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# Diagnostic ambivalence: psychiatric workarounds and the Diagnostic and Statistical Manual of Mental Disorders

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**Abstract** In 1980 the American Psychiatric Association (APA), faced with increased professional competition, revised the Diagnostic and Statistical Manual of Mental Disorders (DSM). Psychiatric expertise was redefined along a biomedical model via a standardised nosology. While they were an integral part of capturing professional authority, the revisions demystified psychiatric expertise, leaving psychiatrists vulnerable to infringements upon their autonomy by institutions adopting the DSM literally. This research explores the tensions surrounding standardisation in psychiatry. Drawing on in-depth interviews with psychiatrists, I explore the 'sociological ambivalence' psychiatrists feel towards the DSM, which arises from the tension between the desire for autonomy in practice and the professional goal of legitimacy within the system of mental health professions. To carve a space for autonomy for their practice, psychiatrists develop 'workarounds' that undermine the DSM in practice. These workarounds include employing alternative diagnostic typologies, fudging the numbers (or codes) on official paperwork and negotiating diagnoses with patients. In creating opportunities for patient input and resistance to fixed diagnoses, the varied use of the DSM raises fundamental questions for psychiatrists about the role of the biomedical model of mental illness, especially its particular manifestation in the DSM.

**Keywords:** psychiatry, diagnosis, workarounds, sociological ambivalence

## Introduction

In 1980 the American Psychiatric Association (APA) revised the Diagnostic Statistical Manual-III (DSM-III), redefining psychiatric expertise from a psychodynamic model to a biomedical one (Horwitz 2002, Rogler 1997). The revisions emerged as a professional strategy to overcome a period of crisis in psychiatry. By the 1960s American psychiatry was still largely committed to psychoanalysis. This commitment, however, was waning in the face of a number of challenges, including the emergence of other mental health professionals offering alternative therapies to psychoanalysis; critical, social scientific research that exposed the inconsistency and arbitrariness of psychiatric diagnosis (see Kendell *et al.* 1971, Rosenhahn 1973) and an anti-psychiatry movement that popularised dehumanising depictions of the asylum. By the late 1970s the confluence of these multiple critiques compromised the credibility of psychiatry.

Reformers in the APA interpreted the profession's problems as a failure of diagnostic reliability, both in treatment and research, induced by the commitment to the psychodynamic


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model (Kirk and Kutchins 1992). The revisions to the DSM-III sought to increase reliability through standardisation and, in turn, bolster psychiatry's claim to scientificity (Horwitz 2002, Kirk and Kutchins 1992). The intent was to move psychiatry away from the fluid psychoanalytic understanding of mental illness towards a standardised nosology of fixed disease categories. Although agnostic towards schools of psychiatry, this new paradigm of diagnostic psychiatry classifies symptoms into discrete disease entities that are believed to represent organic pathologies (Horwitz 2002). Thus, the revisions to the DSM represented a strategy to attain a biomedical model by understanding illnesses as stable entities that can be explained in terms of specific causal mechanisms located in the body (Rosenberg 2002). They were sold as a way to improve treatment through empirically based research programmes and specific treatment regimens based on rigorous diagnosis (Horwitz 2002). According to Dr Robert Spitzer, chair of the task force for the DSM-III;

> The manual's [DSM] real significance is that it shows psychiatry becoming more of a science. The criteria for making a diagnosis are spelled out with great specificity, and patients will benefit because the diagnoses have treatment implications (quoted in Sobel 1979)[1].

By professional standards the revisions succeeded. The DSM-III and its subsequent editions (DSM-III-R, DSM-IV and DSM-IV-TR) have achieved ubiquity not only in psychiatry, but in the field of mental health generally. DSM-III-R sold 1.1 million copies in just 6 years (Caplan 1995), while recent editions, DSM-IV and DSM-IV-TR, have sold over 800,000 (Carey 2008). The widespread adoption of the DSM by researchers, insurance companies, pharmaceutical manufacturers and other mental health professions represents a validation of psychiatry's claim to expertise. DSM codes organise the institutional infrastructure of the mental health field as they are required for insurance reimbursement, hospital admittance, psychiatric research and professional exams. The ascendancy of the DSM has facilitated the proliferation of pharmaceuticals in the treatment of mental illness (Rose 2004), the new big business of these drugs (Healy 1997) and the increased presence of managed care. Finally, as the DSM is coordinated with the International Classification of Diseases (ICD), its international influence is increasing. By the 1990s psychiatry had solidified its position in the mental health market; through the DSM, it literally defined the field of mental health.

The revisions' scientific achievements, however, have been mixed. Firstly, while the DSM has become the language of the profession, there is little evidence that it has improved diagnostic reliability (Kirk and Kutchins 1992). Spitzer recently admitted, 'To say that we've solved the reliability problem is just not true', (quoted in Spiegel 2005). Secondly, treatment decisions generally do not follow directly from pinpointing a particular diagnostic category; specific treatments for most DSM categories have yet to emerge (the most obvious exception being bipolar disorder). Drugs like selective serotonin reuptake inhibitors (SSRIs) work across a spectrum of disorders and the chemical processes underlying the most successful SSRIs remain poorly understood (Valenstein 1998). Finally, the lack of specific treatments raises questions about the validity of the DSM categories. Understanding the biological mechanisms behind mental illness remains elusive (Horgan 1999, Leo 2004, Wong and Licinio 2001), forcing psychiatry and the DSM to categorise mental illness according to their manifest symptoms.

More than the mixed scientific results, the manner in which the DSM has been incorporated and institutionalised has had negative unintended consequences for psychiatrists in practice. In securing autonomy for psychiatry in the field of mental health, the DSM simultaneously facilitates an infringement on the autonomy of psychiatrists. This

research explores the tensions that emerge at the level of practice and that have resulted from the DSM's strategy to achieve scientificity through standardisation. The first part of this article describes the organisational constraints on psychiatric practice that the DSM facilitates. Standardisation has its cost. As a public proclamation of psychiatry's expert knowledge, the DSM makes psychiatric practice more transparent to outsiders, demystifying psychiatric expertise and enabling the bureacratisation of psychiatric practice. Organisations use the DSM to monitor treatment and infringe on the discretion of psychiatrists. I argue that the DSM's implication in this loss of discretion leads to 'sociological ambivalence' (Merton 1976) towards the DSM and towards diagnosis generally. The second part of the article investigates the strategies or 'workarounds' (Bowker and Star 2000) that psychiatrists employ to cope with their ambivalence and resist bureacratisation. These include employing alternative diagnostic typologies, fudging the numbers (or codes) on official paperwork, and negotiating diagnoses with patients. Finally, I discuss how these workarounds affect psychiatrists' views of the efficacy of the biomedical model of mental illness, specifically the programme of diagnostic psychiatry to achieve such a model. The aim of this study is to capture the complex negotiations psychiatrists make in navigating the difficult circumstances inherited from the shift to diagnostic psychiatry.

## Sociological ambivalence: the perils of standardisation

Contemporary sociological research on the DSM focuses primarily on its production. Though presenting a veneer of scientific objectivity, the production of DSM categories is revealed to be influenced by polemical, extra-scientific causes. This body of research typically focuses on specific problematic categories, most notably attention deficit disorder (Lakoff 2000, Rafalovich 2005), depression (Horwitz and Wakefield 2007), bipolar disorder (Martin 2007), multiple personality disorder (Hacking 1995), personality disorder (Manning 2000), post-traumatic stress disorder (Scott 1990, Young 1995), and late luteal phase dysphoric disorder (Caplan 1995, Figert 1995). Once produced and institutionalised, categories create new ways of being in the world, making up people through a process of classificatory bio-looping that produces the very forms of behaviour they define (Hacking 1995, 2002). As categories proliferate and more types of behaviour are pathologised, psychiatry inhibits alternative parallel understandings of mental problems, over-medicalising deviant behaviour (Conrad 2007, Horwitz 2002).

While there is much research criticising the production of the DSM and its diagnostic categories, less attention has been paid to how it is used in practice.[2] The depiction of the DSM that emerges from the sociological research unwittingly portrays it as a monolithic, powerful object in and of itself; it overstates the power of formal diagnoses and obscures resistance to its through informal work practices by psychiatrists. To correct this portrayal, this study grounds its analysis of the DSM in the complicated, everyday diagnostic practices of psychiatrists, showing how diagnostic psychiatry is undermined in practice.

### *Standardisation as a professional strategy*

The revision of the DSM was part of a professional project by the APA to gain jurisdictional control over mental health work. According to the logic of professionalism, organised occupations are granted privileged positions in the marketplace and discretionary control over their labour because the tasks they perform require specialised, expert knowledge (Freidson 2001). The sophistication of this knowledge justifies professional autonomy. To win recognition for this privileged status – a monopoly over 'the practice of a defined body of

intellectualised knowledge and skill' (Freidson 2001: 198) – professions compete with each other in an interdependent system over professional jurisdictions (Abbott 1988). Control over a jurisdiction can be won only at the expense of other professions. Because what separates a profession from other forms of labour is its control over expertise, abstract knowledge ('the currency of competition' (Abbott 1988: 102)) plays an indispensable role in resolving jurisdictional disputes. Professions strategically alter their abstract knowledge to gain control over a jurisdiction by redefining or seizing problems and tasks. This is what the DSM sought to do and accomplished.

However, the strategy of achieving a biomedical model through codification and standardisation rendered psychiatric expertise more transparent, and therefore more amenable to surveillance and bureaucratisation. The risk of standardisation is that increased transparency can lead to increased surveillance (Bowker and Starr 2000). Professions must strike a balance between publicising and standardising their expert knowledge to justify their claim to a jurisdiction and retaining a degree of opacity to permit them to exclude outsiders to some degree (Larson 1977). The DSM has failed to strike this balance. Psychiatry, through the DSM, defines the field of mental health but these categories, once adopted by external actors (such as insurance companies) with divergent goals, are used to monitor the practice of psychiatrists and to infringe upon their professional discretion. Outside actors have adopted a literal approach to the DSM, embracing a reductionist view of mental illness and a corresponding simplistic biomedical model by which treatment follows directly from diagnosis. Their operating procedures are premised on this understanding, and they expect psychiatrists to conform to it when following their protocols. If professional expertise is premised on autonomy in practice (Freidson 1970, Larson 1977), the exercise of professional judgment (Freidson 1986), asymmetry in expert knowledge (Abbott 1988), and a certain degree of mystification of knowledge, the DSM, as a publicly available guide, enables outside actors to undermine these ideals of discretionary freedom.

*Sociological ambivalence and workarounds*

Given its facilitation of bureaucratisation, psychiatrists hold paradoxical opinions on the DSM. On the one hand, the DSM has shored up the jurisdictional claims of psychiatry and its veneer of scientificity justifies psychiatrists' authority over other mental health providers. On the other hand, the particular strategy of achieving scientificity through standardisation has rendered psychiatric knowledge more transparent and facilitated the imposition of external actors on individual psychiatrists – a situation that is anathema to the logic of professionalism.

By resolving its jurisdictional dispute through standardisation, the APA created unintended consequences that have led to a situation of 'sociological ambivalence' (Merton 1976) for psychiatrists. Noting 'the gross facts of mingled feelings, mingled beliefs, and mingled actions', prevalent in social life, Merton (1976: 5) introduced the concept of sociological ambivalence to identify socially structured situations in which individuals are pulled by conflicting interests. Unlike individualistic psychological theories of ambivalence, sociological ambivalence emerges from structurally induced contradictions that generate tensions manifested in competing demands placed on individuals by an attributed role. The ambivalence experienced by psychiatrists results from a tension experienced by psychiatrists as a member of a profession and as an individual professional, from the tension between capturing professional authority in a system of mental health professions and the desire to exercise individual professional autonomy in practice, free of external meddling. Such ambivalence is particularly acute. It goes beyond the normal concerns of bureaucratisation

because psychiatrists themselves have created the tool through which bureaucratisation is achieved.

Because of its self-inflicted nature, this ambivalence also represents more than the disjoint between formal knowledge and local particularities common in many professions (Freidson 1986). It is fundamental to the identity of contemporary psychiatry, as evidenced in its breadth and persistence. Over two decades ago, Brown (1987) observed the ambivalence experienced by psychiatrists towards diagnosis, noting that in the course of routine diagnostic evaluations in a community mental health centre, clinicians engaged in conflicting and ambivalent kinds of behaviour. Brown located this ambivalence within the organisational context of the community health centre, resulting in attempts to square abstract knowledge with local contingencies of the centre. While these organisational tensions are real, the ambivalence surrounding the DSM traverses organisational contexts. Psychiatrists practising in varied local contexts, both inside bureaucratic organisations and outside in private practices, experience this ambivalence. It cuts to the heart of the identity of psychiatrists as the DSM is both a guarantor of psychiatry's position in the mental health field and a tool wielded against individual psychiatrists to monitor their practice.

Ambivalence is unsettling as it represents a simultaneous attraction and repulsion (Smelser 1998). To resolve these conflicting emotions, individuals develop strategies to negotiate and alleviate their ambivalence (Smelser 1998). Such is the case with the DSM. In opposing this incursion on their autonomy facilitated by the DSM, psychiatrists develop 'workarounds': ad hoc temporary solutions and strategies to problems arising when the official protocol is perceived as hindering the assigned task (Bowker and Star 2000). In doing so, they formally conform to expectations of the DSM, while carving out a space of autonomy. Psychiatrists adopt a number of workarounds to retain professional discretion. By illuminating professional practices built on 'the dynamics of ambivalence' (Smelser 1998: 7), diagnostic practices emerge from this study as a set of complicated negotiations with the DSM by psychiatrists.

## Methodology

Drawing on in-depth interviews with psychiatrists, this study reveals the contradictions and negotiations involved in psychiatric diagnoses, complicating the portrayal in previous research of the DSM as a monolithic entity. The diverse sample includes practising psychiatrists with different backgrounds working in a variety of settings in the New York Metropolitan Area ($n = 36$).[3] A total of 21 psychiatrists in the sample work predominantly in private practice; 15 work mostly in hospitals or in-patient and out-patient clinics. Their experience ranged from 50 years of practice to less than one. All the psychiatrists in my sample had patients on medication, with most ($n = 31$) claiming that over half of their patients were on medication.[4] Each psychiatrist engaged in psychotherapy in addition to medical management, although the ratio between the two varied widely.

Approximately one hour in length, the semi-structured interview consisted of two parts. Firstly, respondents were asked about their diagnostic practices in general (that is, what information they seek, when is a diagnosis made in treatment, who is consulted during this process and what role diagnosis plays in determining treatment). The second part of the interview focused on the DSM specifically, including questions about the perceived strengths and weaknesses of the DSM, its role in the history of psychiatry, its use in practice and its relationship to other facets of their work. By presenting psychiatrists with hypothetical situations and following their reasoning through these situations, the individual interviews

yielded detailed descriptions of each psychiatrist's diagnostic practices, especially as they relate to the DSM. Because issues of diagnosis implicate fundamental conceptualisations of mental illness, the interviews also touched on the value of the biomedical model of mental illness.

## Standardisation and institutional constraints

Diagnosis is not only a ritual that occurs between a doctor and a patient; it is 'a mechanism structuring bureaucratic interactions', (Rosenberg 2002: 240). Codification makes expertise more accessible to outsiders, allows for the bureaucratisation of psychiatric practice and weakens professional autonomy at the local level. As the DSM is adopted by other actors in the mental health field to achieve a variety of ends, competing understandings of the diagnostic categories are brought to bear on the interaction between patient and psychiatrist that can conflict with psychiatrists' views.

Organisations adopt the DSM literally, imposing inflexible understandings of the DSM categories that are lacking in nuance, critical engagement or recognition of the idiosyncrasies of a patient. Mental illnesses are treated as symptom clusters to be cured, not life problems to be sorted out. Folding this literal interpretation into their operating procedures, organisations coordinate their practices according to this literal interpretation, creating a series of constraints on psychiatric discretion. These include:

*Insurance companies*

All psychiatrists in my sample resent the interference of insurance companies on their practice; a resentment compounded by their financial dependence on these companies. Only one psychiatrist in the sample charges patients exclusively out of pocket; every other psychiatrist deals with insurers.[5] Generally, the psychiatrists in my sample lack any hard and fast rule as to how they deal with insurance (that is, whether they receive reimbursement directly from insurance companies or indirectly, with patients paying out of pocket and subsequently being reimbursed by insurers). Their practices vary on a patient-to-patient basis, evolving out of an initial conversation with the patient and followed by continual refinement as problems become identified or changes occur.[6]

Insurance companies require a diagnosis (and sometimes a treatment plan) on their paperwork to determine reimbursement. Interpreting the DSM categories literally, insurers expect the discrete illness to be identified prior to treatment. According to a female psychiatrist with a private practice, 'Insurance companies want to be pretty concrete. They don't care if someone's hovering over the existential abyss. They don't care about people's emotional reality. They want a number'. Once the diagnosis is made they expect the treatment to follow in a certain way, for a certain cost. Driven by the profit motive, insurance companies use the DSM to monitor and standardise treatments in order to lower costs. To monitor the progress of treatment, insurance companies sometimes require updates on the patients' improvement using the Global Assessment of Functioning (GAF), a numerical scale intended to measure the functioning of the patient.

*In-patient settings*

In clinics and hospitals the need to communicate with multiple actors leads to the use of the DSM as shorthand. Diagnostic categories become the currency of exchange in these organisations. Yet different actors in these settings understand the DSM differently; 'Some people tend to use it as the Bible and some people don't give a shit of what it says', (female

psychiatrist, in-patient emergency clinic). Still, even those 'who don't give a shit' are forced to use the DSM to communicate. Additionally, the DSM has become institutionalised in a literal way in the operational procedures of these settings, especially for admission and discharge procedures. Diagnostic categories determine the way in which patients are sorted and organised. Most patients are required to meet a particular GAF score to be admitted or discharged.

*Patients*

Because the DSM is a public document, patients also draw on it. Patients periodically come to the clinical interaction with a DSM diagnosis in mind. The increase in internet-based resources and direct-to-consumer drug advertising allows patients to be more proactive with their doctors. Because these resources tend to present mental disorders as diseases with specific cures, patients come to expect their psychiatrist's orientation to conform to this view. Additionally, as the DSM categories receive cultural validation and people organise politically around them (Lakoff 2000, Martin 2007), patients interpret their individual experiences through the lens of the DSM and demand that psychiatrists do the same.

The literal adoption of the DSM infringes upon psychiatrists' professional discretion and according to psychiatrists, disavows the complicated, fuzzy nature of psychiatric illness. States a male psychiatrist in a private practice, 'Unlike in medicine, in other fields of medicine, you have maybe objective medical based criteria that you can base your findings on. In psychiatry that's a problem. It's a little more subjective'. Another (male psychiatrist, outpatient clinic) concurs: 'There are some things that are really hard to quantify and codify'. Regardless then of individual belief in the usefulness of the biomedical model, all psychiatrists in my sample complained of the way in which the DSM enabled external actors to impose a reductionist biomedical model on them – a model that negated the complexity of mental illness.

## Working around the DSM

To carve a space of autonomous practice psychiatrists develop a series of workarounds to insulate their practice from this literal, reductionist application of the DSM. Workarounds allow psychiatrists to comply formally with the DSM while protecting their professional discretion and autonomy. Psychiatrists employ three types of strategies to reclaim professional discretion in diagnostic practices. These are: (1) employing alternative typologies, (2) fudging the numbers (or codes) on official documentation, and (3) negotiating diagnoses with patients. Within each of these categories exist a range of variations from intentional subversion directed towards the biomedical model to less extreme workarounds aimed at circumventing bureaucratic requirements.

*Alternative taxonomies*

Psychiatrists' use of alternative taxonomies undermines the main DSM's purpose – diagnostic reliability through standardisation. In this workaround psychiatrists make diagnoses according to their understanding of mental illness and then translate them into DSM terms after the fact. Thus, the diagnostic framework applied in practice diverges (often widely) from the standardised assessment of symptoms that the DSM lays out.

The most common alternative taxonomy adopted by psychiatrists in my sample involves a radical shrinking of the DSM. The DSM-IV-R contains approximately 300 different diagnostic categories. Few psychiatrists have working familiarity with the least common

categories. It is common when using a large taxonomy for it to be pared down in practice. However, psychiatrists drastically reduce the numbers of diagnostic categories they use. Some psychiatrists whittle the 300 diagnoses of the DSM down to three or four codes that they repeatedly employ. One psychiatrist diagnoses 'one or two DSM codes always' (male psychiatrist, private practice), while another uses 'the same seven diagnoses over and over' (female psychiatrist, in-patient hospital). In in-patient settings this workaround can take on a collective dimension (such as 'We [the hospital staff] tend to use the same standard diagnoses over and over', male psychiatrist, in-patient hospital). This shrunken version of the DSM undercuts the taxonomy of the DSM by reducing its breadth and discarding a number of categories from the universe of possible diagnoses. Official diagnosis, the lynchpin of the DSM reform, is reduced to a bureaucratic requirement, because 'you have to put something down' (a male psychiatrist with over 30 years of experience).

A more subversive and less prevalent variant of this workaround is to create two broad, differential categories of patients – one group to be treated according to the DSM and another to be insulated from it. Typically, patients are divided according to whether the overriding issue is an axis 1 disorder (that is, mood disorders like depression or anxiety) or an axis 2 disorder (that is, personality disorders like schizoid personality disorder). This binary categorisation of mental illness – problems of consciousness versus problems of the subconscious, objective versus subjective disorders – reflects different psychiatric logics – the newer biomedical model versus the older psychodynamic model. As a result, this initial arrangement roughly maps onto different treatment plans – an emphasis on medication for axis 1 disorders and an emphasis on psychotherapy for axis 2 disorders. The groupings are not perceived to be mutually exclusive, as psychiatrists recognise the overlap and co-morbidity between axis 1 and axis 2 disorders. Rather, this binary categorisation reflects different emphases determined by the psychiatrists' interpretations as to what the proper focus of the therapeutic intervention should be. In many cases this initial arrangement is never refined to a specific diagnostic category. A female psychiatrist in an in-patient clinic states:

> We may stay very long with a differential diagnosis. The way our in-patient clinic works we're encouraged by the attendee on the unit to make the differential as broad as possible . . . so we usually have a leading diagnosis and a bunch of rule outs.

The aim here is not to pinpoint an accurate diagnosis for an individual patient to determine the treatment that would follow; rather, it is to sort patients into two broad groups for organisational purposes. In categorising patients this way psychiatrists create a group of patients who fall outside the authority of the DSM.

The use of alternative taxonomies contains an implicit critique of the biomedical model by de-emphasing the importance of diagnosis. Diagnosis is not determined by an objective assessment of symptoms, but rather through the psychiatrist exercising professional discretion as to the type of treatment the patient may need. For example, a psychiatrist with three decades of experience determines diagnoses according to 'what does this person need and how can I get it for him if I feel he deserves it'. This line of reasoning inverts the traditional chronology of the biomedical model. Treatment does not follow diagnosis; diagnosis follows treatment. The label is applied after the fact and then quickly discarded to justify a treatment based on the psychiatrist's individual normative assessment of the patient's need. The judgment exercised here is more idiosyncratic and opaque than the standardised assessment championed by the DSM.

Because 'giving a diagnosis doesn't really capture the subtleties of the individual' (female psychiatrist, in-patient clinic), psychiatrists do not perceive this workaround as being

unethical. Rather, these psychiatrists worry that the categories do not reflect what they are seeing in their patients. To apply them in a literal way would be an injustice to their patients. According to a female psychiatrist in an in-patient clinic, the DSM is

> a kind of a reductionistic way to think about patients. I mean, we use it, we comply with what's in it, but I don't think it really guides the way we necessarily think of, conceptualise our patients. We try to think of them in terms of personality characteristics.

*Fudging the numbers*

Fudging diagnoses, the most prevalent workaround, emerges as a bulwark against oversight through paperwork. Psychiatrists openly acknowledge that they fudge numbers on forms.[7] The strategy works as follows. Each category defined by the DSM has a code. Insurance companies and hospitals require these codes for reimbursement. But psychiatrists often intentionally misdiagnose a patient on the forms. A male psychiatrist with 50 years of experience states:

> I want to tell you that we all fudge. In order to meet insurance requirements we all fudge, we distort the diagnoses. Very often we use a diagnosis that will be acceptable. . . . So everybody has a major depressive illness. In order to deal with insurance requirements, you have to distort it . . . I mean, I wouldn't lie, but I would stretch the diagnosis. Definitely.

Fudging the numbers provides psychiatrists with autonomy by disguising their actual practices through a superficial compliance with organisational and bureaucratic requirements.

The motivation to fudge originates from two conflicting concerns. In most cases psychiatrists are concerned that their patient will not receive the financial reimbursement necessary to cover treatment. The concern here is how the DSM code given will 'pass muster with the insurers', (male psychiatrist, private practice). Psychiatrists often write down codes for more severe disorders to ensure that insurance companies will cover the cost of treatment or that patients will gain admittance into a hospital. Over-diagnosis reflects psychiatrists' awareness of the growing reach of the DSM and the divergent interests between their goals of providing professional care and the profit motive of insurance companies, who 'do anything and everything not to pay', (male psychiatrist, private practice). A male psychiatrist working in an out-patient Veterans Administration hospital observes:

> The DSM, since it's accepted so widely by insurance companies, bureaucracies, it does have a big influence on whether the doctor or the institution gets paid or whether the patient will get disability or whether he will be excused, get compensation from if it's serious. So if you feel a person deserves to get compensation . . . you would have to have a serious diagnosis.

This psychiatrist, like others, determines what the diagnostic code is, based on his professional judgment about the allocation of resources rather than from a systematic assessment of symptoms. He determines the treatment and compensation he thinks a patient deserves and applies the necessary code to achieve these ends. This normative judgment as to what the patient deserves is not transparent, but is based upon individual, professional discretion that is difficult to codify – precisely the situation the DSM was created to eliminate. The resulting over-diagnosis does not represent a radical departure from the patients' actual symptoms; it is an embellishment that allows psychiatrists to assert their

professional authority by getting patients the treatment they need. As a young female psychiatrist with a private practice acknowledges:

> Sometimes I purposely put down a more intense diagnosis, not ever to lie, but to sort of. If they might be dysthymic but there's a possibility that they might have depression, I put down depression, so that they can get reimbursed.

Counteracting over-diagnoses are worries about stigma. Even though the stigma of mental illness has waned, it remains a pressing concern for both patients and psychiatrists. To avoid the pernicious effects of a stigma, psychiatrists, in consultation with the patient, will 'punt low', (male psychiatrist, private practice), providing a code for a less severe diagnosis. A male psychiatrist with 40 years' experience describes his approach, 'Oh, it's very simple. Everyone gets the same diagnosis. The most benign'. Under-diagnosis results from a recognition that the public nature of the DSM can have negative ramifications for the patient when applying for employment or insurance coverage. One psychiatrist with a private practice expressed a concern that employers, who are 'not stupid', will look up the codes in the DSM and use this information against their employee. Similarly, a less severe diagnosis is beneficial to the patient when applying for insurance policies in the future, especially as insurers use pre-existing conditions to determine the nature and cost of coverage.

Yet, punting low comes with the risk that patients will not be reimbursed for treatment. To negotiate the tension between the need for passing muster with insurers and concerns about stigma, psychiatrists often fudge with the aim of vagueness. Some employ a 'garbage can' diagnosis. For each group of disorders in the DSM there is an option for a 'not-otherwise-specified' (NOS) category (such as a 'bi-polar disorder NOS'). The NOS diagnoses are intended for complicated cases for which a specific diagnosis cannot yet be determined. However, psychiatrists have adapted the NOS category as part of a strategy to give vague diagnoses so as not to invite outside influence on the treatment or any stigma on the patient. They have no intention of refining the NOS diagnosis to find a more accurate one. A young female psychiatrist in an emergency clinic states, 'So what I'll do, I'll often use NOS. And I feel very strongly . . . I mean, I don't like to label people'. A variation on this is to apply the same diagnosis to every patient, having figured out the least severe diagnosis the insurance companies will accept. This has the benefit of ensuring coverage, protecting the anonymity of the patient and avoiding legitimating DSM codes that the psychiatrist may find reductionist. It leaves a paper trail sufficiently vague to prevent intervention by outsiders and provide the psychiatrist with autonomy.

Psychiatrists fudge most often when submitting a GAF (Global Assessment of Functioning) score, given the near-universal hostility towards it. As a seemingly objective measure, the GAF is a major determinant of whether a patient receives care or is admitted to the hospital. According the DSM-IV-TR, the GAF is a scale from 1 to 100 that is divided into 10 ranges of functioning. The stated aim of the GAF is to enable the tracking of an individual patient in global terms using a single measure, to plan treatment, to measure treatment impact and to predict outcomes (American Psychiatric Association 2000: 34). Insurance companies and hospitals use it to monitor patient progress. Consequently, psychiatrists who view the GAF as problematic assign a GAF after the fact to resist the surveillance of treatment it enables. A psychiatrist in an out-patient Veterans Administration clinic describes how he determines the GAF:

> Patients need a low enough GAF so that they can get their benefits. I kinda throw a coin in the air. I use a fairly narrow range and basically, if they're working and functioning well

> enough I'll certainly keep it above 50, depending on how well they're doing. If they are really unable to work, I usually put 45. . . . But it's fairly arbitrary. And sometimes I look at two patients and I wonder why I gave 50 to one and 45 to another. And I don't even change it much when there's a change with the patient. I consider it, to a certain extent, silliness, and to a certain extent dangerous silliness, considering it can be misused.

This fudging undermines the purpose of the GAF. Instead of 'objectively' measuring the patient's functioning, psychiatrists make up a number to fit institutional constraints. This results in a curious trajectory of the patient according to official paperwork in in-patient settings. Psychiatrists keep the GAF low while the patient is in treatment and increase it only when they determine that the patient is ready to be released. Thus, according to the official paperwork, patients do not improve gradually; what is transcribed is a continuously low GAF level followed by an immediate spike of improvement. This creates an official trajectory of patients that is inconsistent with their actual trajectory.

Fudging the numbers represents a grey area ethically, a fact not lost on psychiatrists. They struggle with its implications and worry about 'fraud' (male psychiatrist, university health centre). Psychiatrists are torn between being honest and ensuring that their patients get the proper care and are protected. An older male psychiatrist views this as being 'coerced into dishonesty', adding:

> I feel very uncomfortable doing it [fudging] ethically, but I feel that my responsibility is ultimately to the patient and not the DSM. It's a terrible bind to be in because you want to behave ethically at all times. . . . You have these conflicting forces and in order to treat the patient, you end up having to deceive [the insurance companies].

To resolve these ethical dilemmas, psychiatrists portray fudging as 'spinning' rather than lying (male psychiatrist, in-patient clinic), taking refuge in the inherent fuzziness of diagnostic categories. One female psychiatrist with a private practice admits:

> I'm not going to put something that the patient doesn't have, but I feel like there *is* a range. For any given person you could think about it [the mental disorder] this way or you could think about it that way.

As this quote indicates, the fundamental goal of the DSM (that is, to delineate discrete categories of disease) is not only undermined by fudging; its perceived failure to create a valid nosology becomes a justification for subverting it.

*Negotiating diagnoses with the patient*

The potential problems associated with psychiatrists making non-transparent normative judgments about their patients are mitigated by a willingness to negotiate diagnoses with their patients. Fudging the numbers is often done in consultation with the patient. This practice in itself undermines the biomedical model upon which the DSM is based. According to this model the doctor objectively assesses a patient's symptoms to make the proper diagnosis. The patient is a source of information in so far as she can speak to the symptoms she is experiencing. In contemporary medical practice this information is treated as preliminary, as final diagnostic judgment is withheld until tests are taken. However, because there are no tests or biological markers for mental illness, psychiatrists depend heavily on patient testimony to distinguish the normal from the pathological. The DSM attempts to make diagnoses more scientific by focusing the diagnostic interview on objective clusters of

symptoms. The patient's role is to provide facts to the psychiatrist, who then makes a diagnosis according to DSM guidelines.

Given the dependence on testimony, psychiatric patients can participate more proactively in shaping their own diagnoses than they can in other medical fields. This agency is amplified by psychiatric workarounds. Diagnoses can emerge from negotiations between patients and psychiatrists. Psychiatrists strategise with the patients as to the particular diagnosis they are to receive. A female psychiatrist with a private practice discusses this process:

> In the conversation with the person about what their diagnosis is, today it happened, the conversation about what severity to put, I mean I'm pretty comfortable within a range of reasonable, putting what a person wants or what they feel they have.

As this quote reveals, negotiating with the patient does not mean that the patient has complete control over their official diagnosis. Rather, psychiatrists, recognising the fuzziness of mental illness, are willing to negotiate within a range of possibilities what diagnosis the patient receives on her forms. This workaround is possible because psychiatrists do not view it as important to arrive at a diagnosis in the way defined by the DSM. As one psychiatrist argues, in 'trying to think of your patient as more than a simple label' the DSM label does not 'affect the way I practice'. The DSM label is perceived as a bureaucratic obstacle, and psychiatrists strategise with their patients to ensure that this obstacle is traversed in a way that avoids stigma but achieves coverage. In doing this, the patient is given some power in determining her diagnosis. To get a sense of how contrary this workaround is to the biomedical model, consider how strange it would seem if a cardiologist negotiated a diagnosis over a patient's heart condition.

There is resistance to this practice among psychiatrists. Firstly, for patients with more severe illnesses such negotiation is not feasible. It is easier to negotiate a diagnosis with someone suffering from dysthymia (mild depression), but 'cases of schizophrenia and dementia are difficult', (male psychiatrist, private practice). Secondly, others worry about the forfeiture of professional authority that comes with negotiation. This concern does not only stem from professional arrogance: it also reflects awareness that the professional authority of the psychiatrist is expected by patients and is useful for treatment. Thus, a limit to the adoption of this workaround is an understanding that the authority that comes with professional status is beneficial to psychiatric practice.

Yet even psychiatrists resistant to negotiating diagnoses will discuss strategies to deal with the bureaucratic realities of the DSM. In some cases psychiatrists relegate the discussion of the specific label to conversations about billing and insurance that occur before or after a session and are clearly distinguished from the therapeutic interaction. As one psychiatrist claims, the diagnostic label 'comes up because I have to put something on the bill. I'll bring it up with them [her patients] in that context', (female psychiatrist, private practice). Another psychiatrist who does not talk in terms of specific diagnostic labels will discuss them 'if the patient inquires about the codes of insurance forms'. In this way the discussion of the particular label is cordoned off to the portion of the session dedicated to more bureaucratic issues. A space that is separate from the psychiatric dialogue is created, where the diagnosis can be fudged in conjunction with the patient, while retaining the understanding that this flexibility need not affect the therapeutic interaction. In this space, psychiatrists coach their patients in how to pass muster with insurance companies: 'I sometimes help them with their insurance forms so that they can get reimbursed out of network' (female psychiatrist, private practice).

## The place of the biomedical model in psychiatry

Psychiatric workarounds represent strategic responses to tensions emerging out of the particular history of the profession in the last 30 years – a history characterised by a dramatic shift in expertise towards the biomedical model achieved through the DSM (Diagnostic and Statistical Manual of Mental Disorders). On one hand, psychiatrists benefit from the DSM. The DSM captures legitimacy for psychiatry among the mental health professions as it is a public demonstration of the profession's scientific expertise. Psychiatrists' control over prescribing medication among mental health professionals is a privilege built in part on their identity as doctors facilitated by the DSM. This privileged status translates into prestige and economic rewards. On the other hand, the DSM is a codified, standardised nosology available for public consumption, and therefore, introduces opportunities for outside entities to infringe upon psychiatrists' discretion. Codification makes expertise more accessible to outsiders, undercutting the need for outside expert opinion (Jamous and Peloille 1970). With the DSM, psychiatrists have produced the very tool that outsiders use to erode their professional discretion.

The workarounds that emerge from these contradictory outcomes of the DSM contain within them an implicit critique of the DSM's strategy to achieve a biomedical model. The DSM is premised on the notion that biomedical disorders in the brain are manifest in the symptom clusters displayed by patients. In other words, the symptom clusters reflect an underlying mental illness and thus the way to effective treatment is through the objective assessment of such symptoms. Yet, as this study shows, psychiatrists do not follow this process. Retrospective diagnoses, alternative taxonomies, and negotiating with patients all contain within them an implicit critique of the relevance of diagnosis through symptom clusters. Contrary to the symptoms-based diagnosis-leads-to-treatment process laid out by the DSM, workarounds sever diagnosis from treatment by inverting the temporality (i.e. diagnosis follows treatment) or taking into account additional, peripheral information (i.e. patient's concern over stigma) in making a formal diagnosis. The DSM diagnosis is reduced to a bureaucratic nuisance to be dispensed with as quickly as possible. In the end, the DSM, which sought to move the profession towards the biomedical model through the standardisation of diagnoses, has created incentives for psychiatrists, even those who subscribe to the biomedical model, to undermine its method for attaining the biomedical model. Psychiatric practice is de-standardised in the process.

But what does this implicit critique of the particular method to achieve the biomedical model embedded in the DSM mean for the usefulness of the biomedical model of psychiatry generally; the idea that mental illness is a biological disease located in the brain? The aim of the biomedical model is to identify the biological cause and then find the cure. But if psychiatrists reduce the DSM diagnosis to a bureaucratic obstacle, have they rejected the biomedical model itself? Or are they rejecting the DSM's delineation of how the diagnosis should be made? How do psychiatrists make sense of their workarounds in relation to the biomedical model?

The psychiatrists in my sample expressed varying degrees of support for the biomedical model of mental illness. At one end of the spectrum are the bulk of psychiatrists in my sample ($n = 23$) who either recognise the DSM 'as a necessary evil' (female psychiatrist, private practice) or view it as a positive contribution to psychiatric practice that has been abused by organisations such as insurance companies. According to these psychiatrists, the revisions to the DSM correctly addressed the abuses of the psychoanalytic model:

> There really and truly needed to be a change . . . because [psychoanalysts] had really taken psychiatry away from the medical model. It had taken it into a world of very interesting philosophical thoughts and ideas, but making some very expansive claims for themselves. . . . They were damned arrogant, some of them, with what they were claiming. They were the marines, the super jocks of psychiatry. And they punched way above their weight (male psychiatrist, private practice).

Psychiatrists in this group applaud the focus on diagnosis as a remedy to psychoanalysis in that it can lead to 'focused treatments', (male psychiatrist, children's clinic), but still recognise its inadequacy, as evidenced by their use of workarounds.

Given this orientation, these psychiatrists make sense of their workarounds by appealing to future scientific developments; workarounds are provisional solutions to problems that science will eventually remedy. While the DSM itself may be 'deeply flawed' (male psychiatrist, private practice), these flaws are not inherent in the biomedical project itself. The goal of locating the correct diagnosis that will lead to specific treatment is a laudable goal. Until the biological markers of mental illness are identified the DSM is forced to depend on superficial symptom clusters. This method of categorisation promotes a 'Chinese menu' (male psychiatrist, private practice) or 'cookbook kind of psychiatry' (male psychiatrist, private practice) that institutions demand, based on their crude reading of the DSM. While it is troubling for psychiatrists in this group, the situation is temporary, a result of the natural lag of science. The DSM diagnostic labels are to be seen as 'provisional names of things that we don't fully understand yet' (male psychiatrist, private practice). The problem, according to this logic, is that the insurance companies and other actors fail to recognise the provisional nature of these categories and, in turn, enforce standards upon psychiatrists that are too rigid.

Psychiatrists employing this rationale reinterpret the DSM as a form of 'promissory science' (Fortun, 2001, 2008). This account is feasible, given a certain ambiguity in the original justification for the revisions to the DSM. The revisions were framed explicitly as an exercise to achieve scientificity for psychiatry in the present through diagnostic reliability and, tacitly, were intended as a foundation for future scientific developments in psychiatry through the standardisation of research. This dual purpose reflects an unresolved initial tension in the DSM between the reliability of the diagnostic categories (whether they held up across contexts and between psychiatrists) and their validity (whether the categories reflect actually existing, identifiable mental illness). The revisions focused on reliability, deferring questions of validity to the future. Psychiatrists draw on this tension to dismiss present problems as a temporary nuisance on the road to a more rigorous science of psychiatry. The hope is that psychiatry will follow the trajectory common to other medical fields, becoming more scientific as biological markers for mental illness are discovered. The question remains as to how long these psychiatrists are willing to wait for this future before they dismiss the biomedical paradigm as misguided. They have not reached this point, despite the delay and indications that the DSM has not even solved the problem of reliability. Workarounds are temporary solutions that allow psychiatrists to buy time until a more scientific future is attained.

At the other end of the spectrum are psychiatrists ($n = 11$) who criticise the biomedical approach itself, for it 'leaves out the integrated personality of the individual and attempts to pigeonhole individuals according to clusters of symptoms or behaviour that are artificial' (male psychiatrist, in-patient clinic). For this group of psychiatrists workarounds are less problematic and accounting for them is less complicated. According to this view, the reduction of a complex entity like the mind to biological mechanisms is itself misguided. They view the DSM as 'dehumanising' (male psychiatrist, out-patient hospital clinic) and 'reductionist' (female psychiatrist, in-patient clinic). This reductionism leads directly to the

simplistic understanding of mental illness that is foisted upon psychiatrists. In other words, the impositions on autonomy that the DSM facilitates arise not from its provisional nature, but from its conceptualisation of the nature of mental illness, which is itself reductionist. Given their fundamental opposition to the biomedical model, these psychiatrists look for more subversive ways to undermine the DSM, engaging in the more extreme variations of workarounds to carve a space to practise psychiatry that avoids the biomedical model entirely.

Overall, while psychiatrists engage in similar workarounds, they do so from different motivations that reflect different orientations towards the biomedical model of mental illness. Yet even the psychiatrists committed to the biomedical model engage in workarounds.[8] In general, psychiatrists perceive the DSM's strategy to achieve a biomedical model for psychiatry (that is, a standardised, descriptive nosology) as at best provisional and at worse misguided. This does not mean that the biomedical model of mental illness itself is in crisis, only that it remains a contested terrain among psychiatrists. The biomedical model remains the dominant prism through which mental illness is understood and has achieved great cultural legitimacy. It continues to guide psychiatric research, the development of psychopharmaceutical drugs and the operating practices of mental health organisations. The fact that antidepressants were the most prescribed drugs in the USA in 2005 underscores the strength of the biomedical model (Centers for Disease Control and Prevention 2008: 366). Still, the existence of workarounds reveals that, while powerful, the biomedical model may be challenged in practice, implicitly or explicitly.

## Conclusion

Whether this resistance to the biomedical model remains marginal or is a harbinger for a coming crisis for the biomedical model of mental illness remains a question for the future. What is evident is that the DSM itself has become a magnet for criticism. The sheer variation in how psychiatrists perceive and use the DSM exposes it as a failure in the attempt to unify the profession through standardisation. At the very least, the DSM's particular strategy to achieve the biomedical model has become problematic.

This observation has three consequences for the analysis of psychiatric practice. Firstly, it reforms previous research on the DSM by questioning the implicit depiction of the DSM as a monolithic and homogenising taxonomy. While there is an abundance of research complicating and criticising the production of the DSM, less attention has been paid to how it is used in practice. The operating assumption of this research is the DSM as a powerful object in and of itself. However, the DSM only has power in so far as individual actors apply it in the clinical setting. A more nuanced analysis of the DSM, and of the general trends in psychiatric thought that it embodies, is needed. The findings in this research should give pause to sociologists who criticise over-medicalisation, 'the process by which nonmedical problems become defined and treated as medical problems' (Conrad 1992: 209). If the DSM is the exemplar of the biomedical model of psychiatry and the DSM is continually undermined in practice, a space is opened for potential understandings of mental illness in non-biomedical terms. It may be a precarious space but it exists. Theories of over-medicalisation would do well to recognise it, lest their critiques paint an inaccurate picture.

Secondly, the use of the DSM is varied, representing a complex negotiation between individual psychiatrists' views of mental illness, various constraints placed on their autonomy by outside actors and the local exigencies of the clinical interaction. Out of this morass a repertoire of workarounds is born. More research is needed to examine psychiatric practice in

other regional contexts and among mental health professions to see if similar workarounds take place there. This research demonstrates that a range of workarounds exist, but other contexts are likely to employ different workarounds or perhaps different variations of those found in New York. Similarly, a close analysis of work practices in other contexts could flesh out whether similar dynamics surrounding classification and standardisation exist in other professions, both medical and non-medical.

Finally, workarounds open a space for resistance both by psychiatrists and patients towards the more pernicious effects of psychiatric labelling. The long-held concerns about stigma (Goffman 1961), social control (Foucault 1988, 2006, Rose 1985, Scheff 1966, Szasz 1961), and 'making up people' (Hacking 1995, 2002) are somewhat mitigated by the resistance to the diagnostic categories of the DSM in practice. If medical records are important components in acting on and disciplining the bodies of patients (Bowker and Berg 1997), psychiatrists undermine these records through workarounds. Significantly, some workarounds are often done in consultation with the patients. Psychiatrists will discuss the diagnostic label affixed to the patients' record with the patients themselves, cooperating with them to find a diagnostic category. In the process, psychiatrists afford patients more agency in determining how they are sorted and labelled. While more research (particularly ethnographic observation) is needed to explore how the definition of mental illness is negotiated on the micro level, this study suggests that the DSM diagnosis is only part of the story of diagnostic labelling.

This does not mean that the DSM is irrelevant. On the contrary, the DSM has tremendous influence. It determines the course of psychiatric research, shapes popular understanding of mental illness and remains an important determining factor in the allocation of resources and treatments. There is social power inherent in the naming of disease both in the world of medicine and the wider culture (Rosenberg 2002). Furthermore, this influence increases as the mental health field is globalised through multinational pharmaceutical companies and the coordination with the ICD. What this study intends to show is that resistance to the DSM exists and is common in my sample and, as a result, the DSM is not all-powerful in defining mental illness. To fully understand the ramifications of psychiatric diagnoses, sociologists need to be attuned to the varied and complex practices that have emerged around the DSM.

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## Notes

1 The emphasis on treatment as the goal of the DSM persists. The DSM-IV-TR states, 'Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to

facilitate research and improve communication among clinicians and researchers' (American Psychiatric Association 2000: xxiii).

2 For exceptions see Brown (1987) on diagnosis in a community health centre walk-in clinic; Kirk and Kutchins (1988) on the use of the DSM by social workers; Young (1995) on its use in a Veterans Administration Clinic; Martin (2007) on grand rounds.

3 The gender ratio of the sample (eight women to 28 men) reflects the gender divide in the profession generally (Marcus *et al*. 2001).

4 For 22 psychiatrists in my sample, the patient population on medication exceeded 75 per cent.

5 For some, this interaction is indirect as the responsibility for reimbursement was placed on the patients. All the same, these psychiatrists have to coach their patients on these matters.

6 It is unclear whether this flexibility and negotiation is specific to the New York Metropolitan region or whether it holds true in other contexts. Indeed, this flexibility may be a luxury available to psychiatrists in a more affluent regions.

7 Kirk and Kutchins (1988) identified similar practices among social workers.

8 Three psychiatrists in my sample refused to engage in workarounds. Two of these cited a strong commitment to the biomedical model embodied in the DSM, while the other expressed concern about the legal consequences.

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