, must use DSM categories to describe their patients' problems. Many return to tried and true diagnoses, variations on depression and anxiety (see also, Whooley 2010). Personality diagnoses are rare, and even when they encounter a patient whom they believe could be assigned to such a category, therapists were unwilling to do so (an issue I discuss further in chapter four). Such diagnoses, they argue, are too stigmatizing, in addition to not being helpful with getting insurance reimbursements. But money matters in a second concrete sense: it

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impacts the length of treatment. As I show in the next chapter, psychoanalytic practitioners are

likely to eschew insurance payments for the principal reason that their lengthy, intensive

treatments do not fit the efficient, temporally limited model preferred by third party payers.

Their affective-relational expertise requires a deep and sustained engagement that cannot be

easily translated into the language of symptoms and cures preferred by insurance companies. In

contrast, the targeted and short term cognitive and behavioral interventions are better suited to

the demands of managed care. This is not to say that therapists in these orientations do not chafe

against a system that often constrains them, but their discontent is much more subdued compared

to their analytic counterparts who choose to opt out of the system almost entirely. Techno-

science is not only enmeshed with the world of economics, it has helped develop the very terms

by which success, efficacy, and worth are understood (cf. Porter 1995).

Conclusion

Three main conclusions can be drawn from the history of the psychological sciences:

first, wars played a vital role in their promulgation; second, the project of professionalization was

dependent on wresting jurisdiction over the 'normal' problems of everyday life from 'lay' people

(be they friends and family, the clergy, or non-MDs); third, legitimacy is dependent on

successfully claiming the particular form of 'scientism' dominant at the time. Thus,

psychoanalysis entered the American psychiatric profession through its influence in the two

World Wars; it professionalized by developing institutes which banned social workers and

psychologists from becoming accredited practitioners; and, until the 1960s, it retained its

scientific status by appealing to Freud's legacy. The "evidence-based" therapies emerged out of

the 'scientist-practitioner' model that owes its success to World War II. Behaviorism flourished

in the decades after the war, while the research money made available to psychologists at that

time spurred efforts to find alternatives to psychoanalysis. Since the 1970s, when some of these interventions were becoming established, the US has pursued three other notable wars in Vietnam, the Persian Gulf, and Afghanistan and Iraq. PTSD has become common place (Young 1995), and suicide amongst veterans has come to preoccupy both experts and the public. Here, the cognitive and behavioral therapies have asserted a dominant role along pharmacology (Rosenberg 2012). That these interventions are becoming dominant among the talk therapies is doubtless. Jurisdictions are, Abbott (1988) argued, disputed within the legal system, in public, and in the workplace. The legal domain is not under the purview of this dissertation, but a casual search in the New York *Times* reveals multiple articles extolling the virtues of "evidence-based" interventions (e.g. Carey 2011a, 2012; Rosenberg 2012; Zabludovsky 2012; Brown 2013; Ellin 2013). Psychoanalysis is losing ground on multiple fronts in the workplace as well: in training organizations[29] for psychiatrists, psychologists and social workers, in the treatment of particular mental illnesses (such as psychoses—e.g. Hale 1995, p.301—and phobias), and in its connections with institutions that sustain medical practice (e.g. insurance companies, and the leading mental health organization in this country, the NIMH). This does not, of course, equate to its extinction, but it is a continuing dip in its import among medical practitioners.

The following chapters take up a fine grained analysis of the epistemic practices characteristic of these psychotherapeutic orientations. I do so first to illustrate distinct ways of knowing, and second, to understand the moral authority wielded by the psychological sciences in our society today. In the transition from psychoanalysis to "evidence-based" psychotherapy, we are witnessing a contest between two distinct ways of making knowledge: one, idiosyncratic, particularistic, and self-reflexive; another focused on classification and quantification, statistical

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[29] Arnkoff and Glass (1992, p.667) point out that "a broadly cognitive-behavioral orientation is prevalent in many scientist-practitioner training programs."

averages and generalizability. These, some have pointed out (e.g. Hale 1995, p. 284; Zaretsky 2004), are two ways of conceiving of science. This is not the first such transformation in the psychological sciences, and scholars have detailed how psychologists sought to distance themselves from their philosophical, introspective past, by adopting first, "brass instruments" (Coon 1993; Carson 1999), and later statistical methods (Danziger 1990). Yet what also changes in this transformation is the role of the expert who, rather than being a primary wielder of knowledge, becomes an "actant" in a system of "actants" that includes both human and non-human participants (Latour 2005). Expertise can thus be said to rest not with the individual, but with the institutions in which she trains, becomes credentialed, and practices her skill (Shapin 1998; cf. Lawrence and Shapin 1998).

These distinct ways of knowing have implications for how we imagine and understand well-being and 'normality.' I take seriously Foucault's (1977) notion that knowledge and power are co-constitutive, and conceive of psychotherapeutic work as the application of "technologies of the self" (Foucault 1988). But while all therapies endorse inward-oriented identities that seek change in the individual rather than in structural conditions (cf. Herman 1995; Rose 1996), they differ in the 'kinds' of people they make up (cf. Hacking 1986). The psychoanalytic ideal of a self that integrates past and present, emotions and relationships is slowly eroded by the more fragmented, quantified self of cognitive and behavioral interventions. This has wide ranging implications for how we think of our successes and failures, and for how we relate to communities. We thus must understand how the practices of cognitive and behavioral therapists differ from those of their psychoanalytic counterparts so as to better grasp the changing landscape of 'normality' today.

Chapter 2. *Time, place and psychotherapeutic expertise*

> I talked with my husband once in my office. […] it was a much better spousal interaction because I was in my therapist role. I was sitting in my therapist chair. I was a better listener as a spouse because I was kind of inhabiting my therapist position [...] [and] it's probably Pavlovian.
>
> *Paula, experienced psychodynamic therapist*

It is now common knowledge that time and place are markers of professional control. Freidson (1970) established that professionals' ability to determine when and where they do their work is part of their negotiated autonomy. But less evident are the epistemic functions of time and place. In psychotherapy, as in the hard sciences, the office and temporal framework help establish "laboratory conditions"—as one of my interviewees put it—that 'make visible' (Gieryn 2002, 2006) issues we keep hidden in our everyday lives. As boundaries, the time and place of therapy facilitate two related epistemic processes: they promote the embodiment of therapists' skills, making them nearly "Pavlovian" as Paula told me, and they enable the medicalization of everyday problems. Yet while time and space serve professional and epistemic goals for all psychotherapists, they do so differently for psychoanalytic and "evidence-based" clinicians. Thus, the spatio-temporal dimension of psychodynamic psychotherapy fosters a deep inter-personal rapport, enabling practitioners to use their affective-relational expertise. In contrast, cognitive and behavioral practitioners' offices and temporal horizons engender techno-scientific expert work focused on targeted interventions and symptom reduction.

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Professional authority

The therapy office, the frequency and length of meetings, the exchange of money, and other professional norms restricting interactions between therapists and their patients form the therapeutic 'frame' (Gutheil and Gabbard 1993). The frame sets parameters without which psychotherapeutic work could not take place. Its manifest function is to protect patients: by interacting only at designated times and places, they are shielded from the abuses of power that intimate therapeutic relationships can yield (Gutheil and Gabbard 1993; American Psychological Association Code of Ethics, 2010). Yet such arrangements also protect therapists and their claims to professionalism. Just as the laboratory legitimates the work of scientists (Gieryn 2002, 2006), so the therapy office and the therapeutic hour distinguish clinicians' work as expert and professional. They engender a "symbolic capital" (Bourdieu 1984, 1991) that grants therapists power in the clinical session, and legitimate jurisdiction over the problems that their patients present them with (Freidson 1970; Abbott 1988).

Psychotherapists exercise spatio-temporal authority in similar ways, despite the different historical and institutional trajectories that characterize psychoanalysis and the "evidence-based" therapies. They set the terms of therapeutic interactions by meeting with patients on their own turf: in offices that they seldom leave (despite patients' attempts to the contrary), for periods of time they choose. Therapists carefully avoid meeting their patients outside the office, except for rare circumstances. The dreaded coffee invitation that some participants in this study received, was met with a resounding no. Only three of the 27 psychoanalytic practitioners I interviewed mentioned conducting some therapy sessions outside the office, and two described unusual situations: one's dying patient needed assistance in the hospital, while another's was facing a crisis when the office was made unavailable by ongoing construction. A third discussed her one-

time decision to take a walk outdoors with a patient for whom she believed this would be beneficial. Practitioners of empirically-supported therapies were more likely to leave the therapy room: taking a drive with a patient suffering from a driving fear, touching toilets in bathrooms with germophobic patients, visiting the home of a patient with a hoarding habit were just some of the examples I encountered during my fieldwork at the Psychiatry Clinic. When such situations emerged, they were not surrounded by the uncomfortable air of the forbidden with which my psychodynamic interviewees discussed their ventures outside the office. This may be due to the fact that even when leaving, they transformed the spaces they entered into surrogate offices: the car, the bathroom, and the patient's home became field sites for collecting data and applying therapeutic interventions. Similar to scientists venturing into the Amazonian forest to collect dirt samples (Latour 2005), cognitive behavioral therapists used their observational powers to make sense of and solve their patients' problems as they took place in their everyday lives. Yet, even with such therapeutically sanctioned exceptions, the office remained the primary base for their expert work.

The 45 to 50 minutes of the clinical encounter worked as a boundary that not only allowed therapists to perform their work successfully with multiple patients, but also symbolized their professional power and authority. The temporal limits of the session allow therapists to "segregate their audiences" (Goffman 1959; Zerubavel 1979, 1982), make necessary preparations between patients, and grant each the attention they required. Novices had to learn early on how to achieve this goal by balancing professional demands with patients' needs. Maintaining the temporal boundaries of the therapy session was thought to reflect therapists' expertise, and their patients' commitment to treatment. Patients' regular attendance was interpreted as a signal that they had found the treatment useful, and liked their therapist. Sonora,

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a resident training in cognitive behavioral therapy, told the supervision group that her patients "always showed up, they never missed a session!" The senior psychotherapist interpreted this as evidence that she was "a good provider, because a patient showing has to do with how much they feel like they're connecting with you, and how much they feel like they're getting better." "Never miss[ing] a session" was a sign of a successful treatment, and on this, psychodynamic psychotherapists agreed. Punctuality was similarly significant. An otherwise difficult patient (primarily because of his inability to talk about his feelings) was deemed a successful psychodynamic case because he never missed his appointments. His therapist, a fourth year resident, described him as his "most consistent" patient, "always there 10 minutes early." While practitioners interpreted their patients' collaboration and motivation as a reflection of their own expertise, it is also a symbol of their professional power. This will become clearer in the following pages, where I detail clinicians' own manipulation of these same temporal limits.

In their offices, psychotherapists' "vision is hegemonic" (Henke and Gieryn 2008, p.366), not only with respect to their patients' inner lives, but, more importantly, with regards to the norms that dictate how they inhabit the space. Among all the elements that outfit therapeutic spaces one stands out as constitutive of therapists' power: the chair. In her discussion of psychoanalytic psychotherapy, Luhrmann (2000, p.187) pointed out that therapists' and patients' "chairs are identical so that the patient will not feel belittled by his own chair's inadequacy." While my observations confirm the aesthetic identity of the chairs occupied by patients and their therapists, I also found that they had distinct meanings. Paula's "therapist chair" not only triggered her expert skills, but also symbolized her expertise and authority. That therapists' and patients' chairs have distinct meanings became apparent in some of my interviewees' discussions of undergoing therapy themselves. Elena, a psychologist who had completed extensive training,

and had been practicing what she described as integrative psychotherapy for close to five years, thought that it was necessary for all clinicians to go through therapy, if only to be "able to sit in the client's seat, and to feel that vulnerability." To Elena, being "on the other side" and "humbled in that way" are lessons that all therapists should learn as they venture further into the profession. Her point illustrates the power inscribed in the spatial organization of the office: the therapist's chair is the locus of authority and expertise; it is the foundation for her observant gaze. Conversely, the spaces that patients occupy are places of vulnerability and relative powerlessness.

Patients enter therapists' offices, and are to occupy them within parameters they have little control over. The chairs in which therapists sit session after session are theirs and theirs alone. When a patient attempts to break the formula and sit in the therapist's chair, it is considered a challenge to the practitioner's authority, one that therapists make a point of correcting and discussing. For example, Sonora began seeing Dan at the University Psychiatric Clinic in one of the observation rooms outfitted with a one way mirror. She chose the chair closer to the door, and continued to sit in it throughout the treatment. During one of their initial sessions, Dan went to sit in Sonora's chair, but she quickly intervened, instructing him to sit in the one opposite hers. While only occupying that office one afternoon a week, Sonora had a clear vision of how the space ought to be inhabited. Psychodynamic practitioners adopt a more exploratory rather than corrective attitude. Julia, a young social worker training in psychodynamic psychotherapy was faced with a similar situation. A patient had disclosed an embarrassing secret the previous week, and, when he returned, he headed directly for her chair and sat in it. Julia told me she "didn't really know what to do," so, after she sat in the opposite chair, she said to her patient, "Well, that's interesting. Why did you choose that chair?" They

then explored his motives and emotions, and Julia concluded that the patient's challenge was reflective of the dynamics he was playing out in their relationship—a typical psychoanalytic maneuver. She later integrated his action into how she "conceptualize[s] him […] that he's really struggling with—because of his religious background and his ethnic background—power dynamics in male-female relationships." Her chair (complemented by the patient's chair) thus emerges as an "actant" (Latour 2005) mediating the interaction between Julia and her patient, and facilitating her epistemic work. Moreover, unlike Sonora who was primarily concerned with the skills and tools she would teach Dan that day—applying her own developing techno-scientific expertise—Julia's reaction was reflective of her emerging affective-relational expertise. Yet regardless of their strategy for responding to such spatial challenges, both novices reasserted their (albeit incipient) professional authority: Sonora corrected her patient's action, while Julia "interpreted" it in psychoanalytic terms, appropriating it as a problematic to be understood with the aid of her developing expertise. Both also, inadvertently, helped create differently 'well-disciplined' patients: one who focuses on changing his thoughts through targeted CBT interventions, another who learns that the key to his problems is to be found in his relationships, and developmental history.

From their earliest days training in psychotherapy, novices acquire a fundamental skill: control over the spaces and times of their professional work. The therapy office and the therapy hour are self-enforced boundaries that constitute and reveal practitioners' authority and expertise. Yet as the previous discussion begins to illustrate, these settings carry distinct meanings in the two orientations. The spatial and temporal organization are, Bourdieu (1977) has argued, reflective of a group's (in this case, a profession's) social organization. I showed in the previous chapter that psychoanalytic psychotherapy and its "evidence-based" counterparts have their

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historical roots in different institutional traditions. Psychoanalysis gained its power and

reputation at a time when status and financial success came from establishing private practices

(Hale 1995; Zaretsky 2004). Psychiatry residents training in the 1940s, 50s and 60s left the

world of institutionalized care and community mental health for the prestige and autonomy of the

private office (Coser 1979; Light 1980). It was there that they could conduct psychoanalysis, not

simply by choice, but by necessity as well: psychoanalytic training was extremely expensive,

and only a private practice that attracted well-to-do clients would make such an investment

viable (Light 1980; Zaretsky 2004). Private practices are also the dominant choice among

psychoanalytic clinicians participating in this study (see chapter one). Their relative autonomy

from insurance companies[30] affords them the luxury of adopting longer temporal frameworks,

focused on developing relationships that become therapeutic by virtue of their affective-

relational expertise. These practitioners thus exercise greater independence in their work, though

at the cost of growing marginalization in the field of mental health.

In contrast, cognitive and behavioral clinicians are more thoroughly embedded in the

world of "evidence-based" medicine. Unlike psychoanalytic knowledge that emerged out of

theoretically-informed, yet particularistic and idiosyncratic clinical work, cognitive and

behavioral knowledge is institutionally tied to the psychological laboratory. These treatments

came out of efforts to devise empirically-supported alternatives to psychoanalysis, were

championed by clinicians who conformed to the "scientist-practitioner" model, and consist of the

skillful application of tested interventions (Hale 1995; Beck 1967, 1976). Instead of working in

private offices like their psychoanalytic counterparts, the majority of participants in this study

spent their professional lives in medical organizations: hospitals, clinics, community mental

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[30] Among my interviewees, only established practitioners worked completely off the insurance grid. Younger
practitioners who were just establishing themselves in private practices continue to accept insurance payments, but
spoke of the difficulties associated with such financial arrangements.

health centers, and group practices. They conduct shorter term treatments in standardized offices that eschew individual creativity in favor of scientifically demonstrated reliability. These therapists speak with the authority of evidence-based medicine, and are embedded in systems of techno-scientific expertise.

But spatio-temporal environments are not only the product of long histories that shape the social organization of a profession, while, at a micro level, granting practitioners opportunities to assert their authority. They also shape the 'expert *habitus*' of those whose daily lives unfold within them (cf. Bourdieu 1977). Bourdieu (1977) argues that the Kabyle house is like a book that "is read with the body," which in turn becomes a mnemonic device for arrangements that replicate the dominant social structure (pp. 89-90). Likewise, the clinical room and the therapy hour call forth a particular "bodily hexis" priming therapists towards ways of "feeling and thinking" typical of their orientation (cf. Bourdieu 1977, pp. 93-94). These embodied epistemic practices become evident only when routines are interrupted by unusual events. Paula had a "better spousal interaction" in her office, because she sat in her chair and could thus be a better listener. Sonora and Julia responded to their patients' contestations of authority in ways that conformed to their therapeutic goals. In the following pages, I turn to a longer discussion of the spaces and times of psychotherapeutic work, illuminating their epistemic value. Time and space foster distinct embodied expertises—affective-relational and techno-scientific—and enable clinicians to assert legitimate jurisdiction over their patients' problems.

Space, time and psychotherapeutic knowledge

Psychoanalytic psychotherapy. Psychoanalytic psychotherapists work in personalized spaces, with longer term treatments, and higher frequency of sessions. This spatio-temporal environment fosters an intense focus on the therapeutic relationship, aimed at understanding

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patients' "transference." This is a common process, Chodorow (1999, pp.14-5) explained, by

which we "use experiences and feelings from the past, to give partial meaning to the present as

well as to shape the present, as we act and interpret present experience in light of this internal

past." Psychodynamic therapists are sensitive to the ways in which patients imbue the present

with traces of painful or traumatic pasts, and believe that these can be identified within the

bounds of the therapeutic relationship. To do so, therapists rely on the constancy of the spaces

and times in which they conduct their work. The office is a liminal space, "apart from the rest of

the world," in which patients can, according to an experienced analyst, "feel safe and free to say

what's going on internally with impunity." This freedom is partially fostered by therapists' own

measured responses to what goes on inside the therapy space, responses that I delve into further

in the next chapter. As one of my interviewees put it, it's "the same four walls and the same

person" that patients come to interact with session after session. As such, the constancy of the

therapy space and time constitutes the constancy of the therapist, who remains calm and

composed during patients' emotional highs and lows. Another interviewee told me that by

limiting interactions to the office, and the 45 minutes of the therapy session, patients "won't have

to worry about […] what I think about them otherwise. So if they're very angry at something

that I say, they can express the anger fully without fearing that I would retaliate in some ways."

By setting boundaries between inside and outside therapy, the material environment provides

patients with a sense of safety, while also mediating therapists' expert practices. These

boundaries make possible the unique relationships that psychodynamic therapists rely on as

treatment tools.

Maintaining the safety and constancy of the therapeutic frame was paramount among

therapists' concerns. Clinicians of both orientations spoke of the office as a "safe space" in

which patients could reliably open up about, and work on their problems. I encountered some of the most dramatic arrangements aimed at safeguarding patients' anonymity and confidentiality in psychodynamic therapists' private offices. Double doors at the room's entry, and white noise machines kept sound from exiting and entering the room. Unlike a clinic or a group practice where waiting rooms are common spaces often inhabited by several expecting patients, therapists in private offices could have individual waiting rooms that preserved patients' anonymity. Distinct entry and exit ways ensured that patients leaving a session never saw those awaiting their appointments. Such physical boundary markers assured clients that their secrets and identity were safely guarded, and bolstered therapists' claims to trustworthiness: they showed themselves as expert secret keepers.

Temporal regularity was also important to maintaining the frame. Damen, a third year resident, pointed out that his supervisors "are kind of strict" about going over the allotted time with psychodynamic patients. This, as I will show in the following section, was not the case in the "evidence-based" therapies. When faced with a patient who brings up an important issue in the last five minutes of session, residents in the psychodynamic core class were advised to "keep the frame and [...] assure [the patient] that this is something to talk about next time." This reflected an analytic understanding that patients' reasons for such "door-knob comments"—as residents and their instructors described them—were partly due to an unconscious fear that the therapist will be gone once the door is shut. Patricia, an experienced psychologist and analyst who instructed residents in this therapy, told them that they can "reassure" patients that they "will be there next time" without breaking the temporal boundary of the frame.

The longer term nature of this treatment affords therapists and patients the opportunity to return to the same issue over several sessions, but being on time and ending on time are

considered paramount to establishing a trusting and respectful relationship. Moreover, just as

sitting in the therapist's chair was to be understood through an analytic lens, patients' lateness or

irregular attendance was similarly medicalized. Such infractions were thought of as

manifestations of "resistance," and clinicians attributed them to (among other, more patient-

specific, reasons) patients' unwillingness to address a difficult issue, or anger with their

therapists, attempts to indicate that something was amiss, or re-enact past trauma and test the

therapist, and, lastly, the desire to rebel against the power imbalance built into the therapeutic

relationship. These issues were significant due to their relevance to the therapeutic relationship,

a key focus for psychoanalytic psychotherapists' affective-relational interventions.

Working in private offices afforded these clinicians further resources for fostering deep

therapeutic relationships: first, they were able to make esthetic choices that created personalized

spaces, and, second, they could engage in longer term treatments with frequent sessions. I

discuss each in turn. Private offices[31] revealed common norms about what a therapy space

should be—two chairs, sometimes a couch—while also reflecting therapists' professional and

personal identities. Joy, an experienced psychoanalyst and psychodynamic psychotherapist, had

been in private office for nearly two decades. She occupied a very large room with a separate

waiting area on one of the upper floors of a historic building. As I entered the airy and sunny

space, I noticed a large desk overtaken by papers and a computer, and a bookcase filled to the

brim. The right wing of the room encompassed the therapy setup: Joy's chair positioned by two

large windows and a towering plant faced a coffee table and a medium sized couch with deep

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[31] None of the therapists I interviewed worked in a home office, but they are not unusual (though coming under
greater criticism in the analytic world). As the popular show *In Treatment* illustrated, boundary issues become even
more vivid in such cases (both with respect to patients meeting each other, but also since there is a less clear
demarcation between therapists' private lives and their professional lives). Nevertheless, the argument I make here
regarding private offices applies to home offices as well: the personalization they make possible is reflective and
constitutive of therapists' affective-relational expertise.

seats. Colorful art adorned the walls of the office, and a small table with chairs was tucked away in a darker nook of the room. When I asked about her office, Joy told me that she wanted to "create a very idiosyncratic, unique, psychological space […] in which the [patient] does feel some sense of home." When decorating the room, she was particularly concerned with distinguishing herself from what she thought of as the "fairly stark" offices of traditional psychoanalysts. She told me:

> I think that it's okay to express myself in my office, I mean, within limits, obviously. […] I don't have any pictures around that are highly personal. I do have pictures around […] that tell anybody who's looking something about me, […] about my interest in [a particular region of the world], […] my interest in color, and you know, arts in general, and I think that's fine. And I also think that it contributes to a sense of being in a pleasant place. […] [T]hat's what I want people to feel, 'come be with me in this space and you're welcome to be here.'

Joy's office carried her personal imprints: pictures, art, and travel were some of the interests she felt comfortable sharing with her patients. She didn't reveal "highly personal" information (though on closer inspection one could identify a small framed photo of Joy's daughter as a little girl on the lower shelves of the bookshelf). By choosing to display more of the things that she found meaningful, Joy also declared something about her professional identity: she signaled her rejection of classical psychoanalysis, and her adherence to a more contemporary analytic orientation that shunned the traditional "analytic mask"[32] of "neutrality." Joy balanced her work space by filling it with things that had personal meaning as well as professional significance. The office fostered Joy's affective-relational expertise as the therapeutic connections she formed with her patients depended on their perception of her as a 'real' human being[33].

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[32] When they did mention the "analytic mask," psychoanalytic practitioners who participated in this study did so to reject it: they were not as analysts past, stone-faced and neutral.
[33] Many of my interviewees—from both orientations—spoke about being "human." They usually did so when recalling a particularly strong affective reaction they had had to a patient's story. But only psychoanalytic

Much as therapists in private practice have the freedom to express themselves, they also wish to maintain an image of professionalism and success. Harry's office welcomed newcomers with expansive views, and he had chosen it with a particular goal in mind. When we first met, he told me the story of his early training days, completing an internship as part of his doctoral work in clinical psychology. He recalled with humor the fact that his office, like all the other interns', was in a basement, reached by taking a creaky elevator down, and walking through a long, dimly lit hallway. He felt as though he was at a police station, taking suspects to an interrogation room. Searching for an office years later, he wanted a space that could communicate to his patients, as one of his supervisors told him, "what a wonderful therapist you are." Harry looked for an office "that gives people enough confidence to come back, and get engaged [in the therapy]":

> This particular office, I'm paying more than—than I might at other settings available in town […] so that when patients come in and they look out the window [they] say, "Great view!" [laughter] […] That happened just yesterday, that I met a couple for the first time and one member of the couple really was taken with the view. […] But so the space it seems to me is important to—to convey enough professionalism, […] so instead of ratty, torn couches, these are nice couches. My wife teases me that I live—that this office is like my bizarro world. […] So in my private life I'm nowhere near as neat and orderly as this, right? This is bizarro world. Everything is in place, it's all clean, it gets dusted. [laughs] Well, that's fine, right, that's what patients want when they come into therapy. I also think the office conveys something about me, right? It's not—once early in my career I had to use an office belonging to a colleague, […] a very frilly office, lots of flowery patterns. I mean this is a little more expressive of me.

Unlike an office at a university clinic or a group practice, a private office can be "more expressive" of its occupant, reflecting what he or she wants to communicate to patients. But sometimes, achieving a professional 'look' means inventing a "bizarro" world in which "everything is in place, clean, and dusted." The office has to be a "decent space," Harry told me, so as to give patients the impression that "they're dealing with a professional […] who is at least

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psychotherapists also used this phrase to discuss the necessity that their patients know they are 'idiosyncratic' and 'flawed' human beings. This was deemed as a necessary component to the progression of treatment: only this lack of idealization made possible deep psychoanalytic work.

successful enough" to pay for a good room, one with tasteful decorations, nice furniture, and, sometimes, a great view. If the therapist can have such a nice space, the assumption goes, many patients must seek and be benefited by his or her services. The therapy room is thus meant to not only "convey something" about the therapist as a person (in this case, no "frilly" "flowery patterns"), but also about them as a professional ("what a wonderful therapist you are")[34].

But despite their efforts at personalization, therapists were careful to not overemphasize the aesthetics of space. Harry astutely pointed out that beyond the basic functions of comfort and professionalism, the clinical room need not play a major role in the patient's experience of therapy. He recalled a patient who had been in therapy for two years, and "one day look[ed] at the […] things on the wall above the couch and [said], 'Have they changed?' They haven't changed in a decade! But the person didn't know they were there, right?" Similarly, Joy pointed out that only if somebody is purposefully looking around her office would they learn something about her interests and travels. When patients come to see their psychotherapists, they are there to work on their own problems, and the space should not disturb their focus on that process. Seen in this light, even personalized offices aspired to the neutrality of the muted offices at the University Psychiatric Clinic that I describe next. Yet the question remains, if safety and comfort are the most important functions of a therapy office, why the effort to personalize?

First, therapists in private offices have greater latitude when it comes to the aesthetics of space, and those of my interviewees who practiced "evidence-based" therapies and worked in private offices (four of 17) did as well. They can make choices that reflect both their understandings of expected norms (e.g. patients and therapists sit in separate chairs that do not

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[34] A slightly different image of expertise emerged during my visit to another therapy office. One of my interviewees had a centrally located but small office crammed to the brim with papers and books stacked on the floor around his chair, and the analytic couch. His was not the kind of neat "bizarro" world that Harry had created; instead, his office communicated the image of the intellectual finding order in (material and emotional) chaos.

necessarily directly face each other), as well as their desire to create a space in which they would feel comfortable working for many hours a day. The office must also communicate to patients a sense of the therapist's professional ability and success. At clinics, or even a group practice, such confidence is fostered by the institutional legitimacy those spaces call to mind: medicine is inscribed into the built environment, and the objects that fill it. In private practices, it is up to the therapist to foster patients' confidence: a well-appointed large space with a great view can send a powerful message to the potential client. But psychodynamic therapists' efforts at personalizing the office can also be read as having a second function, directly related to their epistemic project: to impress upon patients a sense of the practitioner as a unique, vibrant human being, capable of developing deep and rewarding therapeutic relationships. Practitioners of "empirically-supported" therapies approach the relationship as a necessary but not sufficient element of treatment; their techno-scientific interventions revolve around isolating and working on the thoughts and behaviors that cause patients difficult emotions In contrast, psychodynamic therapists focus on their patients' affective world, which, they believe, is easier to access when their interlocutor has a sense of an emotional connection with another person, fostered in a space that channels the idiosyncrasies that make them human.

One more material object bears mentioning here: the analytic couch. Used only by clinicians formally trained in psychoanalysis, the couch is thought to facilitate their therapeutic goal of creating an environment rich in affective and relational elements. In recent years, the couch has come under some criticism within the community, as more psychoanalysts have stopped considering it a necessary element of the therapeutic process (Goldberger 1995; Celenza 2005). In theory, the couch was intended to help move therapists and their patients closer to the latter's unconscious (Freud 1963; Ogden 1994; Tyminski 2006). In practice, it was initially only

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partially related to this purpose. Freud retained use of the couch when he parted ways with hypnosis so as to avoid the difficulty of being constantly stared at by patients (Freud 1963, p. 146, points out that he "cannot bear to be gazed at for eight hours a day"). Some of my interviewees have also remarked on the freedom that the couch affords them during clinical sessions: they don't have to monitor their facial expressions, and can more easily follow their patients into their unconscious worlds. But while it obscures therapists' embodied displays of emotions, it doesn't erase them altogether. The analyst is not simply a 'disembodied voice,' but a voice that carries particular meanings through inflection. Thus, while patients cannot see their analysts, they can still impute to them different feelings and attitudes that are, ideally, brought up for discussion, becoming fodder for the psychoanalytic mill.

But more than simply limiting patients' perceptions of their therapists' feelings, and freeing therapists from the challenges of monitoring their displays of emotions, the couch determines the physical location of the two such that therapists' power is clearly signaled. When used, this "non-human actant" (Latour 1988; Cerulo 2009) introduces an embodied dimension into the power relationship between analyst and patient. By the very act of laying down, patients relinquish the ability to observe the therapist's actions, and thus place complete trust in them (even if only tentatively, and temporarily). Conversely, the chair affords analysts a panoptic view of the patient, who is deprived of the possibility of responding in kind as they lay down facing away from the therapist. The couch thus structures interactions between therapists and their patients such that the former are not only vulnerable, but also entirely dependent on the latter for their safety. Such physical dependence can also be replicated in the emotional space of the therapeutic encounter, as patients come to count on their therapists for emotional strength (a phenomenon that analysts sometimes describe as "ego-lending"). Unlike the white board that

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"evidence-based" practitioners sometimes make use of which makes possible some emotional

distancing (I return to this in the following section), the couch invites a turn inward, facilitating a

deeper exploration of the affective and relational dimensions of the clinical encounter. Thus, by

fostering deep affective connections between therapist and patient, the couch is yet another

material object in the spatial environment that furthers the analytic epistemic project, and helps

constitute practitioners' affective-relational expertise.

The temporal dimension of treatment carries similar significance. Scholars in science

and technology studies have fruitfully explored and problematized the places of knowledge

making (Shapin 1995; Knorr Cetina 1999; Gieryn 2002, 2006; Henk and Gieryn 2008), but have

paid less attention to time as an element of scientific practice (but see Dubinskas 1988; Traweek

1988). Actor-network theorists have only attended to time as a measure of the duration of

particular networks. For example, Law (1992, p. 386-7) argues that one of the core concerns of

the actor-network approach is with "how actors and organizations mobilize, juxtapose, and hold

together the bits and pieces out of which they are composed," forming more or less "durable"

networks. In this perspective, temporality is an indicator of the resiliency of networks that make

up actors or organizations. Other sociologists have shown that we can learn more about the

social world by considering temporality beyond duration. They have demonstrated that social

roles are associated with particular times, as distinct temporal flows recall specific ways of

thinking, feeling and doing (Durkheim [1912]1995; Roth 1963; Bourdieu 1977; Zerubavel 1979,

1982; Fine 1990). Moreover, some science and technology scholars have argued that scientists'

distinctive approaches to time set them apart from other occupations, and from each other

(Dubinskas 1988; Traweek 1988). This focus on temporality has lacked from the incipient field

of social knowledge making (Camic, Gross, and Lamont 2011), despite its essential role there.

Whether they take up quantitative studies of 'social facts,' in-depth ethnographies of communities, or historical studies of the past, social scientists' epistemic practices have their own tempo, rhythm and directionality (cf. Bourdieu 1977). Moreover, as I show in the following pages, and in chapter four, the temporal dimensions of their objects of inquiry can lead to distinct processes of knowledge production.

Multiple time-keeping implements occupy the therapy office. Clocks, watches, computers, calendars, and planners help therapists organize their professional time, and keep track of their patients. The very location of some of these temporal tools is significant. Therapists usually set a clock in their vicinity (usually on a small table by their chair), in the patient's line of vision. The close spatial connection between the clock, the chair, and the body of the therapist carries a powerful symbolism: time is limited, and the patient is not only paying for the therapist's expertise, but also for their time. Time, place, money, and the therapist are indelibly linked, but the different connections between these human and non-human "actants" make for distinct forms of expertise.

Psychoanalytic clinicians' approach to the length of treatment, the frequency of sessions, and the structure of time in session distinguishes them from their cognitive and behavioral counterparts, whose temporal practices I examine in the next section. Psychodynamic therapy is organized around open-ended, long term treatments. Such timeframes afford practitioners greater opportunities to uncover and understand their patients' past, and its manifestations in the clinical interaction. Except for circumstances in which mitigating factors limited therapists' or patients' ability to stay in therapy indefinitely (for residents this was most often graduation), psychoanalytic psychotherapists prefer to leave the end point open. Residents working with patients in psychodynamic therapy over one to two years often had difficulty making therapeutic

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endings concrete. Their own and their patients' emotional involvement in the treatment, and difficulty "saying goodbye" were topics of discussion in many of the group supervision sessions I attended. Three elements of the psychoanalytic treatment ideology contribute to longer, open-ended treatments: first, its focus on the therapeutic relationship as a treatment tool; second, the emphasis placed on patients' coming to their own understandings of their problems; third, the nebulous and relatively undefined nature of the goals themselves. Unlike cognitive and behavioral treatments where particular interventions were associated with specific results which, when achieved, signaled the end of treatment, psychoanalytic therapy challenged residents' belief in what completing a treatment means. Paula told me that psychodynamic psychotherapy is akin to "getting a Ph.D. in yourself," and, just like a Ph.D., it can take years to accomplish.

Within the context of a longer treatment, clinical interactions between therapists and their patients were less structured. Sessions were generally driven by patients rather than an agenda (the preferred tool of CBT practitioners). The therapy hour was thought of as a time for patients to reflect, discuss current and former relational and emotional problems, and try to understand them with their therapists' help. Such a process may be ill-served by a structured therapeutic session: an agenda would not allow for the winding of stories and reflections that fill psychodynamic sessions. But this also contributed to the challenges of what the residents thought of as "psychodynamic time." Longer and less rigidly planned than the time of any of the other treatments they provided, residents had to learn a new set of skills for filling it up. Their roles within this distinct temporal horizon were less directive and active, taxing their notions of what it means to be helpful for their patients.

The relative open-endedness of psychodynamic time is set from the very first meeting. Rather than conducting psychiatric interviews, and assigning a DSM diagnosis, psychoanalytic

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psychotherapists tend to let patients talk freely about what prompted them to seek therapeutic

help. Ronald, an experienced psychodynamic therapist and analyst told me:

> I will ask something like, "Well, can you tell me what brings you here to see me?" […]
> and under the optimal situation, somebody that's fairly verbal, been thinking about this, I
> might say very little. So […] the idea is to give them the space to fully express
> themselves as well as they can. And then, what I listen for is, okay, what did they say?
> How did they say it, in terms of psychological mindedness... in terms of... of rationality
> […]. And also, what didn't they say? […] However, if somebody is having difficulty, I
> have no problem interacting with them quite a bit throughout the session. I still don't
> espouse any kind of a checklist. I don't need to know everything. More, I need to know
> what they can talk about and what they can't.

The single question "can you tell me what brings you here to see me" is an ideal tool for

psychodynamic therapists, allowing "somebody that's fairly verbal [and] been thinking" about

their problems to elaborate on their motives for seeking psychotherapy. This can provide the

clinician with a wealth of information, both about the nature of the patient's issues, but also their

emotional lives, and discomforts around those topics they failed to address. Even when patients

had difficulty talking, and Ronald took a more active approach, "interacting with them quite a

bit," he maintained an open-ended strategy. Not driven by the need to match treatment to a

specific diagnosis, Ronald, like many of the experienced psychodynamic practitioners that

participated in this study, avoided using "any kind of a checklist." This is not only symbolic of

psychodynamic practitioners' ambivalence or outright rejection of formal DSM diagnoses (an

issue I return to in chapter three), but also of their open-ended use of time in session. Moreover,

it reflects their relative autonomy from an economic system ruled by insurance companies.

Psychodynamic treatments, proponents argue, require intense immersion from patients

and therapists alike, and this goal can be best achieved by meeting frequently. As is well known,

one of the defining elements of psychoanalysis is the condition that patients meet with their

therapists four to five times a week. Other psychodynamic treatments can range from three times

a week to once a week (only on rare occasions do psychodynamic therapists agree to less frequent meetings). Increasing the frequency of their psychodynamic sessions was a difficult issue for psychiatry residents, as their time was scheduled months in advance, with little flexibility built in. But Lucas, a psychoanalytically inclined resident, became a believer:

> Three times a week is *much* more effective [for psychodynamic treatment]. […] This person with borderline personality disorder was thought to have depression forever and ever and, you know, I didn't even make the diagnosis of borderline 'cause she kept all of this stuff [from me]. I didn't know about the cutting. I didn't know about the burning. I didn't know about the mood lability. […] And I said, "[…] I think it would be most helpful if we were able to meet more frequently and I think that would help you." […] And so she […] agreed with that assessment, and it was when we went to three times a week that […] many of these major changes started to really happen.

Lucas began seeing his patient for once-weekly talk therapy in addition to pharmacology sessions. At the beginning of treatment, he was not aware of her self-destructive behaviors, as she "present[ed] a very shut down appearance in the room." Lucas suggested meeting more often, and, when his patient agreed, "major changes" began: she became comfortable sharing more of herself, telling him about her "cutting," "burning" and "mood lability," all symptoms associated with borderline personality disorder. More importantly, he was able to help her reduce the occurrence of such acts.

The spatio-temporal context of psychoanalytic therapy is structured to further practitioners' epistemic goals—to establish and utilize for the purposes of treatment a deep and affectively rich therapeutic relationship. Their personalized offices invite patients into an environment that bears little resemblance to the medicalized world of "evidence-based" clinicians. Here, patients can disclose their most painful memories, within relationships built over months and years. Patients, whether laying on the couch, or sitting in the chair, submit their feelings and their pasts to therapists' observant gaze. Psychoanalytic practitioners navigate the

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nearly boundless epistemic field with the help of their affective reactions (as I show in chapter three), and skillful management of distinct temporalities (the topic of chapter four).

"Evidence-based" therapies. Most of the practitioners of empirically-supported therapies I interviewed worked in university clinics or group practices[35]. Institutional affiliation is an important marker of credibility and legitimacy for these clinicians; it is symbolic of their belonging to a scientific medical world. In turn, their work reflects the standards of 'evidence' that have come to dominate medical practice, and is supported by insurance companies. Drawing on Bourdieu (1977), and works in science and technology studies (e.g. Knorr Cetina 1999), I have made the argument that the aesthetic characteristics of therapy offices are indicative not only of their occupants' position within the social organization of the profession, but can also reveal distinct forms of embodied expertise. Traweek (1988, p.64) eloquently pointed out the feedback loops linking scientists and their laboratories when she wrote that "[t]he machine makes the scientist, and that kind of scientist makes that kind of machine." Similarly, the therapy room makes the therapist, and different therapists inhabit different kinds of spaces. In the previous section I discussed the importance of personalized offices to psychoanalytic therapists' ability to exercise their affective-relational skills. In contrast, the standardized rooms in which practitioners of empirically-supported therapies conducted their work offered a telling backdrop to their techno-scientific expert performances.

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[35] In the previous section I discussed therapists' concern for their patients' safety. But clinicians were also thoughtful about their own safety, and one of the advantages of working in a university clinic, or a group practice was the possibility of relying on colleagues or even a security guard with particularly aggressive patients. For example, Simia, a young but well respected cognitive behavioral therapist working at the University Psychiatric Clinic recounted a time when one a young man diagnosed with Asperger's syndrome grabbed her hand to express his anger and wouldn't let go. She called security personnel when her words failed to dissuade him from continuing his aggressive behavior.

Practitioners of "evidence-based" therapies working at the University Psychiatric Clinic inhabited offices that looked uniformly muted. Most were engulfed in a beige color scheme, their fluorescent lights softened by strategically placed lamps. A desk, a computer, and an ergonomic chair occupied the far side of most offices, while a small white board took up part of the wall next to the entrance. In the opposite corner, one or two chairs and a small rectangular couch were laid out in L shaped formation. A side table formed a dividing line between one of the chairs and the rest of the sitting area; on it, a clock blared the time in glowing red numbers. A bookshelf or two sometimes accompanied this basic setup, and, when clinicians worked with children, neatly arranged toys and games provided a burst of color to the otherwise subdued landscape.

This spatial environment emphasized the institutional goals of providing uniformly excellent and scientifically vetted treatments. It obscured the fact that such treatments depended on therapists' own skillful customization of different techniques to individual patients. Nevertheless, in these settings, therapists' abilities carried the stamp of approval of an institution that made itself visible in waiting rooms and individual offices. The clinical room was thus more than an interface between the therapist and the patient: it mediated the relationship between the patient and a whole institutional apparatus that formed the not so invisible backdrop for the therapist's work. Cora, a young cognitive behavioral therapist completing her postdoctoral training at the Clinic was fully aware of her role as a representative of the institution. She told me: "I take supervision very seriously because […] when kids are coming [here] and it's a specialty clinic, they're expecting that they're going to get results. […] I am newly graduated, this is a new job, but I should be delivering the same quality service that they would get had they been matched up with any other clinician." Like most of the novices that I spoke to, Cora

invested time and effort into her meetings with her two supervisors. These meetings

strengthened her ability to provide the "best treatment" to her patients, and were an important

tool in her evolving apparatus of expertise. Regardless of her status as a relative beginner, being

a therapist who worked at a renowned "specialty clinic," Cora felt the need to perform up to the

standards that patients anticipated from the university. Thus, the space she worked in was not

only a physical environment that structured her interactions with patients, but a material network

that, in linking her office to a larger institutional setting, shaped and legitimated her work.

In the previous section, I discussed the epistemic and professional value of one particular

element in psychoanalytic therapists' offices: the couch. At the Clinic, practitioners of cognitive

behavioral, and dialectical behavioral psychotherapy made ample use of white dry erase boards,

and I was able to observe some of the ways in which these structured interactions between them

and their patients. Novices were encouraged to stand by the board, and use it in clinical sessions

to explain the basic cognitive behavioral model, or other relevant CBT techniques. Sonora used

the board several times during her treatments: she drew a graph representing unaddressed

anxious feelings over time to explain to her patient Sam, and his parents, how anxiety works; she

made a hierarchy of anxiety inducing situations based on Sam's accounts, and unpacked the

hierarchy by focusing on each of the levels within it; she conducted a "chain analysis" to

understand the flow of events that led Sam to feel anxious and sad. The board is a powerful

expertise-denoting technology, as it allows both patients and therapists to draw on familiar roles,

that of students and teachers, while placing them in distinct physical planes. It is a material

object that embodies "network patterns that are widely performed" (Law 1992, p. 385),

crystallizing established roles and performances commonly associated with didactic

relationships. Though a "non-human participant" (Latour 1988, 2005) in clinicians' work, it conditions therapists to act as teachers, and transforms patients into students.

As their interactions take on a didactic tone, both clinicians and patients can gain some distance from the affective demands of therapeutic interactions. The board helps patients mitigate some of the challenges associated with their role, such as accurate reporting of difficult inner states, thoughts, and behaviors, by allowing them to inhabit (even if temporarily) a role they are perhaps more comfortable with, that of student. It also assists therapists (particularly those in the early stages of their training) with managing the intensity of interacting with a patient whose emotions at times run high. As an experienced therapist in dialectical behavioral therapy astutely pointed out, the board can help "diffuse some of the tension" that can sometimes engulf the therapeutic space. Tim, a resident participating in the CBT supervision group, used the board with special efficacy with a young man whose anxiety was often palpable even from behind the one-way mirror. While he stood by the white board, group members in the observation room noted that the patient's anxiety seemed to have decreased. This can facilitate therapeutic work focused on teaching and learning tools and skills—the core of techno-scientific expertise. The board thus accomplishes two things: it places therapists in the authoritative and knowledgeable position of teachers, and grants them a space for managing their own and their patients' emotions. As a material object that appears in countless classrooms, offices, and science labs, it is symbolic and constitutive of these practitioners' techno-scientific expertise.

While both the white board and the analytic couch place therapists and their patients in different physical planes, they structure the power dynamic between them in distinct ways: the former assigns them to what may be more familiar, though still unequal roles (teacher and student), whereas the latter increases the power difference by relegating therapists and their

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clients to differently vulnerable physical stances (the therapist sitting, while the patient is laying down). Unlike the board—which positions therapists and patients in the hierarchical yet still *public* roles of teacher and student—the couch plunges the patient even further into the domain of the *private* (as he or she rests in a supine position usually reserved for the realm of the home), while allowing the therapist the relative invisibility of their public role. These two therapeutic technologies are (per)formative of therapists' authority and expertise. The couch fosters psychoanalysts' affective-relational expertise and power, while cognitive behavioral psychotherapists embody a techno-scientific expertise as they stand by the board, teaching patients the CBT model, or detailing particular "evidence-based" techniques.

The offices I visited in two group practices provided a slightly different sight from the relatively muted university spaces: windows let in natural light, furniture and decorations preserved a neutral feel, but were not identical from one room to the next. Nevertheless, like those in the university clinics, these spaces afforded clinicians little opportunity for the kind of personalization I encountered in the private offices of psychodynamic psychotherapists. Nor did their inhabitants talk about the fact that they wanted their offices to "reflect something of [them]selves" as some of the psychoanalytic clinicians participating in this study told me. But there is something else to be found in these relatively de-personalized therapeutic spaces: like standardized laboratories that allow for the routinization and legitimation of scientific practice (Henken and Gieryn 2008, p.634), the uniformity and neutrality of these offices conveyed a sense of reliability and objectivity made possible by "evidence-based" treatments. We can thus 'read' techno-scientific expertise in the muted, standardized offices of empirically-supported therapists who work in university clinics or group practices. Ties to insurance companies further

constrain and condition practitioners to enact their expertise in ways that accord with existing 'research and evidence.'

Empirically-supported therapies are organized around targeted interventions into specific problems (identified as DSM diagnoses), and lend themselves to shorter term treatments[36]. During initial therapy meetings, most practitioners of cognitive behavioral therapy discuss the length of treatment with their patients. They usually propose meeting eight to 12 times, when they assess patients' progress, and make a collaborative decision about whether to continue, or taper off treatment. These clinicians consider such a concrete temporal "framework" necessary for remaining focused on their patients' therapeutic goals, and working on specific problems. They also uphold their lesser temporal demands as an important counterpoint to the open-endedness of psychoanalytic treatments, and symbolic of their pragmatic and efficient interventions. A conversation I witnessed in the mentorship on CBT for depression highlighted these distinct approaches. Turner, a third year resident, and Robert, an experienced CBT clinician leading the group, discussed differences between the two treatments:

> Turner: I have been using some CBT with some of my [psychodynamic] patients and challenging their cognitive distortions, and [my supervisor] said 'we kind of have a different approach.' […] My supervisor is definitely more open to CBT techniques, but still [has] a little bit of difficulty where she's kind of saying that we don't want to reduce the anxiety in the room, we want to use the anxiety to understand what's going on [with the patient].
> Robert: That makes sense, but in CBT we're gonna do that lightning fast rather than dragging it out […]. We do want to see what the anxiety is about, but pretty soon what we do want, is to use our techniques to reduce it.

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[36] Dialectical Behavioral therapy works with a somewhat different timeline: it is aimed at patients diagnosed with personality disorders (particularly "borderline personality disorder") who can at times be "lifetime" patients. Nevertheless, it too is structured such that patients can take advantage of concrete interventions through four distinct therapeutic modules (that I detail in chapter four): mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Each module contains particular skills that patients can learn with their therapists or in group therapy, and later apply in their everyday lives. I provide a longer discussion of this modality in chapter four.

Turner's affinity for cognitive behavioral techniques was evident in his frequent attempts at using them in his work with psychodynamic patients, sometimes to his supervisor's disapproval. Such techniques went against the goals of psychodynamic therapy, in this case, "using the anxiety to understand what's going on" in the patient's life, through an in-depth examination of how that anxiety impacts the therapeutic relationship "in the room." Had he followed his supervisor's advice, Turner's insights about the patient's troubles would have only developed over the course of many sessions. In contrast, Robert pointed out that while practitioners of CBT also wish to understand "what the anxiety is about," they are more interested in eradicating it through the targeted tools that make up their techno-scientific kit. Such understanding had little in common with the in-depth exploration of the patient's past and its manifestations in the therapeutic relationship (concerns symbolic of affective-relational expertise) that Turner's psychodynamic supervisor had in mind. CBT practitioners move at "lightning fast" speed compared to their psychodynamic counterparts who, in Robert's words, "drag out" discussions of the roots of their patients' emotional problems. Robert made clear the point of CBT: "pretty soon what we do want is to use our techniques to reduce" the anxious feelings. In cognitive behavioral therapy, the time that elapses between diagnosis and the "active" part of treatment is short, shaping clinicians' work such that it is more structured, and less prone to exploration.

The distinct temporal frames that shaped clinicians' work were also reflected in the ways my interviewees spoke of the longest treatments they had conducted. Many psychoanalytic psychotherapists could think of at least one patient with whom they had worked on a regular basis for several years; the longest period of time I recorded was an ongoing treatment that had been already under way for over two decades of multiple sessions a week. A short term

treatment in psychodynamic psychotherapy was one to two years of once weekly meetings. As one of my interviewees put it, such treatments involve "people who […] are not looking for a life-transforming experience, they're looking to solve a problem." In cognitive behavioral therapy, patients who needed to be seen for one or two years presented more complex constellations of problems, such as, according to another interviewee, "chronic OCD [obsessive compulsive disorder] or GAD [generalized anxiety disorder] or something where their symptoms are always going to go up during periods of stress in their life." When practitioners of cognitive behavioral psychotherapy mentioned having a patient whom they had seen on and off for several years, they often described the treatment as alternating between "supportive" periods (when patients could come in and just talk about their problems), and more active periods (when patients learn and use skills and tools).

In keeping with these differences, clinicians in the "evidence-based" therapies also adopted a divergent approach to session frequency. In these modalities, practitioners meet with their patients anywhere from once or twice a week early in the treatment, to once a year, for "check-in" after the active part of therapy is done. Except for moments of crisis, a modal CBT pace consists of once weekly meetings for a period of two to four months. The shorter length of treatment, and lower frequency of sessions, made each meeting an essential platform for communicating new information, and conducting new problem solving exercises. Contrary to their psychoanalytic colleagues' open-ended approach, these clinicians thought about and accounted for the passing of time from the very first session. This was not only a necessity imposed upon them by the demands of insurance companies, but also a function of their epistemic project: to identify the concrete problems their patients suffer from, and solve them

with targeted techniques. This also led them to adopt a more flexible approach toward the temporal boundaries of each session.

A cognitive behavioral therapist told me that when she talks to patients about the "structure of sessions, [I] describe it as a 45 minute session," but, she continued, once therapy is under way, "if I feel like I'm at a place with a patient where five more minutes or ten more minutes is going to do us good, you know, I will run a 50 or 55 minute session." I heard this opinion echoed during one of the cognitive behavioral treatments I observed, when Sonora asked the senior therapist how she could carry out an important conversation with a patient's parents in the two minutes left of session. She was told to "just go over time." Residents often felt more comfortable bringing up their temporal 'infractions' to the senior instructors in the "evidence-based" mentorships, rather than in the psychodynamic core class where a greater emphasis was placed on maintaining temporal consistency. For example, during one of the meetings of the interpersonal psychotherapy mentorship, Andrea, a third year resident, remarked that her decision to go over regular session time usually had to do with the patient: "with some people, if they really struggle and it was like, all right this is your last chance to get it out, and they finally are able to spit it out, I mean… I kind of figure, all right, I got 10 minutes for dictation and then if I'm running to 05, ten minutes to the next person, […] I can give them another 15 minutes." Holly, the leading psychologist, confirmed that therapists need to distinguish between patients for whom "it's more of a pattern" to want to stay over the allotted time and open up at the end of session, and those for whom "it's where they are in the progression" of their therapy. Similar to their psychoanalytic counterparts who analyzed their patients' temporal infractions, and thus turned them into a source of epistemic power, these clinicians' decision regarding which patients belong to the former category (and thus deserve more time), and which don't, is symbolic of

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their temporal authority, and expertise. Expert knowledge allowed them to decide when bending

temporal norms will be clinically beneficial, and when counterproductive.

Cognitive and behavioral clinicians' temporal practices differed from their

psychoanalytic counterparts in one additional sense. Unlike psychodynamic therapists who let

patients fluidly lead discussions, they adopted a more structured approach to using time in

session. I asked all my interviewees to describe a typical session with a patient. Nico is a

respected clinician who had been practicing cognitive behavioral therapy for five years in a

group practice, and served as a supervisor to novice psychotherapists at the University

Psychological Clinic. Her answer illustrates the time-conscious approach that characterized the

work of practitioners in this modality:

> I usually tend to focus really diagnostically at the first session. […] I'll screen through
> every anxiety disorder and other major things. […] And that tends to take probably
> about 20 minutes of the time. I—I would say probably initially I'll ask [patients] what
> they're presenting for. […] I'd say 90% of the time people are fairly succinct in how
> they describe that. The other 10% of the time we can spend a lot more time talking about
> that initial thing but usually it's fairly succinct. And then again, I'll go into that screening
> for different items and that usually takes about 20 minutes. So that's probably adding up
> to half an hour. And then usually I'll have enough information to come to a diagnostic
> decision at that point […].

Nico's description of a typical first session captures the general outlines of what most of

my respondents practicing "evidence-based" therapies told me: she focused on diagnosis—both

by screening patients according to the DSM, but also by asking them to describe their symptoms

and the problems that brought them in. She communicated a diagnosis (signaling her expertise),

and then proceeded to inform patients about the various treatment options available. Time is

fairly regimented, and accounted for: ten minutes of free conversation with patients who tend to

be "fairly succinct," followed by 20 minutes spent "screening" for diagnoses, and another 15

minutes on available treatments. This is time with a purpose, and patients need to learn quickly

that being concise is essential to getting things done. They accommodate their expectations to the faster tempo of cognitive and behavioral interventions.

On more than one occasion practitioners of empirically-supported treatments commented that one of the biggest barriers they faced was patients' expectation that they could simply come in and talk. For example, the mother of a young child diagnosed with attention deficit hyperactivity disorder (ADHD) was harshly criticized by a group of young practitioners for her inability to speak succinctly. She often caused the members of the CBT group I observed to express frustration and exasperation at her inability to focus on the task at hand, and give brief answers to her therapist's questions (this led them to speculate about her own possibly diagnosable attention deficits). In the interpersonal psychotherapy mentorship, the experienced clinician told residents to follow the "interpersonal inventory," a questionnaire meant to summarize patients' relational history, as close as possible. Her insistence was justified by the fact that patients tended to provide more detail than was needed at that stage in the treatment. Just as they learn to measure their affective reactions (as I show in chapter three), and separate their thoughts from their emotions (a kind of fragmentation that I address in chapter four), patients must also learn to be concise. The temporal demands of "evidence-based" treatments challenge any preconceived notions patients may have about coming into therapy and talking freely—as they may do in an analytic treatment. "Evidence-based" therapists' short and efficiency-oriented temporal registers, and their standardized and neutral offices did little to invite patients to linger.

Cognitive behavioral time is thus not for talking about problems, but for solving them. Some of the therapists I met made use of an "agenda," which broke up the therapy hour into discrete tasks. Setting an agenda gave therapists and their patients a roadmap for the 45 minutes

they spent together, and organized their use of time such that they could focus on the latter's specific "treatment goals." This structured sense of time extended to the 'homework assignments' clinicians gave their patients. For example, during an intensive treatment for obsessive compulsive disorder (OCD), Luna, an experienced CBT therapist, recommended an intervention called exposure and response prevention. Meredith, the patient in question, was desperate: her obsessive violent thoughts terrified her, and she was on the verge of losing her family. The treatment consisted of 'exposing' Meredith to thoughts, objects, and images related to her obsessions, while preventing her usual 'responses.' This was meant to decrease her sensitivity to the obsessive thoughts, and thus reduce her anxiety. Luna began one exposure exercise by asking Meredith to state an obsessive thought. Distraught and embarrassed, Meredith whispered a brief statement. Her therapist proceeded to tell residents that she will have Meredith do "20 minutes of reading the thoughts, 20 minutes of writing the thoughts, and 20 minutes of listening to the thoughts." At the end of the hour, Luna would "measure" Meredith's anxiety on a scale of 1 to 10, and decide on a course of action for the following clinical hour. Then, if her score had "dropped enough," she would "increase the difficulty" of the intervention by making an alteration in the exposure.

Similar to Nico's description of the initial session of treatment, time here is structured: minutes are counted, allotted and used for various parts of the treatment, including the "homework" exercises Meredith was to complete throughout the day. Different activities get their own timeframe, and each contributes to the ultimate goal: decrease the patient's anxiety in response to her OCD thoughts. The structure of this temporal environment doesn't leave much room for introspection and exploration. As I show in chapter four, cognitive behavioral therapists eschew psychoanalysts' focus on "developmental events" in favor of "precipitating

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events." The exposure and response prevention treatment that Luna employed is a perfect example of this orientation: instead of talking about the roots of Meredith's OCD, Luna turned to techno-scientific techniques to intervene in those moments that may trigger it. She understood Meredith's symptoms, and knew what targeted interventions she needed to employ to eradicate them. The treatment's high tempo is matched by Luna's determination to stay focused on their concrete goals. Time was not wasted.

From their muted offices in medical buildings, to the white board, and focused, short spans of therapeutic time, the spatio-temporal contexts in which "evidence-based" clinicians did their work signaled their techno-scientific expertise. Practitioners of these orientations aimed to identify their patients' concrete problems, and apply the best, research-supported interventions. Their offices were not meant for exploratory conversations that meandered into traces of the past. Their temporal rhythms did not allow for lasting relationships to develop. Instead, patients learned to be "succinct," and work to efficiently eradicate their problems through targeted cures applied within regimented temporal frames. Theirs is a selfhood (re)constructed in fragments, from interventions aimed at one or another thought or behavior.

Conclusion

The spatio-temporal environment of psychotherapy furthers practitioners' professional project of holding jurisdiction over the problems of everyday life, while conditioning them to embody distinct forms of expertise. Therapists have complete dominion over the therapeutic context, and they resist—either through direct intervention, or indirectly, through medicalization—any attempts on the part of their patients at changing it. Thus, if patients sit in their chairs, they correct or analyze their action. Should they wish to interfere with the temporal boundaries of the therapeutic session, they risk adding yet another 'symptom' to their ongoing

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problems. Therapists' power in the therapy room is also apparent in their approach to sessions'

temporal flow, when open-endedness, or agenda-setting nudge their interlocutors into conformity

with distinct notions of what it means to be a 'good' patient. But more than signaling therapists'

professional authority, time and place serve epistemic ends.

Therapists are at their best in their chairs, and come to have an embodied sense of the

therapeutic hour. The therapy room concentrates practitioners' skills, and makes them into tools

of treatment (cf. Traweek 1988; Knorr Cetina 1999). Knorr Cetina (1999) has noted that Freud

wanted to emulate laboratory conditions when he began his psychoanalytic explorations. He

thought of his work as science, and sought to replicate scientific objectivity in his own practices:

holding therapy meetings in a room apart, and sitting out of the patient's sight (ibid.).[37] Thus,

just as the laboratory makes invisible things visible through its isolation and re-organization of

the "natural" (ibid.), so do the time and place of psychotherapy. These spatial and temporal

constraints make possible a reality in which emotions and thoughts that are difficult to

incorporate or express in everyday life come to the surface. Mary Douglas (1966) has argued

that spatio-temporal frames are a necessary element of rituals, focusing and changing our

perceptions. Inside these 'sacred' therapeutic frames, relationships flourish that depart from

participants' everyday life. The clinical setting—be it the personalized offices of psychoanalytic

practitioners, or the more muted, standardized ones of their "evidence-based" counterparts—

make possible unusual relationships that replicate the panoptic quality of laboratory

arrangements. Such arrangements are symbolic of therapists' power, and constitutive of their

embodied expertise.

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[37] Gutheil and Gabbard (1993) point out that Freud didn't always hold true to those prescriptions—he analyzed one of his friends and disciples while on vacation, regularly having dinner with him while the treatment was ongoing. Such a relaxed attitude towards these boundaries is unusual and considered a breach of professional ethics nowadays. Therapists are constantly reminded that breaching these boundaries can not only hurt their patients but also place them in legal danger (cf. Gutheil and Gabbard 1993; cf. American Psychological Association 2010).

The issue of time is paramount in this discussion. Therapists skillfully managed the multiple temporalities that came to bear on the clinical session: the length of treatment, frequency of sessions, session structure, the tempo of their interventions, and the temporality of their patients' problems. Cognitive behavioral and psychoanalytic psychotherapists attached different meanings to the passing of time, and used it in distinct ways in their interactions with patients. My data is illustrative of what the few other scholars (see e.g., Dubinskas 1988; Traweek 1988; Zerubavel 1979, 1982; Fine 1990) studying time in expert work have pointed to: professional identity and expertise are shaped by the temporal structures within which they are enacted. Dubinskas (1988, p.4) has shown that "within each community [of experts], the patterning of time is a central aspect of social order and process, as well as a focal point of meaning and knowledge production." Time returns in chapter four, where I show that it can also function as a powerful object of therapeutic intervention. In the previous pages, I have argued that different temporal registers foster distinct kinds of embodied expertise: the open-ended and long timeframe of psychodynamic treatments lends itself to a more flexible use of time in session, more latitude for exploration and insight, and affective-relational interventions. The shorter time spans of empirically-supported treatments make for structured use of time in session, a higher tempo of interventions, and a techno-scientific approach to treatment.

These expert practices signal therapists' distinct sources of credibility, and their moral authority. Psychodynamic clinicians' claims to credibility rest mostly with their practical abilities. Though they draw some legitimacy from analytic institutes, and the remaining cultural caché of psychoanalysis, therapists in this orientation have little besides their own skills to sustain their credibility. The relationships they form with their patients must be convincing and helpful enough to keep patients coming back. In contrast, cognitive and behavioral therapists

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have a whole system of expertise to draw on for credibility. The institutional networks they rely on connect them to scientists in laboratories, insurance companies, and, at the broadest level, evidence-based medicine. These ties help locate clinicians in a relatively dominant position within mental health, while their psychoanalytic counterparts are increasingly sidelined. Yet therapeutic expert practices matter beyond the professional sphere. I have hinted in the pages above at some of the ways by which therapists 'discipline' their patients. From the basics of where and when they can meet with their therapists, to the more subtle choices about where they sit, and whether they talk at length about their past or give only a succinct overview of their problems, patients are made to conform to the demands of therapy. In the next two chapters, I show that therapeutic practices have two further, significant consequences for how patients think of themselves and their illnesses: first, in how they consider their emotions, and second, in the temporal view they develop to explain and solve their problems. These effects are reflective of the models of self each of these therapies promotes: one focused on developing narratives that integrate past and present relational troubles, another emphasizing targeted interventions, measures, and a restricted sense of the past. The following two chapters detail the affective-relational and techno-scientific expert practices that foster such divergent approaches to mental and emotional well-being.

Chapter 3. *The affect and science of psychotherapy*

Psychotherapists are skilled at lending an empathetic ear, and often, that is the most important aid they can provide a patient in distress. Yet practitioners of psychoanalytic and "evidence-based" approaches also aim to equip their patients with skills and tools they can use to overcome emotional problems. They offer distinct 'therapeutic technologies' to people in need: in psychoanalytic therapy, affective self-reflexivity is thought to be the key to gaining insight into the links between past problems and present conundrums. Assiduous self-analysis is thus the goal of every session, and therapists and patients alike practice it together. The "evidence-based" therapies are also concerned with affective self-awareness, but this is secondary to the actual targets of treatment: thoughts and behavior. Patients are equipped with tools to change their self-cognitions and patterns of behavior, which in turn can lead to an alteration of their negative feelings. Thus, what becomes evident upon closer examination of these distinct strategies for alleviating emotional and mental pain is that clinicians wield fairly distinct 'technical' skills. Psychoanalytic clinicians rely on their own affect as an epistemic tool, while cognitive and behavioral clinicians enroll inscriptions and quantification in their pursuits. Expertise is differently distributed in these two systems of knowledge. In one, the practitioner holds the key to expert insight, while in the other, individual clinicians are embedded in expert systems that connect them to academic counterparts who devise and test therapeutic interventions.

Developing tolerance for intense emotions

Empathizing with people who suffer from psychological problems can be a difficult task. Such patients can harm you, deny they have a problem at all, or be less than forthcoming with their difficulties (Luhrmann 2000). This is partially what makes them challenging to treat. And just as medical students learn to develop nerves of steel when dealing with dying and decaying human bodies (Parsons 1951; Smith and Kleinman 1989), so psychotherapists acquire the ability to withstand intense emotional states in close interpersonal situations. They sometimes fear their patients, or feel disgusted by them, often distrust them, and worry about what they may unexpectedly do (Luhrmann 2000). The "feeling rules" (Hochschild 1979, p.566) of psychotherapy dictate that therapists remain calm and composed through the session[38]. Such outward calm can serve as a therapeutic tool, in two ways. For all therapists, it facilitates the communication of empathy. It can also help them model desirable treatment outcomes, such as when cognitive behavioral clinicians engage in "exposure exercises" with their patients. Yet this calm is not an innate quality, it is a skill that therapists build over time, one that becomes an essential element of their habitus.

Novices learn early on that they have to tolerate intense emotions. The most challenging circumstances are those in which patients' stories are either highly affectively charged (e.g. a history of abuse), resonate with the therapist's own past (e.g. going through a parental divorce at a young age), or somehow upset the therapist's moral values (e.g. obsessions over taboo issues). Rather than expressing their "visceral" feelings to patients, trainees learn to focus their efforts on embodying composed, calm, and, most importantly, in-control ways of being. An experienced

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[38] Some of my interviewees told me that one exception to this rule are moments when a patient's particularly disturbing or painful story leads them to express greater empathy through anger or sadness. I discuss these exceptions at greater length in a separate paper.

analyst told residents that the ability to bear patients' pain, and sit with their fears and anxieties is essential to forming trusting therapeutic relationships:

> I think that one of the most helpful techniques to be aware of is staying in your chair, meaning that the patient comes and tells you that they're afraid to talk to you because they're worried that this and the other might happen, and then they do talk to you and nothing bad happens. [It] furthers the treatment. Helps to detoxify their worries and fears so that she shares some of her pain with me and I'm comfortable with it, and interested, and she feels I'm understanding her […].

"Staying in your chair" symbolized, for this analyst, a therapist's ability to tolerate patients' intense emotions, as well as their own reactions to the stories they hear in clinical sessions. The clinician's body language, along with what they say or do not say, are essential elements of their affective communication with patients. Luna, the experienced cognitive behavioral therapist I introduced in the previous chapter, was about to conduct an exposure treatment with Meredith. She warned trainees, "I have assured her that none of you are going to be horrified—if you're gonna be horrified, please use your poker face!" Luna was vehement that the only appropriate outward reaction to Meredith's sexual and violent obsessive thoughts was calm, empathetic, and non-judgmental. She emphasized the therapeutic functions of such an attitude, and told the class that she herself had to go through her own informal "exposure" treatment to become comfortable doing this work:

> I hope also that you see that [patients] need you to be very comfortable with this: [*change of tone, to somewhat cheery, and unaffected*] 'Okay well, so when you're thinking about [watching your best friend get tortured], do you like it? Okay, well, let's [write] that down!' Because [the patient] is looking to me to see how comfortable I am. […] Because she can say you know, 'Luna is throwing these things around, she must really believe that these are just words, and these are just thoughts, and maybe that means that there's something to this [treatment]'... But it takes some practice, I didn't start out being this comfortable!

Tolerating intense feelings and being at ease with uncomfortable issues is an embodied skill: not only did Luna employ a different tone when role-playing the interaction with an

imaginary patient, but she also pointed out that patients will be "looking to me to see how comfortable I am." This could be taken in a literal way: Luna's body language—her facial expression, her tone—communicates to the patient the confidence and ease that comes with the belief that her seemingly insurmountable problems can be solved. The "poker face," and, as the analyst put it, "staying in your chair," thus serve therapeutic functions: through it, therapists model composed and calm ways of being. There is nothing the patient can say that the therapist cannot handle. Their expertise and professional authority are upheld.

And yet while such emotional control is an essential part of every therapist's toolkit, affective states play distinct roles in their work. For psychoanalytic psychotherapists, emotions are an essential source of knowledge about their patients' problems. They use them, from diagnosis to treatment, as clues to what the patient may be feeling, and to the kind of interpersonal troubles they may have with family and friends. Using emotions as epistemic tools, along with skillfully drawing out the affective meanings of significant developmental events (an issue I return to in the next chapter), are integral to these therapists' affective-relational expertise. In contrast, cognitive and behavioral clinicians relegate affective reactions to a secondary role in their expert practices. Their approach comes closer to what previous scholars have described as "affective neutrality" (Parsons 1951), or, later, and more accurately, as "detached concern" (Lief and Fox 1963). Instead of making knowledge out of affect, their expert work consists of the skillful and creative application of inscription and quantification—the building blocks of "techno-scientific" expertise (cf. Latour and Woolgar 1979).

Though the tools therapists use to treat different disorders vary little across diagnoses, for exposition purposes I will focus here on how psychodynamic and cognitive behavioral clinicians respond to Axis I disorders (in the next chapter I turn to their treatment of Axis II disorders, the

second most used group of diagnoses in psychotherapeutic practice). The *Diagnostic and Statistical Manual of Mental Disorders IV-TR* is organized around five axes: psychiatric syndromes (Axis I), personality disorders (Axis II), physical problems (Axis III), psycho-social and environmental conditions (Axis IV), and the patient's general functioning (Axis V). Axis I disorders are thought to have biological bases (Luhrmann 2000, p.47), and include mood and anxiety disorders, some of the most commonly diagnosed problems in American psychiatry today. Of these, depression is both one of the most prevalent mental illnesses in the US[39] and most ubiquitous diagnoses assigned by practitioners in this study. Data from a 2012 report by the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that depression in the US has been hovering between 7.3% of the population in 2005 and 6.5% in 2009. Major depressive disorder has significant costs not only to those who suffer from it, but also for society. Greenberg (2003) and his collaborators estimated that the costs of depression in the year 2000 were $83.1 billion, of which $26.1 billion (31%) were direct medical costs (medical treatments in inpatient and outpatient settings), $5.4 billion (7%) were suicide-related mortality costs (estimated as lost lifetime earnings), and $51.5 billion (62%) were workplace costs (days missed from work, and reduced productivity while at work). Almost half the patients who suffered from a major depressive episode in 2009 received a combination of talk therapy and medication (44.6% to be exact; SAMHSA 2012, p.135), while 14.3% were treated with talk therapeutic methods alone. Given depression's prevalence, and the role that talk therapists play in its treatment, psychotherapeutic expertise is highly consequential for individual patients, and society as a whole.

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[39] Mathers and Loncar (2006) projected that by the year 2030 depression will rank fourth among all diseases worldwide, and first in high-income countries.

Affect and self-awareness in psychodynamic treatment

Novices in psychodynamic therapy are encouraged early on be aware of, and reflect on

their affect during treatment. Andrea, a fourth year resident, presented the case of a depressed

middle aged man. She introduced the patient as "56 years old, [with a] long history of low lying

depressive symptoms, and never really got treated...." She noted the way he talked about

feelings ("uses a lot of intellectualization") and some of the early memories he had brought up in

their initial interview. She connected these to his assertion that he suffered from "melancholia,"

and to his relationship problems. As on other occasions, Terry used this opportunity to

underscore the importance of emotions to residents' work:

> Terry: […] what kind of feeling did you get from this guy?
> Andrea: He chooses his words very carefully […], he became a little bit more
> comfortable with me... he does a lot of isolation of affect but he did finally break down
> crying in the last session just out of frustration... he's reserved, but not guarded... but I
> kind of got the feeling that if I got to know him he would open up a little more....
> Terry: Did you wanna get to know him?
> Andrea: Yeah...

It was important, therapeutically, whether Andrea wanted "to get to know" her patient. If

her interest was piqued, and she "found something to like" about the patient (a requirement that

many of my interviewees considered essential to treatment), then she would be able to help him

by forming a lasting and affectively rich therapeutic relationship. But Andrea's reactions to her

"melancholic" patient did not develop in a vacuum, as she took careful note of his level of

comfort, and his affective experiences: "isolation of affect," "frustration," "reserved not

guarded." She focused on her patient's emotional life, and her own affective reaction to it.

Terry repeatedly told residents that the "data" that psychodynamic therapists have to

work with is both "verbal" and "experiential." Thus, Andrea was to rely on "data about how [the

patient] looks, how he talks, what your affective response to this guy is...." Patients' words are

not a sufficient source of knowledge for the therapist who seeks to uncover unconscious conflicts that patients themselves may not be aware of. Rather, clinicians' own feelings play an important role in how they understand patients' troubles. This starts with diagnosis, when, Terry said, "one of the things that help identify a central problem is feeling it essentially...." Luhrmann (2000, p.113) described psychiatrists diagnosing borderline personality disorder based on how they felt (the chief resident called it the "meat-grinder sensation"). Light (1980, p. 183, italics in original) similarly referenced a resident distinguishing "a sociopath from a schizophrenic by how she *felt* when he threatened her. If she felt he really meant it, he was a sociopath. If not, he was a schizophrenic." Residents in their third and fourth years shared similar accounts in the psychodynamic core class I observed. Terry warned them that "you try to keep your stuff as far out of the field as you can, and what patients particularly with personality disorders are good at doing is pulling you in... and if one can back off and recognize that you're getting sucked in... it's very helpful, because when you can separate your stuff from the patient's stuff then you can work on it much better." On a different occasion, he recalled "a local MD and analyst who says, if a patient walks in feeling bad and you're feeling good, and they walk out and they're feeling good and you're feeling bad, that's the harbinger of a personality disorder." Monitoring oneself was an essential skill in psychodynamic practice, both for therapeutic and professional reasons. Therapeutically, it helped clinicians use their emotions as epistemic tools. Professionally, it allowed them to identify possible openings toward boundary-crossing which they could, in turn, close off. Moreover, it lent them the credibility necessary to justify the kind of idiosyncratic and affective-relational knowledge they relied on during treatment.

This discussion should not be taken to mean that practitioners of psychodynamic therapy rely exclusively on their affective reactions for diagnosis. After all, distinguishing schizophrenia

from sociopathy, or depression from anxiety presumes a knowledge of what those categories mean in the DSM, how they differ, and what kinds of affective reactions they may awaken in the attentive clinician. All the therapists I spoke with had at least a basic knowledge of these classifications—though, as I show in the next section, not all thought about their affective implications. Yet despite such common knowledge, psychodynamic practitioners, as I pointed out here, and in the previous chapter, eschew DSM "checklists" in favor of other indicators. Letting patients talk freely about their motives for seeking psychological help is often thought to be a more productive approach than the diagnostic inventories used by "evidence-based" practitioners. In such relatively open-ended explorations, therapists depend on their emotions as epistemic tools.

Difficult, unstable patients tested the limits of these clinicians' affective abilities. As I mentioned earlier, many participants in this study (regardless of orientation) pointed to the necessity of "finding something to like" about the patient to make their work less difficult. This was especially important for psychodynamic therapists who relied on empathy and self-reflexivity as treatment tools. In one extreme example, a therapist who prided himself on his ability to treat fairly disturbed patients told me that it was nearly impossible for him to work with sex offenders who had served prison sentences. For him, empathizing with such patients would be a very difficult task. On a different occasion, Janice, an experienced psychodynamic therapist and psychoanalyst, discussed a feeling of "dread" that she sometimes got before seeing a patient who had voiced physical fantasies about her:

> I'm always trying to gauge […] how am I reacting to this person […] if I'm feeling put-off or uncomfortable. […] But you know, coming to understand, for instance, that the dread had something to do with, this is a guy who could very well jump into my lap if I'm not clear with him... that those things aren't gonna happen here, you know. […] I can use it in a number of different ways, one, diagnostically […]. I don't usually feel dread for someone who's higher functioning, right, but can sometimes feel dread with

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someone who has kind of a more unstable social, you know, interpersonal world. Or […] it turns out this guy was actually hospitalized at one point for suicidality, so you know, I can make use of my dread diagnostically. […] That there *is* something to be concerned about here....in terms of his ability to hold himself intact.

Janice used her sense of "dread" as a way to understand something about her patient. She didn't ignore it, or attribute it to any number of alternatives (e.g. therapy is difficult, tiredness) but considered it "diagnostically." Like other of my interviewees practicing psychodynamic therapy, she examined her affective experiences to assess whether they would help her understand the patient. When such self-examination led her to attribute her feelings to the therapeutic interaction, these affective states became veritable sources of knowledge. Janice's hunch about her patient's difficult emotional life was confirmed when she learned that he had been hospitalized, and had an "unstable interpersonal world." Her concerns about the potential that he would initiate closer physical contact, as he "could very well jump into [her] lap," contributed to the diagnostic value of "dread," and to her treatment strategy. With this patient, she focused on enforcing and maintaining strict boundaries, and being "clear" about what can and cannot happen in therapy. Expertise here is control of self and other.

Intense self-reflexivity—the kind of attention to self-experiences that therapists hope to foster in their patients as well—makes possible these clinicians' reliance on affect as a source of knowledge. For this reason, Terry often invited residents to think and talk about how they felt. This was not the simple and often satirized interchange typical of psychodynamic therapy—the "how does that make you feel?" that many practitioners fall back on as a tried-and-true method for getting patients to talk about their emotions. These were exercises in a kind of self-awareness that challenged residents' notions of what doctoring means. Medical school prepared residents to deal with patients' problems while paying little attention to their own experiences, beyond the inevitable affective reactions they must channel into empathetic understanding

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(Smith and Kleinman 1989). Yet psychodynamic therapy requires them to develop and sustain

an "awareness of the difference between what a patient thinks and feels, what a therapist thinks

and feels, and how each thinks and feels about the other" (Luhrmann 2000, p.66). The first and

perhaps most challenging lesson for residents was to begin recognizing that their own feelings

mattered, and that they impacted how they did their work.

Along with the residents, I had the opportunity to observe some of Terry's therapy

sessions with John, the patient I introduced in the previous chapter. A young man whose father

had suffered a life-threatening accident, John was struggling with the experience of trying to

relate to him in his final days. After watching an especially poignant part of a session, Terry

asked the residents to talk about their reactions:

> Ely: I'm finding myself feeling sorry for this guy. He has this intense ambivalence for
> his dad that he had hoped one day would be resolved, and to know that you can't actually
> get this resolved… the thought is kind of frightening to me... thinking of relationships in
> my own life, if they were cut off tomorrow... soon I would not have an opportunity to fix
> them…
> Terry: That's a really important thing technically! […] It would impact what you hear
> and what you are suggesting to him... how you can use it, is thinking through in your own
> mind, very quickly, about 'how can my experience be useful with this patient now?' And
> it can be very useful because you're more clear [sic] than the patient is...
> Ely: Hopefully!
> Ravi: And the fact that as a doctor you're trained to deal with that…

In this exchange, Ely openly shared his affective reaction to the material discussed in

session, and Terry affirmed the importance of such self-awareness. A therapist's emotions shape

his perceptions of the patient, changing "what [he] hears" as well as what kinds of interventions

he makes. But, Terry pointed out, since such reactions could impact the direction of treatment,

they could also become valuable therapeutic tools. This is made possible by medical training,

which, as I pointed out earlier, insulates therapists (and perhaps residents especially) to the

vicissitudes of dealing with intense emotions—though of course, as Ely notes, this is only a

"hope" not a fact. Unlike other situations that I detail below, here the emotional distance associated with the role of doctor can aid rather than detract from the therapy.

Self-awareness helps therapists balance affective involvement and professional distance—achieving just the kind of "detached concern" that Lief and Fox (1963) believed was characteristic of medical doctors. But the work that emotions do here goes further than the kind of empathy these scholars of professions had in mind. Clinicians use their emotions to diagnose their patients' problems, and work through them. One way to do this is to attempt to understand how the patient may be feeling in a difficult situation. Another, as I show below, is to attribute one's feelings to the patient's interpersonal problems, and learn how friends and family may be feeling in response to the troubled person. Personal experience can play an important role in both of these processes. Terry again:

> One thing you can do is to think about the specifics of my reaction [to a similar situation]. I have somebody ill, and I don't know whether to run towards them or away from them, and float those feelings as a way to understand how he's dealing with this. So saying, "it sounds like you're feeling like you don't have a place to put your own feelings..." That's based on your own experience and you're making it very, very specific. And the hope is that the patient feels that the alliance has gotten very close. That there's a closeness and empathy... empathy is not saying "yeah I lost my father too," you don't even say that I've gone through that too, but rather, might it feel this way to you? […] So if I were to dispense fatherly advice, 'it's really hard to lose someone you love,' we don't know that it's really hard for him... you're not facilitating what the patient is feeling, but you're prescribing an experience for the patient.

Terry attempted to show the residents how they could use their feelings to understand the patient. He noted that relationships are complicated ("I have somebody ill, and I don't know whether to run towards them or away from them"), and that capturing the patient's reactions ("we don't know that it's really hard for him") through the filter of one's own life experiences is an even more delicate process. Personal experience informs therapists' sense of patients' affective responses, but is not to be disclosed directly. Such disclosure would lead to a weaker

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alliance, and deny the patient a chance to explore and express his own conflicting affective

reactions. Another resident reiterated that "the tension might be between using yourself to help

[patients] learn about where they are, rather than dictating the way they should be." This

captures psychodynamic therapists' efforts: they aim to help patients understand themselves

better by using their own affective states in session, without imposing a particular vision of how

"they should be." This is a different epistemic project compared to that of cognitive behavioral

therapists who consider affect peripheral to their work. Yet these therapists' claims belie the

larger project of the psychological sciences. In doing their work, clinicians promote

"technologies of the self" (Foucault 1988) that instill in their patients particular versions of what

it means to be a functioning human being. As I show in the following chapter, the work of

therapists in both orientations impacts patients' sense of themselves by shaping their "inner

time" (Garfinkel 1967) and the narratives that they tell about themselves and their problems.

Therapeutic expertise is thus imbued with a moral authority that practitioners misrecognize as

epistemic competence.

Clinicians in psychodynamic psychotherapy consider their emotions to be a significant

source of knowledge in a second sense: they are indicative of the feelings experienced by

patients' significant others. Ely, nearing the end of his treatment with a depressed patient who

had difficulties making close friends, recalled the trajectory of their treatment:

> I would try to encourage her, 'think about things, if something comes up over the week,
> we can talk about it, any dreams you'd had,' and she never would […]. And finally […]
> if anything got deep at all, it was toward the end of the session. I pointed this out to her
> and she said 'yes you're right,' and I said to her 'it's interesting, I'm wondering if that's
> how other people feel in relationships with you, if you stay on the surface and things just
> kind of drift apart'....

Ely told the group that he had felt "frustrated" with his patient, but soon realized, with his

supervisor's help, that there was more to his affective reactions. He knew that his patient craved

closer relationships. He experienced this when, towards the end of sessions, she would start

going "deeper" just so she could keep him interested until their next appointment. She was one

of the "door-knob" patients whose temporal practices therapists had to 'discipline.' But her

overall distance and general lack of interactional and emotional depth led Ely to take their

relationship as typical of those she formed outside of therapy. Feelings of boredom and

frustration allowed him to realize that the patient's emotional distance got in the way of her

building enduring relationships with others in her life. He told his colleagues: "I also think that

it was good evidence for her. […] It was so obvious to say 'look what's going on in here, and

what's going on out there, and how similar they are.'" This is reflective of the "clinical wisdom"

that Terry hoped to instill in the residents. He told them: "we don't know what [John]'s like in

the world, we only have his report, but we're trusting that the way he behaves in the office is

reflective of the way he is in the world. It's clinical wisdom." This illuminates the assumption

that there is an underlying dynamic that motivates patients' behaviors in and out of the office.

Psychodynamic therapists hope to grasp how patients' actions, ideas and feelings are

inflected with traces of their past. Most importantly, they must become skilled at "reading" this

past in the context of the clinical relationship. The connection between affect and self-awareness

is paramount here. Therapists must be constantly on guard against their own needs and desires

entering the clinical situation and "distorting" the relationship such that the patient's

transferences—the most important elements in the treatment—get muffled[40]. Psychoanalysts

call therapists' (conscious or unconscious) affective reactions in the clinical setting

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[40] This is one of the primary reasons that psychoanalysts are required to undergo analysis (psychodynamic therapists are expected to be in psychotherapy at some point in their careers as well). The assumption is that, in analysis, therapists work out their own past such that they could better harness it to understand patients. More recent analytic thinking allows that therapy room dynamics are co-constituted by both therapist and patient (Ogden 1994)—this is representative of the phenomenological and relational turn that Hale (1995) and Zaretsky (2004) identified in American psychoanalysis.

"countertransference." Theodore Jacobs, an analyst and author of multiple works on this topic, has argued that this phenomenon includes "not only emotional responses in the analyst deriving from his interactions with the patient, but also those emotional reactions that color and influence his perceptions of the patient, whatever their source" (1991, p.182). In other words, practitioners' affective reactions, having the potential to "influence" their "perceptions of the patient" need to be examined. Countertransference is thus not simply meaningful to the therapist—as an indication of her own conscious and unconscious processes—but can gain epistemic value when attributed to the therapeutic encounter. Janice's sense of "dread," Ely's "frustration," and Terry's own attempts at drawing on his sense of loss to help John are all examples of how the process works. This approach is radically different from cognitive behavioral interventions which, as I show in the following section, seek to minimize the impact of such affective reactions, and replace therapists' subjective perceptions with classifications of symptoms, and measurements of affective states.

When practicing psychodynamic psychotherapy, residents found themselves pulled in divergent directions by their dual roles as doctors and therapists. This "sociological ambivalence" (Merton and Barber 1976; Coser 1979; Light 1980) helped them understand their own countertransference reactions. Some of the residents were keenly aware of how emotions and desires associated with their distinct but temporally overlapping roles may enter the therapeutic encounter. Zoli, a third year resident, told his colleagues about one of his patients: "her life patterns have repeated over the last few years and she gathers the data and she asks me 'what do you think? What is the diagnosis?' And I say, 'why do you want me to reassert this authority?'" Zoli was faced with the paradoxical situation of being a doctor denying his patient a diagnosis. He didn't want to assume the "authority" of science, of "evidence-based" medicine,

and place emotional distance between him and his patient. Rather, he hoped to achieve the affective-relational ideal: to be a thinking and feeling person, sitting with his patient, and understanding her difficulties by virtue of his feelings, identifying her problems in the therapeutic relationship. Such an interaction is unlikely in a cognitive behavioral treatment where therapists focus precisely on assigning a diagnosis, and identifying the specific intervention recommended by research studies. But residents found that feelings congruent with their roles as doctors can get in the way of psychodynamic treatment. In another example, during a discussion of strategies for encouraging patients to talk about their sexual history, Lucas pointed out:

> Sometimes my countertransference can be deceiving 'cause [patients] come to you and say that they've never talked to anybody about this before and then they unload, and they come back the next time and they hate you because they were re-traumatized by talking about the [sexual] trauma…

Lucas's ideological commitment to helping others, and his wish to do so, were satisfied when a patient who had "never talked to anybody" about her traumatic past opened up to him. But his "countertransference" blinded him to other indicators that could have given him a hint of the patient's later regret. He was too caught up in being a good doctor to properly understand and guide the patient. This discussion may seem puzzling. Shouldn't psychodynamic therapists (like all therapists) want to learn as much about their patients as quickly as possible so as to identify their problems? Why would Lucas want to limit how much information patients share with him in the initial sessions, and keep his desire to help them in check? Psychodynamic therapists' approach to treatment differs from that of other mental health workers; they are not trying to collect information to devise a treatment plan, or decide upon an appropriate psychiatric medication. Rather, they seek to know the degree to which what patients tell them, and what they leave out, reflects something of the emotional conflict they are thought to struggle with, and

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reenact in their interpersonal relations. Another resident noted that to recognize such underlying

dynamics "requires a lot of affect tolerance on the part of the therapist." Zoli and Lucas

understood that, in that moment, with their patients, they needed to resist the demands that the

"front stage" imposed upon them—to act as doctors collecting information and assigning

diagnoses—in order to get "backstage" [41] (Goffman 1959), to the transference that the patient

was playing out in the interaction.

Drawing on their affective states to learn about patients' problems was thus a source of

conflict for residents professionally brought up in a medical world revolving around "scientific

knowledge," "evidence," and targeted interventions that overwhelmingly took on a

pharmacological bent. The psychodynamic epistemic toolkit presented residents with a second

source of conflict that crystallized in their approach to the medical record. In contrast to

cognitive behavioral clinicians who, as I show in the following section, relied on extensive

practices of inscription, psychodynamic therapists approached such activities with ambivalence.

Not only did they have difficulty translating their knowledge into terms understandable to a

medical audience composed of non-dynamically inclined colleagues and insurance companies,

they also eschewed inscription in their interactions with patients. Patricia, an experienced

psychoanalyst, warned residents that the psychodynamics of treatment may be significant to the

therapist and others similarly trained, but would be potentially missed or worse, misinterpreted,

by those not familiar with the process. Code-switching thus became an important part of being a

psychodynamic trainee working in a medical hospital.

This was perhaps one of the clearest indicators for residents that psychodynamic therapy

was different from the other interventions they practiced. They, and other psychodynamic

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[41] I am using the term "backstage" here somewhat differently from Goffman's (1959) original formulation to include not only what actors may be consciously thinking and feeling that they do not display to others, but also unconscious dynamics that psychoanalysts think of as essential motivating forces.

therapists working with clinicians of distinct orientations, and with insurance companies, quickly

learned to distinguish between two separate audiences for their notes: outsiders (e.g. non-

psychodynamic therapists, patients, insurance panels) and insiders (other psychodynamically

trained therapists). Patricia cautioned:

> So let's say you think about transference and countertransference, which is informative
> for our purposes, but if I put that in [the medical record], about 'boy, I wanna kill this
> patient as they walk out the door' […] most people wouldn't understand what you were
> talking about! You know we are describing an enactment, and we know what that means,
> but think of a patient reading that.... And I've had the experience of someone wanting
> notes in the middle of treatment and I think that can affect the treatment.... There's a
> protection there... for what you're trying to create....

To Patricia, notes are solely for the use of insiders, those who "know what [it] means" for

a therapist to have violent thoughts about a patient. This is predicated on the assumption that

these feelings are indicative of the patient's own pathology, a pathology that is manifested in the

relationship between therapist and patient in the "transference." Even patients are not privy to

the therapist's notes: such a demand can "affect the treatment" and not necessarily in a positive

way[42]. Thus, to protect themselves from "most people"—i.e. other clinicians, patients, insurance

companies—who "won't understand what you're talking about," residents were advised to be

careful about what kinds of "psychodynamic formulations" they enter into the Clinic's online

system. The implication here is that the psychodynamics of treatment carry significance to the

therapist and others similarly trained, but that significance will not only be missed, but

potentially misinterpreted by those not familiar with the process. This makes psychodynamic

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[42] This may have been one of the factors that contributed to a cognitive behavioral practitioner's perception that she
was not entirely truthful with her patients when practicing psychodynamic therapy during her years in training.
Significant in the following excerpts is also her sense that putting things on paper makes them more transparent or
truthful. She told me: "I felt like there was a conceptualization in my mind and I knew that what I was doing in the
therapy was I am supposed to be doing some sort of corrective experience by having a relationship with this person
but it wasn't explicit. […] And it felt—I don't know—it felt deceptive or sneaky. […] And so it was comfortable to
me to have a therapy where you're very explicit and you're working with them and I often will show 'em on paper,
"Here's what I'm thinking about it. It seems like there's this cycle going on between this thought and this behavior
and this." You know, and so I will often diagram it out with them and I'm collaborating with them and showing
them, 'Does this fit for you?'"

therapy a closed system of authority, nearly autonomous in practice. This is an important element of professional power (Freidson 1970), but one that has also contributed to the marginalization of psychoanalytic psychotherapists, placing them in a precarious position as providers of mental health services. In contrast, their "evidence-based" counterparts, drawing on the legitimacy of science, can rely on closer ties to the financial world of insurance companies, and claim a more central position in the field of mental health.

Terry reiterated the distinction between psychodynamically useful information, and the kind of data insurance companies and other therapists would be interested in: "some kind of dynamic formulations should absolutely go up there [in the medical record]... 'patient has a history of being unable to control her or his self-destructive impulses'.... But that's different from 'the patient sees me the way she saw her sexually abusive father'...." Later, Patricia reminded the residents that insurance companies are "using […] notes […] to determine whether something is medically necessary." Moreover, she told residents, "you're gonna put the medication, the symptoms because that's what's necessary for the patient to get their insurance. If you put anxiety issues they will not get reimbursed, but if you put heart palpitations, difficulty sleeping, they will.... I would not necessarily put the dynamic interpretation because that's not what they're looking for." Insurance companies care about the medical necessity of treatment, and the more physically apparent such necessity is, the better: "heart palpitations" are more convincing than "anxiety issues." Residents thus learn to develop a form of double speak to communicate with such organizations. The "dynamic formulation" rests on distinct assumptions about mental illness, tying it to patients' affectively charged developmental history. Residents, Terry stressed, should "put on their white coats when filling those [insurance forms] out."

Code-switching thus becomes an important part of being a psychodynamic therapist in the medical system, and the medical record a testing ground for clinicians' belonging to two distinct worlds: that of managed-care and evidence-based medicine, and that of psychoanalysis and professional autonomy. A mid-career practitioner told me that not only were her experiences treating people who used insurance and those who paid out of pocket different, but that she also had to be "more aware of […] the things that insurance companies want to hear" with the former. The puzzle of dealing with insurance companies as a psychodynamic therapist reaffirms these practitioners' paradoxical position as both insiders and outsiders to the world of mental health. Practitioners of this orientation thus lead a double life: they communicate with insurance companies by employing the DSM and "behavioral terms," while to themselves and the rest of their community, they think and talk in "dynamic formulations."

The problems of transcribing and translating psychodynamic affective knowledge originate in the therapy room. Psychoanalytic psychotherapists seldom engaged in inscribing activities during sessions—activities that could denote their status as experts (e.g. Zimmerman 1976; Silverman 1987)—emphasizing instead affective engagement. From the inception of the field, Freud (1963, p. 118) discouraged note-taking during sessions. He thought it would be distracting to the therapist, while making the patient feel like their interlocutor's attention is focused elsewhere (ibid.). Freud's ideas have held strong. Terry told residents: "I rarely write notes during session, and if I do, it is because I want to remember a specific piece of data... as more experience comes together, I get an emotional mindset with each patient...." During three evaluation sessions with a patient, Terry learned a great deal about his tumultuous life, but he only wrote down the names of people important to him, and details about his drug use.

Otherwise, he relied on his affective reactions to remember details about the patient's complex history.

But psychodynamic therapists do not eschew inscription altogether. While the demands of insurance companies and medical clinics constrained them to think in DSM and behavioral terms, "dynamic formulations" allowed them to express their views in psychoanalytic terms. One of the ways in which practitioners arrived at such "dynamic formulations" is by writing "process notes." Such notes, one of my interviewees noted, are "meaningful" for the therapist, and do not have to cater to the needs of clinics or insurance companies. As another interviewee put it, process notes capture "everything that happened in the session." This includes a transcript (from memory) of the conversation between clinician and patient, as well as other pertinent bits of information: the patient's demeanor, the therapist's reactions, and any other pieces of experiential data that can contribute to as accurate a reconstruction of the therapy hour as possible. Not all therapists wrote process notes: Terry made clear that they "are very taxing" not only on the therapist's time, but also on their mental energy. This is especially the case when clinicians see multiple patients a day. Therapists undergoing training in psychoanalysis were required to write such notes after every analytic session—these were the data they presented to their supervisor. Terry and Patricia encouraged residents to write process notes for their psychodynamic patients. They made the case that these can be "particularly helpful when you're in the midst of a difficult stretch of therapy... it can be useful to go back and rewrite... and that provides data to use in pattern recognition." When presenting case material in group supervision, residents discussed not only a history of the case, but also snippets of process notes they considered particularly illuminating of underlying dynamics in the therapeutic relationship. Yet, as I argued above, much of the information contained in these process notes, and the

"dynamic formulations" they make possible, serve only a select audience of like-minded colleagues and supervisors. When fulfilling the demands of their positions at the clinic, and entering data into the patient's medical record therapists referenced "psychodynamic formulations" with caution.

We begin to get a sense here of the connections linking psychodynamic clinicians' affective-relational practices to their quasi-autonomous and relatively peripheral position in the world of mental health. These therapists relied on an unusual source of knowledge—their emotions—but had difficulty communicating the import of their insights to an increasingly skeptical medical audience (Hale 1995; Zaretsky 2004). Practitioners of psychoanalytic psychotherapy drew clear boundaries between outsiders and insiders. This makes psychodynamic therapy a closed system of authority, nearly autonomous in practice. Oversight is left entirely to experienced members of the profession, supervisors, and analytic institutes. This is an important element of professional power (Freidson 1970), but one that, viewed in the historical context of the last several decades, may have contributed to sidelining psychoanalytic psychotherapists in the mental health system. Shunning the trappings of "evidence-based" mental health practice, and maintaining autonomy from insurance companies, these practitioners are losing ground to their better positioned colleagues in pharmacology and cognitive behavioral therapy (cf. Strand 2011).

But this is not to say that psychodynamic therapists' expert kit is less epistemically viable. The "emotional mindset" and "clinical wisdom" Terry and Patricia tried to instill in their residents are essential epistemic tools. This approach challenged residents' views of what it means to doctor as they learned how to use their feelings to gain knowledge about their patients' problems   Terry explained to the residents that psychodynamic therapy requires that they depart

from the "disease model of pathology" that the DSM embodies, and begin thinking about "how does this person function?" "Understanding who the patient is" forms the core of the psychodynamic pursuit, and therapists' feelings are the key to its success. The employ of affective states as veritable epistemic tools is constitutive of psychodynamic therapists' embodied affective-relational expertise.

Inscription and quantification in CBT

"… one can, in principle, master all things by calculation."

Weber ([1919]1958, p. 117)

In a classic statement of CBT's 'scientific' approach to mental illness, Aaron Beck argued that "cognitive techniques are aimed at delineating and testing the patient's specific misconceptions and maladaptive assumptions" (1979, p.4). He continued:

> This approach consists of highly specific learning experiences designed to teach the patient the following operations: (1) to monitor his negative, automatic thoughts (cognitions); (2) to recognize the connections between cognition, affect, and behavior; (3) to examine the evidence for and against his distorted automatic thought; (4) to substitute more reality-oriented interpretations for these biased cognitions; (5) to learn to identify and alter the dysfunctional beliefs which predispose him to distort his experiences. (1979, pp.4-5)

From his first writings about cognitive therapy, Beck emphasized the scientism of the interventions and the research studies that backed his assertions (e.g. 1967, 1976; Clark and Beck 1999). We can get a glimpse of this in the very language by which he described the treatment, a distillation of the scientific pursuit where the object of inquiry is the match between patients' inner thoughts and an objective reality. This reality is granted an ontological status similar to nature in the hard sciences: it is objectively out there, and patients can grasp it with the help of their clinicians. Patients "learn" to "monitor" their thoughts, identify "biased" "assumptions," "test" them against "reality," "examine" the "evidence," and, through a number of "operations"

and "techniques," modify them to more accurately reflect reality (ibid.). The operations and techniques hinted at revolve around a complex set of inscription practices, with particular emphasis on quantification, and stand in direct opposition to the talk and emotions-oriented approach of psychodynamic therapists. On more than one occasion I have had interviewees who practiced cognitive behavioral therapy point out that one of the biggest barriers to doing this kind of treatment was patients' expectations that they could simply come in and talk. In CBT, forms, measures, and behavioral exercises supplant narrative.

Inscription creates order from chaos, transforms unwieldy phenomena into diagrams and tables, and makes possible the creation of scientific facts (Latour and Woolgar 1979; Latour 1990, 1999). It also, albeit deceivingly, bestows a certain transparency on the objects of knowledge represented. Inscription (and the larger laboratory apparatus that makes it possible) makes the scientist a scientist, just as much as the scientist makes inscriptions. Inscriptions in the psychological sciences range from books and articles on therapeutic theories and techniques, to the results of experiments and research studies assessing the efficacy of such techniques, to notes that make up medical records, and the forms therapists and patients fill out over the course of treatment, to name just a few. In many inscription activities, "evidence-based" and psychoanalytic psychotherapists are no different: they all produce books and articles, fill out forms, and take notes. But a significant difference emerges when one focuses on their activities during therapy sessions. Whereas cognitive behavioral psychotherapists make active and extensive use of inscription to come to know their patients' mental and emotional states, psychodynamic therapists are much less likely to do so, relying instead, as I showed above, on their emotions as sources of knowledge.

First, practitioners of CBT (akin to interpersonal and dialectical behavioral therapies) use inscriptions to delimit, order, and codify patients' disparate experiences into specific diagnoses. They actively work on bounding off their field of intervention, and turning patients' emotional states into discrete problems that can be addressed with concrete solutions. Specification enters the therapeutic process from the beginning, as therapists diagnose according to the DSM-IV-TR[43]. The DSM seeks to organize, classify and delimit the universe of mental illness. It is one of the most important inscriptions in the world of mental health, a tool broadly used and often criticized (Brown 1987; Luhrmann 2000; Whooley 2010). The DSM is a black box (Latour and Woolgar 1979) that allows practitioners to make certain assumptions about the reality and symptomatology of mental illness. At its inception, the manual was intended as a tool for researchers who needed a standardized way to identify mental conditions (Healy 2002; Strand 2011). Though its originators did not foresee its enormous success in clinical practice (Healy 2004; Whooley 2010; Strand 2011), its transition from the research lab to the therapy room represented a first move towards a more "scientific" practice of psychotherapy (Lakoff 2005b; Whooley 2010).

Yet the DSM does not inform the work of all therapists in similar ways. Novices are more likely to think in terms of its categories as they become socialized into the epistemic culture of the profession. This is partly a function of necessity: first, they are entering a knowledge community in which the DSM is a central communicative tool; second, they tend to work in university clinics and group practices that are, for the most part, financially sustained by

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[43] The DSM-V is scheduled for release in May of 2013 (information retrieved from http://www.dsm5.org/Pages/Default.aspx on February 23, 2013). At the time of my fieldwork, practitioners continued to rely on the DSM-IV-TR. When assigning a DSM-IV-TR code to a mood disorder (captured on Axis I), clinicians conduct a formal psychiatric interview assessing for recurrence of episodes, their severity, the presence of psychotic features, and the stage of development in the course of the symptoms (i.e. whether and how long they have been in remission).

their ties to insurance companies. Among experienced practitioners, cognitive behavioral and

other "evidence-based" therapists conducted formal diagnosis interviews with the goal of

assigning a DSM diagnosis.[44] Such diagnoses, clinicians argued, were useful not only for

reimbursement, but also for symptom conceptualization, and identifying treatment options.

Rather than a burden, insurance requirements for a diagnosis aligned with these practitioners'

expert practices.[45]

One of the tools that CBT therapists used to diagnose depression and track their patients'

moods over the course of treatment is the *Patient Health Questionnaire 9*[46] (see Appendix 1)[47].

The PHQ-9 is a distilled version of the DSM criteria for depression, and is used by patients (self-

administered) and their clinicians. The form includes questions about the frequency of each of

the symptoms listed in the DSM in association with a major depressive episode: depressed

mood, or appearing depressed to others; decreased interest or pleasure in all activities; a marked

weight loss or gain, or appetite that is markedly increased or decreased; excessive or insufficient

sleep; psychomotor agitation or retardation; experiencing fatigue (i.e. tiredness and loss of

energy); feeling worthless or inappropriately guilty; having trouble thinking or concentrating;

repeatedly thinking about death, having suicidal ideation without a specific plan, or attempting

suicide (American Psychiatric Association, 2000). But these are no simple yes/no questions:

rather, they delimit the patient's mental health history to the last two weeks, and ask her to

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[44] Nearly all participants in this study expressed caution about assigning a personality disorder diagnosis to a patient, for fear that it may be "too stigmatizing." This can be read as yet another rejection of psychoanalytic categories of diagnosis—prior to the DSM-III, diagnostic categories focused on personality types as envisioned by psychoanalytic theory (Strand 2011).

[45] This should not be taken to mean that practitioners of the "evidence-based" therapies embraced the restrictions imposed by insurance companies. A dialectical behavioral clinician criticized the "barriers" that insurance companies placed in the way of treatment when limiting the number of covered therapy sessions.

[46] Form available online, retrieved from: http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf on January 15, 2011.

[47] There are other questionnaires that participants in this study used: the RADS (Reynolds Adolescent Depression Scale), and the BDI (Beck Depression Inventory). Though they work with different questions and numerical scores, they are all organized around DSM categories, and perform a similar function: simplification and containment.

specify how often she experienced each of the symptoms, assigning every category a number (see columns). Added up, these numbers signify a score that is in turn translated into a classification of depression by severity: minimal (1-4 points), mild (5-9), moderate (10-14), moderately severe (15-19) and severe (20-27). It is noteworthy that other than scoring a 0 on all the measures, even some feelings of sadness or loss of interest qualify as "depression" (albeit in its "minimal" stage). The PHQ-9 thus encases a range of disparate experiences into a well-defined, contained diagnosis that fosters the symptom-driven interventions of the "evidence-based" therapies.

Inscriptions allow for expert knowledge to become embodied, material. Abbott (1991) has argued that "a form for a will, for example, contains within its very organization some of the expertise a lawyer would offer in drawing a will" (p.21). But forms don't merely transfer expertise from producer to user. The DSM and the PHQ-9 help cognitive behavioral therapists create knowledge about mental illness. These clinicians are not simply engaged in the application of received "abstract" knowledge produced in the lab: in interactions with patients, through the mediation of these and other 'scientific' instruments, psychotherapists create local knowledge about their patients' particular experiences of mental illness. This knowledge is inscribed and quantified such that it can, with relative ease, exit the local context in which it was produced. Moreover, participants in this study asserted their expertise and authority by asking patients to fill out the PHQ-9, and bring it in for evaluation. In other words, while patients could self-administer the questionnaire, clinicians retained the privilege to interpret its results. As such, the DSM, PHQ-9, and the practices that accompany them are not neutral. They turn patients' distressing experiences into clinicians' scientific knowledge, and bestow upon the latter the power to make authoritative truths about the former.

Inscriptions were deemed necessary not only for diagnosing, but also for treating

depression and other mental illnesses. Beth, a middle-aged white woman suffering from

depression[48], had come to the University Clinic at the recommendation of her psychiatrist. She

agreed to have her initial session in a therapy room with a one way mirror, thus contributing to

psychiatry residents' education. She was smartly dressed, but her low tone of voice and overall

demeanor betrayed her low mood. Robert, the experienced cognitive behavioral therapist who

instructed residents in CBT, began by telling Beth that he had read her psychiatrist's notes, and

learned that she "struggled with depression and [is] … in remission." Beth told Robert that,

when she feels depressed, her "motivation … take[s] a dive," and she "start[s] withdrawing, and

pulling back from normal activities." She found "family activities" especially burdensome, and,

while she sometimes participated "if someone suggest[ed] doing something that sounds like

fun," often she didn't. Robert listened carefully, writing things down in a legal pad. He

reaffirmed her lack of "desire" to join in social gatherings, summarizing her experiences: "once

you get there it's ok, but getting there is kind of hard." But Robert didn't solely rely on Beth's

psychiatrist's notes, and his own writing. He also used the self-help book *Feeling Good*[49]

(Burns 1999) to introduce his patients to CBT, recommending certain chapters based on the

particular issues the patient was struggling with, but always starting with the first three. These

were significant not only because they provided a general overview of cognitive behavioral

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[48] In many ways, Beth is a typical patient suffering from depression. In 2009, 8.2 percent of women received this diagnosis compared to 4.8 percent of men. 18-25 year olds are most affected (8%) followed by 26-49 year olds (7.6 %) and those who are 50 or older (4.9%). Those identifying with two or more races were most likely to be diagnosed with depression (10.4%) followed by whites (7%). These data originate with the SAMHSA 2012 report—see esp. table 4, p.92.

[49] The book was first published in 1980, and has sold more than three million copies according to the author's amazon.com page (information retrieved in October 2012). This strategy is becoming increasingly widespread; a recent New York *Times* report (Morris 2013) announced the rise of "bibliotherapy" in the UK where therapists recommend well-written and popular self-help books.

therapy, but also because they introduced patients to concepts such as "cognitive distortions," a

cornerstone in CBT treatments. Beth received a similar recommendation:

> Robert: So in terms of where we can go from here, would you like to set up a series of sessions to work on these goals? […] I usually recommend that we meet once a week... We can start out that way and see how that goes... Typically I recommend that people schedule ten sessions so we can have a time frame to work with. […] The *Feeling Good* book I would recommend, and this is not written in stone, that you read the first three chapters... there's a list of ten cognitive distortions in chapter three that we commonly think people have... and we can talk about it....

Robert ended his first session with Beth by setting the temporal frame for treatment (ten

sessions at once a week) and recommending she read the first three chapters of *Feeling Good*,

paying special attention to the "cognitive distortions" list. This list was one of the most common

tools clinicians used in their treatments. Patients would look over it in session, identify the

"distortions" they employed most often (e.g. "all-or-nothing thinking," "overgeneralization,"

"disqualifying the positive," or "personalization"), and discuss them with their therapists. The

exercise was meant to not only normalize patients' experiences, but also to habituate them to the

activity of observing their thinking, and classifying their thoughts according to their

"truthfulness" or "accuracy."

One of the ways in which patients would learn how to identify and counter "distorted"

thoughts was through the use of a "dysfunctional thought record" (Appendix 2). Neatly divided

into columns, the form helps create order out of what may seem like a chaos of negative feelings.

It links negative emotions to particular thoughts and situations, helping the patient identify the

thought as "automatic" and "distorted," and rectify it by proposing an alternative, more

"realistic" thought. After the list of cognitive distortions, the thought record was one of the most

widely used forms in the cognitive behavioral treatments I observed. These tools, along with the

DSM, and manuals for particular treatments, helped therapists organize their patients' disparate

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experiences into standard symptoms that could be treated with "evidence-based" interventions. They functioned as the maps, the pedocomparator, the Munsell code, and other classification tools that Latour (1999) witnessed scientists use to make sense of the Amazonian soil.

In addition to using pre-existing forms and manuals, cognitive behavioral therapists actively engaged in the act of writing in therapy sessions. Those working at the University Clinic often made use of the white board for explaining the basic CBT model (a triangle linking thoughts, behaviors and emotions), and applying other CBT techniques (e.g. a chain analysis). The board was thus not only a signifier of the therapist's authority—as an expert, a teacher (I cover this in chapter two)—but also helped "translate" (Latour 1999) the patient's disparate emotional experiences into a coherent, concrete and bounded problem with a specific solution. Inscription was thus a frequent activity during cognitive and behavioral therapy sessions. As Robert discussed the particular affective reactions that one of his depressed patients had to a distressing interaction with his wife, he carefully noted those down. Sonora, a resident training in cognitive behavioral techniques, always had a pad and pen resting on her knees during interactions with her patients. Therapists' notes were later incorporated into patients' medical records, one of the building blocks of medicine (Berg 1996). Such records allowed therapists to communicate with each other, particularly in cases where multiple providers were involved in the process of care (i.e. a psychiatrist and a social worker). For example, Sonora read the notes of her patient's psychiatrist, and learned—to her dismay—that the young man had complained of the slow pace of therapy. She was puzzled by this, given her multiple attempts at getting Sam to do the exercises she personalized for him in the course of their cognitive behavioral treatment. This allowed her to have a more extended conversation with him about his expectations of

treatment, and his own feelings of hopelessness. Her notes, and the medical record, granted

Sonora the legitimacy to place responsibility for success (or failure) in her patient's court.

Novices training in CBT had to learn how to use inscriptions at various stages in the

treatment process: diagnostic questionnaires helped them identify patients' problems, manuals

would give them session-by-session instructions on the course of treatment, forms and exercises

could fill up the 50 minutes of "active" therapy they engaged their patients in. Yet despite the

emphasis on writing and using forms, trainees were warned not to become too absorbed with

taking notes: they needed to create an empathic connection with patients, so as to facilitate

honesty and openness. Sonya, an experienced clinician who served as a supervisor at the

University Psychological Clinic, told me that she tries to get her supervisees to "relax," and

avoid adopting "a very intellectual approach" focused on getting all the details about the

patient's condition rather than connecting with them empathically. This, she noted, is one of the

dangers of being inexperienced: that you try to "project more [confidence] by having more

information." One could see the attraction of this approach to young practitioners: taking notes,

novices are doing *something,* even as they may feel otherwise powerless and confused (as many

of my interviewees pointed out). As they take notes, cognitive behavioral therapists appear as

scientists recording data. This data is evaluated and, to return to Beck's (1979) outline of the

cognitive approach to depression, once therapist and patient have jointly examined the

"evidence," they can devise particular "techniques" that will help the patient combat their

distorted view of reality. Such techniques, as I've pointed out above, tend to overwhelmingly

revolve around forms (e.g. cognitive distortions, the dysfunctional thought record), and other

inscriptions (e.g. writing down pros and cons of worrying in an anxiety treatment).

Patients actively participate in inscription practices, making therapy a collaborative endeavor. They supply the "data" for cognitive behavioral therapists' diagnoses, while their active engagement in exercises is deemed essential to therapeutic success. A practitioner specializing in CBT, one of the few I met in private practice, told me, "I try really hard to get people to do paperwork, […] 'cause a lot of people don't wanna write stuff down. But it's always so helpful!" Inscription is thus not only a tool for therapists, but also for patients to better understand and keep track of their moods, and the work that they do. For instance, patients are expected to use copies of the "dysfunctional thought record" at home, isolating and analyzing their thoughts in the way dictated by the form. At the end of one of their initial sessions together, Robert advised one of his depressed patients to "continue working on accepting yourself when you make mistakes," to read through *Feeling Good*, and most importantly, "try to at least keep track of those [distorted] thoughts." Should the patient fail to do his "homework"— as CBT practitioners referred to the exercises they asked their patients to complete between sessions—Robert would reinforce the importance of the exercise by doing it together in session. In fact, even before assigning him this to-do list, Robert demonstrated how to fill out a thought record by analyzing an upsetting situation the patient had experienced in the previous week.

Yet it isn't simply their thoughts that patients are expected to track and write down: they also do so with their behaviors and their moods. Some of the behaviorally oriented forms (e.g. a "weekly activity schedule," or a "mastery and pleasure schedule") help patients track their activities, and connect them to their feelings. A common tool in dialectical behavior therapy is a "diary card" in which patients are meant to record their activities, moods, and thoughts. This, one of my interviewees pointed out, "gets the person active in their own treatment." This "active" orientation is an essential element of success, and one that practitioners of the

"evidence-based" therapies often invoke when distinguishing their methods from those of psychodynamically oriented clinicians. But just as patients in psychoanalytic therapy learn that affective self-reflexivity is the desired way of being, clients of cognitive and behavioral practitioners are similarly 'disciplined' to suit therapists' expectations. They learn to distinguish thoughts from emotions, to track both, while also recording their behaviors. They also learn that writing things down is the key to problem-solving and to getting things done.

When tracking their moods, patients were faced with perhaps the most radical transformation yet: the quantification of their emotional states. A key aspect of inscription (Latour 1999), quantification has yet to engage much interest from scholars interested in work despite its importance in the production of expert knowledge and legitimacy (see e.g. Porter 1995; Espeland and Stevens 2008). My observations revealed this to be one of the central features of cognitive behavioral treatments of a variety of mental health problems. Quantification enters treatment from its very inception: the PHQ-9 quantifies mood, classifying depression in terms of severity, and tracking treatment progress over time. Holly, an experienced psychologist training residents in interpersonal psychotherapy affirmed the importance of this measure:

> Some IPT trainers insist that you do a depression measure every session and I do agree with that… it validates the person's diagnosis and monitors the impact of the treatment on their symptoms, and then also it helps to communicate optimism to the person…. So you're starting at a 25 [on the PHQ-9] and we'd like to go to below 10 that's our goal…

Recall that on the PHQ-9 scale, a score of 25 was in the range of severe depression, whereas mild and minimal depression were below ten. This drop would provide a clear indication of symptom remission, but even incremental changes can help "communicate optimism" to patients who often feel helpless about their situation. Similarly, Robert told

residents that he "always check[s] the measures," and brings up significant changes with patients. He advocated for the "daily mood record."[50] :

> The next form [is] a daily mood record. On the left side it's got their mood score from 0 to 10 and on the other side it has a number of pleasant activities... you don't have to initially include that piece [the pleasant activities], but if you look at this as a daily mood record you can have people do this before they go to bed... you can go over it with them looking for significant ups and downs. […] It also can be a corrective for a person thinking that "I always feel the same," that there's no fluctuation, by seeing that there's some change...

Numbers are powerful indicators of how patients feel, challenging their thinking about the consistency of their moods over time. They are essential to CBT clinicians' expert kit, and are incorporated into their treatments. The quantification of emotional states thus plays a key role in not only identifying depression, but also "tracking" its development over the course of treatment. Practitioners of CBT make use of measures at regular intervals during therapy, as often as every session, or even multiple times a session. This practice is especially common in treatments for anxiety.

During the exposure treatment I introduced in chapter two, Luna had Meredith look at scissors, pliers, a hammer, and other household tools, and rate her anxiety on a scale from 1 to 10[51]. These scores helped them in two complementary ways: it allowed Luna to identify the specific nature of the patient's thoughts and thus personalize the exposure therapy, and it gave Meredith a sense for the unevenness of her experiences—not everything was extremely scary and dangerous—and for her improvement. Luna began their third session by asking Meredith

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[50] In the Couples and Marriage Therapy mentorship I observed, residents learned about "mood charts" to be completed by each family member. These, according to Linda, the experienced social worker who served as the residents' instructor, can function as a "thermometer of tension" in the family. This allows therapists to provide evidence for the important consequences of "decreased expressed emotion" specifically "criticalness, nasty comments, as well as a lot of intrusiveness, over involvement, and angry interactions." This, she concluded, "is a model [of treatment] that gets people to look at their mood via instruments."

[51] This way of measuring anxiety is also known as SUDS: Subjective Units of Distress Scale.

about her anxiety, and Meredith knew exactly what she meant: she wanted her SUDS score, not

a phenomenological account of how she was feeling.

Improvement is thus read in changing measures of anxiety or, in the case of the PHQ-9,

depression. Holly reaffirmed the need for such measures by enrolling the help of research

studies to assert the priority of scientific over subjective assessments. She told residents that "a

number of outcome studies […] have shown, and this is not good news for any of us, that

clinicians are not very good at detecting how the therapy is going subjectively." They must rely

instead on "objective measures" to better understand patients' experiences. In other words,

regularly measuring patients' progress with a tool such as the PHQ-9 is more reliable than

therapists' own subjective assessments of "how the therapy is going." Moreover, therapists

spoke of using measures to track not just patients' progress, but also the strength of the

therapeutic relationship. All of my interviewees were keenly aware of research findings

attributing the efficacy of psychotherapy to the alliance between therapist and patient. At the

clinic where Sonya served as a supervisor, novices learned to "track outcomes, and the

relationship." A structured questionnaire asked patients to rate several elements:

> "How connected do you feel to your therapist? How much do you—do you and your
> therapist agree on what the goals are of therapy? And how much do you and your
> therapist agree about how you're going to meet those goals?" […] And so there's [sic]
> these […] three subscales of the Working Alliance Inventory, and so we actually get a
> […] score, and they fill it out [in the waiting room] so it's not in our view, and then we
> get it and we talk with them about it […] if there's notable changes.

Once more, it is not left up to the therapist to "subjectively" assess the strength of the

therapeutic relationship. Rather, the "Working Alliance Inventory" score can function as a tool

for discussion of the therapeutic process. Patients are encouraged to describe their experiences

in session, their scores expounded upon and explored during the clinical interview, when

therapists can ask: "How do you feel about how we're working together? Are we on the same

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page? Does this feel like it's helpful? Is there anything that we could be doing that would feel more helpful to you?" Though not left to speak for themselves, measures can help rectify the course of treatment, or validate therapists' own expectations. The fact that clinicians' subjective assessment of therapeutic progress is replaced by numbers is significant, since "measurements […] are granted a powerful role in validating knowledge" (Knorr Cetina 1999, p.53). This is credibility inscribed, vetted, objective, and, most importantly, institutionalized.

Finally, measures are consequential for whether third party payers contribute to the costs incurred by the patient—an example of "liquidity" tools (Lakoff 2005a) that facilitate communication between patients, therapists and insurers. Turner made the following remark about a patient who had been doing better in his care: "Her depression and anxiety scores have been going down continuously, which unfortunately means that she'll have to start paying out of pocket because her insurance won't pay for [treatment] any longer...." Turner was pleased with his patient's progress, but wanted to continue their therapy by turning to psychodynamic techniques to explore the roots of her troubles. But the scores were taken by the insurance company to indicate the end of treatment: the patient felt better, and there was no need to reimburse for further therapy. Insurers can thus at times trump therapists' expertise through material constraints. Being embedded in a system of expertise that legitimates their work, therapists (like Turner) working in clinics and group practices are also ceding some of their autonomy. In contrast, historical and institutional circumstances have made possible psychoanalytic practitioners' greater independence, but at the cost of jurisdictional claims over mental illness. In addition, they are precluded from claiming the scientific credibility their counterparts in cognitive and behavioral therapies draw on.

I emphasize practices of quantification because numbers carry particular meanings related to objectivity and scientific legitimacy. Particularly in the field of mental health, where symptoms can often be diffuse, and illness a slippery phenomenon, assigning numbers to mental and emotional states can stabilize and make real otherwise obscure phenomena. Espeland and Stevens (2008, p.402) argue that numbers are imbued with authority through four mechanisms: "(1) our sense of their accuracy or validity as representations of some part of the world; (2) in their usefulness in solving problems; (3) in how they accumulate and link users who have investments in the numbers; or (4) in their long and evolving association with rationality and objectivity." By quantifying emotional states, and putting such numbers to work in their treatments, "evidence-based" therapists claim a rationality and objectivity that sets them apart from their psychoanalytic counterparts. Moreover, such rationality and objectivity are consequential for the economics of care, as insurance companies use these quantitative indicators as bases for reimbursement decisions. Lastly, numbers are consequential for how patients themselves perceive their emotional states. Inscription and quantification thus help practitioners and their clients create "objective" knowledge about mental illness, but also lead to a distinct form of expertise. This techno-scientific approach de-emphasizes the role of clinicians' personal experiences with patients. Moreover, it situates individual therapists into networks of knowledge that link them to scientists in labs conducting efficacy trials, as well as patients and their insurance companies. Their autonomy is diminished as their expertise becomes a collective undertaking.

Conclusion

The previous pages have focused on opening the "black box" (Latour 1987) of psychotherapeutic expertise, demonstrating that therapists in psychodynamic and cognitive

behavioral therapy use distinct "epistemic machineries" (Knorr Cetina 1999) to render their patients' problems knowable. This analysis suggests that expertise is not simply related to what professionals know—their abstract knowledge (Abbott 1988)—or the institutional and organizational arrangements that bolster their claims to autonomy (Freidson 1970). Rather, it is tightly linked to their embodied practices and affective experiences.

The "black box" of psychoanalytic therapy is, as Stengers (1990) put it, the "analytic scene." The therapeutic encounter is the focus of psychodynamic clinicians, and their affective and relational abilities make it a powerful treatment tool. Psychodynamic therapists focus on developing a keen sense for the complex set of feelings their patients experience, and how these feelings impact the therapeutic relationship. Practitioners' skillful attunement to their patients' internal lives is the result of intense self-reflexivity, with particular emphasis on their affective reactions, and, at times, their past experiences. Thinking psychodynamically entails a degree of affective self-awareness that depends on finding the right balance between professional distance and affective intimacy. These clinicians eschewed classification and ordering in favor of narrative constructions of the patient's difficulties in "dynamic formulations." Such formulations focused on the history of clients' problems (an issue I return to in the next chapter), and how this history is instantiated in the present. Insight is success, but this doesn't easily translate into the kinds of "outcome measures" favored by evidence-based medicine. Their inscriptions target like-minded audiences, and practitioners become accustomed to code-switching as they address the medical world of "evidence-based" therapies, and insurance companies. Consequently, unlike the systemic techno-scientific expertise of their cognitive behavioral counterparts, psychodynamic therapists' approach is "local" and idiosyncratic. Their

authority rests on the continued hold that psychoanalysis exercises on the American psychological imagination, and on tools that remain obscure to most observers.

Cognitive behavioral therapists' techno-scientific interventions relied on inscription and quantification to order and classify a set of discrete and elusive phenomena into coherent diagnoses. They approached depression as an illness characterized by "dysfunctional beliefs," and "cognitive distortions" about the nature of reality. These beliefs, in turn, were to be replaced with "reality-oriented" thoughts through a series of targeted techniques (e.g. using a dysfunctional thought record). Progress was inferred from decreasing depression or anxiety scores. This epistemic machinery relies for its functioning on the DSM, forms, manuals, measures, and clinical trials—the cornerstones of "evidence-based" mental health care. Within this system of techno-scientific expert knowledge, the practitioner's affect and intuition take secondary roles. Clinicians' contributions to treatment are nested (and relatively concealed) within institutional systems of diverse caregivers and third party payers. Their expertise is thus an emergent effect of networks of diverse actors.

This chapter also shows that therapists' project of control continues in their expert practices. In the previous chapter, I made the case that space and time are two essential elements of therapeutic control: within these contexts, clinicians determine the parameters and nature of interactions with patients. Their chairs are the locus of therapeutic knowledge, while the couch, the white board, and the clinical hour help place patients' problems under therapeutic jurisdiction. In this chapter, I showed that therapeutic expert practices, be they affective-relational or techno-scientific, continue this tendency towards control. Again, control is both self and other oriented. Therapists manage their emotions, learning how to tolerate extreme feelings. They also 'discipline' patients such that they adjust to the epistemic demands of their orientation.

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Here, we begin to gain a clearer perspective on the moral authority of therapeutic "technologies" as patients are molded to better fit distinct models of selfhood: an affectively driven, relationally oriented ideal in psychoanalytic therapy, and one focused on fragmentation, classification and measurement in the cognitive behavioral therapies. But there is an additional element to these technologies that I have only hinted at here, temporality, and I turn to this next.

Chapter 4. *Treating personalities: time, skill and the therapeutic relationship*

> "We are made what we are by events, and as self-narrators we live these through a meaning which the events come to manifest or illustrate."

> Charles Taylor, S*ources of the self*[52]

People, Taylor (1989) argues, construct their identities around events which they imbue with meaning. They "find an identity through self-narration" (1989, p.289, also, Somers and Gibson 1994), and psychotherapy is one place for patients to construct such narratives. It is the professional instantiation of the confessional mode which has become definitive of the modern condition (Foucault 1978). In the liminal spatio-temporal environment of psychotherapy, patients voice their best-kept and most painful secrets. Their interlocutors are professionals endowed by institutional and cultural conditions with a nearly sacred duty: to listen, without judgment, and help, to the best of their abilities. Yet psychodynamic and "evidence-based" clinicians adopt distinct approaches towards the task of making sense and meaning out of the events their patients try to order into self-narratives. As I show over the following pages, whether they focus on "developmental" events, as psychoanalytic therapists tend to do, or simply on "precipitating" ones as is the case in "evidence-based" practices, clinicians impact their patients' identities. They promote distinct "technologies" for ordering and making meaningful the experiences that make up their patients' narratives.

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[52] The quote is from Charles Taylor's (1989) book *Sources of the self,* p.289.

Time and selfhood

In the introduction to this dissertation, I argued that time is more than a structural element that "constrains" us (cf. Richardson 1990). In chapter two, I showed that temporality functions both as a boundary that bestows professional authority and legitimacy on psychotherapeutic practices, and as an epistemic tool. The time of therapy, along with the therapy room, make possible clinicians' jurisdictional claims over their patients' problems. Within this spatio-temporal environment, patients' lateness and "door-knob comments" are taken as indicators of their commitment to treatment, motivation to get well, the strength of the therapeutic relationship, and, in psychodynamic therapy particularly, their relational problems and anxieties. Moreover, within these contexts clinicians' distinct expert dispositions become embodied. Psychoanalytic therapists hone their affective-relational skills within longer term, open-ended temporal frames. Such frames afford them the necessary opportunities to expertly use their emotions as sources of knowledge about how their patients' past problems manifest themselves in the therapeutic relationship. In contrast, cognitive and behavioral therapists' techno-scientific expertise develops within shorter timeframes. They emphasize efficient, targeted interventions that comprise differentiating, classifying and quantifying emotions, thoughts and behaviors. But psychoanalytic and "evidence-based" therapeutic interventions carry another significant temporal implication for patients and their sense of self. This only becomes apparent upon closer examination of the link between psychotherapeutic expertise, time, and identity narratives.

Scholars who have examined the role of time in identity construction have tended to emphasize periods of change. Two arenas have been especially fruitful for this research: people's experiences of illness, and work. Thus, Roth's (1963) concepts of "careers" and "timetables" captured the ways in which patients attempted to gain knowledge about, and control

over their fates by structuring their lives around series of events in the hospital. Calkins (1970) showed that staff and patients at a rehabilitation clinic had distinct experiences of time: the former working with "mechanical," linear time, while the latter experienced time as "cyclical," moving from crisis to crisis or turning point to turning point. Similarly, Charmaz (1991) focused on the temporal experiences of people suffering from chronic illness. Her work illustrated the ways in which time and "self-concept" are co-constituted, as people's illness impacted their use and planning of time. Similar to the institutionalized patients in Calkins' (1970) study, Charmaz's (1991) interviewees structured their experiences around "turning points." These moments, she argued, serve as "points of reference and benchmarks of change" in which self-identity is placed into question and, potentially, re-imagined (1991, p. 198). Imbued with emotional force, such events can place the present and future in question, and re-configure the past (ibid.).

Capitalist and technological changes have also been fertile grounds for understanding the relationship between time and self. In one of the earliest discussions on this theme, Thompson (1967) showed that the industrial revolution changed the temporality of work from a natural to a socially imposed order sustained by punch cards and factory whistles. This, he argued, led to the rise of the "job," and the radical separation of work and home. Later, Hochschild's (1997, 2003) empirically rich illustration of the gendered and classed nature of temporal experiences in modern families demonstrated that time is a scarce commodity that carries distinct meanings to differently positioned actors. Sennett (1998) was similarly concerned with broad economic and technological changes, and their social and personal impact. He cogently described the ways in which the new, "flexible" capitalism, with its emphasis on immediate change and risk-taking, is affecting relationships between individuals and their communities. Thus, when IBM downsized

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its labor force in the early 1990s, many programmers had to re-imagine their futures without the structure of an IBM career (Sennett 1998). The layoff was a "turning point" in these programmers' lives, spurring them to shift their identities and social roles. Many became more involved in the religious lives of their communities, shunning other forms of civic engagement they had previously pursued. Other scholars have similarly argued that the intersection of "collective" or "social" time, and "individual" or "autobiographical" time (Sorokin and Merton 1937; Thompson 1967; Richardson 1990) is a rich site for understanding the evolution of modern selves. Sennett (1998) shows that at crucial turning points, people reconstruct their sense of self, and they do so primarily through narrative.

Through narrative, people impose meaningful order upon life events (White 1980; Taylor 1989; Richardson 1990; Cronon 1992, Somers and Gibson 1994). We can only "discern the meaning of any single event," Somers and Gibson (1994, p.59) argue, "in temporal and spatial relationship to other events." As such, a defining element of narrative is temporality: people "experience and interpret their lives in relationship to *time*" (Richardson 1990, p.124, italics in original), and psychotherapy is an important locus for the intersection of social and autobiographical time. Therapy rooms and clinical sessions offer propitious environments for the development and application of temporally inflected "technologies of the self" (Foucault 1988). Time matters here both as a frame for therapeutic work (the subject of chapter two), and as an object of intervention. I will show in the following pages that, in psychoanalytic therapy, the goal is to gain insight into affectively charged "developmental events." In contrast, cognitive and behavioral therapists make change-oriented interventions into "precipitating events" their primary emphasis. Thus, the therapies promote distinct versions of what it means to be a healthy person by working on patients' "inner time" (Garfinkel 1967), their narrative sense of self.

Garfinkel's (1967) notion of "inner time" refers to the process of "historicizing the person's biography" by "select[ing] and order[ing] past occurrences so as to furnish the present state of affairs its relevant past and prospects" (ibid., p.95). "Inner time" and "historicization" thus go hand in hand, and are a common part of people's identity-work. Garfinkel (1967) used this concept to understand how Agnes managed the socially loaded act of "passing." It wasn't simply that she chose when and where she would accomplish her assumed role of "natural female." As Garfinkel (1967, p. 166) put it: "It is not sufficient to say that Agnes' situations are played out over time, nor is it at all sufficient to regard this time as clock time. There is as well the 'inner time' of recollection, remembrance, anticipation, expectancy." In other words, the calendrical time that structures our lives (and is largely socially determined) intersects with our own affectively charged memories of the past, and expectations of the future to constrain and construct our sense of self. "Inner time," Garfinkel asserts, is essential to Agnes's "mastery of her practical circumstances," as well as her ability to (re)construct a coherent narrative, and convince herself and others of her "normalcy" (1967, p.166). Thus, people build identities through narratives that filter social and cultural norms through an internal sense of time (Garfinkel 1967; Taylor 1989; Richardson 1990; Cronon 1992).

Narrative is thus essential to making "social time" individually significant, and imbuing "biographical time" with culturally-appropriate meanings. Through the mediation of memory, people create wholes out of disparate experiences, embed these into larger stories about themselves, and link their own lives to the communities they belong to (Richardson 1990). Collective and individual times are bound to intersect, and their meeting is morally weighted. When constructed in collaboration with or by professionals, narratives become implicated in webs of authority and morality (White 1980; Hacking 1995). Experts can weigh in on important

choices about how events can be ordered and become meaningful (White 1980). A node in our "confessional" society (Foucault 1978), psychotherapy implicitly endows practitioners with the moral authority to make just such choices. Expert practices drawing on "clinical wisdom" (in psychodynamic therapy) or laboratory research (in the "evidence-based" interventions) assert an ethical force that passes under the guise of practical treatment decisions. As they define and treat their patients' problems, therapists communicate that some temporal and historicizing practices are more valuable than others. I showed in chapter two that psychoanalytic therapists favored sustained interactions in long-term treatments facilitating the affective (re)construction of their patients' past. I will show over the following pages that these clients' "inner time" is shaped by narratives that link past and present, and emphasize the affective weight of "developmental" events. In contrast, "evidence-based" psychotherapists expected patients to be "succinct," as one participant in this study put it. Clients were to learn early on to distinguish relevant from superfluous information, and provide appropriate material for the cognitive and behavioral exercises they engaged in with their therapists. As Meredith learned to quantify her anxiety, and Beth to identify her "distorted cognitions," they also, I argue, developed a distinct sense of "inner time," one focused on "precipitating events." They learned to classify and quantify their inner sensations, and work on them within short term, change-oriented therapies.

I distinguish between "developmental" and "precipitating" events to capture the distinct temporal frames implicit in psychoanalytic and "evidence-based" psychotherapeutic practices. Neither of these categories is natural—experiences become one or the other (or both) based on meanings that we assign them. *Developmental events* are those that, in the process of retrospective narrative reconstruction gain an essential, explanatory role in a person's growth. They tend to be affectively rich experiences from the past that come to shape our sense of who

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we are. While traumatic events are most common among people with mental health problems, not all such formative experiences have to be so. Having a teacher praise your presentation abilities in third grade can be just as significant to one's trajectory as moving often is to another's social life. The "turning points" that Charmaz (1991) and Sennett (1998) describe in their accounts of changing identities are just such developmental events, points around which people reevaluated and redefined who they are.

"Precipitating" circumstances facilitate or hasten the occurrence of an experience. In the case of mental and emotional difficulties, these are moments in the recent past that bring about a mental and emotional crisis. Examples include walking outside in the case of a patient suffering from agoraphobia, or failing to get out of bed for a whole day, and engaging in self-blame, for a depressed patient. Such situations become especially significant in the explanatory scheme of "evidence-based" psychotherapies, where they function as causal links in patients' illnesses, and are thus primary targets of therapeutic intervention. Thus, a CBT treatment of depression would target precisely those behaviors (e.g. staying in bed for hours) and thoughts (e.g. "I am a failure") that are thought to obstruct the accomplishment of a healthy self. Patients are expected to assume an "active" role in bringing about change by learning to avoid responding to precipitating circumstances in ways typical of their difficulties. Precipitating events can lose their explosive potential. Equipped with the right empirically-tested tools, clients become less socially anxious, less depressed. They learn to recognize an impulse to punch a stranger and control it.

Psychoanalytic practitioners and their colleagues in the "evidence-based" therapies engage in distinct temporal projects. Psychodynamic clinicians' longer and relatively open-ended temporal frames (covered in chapter two) foster an affective-relational expertise focused on reconstructing (and co-constructing) past and present. Conversely, "evidence-based"

practitioners' techno-scientific expertise becomes apparent in their shorter treatments and structured use of time in session (as I demonstrated in chapter two). Their targeted interventions also make clear the shorter temporal horizons of their knowledgeable practices. These divergent temporal emphases play another, perhaps more important role: through them, therapists shape their patients' "inner time," their sense of themselves and their problems. The psychoanalytic focus on the roots of mental illness presents clients with the possibility of fashioning coherent developmental narratives. Their current problems are not to be solved, but, rather, to be understood in the context of their longer histories. In an "evidence-based" treatment, therapists' emphasis on the recent past, and targeted, efficient interventions focuses patients on change. This fosters a present and future-orientation, as solutions to difficulties are sought in cognitive and behavioral responses to precipitating events.

I mentioned in chapter one that one of the strategies by which psychiatry grew its jurisdiction to encompass the problems of everyday life, and their prevention, is by adopting a focus on the "personality" (Lunbeck 1994). This ubiquitous and flexible object of intervention (Lunbeck 1994) dominated psychotherapeutic thought and work until the third edition of the DSM. The first two editions reflected psychoanalytic preeminence in the field, and centered on personality types; these were replaced by the axiomatic model of mental illness introduced in the DSM-III, and an increased emphasis on Axis I disorders (Healy 1997; Lakoff 2005a, b; Strand 2011). Over the following pages, I illustrate the temporal dimension of therapeutic expertise by focusing on a set of problems that—unlike the Axis I disorders of the previous chapter—conjure their agreement in one crucial respect: the development of illness. Axis II disorders[53] comprise

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[53] I will focus on one of the most common Cluster B diagnoses, borderline personality disorder (BPD). Cluster B diagnoses, which include, along with BPD, "antisocial," "histrionic" and "narcissistic," are characterized by intense interpersonal conflicts, as well as dramatic, emotional, and attention-seeking behaviors. They are distinguished

personality problems that are different from, though not entirely unrelated to the "mental" states

that make-up diagnoses on Axis I (e.g. major depression disorder). Luhrmann (2000, p.47)

pointed out that "psychiatrists say that Axis I disorders are like 'states'—you go into and out of

them—while Axis II disorders are like 'traits,' such as having brown hair." Thus, unlike Axis I

problems, personality disorders are thought to develop early in an individual's life, becoming

entrenched, and thus more difficult to treat.

Though less widespread in the population than the most common mental health problems

today (e.g. depression, anxiety), personality disorders continue to present psychotherapists and

other mental health workers with their most challenging cases. Clinicians at the University

Psychiatric Clinic were more likely to think about and work with such diagnoses than those

practicing outside this medical setting[54]. This is due to three interrelated reasons: first, the clinic

boasted a concentration of dialectical behavioral therapists focused on treating patients

diagnosed with borderline personality disorder; second, it tended to attract patients who suffered

from more severe difficulties; and third, many clinicians there had spent time on the psychiatry

inpatient wards, and at the VA, where they had encountered a patient population with more acute

problems, and were thus more inclined to think in terms of personality diagnoses. One of the

most common personality diagnoses I encountered during my fieldwork was borderline

personality disorder (BPD). The specific DSM-IV-TR criteria for a diagnosis of "borderline

personality disorder" include: attempts to prevent abandonment, unstable relationships, identity

disturbance, impulsiveness, self-mutilation or suicide threats or attempts, instability of moods,

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from Cluster A (which includes "paranoid" "schizoid" and "schizotypal"), and Cluster C (which contains
"avoidant," "dependent" and "obsessive-compulsive" diagnoses) (American Psychiatric Association, 2000).
[54] Whether practicing psychoanalytic therapy or one of the "evidence-based" approaches, participants in this study
were weary of assigning a personality disorder diagnosis, for two reasons: first, because they thought it would be, as
one of my interviewees put it, "too stigmatizing," and second, as another participant stated, "I'm not sure it would
help [patients] get reimbursed." Many practitioners consider insurance companies' reluctance to pay for the
treatment of these conditions to be one of the most important barriers to treatment (Chessick 1997; Gabbard 1997;
Gunderson 2011).

feelings of emptiness, out of control anger, and brief paranoid ideas (American Psychiatric Association, 2000).

People thought to suffer from this disorder comprise between 0.5% and 5.9% of the total population in the US, and make up the biggest proportion of patients with a personality problem in outpatient and inpatient psychiatry (Leichsering et al. 2011). Many people undergoing difficulties associated with this diagnosis do not enter treatment (ibid., Gunderson 2011). Yet, despite their relatively small numbers, patients diagnosed with this disorder tend to use more mental health services than their counterparts with major depression (Bender et al. 2001), or those in all of the other personality diagnoses (Zanarini et al. 2004). I will show over the following pages that, while therapists in the psychodynamic and "evidence-based" orientations agree on the developmental nature of the "personality" and its "disorders," they approach such problems in nearly diametrically opposed ways. The former work with a keen sense for the continuity between past and present both intra-subjectively and relationally. They manage layered temporalities, skillfully juxtaposing the past and present of their patients' troubles, and the temporality of the clinical bond. "Evidence-based" therapists, of whom I focus on dialectical behavioral practitioners, focus on targeted treatments with limited temporal spans. They foster a condensed sense of the past, and promote present and change-oriented interventions. These distinct temporal approaches are typical of therapists' treatments of other mental and emotional problems as well. They are essential to the kinds of ideal selfhood the therapies promote, and shape how we understand what it means to be a well-functioning individual.

Developmental time in psychoanalytic psychotherapy

Terry, Patricia, and other experienced analysts who would sometimes visit the mentorship, presented residents with a unique perspective in a mental health care system focused

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on symptoms and short-term solutions. They consistently reminded them to think historically about their patients' problems. Terry modeled this orientation by always providing details of his patients' past, and experiences growing up. This was the key to "understanding who the patient is." But this was not an easy task for residents, one made even harder by an especially intensive two years on the inpatient unit. Their experiences on the unit supplanted understanding by intervention. Turner admitted that he found the psychodynamic approach puzzling:

> [Psychodynamic therapy] is pretty dramatically different. […] the model until [third year] is that you come in with pieces of information [about the patient]… that help you make a decision, and then once you make a decision you leave. […] You don't even have any concept about how to deal with an outpatient where you're trying to use the [50 minute session] time for therapy. With an inpatient you are trying to assess the treatment, the medication issues, the symptoms...

Residents' psychiatric training until third year was focused on "symptoms" and their treatment, particularly "medication issues." Entering outpatient psychiatry, especially a treatment as open-ended as psychoanalytic therapy, was a radical departure from this model. This presented residents with the puzzle of dealing with what I introduced in chapter two as "psychodynamic time." How are they to fill 50 minutes, when all they are used to on the inpatient ward is a fraction of that? Terry's training was different: he "learned the fundamentals of psychodynamics […] in a six months ER rotation." At that time, doing a consultation was still focused on "understand[ing] who your patient is, and why are they crazy at this moment."

As I argued in the previous chapter, psychoanalytic practitioners attempted to "understand who the patient is" by using their emotions as epistemic tools, and treating interactions in the therapy room as illustrative of those outside it. This was their "clinical wisdom." A veteran psychoanalyst who came to speak to residents about his craft told them that "unlike any other therapy, psychodynamic therapy pays a premium for establishing a relationship... it's a relationship between two adults, two equals, and at the same time it's

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asymmetrical." This asymmetry was essential to achieving the goals of therapy: only if patients knew very little about their therapists could they treat them as they would their parents (and other significant others in their lives), and thus inadvertently reveal the roots of their problems. Though he acknowledged that the initial stages can be "very awkward" for both patients and beginning therapists, he nevertheless reiterated that "using the relationship as a bedrock for the process [of treatment] is very important." Therapy with clients suffering from personality difficulties entailed two complementary, relationally-focused interventions: first, working with their "transference" to understand how their past problems impact their current relationships, and second, maintaining boundaries.

But psychodynamic therapists approached patients diagnosed with a personality disorder warily. They had misgivings about treating them because, as one of my interviewees put it, "it's hard for them to...to really contain [their] impulses. They do what they need to do, and it's hard to really observe and make sense of." "Making sense" of patients suffering from borderline personality disorder was a nearly insurmountable barrier to a treatment premised on the assumption that understanding the roots of a mental and emotional problem will lead to its redress. This is not to be taken as an indication that these clinicians ceded the "personality" territory to their "evidence-based" counterparts. Terry asserted that a "long treatment" could be helpful for such patients, while admitting that "there's been a lot of work for folks that are borderline personality disorder and it's been shown that only short term therapy [DBT] works." Yet given residents' patient population, discussions of psychoanalytic treatment for personality disorders occurred regularly. Through these, residents learned to focus on the formative events at the root of patients' difficulties, and how these problems become manifest in the therapeutic relationship.

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More than therapists adopting short-term interventions, psychodynamic practitioners thought about the self and its development. Allan, an experienced therapist told me: "I put a tremendous emphasis on looking at things developmentally. And I think that is a real hallmark […] of psychodynamic treatment." Yet not all developmental events are equally important. Terry told residents:

> All experiences are important but there are some really critical times, and certain minimum requirements for adequate development of personality... that idea has been supported over and over by research... as we start to understand more and more about that, certain things become more and more clear... how individuals approach the world because the past has molded certain expectations, and [how] we go into encounters expecting how they will turn out....

"Adequate development of personality," Terry pointed out, is dependent on smooth transitions through "critical times." This was not simply Freudian theorizing, but rather, Terry asserted, findings affirmed by ongoing research endorsing psychoanalysts' belief that people tend to relate to others based on previous experiences. I heard this assumption reiterated by my interviewees. Bonnie, a social worker who had practiced psychodynamic therapy for more than 30 years, told me that "the mission" of psychotherapy is to understand […] what the underlying issues are, historically, with [patients'] families." Thus, when she evaluated clients she focused on whether they encountered developmental "stumbling blocks." Experiences charged with a negative affective meaning can lead them to "get fixed in certain levels of development," which would in turn impact all of their present relationships. Bonnie told me that "sometimes you do see a 50 year-old still an adolescent in many, many ways. And as a matter of fact, in the transference, you become the parent that an adolescent has, and the adolescent wants to get rid of temporarily [laughs]." In psychodynamic therapy the past comes alive in the present, and patients relate to their therapists as they would to their parents. This is the space where a 50 year-old is "still an adolescent" working through (and re-enacting) the difficulties he had had

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decades ago. Unlike the physical ailments that forced a break between past and present in the

narratives of Charmaz's (1991) interviewees, emotional problems viewed through a

psychoanalytic lens conjure a problematic earlier time that is ever present. The past is 'always

already' there, and the work of a psychodynamic therapist is to help patients uncover its

manifestations. For clients diagnosed with BPD, this required insight into how unstable early

experiences translated into stormy present ones, and problematic views of self and other.

Terry's and Patricia's discussions of psychoanalytic theory made the greatest difference

when they attempted to link it with specific diagnoses and treatments. This became clearest as

they guided residents through thinking developmentally about borderline personality disorder,

and its manifestations in the therapeutic relationship. Terry pointed out that:

> […] by definition we call people borderline if they have trouble understanding that their
> wishes are not the same as your wishes. […] They evolved over time in a way that the
> aggressive drive is integrated with others in ways that they don't understand that
> another's disagreement does not constitute annihilation or rejection... In the positive or
> normal development, my wanting something and you wanting something too does not
> mean necessarily that you don't want me to have it.

The main problem that patients diagnosed with BPD face, Terry told residents, is their

inability (reinforced over time) to distinguish between their own and other's wishes, granting

each their own individuality. The "aggressive drive"[55] is, in Terry's telling, overly reactive in

such patients, such that "disagreement" and "rejection" become interlinked as necessary cause

and effect. This is primarily due to these patients' failure to grant others motives that do not

reference back to them. Someone with a "positive or normal development" would be able to

make this distinction, and recognize others' agency and individuality.

Fonagy (1991), an analyst who has written extensively about the clinical and theoretical

aspects of treating such patients, has pointed out that "they manifest an interpersonal

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[55] This reflects Freud's theory of personality as a tripartite structure composed of id, ego and super-ego ([1923]1989, [1929]1989); their interplay at various stages in a person's life are thought to make up individual development.

hypersensitivity which leads to dramatic alterations in their relationships, a fragmentation of

their sense of identity, and overwhelming affective response and mental disorganization"

(p.639). "Hypersensitivity" to interpersonal dynamics becomes manifest in the therapy setting

through "complaining" or "extreme passivity" as Lucas, one of the residents, put it, or,

paradoxically, aggressive "help rejection." These behaviors, Terry argued, can be explained as

"defenses." He told residents that "[the patients] are basically showing you how they feel." This

made working with such clients, Lucas thought, "very difficult." He continued:

> Lucas: I guess I think of [help rejection] as a defense, but some people employ it more
> than others. […] The lack of insight is 'no, I really want help, you're just not helping
> me!' And it feels very aggressive...
> Terry: Why would the individual employ aggression in response [to help]? […] it's
> probably [that] the experience of being close with somebody is one that is quite
> frightening... And it's a response to feelings that they fear […] and this idea of a terrible
> visceral kind of worry about that kind of closeness... I think it's pretty clear that it's tied
> to early experience...

"Early experience" is the explanatory timeframe employed here. Difficulties classified as

personality disorders, psychoanalysts argue, can result from "unempathic" parental care,

traumatic experiences, or a "poor" "mother-child 'match'" (Kernberg and Michels 2009, p. 506).

It is because of such developmental events that patients diagnosed with BPD suffer from

interpersonal problems "with a particular ferocity," as Terry put it. In the transference, Fonagy

(1991, p.639) argues, patients' "submissiveness can suddenly turn to disparagement and rage of

remarkable intensity." Such sudden changes may be indicative of how they themselves were

treated as children, receiving help and cooperation in one moment, and being punished the next.

This confusing interpersonal communication leads patients to develop "feelings that they fear,"

as Terry put it. Patients react to their "visceral" worry about intimacy—a closeness that

psychodynamic therapists employ as an essential treatment technique—by rejecting help, and,

Terry later pointed out, having difficulty "maintaining boundaries."

Clients who suffer from these problems are also thought to be extremely seductive, engaging their therapists in, at the most extreme, "erotic interchanges" or "sexual acting out" (Chessick 1997, p.94)[56]. Many of my interviewees remarked on the necessity of building strong boundaries in treatments with BPD patients, both for professional and therapeutic reasons. Janice, the experienced practitioner I introduced in the previous chapter, told me that "a lot of people who have a history of severe childhood trauma […] often end up with borderline personality disorders or borderline traits." This, she said, means that "they have a history of unstable relationships," and will most likely engage in "a lot of testing the boundaries in the therapeutic relationship." Knowing this, she adopts the strategy of being "very explicit and firm about what those boundaries are because they're necessary for the treatment to succeed." This is "a way of modeling […] something that [patients] didn't have growing up." Thus, Janice limited phone calls[57], always ended session on time even when patients would want to extend it, insisted on conducting therapy in her office rather than other, more casual environments, and eschewed physical contact. Such experiences have the potential to become formative: lacking "good boundaries" in childhood, a patient can learn what they are in the context of a well-defined and contained therapeutic relationship. Formative experiences also fill the sessions of cognitive and behavioral therapists who provide their BPD clients with "radical acceptance," and teach them how to recognize and control their intense affective reactions. Yet these clinicians do little to uncover patients' developmental history, focusing instead on present-oriented change.

Psychoanalytic theory espouses the inevitability of re-living the past in the present (cf.

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[56] This formulation places responsibility for such "interchanges" entirely on patients, but cases abound of therapists themselves being the perpetrators.

[57] It is common practice in DBT that practitioners give their phone numbers to their patients to use in moments of crisis (Lynch et al. 2007, Neacsiu et al. 2012). My psychodynamic interviewees were less likely to do so. Moreover, while Nora, the experienced Dialectical Behavioral practitioner who ran the mentorship, told residents that all her clients had her home phone number, she acknowledged that every therapist has their "limits" and they should respect them.

Chodorow 1999). As I pointed out in the previous chapter, the concepts of "transference" and "counter-transference" help therapists make use of their affective reactions as knowledge about their patients within the context of the therapeutic relationship. Harry, an experienced psychodynamic therapist, told me that "in the psychoanalytic model, *everybody* is trying to use the world and use significant others in their world as a way of enacting their own psychic experience of the world." This, he continued, is a way "of getting, in a sense, others to live out the drama... of... of their past so they can then re-experience and re-master it, or undo the damage in some way." "Living out the drama" can help patients master essential developmental events, and psychodynamic therapy is one (if not *the*) place to do so. Lucas aimed to help one of his patients do just this. In his third residency year, he began treating Elise, a patient who subsequently had shown marked improvement. When he presented the case in group supervision, Lucas described her as a typical BPD patient:

> Her approach to feelings was to not experience them at all, or to have a crisis which was displaced in time and place and often person. So she would be upset with me, and instead of telling me, she would look completely fine, I would have no idea, and then four days later she would send me an angry email about random things... […] The pattern was very telling, she would cut or burn immediately after our sessions. […] So she went through a period of time where leaving me after therapy was extremely painful... now we've gotten to the point where she can say that leaving me feels bad.

Elise's difficulties, Lucas believed, were related to "her family history." Yet only after they began meeting three times a week during an intense psychodynamic treatment did he come to learn how her problems manifested themselves: "she revealed that she was drinking daily a lot, a lot of marijuana smoking, cigarette smoking, cutting and also an eating disorder NOS [not otherwise specified]." During therapy, Lucas focused on "pointing out what she was not saying," feelings that she would express after their sessions by sending him angry emails, or cutting, burning, and abusing alcohol. Being able to "*say* that leaving [her therapist] feels bad"

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is progress for someone who had a difficult time expressing her affect in non-self-destructive ways. Lucas's assiduous affective focus in sessions made possible Elise's own emotional expressions. When he presented part of his process notes, I was struck by the frequency with which he would make statements, and ask questions such as "What are you feeling right now?" "Are you ashamed?" "I wonder if you're judging yourself." "You look terribly conflicted right now." "I wonder whether leaving or saying goodbye is painful for you." "My intention isn't to make you uncomfortable I just want to help you understand…." The point is, of course, that it isn't simply the patient who wishes to understand, but the therapist as well, and Lucas was able to gain insight into his patient's separation induced pain. This was a developmentally charged experience for Elise, and working with her emotions in the "here and now" of the therapy session afforded Lucas the opportunity to learn this essential fact. In such emotionally charged moments psychodynamic therapists could make the most of their affective-relational skills: they showed themselves as expert observers of their patients' emotions, and interpreters of their problems in the context of their troubled past.

As I will show in the following section, practitioners of cognitive and behavioral therapies also attempted to teach their patients better ways to express and control their emotions. Yet they did so by focusing on specific skills targeted at various intra- and inter-subjective difficulties. Lucas was similarly concerned with Elise's ability to recognize and express her feelings, and he too sought to illuminate this problem as he repeatedly asked her how she felt, and gave voice to what he believed she was experiencing. Yet in a psychodynamic treatment, "learning skills" is not a strictly behavioral exercise, nor is it a stand-alone focus. Rather, it is necessarily intertwined with understanding the roots of those problems. On a different occasion, Terry brought up the example of a young man who had difficulties expressing his feelings:

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I have a kid I've been treating for a number of years […] [whose parents are] very emotionally restricted individuals, and they basically ran interpersonal relationships as if they were courtroom negotiations. And that affected the young child. […] The [parents'] response to early upset was not physical nurturing, I mean there was enough, he didn't die, but it was generally reasoned argument. And that doesn't wash with a three year-old really well... And how it resulted for him was an incredible rigidity about being upset. And the way he can respond to that is to close out the world […] and it's a very rigid defense and it doesn't make for much success interpersonally. […] But what happens in therapy is that when I push too hard, he erupts, and starts to throw things.

Terry immediately identified the young man's problem as originating in his past: his "emotionally restricted" parents "ran interpersonal relationships as if they were courtroom negotiations." This lack of affective nurturing led to difficulties for the patient who, when pushed "too hard," "isolates" or "erupts." The patient's affective experiences in response to his parents' emotional coldness thus emerged as significant developmental events. These impacted his later affective life, an influence that Terry was able to identify during the "number of years" they worked together. To one of the residents, this was a behavioral problem. Lucas hypothesized that such behavior was reinforced when his parents' "facade only broke down when he erupted." Terry asked Lucas how he would approach treatment with such a patient.

> Lucas: I don't know what you do, but I would try to show him that it's not gonna work with you, and the other thing is that he can intervene a lot earlier by using words and communicating how he feels in that way….
> Terry: And the question is how does one help a patient realize that? You could lecture them on it? Would that work?
> Lucas: Well, my sense is that CBT would be to explore their thoughts and then teach them, but in dynamic I think that would be called an interpretation. But again I think it becomes an experiential thing where he watches you not be phased, not react.
> Terry: And how long will that take?
> Lucas: A long time...

Through careful questioning, Terry helped Lucas and the other residents understand that "lecturing" patients on how to resolve their problems would not be effective. This was a subtle dismissal of cognitive and behavioral treatments that take a more direct, interventionist approach towards mental illness. Rather than "exploring [the patient's] thoughts" and teaching them how

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to act differently, psychodynamic therapists focus on "experiential" learning. The patient would see Terry "not react" when he angrily erupted, and would eventually learn that maintaining good relationships requires a different way of expressing anger. This, Terry pointed out, would take a long time, but it would "work" better than educating the patient on his interpersonal deficiencies. Yet as I show in the following section, such modeling is also essential in cognitive and behavioral interventions. The difference is in the focus of treatment: here, the patient's developmental history is paramount to understanding his current problems. In CBT, the precipitating event that led to the patient's "eruption" would be the target of interventions.

Patients are differently receptive to therapists' attempts at identifying how interpersonal dynamics play out in the therapy room. Harry told me that, when treating patients with traumatic childhoods who have an "all-consuming" sense that "they're living out [the drama], […] the work in the therapy is the attempt to be with them, be with them in the present, to be with them in the moment, and yet, to find a way of...of talking to them about that over time." The present is thus a re-enactment of the past, and the therapeutic goal is to "be with [the patient] in the moment." Allan told me that with many of his patients, he doesn't talk "explicitly about what's going on between them and me, and how it is a reflection of things that went on with their parents." Rather, they discuss patients' ongoing relationships, and try to draw out their developmental roots. All the while, Allan thinks of how that may be apparent in the therapeutic relationship. Such attention to the relationship, Allan pointed out, has to be "smuggled in" with patients who "don't […] want to address it." In the spatio-temporal environments of psychodynamic therapy, the past is always present, and therapists manage multiple temporalities. As they think through the affective meanings characteristic of patients' significant

developmental events, they also track the evolution of the therapeutic relationship, and its function as a stage upon which "the drama" of the past plays out in the present.

Psychoanalytic belief in the power of insight crystallized in therapists' attempts at building narratives around patients' developmental history. Identifying the "critical moments" and "stumbling blocks" that could have impeded "normal" development was paramount to making sense of patients' problems. I pointed out earlier that narratives arranged around "turning points" are essential to how we construct a suffering self in our society (Charmaz 1991; Sennett 1998). In psychodynamic therapy, constructing such a self is dependent on long-term relationships in which affective engagement serves as a source of knowledge about how the past affects the present. Thus, clinicians' affective-relational expertise is aimed at creating propitious conditions for such relationships (as I showed in chapter two), enrolling therapists' own emotional reactions as sources of knowledge (covered in chapter three), and putting their relational abilities to task by identifying patients' developmental problems in the transference. Their cognitive and behavioral colleagues are less concerned with the past, focusing techno-scientifically on intervening into, and diffusing precipitating events.

Working towards change in the "empirically-supported" approaches

Dialectical behavioral therapy is an "evidence-based" cognitive and behavioral intervention, and one of the most common treatments for people diagnosed with borderline personality disorder (Linehan 1993; Linehan et al. 2006; Lynch et al. 2007; Neacsiu, Ward-Ciesielski, and Linehan 2012). The treatment was designed for patients who are suicidal (ibid.). Personal experiences, clinical practice, and research led Marsha Linehan—the treatment's originator—to mix the approaches that later became DBT: namely, behavioral interventions, a dialectical philosophy, and Zen meditation techniques (Carey 2011b; Neacsiu et al. 2012). The

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therapy emphasizes interventions aimed at changing behaviors, and teaching mindfulness and acceptance (Lynch et al. 2007; Neacsiu et al. 2012). The therapeutic regimen includes individual psychotherapy, skills training groups, phone coaching, and, for clinicians, a consultation group (Linehan et al. 2006; Lynch et al. 2007; Neacsiu et al. 2012).

I observed some of the training that residents received in this therapeutic modality in a six month mentorship led by Nora, a social worker and experienced psychotherapist. From the very first meeting of the DBT mentorship, Nora emphasized the treatment's departure from psychodynamic interventions (even as she later would encourage residents to employ some psychoanalytic concepts, such as "defense mechanisms," to understand, for example, why patients were combative in session). She told residents that "at this [university] clinic, for a long time, having […] an analytic type model, we've actually lost patients because we weren't teaching them how to cope." Teaching patients "how to cope" rather than gaining insight into the roots of their problems is thus the primary goal of DBT practitioners. Just as with other "evidence-based" treatments, cognitive and behavioral change achieved by intervening into "precipitating" events is the primary goal.

Yet careful investigation reveals two important points of convergence between this treatment modality and psychoanalytic approaches: first, clinicians agree on the developmental nature of personality problems, and, second, they too emphasize modeling good or desirable behaviors to patients in the therapy session (I return to this later in the section). DBT adheres to the view that patients' personality problems are due to the interplay between "a biological tendency toward emotional vulnerability," and "an invalidating rearing environment" (Lynch et al. 2007, p. 183; see also Linehan 1993; Leichsenring et al. 2011; Neacsiu et al. 2012). The "invalidating rearing environment" is precisely the explanatory mechanism that psychoanalytic

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practitioners turn to when they attempt to gain insight into their patients' difficulties. Though they recognize its importance to the trajectory of their patients' illness, DBT clinicians relegate the past to the background of their treatments, and leave the biological side of disease to psychiatrists [whose pharmacological interventions, some argue (e.g. Leichsenring et al. 2011) have not been particularly successful]. When residents brought up cases for discussion, they briefly referenced patients' histories, mostly to acknowledge the "invalidating" conditions that fostered their psychiatric problems. Such histories were not to be the focus of DBT interventions. Instead, as I show over the following pages, they worked on "precipitating" events to equip clients with tools to diffuse their intense affective reactions.

That "evidence-based" clinicians believed in the importance of upbringing was evident, though implicit, in their discussions of "schemas" and "normality." "Schemas," the mental structures by which we organize and make sense of the world (DiMaggio 1983; Strauss and Quinn 1997; Brubaker, Loveman and Stamatov 2004) develop over long periods of time. They are also an essential target of cognitive interventions. This, Robert told the residents training in CBT for depression, "does illustrate that there's some similarity between cognitive therapy and psychodynamic therapy because we do look at how patients grew up […] to figure out how their thoughts and beliefs came about." Nevertheless, he reiterated that CBT clinicians "don't dwell" on the past, focusing instead "on the here and now, solving the problems of the present." Talking about the past is only pursued in the service of motivating patients to change: "I was doing this with a patient and he can see that if he knows where those beliefs came from, they're not universal truths, and they can be undone." Robert's point echoes Beck's own writings about differences and similarities between psychoanalytic and "evidence-based" orientations. Beck and his collaborators (1990, p.4) pointed out that "cognitive therapy theorists share with

psychoanalysts the concept that it is usually more productive to identify and modify 'core' problems in treating personality disorders." Yet they differ, Beck et al. (ibid.) argued, "in their view of the nature of this core structure": whereas psychoanalysts focus on the unconscious, cognitive therapy "holds that the products of this process are largely in the realm of awareness" (ibid.). Seeing such problems as largely conscious determined the distinct temporal focus of CBT and other "evidence-based" interventions.

Linking mental problems to schemas, and thus development, became apparent in how therapists in my field site spoke about 'normality.' Deviance forces social actors to reconsider what normality is (Durkheim 1951), and therapists' experiences with patients who tended to express their emotions in self-destructive ways made them more aware of what they would expect from a "normal" person. Discussions of normality emerged around questions of how therapists may view or experience a situation that had caused patients an inordinate amount of distress. For example, Jeremy, the senior therapist in CBT for anxiety I introduced in chapter one, would often ask residents for their opinions on situations ranging from religious beliefs and job security, to cleanliness and sexual relations. Discussing "normality," or as Jeremy would put it, "the truth," would then transition into redressing patients' "cognitive distortions" such that they are more in keeping with "reality." In DBT, discussions of personal development served to remind residents of the importance of upbringing in how people respond to distressing situations. Nora asserted that regulating one's emotions is "a skill" that some "people don't know how to do." Though it may come naturally to residents because of their "[professional] training or original family," for others, especially their patients, it is something to work on. Patients diagnosed with borderline personality disorder, Nora said, "are just acting, and don't know how they feel. We teach them that they can feel without having to act." The "emotional habitus"

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isn't a simple matter, and when one's personal or professional development does not provide opportunities for its growth, its embodied expressions take unacceptable forms such as "cutting" or suicide. Development is thus key to accomplishing 'normal' selfhood.

Yet even though clinicians in psychoanalytic and "evidence-based" therapies agree on the partially developmental causes of their patients' problems, they adopt distinct interventions. Cognitive and behavioral clinicians and researchers devise treatments which revolve around the use of exercises, forms, and measures, to educate patients about the "distortions" in their thinking, and help them gain a more "objective" perspective on "reality." Dialectical behavioral therapists thus focused on teaching patients diagnosed with borderline personality disorder affective and interpersonal skills that emphasized cognitive and behavioral change. In learning "how to cope," as Nora put it, patients diagnosed are equipped with tools that help them diffuse potentially explosive situations. The bulk of these clinicians' work is thus dedicated to untangling the cognitive and behavioral underpinnings of precipitating events, and providing patients with the tools to overcome them.

Examples of such events from my fieldwork abound, and range from the dramatic, like losing a loved one, losing one's job, or learning that one cannot have biological children, to the relatively mundane, like getting into a car, or speaking to someone on the phone. Each of these situations had the potential to trigger patients' suicidal desires, their anxiety, sadness, or other, painful emotions. One trainee's patient would start "arguments with her husband in public places and then [get] really embarrassed about that." Employing dialectical behavioral tools, the therapist taught her "to identify and name the emotion" she may be experiencing when such situations occur; this, the resident said, "has been really helpful" for the patient to control her outbursts. Jack, a fourth year resident, introduced a patient who "has borderline personality with

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depressive traits [and] was recently fired." She had come into one of their sessions and "was talking about getting back at her boss... [*Jack described what his patient was proposing to do*] and she was asking me if that is illegal." Using a DBT technique, Jack "tried to reframe the question as 'how effective is that for you?' and she eventually engaged with it, [though] she was pushing back and saying 'just 'cause you think this is wrong it doesn't mean that I shouldn't do it'... and I said 'well this is not about right and wrong but it's about doing what works.'" Residents quickly learned to respond to patients' accounts of precipitating situations with DBT tools, training them how to identify and name their emotions, and "doing what works." Why the patient would seek revenge in situations where she felt slighted was not to be understood in light of her developmental history, but to be changed through a cognitive technique.

Similarly, when Aaron treated a patient whose difficult relationship with her father drove her to briefly consider homicide, he did not dwell on the past, but sought to teach her how to diffuse her intense feelings in the moments that precipitated them. In one of the early meetings of the DBT mentorship, Aaron described "an incident" that his patient had brought up: she was talking with her father "about their respective ailments but she thought he was not listening to her and that escalated... she was having a lot of conflicting thoughts where she wanted to kill her dad but at the same time she loves her dad." Puzzled by what he could do in such a situation, Aaron asked the help of the DBT group. Nora proposed that he start with "validation." An essential part of the stance of "radical acceptance" at the core of DBT, "validation" was always the first step in such interventions. Then, Nora returned to a DBT skill:

> In the handouts on Friday I gave you a homework assignment that's in emotion regulation... So I'd get that out and get her to practice... so if she picked any of those emotions in the circle, I'd ask what the precipitating event was that made her feel that way... so I'd stick with "whats"... and then ask her about how she felt about it... I'd get her belief about it... I'd teach her to know what that feels like in her body... "action-urge," so what was your action-urge towards your father? You wanted to kill him...

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The patient's anger, and her impulse to kill her father become here targets of intervention. In typical "evidence-based" fashion, the client would get a "homework assignment" requiring her to "practice" identifying her emotions and their precipitating events. When she would bring the form with her completed assignment, her therapist would ask "what" questions aimed at reconstructing the chain of events that led to her "action-urge" to kill her father. Here, the "precipitating event" is the key to understanding and change. On a different occasion, Nora reiterated that she would "want [her patients] to know what the precipitating events might be, what they're feeling in their body, so that we can move into experiencing the emotions, so that we can be more available and make more wise-minded decisions." Precipitating events are canvasses for these therapists' techno-scientific interventions. Moreover, as I also showed in the previous chapter, the patient becomes an active participant in the process of change by engaging in inscription practices that transform her problems into objects of therapeutic intervention.

I mentioned in chapter two that one of the most common dialectical behavioral tools that residents were encouraged to use with their patients (and that they employed in CBT as well) was the "chain analysis." This too made plain the more limited temporal span of their techno-scientific interventions. This technique is structured around a series of questions that traces the mundane events and affective states leading up to a stressful moment in the patient's life. In keeping with her emphasis on applying DBT skills to oneself (an issue that I return to below), Nora prompted one of the residents to be the therapist analyzing one of her own routine difficulties. Her "problem behavior" was being late for the mentorship, and, as a surrogate patient, she submitted herself to detailed questioning. Victoria, a third year resident, 'played' the

therapist and inquired into the events of the morning that had led to Nora's delay[58]. She asked

about Nora's "feelings, vulnerabilities, events that happened right before this problem behavior"

as well as the behavior's "consequences." After the exercise, Nora pointed out:

> The other thing to take note with the chain analysis is that it's behavioral and so thinking
> in that way... so beginning to target the behavior, what led up to that behavior, and what
> could have been different and what led up to that behavior... And it is a different process
> because we value a [psycho]dynamic understanding of behavior and that's not what this
> is... she's [Marsha Linehan] always said, DBT is CBT... now she's saying it's almost just
> behavior treatment.... […]

One of the residents remarked that the chain analysis made him think of "one of the

common criticisms of psychodynamic therapy, that there's a lot of insight, but the behavior has

to change." The chain analysis provided the opportunity to once more distinguish the DBT

approach from its "dynamic" counterpart. Rather than insisting on an examination of the

relational underpinnings that may have predisposed Nora to be late that morning (as perhaps a

traditional psychodynamic treatment would have it), a DBT "chain analysis" uncovered the

immediate stressors that, when compounded, led to an undesirable behavior. Thus, it was Nora's

difficulty with getting out of bed when the alarm first went off at 5AM that set in motion a

"chain" of behaviors that became progressively more stressful as time grew increasingly scarce.

The only "insight" that is relevant here is that distressing emotions are the product of immediate

environmental and behavioral circumstances, and that these can be changed. Patients can gain

mastery over their emotions by asserting cognitive and behavioral control over precipitating

events. In DBT, CBT and IPT (the three "evidence-based" therapies I observed) they do so by

learning skills.

DBT skills were grouped into four modules: mindfulness, distress tolerance, emotion

regulation, and interpersonal effectiveness. These four modules, Nora pointed out, match "the 4

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[58] Role play is an essential educational tool that instructors employed. This is part of an apprenticeship model that
continues to hold strong in medicine (Summerson Carr 2010).

problem areas: instability of sense of self, instability of affect, of relationships, and marked

impulsivity. Another way that Marsha Linehan talks about it," she continued, "is disregulation:

of affect, of sense of self, of relationships, of cognition, of behavior." We continue to see here

the fragmentation and classification typical of "evidence-based" interventions. Patients'

problems are broken up into those of self-view, of emotions, relationships, thoughts, and

behaviors. Each of these can be changed through targeted techniques that rely on inscription and

quantification. I mentioned earlier that group therapy is an important part of DBT interventions.

Such groups focus on skills-training. At the University Psychiatric Clinic, each module lasts a

month, and patients can rotate in and out, focusing on the particular one they need. The skills

they learn are then reinforced in individual therapy sessions, as clinicians ask patients to apply

them to their problems.

 "Mindfulness" is a core concept in DBT and the basis of all the other work that patients

are expected to do. Nora emphasized the importance of balancing "rational mind" with "emotion

mind" particularly in instances when patients are trapped in the former (as most who are

diagnosed with borderline personality disorder are thought to be). This helps patients attain a

state of "wise mind" which, Nora pointed out, "balances thoughts and emotions and helps us

make the best decisions." Thus, the patient who felt like killing her father had to learn to

develop a "wise mind" that would help her "balance" her emotions with a rational understanding

of the consequences of such an action. Nora explained the concept by drawing three intersecting

circles on the board:

> […] the circles are the reasonable mind, the emotion mind, and the wise mind is in the
> middle, and you get there through synthesis of how you feel and what you're thinking
> about... so the "what" skills—observe, describe, participate—and "how" you say it, is so
> critical—non-judgmentally, effectively, one-mindfully... being effective, means not doing
> too much or too little...

To achieve a state of rational and emotional equilibrium, patients were to "observe, describe" and fully "participate" in the current moment, while doing so "non-judgmentally, effectively, [and] one-mindfully." Later, Nora reminded participants in the mentorship that "the mindfulness module […] undergirds all the other ones: you need it to regulate your emotions, have relationships and […] it addresses sense of self so it teaches our patients to be grounded, to be where we are." Later in the mentorship, Aaron gave an example of how he had used mindfulness skills to help a patient navigate through a crisis:

> I have a patient who is... relapsing into a depression specifically because she can't get pregnant... in this last month she found out that she wasn't pregnant after having tried to get pregnant for about a year, and that sent her into this spiral of despair... she told me specifically that she was going to kill herself because 'if you can't have kids what's the point of being on this earth?' […] So she was a bit on the emotional side. So what I tried to do with her is walk through some of the facts and get her through a more balanced mindset...

Aaron had told the group that he was quite worried about his patient: he didn't know how exactly he could help her, and was convinced her feelings of hopelessness were strong enough to lead her to attempt suicide. She had just experienced an intensely emotional precipitating event, learning that she hadn't become pregnant despite multiple attempts. This "sent her into [a] spiral of despair." In session, she was "on the emotional side," and Aaron tried to "walk her through some of the facts" that lined up with what Nora called "rational mind," reminding her why life was still worth living despite not having biological children. This, he hoped, would get her into "a more balanced mindset." Mindfulness teaches clients to become centered in the present moment by developing their awareness of themselves and their environment. It is an especially useful skill when they face particularly distressing precipitating moments. The other three modules work with a similar temporality.

"Distress tolerance" focuses on teaching patients four skills for tolerating painful events: "distract with wise mind accepts," "self-soothe the five senses," "improve the moment," and weigh the "pros and cons" (Linehan 1993). In addition, the "emotion regulation" and "interpersonal effectiveness" modules are similarly organized around skills and activities that patients and therapists can practice together in session, and later apply in everyday life. As I argued in the previous chapter, much of this work revolves around forms and inscriptions. For example, handouts aimed at teaching patients how to regulate their emotions list the words associated with various emotions such as love, anger, fear, or shame, as well as their attendant physical expressions (e.g. one hugs people, or jumps up and down when experiencing joy, yells, and attacks when feeling anger, cries, screams or flees when feeling fear). Another handout focuses on interpersonal effectiveness by discussing the "DEAR MAN" acronym, a shorthand for remembering the skills of describing the current situation, expressing feelings, asserting oneself by asking for what you want, reinforcing the consequences of particular actions, staying mindful, appearing confident, and negotiating for alternatives that satisfy all involved (Linehan 1993). Here, as with other kinds of skills and tools, the goal is to achieve change in the present by intervening in potentially explosive events, and transforming one's response to them.

Patients learn these skills by doing "homework." Like their counterparts in CBT, DBT therapists assign clients homework that requires them to practice their skills. Nora told the residents that "behavioral treatments require practice... that's why in CBT you have all those booklets, and [clients] write down the automatic thought and what is distortion. Patients have to practice and that's why Linehan dragged it into DBT... my patients have this solution path in their brain, [such as] if I don't have kids I'll kill myself, and we have to build a different path." Practice makes for a healthy emotional life, and DBT clinicians, like their CBT colleagues, turn

to exercises, forms, and measures to facilitate their patients' therapeutically-sanctioned practices. Maladaptive "solution paths" can be changed through repeated practice of cognitive and behavioral techniques in precipitating circumstances. For example, a handout covering distress tolerance skills asks patients to note which strategies they employed in stressful situation, followed by a measure of their distress before and after using the technique. In the previous chapter, I mentioned that DBT practitioners employ diary cards that require patients to track their moods and behaviors daily. Nora told the residents:

> If we're gonna use diary cards, where people rank the level of suicidality... it's a really easy way when they bring in the suicide card, to say 'oh, I see that you had some suicidal thoughts last week.' and you can do a chain analysis on that. But if they haven't done [the diary card], you can do it right there, and you're still reinforcing that brain that you're interested, that you're not gonna avoid these tough topics, like 'what's your level of misery'….

Nora reminded the residents the basic rule of homework: if the patient doesn't do it on their own, you do it with them, so as to reinforce the necessity of putting skills into practice. This has the vital therapeutic effect of encouraging patients to talk about their "level of suicidality" or "level of misery" (levels that, in techno-scientific fashion, are measured on scales). It also reinforces therapists' expertise: unlike their patients who may want to avoid the difficulties of dealing with extremely painful emotional states, clinicians possess the training and affective strength to withstand and work on such problems. Once more, we see here an emphasis on measurement and inscription, applied within time-limited interventions.

I mentioned earlier in this section that therapists in the "evidence-based" therapies and psychoanalytic clinicians have two things in common: first, agreement on the developmental nature of personality problems, and second, modeling good or desirable behaviors. I have shown thus far that, though they may converge on the long-standing nature of some patients' problems, practitioners in these orientations adopt distinct interventions for treating them: while

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psychoanalytic clinicians focus on the therapeutic relationship to discover the developmental events that shaped patients' personalities, "evidence-based" practitioners are more interested in identifying "precipitating events" that hasten patients' emotional crises, and diffusing them through cognitive and behavioral interventions. Yet there is one kind of intervention that therapists in both orientations agree on: modeling. In the previous section, I mentioned Janice's attempts at modeling "good boundaries" to a patient who had had a history of "unstable interpersonal relationships." In a similar vein, Terry spoke about modeling appropriate ways for expressing anger to a patient whose "emotionally restricted" parents failed to provide him with less eruptive communicative tools. "Evidence-based" treatments made such modeling an explicit part of clinicians' interactions with patients.

Nora repeatedly emphasized the need for "model[ing] positive outcomes" to patients. She told the residents that "with DBT we teach our patients skills and we learn those skills ourselves…." Some of this learning, she pointed out, happened organically: "that's for the patient but oh yeah, I used that with my wife, or I used that with my kid, and it worked...." The focus on learning DBT skills took some residents by surprise. Cedric, a third year resident who was just starting his training in outpatient psychiatry, stated:

> Cedric: One thing that you brought up is that we have to practice what we preach... but it's not something that I've gotten in other mentorships... but it's useful because truly before we can ask a patient to get insight and engage in these activities, we should have some insight about it ourselves, so there's a potential for everybody getting something out of it aside from the skills themselves...
> Nora: […] Marsha [Linehan] teaches us not to share when we try to use skills and it doesn't work... We have to model positive outcomes... […] We have to be careful about using disclosure...

Nora cautioned the residents that therapists don't "share when [they] try to use skills and it doesn't work"—an almost superfluous statement given how much credence "positive modeling" grants therapists. Yet "practicing what they preached" was indeed a new expectation

for residents, who came to psychiatry long after the (often implicit) requirement for being in one's own therapy that dominated American psychiatry until the 1970s (e.g. Light 1980; Luhrmann 2000) was eradicated from training programs. One could see similarities here to the expectation that therapists reflect on their own feelings during psychodynamic treatment. In psychodynamic therapy, as in DBT, residents were compelled to learn about their own feelings so as to better help their patients. Similar to their psychodynamic counterparts, DBT practitioners at times took their affective reactions as sources of knowledge about their patients. But this was a far less important part of a treatment focused on "behavioral change" and cognitive transformation.

'Practicing what they preach,' as Cedric put it, was an attitude clinicians in other "evidence-based" orientations adopted as well. When they deemed it necessary, CBT therapists would also engage in the kinds of exercises they asked their patients to do. They would practice the relaxation or exposure exercises they asked their patients to perform. A common theme voiced by practitioners of cognitive and behavioral techniques working with "anxiety patients" was that they themselves needed to participate in the behavioral exercises they asked their patients to do. Nina, an experienced cognitive behavioral therapist specializing in anxiety disorders, told me:

> [W]e do a lot of stressful things in session, […] and I do everything. I do not ask my patients to do anything that I don't do myself. And I think that's helpful for them, you know, especially when we're doing exposures that can be pretty anxiety-provoking. If I'm asking them to eat something off the floor, I eat if off the floor too [laughs], and if I'm asking them to...touch a toilet seat, I touch it too... so that they're not doing it alone... and...and to help them to...to see, you may not be wanting to do this every day, but it's not going to hurt you. I can do this too. So to be a good model for them.

Nina engaged in the exposure exercises she asked her patients to do because it was "helpful for them" to see her performing anxiety-provoking things, while maintaining a calm

demeanor. This, she thought, was necessary for successful treatment: she can "be a good model" for her patients and show them that "it's not going to hurt" to engage in stressful tasks. She set her own anxieties aside and was able to think logically about the situation—she knew that touching a relatively clean toilet seat, or eating off of a relatively clean floor, chances are she won't get sick. During such exercises, Nina communicated her expert knowledge in embodied ways, practicing what she preached. She was "a good model" for her patients, demonstrating the power of logic, composure, and calm while facing anxiety provoking situations. Moreover, she focused on change in the present, rather than insight into the past.

"Evidence-based" practitioners underscored the value of change through tools that can mitigate the effects of potentially dangerous precipitating events. Though they agreed with their psychoanalytic counterparts on the developmental nature of patients' personality problems, and engaged in modeling positive behaviors, they also adopted other distinct interventions. Such interventions amount to a techno-scientific approach to mental illness. Equipped with inscriptions, measures, research and evidence, and targeted techniques, practitioners of this orientation have little time for piecing together historical narratives out of the emotionally intense stories their patients present them with. Instead, they use their epistemic tools to orient their clients towards more immediate self-transformation.

Conclusion

Patients diagnosed with personality disorders present therapists with intense and often frustrating challenges[59]. Such patients test practitioners' expertise, often refusing to engage in the treatment process, making desperate attempts at expressing their intense emotions in self-injurious ways. They push the boundaries of the therapeutic frame, and demand much of the

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[59] One might argue that the causal arrow works in reverse here: that therapists tend to diagnose those patients they find challenging with personality disorders.

therapist's attention and time. The etiology of their problems is poorly understood, though in recent years the "bio-psycho-social" descriptor has become a shorthand for signifying a multi-causal illness trajectory (Kernberg and Michel 2012). Yet despite widespread agreement on the temporal frame of these problems—they tend to begin afflicting people in early adulthood, and have developmental roots—practitioners of different therapeutic orientations adopt distinct treatment strategies. These differences are characteristic of their epistemic cultures and, I argue here, can be best understood by attending to the issue of temporality.

Psychodynamic psychotherapists conduct a treatment focused on disentangling the effects of the past on the present. In this scheme, illness is a result of moments or periods of time when "normal" development went awry. Constructing narratives that build continuity between past and present is, for these clinicians, dependent on their ability to understand how patients' past 'dramas' manifest themselves in their present relationships. They do so in the context of a therapeutic relationship in which "transference" is constantly played out. It is understood here that patients aren't the only ones bringing their past to bear on the present, but therapists' do so as well. Monitoring their own "inner time" (the counter-transference I discussed in the previous chapter) becomes for these therapists paramount to building a relationship that can function, along with their emotions, as an epistemic tool. Time here is layered, and therapists learn to manage multiple temporalities, distinguishing between their own and their patients' past and present experiences, understanding how they become entangled in the "here and now" of the session. Moreover, they vigilantly guard the temporal and spatial frame of treatment, while monitoring therapy's development over its long duree. Patients learn not only to value affective self-reflexivity, but are socialized to historicize their every thought, feeling, and action.

Dialectical behavioral and cognitive behavioral practitioners take a techno-scientific approach that builds on their use of inscriptions and measures. Inscriptions, Latour (1999) argues, compress time and space, making possible overlaps and classificatory schemes that would not be visible otherwise. A similar process is at work in therapeutic interventions. The forms and measures these clinicians rely on transform mental illness into a phenomenon with a limited temporal frame, in which the recent past and the immediate present are the primary horizons of treatment. Understanding developmental experiences is sidelined by interventions into the cognitive, behavioral and affective effects of precipitating events. Difficult situations in patients' recent past become important treatment materials which present therapists with the opportunity to apply their expert knowledge. For patients, recovery is a series of exercises in which they employ the tools and skills they learned in therapy to particular thoughts, emotions or behaviors. Time is to be spent on efficient problem-solving through directed, "research-based" solutions. Their developmental 'inner time' remains relatively unchanged and unchallenged, as they construct selves that are realized in series of performative present moments focused on achieving a sense of balance between affect, thinking, and action.

Though these differences set practitioners of psychoanalytic and "evidence-based" therapies apart, they should not be taken as absolute. The distinction between developmental and precipitating events is one of degree, and therapists encounter and work with both. Rather, my argument here has been that though clinicians recognize the importance of both types of events in patients' illness and self-development, they tend to focus their efforts and their treatments on one or another based on their ideological commitment. In this process, they exercise a moral authority that allows them to intervene in patients' self-narratives such that they impact both the ordering of events, and the meaning that people attach to them. These elements are essential to

identity construction. Thus, as "*technologists* of the self" therapists are in a position to shape their patients' sense of who they are, what it means to be sick, and, conversely, what it means to be normal. For one, ideal selfhood is affectively insightful and temporally integrated. For another, it is ever ready for change, efficiently intervening into affectively charged events so as to 'balance' thoughts, behaviors and emotions.

Conclusion. *Expertise, professionalism, and selfhood*

"…the way we conceive of mental illness affects the way
we conceive of ourselves as people, and particularly the way we
conceive of ourselves as good people when we are confronted by
another person's pain. It affects our moral instincts about what it
is to be human."

T.M. Luhrmann, *Of two minds*[60]

The psychological sciences hold out the promise of mastery over the problems of

everyday life. In a society where individualism and self-determination obscure our

embeddedness in cultures and structures that constrain our life chances, we are compelled to

become agents of our destinies and our selves, to be self-determined, self-reflexive, in control

(e.g. Foucault 1988; Giddens 1991; Sennett 1998). Multiple paths for achieving such feats of

'ideal selfhood' present themselves to potential patients. This dissertation examines two

dominant talk therapeutic approaches that proffer such 'technologies' of self: psychoanalytic

and "evidence-based." Pursuing this comparison has allowed me to achieve three goals: first,

propose and substantiate a model of expertise that distinguishes affective-relational from techno-

scientific practices, second, outline these approaches' implications for professional power and

jurisdiction, and third, discuss their consequences for how we understand what it means to be a

well-functioning human being, a 'normal' 'psychological citizen.' This work furthers our

understandings of the links between expertise and emotions, temporality, and professional status.

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[60] Excerpt from T.M. Luhrmann (2000), *Of two minds: An anthropologist looks at American psychiatry*, p. 266.

We can think of psychoanalytic and "evidence-based" clinicians as embodying modes of "thinking, feeling and doing" typical of their therapeutic "habitus" (cf. Bourdieu 1977). In offices that try to recreate "laboratory conditions," practitioners develop embodied dispositions typical of their profession. They work within liminal times and spaces that bestow upon their enterprise a nearly sacred aura, creating a social order distinct from that of 'normal' interactions. Within these spatio-temporal environments, therapists acquire affective dispositions that are definitive of their work. As I showed in chapter three, they attain a high degree of tolerance for their patients' painful emotions, and become able to respond in empathetic ways. They learn to "stay in their chairs" as patients express intense rage, pain, fear, sexual desire, hatred, misery, or suicidal ideas. Psychotherapists practice an affective "asceticism" that affords them the professional authority to listen to their patients' problems, and legitimately intervene in their development. They do not, as some of my interviewees pointed out, seek to get their own emotional needs met in the therapy session (though the extent to which this does happen is nearly impossible to identify). This is partially enforced, as I show in chapter two, by professional norms limiting clinical interactions (with a few sanctioned exceptions) to the bounds of the therapy office. The office thus becomes a space of deeply uneven emotional and interpersonal experiences that are intended to facilitate patients' openness, and ensure their safety. It also reaffirms therapists' professional status and power. Within the controlled context of psychotherapy, the clinician's vision is hegemonic.

Throughout the previous pages, I have shown that psychotherapists possess distinct "technical" expertises (Collins and Evans 2007) which can be understood as approximate instantiations of two ideal types: affective-relational and techno-scientific. The first has received little consideration in studies of expertise and the professions, but a recent call for

greater attention to practices of social knowledge-making (Camic, Gross and Lamont 2011) has

the potential to change this. Creating "social knowledge" about the "actions, behaviors,

subjective states, and capacities of human beings" (ibid., p.3) is a task that does not easily or

always lend itself to measurement and quantification. Affective-relational expert practices fill

those gaps. Psychoanalytic psychotherapists embody this expertise as they rely on their

emotions as epistemic tools, and build therapeutic relationships aimed at revealing the formative

developmental events that shaped patients' present problems. In other words, clinicians use their

affective reactions to understand patients' feelings and interpersonal difficulties as they manifest

themselves in the therapy room. I show in chapter three that practitioners' emotions go beyond

empathy. Rather, they self-reflexively analyze their feelings as possible manifestations of their

own personal experiences, and then put them to use as lenses for understanding patients. The

concept of "transference" captures these therapists' attempts at identifying patterns within the

therapeutic relationship that signify how patients re-enact troubled past relationships and

experiences. Psychoanalytic clinicians' focus on developmental events and their affective

underpinnings allows them to exert a powerful influence on their patients' self-narratives.

Their counterparts in the "evidence-based" therapies are no less influential, but the

'technologies' they advance are quite distinct. Instead of affect and relationality, their epistemic

project revolves around measures, inscriptions, and compressed temporal frames. Their practices

resemble the techno-scientific expertise we encountered in the laboratories examined by Latour

(1987, 1999; with Woolgar 1979), Collins (1974), and Knorr Cetina (1999). They make

extensive use of inscriptions, including the DSM, diagnostic inventories, homework forms, and

measures of moods and anxiety. Though they acknowledge the importance of developmental

events to the trajectory of some mental illnesses (particularly those classified in Axis II of the

DSM, the personality disorders), cognitive and behavioral practitioners eschew examinations and reconstructions of their patients' pasts, in favor of intervening into "precipitating events." Such events hasten emotional crises; clinicians attempt to diffuse their consequences through targeted techniques. Like their psychoanalytic counterparts, practitioners of empirically-supported therapies recognize the importance of the therapeutic relationship—of having someone listen, empathetically and non-judgmentally. But "skills matter" as well, as some of my interviewees told me, and they matter as much as, if not more than empathy. Teaching patients how to change and control their thinking and behavior requires these clinicians' expertise at assigning a diagnosis, choosing between treatment options, personalizing interventions, motivating patients to follow the treatment, and do their "homework."

The typology I construct in this dissertation has implications for how we understand expert work and credibility, professional autonomy and jurisdiction, and, at the broadest level, the moral authority of expertise. First, I extend notions of expertise by showing that emotions can serve as essential epistemic tools. Though some scholars have begun to illustrate the affective underpinnings of work in the natural sciences (e.g. Knorr Cetina 2001; Parker and Hackett 2012), less is known about their relevance to the making of "social knowledge" (but see Knorr Cetina 2011). Unlike previous studies that emphasize the importance of empathy for engagements between experts and their clients, with their objects of knowledge, or with each other, I show that emotions function as epistemic tools by which therapists diagnose and treat their patients' problems. Psychoanalytic therapy is not singular in this respect. While organizational scholars have pointed to the greater technicization of the workplace (e.g. Barley 1996), psychotherapists—even those in the "evidence-based" therapies—rely on a combination of abstract knowledge, established techniques, and personal experience to enact their expertise.

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Self-help books have long claimed to help Americans solve nearly every problem they face, and

lift themselves to a higher level of social, economic, or interpersonal being[61] (cf. Giddens 1991;

Illouz 2008). More current and technologically sophisticated, smartphone 'apps' are to help

decrease anxiety, potentially making interactions between therapists and patients obsolete (Carey

2012). Yet therapists' expertise cannot be completely automated. Experience allows clinicians

to modify their interventions to suit the particular problems and motivational slumps patients

face. Nothing can replace a trained practitioner's empathy and validation. Given the growing

importance of service professions in our society (Gorman and Sandefur 2011), future studies

could refine and further elaborate the dimensions of affective-relational expertise, and its

valuation as a form of "professional capital."

Several professions and occupations are ripe for such examination. I pointed out in the

introduction that teachers, coaches, art dealers, and talent scouts, to name just a few, rely on

some form of intuition fueled, at least in part, by their affective responses to the problems and

clients they face. In an enlightening book on "the making of Olympic swimmers," Chambliss

(1988) relates the travails of Mark Schubert—a celebrated coach whose training regimens

produced multiple national and international medalists. Schubert's coaching style (an embodied

expertise in itself), and his relationships with the swimmers changed over the years as he became

more confident in his abilities (Chambliss 1988). In another example, Cohen (2012) discussed

the difficulties of authenticating art in the early twentieth century, and shed light on the life and

approach of Bernard Berenson (a famed authenticator of the time) whom she quotes saying:

"Sympathy kept under the control of reason has a penetrating power of its own, and leads to

discoveries that no coldly scientific analysis will disclose" (p.67). It was his sympathy for the

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[61] A recent article noted that along with prescribing drugs, doctors in London will also be recommending such self-help books to patients suffering from depression and anxiety (Morris 2013).

artist and the affective conditions in which the work of art was produced that Berenson cited as his special expert skill. This statement could just as easily be applied to psychoanalytic work with patients: it is this ability to understand by appealing to affect that sets their expertise apart. Ethnographers similarly use affective and relational skills as they immerse themselves in new settings, come to know new people, and face the emotional challenges of leaving the field, and doing justice to the data they collected (cf. Chodorow 1999). Moreover, calls for greater empathy on the part of doctors, and its importance to successful treatments have emerged in specialized literatures and the popular media (Halpern 2001; Chen 2012; Riess et al. 2012). Lastly, a growing body of literature is touting "emotional intelligence" as an essential element in managerial and leadership work (Goleman 1998; Goleman, Boyatzis and McKee 2002). Affective elements of expert work cannot be overlooked—they are essential to these, and other professionals' embodied expertise. We must understand how affective-relational skills are balanced with other techno-scientific demands, and how each is valued in different professional domains. At stake are experts' credibility, jurisdiction, and autonomy.

This brings me to a second set of contributions this dissertation makes to existing scholarship: it illustrates distinct bases of expert credibility, and provides empirical evidence for the differential distribution of professional jurisdiction and autonomy within a profession. I have argued that affective-relational and techno-scientific epistemic practices represent two modes of knowing that place distinct emphasis on the individual and her abilities. In chapter one, I showed that psychoanalytic and "evidence-based" expertises emerged out of distinct historical traditions: one from clinical work, another from laboratory science. Clinical work is dependent on experts' creativity, self-awareness, reflexivity, experience, affective life, and other idiosyncratic traits. This knowledge is local, particularistic, and embodied, it is a kind of "metis"

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(Scott 1998) that comes from experience, and trial and error. In psychoanalytic therapy, practitioners' embodied experiences during the clinical hour are crucial epistemic tools. And though self-reflection is also a part of some "evidence-based" practices—dialectical behavioral therapy in particular—it is not put in the service of gaining knowledge about the patient and her problems. Rather, in the tradition of behavioral interventions, it serves, as Nora put it, to "model positive outcomes," calm and composed ways of being (Glass and Arnkoff 1992).

Laboratory work, while still requiring experts' embodied dispositions (Polanyi 1962; Garfinkel, Lynch and Livingston 1981; Lynch, Livingston and Garfinkel 1983; Pickering 1992; Knorr Cetina 1999) relies to a larger extent on a knowledge-making apparatus in which the scientist's body is one of many "epistemic machineries" (Knorr Cetina 1999). While clinical knowledge depends on the therapist's personal experience with the patient, laboratory knowledge is, as some scholars have argued, "instrument-mediated" (Danziger 1990; Coon 1993; Carson 1999). Similarly, in the "evidence-based" therapies, knowledge is made through the DSM, diagnostic inventories, and measures. Individual skills become just one of many tools in these therapists' epistemic project. This knowledge is standardized and rationalized, it is transferrable and generalizable, driven by specification and classification of problem areas.

Affective-relational and techno-scientific knowledges thus enroll distinct sources of legitimacy. Shapin (1998, p.45) argued that until the nineteenth century, people espoused "conceptions of virtuous and sacred knowledge attached to special persons inhabiting special bodies." This is akin to the credibility of psychoanalytic psychotherapists who, relying on prolonged self-reflexivity, create authoritative knowledge about their patients. In contrast, "evidence-based" therapists draw on institutional sources of legitimacy. "Heroically self-denying bodies and specially virtuous persons" are replaced in the world of knowledge-

production by organizational guarantors of truth (Shapin 1998, p.45). Expertise thus becomes an emergent effect of networks of "actants": people, machines, universities, hospitals, laboratories, to name just a few (cf. Latour 2005). Expertise, Abbott (1991) has argued, can become embodied in objects, organizations, or individuals, and we must recognize these manifestations to better grasp its relationship to individual knowledge. Techno-scientific expertise, revolving around inscriptions, measures, and "research and evidence" ties the individual to larger systems of knowledge and legitimacy. It downgrades personal skill to the status of one of many embodied sites for expert knowledge (cf. Abbott 1991; cf. Latour 2005), while placing practitioners within larger systems of legitimacy and institutional power. This has implications for professional jurisdiction and autonomy.

Psychoanalytic approaches have become increasingly sidelined in psychiatry (Hale 1995; Healy 1997; Luhrmann 2000; Metzl 2003; Zaretsky 2004; Lakoff 2005). In psychotherapy, where 'sacred' knowledge was traditionally created within affectively rich relationships between psychoanalytic practitioners and their patients, the question facing the field today is whether it can proceed without relying on such affective depth. It is already moving in that direction as more patients are funneled into pharmacological treatments to the detriment of talk-therapeutic ones (Luhrmann 2000). Yet even as pharmacological interventions transformed the management of mental illness, psychodynamic therapy remained for some time its primary talk-therapeutic alternative (Coser 1979; Light 1980; Luhrmann 2000). This too is changing. "Evidence-based" talk therapies are growing their jurisdiction, and I have shown two important pathways by which they are doing so: first, by emphasizing the "measurability of their results" (Abbott 1988, p.46), and, second, by promoting concrete interventions (Abbott 1988, p.59).

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In chapter three, I showed that therapists in cognitive and behavioral therapies rely on measures not only to capture their patients' distress, and their progress through treatment, but also to communicate with insurance companies. Through various scales and diagnostic interviews, clinicians in this orientation have thus managed to quantify what previously seemed unquantifiable: emotional well-being. I argued that numbers help create a space of "liquidity" (Lakoff 2005a) linking these clinicians to other actors and institutions in the medical field. Numbers bestow authority and legitimacy, and function as a common language (Espeland and Stevens 2008) tying practitioners to some of the most important players in the field of mental health, insurers. In chapter four, I illustrated these therapists' targeted interventions into the cognitive and behavioral underpinnings of "precipitating" events. These techniques have broad appeal: insurance companies can control what they pay for, psychiatrists can employ them in short pharmacological appointments, patients seem to gain more control over their illness because the techniques disaggregate its workings into more manageable components. Yet these interventions serve another, more important function: they strengthen "evidence-based" therapists' jurisdictional claims. The treatments are specialized enough so as to afford this segment of the profession stronger control (cf. Abbott 1988, p. 59). Moreover, they have drawn increased attention in the public sphere, another essential jurisdictional battle field (ibid.).[62]

Though losing some of their jurisdictional territory[63], psychoanalytic clinicians have maintained an essential professional attribute: autonomy. The majority of the psychoanalytic psychotherapists who had finished their training and participated in this study ran private offices,

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[62] For example, a spate of New York *Times* articles in recent years have praised "evidence-based" therapies, ranging from topics detailing the efficacy of virtual CBT for Juarez residents suffering from PTSD (Zabudovsky 2012), to CBT for elderly patients suffering from depression or anxiety (Ellin 2013), and a modified version of CBT offered to patients diagnosed with schizophrenia (Carey 2011). A 2013 article by Harriet Brown in that same newspaper critiqued the mental health field for not implementing cognitive and behavioral therapies faster and more effectively.

[63] Some diagnoses, such as psychosis (Hale 1995) and borderline personality disorder are now under the nearly complete jurisdiction of psychiatrists and dialectical behavioral therapists.

away from the inquisitive eyes (or forms) of insurance companies. As I showed in chapter three, when they do work in clinics where they interact with the larger medical establishment, they manage the "sociological ambivalence" (Merton and Barber 1976) of their roles by code-switching. When writing their notes, they distinguish between audiences of like-minded peers, and those colleagues, and insurance companies less interested in unconscious and developmental processes. Yet their autonomy has come at the price of organizational ties, as more and more psychoanalytic practitioners have difficulty getting reimbursed for the services they offer, and find a place within the established institutions of the medical world[64]. It seems their mastery of the technical language of "evidence-based" therapy is incomplete.

These findings suggest that jurisdiction and autonomy are professional attributes that must be considered separately. Freidson (1970) argued that autonomy is one of the defining elements of a profession, a hard-won freedom to self-govern obtained from the state in exchange for training and credentialing systems guaranteed by self-policing. In other words, autonomy insures professions' independence in managing work within their jurisdictional domain. Autonomy in medicine has been treated as an uncontroversial good, and debates over its loss have flooded medical sociology since the onset of managed care (e.g. Haug 1988; McKinlay and Marceau 2002; Timmermans and Kolker 2004). In keeping with arguments made by Timmermans and his collaborators (with Berg 2003; with Kolker 2004), this study suggests that we must examine professional practices, in addition to institutional arrangements, to understand professional independence. I have shown that, though their jurisdiction over mental illness may be shrinking, psychoanalytic psychotherapists are still able to wield a great deal of control over

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[64]This shouldn't be taken to mean that their expertise is increasingly irrelevant. Psychoanalysis has historically appealed to a select clientele made up of the wealthier, highly educated, and creative classes (Kadushin 1966), and its marginalization in the world of medicine will do little to affect this. Moreover, psychoanalysis has become a staple in academic discourse, particular feminist and queer identity studies (Zaretsky 2004).

their training, professional ethics, and expert practices. Yet autonomy is not by necessity an absolute gain for a profession, as psychoanalysts have been losing their grip over mental illness. Thus, practical attempts at maintaining autonomy can work against a profession's efforts at upholding its jurisdiction.

Though I have argued that affective-relational and techno-scientific expertises have their strengths in dealing with mental illness, I also suggest that they are differentially valued in medicine, and in our society at large. They are imbued with distinct forms of credibility—one personal, another institutional—that make for divergent claims to authority. One last element sets these practices apart, and has broader implications: temporality. Previous scholars illuminated the distinct temporal frames that distinguishes the work of doctors and nurses (Zerubavel 1979, 1982), scientists and managers (Dubinskas 1988), and physicists at various stages of their careers (Traweek 1988). This dissertation adds an additional dimension to understandings of time and expertise. Temporality is important in therapeutic expert practices in two related senses: first, as a frame that constrains therapists' work with their patients (the kind of structuring mechanism that previous scholars have elaborated), and second, as a target of clinical intervention. In both these senses, therapists in psychoanalytic practice work with expansive notions of time: they recommend open-ended, long-term treatments, attend to their own and their patients' developmental time, and focus on the formative events that reverberate into present emotional and relational problems. In contrast, "evidence-based" therapists' temporal frames are more compressed: they emphasize shorter treatments in which the historical development of patients' problems is relegated to the background. They stay in the present (broadly construed), by examining precipitating events, and promoting change-oriented interventions. Their temporal practices fit with current medical emphases on efficacious and

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targeted treatments, further strengthening these therapies' claims to dominance in mental health. These distinct temporal approaches have a larger consequence: they lend themselves to different ways of thinking about what it means to be a well-functioning human being.

Scholars have argued that an essential and nearly universal way that people construct identities is through narrative (Taylor 1989; Richardson 1990; Cronon 1992). Such narratives result from ordering events and imbuing them with meaning (that often becomes apparent post-hoc) (ibid., also, Charmaz 1991; Sennett 1998). This amounts to constructing historically informed "inner times" that fit with our (evolving) conceptions of self (Garfinkel 1967). Experts assert an authoritative role in this process (cf. White 1980), and therapists are centrally positioned to wield such influence (cf. Foucault 1988; cf. Giddens 1991; cf. Illouz 2008). Yet, as I argue in chapter four, they promote distinct versions of selfhood depending on their epistemic techniques. Thus, psychoanalytic practitioners emphasize the integration of past with current emotional and interpersonal circumstances achieved through self-awareness in the context of a therapeutic relationship. Developmental time is granted explanatory power in understanding who we are. "Empirically-supported" therapies construct the self as an entity made up of more or less malleable components (i.e. behaviors, thoughts, feelings), that can be changed through targeted, discrete tools. Inner time here revolves around precipitating events that gain significance as platforms of cognitive and behavioral interventions. History takes a back seat to personal change. Compartmentalization, quantification and measurement constitute a powerful form of self-knowledge that is becoming wide-spread in our society.

Both of these models reify the importance of one aspect of selfhood. Psychoanalytic therapy fetishizes the past and the personality[65], while the "evidence-based" therapies—

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[65] Such depth was not always beneficial to patients, as many experienced abuse (emotional, financial, and sometimes physical) at the hands of their therapists.

including psychopharmacology—overemphasize the executive power of the brain and mind. A mix of approaches may be the best method for intervening into the complex field of mental illness, and my data showed that such eclecticism, however tenuous, does exist. Yet quantification is becoming more visible in our society, both at the institutional (Porter 1995) and at the individual levels. Movements like the *Quantified Self* have taken the idea of measurement and applied it to the most mundane and minute everyday behaviors. Its members, who regularly meet for conferences to share stories that often detail various life improvements that resulted from computing diverse aspects of their lives, are dedicated to "self-knowledge through numbers," tracking issues as diverse as stress, time, money, weight, and chocolate intake[66]. Technological advances make possible quantifiable improvements. Developmental history is downplayed here. No longer is the family the locus of personal development. Individualism reigns, and change can only come from within, as people learn to track and change their thoughts, behaviors and emotions.

In sum, this dissertation proposes a typology of expertise that distinguishes between affective-relational and techno-scientific approaches, and provides empirical evidence in support of this classification. I argue that, in the psychological sciences, these epistemic projects have distinct historical roots (the clinical setting, and the laboratory, respectively), which shape the work characteristic of each. One of the main contributions this dissertation makes to existing scholarship is to illuminate the epistemic practices that sustain distinct forms of knowledge, with particular emphasis on affect and temporality. I show that emotions can function as valuable epistemic tools, and that time is not simply a frame that structures therapists' professional work, but also a target of clinical intervention that links therapeutic practices to patients' self-identities. In addition, I argue that affective-relational and techno-scientific approaches position individuals

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[66] Accessed http://quantifiedself.com/ on May 29, 2013.

in distinct relationships to systems of expertise. I suggest that the former presupposes a skilled and self-reflexive individual as the locus of knowledge. Techno-scientific approaches rely on networks of "black boxes" (Latour and Woolgar 1979) in which individual skills are one of many institutionally sustained and legitimated tools of knowledge production. These expert practices have implications for how we understand professional autonomy, and jurisdiction. Lastly, they shape our understandings of what it means to be a 'normal' self in our culture.

We see here that practitioners of affective-relational and techno-scientific expertises pursue distinct kinds of goals, have different conceptions of success, and draw on divergent sources of legitimacy. The former espouse the value of "insight," and consider their treatments successful when their patients can construct an affectively rich, historical narrative about their past and present. Their legitimacy is not only the result of years of training (which, for psychoanalysts is quite extensive), but also of self-reflexivity and affective awareness. These embodied dispositions are the roots of therapists' idiosyncratic knowledge about patients' particular problems. Practitioners of techno-scientific approaches aim to foster change, and to do so in measurable increments. Patients learn to distinguish between thoughts, behaviors and emotions, and to quantify and change them through targeted techniques. Clinicians in these orientations are endowed with an institutional legitimacy that stretches from the therapy room to the laboratory, to hospitals, universities and insurance companies.

The larger point that this dissertation makes is that expertise is imbued with a moral authority that often becomes naturalized as epistemic power. Because they seem to offer explanations and treatments for some of the most stigmatized human conditions (those classified under the rubric of mental illness), psychotherapists are granted the legitimacy to intervene into, and shape our schemas of the good, of 'normalcy,' of 'ideal selfhood.' Yet, as psychoanalysis

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demonstrated in the decades of its glowing popularity, such a mandate can be easily abused. The "evidence-based" approaches are following a similar path of expansion and domination. Their appeal and availability may make them into an even more powerful force than psychoanalysis ever was. The danger lies with the individualism that such therapies foster. Though psychoanalysis has been criticized for doing just this (e.g. Laing 1971; Szasz 1974; Lasch 1978), its appeal to the relatively highly educated, and better off neutralizes some of the negative consequences of such individualist interventions. With their wider applicability, "evidence-based" treatments reach suffering individuals from lower socio-economic rungs (Beck 1995) who are in danger of internalizing a view of the world that furthers the already prevalent individualist ethic dominant in our society. Such individualism obscures the value of social and cultural resources in favor of a focus on the self.

Psychoanalysis taught us to blame our parents. The "evidence-based" therapies turn the critical gaze upon ourselves, as failures and successes become chiefly our own. Self-blame is balanced by an outsized belief in our powers to succeed through self-transformation. Relationships recede into the background and the self emerges as *the* agentic power. This orientation deepens, refines and justifies the rationalist and intellectualized attitude Simmel ([1903]1971) identified in the metropolis dweller who built a protective shield against the external environment. But it also threatens to change the criteria by which we form communities,[67] or, detrimentally, further undermine the remaining bases of community that have been already eroding since the onset of the second industrial revolution.

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[67] Think for example of *e-harmony* and other dating websites that claim to match potential couples by measuring their compatibility on a variety of axes. In a different field, advanced statistics are increasingly replacing less technical ways of understanding athletic performance (Eder 2012). Such measures are then used to make recruitment decisions, and match athletes in teams.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been
bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns   [＿＿] + [＿＿] + [＿＿]

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).   TOTAL: [＿＿＿＿]

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10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

 - if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3

3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.

5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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THOUGHT RECORD

Directions: When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** and as soon as possible jot down the thought or mental image in the Automatic Thought Column.

DATE/ TIME	SITUATION 1. What actual event or stream of thoughts, or daydreams, or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	AUTOMATIC THOUGHT(S) 1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	EMOTION(S) 1. What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	ALTERNATIVE RESPONSE 1. (optional) What cognitive distortion did you make? (e.g., all-or-nothing thinking, mind-reading, catastrophizing, etc.) 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	OUTCOME 1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0-100%) is the emotion? 3. What will you do ? (or did you do?)

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of changing my thinking? (5) What should I do about it? (6) If _____ (friend's name) was in the situation and had this thought, what would I tell him/her?

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