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Rachel A. Askew Date

Decisions, Decisions: How Professional Affiliation Shapes Mental Health Trainees' Clinical Judgments and Approach to Care

By

Rachel A. Askew
Doctor of Philosophy

Sociology

_____
Timothy J. Dowd, Ph.D., Chair

_____
John Boli, Ph.D.

_____
Cathryn Johnson, Ph.D

_____
. Tracy Scott, Ph.D.

_____
Benjamin G. Druss, M.D., MPH

Accepted:

_____
Lisa A. Tedesco, Ph.D.
Dean of the James T. Laney School of Graduate Studies

_____
Date

Decisions, Decisions: How Professional Affiliation Shapes Mental Health Trainees' Clinical Judgments and Approach to Care

By
Rachel A. Askew
M.A., Rutgers University, 2000

Advisor: Timothy J. Dowd, Ph.D.

An Abstract of
a dissertation submitted to the Faculty of the
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Abstract

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By Rachel A. Askew

This mixed-methods study compares how mental health trainees from various professional disciplines approach, diagnose and treat their patients or clients, paying particular attention to differences that arise based on a trainee's professional affiliation and theoretical orientations. The study focuses on advanced clinical trainees enrolled in three training programs - the top professional training programs in psychiatry, clinical psychology, and social work in Georgia. In order to assess the amount and source of variation in clinical decisions, I asked trainees to evaluate an identical written case study of a patient manifesting symptoms of anxiety and depression. In order to gauge trainees' views of their work and general approach to working with patients I concurrently conducted in-depth, semi-structured interviews with a subset of trainees from each of the professional programs. Results indicate that trainees' diagnostic- and treatment-related judgments and the way they work with patients reflect neither full uniformity nor complete divergence. Trainees share broad ideas regarding diagnosis and treatment yet diverge in their application of these ideas based on professional affiliation and preferred theoretical orientations to care. This study suggests that professional beliefs and practices will never be homogenous in an organizational field that contains multiple disciplines competing for clients.

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TABLE OF CONTENTS

TABLE OF FIGURES, TABLES, AND APPENDICES

Figures

Tables

Appendices

Chapter 1: Introduction

PROJECT OVERVIEW

Each year, more than one-in-six Americans (17.9%) seek professional help for mental health problems (Wang et al. 2005). Mental health care in the United States, however, is characterized by a large amount of variability, both in content (Ettner and Link 2007) and in quality (Institute of Medicine 2006). Regarding the content of such care, American mental health professionals frequently do not agree on *diagnosis* or what's wrong with a patient (e.g., Kirk and Hsieh 2004), on *etiology* or what's causing the problems (e.g., Wyatt and Livson 1994), or on *treatment* or what kind of intervention(s) to make (e.g., Turner and Kofoed 1984). As for the quality of such care, a report put out by the National Institute of Mental Health (1999) called for research into mental health providers' clinical judgments precisely because of the variability in care received and the uneven degree to which providers implement interventions that randomized clinical trials have shown to be effective. To date, clinical judgment studies (e.g., Neighbors et al. 2003) have examined a number of provider-level factors (e.g., a provider's race) that may affect mental health professionals' clinical judgments. One factor that merits further attention is a clinician's professional affiliation. Those clinical judgment studies that examine multiple professional groups (e.g., McKinlay et al. 2002) tend to find differences in clinical decision making based on professional affiliation, or based on the specific training and expertise that accompanies membership in one particular disciplinary field versus another (e.g., psychiatry vs. psychology). Currently, however, the clinical judgment literature offers no overarching theoretical framework to explain differences in clinical judgments based on professional affiliation.

Theoretical developments from sociology's neoinstitutional theory (e.g., DiMaggio and Powell (1991) and the sociology of professions (e.g., Abbott 1988; Bucher and Stelling 1977) offer a potential bridge for this gap in the clinical judgment literature. Professional affiliation may influence a provider's clinical decisions by shaping the institutional lenses through which individual clinicians come to view their clients. Professionals' initial *cognitive socialization* (Zerubavel 1997: 15) – that is, the process through which professionals learn to think like other members of their profession – takes place during university training. Consequently, this study focuses on advanced clinical trainees enrolled in graduate programs in mental health in order to examine how professional socialization processes shape professionals' decision making and approach to working with patients or clients.[1]

Three research questions propel this study. 1) To what degree do mental health trainees' approach to care and clinical (i.e., diagnostic and treatment-related) judgments vary? 2) Does professional affiliation help explain some of the variability in trainees' clinical decision making and approach to care? and 3) In what ways is professional affiliation associated with trainees' clinical decision making and approach to care?

This dissertation focuses on advanced clinical trainees enrolled in three training programs: the top professional training programs in psychiatry, clinical psychology, and social work in Georgia. This study employs a *mixed-methods triangulation design* (Creswell and Plano Clark 2007), a design that entails collecting both quantitative and

[1] While conducting the interviews it became clear that psychiatry residents prefer the term 'patient,' while clinical psychology and social work trainees prefer the term 'client.' I attempt to follow their preferences whenever possible throughout the course of this dissertation. In cases where both psychiatrists and other providers are discussed simultaneously, however, the terms 'client' and 'patient' are used interchangeably. I discuss the reasons interviewees give for their preferences in Chapter 5.

qualitative data on the same topic to gain a more complete picture of a research area than would be possible if one were to take either a quantitative or qualitative approach in isolation. In order to assess the amount and source of variation in clinical decisions trainees were first asked to evaluate an identical written case study of a client manifesting symptoms of anxiety and depression. I measured students' case conceptualizations and clinical decisions regarding the case study via quantitative analyses performed on data from the self-administered survey. Subsequently I conducted in-depth qualitative interviews with a subset of students from each of the three professional schools to investigate trainees' approach to working with clients more generally. The interview questions supplement the survey questions on concepts such as diagnosis and treatment options, while the survey questions supplement the interview data on professional socialization processes. Thus, each data source functions as a means of testing the validity of conclusions drawn from the other data source.

The remainder of the chapter progresses in the following way. First, I begin by explaining why mental health professionals' clinical decisions and their approach to care is an important topic of study. I then explain why this study focuses on multiple professional disciplines within the U.S. mental health field, namely that of psychiatry, clinical psychology, and social work. I move on to explain the purpose of studying clinicians-in-training. I then offer a roadmap for the organization of the rest of the dissertation, and finish this chapter by outlining some contributions this study aims to make.

WHY STUDY MENTAL HEALTH PROFESSIONALS' CLINICAL DECISIONS?

Symptoms of mental disorders are widespread among the American population. The most recent nationally-representative study of the prevalence of mental disorders in the U.S. found that *nearly half* of Americans (46.4%) have had symptoms that would merit a diagnosis of a psychiatric disorder at some point in their lives (Kessler et al. 2005a). Furthermore, much of the reported psychopathology had occurred in the prior year. More than one-in-four American adults (26.2%) had suffered from symptoms in the prior year that qualified them for a psychiatric diagnosis (Kessler et al. 2005b).

In addition to their pervasiveness, psychiatric symptoms and conditions are also debilitating. The *Global Burden of Disease* study, conducted by the World Health Organization, the World Bank, and Harvard University, developed a measure of disease burden based on years of healthy life lost to either disability or premature death. This measure, Disability Adjusted Life Years, or DALYs, was developed in order to estimate the relative burden on populations caused by different diseases and disabilities. The update of the *Global Burden of Disease* study estimated that in the United States neuropsychiatric conditions caused more of a disease burden than any other category of disease, including cardiovascular disease and cancer. Among neuropsychiatric conditions, unipolar depressive disorders accounted for the greatest disease burden (World Health Organization 2008).

The heavy disease burden associated with mental health problems is partially attributable to the fact that many who seek and receive care for such problems in the U.S. do not receive adequate care. A recent analysis of mental health service utilization based on data from the National Comorbidity Survey Replication (NCS-R) estimated that of the

treated patients who qualified for a DSM-IV diagnosis, only one-third (32.7%) received "minimally adequate treatment" (Wang et al. 2005) – that is, treatment in line with evidence-based clinical guidelines (either psychotherapy, pharmacotherapy, or a mixture of the two) and of a sufficient duration to allow for significant improvement. Some of the uneven nature of mental health service provision can be attributed to the great variability in care received outside the mental health specialty sector (i.e., care delivered by general practitioners not specifically trained to treat mental health problems). Nevertheless, even among those treated by professionals in a mental health specialty setting, less than half (48.3%) received minimally adequate treatment (ibid).

One reason that many Americans seeking mental health care may not receive adequate treatment is that they terminate treatment—both drug therapy (i.e., pharmacotherapy) (e.g., Joffe 2006; Olfson, Tedeschi, and Wan 2006) and talk therapy (i.e., psychotherapy) (e.g., Reis and Brown 1999) — prematurely. One rationale for dropping out of treatment is that the client does not feel she and the provider see eye-to-eye. That is, the client and provider may not agree on the problems to be solved, on the severity of the problems, on the treatment goals, or on how to pursue treatment goals. Research that has investigated the impact of the quality of the "working alliance" (Bordin 1979; Horvath and Luborsky 1993) or "therapeutic alliance" (Krupnik et al. 1996) between client and provider suggests that clients who share their provider's point of view are less likely to drop out of both pharmacotherapy (e.g., Arnow et al. 2007) and psychotherapy (e.g., Arnow et al. 2007; Corning, Malofeeva, and Bucchianeri 2007; Reis and Brown 1999) prematurely, and have better overall outcomes (Krupnik et al. 1996) than do clients who share weaker therapeutic alliances with their clinicians.

A client benefits, then, when her understanding of her problems and of viable solutions to those problems converges with her clinician's view. It is consequently critical that we gain a coherent picture of which factors systematically affect mental health professionals' understanding of their clients' problems and thereby affect how they diagnose and treat their clients. If clients are aware of factors that regularly shape clinicians' viewpoints, they will be better able to choose providers whose clinical judgments are likely to align with their own thoughts about their problems, thus increasing the possibility that the client and clinician form a favorable therapeutic alliance, a factor tied to better clinical outcomes. To that end, this study seeks to identify factors that shape mental health practitioners' views of and clinical judgments regarding their clients. Specifically, this study focuses on the ways that professional affiliation affects clinical trainees' diagnostic- and treatment-related decisions when faced with clients who present with symptoms of anxiety and depression, two of Americans' most common mental health problems (Kessler et al. 2005b).

WHY FOCUS ON MULTIPLE PROFESSIONAL GROUPS?

The majority of studies on clinical judgment do not compare professionals from differing occupational groups (cf. Garb 1998). Instead, most clinical judgment research either lumps together providers from different professions (e.g., Witteman and Koele 1999), thus implying that professional affiliation should not have an appreciable effect on work practices and decision making, or focuses on a group of clinicians from a single profession (e.g., Loring and Powell 1988), a methodological choice that serves to control for any variation that introducing multiple professional affiliations would introduce. Nevertheless, clinical judgment studies that lump together different types of

professionals, as well as those studies that focus on providers from a single profession, both fail to estimate the effects that one's professional affiliation may have on clinical care and decision making. Given that a main point of Abbott's seminal (1988) work on professions is that the ongoing jurisdictional struggles between different professions working in a particular organizational arena are central to determining the work that professionals from any single discipline do, studies that overlook the potential effect of professional affiliation on clinical decision making are at best incomplete and at worst misleading. Moreover, those studies of mental health professionals that *have* compared the approaches taken and decisions made by professionals from multiple professions have uncovered interesting differences. These differences based on professional affiliation include clinicians' attitudes toward client collaboration in mental health services (Kent and Read 1998), clinicians' beliefs about the etiology of mental problems (Strauss et al. 1964; Wyatt and Livson 1994), and clinicians' views of their role in working with people suffering from mental health problems (Davies et al. 2006). In order to estimate the effects that professional affiliation has on clinical decision making, the present study compares the approaches and clinical decisions of several different professional groups of mental health providers – namely psychiatrists, clinical psychologists, and social workers.

The present study focuses on psychiatry, clinical psychology, and social work – three of the core disciplines that make up the U.S. mental health workforce (Scheffler and Kirby 2003; Robiner 2006). Estimates of the number and practice patterns of mental health professionals are inexact due to the absence of a national entity with the capacity and authority to track professionals across disciplines (Mechanic 2008; Robiner 2006).

Nevertheless, the most recent report on mental health practitioners put out by the Substance Abuse and Mental Health Services Administration places the number of practicing psychiatrists in the early 21st century at around 40,000, the number of practicing licensed psychologists in 2002 at 88,500; and the number of clinically-trained social workers in 2000 at approximately 97,000 (Duffy et al. 2004). Each profession follows a unique work pattern. For example, the primary employment setting for a plurality of psychiatrists (21%) is a hospital; for a plurality of psychologists (17%) is an academic setting, and for a plurality of clinical social workers (23%) is an outpatient mental health clinic (ibid). Moreover, the makeup of each profession's clientele is somewhat different. As an example, psychiatrists take disproportionate care of the sickest patients, including patients presenting with psychotic and bipolar disorders (Mechanic 2008; Pingitore et al. 2002; Sturm and Klap 1999) relative to the other mental health professions. Nevertheless, the majority of each group (95.7% of psychiatrists, 89.4% of psychologists, and 71.8% of clinical social workers) provides direct patient care (Duffy et al. 2004). Furthermore, patients presenting with mood and/or anxiety disorders make up a large percentage of psychiatrists' (Pingitore et al. 2002), psychologists' (ibid), and clinical social workers' (Timberlake, Sabatino, and Martin 1997) weekly caseloads. Thus, the majority of each profession is involved, to some degree, in diagnosing and treating patients with mental health problems, and a large proportion of each profession's time is spent on working with patients with problems related to depression and anxiety, the focus of the present study. It remains unclear, however, how mental health treatment provided to the same patient by practitioners from different disciplines may differ (Sharfstein 1998). Indeed, Teresa Scheid (1994: 683), writing about the U.S. mental health arena

posits: "One sociologically interesting question is whether different groups of providers hold different treatment ideologies." The current study, by asking trainees from disparate mental health professions about their approach and clinical impressions regarding a fictional woman presenting with a relatively common mix of familial strife and symptoms of depression and anxiety, seeks to parse out clinical differences in judgment and approach due to professional affiliation.

WHY STUDY CLINICAL TRAINEES?

In addition to identifying differences in clinical judgment based on professional affiliation, this study also seeks to investigate the ways that university training fosters these differences. Merton (1957: 278) defines *professional socialization* as "the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short, the culture - current in groups of which they are, or seek to become, a member." Similarly, Berger and Luckmann (1966: 138) define *secondary socialization* as "the acquisition of role-specific knowledge" and explain that secondary socialization entails acquiring "role-specific vocabularies, which means, for one thing, the internalization of semantic fields structuring routine interpretations and conduct within an institutional arena." Thus, as a result of ongoing professional socialization, one learns a specific vocabulary associated with that profession, one learns how to perform tasks that members of that profession routinely execute, and perhaps most importantly, one internalizes a specific way of interpreting the world and conducting oneself within that organizational field. Given my interest in the ways in which professions shape members' decision making, coupled with the fact that the first, most intense and sustained

professional socialization that clinicians undergo takes place during post-graduate university training, this study's respondents are post-graduate clinicians-in-training.

THE ORGANIZATION OF THE DISSERTATION

The remainder of this dissertation proceeds as follows. Chapter 2 provides the theoretical basis by which I approach mental health trainees' clinical judgments and training. In particular, I draw from and combine several theoretical frameworks from organizational sociology: decision-making theory, neoinstitutional theory, and insights from the sociology of professions. Briefly, the theoretical traditions fit together in the following way. March and Simon's (1958) decision-making theory provides the concept of the boundedly-rational actor, an actor constrained by limited information and a particular vantage point, often without clear preferences or objective means to compare choices. The boundedly-rational actor consequently makes good-enough decisions (satisfices) rather than best decisions (maximizes).

Neoinstitutionalism introduces the concept of *institutional logics* (Friedland and Alford 1991), or cognitive maps that guide the activities and beliefs of individuals within particular organizational fields such as the field of mental health care. Institutional logics constrain how actors perceive the world. As such they provide an explanation for why boundedly-rational actors operating within the same organizational field make similar decisions. Neoinstitutional theory holds that members of the same profession are influenced by the same logic via a process called *normative isomorphism* (DiMaggio and Powell 1991). Not all organizational fields, however, contain a single, overarching logic (Friedland and Alford; Lounsbury 2007). What of an organizational field that contains multiple, competing logics, and multiple, competing professions? How do actors within

such variegated fields choose between logics? Abbott's (1988) work on the sociology of professions offers one potential answer. In an organizational arena characterized by multiple potential logics and different professions fighting over jurisdictions, professionals from a particular discipline share a logic. Each *professional logic* within any given organizational field contains elements that directly conflict with the logics shared by professionals from competing professions, as well as elements that are widely shared by all professions.

I additionally draw from the professional socialization literature which emphasizes that as trainees move toward gaining professional credentials via university training professionals-in-training learn not only how to do the work of the profession but also to think like members of their profession. This literature helps to explain how professionals from the same occupation come to share a logic. That is, it unpacks part of the process of normative isomorphism – homogeneity based on professional affiliation – that neoinstitutionalists emphasize.

Chapter 3 outlines my research methodology. The chapter details the study's research design, sample, recruitment process, data collection procedures, procedures to protect research subjects, and measures. Additionally Chapter 3 describes the data analysis strategies that I apply to both the survey and interview data.

Chapters 4 and 5 contain the results of my quantitative and qualitative analyses. Each chapter investigates a particular brand of clinical judgment – namely, diagnostic judgments and treatment recommendations, respectively. Chapters 4 and 5 each begin by briefly detailing the extant studies that look at a particular brand of clinical judgment among multiple types of mental health professionals. Thus, for example, Chapter 4

begins by summarizing main findings of diagnostic studies that included subjects from at least two of the three professional groups. Next, both Chapters 4 and 5 report on the survey results on trainees' clinical judgments about Jessica, the fictional woman from the case study. That is, following an overview of the existing literature pertaining to a particular type of clinical judgment, Chapter 4 next covers trainees' diagnostic judgments and Chapter 5 next covers trainees' treatment decisions. Following each chapter's analysis of survey respondents' decisions regarding Jessica in particular, the chapters then turn, respectively, to interviewees' open-ended responses about diagnosis and treatment more generally. Chapter 6 is the concluding chapter in which I summarize my findings, draw conclusions, and suggest directions for future study.

STUDY CONTRIBUTIONS

This dissertation makes several contributions. The first research question, by gauging the level of consensus in diagnostic and treatment decisions among mental health trainees on the brink of independent professional practice in a number of disciplines, assesses the degree to which mental health trainees are actually interchangeable in their dealings with clients. In the face of several potentially rationalizing trends affecting the mental health arena (e.g., the spread of managed behavioral care and evidence-based clinical guidelines), the question of provider interchangeability is an important one for medical and organizational sociology, as well as for consumers of American mental health care attempting to navigate our decentralized system.

The second and third research questions ask whether, and in what ways, professional affiliation affects trainees' clinical approach and decision making. These questions lie at the intersection of organizational sociology and cultural sociology by

asking how occupational culture and structure affect a set of work decisions made in an organizational field where different professional groups regularly compete for clients. Moreover, identifying sources of difference in trainees' views and practices is important if the U.S. mental health field as a whole is to move toward providing greater consistency in the content (diagnosis and treatment practices) and quality of its mental health care.

Chapter 2: Theoretical Framework and Background

This chapter is divided into three sections, each section dedicated to one of three research questions that drive this project.

RESEARCH QUESTION #1*:* *To what degree do mental health trainees' approach to care and clinical (i.e., diagnostic and treatment-related) judgments vary?* Two theoretical traditions speak to the question of how much variation currently exists in providers' clinical decisions and work practices. Specifically, in the following section I combine decision-making theory from organizational studies and neoinstitutional theory from sociology to theorize about the current level of consensus within the U.S. mental health field.

Two divergent pictures of decision making compete in the organizations literature (March and Heath 1994). The rational actor or strategic actor model of decision making assumes that decision makers have full information about all of the alternatives open to them, and having this information, they proceed to lay out each alternative, assign each alternative a set of consequences, and decide on the alternative that will lead to the best consequences (they engage in "maximizing" behavior). According to the rational actor model of decision making, different rational actors faced with an identical choice should make the same decision. In contrast, Herbert Simon and colleagues ([1947] 1997; 1958) propose that there is no unconditionally rational actor. Instead, they argue, one can only be rational relative to a frame of reference. That is, there are cognitive limits on rationality, and decision makers can only ever hope to be *boundedly rational*. Actors make decisions based on a limited, simplified model of the situation. The boundedly

rational actor does not have full information about each of the alternatives available, does not have complete information about all of the consequences tied to those alternatives, and may not have a way of systematically ordering the consequences in order to arrive at the "best" decision. That is, the boundedly rational actor is not able to maximize her decisions. As a result of the actor's limited model of the situation, the boundedly rational actor makes a *good-enough* decision, or engages in what March and Simon refer to as "satisficing." March and Simon (1958:139) explain that, according to a bounded-rationality view of decision making, "the organizational and social environment in which the decision maker finds himself determines what consequences he will anticipate, which ones he will not; what alternatives he will consider, which ones he will ignore."

I take a boundedly-rational view of decision making. That is, decision makers work from partial information about alternatives and consequences tied to these alternatives, and they do not calculate an objective 'best' choice ("maximize"), but instead choose a satisfactory alternative (they "satisfice") based on their interpretation of the limited information they possess (March and Simon 1958; Simon [1947] 1997). The bounded-rationality view of decision making begs a question, however. Namely, if decision makers work from limited information that they then must interpret in order to make satisfactory decisions, what limits the information that they deem relevant and points them toward particular interpretations and away from other interpretations?

The cognitive blueprints available to decision makers within the American mental health field constitute that field's *institutional environment* (Meyer and Rowan 1991), according to the neoinstitutional tradition within organizational sociology. An organizational field's institutional environment "encompasses the cultural belief systems,

normative frameworks, and regulatory systems that provide meaning and stability to a sector" (Scott et al. 2000:3). A field's institutional environment serves to constrain decision-making in a field that would otherwise be chaotic due to its ambiguous technology and unclear measures of success or failure (Levitt and Nass 1989). An institutional environment may contain a single, dominant blueprint for how to understand phenomena and organize work, or it may contain multiple cognitive blueprints, or *institutional logics*, which Scott et al. (2000:20) define as "the cognitive maps, the belief systems carried by participants in the field to guide and give meaning to their activities." A weak institutional environment is one in which conformity to a predominant belief system is not essential for actors working within that environment (Alexander and D'Aunno 1990). A weak institutional environment, then, is one in which multiple institutional logics – and thus multiple interpretations of the phenomena contained within that environment – coexist. By gauging the degree of consensus in clinical trainees' diagnostic and treatment-related decisions, Research Question #1 is meant to assess the strength of the U.S. mental health care's institutional environment, or the degree to which the field is institutionalized.

In the 1980s and early 1990s scholars weighed in on the strength of the American mental health field's institutional environment at that time. In 1985 John Meyer, one of the founders of the neoinstitutional perspective in organizational sociology, described the American mental health "system" as disjointed: "The striking aspect of the mental health system is that there are no consensual institutional rules defining people as healthy or sick, better or worse, or for differentiating between a clearly successful treatment or a failure. One can find authoritative opinion on every side of every question – everyone is

sick and needs treatment, or almost no one does" (Meyer 1985:594). This dissensus among American mental health professionals was due, according to Meyer, to the weak institutional environment in which mental health care was embedded. In 1990, Alexander and D'Aunno likewise used the American mental health sector as an illustration of a prototypical weak institutional environment. They wrote: "Mental health treatment in the United States provides a useful illustration of competition among rival belief systems within a sector. A variety of beliefs about how to treat mental health problems has existed for decades within the mental health sector" (Alexander and D'Aunno 1990:72). The lack of consensus described by these scholars predicted a relatively large amount of variability in what tasks got done and how they were accomplished in the mental health arena during the times when they were writing -- the 1980s and early 1990s. Given the lack of consensus prevalent in the U.S. mental health organizational field a mere twenty years ago, the current study should find widespread disagreement about some aspects of care and some clinical decisions.

Nevertheless, the neoinstitutionalist perspective does not maintain that an organizational field's institutional environment is static (Powell 1991). A once-weak institutional environment may strengthen, and a strong institutional environment may destabilize. Moreover, the institutional logic or logics embedded in a given field's institutional environment may change over time. Indeed, institutional studies have charted how logics change over time in such varied American fields as higher education publishing (Thornton and Ocasio 1999), the health care sector (Caronna 2004; Scott et al. 2000), the railroad industry (Dobbin and Dowd 2000), and the music industry (Dowd 2003).

Given that a field's institutional environment can change over time, it may be that the level of consensus among mental health providers has shifted significantly over the past fifteen or twenty years. Three rationalizing trends within the American mental health field may indeed have led to greater uniformity in providers' clinical judgments in recent years, especially with regard to routinely-seen mental health problems. The three developments include 1) an overhaul of the diagnostic classification system that clinicians use to categorize cases of mental illness (e.g., Rogler 1997; Thornton 1992); 2) the spread of managed behavioral health care (i.e. managed care as an organizational model) throughout the mental health field (Fox, Graves, and Garris 1999; Mechanic 2008); and 3) the use of evidence-based clinical guidelines within the mental health field (Garb 2005). These developments have the potential to strengthen the mental health field's institutional environment, thus engendering greater uniformity in clinical judgments via two institutional processes: coercive and mimetic isomorphism (DiMaggio and Powell 1991). *Coercive isomorphism* refers to pressures exerted on actors by other powerful players within their organizational field to follow certain rules or ways of doing business. *Mimetic isomorphism* refers to actors within a particular organizational field willingly copying other successful actors' practices as a way of managing uncertainty.[2]

One potentially unifying development in the mental health field was the transformation of psychiatry's diagnostic system in the late 1970s. This system (embodied in *The Diagnostic and Statistical Manual of Mental Disorders*, or DSM) was transformed from an overlapping, vague system where clinicians assigned diagnoses based on what they believed was causing their client's problems to a system made up of

[2] A third type of isomorphism, *normative isomorphism*, is discussed in the section on Research Question #2.

distinct categories where diagnoses are assigned based on explicit diagnostic criteria and decision rules tied to a patient's observable symptoms (APA 1980). Prior to DSM-III (APA 1980), the DSM was seldom used by clinicians as a clinical tool (Thornton 1992) and, when used, diagnostic agreement among clinicians was notoriously low (e.g., Klerman 1978; Matarazzo 1983). Indeed, one of the reasons for psychiatry's crisis of legitimacy and identity in the U.S. (e.g., Horwitz 2002; Kirk and Kutchins 1992) in the 1950s and 1960s (detailed in the section on Research Question #3) was the fact that diagnostic agreement among clinicians was low and diagnoses were not treatment-specific in versions of the DSM prior to the third revision, published in 1980. According to the crafters of DSM-III, the new diagnostic classification system (embodied in DSM-III and later editions of the diagnostic manual) should make it much easier for clinicians from different professional backgrounds, as well as from different theoretical backgrounds within those professions, to reach the same diagnostic conclusions when faced with the same patient, as it eliminates the need to make clinical inferences based on what the clinician thinks is causing her client's problems. That is, proponents of DSM-III (and later revisions) argued that the manual's focus on overt symptoms would (APA 1980) – and later, had (e.g., Klerman 1986) – eliminated much of the variability in diagnostic decision making. DSM III's critics, however, would vociferously argue that DSM III did not demonstrate high reliability among clinicians (e.g., Kutchins and Kirk 1986). Empirical studies on providers' diagnostic reliability have been mixed, with some studies finding high interrater reliability among providers (e.g., Grove 1987; Matarazzo 1983) while other studies report moderate to low diagnostic consistency (e.g., Kutchins and Kirk 1986; Kirk and Kutchins 1992).

Regardless of the question of the DSM III's effect on diagnostic reliability, however, the advent of DSM-III has had one indisputable impact: the widespread use of the DSM throughout the mental health field (Mechanic 2008). The widespread adoption of DSM as the official diagnostic system by most U.S. mental health organizations, insurance companies, and courts represents a significant strengthening of the mental health field's institutional environment. DSM has become institutionalized as a result of both coercive and mimetic isomorphism. For example, most third-party insurers mandate that patients have a current DSM diagnosis if their clinicians wish to be reimbursed for services rendered. Thus, due to coercive isomorphism in the form of pressure from third party insurers, clinicians are much more likely now to assign clients DSM diagnoses than they were prior to DSM-III. Mimetic isomorphism is also likely at work here, as mental health organizations and the clinicians working within them recognize that they must follow their high-prestige counterparts (i.e., psychiatrists) in using DSM diagnoses if they are to remain respected players within mental health and viable members of interdisciplinary mental health teams (Williams 1981).

Two other developments, both of which have been underway since the 1990s (Mechanic 2008; Weissman et al. 2006), also have the potential to bring about greater homogenization within the U.S. mental health field. Namely, these developments are the spread of a managed care model and the diffusion of evidence-based clinical guidelines within the mental health arena. Third-party reimbursement for mental health services, embedded in the behavioral managed health care approach that has come to dominate the mental health field (Fox et al. 1999; Mechanic 2008) since the 1990s, has become commonplace. As noted above, insurance companies and the federal government (when

covering mental health services under Medicare and Medicaid) typically require clinicians to assign their clients a DSM diagnosis if they are to be reimbursed. Consequently, as out-of-pocket costs for patients has fallen in recent decades as a proportion of total mental health service costs (Frank and Glied 2006) relative to the proportion covered by third parties, diagnosing patients based on the DSM classification system has likely expanded. Another potentially homogenizing managed care trend is utilization review (in the form of precertification review and concurrent review). Under precertification review, a therapist must seek permission from the utilization reviewer before initiating specified expensive diagnostic and treatment practices. Under concurrent review for psychotherapy, the reviewer only authorizes a few sessions of psychotherapy at a time, requiring the clinician to justify her proposed extension to the therapy's duration (Mechanic 2008). Both forms of utilization review should minimize the amount of treatment variation between providers by centralizing decision making. Thus, the diffusion of the managed care model of organizing should bring about less divergence in clinicians' diagnostic and treatment decisions through the process of coercive isomorphism, as insurers insist on DSM diagnoses and overseeing some treatment decisions for providers who wish to be reimbursed for their services by third parties.

The third potentially homogenizing factor at play in recent years is the diffusion of evidence-based clinical guidelines throughout the U.S. mental health field. Such guidelines are a form of *evidence-based practice*, a current movement to apply scientific research findings to the care of individual patients (Tanenbaum 2005). Clinical guidelines act as a rationalizing force within organizational fields, shaping how professional decisions get made by focusing practitioners' attention on a delimited number of

treatments that have gained wide acceptance (Fennel and Leicht 1997). The diffusion of evidence-based clinical guidelines for mental health clinicians could potentially unify treatment recommendations and strengthen mental health's institutional environment by directing clinicians to choose only the treatments that have been vetted through randomized clinical trials. Both coercive and mimetic isomorphism may cause clinicians to follow these guidelines. For example, clinicians working with patients who carry third-party insurance may only be reimbursed for particular evidence-based types of therapy (coercive isomorphism), and clinicians may mimic successful colleagues' use of certain evidence-based treatments in order to gain legitimacy (mimetic isomorphism). Despite evidence-based practice's potential for standardizing practice, however, early reports (e.g., Garb 2005; Timmermans and Kolker 2004) suggest that only a small percentage of health care professionals actually follow the practices laid out in evidence-based clinical guidelines. Moreover, practitioners' disparate beliefs regarding what constitutes 'evidence' and 'effectiveness' may mean that even the practices of those committed to evidence-based practice likely varies considerably (Tanenbaum 2005). Nevertheless, the widespread interest in evidence-based medicine and evidence-based practice more generally over the last 15 years (Hamilton 2005) suggests a shift toward greater standardization of clinical judgments in the mental health field.

Recent neoinstitutional scholarship suggests that within any organizational field some organizational practices will reflect general consensus, while other practices will reflect dissensus, depending on the degree to which a practice is institutionalized, or the degree to which an institutional standard is taken for granted as a social fact (Alexander and D'Aunno 1990; Goodrick and Salancik 1996). When the rules on which a practice is

based are fully institutionalized, there is little room for divergence. When the rules on which a practice is based are uncertain or only broadly explicated, there is a range of acceptable actions considered legitimate within a particular institutional context (Johnson, Dowd, and Ridgeway 2006). The largest amount of between-hospital variation in cesarean section rates, for example, occurs under conditions of medium-risk births, conditions under which there is no set agreement on whether a cesarean section's potential health benefits outweigh its risks (Goodrick and Salancik 1996). Under conditions of low-risk and high-risk births, conversely, conditions under which the field tends to agree on whether or not to perform c-sections, Goodrick and Salancik (1996) find little between-hospital variation in cesarean section rates (c-sections are uncommon in low-risk and common in high-risk births).

Thus, it may be that the U.S. mental health field's current institutional environment contains a number of distinct institutional logics that organize mental health care, but that all of these logics share some broad organizing principles, or generic "rational myths" (Meyer and Rowan 1991). It is these shared organizing principles that allow providers working from different logics to coexist and, at times, even work together. Recent work in the neoinstitutional tradition (e.g., Lounsbury 2007; Zilber 2006) demonstrates how actors working in the same institutional environment can translate the specifics of shared rules differently, based on the institutional logics that organize their thoughts, feelings, and actions. Consequently, it may be that virtually all mental health providers assign diagnoses that appear in the DSM because of third-party insurance requirements, but that the types of diagnoses they assign vary because rules for applying the DSM categories are incompletely institutionalized. Likewise, it may be that

mental health clinicians widely agree that people manifesting psychological distress need professional mental health help, but those same clinicians disagree on what specific types of help to provide.

Existing studies that look at diverse groups of mental health providers lend credence to the idea that the majority of providers share some broad understandings of how mental health care should be organized yet diverge in their specific interpretations of these vague principles. For instance, Strauss et al. (1964) found agreement among practitioners working in a Chicago psychiatric hospital that the patients should be treated on an in-patient basis, but found providers' beliefs diverged with respect to which aspects of care were most beneficial to patients. As another example, as noted above, clinicians' use of the DSM has become widespread since the advent of DSM III (Mechanic 2008), but the ways in which different providers use the DSM and their attitudes toward the DSM may differ based on the particular institutional logic guiding each provider's diagnostic decisions. A case study by Pescosolido, Figert, and Lubell on the mental health care provided in two hospitals found that some providers had "little use for" (1996:47) the DSM, while others supported using the DSM criteria sets in arriving at diagnoses and for treatment planning. In both studies, providers' clinical judgments differed along professional lines.

Thus, neoinstitutional theory suggests the following hypothesis:

Hypothesis 1: There will be widespread agreement among mental health trainees about aspects of care that are highly institutionalized and widespread disagreement among trainees about aspects of care that are incompletely institutionalized.

In summary, then, by measuring the amount of variation that mental health trainees display in a range of clinical judgments when they are faced with the same

patient, this study seeks to tap into the current strength of the U.S. mental health field's institutional environment. Does chaos reign in a very weak institutional environment, with innumerable logics available to guide and explain behavior and meaning? Does the mental health field represent a very strong institutional environment, with virtually everyone following a single dominant institutional logic which renders most aspects of care taken for granted? Or does the current institutional environment within American mental health care fall in between these two extremes, containing some broad beliefs, rules, and conventions (Douglas 1986) that are unanimously agreed upon, while allowing room for varied interpretations of these rules based on the particular institutional logic that a participant uses to guide her? Chapters 4 and 5 will address the amount of variation evident in trainees' clinical decisions regarding diagnosis and treatment, respectively.

RESEARCH QUESTION #2: *Does professional affiliation help explain some of the variability in trainees' clinical decision making and approach to care?* The current study extends the organizational sociology literature by marrying DiMaggio and Powell's (1991) neoinstitutional work on sources of organizational isomorphism with Abbott's (1988) work on professions' jurisdictional battles. Neoinstitutional theory joined with Abbott's theory on the system of professions (1988) predicts that professional affiliation will help explain variation in clinical decision making due to the homogeneity among providers with the same professional affiliation and heterogeneity between providers of different professional affiliations working in the same organizational field.

In addition to coercive and mimetic isomorphism, DiMaggio and Powell (1991) also describe *normative isomorphism*, or uniformity among professionals from the same

discipline. Past neoinstitutional studies on coercive (e.g., Lehrman 1994), mimetic (e.g., Fennell and Alexander 1987), and normative (e.g., Galaskiewicz 1985) isomorphism exclusively focused on how one or more of these processes work within a particular organizational field to bring about greater *uniformity*. This study departs from past neoinstitutional studies by asking whether and in what ways normative isomorphism, or professionalization, may actually be a source of *variation* in organizational practices net of the homogenizing impact of the coercive and mimetic isomorphic processes (e.g., the diffusion of evidence-based clinical guidelines) concurrently at work in the mental health field. In their discussion of normative isomorphism, DiMaggio and Powell (1991) discuss professions solely as sources of uniformity in organizational fields. Yet what of the impact of different professional groups on an organizational field like the American mental health field where different professions openly compete for clients?

DiMaggio and Powell (1991) argue that homogeneity among professionals from the same discipline— normative isomorphism—emanates jointly from professionals' university training and from their membership in professional networks, both of which transmits and solidifies a particular cognitive worldview and an understanding of professional norms. Thus, professionals from a particular discipline (e.g., clinical psychologists) share an understanding of their clients and their clients' problems with other members of that discipline. Put another way, professionals from the same discipline share an institutional logic or a way of viewing the world. As noted in the previous section, the concept of an institutional logic dovetails with work within cultural and cognitive sociology (e.g., Cerulo 2002; DiMaggio 1997; Fleck [1935] 1979; Zerubavel 1997) that holds that as members of particular social groups or 'thought communities' we

are socialized to focus our attention on certain things and away from others, to process information using the same sorts of schematics, and to classify and find meanings in things in the same way that others who belong to that social group do. In other words, professionals from the same discipline at a particular place and time share a vision of themselves and their work because they share a *professional logic*, a particular type of institutional logic. A professional logic is a way of seeing, thinking about, approaching, and carrying out work that professionals from a particular discipline have in common with other members of their profession. Clinicians (including clinical trainees) from the same discipline should make similar clinical judgments because of their shared professional logic.

Yet while clinicians trained in the same profession should make similar clinical judgments when faced with the same case, clinicians trained in separate professions to perform identical or similar tasks should exhibit variability from one another in their clinical judgments. Abbott (1988) explains that a profession's jurisdictional claim – its claim that society should recognize its cognitive structure by affording it certain exclusive rights, such as the right to treat clients, the right to receive payment for services rendered, and the right to control professional training and licensure -- rests on a profession's system of abstract knowledge. Multiple professions in competition for the same clients (as are psychiatry, clinical psychology, and social work) argue for jurisdictional rights based on their unique system of abstract knowledge. It follows that a profession's system of abstract knowledge must necessarily be *distinct* in some ways from its competitors' systems or else it will likely be subsumed under a competitor's abstract knowledge system. Given that professional training involves getting a firm

grounding in a profession's basic abstract concepts and theory (Abbott 1988) so that practitioners will know when and how to apply their abstract professional knowledge system to individual cases (Freidson 2001), professions with distinct systems of abstract knowledge should produce professionals with divergent understandings of how to understand and treat their clients. In summary, DiMaggio and Powell's work on sources of isomorphism (1991) combined with Abbott's work on professions suggest that professional affiliation may be a source of *variation* in a field where professions compete for clients. Thus, while recent editions of the DSM, the spread of managed care, and the diffusion of evidence-based clinical guidelines throughout the mental health field have the potential to bring about some uniformity of clinical judgments due to coercive and mimetic isomorphism, systematic differences may exist in the ways that particular professional groups *apply* evidence-based guidelines and the DSM to cases. That is, systematic differences in clinical judgment may be due to normative isomorphism, or professionalization.

There is a dearth of studies that have explored the role of professional affiliation on clinical decision making, among health practitioners more broadly, and in the mental health field in particular. The following paragraphs detail the results of the only empirical studies I was able to locate. The studies outside the mental health field that compared the clinical decisions of doctors from different medical specialties (Bertakis et al. 1998; Manu and Schwartz 1983; McKinlay et al. 1997; McKinlay et al. 2002; Pfohl 1977) each found differences based on physician specialty. For example, Bertakis et al. (1998) found that internists spent more time with patients going over technical issues such as explaining the results of medical tests than did family practitioners, while family

practitioners spent more time than internists did on discussing the interpersonal aspects of patients' health. Similarly, McKinlay et al. (1997) found that, with respect to identical patients presenting possible cases of breast cancer to physicians of varying specialties, surgeons were less likely than oncologists to make a diagnosis of breast cancer and were more certain of their diagnoses than were oncologists.

With respect to the impact of professional affiliation on care within the mental health field in particular, I was able to locate sixteen studies that both included respondents from multiple mental health professions and also drew conclusions about the potential effects of professional affiliation. Of these sixteen studies, thirteen (Clavelle and Turner 1980; Davies et al. 2006; Falvey 2001; Hutschemaekers, Tiemens, and Kaasenbrood 2005; Jensen and Bergin 1988; Johnson et al. 2000; Kent and Read 1998; Kirk and Hseih 2004; Pescosolido et al. 1996; Plaud, Vogeltanz, and Ackley 1993; Pottick et al. 2007; Strauss et al. 1964; Turner and Kofoed 1984; Wright 1997; Wright et al. 1980; and Wyatt and Livson 1994) reported finding differences in providers' clinical judgments or approach to care based on providers' professional affiliation, while three (Davis, Blashfield, and McElroy 1993; Falvey, Bray, and Herbert 2005; Wakefield, Pottick, and Kirk 2002) reported no differences in approach to care between different groups of mental health professionals. In summary, then, insights from joining neoinstitutional theory with Abbott (1988), combined with the empirical results of most studies that look at the effect of professional affiliation on clinical care, suggest that a trainees' professional affiliation will affect at least some aspects of care.

Alternatively, however, it may be that professional affiliation does not predict differences in mental health practitioners' clinical judgments due to variability *within*

professions. Within the sociology of professions literature, Freidson (1984; 1986) describes how a profession is not made up of a monolithic group of like-minded individuals pursuing the same interests. Instead, there is role-differentiation within professions, with professions broken into three groups: academics, managers/administrators, and practitioners (Freidson 1986). It follows from Freidson (1984; 1986) and others (e.g., Bucher and Stelling 1977; Bucher and Strauss 1961; Fennell and Leicht 1997; Hafferty and Light 1995; Light 1980) whom describe professions as internally stratified that it may be an individual's position within a profession (e.g., practitioner vs. manager) rather than professional affiliation per se (e.g., psychiatrist vs. social worker) that explains some of the variability in professionals' clinical judgments. Glynn (2000) found, for example, that within the Atlanta Symphony Orchestra, disagreements between musicians (practitioners) and administrators over organizational identity and how to invest resources led to the 1996 musician's strike. She did not report, however, that different groups of musicians (e.g., members of the brass vs. the string section) argued with one another over identity or resources. Along a similar vein, Barley, Meyer, and Gash (1988) found that practitioners held distinct conceptions of organizational culture from academics, and that academics' viewpoints did not change practitioners' ideas over time.[3] Thus, it may be that practitioners make similar judgments to other practitioners and that managers make similar judgments to other managers under similar organizational conditions, regardless of an individual's professional affiliation.

The current study focuses on mental health practitioners, or, to be precise, on those training to undertake clinical work. Therefore, potential distinctions between

[3] Interestingly, Barley et al. (1988) did find that academics' conception of organizational culture changed to become more like practitioners' over time.

professionals due to role differentiation (i.e., practitioner, manager, academic) later in professionals' careers are not at issue here. However, there exist other within-profession differences that may affect practitioners' clinical judgments, and may outweigh effects that professional affiliation has on a professionals' approach to clients and decision making. Bucher and Stelling (1977:21), for example, describe professions as containing different "*segments"* of providers: "Members of a segment share a professional identity; they also have similar ideas about the nature of their discipline, the relative order of importance of the activities it includes, and its relationships to other fields." Hunter (1996:799) makes this same distinction when he describes intra-professional *tribalism*: "All of these tribes have slightly different goals and perceptions of what constitutes effective care and are pulling in somewhat different directions." Thus, within-profession differences may outweigh between-profession differences. Within-profession differences include years of experience, a clinician's theoretical orientation, and the settings in which she works. While studies have typically found no effect of practitioners' years of experience on clinical decision making (Garb 1998), studies have found differences in judgment due to both theoretical orientation (e.g., Cohen and Oyster-Nelson 1981; Pottick et al. 2007) and work setting (e.g., Hirschowitz et al. 1992; Zimmerman, Coryell, and Black 1990), although findings have been mixed with respect to the effect of theoretical orientation.

With respect to theoretical orientation, a number of studies have found that those clinicians who worked from a psychodynamic orientation tend to judge patients as more impaired, to view treatment obstacles as more formidable, and are more likely to apply diagnostic labels to patients than are clinicians with other orientations such as

behavioral/cognitive orientations (Cohen and Oyster-Nelson 1981; Eels and Lombart 2003; Faller, Wagner, and Weiss 2002; Gingerich, Kleczewski, and Kirk 1982; Kubacki and Chase 1998; Langer and Abelson 1974; Pottick et al. 2007). Nevertheless, other studies that have looked at the effect of theoretical orientation on mental health care have found more similarities between practitioners practicing from different theoretical orientations than they have found differences (e.g., Goldfried, Raue, and Castonguay 1998; Hayes and Wall 1998; Messer and Wampold 2002; Schottenbauer, Glass, and Arnkoff 2007). Morant's (2006) case study of British and French mental health practitioners offers an explanation for the varied findings with respect to theoretical orientation. Rather than practicing strictly from one pure theoretical orientation versus another, Morant's respondents melded ideas and techniques from different approaches together into an eclectic approach to therapeutic work, paying no heed to conceptual incompatibilities between approaches. Thus, it may be that there are significant differences between cognitive-behavioral and psychodynamic practitioners among those who adhere *strictly* to one orientation, but that those differences are blunted for most practitioners because the majority of practitioners actually pull from more than one theoretical orientation.

With respect to work setting, different types of settings may cater to clientele with different needs, may offer clinicians varying levels of opportunities to apply diagnostic labels or offer specific treatments, and may place greater emphasis on some diagnoses or treatments over others. Hirschowitz et al. (1992), for example, found that those working in hospitals with a strong emphasis on academic psychiatry adhered to DSM criteria to a greater degree when assigning diagnoses than did those working in hospitals that did not

emphasize academic psychiatry. Relatedly, Sosin (2002) found that the length of care was greater for patients in behavioral managed care organizations that emphasized professional discretion than was the length of care provided at managed care organizations that emphasized strict adherence to rules.

Thus, the effect of professional affiliation on clinical decision making may be obscured or overridden by the possible effects of a practitioner's theoretical orientation or work setting. Alternatively, while one's theoretical orientation or the organizational context(s) in which one works may help explain differences in clinical judgments, so too may one's professional affiliation. Put another way, professional affiliation may affect practitioners' clinical judgments net of one's theoretical orientation and work setting. The current study focuses on the effects of professional affiliation on patient care while concurrently estimating the impact that other factors, such as a trainees' theoretical orientation, have on care.

Hypothesis 2: Within the mental health field, a clinician-in-training's professional affiliation will help explain variability in some types of clinical decision making, net of the effect of other sources of variability such as a trainee's preferred theoretical orientation.

The next section of this chapter focuses on Research Question #3, which addresses the types of clinical decisions that may be affected by a trainee's professional affiliation.

RESEARCH QUESTION #3: *In what ways is professional affiliation associated with trainees' clinical decision making and clinical approach?* While psychiatry, clinical psychology, and social work all currently treat people suffering from mental and emotional problems, three factors point to potential differences in the way that each profession conceptualizes mental illness and contributes to mental health care. These

factors are: 1) the shifting jurisdictional boundaries between the professions over time, which are embedded in the mental health field's dynamic institutional environment; 2) their unique professional logics, or the particular mental lenses that the different professions use to view their work in general and the mental health field in particular; and 3) their relative statuses within the mental health field. I will discuss each of these factors below, and then will discuss how these three factors may engender differences in clinical decision making. I end the section by formulating hypotheses about professional differences based on these three factors.

Shifting Jurisdictional Boundaries in a Changing Institutional Environment

The three professions' origins

This section charts the shifting jurisdictional boundaries between psychiatry, clinical psychology, and social work in the U.S., from the mid-nineteenth century to the present day. In the mid-nineteenth century, the prevailing *treatment ideology*—or the widely-shared sets of ideas among individuals in the mental health field about the etiology and treatment of mental illness, a set of ideas embedded in the field's institutional environment – was one of *curing* mental insanity in lunatic asylums, or mental institutions, through a combination of a drug and moral regimen (Grob 1994). The creation of asylums in the early nineteenth century was based on the assumption that insanity, if identified early and treated, could be cured. In asylums, patients were treated both via a drug regimen of narcotics, tonics, and cathartics and via a moral regimen of early rising, cleaning of persons and possessions, and the performance of jobs within the institution. In this context, those who could follow rules gained greater autonomy, while those who acted violently lost autonomy in an effort to appeal to a patients'

reasonableness (Grob 1994). American psychiatry grew out of the context of the asylum (Grob 1994; Mechanic 1999), and the supremacy of the psychiatric superintendent in nineteenth century mental institutions was unchallenged (Grob 1991). Neither clinical psychology nor social work had a place in nineteenth century American asylums. In fact, both professions developed late in the nineteenth century in organizational contexts outside the asylum, and in their infancy at the end of the nineteenth century, neither clinical psychology nor social work envisioned themselves working with psychopathology (Fancher 1995).

Rather than emerging from the context of the asylum as American psychiatry did, clinical psychology and social work emerged in response to child development problems and poverty, respectively. Clinical psychology originated in the late 1890s out of concern for the problems of children – in particular, educational and learning problems (Benjamin 2005; Fancher 1995). Lightner Witmer, a leader in the field of psychology, looked to use the emerging science of psychology to help combat children's learning and behavioral problems through intelligence and psychological testing and remedial treatment (Benjamin 2005). Witmer opened the first psychological clinic at the turn of the twentieth century (Benjamin 2005), a clinic geared toward helping struggling children.

The social work profession in the United States evolved from two different types of volunteer work undertaken in the late nineteenth century to combat the pernicious effects of poverty that accompanied rapid industrialization and exploding rates of immigration: Charity Organization Societies and the Settlement Movement (Dorfman 1988). Charity Organization Societies were based on the idea that poverty resulted from moral inferiority, and that by giving financial relief to destitute families, one was

encouraging dependence. Charity Organization Societies were tasked with determining the worthy from the unworthy poor, doing a thorough investigation of individual need, and sending out so-called 'friendly visitors' to the worthy poor who would befriend needy families and lead them out of poverty by modeling morals such as diligence and thrift. By 1900, Charity Organization Societies interested in promoting the professionalization of "Applied Philanthropy" (social work in its infancy) moved away from volunteer work toward paid staff. The Settlement Movement, unlike the Charity Organization Societies, was a form of political activism motivated by the belief that environmental factors (such as inadequate housing, unemployment, and poor working conditions) heavily contributed to poverty and suffering among urban dwellers. Thus, the Settlement Movement was undertaken by young men and women (such as Jane Addams), geared toward bringing reform to poor communities. These reformers set about creating desperately-needed social services, such as day-care centers, libraries, employment bureaus, literacy classes, and recreational clubs in poor communities, and chose to live in the neighborhood settlement houses in these communities. The Settlement Movement was short-lived, declining after WWI, but over time the first paid social workers, emerging as they did out of Charity Organization Societies, came to adopt the Settlement Movement mindset that environmental factors – rather than moral failings – were primarily driving society's ills.

Psychiatry's early relationships with Clinical Psychology and Social Work in the U.S.

Within the U.S., clinical psychologists and social workers had different initial dealings with psychiatrists (Fancher 1995). The legacy of clinical psychologists' and social workers' earliest cooperative work with psychiatrists remains salient for the work

that mental health professionals do today. Clinical psychology, as noted above, grew out of the discipline of psychology, or the newly-emerging science of the mind. With respect to psychopathology, clinical psychologists in the early decades of the twentieth century were most involved in developing, administering, and interpreting psychological tests that were then used to plan treatment that physicians would subsequently implement (Benjamin 2005). Clinical psychologists were hired by the federal government during WWI to do extensive testing on potential recruits to determine which men would best withstand the trauma of war (Benjamin 2005; Grob 1991). By the 1920s, clinical psychologists were working independently, providing testing services in settings such as schools and businesses, and were in charge of psychological testing on multidisciplinary teams in child guidance clinics and inpatient mental hospitals, where they worked alongside psychiatrists and social workers (Benjamin 2005). Psychiatrists saw the benefit of having clinical psychologists in these settings since psychiatrists themselves were not trained in psychological testing and were uninterested in doing testing, but they also considered such testing important, although supplementary, to assessing psychopathology (Cummings 1990; Grob 1991). While psychiatrists offered little resistance to clinical psychologists providing psychological testing, psychiatrists would fight hard against clinical psychologists' push, following WWII, for the right to provide psychotherapy (Grob 1991).

Social workers, who had a background in studying urban conditions, and in visiting needy families and helping to improve their circumstances, provided a number of services in mental hospitals and child guidance clinics in the early years of the twentieth century (Fancher 1995). Psychiatrists wanted information about patients' family and

social circumstances in order to provide better care to their patients, and they also saw a need for managed aftercare of patients released from hospitals. Psychiatrists, however, had neither the time nor the inclination to perform these tasks, so relegated them to social workers. Unlike psychological testing, which psychiatrists were not trained to provide, psychiatry did not feel ill-qualified to take familial histories or provide a transition for patients leaving institutions. Instead, psychiatrists simply did not want to perform these tasks so they handed them off to a lower-status profession (Fancher 1995).

Thus, while clinical psychologists worked independently in some settings and had extensive training in research methodology and psychological testing -- training that psychiatrists lacked -- social workers employed in the mental health field in the early twentieth century worked exclusively as subordinates to psychiatrists, performing duties that psychiatrists did not wish to complete, and consequently farmed out. Furthermore, while clinical psychology had its own theoretical orientation to work from during the first decades of the twentieth century, social work did not (Grob 1991). Behaviorism, or the idea that all things that animals (including humans) do can be considered behaviors, and that over time behaviors can be changed through conditioning responses, was the premier theory in psychological circles at this time. This theoretical tradition spawned behavioral therapy in the 1950s, which would challenge the preeminence of psychoanalytic psychotherapy (an orientation developed by psychiatrists), and ultimately come to dominate the field in the 1960s (Fancher 1995). Social work, on the other hand, lacked their own theoretical tradition from which they could base their practices (Dorfman 1988; Grob 1991; Loseke and Cahill 1986).

Social workers worked from their own unique professional logic[4] – a person-in-environment logic that focused attention on the impact that a person's social environment has on their beliefs, behaviors, and life chances – and social work developed its own method of collecting information and attending to the effects of social environment on outcomes, a method which they called *social casework* (Dorfman 1988). Nevertheless, social work was an applied, derivative discipline that lacked a theoretical or research tradition of its own (Grob 1991), borrowing theories to guide their practices from other disciplines such as sociology, psychiatry, and psychology (Abbott 1988; Grob 1991; Phillips 2000). Indeed, they borrowed most heavily from psychoanalysis (Abbott 1988; Danto 2009), rendering them beholden to psychiatry for some of the main ideas guiding their practices. Grob makes the case that social work's *jurisdiction*, or what Abbott (1988) defines as the tie between a profession and its work, was on shakier territory than was clinical psychology's jurisdiction as a result: "Casework in a hospital or clinic setting, after all, was hardly a firm foundation for the creation of professional autonomy and boundaries. The intellectual foundations of casework were unclear and constantly shifted between psychological and sociological extremes (Grob 1991:116). When social workers pushed for higher standards of education and training in the first half of the twentieth century so that they could offer psychotherapy, psychiatry successfully fought their efforts (Fancher 1995) on the grounds that social work had no legitimate claim to offer direct care.

[4] A professional logic consists of a broad set of abstract principles guiding professionals' thought and behavior and generally operates at a level above theoretical orientations. Every professional discipline works from a single professional logic. Within professions, however, there are a variety of theoretical orientations that members of that profession may choose to guide their practices.

World War II and American mental health's shifting institutional environment

From the turn of the twentieth century through the 1940s, psychiatrists had been making a significant shift. This shift included a move out of asylums and toward outpatient care, a shift away from drug and moral therapies and toward psychotherapy (predominantly psychoanalytic psychotherapy), a shift away from a singular focus on curing mental illness to both curing and preventing mental illness, and, most importantly, an expansion of their jurisdiction to include not just those with psychoses and other serious mental illnesses, but also those with neurotic problems and other problems of everyday life (Grob 1994). That is, the treatment ideology that had prevailed in the mental health field in the nineteenth century was being replaced by an ideology that favored outpatient care, psychotherapy, and a broad definition of mental illness over institutionalized care and somatic therapies for the relatively small percentage of the population who exhibited severe and chronic psychotic and manic symptoms. Fancher (1995: 83) writes: "Every revolution, it is said, contains the seeds of its own destruction; so it was with changing the idea of mental illness from the idea of insanity to the ideas of neurosis, social maladjustment, and personality problems." Prior to WWII, psychiatrists had managed to stymie the other professions' attempts to offer psychotherapy, except in rare cases, and always under a psychiatrists' supervision (Grob 1991). The advent of WWII, however, proved to be a turning point in psychiatrists' efforts to continue to be the sole providers of psychotherapy.

During WWII, psychologists and social workers were employed to help provide mental health services to soldiers. Psychologists served the armed forces by providing psychological testing, evaluation, and therapy, and social workers served draft boards by

gathering information on the mental and familial histories of potential draftees, and in some cases providing therapy to soldiers as well (Fancher 1995). Anticipating a need for psychological services for veterans that psychiatrists alone could not meet, the federal government in 1942 called on the Veteran's Administration (VA) and the United States Public Health Service (USPHS) to expand the pool of mental health professionals (Benjamin 2005). The VA and USPHS responded by pouring money into doctoral training programs; clinical psychology received the greatest boost from the government funding (Benjamin 2005). The government's decision to expand the mental health workforce due to anticipated need from veterans turned out to be prescient. Fully 40 percent of the casualties from WWII were neuropsychiatric in nature (Cummings 1990).

In addition to creating a pool of veterans in need of psychological help and, subsequently, a larger mental health force to provide those services, WWII also helped to shift the care and treatment of the mentally ill from inpatient hospitals to the community (Grob 1991; Grob 1994). The sheer number of veterans that succumbed to the stress of war suggested that neuropsychiatric conditions may be widespread in the general public as well. Furthermore, treatment of veterans in noninstitutional settings produced favorable outcomes. Indeed, the more isolated the affected soldier, the farther away from a soldier's unit, the worse off his outcomes. This implied that civilians would be better off if they were provided outpatient treatment in a community setting rather than being removed from their support systems and placed in an institution (Grob 1994).

The end of WWII also ushered in a new era of government spending and involvement in mental health care. In 1946 President Truman signed the National Mental Health Act, which led to the creation of the National Institute of Mental Health in 1949.

Postwar government spending on mental health care skyrocketed, first with the National Mental Health Act offering money for training, for research (the largest share of which went to clinical psychology), and for construction of clinics and treatment centers; then with NIMH helping to establish community-oriented and preventive programs throughout the U.S. (Grob 1994). Beginning in the 1950s, psychologists began pushing for autonomy, state certification, and licensing laws that would allow them to provide outpatient psychotherapy (Cummings 1990) and graduate-level social workers established their dominance over their less credentialed counterparts (Dorfman 1988) and began pushing to provide psychotherapy as well (Grob 1991). Psychiatrists responded by successfully arguing (against Freud's expressed beliefs) that psychoanalysis was a form of medical treatment and that lay people could not provide it (Danto 2009). This kept lay people from practicing psychoanalysis until the late 1980s, when the American Psychoanalytic Association finally succumbed and agreed to admit nonmedical providers as members, after a series of long and costly legal battles (Wallerstein 1998).

The fact that social work did not aggressively pursue state certification and licensing directly following WWII (Grob 1991), a vital step in the creation of a jurisdictional settlement, combined with their lack of a unique intellectual foundation, and the fact that nonmedical analysts were barred from providing psychoanalysis until the late 1980s, has effectively served to keep social work in a subordinate position to psychiatry in all mental health settings, despite gains made on these fronts in recent years. In contrast, the infusion of federal money for training programs in clinical psychology following WWII, their successful campaign to gain the right to independently offer

psychological testing and psychotherapy in outpatient settings[5], their discipline's grounding in science and the scientific method, and clinical psychology's unique academic knowledge system (that spawned behavioral therapy, and later gave birth to a variety of other orientations such as humanistic psychotherapy), all set the stage for clinical psychology to emerge as a major competitor to psychiatry in the mid-twentieth century just as the majority of care shifted from inpatient to outpatient settings and the number of conditions treated by mental health workers enlarged to include neurotic, personality problems, and problems of living.

From the mid-twentieth century to the present: Another profound shift in the mental health field's institutional environment

Clinical psychology began their push for licensure and certification in the 1950s (Cummings 1990), and the 1950s also saw the development of behavioral therapy within clinical psychology (Fancher 1995). Nevertheless, psychoanalytic psychotherapy was the preeminent psychotherapy practiced during the 1950s (Hale 1995), and only physicians could practice it (Danto 2009). By the 1960s, however, behaviorism and behavioral therapy had gained a strong foothold in the mental health field, replacing psychoanalysis as the most popular form of psychotherapy (Fancher 1995; Hirshbein 2004), and psychologists came to dominate the practice of psychotherapy (Benjamin 2005). The 1960s and 1970s marked clinical psychology's "Golden Age" as clinical psychology's reputation within the mental health field grew (Benjamin 2005) at the same time that psychiatry's reputation was under fire.

[5] Clinical psychologists in the U.S. began their drive for licensure and certification in 1950. By 1977, clinical psychologists had won the right to practice independently in outpatient settings in all 50 states (Cummings 1990).

Psychiatry's reputation and jurisdiction came under attack during the 1960s and 1970s from a number of avenues. Psychiatry was criticized for its focus on psychoanalysis and for focusing on the type of people who gravitated toward analysis: wealthier, higher-class patients with less severe ailments. The argument was made that psychiatrists were handing off the care of the severely mentally ill in institutions to lower-echelon mental health workers whose main objective was to keep patients from acting out, rather than trying to treat or cure them (Abbott 1988; Kirk and Kutchins 1992), essentially abandoning their neediest, most vulnerable patients. Additionally, unprecedented increases in demand for psychotherapeutic services during the 1950s and 1960's made it impossible for psychiatrists to care for everyone who desired treatment (Abbott 1988), and psychologists and social workers stepped in to meet this demand. While in the early 1950s psychiatrists provided supervision to clinical psychologists and social workers providing psychotherapy (Abbott 1988), over time most clinical psychologists (Cummings 1990) and about 20 percent of social workers with a clinical license (Mechanic 2008) came to provide psychotherapy independent of psychiatric (or other) oversight. Moreover, psychiatry's mid-century primary adherence to a psychodynamic orientation and its openness to psychosocial explanations for the emergence of mental illness further diluted its shaky connection to medicine (Rogler 1997), a turn of events that greatly distressed the more biologically-oriented psychiatrists. Finally, as noted earlier (see page 18), psychiatrists at this time were plagued by questions about the lack of validity and reliability – and thus, the usefulness – of psychiatry's diagnostic system, the system embodied in DSM versions I (1952) and II (1968) (Kirk and Kutchins 1992; Klerman 1978). In summary, the late 1950s, the 1960s,

and the 1970s marked a particularly contentious time period for American psychiatry (Rogler 1997), as they faced criticisms from both inside and outside the psychiatric profession. In contrast, these decades saw both clinical psychology and social work gain ground.

Psychiatry's response to these crises came in the form of a scientific revolution (see Kuhn [1962] 1970), or a paradigmatic shift in psychiatry's guiding professional logic (Horwitz 2002; Kirk and Kutchins 1992; McCarthy and Gerring 1994; Rogler 1997). Dominated by the psychodynamic faction within psychiatry for most of the twentieth century (Hale 1995), psychiatry in the late 1970s became and remains dominated by its neo-Kraepelinian faction, a group intent on the remedicalization of psychiatry that conceptualizes psychological problems as discrete disease entities, brought on primarily by biological or genetic causes (Rogler 1997). This move has been labeled a "neuropsychiatric revolution" (Johnson et al. 2000), and the shift in psychiatry's professional logic toward biological psychiatry (also known as the biomedical model of mental disorders) and away from psychodynamic psychiatry with its focus on psychosocial causes and treatments of mental illness has had a profound effect on the mental health field (Horwitz 2002).

One effect of this scientific revolution has been the widespread adoption (Mechanic 2008) of a symptom-based diagnostic classification system that conceptualizes mental health disorders as discrete rather than overlapping – the system embodied in DSM III (1980) and more recent editions – by the vast majority of mental health professionals from varied professional disciplines. Another notable effect of Neo-Kraepelinians' rise to power within psychiatry has been an increased emphasis on: 1)

biological determinants of mental disorders, on 2) pharmacological research and, consequently, on 3) the prescription of psychotropic medication for a range of mental health issues (Scheffler and Kirby 2003). Recent studies suggest a trend of psychiatrists providing less psychotherapy (Mojtabai and Olfson 2008; Olfson, Marcus, and Pincus 1999) and more pharmacology (Olfson, Marcus, and Pincus 1999) to patients in recent years than they have in the past. Currently, psychiatry is the only mental health profession that has the authority to prescribe medications in all U.S. states. The widespread acceptance of the use of psychotropic medications and the belief that biology plays a role in the etiology of many mental health problems appears to have spread field-wide, however. Indeed, studies demonstrate both clinical psychology's (Wyatt and Livson 1994) and social work's (Moses and Kirk 2006; Walsh et al. 2005) growing acceptance of the role of genetics and biology in the formation of mental disorders and the place of drug therapy in mental health treatment, although neither of these disciplines likely gives as much weight to biological explanations and psychopharmacological treatments as does psychiatry (e.g., Wyatt and Livson 1994). A final effect of the field's biomedical turn has been psychiatry's reaffirmed dominance of the mental health field in light of their medical credentials, a dominance that was placed in jeopardy by their loss of control over psychotherapy in the 1960s (Horwitz 2002).

In conclusion, the past several decades have brought a number of alterations to each mental health profession's jurisdiction, and each of these changes was driven, at least in part, by managed care's focus on cost control (McFall 2006). Psychiatry has had to cede the lion's share of psychotherapy to other professions – clinical psychology, social work, and master's level therapists from other disciplines (Abbott 1988) – who are

collectively willing to receive lower fees for psychotherapy than are psychiatrists. Along the same lines, clinical psychology, the profession that dominated psychotherapy in the 1960s and 1970s (Benjamin 2005), has been overtaken by social work as the primary provider of psychotherapy (Dorfman 1988; Simpson, Williams, and Segall 2007), as third- party insurers prefer to reimburse social worker's lower fee schedule.[6] For the same reason, psychiatry's stronghold on prescribing psychotropic medications appears to be loosening, as in recent years clinical psychologists, supported by a cost-conscious logic that favors reimbursing the group of providers with the lowest fee-schedule, have earned prescription privileges in New Mexico and Louisiana (Benjamin 2005). While prescription privileges for clinical psychologists – even among clinical psychologists – is a contentious issue (McFall 2006), a recent study by Sammons and colleagues (2000) finds general support among clinical psychologists for prescriptive authority and there are currently legislative proposals in more than 20 other states seeking the same rights (Benjamin 2005).

Thus, since WWII, the U.S. mental health professions have been embroiled in what Abbott (1988) terms an "intellectual jurisdictional settlement," where one high-status profession "retains control of the cognitive knowledge of an area but allows (or is forced to allow) practice on a more-or-less unrestricted basis by several competitors" (Abbott 1988:75). This type of jurisdictional settlement is precarious, given that nothing prevents the challenger professions from developing academic programs of their own that have the potential to overtake the dominant profession's way of organizing work. Indeed,

[6] Each profession's fee schedule is tied to their credentials and years of training. Psychiatrists, as medical doctors, earn more for the same service than do clinical psychologists and social workers. Clinical psychologists, due to their doctoral degrees, earn more than do social work practitioners, for whom the master's is the standard degree (Robiner 2006).

this is exactly what happened in the 1960s and 1970s when clinical psychology's behaviorism overtook psychiatry's psychoanalysis as the prominent type of psychotherapy offered. As Abbott points out, it was this very threat from clinical psychologists that led psychiatry to switch from a psychodynamic professional logic to a biomedical logic: "The recent rise of biological psychiatry is an obvious retreat to the secure professional heartland" (Abbott 1988:75).

Each Profession's Distinct Professional Logic and Approach to Care

I now turn to delineating each discipline's current professional logic. As noted above, psychiatry, a medical specialization, presently adheres to a biomedical model of mental disorders. This model holds that psychiatric conditions are discrete disease entities not unlike other diseases. As such, a correct diagnosis of a condition is critical to understanding a condition's etiology and prognosis, and in making treatment recommendations (Horwitz 2002; Kingsbury 1987). Psychiatrists are taught that science is a set of facts to be learned and are taught to search for the one accurate diagnosis that will point the way toward the appropriate treatment (Kingsbury 1987). While psychiatry officially recognizes that a variety of biological, psychological, and social factors may affect the emergence and development of mental diseases, its medicalized system of classification, DSM, gives primacy to genetic and biochemical factors in causing psychopathology (Horwitz 2002). Moreover, psychiatry's increased use of pharmacotherapy and its decreased use of psychotherapy in recent years (Olfson, Marcus, and Pincus 1999) also suggest psychiatrists elevate the role of biochemistry over psychosocial factors in effecting change in patients' symptoms.

Clinical psychology trains its members to be "scientist practitioners," a model that places equal emphasis on research and clinical practice and proposes that practitioners be able to apply the scientific method and up-to-date research findings to their clinical work (Petersen 2007). Clinical psychologists, unlike psychiatrists and social workers, consequently receive extensive training in research methods (Kingsbury 1987) and are typically required to write a dissertation based on their own primary research (Petersen 2007). As a result, clinical psychologists come to view science as a process, a method of inquiry that involves repeated hypothesis testing and replication, rather than a set of facts to be memorized (Kingsbury 1987). Additionally, rather than being united under a single theoretical paradigm such as behaviorism or cognitive neuroscience, clinical psychologists share with one another a skepticism toward viewing any one theory as providing the only explanation for a client's symptoms or any one type of therapy as providing the only solution (Strauman 2001). Thus, while clinical psychologists are familiar with the medical model, they see this model as only one of many potential models (e.g., a cognitive-behavioral model, an interpersonal model) that can be used to understand an individual's psychological problems; clinical psychologists believe the models should be judged by their utility in explaining and helping to relieve an individual's problems (Kingsbury 1987; Strauman 2001). The discipline therefore embraces multiple treatment models and views many models as complementary. Indeed, clinical psychologists often blend methods when working with clients (Kingsbury 1987; Strauman 2001).

Moreover, unlike psychiatrists who view deriving the correct diagnosis as central in making treatment recommendations, clinical psychologists are ambivalent about

diagnosis. They see diagnoses as important in helping to orient a clinician, but also see diagnoses as potentially stigmatizing and hold that the current diagnostic nosology (i.e., classification system) is only one way of diagnosing cases (cf. Follette 1996; Jensen and Hoagwood 1997). Indeed, a study done in the early 1980s found that when given a list of different types of diagnostic classification systems that they could potentially use to diagnose their clients, the first choice for a majority of clinical psychologists was a social-interpersonal nosology, while their last choice was the system codified in DSM-III and later editions of the manual (Smith and Kraft 1983). This ranking reflects the relative weight clinical psychologists give to social factors over biological factors in causing psychological problems, although the American Psychological Association's recent efforts to lobby for prescription privileges for clinical psychologists may reflect a trend toward increased acceptance of the medical model of mental disorders (Levine and Schmelkin 2006).

Clinical social work, or social workers engaging in direct practice with individuals and groups, takes a "person-in-environment" or a "person-in-situation" perspective toward care, emphasizing environmental causes of mental problems and the role that a client's family, friends, and community play on an individual's development and well-being (e.g., Dorfman 1988; Simpson et al. 2007). A client's unique social location (in terms of race, ethnicity, gender, SES, etc.) is seen as a critical determinant of her problems and successes (Kirk et al. 1999). Of the three mental health professions, social work is historically the most concerned with social justice, often focusing on making disadvantaged or vulnerable populations aware of potentially-helpful resources that are available to them. Indeed, writing about the U.S., Cummings (1990:489) asserts

that "clinical social work, because of its roots in addressing poverty, [brings] to the mental health arena a social conscience." Moreover, a recent study found that social workers from different countries share a professional viewpoint that emphasizes social justice and attributes poverty to structural causes rather than to personal failings (Weiss 2005).

While psychiatry (Light 1980) and clinical psychology (Ganzach 1997) focus primarily on a client's abnormality or psychopathology, social work also focuses on a client's abilities and strengths (Kutchins 1995; Simpson et al. 2007). Clinical social workers are taught to view each client as a unique individual and to take a client-centered approach to care (Dorfman 1988). Simpson, Williams, and Segal (2007:7) note that clinical social work "is about professional competence in empowering the clients to recognize their internal strengths and to negotiate the external resources toward their health and well being." With respect to social work's preferred therapeutic approach to clinical practice, social workers are like clinical psychologists in that they do not see any one treatment model (e.g., biomedical model) or any one type of therapy (e.g., psychodynamic therapy) as being the only – or even necessarily the best – route to understanding and helping a client. Instead, the trend within clinical social work has been toward a "pluralistic approach to clinical practice" (Dorfman 1988:22), where practitioners work from more than one theoretical orientation at a time with a particular client.

With respect to diagnosis, social workers are concerned with the potentially stigmatizing effects that assigning diagnostic labels may have on clients and remain dubious about the potential benefits that assigning a diagnosis will have in helping social

workers make treatment recommendations (Kirk, Suporin, and Kutchins 1989; Kutchins 1995). Nevertheless, some within the social work profession have shifted toward emphasizing the importance of diagnosis in patient care (see, e.g., Corcoran and Walsh 2006; Turner 2002; Williams 1981) and favor the system embodied in DSM-III and later editions, citing the necessity of embracing the current system of psychiatric diagnosis if they are to successfully communicate with other types of professionals on mental health teams (Williams 1981). Finally, with respect to evidence-based practice (EBP), or incorporating only those therapies that have proved effective in clinical trials, the last decade has seen social work's interest in evidence-based clinical practice increase (e.g., Gambrill 1999). However the amount of training received on EBP and the general emphasis placed on evidence-based practice is lower in social work than it is in clinical psychology and psychiatry (Thyer 2007; Weissman et al. 2006).

Each Profession's Current Relative Status within the Mental Health Field

In addition to the professions' historical relationships with one another and the distinct professional logics that shape how the three mental health professions view and treat their patients or clients, the professions also currently differ along status lines. Mechanic (2008) explains that psychiatrists are at the top of the status hierarchy. Psychiatrists remain dominant due to their medical-doctor (MD) status, their ability to prescribe medication, their ability to hospitalize patients and provide independent treatment within hospitals, and their greater ability to be reimbursed for services rendered under a variety of insurance plans. Furthermore, psychiatrists virtually always act as team leaders on those interdisciplinary mental health teams that include a psychiatrist.

Clinical psychologists are next in line in the status hierarchy (Mechanic 2008). Clinical psychologists earn a PhD, rather than an MD, but are trained in research and psychological testing, skills that the majority of psychiatrists do not have. They have largely gained the right to work independently of psychiatrists; in most areas clinical psychologists can be reimbursed for psychological services such as assessment and psychotherapy without being associated with a practicing psychiatrist or mental health clinic. Additionally, in recent years some clinical psychologists have pushed for a) the right to prescribe a number of psychotropic drugs, and b) hospital privileges, or the right to treat patients independently in a hospital setting and serve on the staff of a hospital, and a few states have granted clinical psychologists one or both of these privileges (Plante 2005).

Clinical social workers, despite providing the largest amount of outpatient psychotherapy of any of the mental health professions and comprising the majority of the mental health professional groups (Duffy et al. 2004), are plagued by the lowest status of the three mental health professions (Barbour 1986; Loseke and Cahill 1986; Mechanic 2008). Historically, female-dominated professions have lower earnings potential than do male-dominated professions (Ozawa and Law 1993), and social work is a feminized profession (Grob 1994). In fact, the trend since the 1970s has been toward women in social work accounting for a greater percentage of graduates, faculty, and practitioners (Schilling, Morrish, and Liu 2008). Moreover, a plurality of clinical social workers work in outpatient clinics and social agencies on a salaried basis; less than one-fifth work primarily in independent practice, as receiving third-party reimbursement independent of a higher-ranked professional (e.g., a psychiatrist) remains a difficulty, despite the fact that

social work's ability to practice independently has been boosted of late through the expansion of managed care (Mechanic 2008). While psychiatrists earn an MD and clinical psychologists earn a PhD, the master's in social work is the professional clinical degree, and a few states allow social workers with only a bachelor's degree in social work to practice in clinical settings (Bureau of Labor Statistics 2009).

Clinical social work practice in the U.S. occupies a liminal professional position. For example, the title "clinical social worker" is not conferred by an educational institution. Instead, those who seek to become licensed clinical social workers move through the same process of graduate education as all other masters-level social workers, and become clinical social workers through a two-fold process after graduating with a masters of social work degree. The process includes a) post-masters training and experience that is specific to the individual seeking advancement while concurrently meeting state requirements, and b) passing a clinical licensing or certification exam that is specific to the state in which one chooses to practice (Phillips 2000). The licensure and certification for social work varies considerably between states (cf. the Association of Social Work Boards web site at http://www.aswb.org/), with most states regulating at least two types of social work practice. A common distinction is between the social worker who has graduated with an MSW but has not taken the licensing exam (master of social work), the social worker who has graduated with an MSW and passed the MSW licensing exam (licensed master of social work), and the clinical social worker who has graduated with an MSW, engaged in several years of supervised post-graduate clinical work, and has taken a clinical licensing exam (licensed clinical social worker). Most states, including Georgia, for example, allow social work practitioners to engage in some

types of clinical work once they have become a licensed master of social work, as long as their work is supervised by a practitioner (not necessarily a social worker) with several years of clinical experience. In short, then, those engaged in clinical social work are a varied group, reflecting a range of experience, licensure, and certification. And while becoming a licensed clinical social worker in most states requires several years of supervised, post-graduate clinical experience and having passed a separate clinical exam, the variation in the credentials of those social workers engaged in direct practice with clients with mental health problems contributes to social work's lower status in the mental health field compared to the more evenly-regulated professions of psychiatry and clinical psychology. In summary, then, psychiatrists are on top, clinical psychologists follow close behind them, and social workers come in third in the mental health professional status hierarchy.

Predictions about Professional Differences in Trainees' Clinical Approach and Decisions

If the three professions' historical jurisdictional battles, distinct professional logics, and current status differences are driving variations in practitioners' clinical decision making and approach to care, what patterns would we expect to find?

Diagnosis

With respect to their views of diagnosis, psychiatry holds that diagnosis is critical in making treatment recommendations (Kingsbury 1987; Light 1980), and psychiatry regained its dominance in part due to their 1980 overhaul of the DSM diagnostic system (Rogler 1997). Social work, though it has begun to move toward accepting the role of diagnosis in patient care (e.g., Williams 1981), has historically been concerned with the stigmatizing effects of assigning a diagnostic label, and has been skeptical about the

potential benefits assigning a label has for treatment planning, particularly due to social work's focus on empowering clients (e.g., Kutchins and Kirk 1995). Clinical psychology views diagnosing a client as important but potentially stigmatizing (Kingsbury 1987) and views the current psychiatric nosology as the least appealing potential diagnostic system (Smith and Kraft 1983). With respect to status differences, Horwitz (1982) and Chesler (1972) hold that the likelihood of assigning a psychiatric diagnosis and the severity of that diagnosis vary as a function of the clinician's social distance from the client. The greater the social distance between the clinician and the client, the more likely the clinician assigns a psychiatric label, and the more severe a diagnosis she will assign. Therefore, with respect to attributing a client's presentation to the presence of a mental disease or disorder vs. the result of everyday problems-in-living, the professions' views toward psychiatric diagnosis and the professions' status differences jointly suggest that psychiatry should be the most likely to view a client as disordered, social work should be the least likely, and clinical psychologists should fall somewhere in between the two.

Hypothesis 3a: Psychiatry residents will be the most likely to view a client as disordered, followed by clinical psychology trainees, and then social work trainees.

In keeping with the argument made by Horwitz (1982) and Chesler (1972) regarding the severity of a psychiatric label increasing as the distance between provider and patient increases, it follows that when clinicians do judge a patient or client to be suffering from a mental disorder, psychiatry residents, due to their greater social distance from their patients based on their M.D. status, will assign a more severe diagnostic label than will either clinical psychologists or social workers.

Hypothesis 3b: Psychiatry residents will assign a more severe diagnostic label to a patient than will their counterparts in clinical psychology and social work.

Treatment and approach to care

While psychiatrists currently subscribe to a "single dominant perspective," (Strauman 2001:1129), namely the biomedical model of mental disorders (Horwitz 2002), clinical psychologists (Benjamin 2001; Strauman 2001) and social workers (Dorfman 1988) both embrace the idea that there is no one single 'best' way of approaching psychological problems. As a result, it is likely that social workers and clinical psychologists are more likely to regularly draw from multiple theoretical orientations to treatment than are psychiatrists.

Hypothesis 4a: Psychiatry residents will report using fewer theoretical orientations in their clinical work, on average, than will clinical psychologists and social workers.

Regardless of the average number of theoretical orientations to which trainees from each profession subscribe, the historical backgrounds of the theoretical orientations themselves, along with each profession's distinct professional logic, should lead to the different professions favoring different theoretical orientations. Given psychiatry's current biomedical paradigm, and the fact that psychiatry is the only mental health profession whose trainees go through medical school, psychiatry should favor using a biomedical orientation more than the other professions, who tend to lean toward more psychosocial explanations for psychological problems than do psychiatrists (e.g., Johnson et al. 2000; Levine and Schmelkin 2006; Wyatt and Livson 1994).

Hypothesis 4b: Psychiatry residents will be more likely to use a biomedical orientation than will clinical psychology or social work trainees.

Both psychiatry (Hale 1995) and social work (Danto 2009) historically are indebted to the psychoanalytic or psychodynamic tradition in psychotherapy. Clinical psychology, however, has traditionally seen psychoanalysis as psychiatry's jurisdiction

(Fancher 1995). Indeed, clinical psychology developed behavioral therapy, and later helped to develop cognitive-behavioral therapy in order to "repudiate psychoanalysis" (Fancher 1995:184) and to gain "emancipation from their servitude to psychiatrists" (Fancher 1995:145). Given clinical psychology's grounding in behavioral science and behavioral therapy (Benjamin 2005; Fancher 1995), as well as its later addition of cognitive constructs to behavioral therapy in an attempt to "conceptualize and attempt to modify internal events without resorting to psychodynamic concepts" (Fancher 1995:184), clinical psychologists should favor using a cognitive-behavioral orientation more than should psychiatrists.

Hypothesis 4c: Psychiatry residents and social work trainees will be more likely to use a psychoanalytic or psychodynamic orientation to practice than will clinical psychology trainees.

Hypothesis 4d: Clinical psychology trainees will be more likely to wield a cognitive-behavioral orientation than will psychiatry residents.

Social work's distinct professional logic, namely its person-in-environment or person-in-situation approach to service, emphasizes a holistic approach to helping people overcome their problems by simultaneously paying attention to individuals, their families, and the broader social contexts in which they reside (Robiner 2006). This professional logic is compatible with a family-systems orientation that conceptualizes individuals as members of a familial unit, as well as a strengths-based perspective that emphasizes the importance of paying attention to individuals' strengths as well as their shortcomings or psychopathology (Allison et al. 2004). Given that both psychiatry (Light 1980) and clinical psychology (Ganzach 1997) tend to focus on individuals and their psychopathology more than they do an individual's strengths or environment, it is likely

that social work trainees will favor person-in-environment, family-systems, and strengths orientations more than will trainees in psychiatry or clinical psychology.

Hypothesis 4e: Social work trainees will be more likely to use a person-in-environment, family systems, or strengths orientation than will psychiatry residents or clinical psychology trainees.

For the same reasons that different professions should favor different theoretical orientations to practice – namely, their distinct professional logics and each profession's historical role in developing and utilizing particular theoretical orientations—so too should different professions favor different types of clinical interventions when they are faced with the same patient or client. Additionally, different professions should favor interventions that they typically provide that their competitor mental health professions generally do not. That is, professions should favor interventions over which they have complete or partial jurisdiction.

Thus, psychiatry should be more likely to provide or refer for psychopharmacology, and should rate psychopharmacology's likely efficacy higher than either clinical psychologists or social workers. Relative to social work, clinical psychology, with its recent push in various states to gain the right to prescribe psychotropic medications, should rate psychopharmacology's likely efficacy for a given patient higher, and should be more likely than social workers to prescribe or refer a patient for psychopharmacology.

Thus, with respect to a patient or client presenting with symptoms of depression and anxiety:

Hypothesis 4f: Psychiatry residents will rate the likely efficacy of psychopharmacology higher than will clinical psychology trainees and social workers, and clinical psychology

trainees will rate the likely efficacy of psychopharmacology higher than will social work trainees.

Hypothesis 4g: Psychiatry residents will be more likely to provide or refer for psychopharmacology than will clinical psychology trainees and social work trainees; clinical psychology trainees will be more likely to refer for psychopharmacology than will social workers.

Given psychiatry's and social work's history in working from a psychodynamic orientation, a history that clinical psychology does not share, psychiatry and social work should be more likely to provide or refer for psychodynamic psychotherapy, and should rate psychodynamic psychotherapy's likely efficacy higher than should clinical psychologists. Given the fact that cognitive-behavioral therapy emerged as a challenge to psychiatry-dominated psychodynamic psychotherapy, clinical psychologists should be more likely to provide or refer for cognitive-behavioral therapy, and should rate cognitive-behavioral therapy's likely efficacy higher than should psychiatrists. Social work, with its emphasis on the ways an individual interacts with others and is embedded in larger social environments, should be more likely to provide for family or couples therapy, and should rate the efficacy of those therapies higher than should either psychiatrists or clinical psychologists. Finally, given the fact that psychiatry is a medical discipline and that the majority of psychiatrists' training takes place in inpatient settings, psychiatrists should be more likely to recommend inpatient hospitalization, and will rate the likely efficacy of inpatient hospitalization higher than clinical psychologists or social workers.

Thus, with respect to a patient or client presenting with symptoms of depression and anxiety:

Hypothesis 4h: Psychiatry residents and social work trainees will rate the likely efficacy of psychodynamic psychotherapy higher than will clinical psychology trainees.

Hypothesis 4i: Psychiatry residents and social work trainees will be more likely to provide or refer for psychodynamic psychotherapy than will clinical psychology trainees.

Hypothesis 4j: Clinical psychology trainees will rate the likely efficacy of cognitive-behavioral psychotherapy higher than will psychiatry residents.

Hypothesis 4k: Clinical psychology trainees will be more likely to provide or refer for cognitive-behavioral psychotherapy than will psychiatry residents.

Hypothesis 4l: Social work trainees will rate the likely efficacy of family or couples therapy higher than will psychiatry residents or clinical psychology trainees.

Hypothesis 4m: Social work trainees will be more likely to provide or refer for family or couples therapy than will either psychiatry residents or clinical psychology trainees.

Hypothesis 4n: Psychiatry residents will rate the likely efficacy of inpatient hospitalization higher than will clinical psychology or social work trainees.

Hypothesis 4o: Psychiatry residents will be more likely to recommend a patient for inpatient hospitalization than will clinical psychology or social work trainees.

The three professions likely will also differ in their approach to care and in the distance that they seek to maintain between themselves and their patients. Psychiatrists are trained to fix their patients with a *medical gaze*, to use Foucault's term (1973). That is, psychiatrists are trained as medical doctors to look beyond patients' overt symptoms, illness presentations, and even, at times, their humanity, in order to better determine the underlying reality of a patient's psychiatric disease. Of the three mental health professions, psychiatry, with its medical gaze and high status compared to patients and other mental health professionals, will likely treat their patients with the most formality and will seek to maintain the most distance between themselves and their patients. Clinical psychologists, who do not receive medical training, but are trained to objectively

hypothesis-test through the use of the scientific method (Petersen 2007), will likely approach clients in a less-detached manner than psychiatrists, but will likely introduce more formality and authority into the therapeutic relationship than will social workers. Social workers, whose training emphasizes client empowerment and client involvement in the treatment process (Landau 1999; Simpson, Williams, and Segall 2007), and whose status in the mental health field is lower than that of clinical psychologists' and psychiatrists', will be most likely to approach clients with little formality and to maintain the least distance between themselves and their clients.

Hypothesis 4q: Psychiatry residents will maintain the most formality and distance; social work trainees will maintain the least formality and distance; and clinical psychology trainees' level of formality and distance in their interactions with clients will fall in between that of psychiatry residents' and social work trainees'.

In summary, my three research questions address the amount of extant variability in clinical decision making among U.S. mental health trainees and question whether and in what ways a trainee's professional affiliation impacts her clinical decisions and approach to care. The following chapter, Chapter 3, details my research methodology, or the ways in which I go on to address the study's research questions.

Chapter 3: Research Methodology

BACKGROUND

As noted in Chapters 1 and 2 this project concerns how mental health trainees approach care and the clinical judgments they make during case conceptualization and treatment planning. When faced with the same patient or client, are professionals' diagnostic- and treatment-related decisions similar, altogether dissimilar, or do they vary systematically along professional lines? To that end I pose three research questions. First, to what degree do mental health trainees' approach to care and clinical (i.e., diagnostic and treatment-related) judgments vary? Second, does professional affiliation help explain some of the variability in trainees' clinical decision making and approach to care? Finally, in what ways is professional affiliation associated with clinical decision making and approach to care among clinical trainees?

RESEARCH DESIGN

This study focuses on advanced clinical trainees enrolled in three training programs: Emory's General Psychiatry Residency program, Emory's Clinical Psychology program, and University of Georgia's Master of Social Work program. I employ a mixed-methods triangulation design (Creswell and Plano Clark 2007), a design used to obtain different yet complementary data on the same topic. The triangulation design involves collecting quantitative and qualitative data concurrently and assigns equal weight to both data sources. I employ the "convergence model" (ibid) of the triangulation mixed-methods design, a model where quantitative and qualitative data are collected separately on the same topic and then the results from each data source are merged during interpretation. The convergence model helps researchers reach valid conclusions about phenomena by gauging larger trends from quantitative data sources and then enriching

those findings with the depth and understanding that come from qualitative lines of inquiry. In order to address trainees' clinical judgments I asked the full population of advanced psychiatry residents and clinical psychology graduate students from Emory University and master's of social work students from the University of Georgia to participate in evaluating a written case study of a client manifesting symptoms of anxiety and depression. I measured participating trainees' case conceptualizations and clinical decisions regarding this case via a self-administered survey (the quantitative component). In order to both validate and enrich the survey data on clinical decision making and collect separate information about trainees' approach to working with clients I concurrently conducted in-depth, semi-structured interviews with a subset of trainees from each of the professional programs (the qualitative component). For the remainder of this chapter I break the study down into its two components, the survey (quantitative) component and the interview (qualitative) component, where applicable.

Research Design Rationale

Rationale for whom to study

This study's research design is based on both theoretical and practical concerns. DiMaggio and Powell (1991) cite university training as a key component of professionalization, namely because formal education conveys a profession's distinct institutional logic. Over time, as clinicians move farther away from their university training and come to work with different types of mental health professionals in varied organizational settings it is likely that the effects of professional affiliation on clinical approach and decision making wane. I chose to study clinical trainees in order to capture the impact that professional affiliation has on clinicians' beliefs and practices at a time

when the cognitive models conveyed during university training are freshest in clinicians' minds. Additionally, by studying clinical decision making among advanced trainees, I focused on individuals who are at roughly the same place in their professional careers, effectively controlling for the effect of clinical experience on decision making.

I chose to study trainees in psychiatry, clinical psychology, and social work because these three fields represent the three main mental health professions (Mechanic 2008). Moreover, while a number of clinical judgment studies focus on only two of these groups, generally psychiatry and psychology (e.g., Wyatt and Livson 1994), or psychology and social work (e.g., Wakefield, Pottick, and Kirk 2002), any two of these three professional groups may align on some aspects of care yet split on others. I chose to study clinical trainees from the top-ranked programs in psychiatry, clinical psychology, and social work[7] in one state in order to capture decision making among a group of each profession's most promising recruits, effectively controlling for selection effects that might emerge if I were to study clinical trainees enrolled in professional programs of varying quality. While there may be a different type of selection effect that emerges based on the type of individuals who apply and are accepted into different types of professional programs (e.g., schools of social work vs. medical schools), it is not possible to control for these type of effects. I cannot, for example, randomly assign individuals to apply to social work or medical programs.

Finally, I focused on the top professional programs in *Georgia* – namely the general psychiatry and clinical psychology programs at Emory University and the master

[7] Rankings of clinical psychology and social work programs are based on the 2008 *U.S. News and World Report* graduate school rankings (listed in *References* under Graduate School Rankings). Given that *U.S. News and World Report* does not rank residency programs the rankings of psychiatry programs came from a report put out by the U.S. Department of Health and Human Services (2006).

of social work program at the University of Georgia – due to recruitment concerns. As an Emory graduate student I approached students and faculty at Emory in the role of an "insider" (Lofland and Lofland 1995), thus increasing my odds of successful recruiting at two of the three professional programs.

Rationale for having participants evaluate a written case study (vignette)

Many studies of clinical decision making (e.g. Dixon, Gordon, and Khomusi 1995); Kirk and Hsieh 2004; Kirk et al. 1999; Loring and Powell 1988; Pottick et al. 2007; Pottick et al. 2003; Schulman et al. 1999; Wakefield et al. 1999; Wakefield, Pottick, and Kirk 2002) have had clinicians evaluate a written or videotaped case study of a patient. The merits and limitations of this approach vs. having clinicians evaluate a patient face-to-face have been extensively argued elsewhere (e.g., Dixon et al. 1995; Hare-Mustin 1983; Hyler, Williams, and Spitzer 1982; Loring and Powell 1988). Briefly, having clinicians read about or watch the case presentation of a patient is limited in that it does not allow for the patient-clinician interactions that take place in a naturalistic setting and may alter a clinician's diagnostic- and treatment-related judgments. Nevertheless, asking respondents to evaluate an identical case summary or case presentation allows the researcher to control for patient characteristics (e.g., a patient's method of presentation and interpersonal cues) that, while not the focus of the research, may substantially affect clinical decision making and confound results. By asking clinical trainees to evaluate a case study stripped of organizational context and the client's insurance information, this study controls for the effect of the organizational setting in which decisions are made (Zimmerman, Coryell and Black 1990) and the effect of clients' insurance coverage

(Hirschowitz et al. 1992) on clinical decisions, factors found to influence clinical decision making.

Rationale for survey

The amount and source of variation in trainees' clinical decisions are best measured quantitatively according to distinctions between quantitative vs. qualitative research made by Ragin (2004) and Collier, Seawright, and Brady (2004). Specifically, these authors note that research that seeks to document general patterns characterizing a population of observations, as well as research that tests existing theories and focuses on the relationship between independent (e.g., a trainee's professional affiliation) and dependent (e.g., a trainee's recommended treatment interventions) variables is typically measured quantitatively, often via a survey instrument. Accordingly, I measured advanced Emory and UGA mental health trainees' clinical judgments by having all trainees read an identical case study about "Jessica" and fill out a survey that gauges how trainees would diagnose and treat Jessica were she to present to them in a clinical setting. A number of recent clinical judgment studies (e.g. Hsieh and Kirk 2003; Pottick et al. 2007), have likewise assessed clinical judgments by having clinicians evaluate an identical written case study and record their decisions via a brief survey.

Rationale for interviews

Qualitative research is best used for gaining a rich, in-depth understanding of a small number of cases and is particularly effective in elucidating how and why things happen (Ragin 2004), including uncovering the cognitive models that underpin behavior. Thus, a qualitative approach is appropriate to gain an understanding of how trainees approach working with clients, how they view their clinical work, and the reasons behind

their behaviors and beliefs. Due to the private nature of clinical interactions between patients and mental health providers I opted to interview trainees about how they view and work with clients rather than attempt to gain access to provider-patient interactions. Moreover, due to budget and time limitations, I opted to interview advanced trainees about the professional socialization processes that have shaped their beliefs and practices rather than attempt an observational study that documents clinicians' university training over many years.

Rationale for use of multiple methods

A mixed-methods design is well-suited for this project. In instances where both the questionnaire and the interview guide speak to the same topic (e.g., treatment interventions regularly used for patients with anxiety and depression) each data source serves as a check on the other data source's validity. Additionally, each data source supplements the other. For example, the survey asks about trainees' primary diagnosis for Jessica while the interview asks about trainees' use of and approach to diagnosis more generally.

SAMPLE AND RATIONALE

Survey Component

I sought to survey all of the advanced clinical trainees enrolled in Emory's General Psychiatry Residency Program, Emory's Clinical Psychology Program, and the University of Georgia's (UGA) Master's of Social Work Program. I focused on advanced students because studies typically find that trainees just entering a clinical program make clinical judgments similar to lay people, while advanced trainees make judgments commensurate to seasoned professionals in their given field and unlike those made by lay

people (Garb 1998). For Emory's Psychiatry and Clinical Psychology Programs (lasting four and five years, respectively) advanced trainees included students currently in their 2nd year and beyond.[8] For the UGA Master's of Social Work Program (which includes two full-time *clinical* tracks: a four-semester track and an accelerated three-semester track available to students who recently earned their Bachelor's in Social Work) I designated those full-time clinical-track students in the final year of their master's training as advanced trainees.

Given that I wished to recruit the full population of advanced students in these programs, no sampling was required. In order to compile a list of students eligible for the survey component of the study I followed two steps. First I developed an initial list of potential respondents by going to each of the departmental websites and taking down students' names. Next I met with the administrator in charge of graduate or post-graduate students from each program and with their help modified the list based on current enrollment and this study's inclusion criteria (e.g., full-time students). The UGA School of Social Work does not list names of its master's students on their website. For UGA, then, I relied strictly on the list generated by the program's administrator for the master's program.

Fifty-one out of eighty-four UGA master's of social work students participated in the survey component of the study, for a sixty-one (60.7%) percent response rate for this program. Twenty-three of twenty-five clinical psychology trainees participated in the

[8] Recruiting psychiatry residents proved much more difficult than recruiting trainees from the other programs. As a result, I expanded the purview of the survey component to include psychiatry residents in their first year of the program. This expansion seemed justified given that all psychiatry residents had completed four years of medical school – including a psychiatry rotation – prior to entering Emory's General Psychiatry Residency Program and consequently shared similar training experiences with one another and were not beginning clinicians.

survey portion of the study, a response rate of ninety-two percent. Thirty-two of fifty-one possible psychiatry residents participated for a response rate of sixty-three (62.7%) percent. Overall, one hundred and six clinical trainees out of a possible one hundred and sixty trainees completed the survey component of the study, for an overall response rate of sixty-six percent (66.3%).

Interview Component

I sought to interview a subset of thirty students who participated in the survey component of the study to discuss ways in which their graduate training shaped their clinical approach to working with patients or clients. I included for consideration only those trainees who indicated they expected to pursue some clinical work after graduation (e.g., I excluded those respondents who intended to pursue a career in health care administration).[9] For psychiatry residents I had opened the survey component of the study to include first-year trainees (see footnote two); only psychiatry residents in their second year and above, however, were eligible for the interview component of the study since a number of sections on the interview revolved around residency training. Given the study's focus on the ways in which professional affiliation shapes trainees' approach and clinical decisions, I looked to recruit an equal number of respondents from each of the three professional groups (psychiatry, clinical psychology, and social work) to interview. That is, I sampled *purposively* based on theoretical considerations rather than randomly choosing thirty trainees from my pool of survey respondents (Miles and Huberman 1994).

[9] Survey question #20 (Appendix 3-C) elicited what type of work trainees expected to do after they graduated.

In addition to choosing interviewees based on professional affiliation I also sought to interview trainees with varying theoretical orientations. That is, when deciding whom to interview I made an effort to interview trainees within each program who endorsed different primary orientations as guiding their clinical work. I did this so that I could explore the ways that theoretical orientation may affect one's clinical approach. Finally, within each professional school I chose both male and female and white and minority respondents so I could examine the possible effects of gender and race on trainees' clinical approach. The final number of interviewees was thirty-three, eleven from each of the professional programs. Table 3-A displays the gender, race, and primary theoretical orientation(s) of survey respondents and interviewees from each of the professional programs. The percentage of respondents in each category is similar for the full sample of survey respondents and the subset of survey respondents who participated in the interview portion of the study.

RECRUITMENT

Survey Component

I first contacted the director of graduate studies at each of the three professional programs via telephone to elicit their support for the study. After gaining their support I then contacted the departmental administrator handling graduate and/or post-graduate students at each of the programs to a) gather a list of instructors teaching courses attended by advanced trainees and b) cross-check the initial list of advanced trainees I had generated virtue of information contained on each program's website. Subsequently I contacted instructors teaching courses attended by advanced trainees and asked permission to introduce and administer the surveys during class time (see Appendix 3-A for the letter sent to instructors of graduate classes). In introducing the study in classes I

a) introduced myself; b) briefly described the study's purpose; c) explained what their participation would entail; d) explained that their participation is completely voluntary, and that participation will not affect their grade in the course in any way; while simultaneously e) emphasizing that their participation would be helpful to me in assembling an accurate picture of clinical decision making among Emory's/UGA's student clinicians.

To those students whom I did not encounter in classes where I introduced the study, I sent a recruitment email explaining the study and asking for their participation (see Appendix 3-B for the text of the email I sent to students I had not reached in classes). The recruitment email contained the same information that I voiced verbally when introducing the study during classes. It explained that students interested in participating had two options. Either they could take the survey online or I would meet them to administer the survey at a time and place convenient to them. For those students interested in taking the survey in person I offered my contact information so that we could schedule a time to meet.

I was unable to reach a large number of psychiatry residents and clinical psychology students in classes. As a result I introduced the study to most of the trainees from these groups via email. In order to increase participation in the survey component of the study among these groups, then, I offered survey respondents from these two professional schools a twenty-dollar gift certificate to a business of their choice for participating. Unlike my difficulty securing class time to administer the survey to clinical psychology and psychiatry trainees, however, I was able to introduce and administer the survey to the majority of master's of social work students during one of their classes. As

a result I did not offer a gift card incentive to social work trainees for their participation in the survey component of the study.

Interview Component

I included a question at the end of the survey instrument asking respondents if they would be willing to talk with me one-on-one about their training experiences and clinical approach (please see the final page of the survey instrument, Appendix 3-C, for the interview recruitment text). I directed survey respondents who indicated that they might be interested in participating in the interview component of the study to include their contact information on the last page of the survey instrument. I then selected interviewees based on the criteria outlined in the interview component section of the "Sample and Rationale" segment of this chapter (above). In order to thank interviewees for their time, I offered forty-dollar gift cards for participation in the qualitative portion of the study (the interview).

DATA COLLECTION PROCEDURES

Pretesting

Prior to primary data collection I pretested both the survey instrument and the semi-structured interview guide with a handful of advanced trainees in clinical psychology at Texas A&M University, in psychiatry at Baylor University, and in social work at The University of Texas at Houston during the 2007 fall semester (September through December 2007). Prior to primary data collection I resided in College Station, TX, and thus had access to students at these Texas universities. I offered students a $50 gift card to thank participants for their time. In addition to administering the survey and interview components of the study I also asked respondents for feedback regarding the wording and content of the questionnaire and interview guide. I asked each respondent,

for example, to evaluate the wording of both survey and interview questions for clarity and asked if they considered response categories on the survey instrument valid and exhaustive. Moreover, I asked if there were questions that I had not asked (either survey or interview questions) that they felt should have been asked. As a result of their feedback I modified both the survey instrument and the interview guide. The final versions of the survey instrument and the interview guide appear at the end of this chapter as Appendices
3-C and 3-D respectively.

The following section refers to primary data collection. I collected both survey and interview data during the spring semester of 2008 (February through May 2008). I administered surveys and conducted interviews in Atlanta, GA for the two programs at Emory University (Emory's General Psychiatry Residency Program and Emory's Clinical Psychology Program), and in Athens, GA for the UGA Master's of Social Work Program.

Survey Component

The case study took about five minutes to read, and the survey took approximately ten to twenty minutes to complete. I administered as many surveys as possible during trainees' class time. For those trainees I was unable to reach during class time, I contacted them separately via email and offered them the option of taking the survey online or having me administer the survey in person at a time and location of their choice (see *Recruitment*, above). All respondents who did not complete the survey during class time opted to take the online version of the survey which exactly mirrored that of the paper version. I created and administered the online version of the survey via Qualtrics, a web-based survey software package available to Emory students and faculty

through Emory's Goizueta's Business School. Trainees were sent a link to the online survey via email and took the survey at a time convenient to them.

Interview Component

I conducted face-to-face interviews with each interviewee at a location of their choosing. All but two of the interviews with clinical psychology and psychiatry trainees took place in a private room at one of the locations where the trainee conducted psychotherapy. One of the outlying interviews took place in the trainee's home while the other took place at my office at Emory University. The social work trainees, in contrast, did not have offices or access to space at their internships. As a result the social work interviews took place in myriad settings, including coffee shops, the UGA library, and at trainees' homes.

The interviews generally took between one and two hours to complete. The shortest interview lasted 45 minutes while the longest lasted 113 minutes. All interviews were audio taped and transcribed with respondents' permission. I used a semi-structured interview guide (see Appendix 3-D) to direct the interviews, allowing me to collect rich, comparable data on how trainees' university experiences shape their approach to care and clinical decisions, while simultaneously allowing students to structure their own responses (Creswell 1997; Silverman 2000). Immediately following each interview I recorded general impressions and unanticipated topics that arose that suggested emerging themes and revisions to the interview guide, a standard practice when conducting qualitative research (Lofland and Lofland 1995). For example, I initially interchanged the terms 'clients' and 'patients' with all interviewees to refer to the people seeking mental health treatment. Almost immediately, however, it became clear that clinical psychology and social work trainees favored the term 'clients' while psychiatry residents would only

use the term ‘patients.’ In addition to adapting the language of the interview guide to reflect professionally-shaped preferences, I also added a question to the interview guide asking each interviewee which term they preferred and why.

ETHICAL CONSIDERATIONS

Prior to collecting data I gained approval to conduct research with human subjects from the Institutional Review Boards (IRBs) at Emory University and the University of Georgia. The Institutional Review Boards at Emory University and the University of Georgia both approved this research protocol with human subjects in January 2008.

Informed Consent

I followed separate informed consent procedures (including separate informed consent forms) for both components of this project (i.e., the survey component and the interview component). Thus, prior to participating in each study component, potential subjects were advised what their participation would entail, that their participation was completely voluntary and not tied to course credits or graduation status, and that they could stop participating at any time.

Survey component

When administering the survey in trainees' classes I explained who I was, the purpose of the survey component of the study, the voluntary nature of the study, what participation would entail, that they could skip questions and stop participating at any time. I then handed out two copies of the informed consent form for the survey component (Appendix 3-E). I advised trainees to read through the informed consent form and ask any questions they may have before choosing whether or not to participate. I asked that those trainees interested in participating sign and date one of the consent forms and hand it in to me, while those that do not wish to participate write their names at the

bottom of one of the consent forms and indicate: "I do not wish to participate in this study." Thus, I had all of the trainees hand in one of the consent forms (which they either signed or on which they indicated that they did not wish to participate). I advised them to hold on to the other copy of the informed consent form for reference, should they need it.

In the online version of the survey the informed consent form (a form identical to the one handed to trainees during class) was the first screen trainees saw. At the end of the form trainees were asked to indicate whether they did or did not wish to participate. Those trainees who indicated that they did not wish to participate were then taken to a screen thanking them for their time. Those trainees who indicated that they did want to participate were told to print up the consent form for their records and then were taken to Survey Question #1.

Interview component

For those students that I recruited for the interview component of the study I had them meet me individually in a convenient private location. Prior to beginning the interview I explained who I was, the purpose of the interview component of the study, the voluntary nature of the study, what participation in the interview would entail and that they could decline to answer questions and could end the interview at any time. I then handed the trainee two versions of the informed consent form for the interview component (Appendix 3-F) and advised the trainee to read through the informed consent form and ask any questions she had. I asked that those trainees who wanted to participate sign and date one of the consent forms and hand it to me, while those who did not wish to participate simply let me know verbally. I advised participants to hold on to the other copy of the informed consent form for reference, should they need it. I then verbally

asked permission to tape record participants' interviews and explained that should they wish the tape recorder to be turned off at any time they simply were to let me know and I would honor their request.

Confidentiality

Survey component

Participation was not anonymous. I had respondents write their names on the surveys in order to keep track of who had already completed the survey, and I asked survey respondents interested in participating in the interview component of the study to write their names and contact information on the final page of the survey so that I could schedule interviews. When I administered the survey in classes I asked that those trainees who chose not to participate hand in a consent form (indicating that they declined to participate) and a blank survey instrument at the same time their participating classmates hand in their completed surveys. Thus, it was not plain who had participated and who had chosen not to. This procedure allowed me to keep track of the trainees that had participated, the trainees that did not want to participate, and the trainees to whom the study had not yet been introduced while also maintaining confidentiality.

I maintained data confidentiality, moreover, by stripping surveys of respondents' names and contact information immediately after I received the completed surveys in the case of surveys administered in person and immediately after I downloaded the data in the case of surveys submitted online. Put succinctly I de-identified the surveys. I replaced names with code numbers so that participants' responses could not be tied to them personally. The document that listed participants' names and contact information with their code numbers (the re-identification link) was kept in a locked file cabinet in my

home to which only I had access. All de-identified survey data files were stored on my password-protected personal computer and the paper copies of the de-identified survey documents themselves were secured in a locked file cabinet in a locked office on Emory University's campus. Thus, the data files and survey instruments were both stored in a separate location from the list that allowed the instruments and files to be re-identified.

Interview component

All data collected in conjunction with the interview component of the study, including digital audio files, transcriptions, and researcher notes, were identifiable only by the code numbers generated during the survey component of the study. Thus, these materials did not need to be de-identified as they were associated with code numbers rather than names from the outset. As with the survey component of the study, digital data files were stored in two places – original data files were stored on my personal (password-protected) computer and copies were kept in a locked file cabinet in a locked office on Emory's campus to which only I had access. Handwritten research notes were also kept in this locked cabinet on Emory's campus. The list that linked code numbers with respondent names was kept separately in a locked file cabinet in my home.

Both study components

Once data collection ended I deleted and/or destroyed recruitment emails, the list detailing which trainees participated in the study and their contact information, the de-identified paper surveys and the re-identification link. I also deleted data files associated with the study from my computer. I transferred copies of the de-identified data files from both study components from their location on Emory's campus to my home where they remain safely locked away for future analyses.

MEASURES

Instruments

Vignette

The case study or vignette represents an American with a "typical" symptom profile, yet one sufficiently ambiguous so that there was not only one obvious "correct" diagnosis and treatment plan. In developing the case I analyzed data from the National Comorbidity Survey Replication (NCS-R), a representative national survey that provides the most up-to-date data available on the incidence and prevalence of psychiatric symptoms among Americans (Kessler and Merikangas 2004). In order to develop the case I selected a subset of individuals from the NCS-R database who qualified for both a non-psychotic mood disorder and an anxiety disorder, disorders that often co-occur in the same individual (Kessler 2001) and are the two most common types of mental disorders that Americans qualify for based on their symptom profiles (Wang et al. 2005). I generated descriptive statistics for this subset (i.e., symptom frequencies; mean age; modal race/ethnicity; modal gender; modal professional status) in order to develop a picture of the average American suffering from both an anxiety and a mood disorder.

The result is "Jessica," a 39-year-old white paraprofessional with a history of panic attacks, overwhelming sadness, worry, and difficulty sleeping and concentrating. In order to make the case more realistic I added personal details (e.g., Jessica is a married mother of two children working as a paralegal who enjoys reading mystery novels) and context (she presents for treatment due to recent panic attacks that occurred while she was driving; Jessica's marriage is strained) to the case study.

Two texts published by the American Psychiatric Association (Frances and Ross 2001; Spitzer et al. 1994) compile case studies of real patients who have presented to

mental health clinicians. The texts are used to train mental health clinicians how to differentially diagnose based on DSM-IV's (1994) criteria sets. I modeled the format of the case study on cases presented in these two publications, as well as on case studies that appeared in clinical judgment studies such as Loring and Powell (1988) and Kirk and Hsieh (2004). The one-page case study that I asked trainees to evaluate appears in this chapter as Appendix 3-G.

Survey

The survey instrument (Appendix 3-C) includes questions about whether trainees would diagnose Jessica (the woman described in the case study) and the primary diagnosis they would assign, the type of treatments they feel would be most effective in treating her, and the type of treatments they would actually engage Jessica in or refer her for. Additionally, the survey includes questions about the amount of time trainees have spent on various activities (such as on conducting therapy sessions or meeting with supervisors) during their university training. Finally, the survey includes questions on trainees' background characteristics, such as professional affiliation, theoretical orientation(s), sex and race, characteristics that have the potential to impact clinical decisions. Whenever possible, survey questions were adapted from existing clinical judgment surveys, including those used by Hsieh and Kirk (2003), Kales et al. (2005), and Wyatt and Livson (1994).

Interview

The interview guide (see Appendix 3-D) gets at broad questions about how trainees understand the role of diagnosis in clinical work, the type of clinical interventions that members of their profession typically use to treat patients or clients,

and about their training experiences and how these experiences have shaped their clinical approach. Additionally the interview guide contains questions that ask trainees about their experience working with other types of mental health professionals and asks them to compare how clinicians from different professions and from different theoretical orientations approach clinical work. Thus, the interview guide supplements the survey questionnaire on concepts such as diagnosis and treatments while also exploring separate questions about trainees' approach to care, professional identity and professional socialization.

DATA MANAGEMENT AND ANALYSIS

Data Management

I entered survey data from the paper-and-pencil version of the survey into the data management program SPSS version 15.0 (SPSS Inc. 2006). I used Qualtrics, a web-based survey software package, to build the online version of the survey. Qualtrics houses password-protected survey responses that the researcher is able to download into an Excel data worksheet. I transferred the online survey data from Excel into SPSS and then merged the two SPSS data files: the file associated with the paper version of the survey and the file associated with the online version. After merging these files I cleaned the data in preparation of performing univariate, bivariate and multivariate analyses (detailed below under *Data Analysis*). I used the qualitative data analysis software program MaxQDA (Verbi Software 2007) to facilitate data management of the interview data.

Data Analysis

Survey component

Table 3-B displays key dependent variables measured via the survey instrument, as well as the corresponding concepts that these variables mine, the measures I used to

capture these variables, and the types of bivariate and multivariate analyses I used to predict the dependent variables. Table 3-C, similarly, displays key independent variables with their corresponding concepts and measures. The rest of this section details the types of bivariate and multivariate analyses I use to interrogate the survey data.

Bivariate analyses

Chi-square crosstabulation analysis

A chi-square analysis tests the independence of the relationship between two categorical variables that are presented in contingency tables of rows and columns (Morgan et al. 2004). The null hypothesis of a chi-square analysis is that the two variables examined are independent of one other. When observed frequencies are similar to expected frequencies the chi-square (χ^2) value is small and the null hypothesis of independence of the two variables is retained. When, however, observed and expected frequencies are sufficiently large to yield statistical significance, the chi-square value indicates that the two variables are not independent of each other. That is, they are related.

T-test analysis

A t-test analysis or, more formally, the Student's t-test of Difference of Means, is used to compare two groups to see if there is a significant difference in their means. The t-test is appropriate to use when you have a continuous dependent variable and a dichotomous independent variable (Garson 2008d).

Analysis of variance (ANOVA)

Analysis of Variance (ANOVA) is used to compare means of two or more groups to see if there are significant differences in these means. Like a t-test, a one-way ANOVA

is used to test the differences in means of a continuous dependent variable by one single factor (Garson 2008c). While a t-test is only appropriate to use when your independent variable is dichotomous, however, it is appropriate to use a one-way ANOVA model when your independent variable is dichotomous *or* when your independent variable has more than two categories. The key statistic for ANOVA is the F-test of difference of group means, testing if the means of the groups for each value of the independent variable are different enough not to have occurred by chance (ibid). If the group means do not differ significantly that suggests that the independent variable did not have an effect on the dependent variable and the null hypothesis of independence of the two variables is retained. If the omnibus F-test shows that overall the independent variable is significantly related to the dependent variable, then one determines which values of the independent variable have the most to do with the relationship by running post-hoc pairwise multiple comparison tests of significance.

Multivariate analyses

Binary logistic regression

A binary logistic regression (also referred to simply as a logistic regression) is used to predict a dichotomous dependent variable from an independent variable measured at any level (Garson 2008a). When a logistic regression includes multiple independent variables (i.e., when performing a multivariate analysis) the coefficient for any one independent variable takes into account (controls for) the effects of the other predictor variables on the dependent variable. A logistic regression underscores the probability of a particular outcome for each case. The odds of being in one outcome category vs. another outcome category can be examined using an odds ratio (OR). The odds ratio takes values

between zero (0) and infinity, and an odds ratio of one (1) suggests the independent has no effect on the dependent variable (Garson 2008b). Odds ratios greater than one indicate a positive relationship between an independent and a dependent variable, while odds ratios less than one indicate a negative relationship between an independent and a dependent variable.

Multinomial logistic regression

Multinomial logistic regression is an extension of binary logistic regression that is appropriate for use with a categorical dependent variable that has more than two response categories that cannot be ranked in a meaningful way (Garson 2008a). This technique compares two outcome categories while simultaneously taking into account (adjusting for) all other outcome categories, as well as the predictors (Hosmer and Lemeshow, 2000). Each of these simultaneous comparisons yields a separate coefficient with a corresponding standard error, odds ratio, significance level, and confidence interval. For each binary outcome category except the reference category a linear predictor is estimated. For example, three binary outcome categories (e.g., a dependent variable measuring treatment effectiveness for which the outcome categories are high, medium, and low effectiveness) would result in the estimation of two regression equations. That is, if the reference category for the preceding example was high effectiveness, regression equations would be generated for the medium and low effectiveness categories. Resulting regression equations reflect the probability that a response falls into a particular outcome category compared to the reference category (Garson 2008a).

Analysis of covariance (ANCOVA)

An Analysis of Covariance (ANCOVA) model is used to test the effects of categorical independent variables on a continuous dependent variable while simultaneously controlling for the effects of selected other variables, or covariates (Garson 2008c). ANCOVA belongs to the ANOVA family of analyses, and as with one-way ANOVA the key statistic is the F-test of difference of group means. The F-test gauges whether the group means for each value of the independent variable are different enough not to have occurred by chance (ibid). Again, as with a one-way ANOVA, an omnibus F-test for an ANCOVA gauges whether an independent variable is related to the dependent variable overall but does not indicate which categories of an independent variable are driving the relationship. In order to determine which values of a predictor variable significantly contribute to the relationship between a predictor and dependent variable one uses post-hoc multiple pairwise comparison tests of significance (ibid).

Post-hoc pairwise multiple comparison tests for ANOVA family

As noted above, with the ANOVA family of analyses a significant omnibus F-test suggests that the independent and dependent variables are related, but does not indicate which categories of the independent variable have significantly different group means. A post-hoc pairwise multiple comparison test is necessary to determine which categories of the independent variable differ significantly. When the variances of the compared groups are similar, a Tukey's Honestly Significant Difference (HSD) test is one of the most recommended and used procedures to make follow-up multiple pairwise comparisons (Toothaker 1993). Throughout the dissertation in the case of a significant omnibus F-test (associated with one-way ANOVAs and ANCOVAs) I use a Tukey's HSD post-hoc test

when the assumption of homogeneity of variances is met. When this assumption is not met different post-hoc tests are indicated. A Tamhane's T2 post-hoc test is one of the appropriate tests to use to test the significance of mean differences between categories when the assumption of homogeneity of variances is not met (Sahai and Ageel 2000). Consequently I use a Tamhane's T2 post-hoc test to determine which groups significantly differ from one another when variances are unequal.

Survey analysis decisions: Theoretical orientations

I chose to ask survey respondents to select *all* the theoretical orientations that they regularly used in their clinical work (Survey Question #23, Appendix 3-C) rather than selecting only one major orientation (i.e., I made this a multiple-response-option question). I made this decision based on feedback I gained during pre-testing that suggested that a close-ended question did not accurately reflect most respondents' use of theory. Instead of generally using a single theory to guide clinical work most respondents reported using numerous theories simultaneously. A multiple-response survey question must be recoded for use in bivariate and multivariate analyses, however. I recoded Question #23 into a series of dichotomous variables. That is, each theoretical orientation has its own recoded variable (e.g., respondent regularly uses medical/biological orientation – yes or no). Also due to feedback acquired during pretesting I included a large number of theoretical orientations as response categories in Survey Question #23. For analysis purposes, however, I only include orientations selected by ten percent of respondents or more. Thus, I excluded the transtheoretical and feminist orientations from all analyses.

The fact that there are a relatively small number of survey respondents (N = 106) and many predictors (gender, race, professional affiliation, seven theoretical orientations,

and - in some analyses - primary diagnosis) poses a degrees-of-freedom problem (also called overfitting a model). That is, the more predictors in a model, the fewer values that are free to vary in the final calculation of a statistic and the less accurate your model becomes at predicting an outcome (Babyak 2004) since the model tends to exaggerate minor fluctuations in the data. In order to reduce the number of degrees of freedom in my multivariate models I chose to include only those orientations that were significant in the bivariate model.

Also at issue with respect to including multiple orientations in a model was the potential problem of multicollinearity. Multicollinearity refers to multiple predictor variables that are so highly correlated or associated that they challenge the reliability of individual regression coefficients. In particular, the family-systems orientation, strengths orientation, and person-in-environment orientation are highly associated.[10] As a result I combined these three orientations for each of the multivariate analyses.

Interview component

I had the interviews professionally transcribed. I subsequently reviewed each transcript in its entirety in conjunction with its corresponding digital audio file and corrected the transcripts where appropriate. The qualitative data analysis software program MaxQDA (Verbi Software 2007) facilitated coding and analysis of the interview data. For example, data exploration tools within the software allowed me to search for particular codes, words and phrases within interviews and analytic memos. The program also enabled me to group and compare data both by demographic variables (e.g.,

[10]Seventy-three percent of respondents who endorsed a person-in-environment orientation also endorsed a strengths orientation; eighty-one percent of those who endorsed a person-in-environment orientation also endorsed a family-systems orientation; eighty-three percent of those who endorsed a strengths orientation also endorsed a family-systems orientation.

professional affiliation, gender) and by variables identified during analysis (e.g., trainees that had interned in inpatient settings vs. those who had not). Finally, MaxQDA enabled me to modify the coding frame and the relationships between codes as my understanding of the data developed.

I analyzed the interview data via the three procedures described by Miles and Huberman (1994): *data reduction*, or selecting and focusing on particular aspects of the data (e.g., coding, using research questions to guide analysis); *data display*, or visually organizing the data in a way that facilitates the identification of themes and patterns; and *conclusion drawing and verification*, the ongoing process of assessing what the data mean and repeatedly testing the emergent meanings for plausibility and confirmability. All three of these procedures take place before, during and after data collection is finished. The Miles and Huberman approach has the benefit of allowing the researcher to approach the data both deductively and inductively. That is, a researcher's a priori concerns (shaped by prior research and theory) influence coding, data organization, and identification (and verification) of themes, yet the iterative nature of these processes also allows the researcher to uncover unanticipated themes that then shape subsequent analyses.

Coding qualitative data can be both descriptive and inferential. Miles and Huberman (1994) describe three types of coding – descriptive, interpretive, and pattern coding – that allow for both descriptive and inferential analyses. Descriptive coding involves describing segments of text and requires no interpretation. That is, it is descriptive analysis. Interpretive coding, a form of inferential analysis, refers to a higher level of analysis where sections of text are coded with theoretically-shaped and emergent

themes. Pattern coding is more inferential still, establishing links between indicators, codes, concepts, and themes.

Beginning with a small number of interviews (three), I generated an initial set of descriptive codes, and then tested and refined these codes by analyzing the rest of the interviews. As the coding progressed beyond description into exploration and explanation, I sorted and refined the descriptive categories into a priori theoretical concepts and emerging themes (interpretive coding). The last step in the process was to finalize core categories and their relationship to one another (pattern coding) and formulate hypotheses and draw conclusions based on themes reflected in the data.

Tables 3-D and 3-E display the framework I used to analyze interviewees' use of diagnosis in clinical work. Table 3-D ties the concept of diagnosis to the interview questions I asked regarding diagnosis and the descriptive and inferential codes that emerged from the data. Table 3-E shows the intersection of the highest-level inferential codes (pattern codes) with professional affiliation. Similarly, Tables 3-F, 3-G, and 3-H display the analytic framework I used to explore interviewees' general approach to care. Table 3-F charts the indicators and the corresponding interview questions I used to gauge interviewees' clinical approach, as well as the descriptive, interpretive, and pattern codes that emerged from the interviews. Tables 3-G and 3-H display the intersection of pattern codes with professional affiliation. The following chapter presents the results related to trainees' diagnostic approach and decision making.

Table 3-A: Gender, Race, and Primary Theoretical Orientations[a] of Survey Respondents and Interviewees by Professional School

	All Respondents		Psychiatry		Clinical Psychology		Social Work	
	Survey	Interview	Survey	Interview	Survey	Interview	Survey	Interview
Gender	%	%	%	%	%	%	%	%
Women	78.3	69.7	62.5	54.5	69.6	72.7	92.2	81.8
Men	21.7	30.3	37.5	45.5	30.4	27.3	7.8	18.2
Race								
White	69.2	66.7	50	63.6	77.3	81.8	78	81.8
Minority	30.8	33.3	50	36.4	22.7	18.2	22	18.2
Primary Theoretical Orientation(s)								
Medical/biological	32	33.3	93.8	100	0	0	4.3	0
Psychodynamic	20	30.3	37.5	45.5	22.7	27.3	6.5	18.2
Cognitive-behavioral	44	48.5	18.8	18.2	72.7	63.6	47.8	63.6
Interpersonal	15	15.2	6.3	0	54.5	45.5	2.2	0
Family Systems/Strengths/ Person-in-Environment[b]	34	30.3	6.3	9.1	4.3	0	64.7	81.8

[a]Respondents were asked to write in which "one or two orientations" are "primary" in their clinical work. As such, percentages do not add to 100 percent.

[b]Respondents who indicated either the family systems, strengths, or person-in-environment orientations as primary are counted as endorsing this combined orientation.

Table 3-B: Survey Research Design – Dependent Variables

Research Questions	Key Concepts/ Indicators for Dependent Variables	Measures	Variable Attributes	Types of Analysis Performed
RQ1: To what degree do mental health trainees' clinical judgments about diagnosis and treatment recommend-ations vary? **RQ2:** Does professional affiliation help explain some of the variability in trainees' clinical decision making? **RQ3:** In what ways is professional affiliation associated with clinical decision making among clinical trainees, net of other provider-level factors?	**DIAGNOSIS**			
	Disordered/Not Disordered	"In your opinion, does Jessica have a mental disorder?"	Yes/No/I'm not comfortable with the term 'mental disorder'	Chi-Square
	Primary Diagnosis	"If you were asked to make a DSM diagnosis based on the information contained in the case study, what would be your primary diagnosis?" *[Please Choose Only One Response]*	Close-ended; lists various non-psychotic mood and anxiety disorders from DSM-IV; also offers 'would not diagnose' and 'other' options	Chi-Square, Multinomial Logistic Regression
	Importance of Accurate Diagnosis for Treatment Planning	"How important is determining Jessica's *accurate* DSM diagnosis to your treatment planning?"	1 through 9, 1 = Not at all Important 9 = Extremely Important	ANOVA, t-tests, ANCOVA
	TREATMENT	"For each intervention listed below, please indicate how effective you think it is likely to be in helping Jessica."	1 through 9, 1 = Not at all Effective 9 = Extremely Effective	ANOVA, t-tests, ANCOVA
	Likely Effectiveness of Various Interventions	*Example* = Medication Consult/Psychopharmacology		
	Provide or Refer for Various Interventions	*Combine the two following survey questions in analyses:* "Please indicate which of the following intervention(s) you would initially use to treat Jessica." ***[****Please Select All That Apply****]*** "Please specify what type(s) of referral(s) you would make."	*Close-ended, lists various interventions such as:* -Medication Consult -Cognitive-Behavioral Therapy - Family/Couples Therapy -Inpatient Hospitalization *Open-ended, recoded into:* -Medication Consult -Individual Psychotherapy (any type) -Family/Couples Therapy -Inpatient Hospitalization	Chi-Square, Logistic Regression

Table 3-C: Survey Research Design – Independent Variables

Research Questions	Key Concepts/ Indicators for Independent Variables	Measures	Variable Attributes (After Recoding, When Applicable)
RQ1: To what degree do mental health trainees' clinical judgments about diagnosis and treatment recommend-ations vary? **RQ2:** Does professional affiliation help explain some of the variability in trainees' clinical decision making? **RQ3:** In what ways is professional affiliation associated with clinical decision making among clinical trainees, net of other provider-level factors?	***Professional Affiliation*** Type of University Program Enrolled In	"What graduate or postgraduate program are you currently enrolled in?"	- General Psychiatry Residency - Clinical Psychology - Social Work
	Theoretical Orientation(s) Theoretical Orientation(s) that Guide Treatment Sessions Primary Theoretical Orientations Number of Theoretical Orientations	"Please choose the theoretical orientation(s) that guide, or will guide, the majority of your treatment sessions:" *[Please Select All That Apply] (Survey Q. 23)* "Of the theoretical orientations listed in Q.23, please indicate which one or two orientations are ***primary*** in your work with most clients." Sum orientations selected in Survey Q. 23 (above)	-Medical/Biological -Psychodynamic -Cognitive-Behavioral -Interpersonal -Family Systems -Strengths -Person-in-Environment -Humanistic/Existentialist -Integrative/Eclectic -Other Range = 2 – 14
	Gender	"What is your sex?"	-Female -Male
	Race	"Are you of Hispanic or Latino Descent?" (Yes/No) "What is your race?" (White/Black/Asian/Native American/Multiracial/Other)	-White -Minority (includes Latino)
	Primary Diagnosis[a]	"If you were asked to make a DSM diagnosis based on the information contained in the case study, what would be your primary diagnosis?" *[Please Choose Only One Response]* -No diagnosis -Major Depressive Disorder -Major Depressive Episode -Dysthymia -Panic Disorder -Social Anxiety Disorder -Obsessive Compulsive Disorder -Generalized Anxiety Disorder -Other	-Major Depressive Disorder (MDD) -Generalized Anxiety Disorder (GAD) -Panic Disorder -Other (includes all other diagnoses)[b]

[a]Primary diagnosis was only used as an independent variable in models that predicted likely treatment effectiveness, treatment recommendations, and the importance of an accurate diagnosis to txt planning.
[b]The single respondent who indicated that Jessica did not have a mental disorder was excluded from the variable 'primary diagnosis.'

Table 3-D: Qualitative Research Analysis Framework – Role of Diagnosis in Clinical Work

Research Questions	Concepts	Indicators (Variables)	Interview Questions (Measures)	Analysis Codes		
				Descriptive	*Interpretive*	*Pattern*
RQ 1. To what degree do mental health trainees' approach to care and clinical (i.e., diagnostic and treatment-related) judgments vary?	Diagnosis	Role of diagnosis in clinical work	"Is diagnosing patients/clients central to the work you do?" *If yes*, "How so, and why?" *If no*, "Where does diagnosis fit into your work, if at all?" "Does arriving at a diagnosis affect your treatment planning?" *If yes,* "How so?" *If no*, "Why not? What factors do affect your treatment planning?"	**Diagnosis Affects Treatment Planning** -- Medication management (e.g., yes/no to medication; type of medication; dosage) --Psychotherapy (e.g., yes/no to therapy; type of therapy; focus of therapy) --Evidence-based practice – need diagnosis to look up accepted practices **Diagnosis Affects Patient Evaluation** --e.g., diagnosis shapes which questions to ask --e.g., diagnosis helps to focus trainees' attention **Diagnosis Affects Work with Other Providers** --e.g., linguistic shorthand between providers --e.g., helps us understand psychiatrists' perspective **Diagnosis Affects Access to Resources** --e.g., insurance benefits --e.g., disability benefits **Diagnosis Not Central** --e.g., not that important to therapy --e.g., only important to distinguish psychotic from non-psychotic --e.g., DSM = faulty classification system ;thus, diagnosis = marginal **Diagnosis Potentially Harmful** --e.g., diagnoses carries stigma	**Positive** --e.g., diagnosis helps direct treatment decisions; diagnosis facilitates provider-provider communication **Neutral** --e.g., little effect on what takes place in therapy room; sometimes it is helpful, sometimes isn't **Negative** --e.g., Can narrow a clinician's gaze too severely; diagnostic label can be stigmatizing for clients	Diagnosis is critical and central; directs txt planning, Understanding diagnosis is important in order to work with other types of mental health professionals Diagnosis matters but is secondary to individual client presentation re: txt planning DSM is flawed; needs a revision/overhaul Psychiatric labels can be harmful

Table 3-E: Role of Diagnosis in Clinical Work (Pattern Codes)

Research Question 2: Does professional affiliation help explain some of the variability in trainees' approach and clinical decision making?

Research Question 3: In what ways is professional affiliation associated with trainees' clinical approach and decision making?

Pattern Codes	**Diagnosis is critical and central; it directs treatment planning**	**Understanding diagnosis is important in order to work with other types of professionals**	**Diagnosis serves some purposes but for treatment planning is secondary to individual client presentation**	**DSM is flawed and should be revised/overhauled**	**Psychiatric labels can be harmful**	**Other factors besides Professional Affiliation affecting views of and use of diagnosis**
Professional Groups' Leanings	Psychiatrists	Social Workers	Clinical Psychologists Social Workers	Clinical Psychologists	Social Workers	Setting (inpatient vs. outpatient Theoretical Orientation (psychodynamic)

Table 3-F: Qualitative Research Analysis Framework – Clinical Approach

Research Questions	Concepts	Indicators (Variables)	Interview Questions (Measures)	Analysis Codes		
				Descriptive	*Interpretive*	*Pattern*
RQ 1. To what degree do mental health trainees' approach to care and clinical (i.e., diagnostic and treatment-related) judgments vary?	Clinical approach	Clinical Focus	"What do you see as the core work of insert R's profession?" "What are insert term for professionals from R's discipline 's main objectives in their work with clients/patients?"	Stabilize patient Treat mental illness Reduce patients' symptoms Help with functioning/quality of life Help patients find insight Help client thrive in social systems Understand and support client Empower client	*Reduce Negatives* --e.g., reduce pain, symptoms *Bolster Positives* --e.g., empower clients; note clients' resilience	Psychopathology Strengths/Positive Psychology
		Clinician-Help-Seeker Relationship	"What are some commonalities/ differences between how your profession and other types of mental health professionals approach and work with clients/patients?"	**Commonalities:** Therapeutic alliance/ rapport Use of psychotherapy **Differences:** Our profession… Is based on objectivity Maintains appropriate boundaries Is based on scientific inquiry/hypothesis testing Focuses on client rights/ involvement Learns from clients Focuses on Resources	*Hierarchical Relationship* (e.g., clinician has final say; clinician as teacher; frustration over patient noncompliance) *Strive to Minimize Power Differences* (e.g., meet client where they are; both parties contribute; client has right to decide treatment)	Clinician as Expert Equal Partnership Client as Guide/Expert
			"Do you prefer using the term patient, the term client, or some other term when referring to the people who seek your care?"	Patient Only Client Only Both, Depends on Setting		

Table 3-G: Clinical Focus (Pattern Codes)

Research Question 2: Does professional affiliation help explain some of the variability in trainees' approach and clinical decision making?

Research Question 3: In what ways is professional affiliation associated with trainees' clinical approach and decision making?

Pattern Codes	**Psychopathology**	**Strengths/Positive Psychology**	**Other Factors Besides Professional Affiliation Affecting Clinical Focus**
Professional Groups' Leanings	Clinical Psychologists Psychiatrists	Social Workers	Theoretical Orientation (Family Systems/Strengths/Ecosystems; Cognitive-Behavioral; Psychodynamic) Race Gender

Table 3-H: Clinician/Help-Seeker Relationship (Pattern Codes)

Research Question 2: Does professional affiliation help explain some of the variability in trainees' approach and clinical decision making?

Research Question 3: In what ways is professional affiliation associated with trainees' clinical approach and decision making?

Pattern Codes	**Clinician as <u>Expert</u>**	**Equal Partnership/ <u>Collaboration</u>**	**Client as Guide/ <u>Expert</u>**	**Other factors besides Professional Affiliation <u>affecting tenor of relationship</u>**
Professional Groups' Leanings	Clinical Psychologists Psychiatrists Social Workers			Type of Intervention (i.e., medication vs. therapy) Gender

Appendix 3-A

Initial Contact with Instructors of Graduate Classes

Date

Dear Dr. X,

Hello! My name is Rachel Askew. I am a Ph.D. candidate in the Sociology Department at Emory University and I am writing to ask for your help with my dissertation research project. The focus of the project is clinical decision making by mental health professionals. I am particularly interested in the ways that university training shapes providers' diagnostic and treatment decisions.

To that end I am interested in recruiting returning graduate students in Clinical Psychology at Emory/Psychiatric Residency at Emory/Master's of Social Work at UGA and have received permission from the Director of Graduate Studies, Dr. X, to do so. Given that you are currently teaching a graduate class teaching this population, I am writing to ask if it would be possible to introduce my study during your class and then administer your class a brief questionnaire. The total amount of class time involved would be between 10 and 15 minutes.

I plan to ask those students who agree to be a part of the project to a) read a short case summary of an individual presenting with emotional and mental problems, and b) complete a brief questionnaire about the clinical decisions they would make based upon the case study. Additionally, I plan to conduct face-to-face in-depth interviews with a smaller number of willing students in order to gauge the ways in which university training and professional socialization affect approaches to decision making. I would not, however, take up any of your class time with this latter component of the project. The interviews will take place at a time and place of the student's choosing.

I would really appreciate the opportunity to speak with you about this project and answer any questions you might have. What time or times during the week would be most convenient for you to speak on the phone? I look forward to the possibility of working with you on this project!

Sincerely,

Rachel Askew
Department of Sociology
Emory University
1555 Dickey Drive
Atlanta, GA 30322
Phone: (404) 889-5621
Email: raaskew@emory.edu

Appendix 3-B

Initial Contact with Clinical Trainees

Date

Dear student's first name,

Hello! My name is Rachel Askew. I am a doctoral student in the Sociology Department at Emory University. I am recruiting returning graduate students (students currently in their 2nd year and beyond) in Clinical Psychology at Emory/Psychiatric Residency at Emory/Masters of Social Work at UGA to participate in my research on clinical decision making by mental health professionals. I am particularly interested in the ways that university training shapes providers' diagnostic and treatment decisions.

Your participation would entail a) reading a short case summary of an individual presenting to a mental health provider, and b) completing a brief questionnaire about the clinical decisions you would make based upon the case study. The case study takes about 1-2 minutes to read, and the survey takes approximately 10 minutes to complete.

Your participation would be extremely helpful to me. Given that there are only a small number of returning graduate students in X department your participation would help ensure that I get a full picture of decision making among student psychologists/social workers/psychiatrists at Emory University/UGA. Additionally, you may find reading the case study and taking the survey interesting and informative.

I would really appreciate the opportunity to speak with you about this project and answer any questions you might have. And if you are interested, I would love to have you read the case study and take the brief survey. We can meet wherever is most comfortable and whenever is most convenient for you. Alternatively, for your convenience you can take the survey online by going to the following link: XX. As a token of my gratitude I am offering respondents a twenty dollar gift certificate to the business of your choice.

Would you be interested in participating in this project? I look forward to the possibility of working with you!

Sincerely,

Rachel Askew

Department of Sociology
Emory University
1555 Dickey Drive
Atlanta, GA 30322
Phone: (404) 889-5621
Email: raaskew@emory.edu

Appendix 3-C: Survey Instrument

Respondent's Name (Please Print): _____

Mental Health Clinical Trainee Questionnaire

1. In your opinion, would Jessica benefit from seeking professional help from a mental health (MH) provider?

[ ] Yes, MH Help Beneficial

[ ] No, MH Help Not Beneficial

2. In your opinion, would Jessica benefit from seeking professional help from someone OTHER than a mental health provider?

[ ] Yes, Other Help Beneficial, but Only If Jessica ALSO consulted a MH specialist ***(GO TO #2A)***

[ ] Yes, Other Help Beneficial Regardless of whether Jessica Consulted a MH specialist ***(GO TO #2A)***

[ ] No, Other Help Not Beneficial ***(SKIP TO #3)***

2a. *If yes:* Please specify what type(s) of professional help OTHER than that offered by a mental health provider you feel would benefit Jessica:

_____

3. In your opinion, does Jessica have a mental/psychiatric disorder?

[ ] **Yes**, Jessica does have a mental disorder

[ ] **No**, Jessica does not have a mental disorder

[ ] I'm not comfortable with the term 'mental disorder.'

4. If you were asked to make a DSM diagnosis based on the information contained in the case study, what would be your primary diagnosis? ***[****Please Choose* ***Only One*** *Response****]***

[ ] I would not assign a diagnosis because I do not believe Jessica has a mental disorder.
[ ] Major Depressive Disorder
[ ] Major Depressive Episode
[ ] Dysthymia
[ ] Panic Disorder
[ ] Social Phobia (Social Anxiety Disorder)
[ ] Obsessive-Compulsive Disorder
[ ] Generalized Anxiety Disorder
[ ] Other ***Please Specify:*** _____

5. Please indicate the extent to which you think each of the following may have been ***contributing factors*** to Jessica's problems:

a. Heredity / Genetic predisposition

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

b. Brain dysfunction / Biochemistry

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

c. Jessica's life experiences / Stressful life events

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

d. Jessica's personality / Temperament

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

e. How Jessica interprets or thinks about stressful events

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

f. **Unresolved conflicts in Jessica's intimate relationships**

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

g. Jessica's social support network

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

h. Jessica's coping strategies

1	2	3	4	5	6	7	8	9
Not at all Likely								Very Likely

6. What, in your view, is the ***primary*** factor contributing to Jessica's problems?

7. The following are types of information that clinicians sometimes use to evaluate and plan treatment for their clients. Please indicate how important you think each would be in assessing and planning treatment for Jessica.

a. Laboratory Work-Up/Blood Tests on Jessica

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

b. Jessica's Psychological Assessment Test Results

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

c. Jessica's Previous Mental Health Treatment Records

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

d. Detailed Information about Jessica's Current Interpersonal Relationships

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

e. Jessica's Full Medical History

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

f. Information on Jessica's Social Support Networks

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

7. (*Continued*): The following are types of information that clinicians sometimes use to evaluate and plan treatment for their clients. Please indicate how important you think each would be in assessing and planning treatment for Jessica.

a. Information about Jessica's Developmental Relationships

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

b. Jessica's Insurance Information

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

c. Jessica's Personality Assessment Test Results

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

d. Jessica's Family History of Mental Illness

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

e. Details about Jessica's Past Stressful Life Events

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

f. Standardized Diagnostic Instrument Based on DSM Diagnoses

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

7. (*Continued*): The following are types of information that clinicians sometimes use to evaluate and plan treatment for their clients. Please indicate how important you think each would be in assessing and planning treatment for Jessica.

a. Standardized Diagnostic Instrument NOT Based on DSM Diagnoses

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

b. Recent Research Literature Related to Jessica's Condition

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

c. Information about Jessica's Current Stressors

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

d. Jessica's Assessment of Her Problems

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

e. Jessica's Treatment Preferences and Goals

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

8. Is there any other information not included in Q.7 that you would like to have in order to evaluate and plan treatment for Jessica?

[ ] Yes, I would like other information ***(GO TO #8A)***

[ ] No, I don't want any other information

8a. *If Yes:* Please list any other information that would help you to evaluate or plan treatment for Jessica.

_____

_____

9. Which piece(s) of information contained in the case study are the most relevant to you in evaluating Jessica?

10. How important is determining Jessica's *accurate* DSM diagnosis to your treatment planning?

1	2	3	4	5	6	7	8	9
Not at all Important								Extremely Important

11. For each intervention listed below, please indicate how effective you think it is likely to be in helping Jessica:

a. Pharmacotherapy/Drug Management

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

b. Interpersonal Individual Psychotherapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

c. Psychodynamic/Psychoanalytic Psychotherapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

11. *(Continued):* For each intervention listed below, please indicate how effective you think it is likely to be in helping Jessica:

b. Group Therapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

c. Couples Therapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

d. Family Therapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

e. Cognitive-Behavioral Therapy

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

f. Electroconvulsive Therapy (ECT)

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

g. Inpatient Hospitalization

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

j. Alternative therapies (such as Biofeedback or Relaxation Therapy)

1	2	3	4	5	6	7	8	9
Not at all Effective								Extremely Effective

12. If Jessica presented to you in a clinical setting, would you offer to treat her?

[ ] Yes, I would treat Jessica ***(GO TO #12A)***

[ ] No, I would not treat Jessica ***(SKIP TO #13)***

12a**.** *If Yes:* Please indicate which of the following intervention(s) **YOU** would initially use to treat Jessica. ***[****Please Select* ***All*** *That Apply****]***

[ ] Pharmacotherapy/Drug Management
[ ] Interpersonal Individual Psychotherapy
[ ] Psychodynamic/Psychoanalytic Psychotherapy
[ ] Administer structured psychological/personality test(s)
[ ] Group Therapy
[ ] Couples Therapy
[ ] Family Therapy
[ ] Cognitive-Behavioral Therapy
[ ] Electroconvulsive Therapy (ECT)
[ ] Inpatient Hospitalization
[ ] Alternative therapies (such as Biofeedback and Relaxation Therapy)
[ ] Other ***Please Specify:*** _____

_____

12b. *If Yes:* In making these initial treatment recommendations, what treatment goals would you and Jessica be pursuing?

_____

_____

_____

_____

_____

13. If Jessica presented to you in a clinical setting, would you offer to refer her to another provider, either in addition to, or instead of, treating Jessica yourself?

[ ] Yes, I would refer Jessica ***(GO TO #13A)***

[ ] No, I would not refer Jessica ***(SKIP TO #14)***

13a. *If yes:* Please specify what type(s) of referral(s) you would make:

_____

_____

13b. *If yes:* How might this/these referral(s) help Jessica?

_____

_____

_____

_____

PLEASE PROCEED TO NEXT PAGE…

BACKGROUND QUESTIONS

14. Your age: _____ years

15. What is your sex? Male…….[ ]
Female… …….[ ]

16. Are you of Hispanic or Latino descent?

[ ] Yes
[ ] No

17. What is your race?

[ ] White/Caucasian
[ ] Black/African American
[ ] Asian/Pacific Islander
[ ] Native American
[ ] Multiracial
[ ] Other ***Please Specify:***_____

18. What graduate or postgraduate program are you currently enrolled in?

[ ] General Psychiatric Residency
[ ] Clinical Psychology
[ ] Clinical Social Work

19. What year of your graduate or residency program are you currently enrolled in?

[ ] First year
[ ] Second year
[ ] Third year
[ ] Fourth year or beyond

20. What kind of work do you anticipate you'll be doing after you graduate?

_____

_____

_____

21. The following is a list of activities that mental health clinicians sometimes engage in during their university training. For each of the following, please indicate how much time you have spent on each:

a. Attending seminars/classes

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

b. Preparation for seminars/classes or presentations

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

c. Research, primary or secondary (e.g., literature reviews)

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

d. Meeting with supervisors

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

e. Observing *others* conduct individual therapy sessions

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

f. Observing *others* conduct family, couple, or group therapy sessions

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

g. Conducting initial client assessments/evaluations or taking case histories

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

h. Administering standardized instruments (e.g., diagnostic, personality, or psychological instruments)

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

21. *(Continued):* The following is a list of activities that mental health clinicians sometimes engage in during their training. For each of the following, please indicate the amount of time you have spent on each during the course of your mental health training:

a. Diagnosing clients

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

b. Treatment planning

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

c. Conducting individual therapy sessions

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

d. Conducting family, couple, or group therapy sessions

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

e. Communicating with other mental health team members about clients' needs

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

f. Medication management

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

g. Ongoing evaluation of clients' condition and their response to treatment

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

h. Engaging in psychotherapy with *you* as the *client,* someone else as the clinician

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

21. *(Continued):* The following is a list of activities that mental health clinicians sometimes engage in during their training. For each of the following, please indicate the amount of time you have spent on each during the course of your mental health training:

a. Administrative tasks, such as filling out billing forms

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

b. Case Management

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

c. Teaching

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

d. **Other** ***Please Specify:***_____

1	2	3	4	5
None	A Little	Some	A Fair Amount	A Great Deal

22. Did you work as a clinician in the mental health service sector prior to enrolling in this graduate program?

[ ] Yes ***(Go TO #22a)***
[ ] No ***(SKIP TO #23)***

22a. *If yes:* In what capacity did you work in the mental health service sector prior to enrolling in this graduate program?

_____

22b. *If yes:* How long did you work in the mental health service sector prior to enrolling in this graduate program?

[ ] Less than 6 months
[ ] 6 months to one year
[ ] 1 to 5 years
[ ] > 5 years

23. Please choose the theoretical orientation(s) that guide, or will guide, the majority of your treatment sessions: ***[Please Select <u>All</u> That Apply]***

[ ] Biological/Medical
[ ] Psychodynamic/Psychoanalytic
[ ] Interpersonal /Individual Psychology
[ ] Person-in-Environment/Eco Systems/Ecological
[ ] Cognitive
[ ] Behavioral
[ ] Cognitive-Behavioral
[ ] Strengths Perspective
[ ] Family/Systems
[ ] Transtheoretical
[ ] Integrative/Eclectic
[ ] Humanistic/Existentialist/Gestalt
[ ] Feminist
[ ] Other ***Please Specify:*** _____
[ ] Don't Know

24. Of the theoretical orientations listed in Q.23, please indicate which one or two orientations are ***primary*** in your work with most clients.

_____

_____

THANK YOU FOR YOUR TIME!

Would you be willing to speak to me one-on-one about how your university training has affected your clinical approach and decisions (e.g., diagnostic decisions, treatment decisions) about clients? I am offering interviewees a $40 gift card to Amazon.com (or the business of their choice) in appreciation for their time. Participation is completely voluntary.

[ ]
Yes, I am potentially interested in being interviewed

[ ]
No, I am NOT interested in being interviewed

↓

Please include contact information so that I can reach you to give you more information about the in-person interview and set up a time for us to meet:

_____

_____

Appendix 3-D
Open-ended Interview Guide

A. DECISION TO ENTER FIELD

What was it that drew you to psychiatry/clinical psychology/clinical social work as a career?

B. THE REAL WORK OF THE PROFESSION

What do you see as the "real work" of your profession?

What might [insert whatever they say is the "real work" – e.g., helping patients/curing disease, etc.] entail for a typical client?

Is diagnosing patients central to the work you do? If yes, how so? If not, where does diagnosis fit in to your work, if at all?

C. THE TRAINING PROGRAM

Now I'd like to talk specifically about your training at Emory/UGA. Would you please take me through the major phases and highlights of your program at Emory/UGA? [Probe about required/elective courses; exams; internships (type, length, and experiences)]

How much emphasis does your program place on diagnosis? Do you get the sense that your program is typical among psychiatric/clinical psychology/clinical social work programs in the emphasis it places on diagnosis, or don't you know?

Has any of your training focused on working with the Diagnostic and Statistical Manual of Mental Disorders (DSM)? If so, what did this training consist of?

How much emphasis does your program place on different theoretical orientations to working with clients? Do you get the sense that your program is typical in the emphasis it places on different theoretical orientations for working with clients, or don't you know?

How much emphasis does your program place on various therapeutic approaches to helping clients? Do you get the sense that your program is typical in the emphasis it places on various therapeutic approaches, or don't you know?

Has any of your training focused on evidence-based treatments or evidence-based clinical guidelines? If so, what did this training consist of?

D. THE TRAINING PROGRAM'S EFFECT ON WORKING WITH CLIENTS

What aspects of your training have most readied you to work with clients? [Probe about interactions with faculty, with other students, and with patients during training]

How have particular aspects of your training readied you to work with clients? [Probe about interactions with faculty, with other students, with patients during training]

E. COMPARING YOUR PROFESSIONS WITH OTHER PROFESSIONS; OTHER THEORETICAL ORIENTATIONS

Do you think there are differences between how [insert respondent's professional affiliation] and how other mental health professionals approach and work with clients? If yes, what kind of differences?

Do you think clinicians with different theoretical orientations approach and work with clients differently? If so, how might theoretical orientation affect one's dealings with clients?

F. FUTURE WORK

What kind of work do you anticipate you'll be doing after you graduate?

G. TERMINOLOGY

Do you prefer using the term patient, the term client, or some other term when referring to the people who seek your care? Why?

THANK YOU FOR YOUR TIME!!

WOULD YOU LIKE ME TO SEND YOU A COPY OF ANY REPORTS OR PUBLICATIONS THAT COME OUT OF THIS RESEARCH? ***[IF YES, ASK FOR EMAIL ADDRESS]***

Appendix 3-E: Emory University Consent to be a Research Subject

Title of Study: Decisions, Decisions: How University Training Shapes Mental Health Professionals' Clinical Judgments – Survey Component

Principal Investigator: Rachel Askew

Sponsor's Name: This study is under review for funding by the National Science Foundation.

Introduction and Purpose: You are invited to take part in a research study on student clinicians' decision making. I am a doctoral student in the Department of Sociology at Emory University. I hope to learn more about the decisions students like you make about your clients – decisions about how to identify your clients' problems and how to help your clients. I am asking you to participate because you are training to be a clinician in the [insert program name].

Procedures: If you agree to be a part of this study, I will ask you to read a case study (1-page in length) that describes a potential client, and then I will ask you to fill out a short questionnaire based on your evaluation of this case study. If you would like to skip any questions, please feel free to do so. Reading the case study should take a few minutes, and completing the questionnaire should take between 5 and 10 minutes. The total amount of your time involved, therefore, would be between 10 and 15 minutes. The final question on the questionnaire asks if you would be willing to speak with me in more detail about your training experiences in a one-on-one interview at a time and place of your choosing. If you would be willing to be interviewed, the questionnaire asks that you include contact information on the last page of the questionnaire so that I can contact you later to set up a convenient time for the interview. If you do not wish to be interviewed, simply leave the space allotted for contact information blank.

Risks and Benefits: I do not anticipate any risks to you by taking part in this study. And although you may not benefit directly, the information you provide will contribute to our knowledge about clinical decision making.

Confidentiality: I will keep your responses to questions confidential. The results of this study may be presented at conferences or published. If so, your name and other facts that might identify you will not appear. Initially I will have you write your name on your questionnaire so I can keep track of who has already participated and whom I still need to contact. However, immediately after I receive your completed questionnaire, I will assign your questionnaire a study number and will black out your name and any contact information so that your responses cannot be tied to you personally. All questionnaires, the list of study participants, and contact information for those willing to participate in the interview component of this study will be kept in a locked filing cabinet. Only I have access to this file cabinet, which is located in a locked office on Emory University's campus. After the completion of this project, those materials will be destroyed.

All the information you provide will be treated in the strictest confidence and may not be disclosed unless required by law or regulation. Agencies that make rules and policies about

how research is done have the right to review these records. Those with the right to look at your study records include the Emory University Institutional Review Board and the Office of Human Research Protection. We will keep your records private to the extent allowed by law.

Contact Persons: If you have any questions or concerns about this study I invite you to ask them now. If you have questions about this study later, you can reach me by phone at (404) 889-5621 or by email at raaskew@emory.edu. You may also contact my advisor, Dr. Tracy Scott, at (404) 727-7515 or by email at tscott@emory.edu.

If you have any questions about your rights as a participant in a research study, you may contact Dr. Colleen DiIorio, Chair of the Institutional Review Board, Emory University, which oversees the protection of people who participate in research. She can be reached at (404) 712-0720 or by email at irb@emory.edu. I will leave you a copy of this consent form so you will have all of this contact information.

Voluntary Participation and Withdrawal: Whether or not you participate in this study will not affect any of your course grades or affect your standing in your academic department in any way. Your participation is completely voluntary and you have the right to refuse to be in this study. In addition, you can stop at any time after giving your consent.

I have read the above information, and agree to the conditions outlined. I have been given satisfactory answers to any questions about the project. I am 18 years of age or older, and I give my consent to be a part of this research study.

_____	_____	_____
Signature of Participant	Name of Participant (PRINT)	Date

_____	_____	_____
Signature of Principal Investigator	Name of Principal Investigator	Date

Appendix 3-F: Emory University Consent to be a Research Subject

Title of Study: Decisions, Decisions: How University Training Shapes Mental Health Professionals' Clinical Judgments – Interview Component

Principal Investigator: Rachel Askew

Sponsor's Name: This study is under review for funding by the National Science Foundation.

Introduction/Purpose: You are invited to take part in a research study on student clinicians' decision making. I am a doctoral student in the Department of Sociology at Emory University. I hope to learn more about the ways in which university training prepares student clinicians to work with clients. I am asking you to participate because you are training to be a clinician in the University of Georgia's Master of Social Work program.

Procedures: If you agree to be interviewed about how your university training prepares you to work with clients, our conversation should last between 45 minutes and an hour, but it is ultimately up to you. The interview will be conducted in a location that is convenient for you. And if it is all right with you, I would like to tape record our conversation. This will let me focus on our conversation without worrying about writing everything down. If at any point you would like me to turn off the tape recorder, just let me know and I'll turn it off right away. Also, if you would like to skip any questions, please feel free to do so. If you tell me something today that you later decide you would rather leave out of my research, please just let me know, and I will make sure that it is not included. In appreciation of your time you will receive a $40 gift card to Amazon.com.

Risks and Benefits: I do not anticipate any risks to you by taking part in this study. And although you may not benefit directly, the information you provide will contribute to our knowledge about how clinicians learn to work with clients.

Confidentiality: I will keep your responses to questions confidential. I will use a study number rather than your real name on study records where I can so that any information you give will not be tied to you personally. The results of this study may be presented at conferences or published. If so, your name and other facts that might identify you will not appear. All tapes and transcripts will be kept in a locked filing cabinet, which only I will have access to, and in a locked office on Emory University's campus. After the completion of this project, those materials will be destroyed.

All the information you provide will be treated in the strictest confidence and may not be disclosed unless required by law or regulation. Agencies that make rules and policies about how research is done have the right to review these records. Those with the right to look at your study records include the Emory University Institutional Review Board and the Office of Human Research Protection. We will keep your records private to the extent allowed by law.

Contact Persons: If you have any questions or concerns about this study I invite you to ask them now. If you have questions about this study later, you can reach me by phone at (404) 889-5621 or by email at raaskew@emory.edu. You may also contact my advisor, Dr. Tracy Scott, at (404) 727-7515 or by email at tscott@emory.edu.

If you have any questions about your rights as a participant in a research study, you may contact Dr. Colleen DiIorio, Chair of the Institutional Review Board, Emory University, which oversees the protection of people who participate in research. She can be reached at (404) 712-0720 or by email at irb@emory.edu. I will leave you a copy of this consent form so you will have all of this contact information.

Voluntary Participation and Withdrawal: Whether or not you participate in this study will not affect any of your course grades or affect your standing in your academic department in any way. Your participation is completely voluntary and you have the right to refuse to be in this study. In addition, you can stop at any time after giving your consent.

I have read the above information, and agree to the conditions outlined. I have been given satisfactory answers to any questions about the project. I am 18 years of age or older, and I give my consent to be a part of this research study.

_____	_____	_____
Signature of Participant	Name of Participant (PRINT)	Date

_____	_____	_____
Signature of Principal Investigator	Name of Principal Investigator	Date

Appendix 3-G: Case Study

Jessica S., a 39-year-old paralegal, seeks consultation because she's recently experienced two episodes during which she suddenly became very nervous that she was in imminent danger. During these episodes her heart began racing and she had trouble getting enough oxygen due to shortness of breath. Both episodes passed within 10 or 15 minutes of Jessica sitting on the floor and putting her head between her knees. She mentions that the episodes were not preceded by physical exertion – one episode began when she was sitting in traffic, and one occurred when she was sitting at her desk at work. She explains that she felt overcome by terror "out of the blue," and confides that she is worried about having another episode like this while driving, especially given that she often drives her children around. Her husband urged her to consult with a professional after the last episode forced her to pull over to the side of the road and phone him for help.

Upon evaluation, Jessica reports that she's experienced periods of intense worry and overwhelming sadness since she was in her early 20s. She explains that "that's how it's always been" and notes that her father and one of her sisters "are also like this." When pressed about the length of such periods in her life she will only say that they "seem to last forever," but that some days are much worse than others. She explains that some days are characterized by worrying about "every little thing," from her parents' failing health to being late to work to concern that she'll forget to pick up all the ingredients for dinner. Other days she feels overwhelmed by a sense of hopelessness and despair. On these days she feels like her whole life is meaningless and "a waste" and has trouble getting herself out of bed. On her worst days she feels both anxious *and* sad. While she always manages to get herself to work, she frequently has trouble concentrating and staying awake and believes her position at work may be in jeopardy as a result.

While Jessica does profess a passion for gardening and reading mystery novels in her free time she confides that on her worst days nothing can cheer her or keep her from mentally cataloguing all that can and usually *does* go wrong in her life. She's had trouble sleeping for many years, waking frequently during the night, and reports that occasionally the sadness and worry get very bad and are accompanied by headaches and nausea. She is clearly embarrassed that she can't control her thoughts and admits that she occasionally believes that her family would be "better off without having to worry" about her. When pressed she says that she would never actually commit suicide because "taking one's life is a mortal sin."

Jessica thinks her husband and 15-year-old daughter are getting increasingly irritated with her "moods" and her "ridiculous" concerns. She recalls a recent fight when her husband told her to "snap out of it already and stop feeling so sorry for yourself! Everyone has problems…you need to learn to deal." She also mentions that her daughter shows her "very little respect" ever since her daughter started attending high school. Jessica does believe that her husband and kids care about her, however, and she hates to worry them. They are all worried about the recent episodes that left her terrified and immobilized. Jessica smiles when she mentions her 10-year-old son, although she says "soon he won't need me anymore either." When asked if she has friends she can talk to besides her husband, Jessica says "not really," explaining that meeting and interacting with people makes her feel uncomfortable and awkward, and that social situations tend to exacerbate her feelings of anxiety and low self-worth. This recently came to a head when her daughter asked if she could bring some friends over for dinner and Jessica asked her not to because she wasn't "feeling well and you know how strangers wear me out." Jessica's daughter was clearly disappointed and proceeded to storm out of the house. This led Jessica to feel guilty because she was "always letting everyone down."

Chapter 4: Trainees' Diagnostic Decisions and Use of Diagnosis in Clinical Work

This chapter focuses on mental health trainees' diagnostic decisions and their use of diagnosis in clinical work. Throughout this and the following chapter I pay primary attention to comparisons between the three professional groups: trainees in psychiatry, clinical psychology, and social work. After summarizing the existing research on the use of diagnosis by mental health providers from different professional groups, the chapter begins by detailing the survey results regarding trainees' diagnostic judgments about the woman from the case study. Survey respondents were asked whether the woman would benefit from professional intervention, about the nature of her presenting problem, and about how important ascertaining an accurate DSM diagnosis would be to planning her treatment. The following section of the chapter focuses on the role that diagnosis plays in trainees' clinical work as described by interview respondents. Both of these sections address Research Questions 1, 2, and 3, which gauge the degree of variability in trainees' diagnostic decisions and practices (Research Question 1), the extent to which professional affiliation helps to explain diagnostic variability (Research Question 2), and the types of differences in diagnostic decisions and practices that emerge between the professional disciplines (Research Question 3).

PRIOR DIAGNOSTIC RESEARCH FEATURING MULTIPLE PROFESSIONAL GROUPS

To date, relatively few studies have explored whether mental health providers' use and attitude toward psychiatric diagnosis differs by their professional affiliation. I was able to locate only eight studies on diagnosis that included providers from multiple professions. Moreover, it is difficult and potentially misleading to compare findings from

these studies, due to their differences in sampling techniques (e.g., national samples vs. case studies), differences in professional groups studied (some looked at all three professional groups – social workers, clinical psychologists, and psychiatrists – while others looked at two of these three groups), differences in mode of study (e.g., studying live decision-making in clinical settings vs. having providers read and respond to case studies or vignettes), differences in version of the DSM used by study participants, and differences in types of mental disorders studied (e.g., personality disorders vs. psychotic disorders). Nevertheless, the current section attempts to summarize the extant literature on the use of diagnosis among different types of mental health professionals.

Together, the eight studies looked at three areas relating to diagnosis – the question of whether a person is suffering from a mental disorder or not, the type of diagnostic label to apply to a particular patient or client, and the utility and value that mental health providers place on diagnosis in clinical settings. Two studies looked at providers' judgments regarding disorder attribution (Pottick et al. 2007; Wakefield, Pottick, and Kirk 2002). Both studies had clinicians read case studies and render a judgment about whether the adolescent described in the case study who was demonstrating antisocial behaviors had a mental disorder. Pottick et al. (2007) compared each of the three professional groups, while Wakefield et al. (2002) compared clinically-experienced graduate students in social work and clinical psychology, but not psychiatry. Wakefield et al. (2002) found no differences between the disorder attributions of the clinical psychology and social work students and the authors did not address the lack of differences between the two professional groups. In contrast, Pottick et al. (2007) found that social workers are the least likely to judge the adolescent as disordered, followed by

clinical psychologists, and then psychiatrists. The authors suggest that differences in professional socialization processes among the three groups may contribute to differences in judging the presence or absence of disorder. They note that compared to psychiatrists social workers have far less training on using DSM-IV, and that psychiatrists have more opportunities than social workers to practice applying diagnostic criteria in their work settings. That is, unlike the majority of psychiatrists and psychologists, the majority of social workers do not work in typical clinic settings. The authors were perplexed by the significant differences between psychologists and psychiatrists, however, noting that the work settings for the two groups are similar and that psychologists receive extensive training on clinical testing, measurement, and applying DSM-IV criteria, training that should decrease differences between psychiatrists' and psychologists' disorder attributions. Pottick et al. (2007) suggest differences between psychologists and psychiatrists in their interpretation of DSM is an area ripe for future study.

Three studies examined the question of *which* diagnosis or diagnostic label to apply to particular patients. The two studies that included social workers both found social workers assign less severe diagnostic labels than their professional counterparts (Kirk and Hsieh 2004; Wright et al. 1980). Wright et al. (1980) found the level of severity of the assigned diagnosis increases with the status of the diagnosing professional (i.e., social workers assign the least severe, followed by psychologists, and then psychiatrists with the most severe diagnosis), but only among male professionals[11]. That is, female professionals from all professional disciplines are more lenient than male professionals in the severity of the diagnoses they assign. The authors attribute the gender

[11] This study (Wright et al. 1980) took place before the advent of DSM-III, the version of the manual reputed to cut down on diagnostic variation. Thus, this study's findings may not hold for professionals working with more recent versions of DSM.

difference to female socialization "which fosters empathy and inhibits aggression" (Wright et al. 1980:251). Kirk and Hsieh (2004) found that social workers differ from both psychologists and psychiatrists (who do not differ from one another) in the type of diagnoses (and, thus, in the level of diagnostic severity) they assign, with social workers assigning less severe diagnoses than the other two groups. The authors suggest a number of reasons that social workers may differ in their application of DSM criteria, including differences in training and orientation, social workers' unwillingness to apply potentially-stigmatizing labels, and their greater likelihood to attribute problem behaviors to environmental – rather than internal – causes. Kirk and Hsieh (2004) end their discussion of professional differences by calling for future study into the issue. Similar to Kirk and Hsieh (2004), Davis, Blashfield, and McElroy (1993) do not find differences between psychologists and psychiatrists in the diagnoses they assign. The authors of this study do not attempt to explain this lack of difference in diagnostic patterns between psychologists and psychiatrists.

Finally, three articles compared different professions' *approach* to diagnosis, with two of the pieces (Kingsbury 1987; Wyatt and Livson 1994) comparing only psychiatrists and psychologists and one study (Pescosolido, Figert, and Lubell 1996) comparing psychiatrists and social workers, but not psychologists. Both articles that compared psychiatrists to psychologists found that psychiatrists value diagnosis more than do psychologists. While providers from both professions acknowledge that diagnosis plays a role in clinical work, psychologists tend to see diagnosis as less useful and less objective than do psychiatrists. Both studies suggest differences may be a function of professional training. Kingsbury (1987) was in the unique position to report on the two professions

given that he trained as both a clinical psychologist and, later, as a psychiatrist. He noted that differential diagnosis is central to psychiatrists because "in medical training…diagnosis implies cause, from which follows rational treatment" (Kingsbury 1987:154). Alternatively, to the clinical psychologists, diagnoses were "at best, a useful first part of the picture…although some camps within psychology felt diagnosis to be unimportant or worse" (Kingsbury 1987:153). Pescosolido et al. (1996), in their case study on the use and evaluation of DSM in psychiatric inpatient units, found the vast majority of both psychiatrists and social workers report that the DSM is a central part of their work, albeit for different reasons. Psychiatrists are more likely than social workers to see the DSM as "very important" for "insurance" and for "treatment planning" purposes, while social workers are more likely than psychiatrists to deem the use of DSM "very important" for making "reliable and valid diagnoses."

These findings suggest that, of the three professional groups, psychiatrists place the highest value on diagnosis, are the most likely to judge a person as disordered, and to apply a more severe diagnosis. The social workers, on the other hand, are the least willing to label a person disordered and to apply severe diagnostic labels, although in some contexts they see the DSM as a central part of their clinical work. The clinical psychologists fall between the two other groups, sometimes siding with the psychiatrists, sometimes siding with the social workers, and sometimes standing separate from the other two professional groups. Moving away from prior research, I now turn to the diagnostic decisions made by trainees from the current study. As detailed in Chapter 3, trainees read an identical case study of a woman ("Jessica") presenting with symptoms of depression, anxiety, and relationship troubles, and subsequently filled out a survey

regarding the clinical decisions they would make if this woman presented to them in a clinical setting.

SURVEY RESULTS: DIAGNOSTIC DECISIONS

General Nature of Problem

When a client or patient presents to a mental health provider, one implicit decision the provider makes is about whether or not the person is presenting with a *mental health* problem. That is, would at least some of the client's problems be appropriately addressed by a mental health provider? All survey respondents (100%, n = 106) agree that the woman from the case study would "benefit from seeking professional help from a mental health provider" (Q.1). Moreover, all respondents (100%, n = 105) who answered Question #12 indicate that they personally would treat her, should she present to them "in a clinical setting" (Q.12).

Is Problem a Mental Disorder?

A related clinical judgment concerns whether or not someone is suffering from a diagnosable mental or psychiatric disorder. Respondents were asked, "In your opinion, does Jessica have a mental/psychiatric disorder?" (Q.3) and were asked to choose either yes, no, or "I'm not comfortable with the term mental disorder." Table 4-A presents the results of bivariate crosstabulation analyses predicting whether or not respondents consider this a mental disorder.[12] The majority (90.4%, n = 104) of trainees agree that this

[12] It was not possible to estimate the effects of individual predictors on whether or not respondents would characterize this a disorder while simultaneously controlling for other predictors via a multivariate analysis because a number of predictors lacked variation on this dependent variable. For example, all psychiatrists and all male respondents indicated that they would characterize Jessica as having a mental disorder. As a result, it is impossible to accurately estimate the coefficients for psychiatrists and men. Thus, only bivariate relationships are discussed here. A crosstab of disordered/not disordered by profession that only included social workers and psychologists did not reveal a significant difference between these two groups ($\chi^2 = 0.8$, $df = 1$, $n = 72$, $p = 0.4$, $\varphi = .103$).

is a mental disorder. Notably, of the 10 respondents who decline to characterize this as a mental disorder, only one indicates that this is not a disorder. The remaining nine are simply "uncomfortable with the term mental disorder."[13] Trainees' willingness to identify this as a mental disorder, or comfort level with the term 'mental disorder' is contingent upon professional affiliation. Social workers are less willing than psychiatrists to characterize this as a mental disorder (83.7% vs. 100%), with clinical psychologists falling in between the other two professional groups (91.3%). The small to medium-sized relationship ($\varphi = .240$) (Cohen 1988) between a trainee's professional affiliation and her decision to classify this as a mental disorder is marginally statistically significant ($\chi^2 = 6.0$, $df = 2$, $p = .051$).

Additionally, two theoretical orientations are significantly associated with a respondent's lower likelihood of characterizing this as a mental disorder. Eighty-two percent of those who report working from a family-systems perspective view this as a mental disorder compared to ninety-eight percent of others ($\chi^2 = 6.8$, $df = 1$, $p < .01$, $\varphi = -.260$). Similarly, eighty-one percent of those who endorse a strengths perspective versus ninety-seven percent of others characterize this as a mental or psychiatric disorder ($\chi^2 = 7.0$, $df = 1$, $p < .01$, $\varphi = -.264$). The relationships between trainees' designation of this as a disorder and these two theoretical orientations are both small-to-medium sized.

Two of the orientations that social work trainees favor are the family systems and the strengths perspective, both perspectives associated with greater unease over characterizing this as a mental disorder. Three-quarters of social workers report practicing from a family systems-perspective, compared with just one-third of clinical

[13] Given that only one respondent selected "no," indicating that Jessica "does not have a mental disorder," I combined the response categories "no" and "I do not feel comfortable with the term mental disorder" in all analyses related to this variable.

psychologists and one-fourth of psychiatrists ($\chi^2 = 22.9$, $df = 2$, $p < .001$, $\varphi = .476$). Similarly, three-quarters of social workers report regularly working from a strengths perspective, compared to nine percent of psychologists and thirteen percent of psychiatrists ($\chi^2 = 44.4$, $df = 2$, $p < .001$, $\varphi = .663$). Factors that make these theoretical orientations attractive to social workers may also be responsible for individuals from these three groups feeling reluctant to label a client as mentally disordered. Social workers favor these two orientations to treatment because social work's cognitive worldview or professional logic includes both a focus on the systems in which individuals are embedded (for example, our families, schools, and larger communities) and a focus on building on individuals' assets and resources rather than trying to reduce individuals' deficits (e.g., Hopps and Morris 2000). A family-systems orientation, similarly, focuses clinicians' attention on the family unit as a whole and on how the unit affects each of its members (Minuchin 1985), while a strengths perspective attempts to build on the assets or strengths that a client brings to a therapeutic relationship (Allison et al. 2004). Why, then, might social workers, as well as those who work within a family systems or a strengths perspective, be more reluctant to characterize this as a mental disorder? The focus on understanding an individual in context that both a social work perspective and a family-systems orientation share may make trainees hesitant to conceptualize an individual as having a disorder. Under these rubrics the problems described in the case study are the result of disorder in the *systems* in which an individual is embedded. Similarly, the focus on bolstering an individual's strengths (a focus shared by both social workers and those working from a strengths perspective) may make trainees reluctant to embrace the idea that their clients' problems stem from a mental

disorder. For professionals who set out to bolster assets, a focus on deficits may seem counterproductive or even harmful to a clients' progress.[14]

Primary Diagnosis

The decision about whether to categorize someone as suffering from a mental disorder is only one of several that mental health providers must make. Another type of diagnostic decision that providers routinely face is about the specific nature of a client's presenting problems. That is, which diagnostic category best reflects a client's condition? The case study (see Appendix 3-G) includes information about the woman's strained interpersonal relationships and about her depressive and anxiety-related symptoms, such as her recent onset of panic attacks (although her episodes are not explicitly identified as 'panic attacks'). Based only on the information contained in the case study, survey respondents are asked for their primary DSM diagnosis from among a list of relatively common mood and anxiety disorders (see Q.4, Appendix 3-C, for the full list of diagnoses respondents could choose). Respondents also had the option to indicate that they "would not assign a diagnosis because [they] do not believe Jessica has a mental disorder," as well as the option to choose 'other' and specify another (unlisted) DSM diagnosis.

DSM diagnoses, especially for disorders that have been extensively studied (e.g., Major Depressive Disorder), contain very specific criteria with respect to the number and duration of symptoms in order to qualify for a diagnosis (cf. DSM-IV-TR 2000 for examples). The case study, however, was left purposefully ambiguous due to the fact that health providers routinely face some degree of uncertainty in their dealings with patients

[14] Psychologists who embrace these orientations are less likely to label Jessica as mentally disordered, but all psychiatrists, regardless of orientation, judge Jessica to be suffering from a mental disorder.

(Fox 2000). Patients may not be able to recall specific symptoms and durations, for example, or patients may be too ill to give providers their complete history. Also, an individual's symptom profile may not neatly map onto one particular diagnosis. Many individuals that present for treatment are subsyndromal, meaning that they do not meet the full criteria for a diagnosis, but do meet some of the criteria (Druss et al. 2007). Also, many individuals that qualify for one DSM diagnosis may simultaneously qualify for multiple diagnoses (Kessler et al. 2005b). Anxiety and mood disorders, in particular, have often been found to coexist in the same individual (ibid). Thus, there is no one "correct" DSM diagnosis based on the limited information contained in the case study. The case study includes evidence of depressive symptoms, anxious symptoms – including panic attacks – and problems in interpersonal relationships, but the case study does not give enough information about any symptoms for respondents to assign a diagnosis based on DSM criteria alone. Instead, respondents were made to rely on their best clinical judgment in the face of incomplete information.

DSM's diagnostic system is hierarchical, however, with mood disorders taking precedence over anxiety disorders. That is, an individual who qualifies for a mood disorder and an anxiety disorder simultaneously would be given a primary diagnosis of a mood disorder if a diagnostician followed DSM's diagnostic decision trees (see DSM-IV-TR, Appendix A, 2000). Furthermore, Major Depressive Disorder (MDD) takes precedence over all other mood disorders (with the exception of those that contain symptoms of mania, none of which were included in the list of possible diagnoses to assign). Therefore, following DSM's decision trees (ibid:745-757), Major Depressive

Disorder (MDD) was the most severe disorder respondents were offered as a response category.

Bivariate results for primary diagnosis

Table 4-B presents the bivariate crosstabulation analyses between primary diagnosis and trainees' professional affiliation, race, gender, and preferred theoretical orientations, respectively. Due to the ambiguous nature of the case study, there is a good deal of variability in trainees' responses to the primary diagnosis question. A plurality choose Generalized Anxiety Disorder (39.8%), followed by Major Depressive Disorder (27.2%), and Panic Disorder (10.7%, $n = 103$). All other diagnoses are endorsed by less than ten percent of respondents, and have been combined into the column labeled 'other diagnoses,' including diagnoses written in under the response category 'other.' I excluded the respondents who left the diagnosis field blank ($n = 2$), as well as the one respondent who indicated that 'Jessica does not have a mental disorder' from these analyses.

Having an interpersonal theoretical orientation is significantly associated with a respondent's choice of primary diagnosis. Respondents who report an interpersonal bent are less likely to choose Major Depressive Disorder (15.4%) than are others (41.3%) ($\chi^2 = 9.4$, $df = 3$, $p = .025$, $\varphi = .309$). Thus, those guided by an interpersonal orientation are less likely than others to choose the most severe diagnosis available as a response option. Furthermore, the relationship between primary diagnosis and professional affiliation approaches statistical significance. Thirteen percent of clinical psychologists compared to forty-one percent of psychiatrists assign a diagnosis of Major Depressive Disorder, while thirty-nine percent of psychologists opt for one of the less severe diagnoses such as dysthymia, or they select the 'other' response option, compared to only six percent of

psychiatrists who do so, with social workers falling in between the other two groups on the primary diagnosis question (χ^2 = 11.3, *df* = 6, *p* = .079, φ =.332). Thus, clinical psychologists tend to offer less severe diagnostic labels than do psychiatrists. Survey respondents who choose the 'other' category were given space to fill in which other diagnosis or diagnoses they would assign. The clinical psychologists who selected 'other' did not endorse one single other unlisted DSM diagnosis. Instead they wrote in multiple diagnoses or they listed the diagnoses they would need to rule out before making a final diagnostic decision. This stands in contrast to the social work trainees who selected 'other,' the majority of whom indicated that they do not feel comfortable selecting a DSM diagnosis, and the one psychiatrist who chose 'other' and wrote in a separate, unlisted diagnosis. Thus, in addition to the clinical psychology trainees being more likely than the psychiatry residents to choose a less severe diagnosis, they are also more likely than psychiatrists to equivocate by naming a number of possible diagnoses but refusing to choose one primary diagnosis based strictly on the information from the case study.

With respect to gender, in a bivariate relationship that approaches statistical significance, female trainees are less likely than male trainees to assign a diagnosis of Major Depressive Disorder (21% vs. 50%) and more likely than male trainees to assign a diagnosis of Generalized Anxiety Disorder (43.2% vs. 27.3%) (χ^2 = 7.5, *df* = 36, *p* = .058, φ =.269). Thus, female trainees tend to assign less severe diagnostic categories than do men.

Multivariate results for primary diagnosis

Table 4-C presents the results of the multinomial logistic regression model predicting primary diagnosis. The overall multinomial model for primary diagnosis is

significant ($\chi^2 = 28.8$, $df = 15$, $p = .017$, $n = 97$), predicting twenty-eight percent of the variance in primary diagnosis. That is, the full model that includes the predictors offers a significant improvement in fit over the null model. With respect to assigning a diagnosis of Generalized Anxiety Disorder vs. Major Depressive Disorder, gender is the only significant predictor. Women trainees are five times as likely as male trainees to assign a diagnosis of Generalized Anxiety Disorder rather than a diagnosis of Major Depressive Disorder ($p = .019$). Thus, women trainees favor a less severe diagnosis than do men, even after controlling for other factors that may affect a trainee's diagnostic choice. Indeed, a greater percentage of women trainees than male trainees choose Panic Disorder and 'other' disorder rather than MDD as well, although gender is only significant in predicting the likelihood of Generalized Anxiety Disorder vs. MDD. This finding is in line with other studies that have found women providers faced with the same patient or client are more likely than their male counterparts to assign less severe diagnoses (e.g., Loring and Powell 1988; Pottick, Wakefield, Kirk, and Tian 2003; Wright et al. 1980).

The relationship between professional affiliation and primary diagnosis is also significant. Specifically, compared to psychiatry residents, clinical psychology trainees are ten times as likely to choose a less-severe, infrequently-endorsed primary diagnosis such as dysthymia, or to choose 'other disorder' rather than assign the more severe diagnosis of Major Depressive Disorder ($p < .05$, one-tailed test). Moreover, as noted in the bivariate analysis section on primary disorder, those psychology trainees who chose 'other' diagnosis wrote in a series of possible, rule-out diagnoses rather than choosing one definitive alternative primary diagnosis, while the one psychiatry resident who chose 'other' wrote in a separate diagnosis altogether rather than specifying multiple possible

diagnoses to rule in and out. Thus, compared to psychiatry residents, clinical psychology trainees are more likely to either assign a less severe disorder, or to vacillate by naming a number of possible diagnoses than they are to assign a diagnosis of Major Depressive Disorder. Neither interpersonal orientation nor race significantly predicts primary diagnosis after controlling for gender and professional affiliation.

Thus, mirroring findings from the two studies (Kirk and Hsieh 2004; Wright et al. 1980) that include providers from psychiatry, clinical psychology, and social work, the psychiatry residents are more likely than other mental health provider groups to choose a more severe diagnosis over less-severe diagnostic categories. Unlike Kirk and Hsieh (2004) and Wright et al. (1980), however, studies that both find social workers significantly differ from their psychiatry and clinical psychology counterparts by assigning the least severe diagnoses of the three mental health groups, the current study finds the clinical psychology trainees – not the social work trainees – are the least likely to assign the more severe diagnosis of Major Depressive Disorder.

Importance of Accurate DSM Diagnosis for Treatment Planning

In addition to the judgments providers must make about whether or not to label an individual seeking treatment as having a mental disorder and about the specific diagnosis to assign, providers also must implicitly decide to what degree, if at all, an individual's diagnosis should affect treatment planning. The survey contained a question about the importance of obtaining an accurate diagnosis in planning treatment. On a scale from 1 to 9, with 1 indicating 'not at all important' and 9 indicating 'extremely important,' survey respondents were asked: "How important is determining Jessica's *accurate* DSM diagnosis to your treatment planning?" (Q. 10).

Bivariate results for importance of accurate DSM diagnosis

Table 4-D presents the bivariate relationships between the dependent variable, importance of diagnostic accuracy for treatment planning, and the independent variables: professional affiliation, primary diagnosis, race, gender, and theoretical orientations. The importance of diagnostic accuracy is significantly associated with both interpersonal orientation ($t = 2.8$; $df = 91.5$; $n = 100$; $p < .01$) – an orientation favored by clinical psychology trainees more than by the other two professional groups – and with professional affiliation ($F(2,101) = 6.8$; $n = 104$; $p < .01$). Those trainees who report using an interpersonal orientation with clients deem the role of an accurate diagnosis in treatment planning less important ($M = 6.6$, $sd = 1.8$) than do trainees who do not use an interpersonal orientation ($M = 7.5$, $sd = 1.3$). With respect to professional affiliation, clinical psychologists deem an accurate diagnosis less important for treatment planning ($M = 6.0$; $sd = 2.0$) than both psychiatrists ($M = 7.4$; $sd = 1.1$; $p = .014$) and social workers ($M = 7.3$; $sd = 1.5$; $p = .029$).

Multivariate results for importance of accurate DSM diagnosis

An Analysis of Covariance (ANCOVA) model is used to test the effects of categorical variables on a continuous dependent variable, controlling for the effects of selected other variables, or covariates (Garson 2008c). Given that 'importance of accurate diagnosis for treatment planning' is a continuous variable and that all of my independent variables (e.g., race, professional affiliation) are categorical variables, I use an ANCOVA model to estimate the effect of each independent variable on 'importance of accurate diagnosis for treatment planning,' while simultaneously controlling for the effects of other possible factors.

Table 4-E presents the ANCOVA results for importance of determining an accurate DSM diagnosis for treatment planning. The model explains twelve percent of the variance in importance of 'accurate DSM diagnosis.' None of the independent variables – professional program, primary diagnosis, race, gender, or interpersonal orientation – are significant at the $p < .05$ level. However, the eta for professional program (.224) indicates that a trainees' professional program or professional affiliation has a small-to-medium-sized effect on importance of 'accurate DSM diagnosis.' Due to the small-to-medium effect size associated with professional program, I ran a post-hoc test to determine whether there are significant mean differences between the professional groups in their 'importance of diagnosis' scores. Clinical psychology trainees score importance of accurate diagnosis for treatment planning significantly lower than do both psychiatrists ($p = .002$) and social workers ($p = .004$). Thus, similar to the findings on primary diagnosis, it is the clinical psychology trainees rather than the social work trainees that stand as the greatest contrast to the psychiatry residents on the question of the importance of determining accurate diagnosis in order to plan treatment. This runs counter to prior research on the three professional groups that finds the greatest diagnostic differences exist between social workers and psychiatrists (Kirk and Hsieh 2004; Wright et al. 1980).

Section Summary

All survey respondents agree that the woman from the case study would benefit from professional help with a mental health provider, and all agree that they would treat her, should she present to them in a clinical setting. Thus, there is uniformity in a number of trainees' diagnostic judgments. Professional affiliation shapes a number of trainees'

other diagnostic decisions, however. The psychiatry residents stand apart from the other two professional groups in their comfort with applying a 'disorder' label, and in their greater endorsement of the most severe diagnostic label available among response options. Specifically, the psychiatry residents are significantly more likely to apply a 'disorder' label than are the social work trainees, and the residents are more likely than the clinical psychology trainees to choose the more severe Major Depressive Disorder over the possibility of choosing either less severe diagnoses or writing in multiple possible diagnoses rather than one definitive diagnosis. Thus, while in one case the psychiatry residents significantly differ from the social workers, and in another case they significantly differ from the psychologists, the psychiatry residents are consistently the most comfortable assigning diagnostic labels. In addition to their greater comfort with assigning diagnostic labels, the psychiatric residents are also the group that places the highest value on an accurate DSM diagnosis in terms of planning treatment, although the social workers place a similarly high value on accuracy of DSM diagnosis for treatment planning.

In addition to a trainee's professional affiliation, a trainee's preferred theoretical orientations and gender also shape some of her diagnostic judgments. Endorsing a family-systems or strengths orientation – orientations associated with emphasizing an individual's positive attributes and considering her situation in context – are associated with a lower willingness to label a client's problem a "mental disorder." Moreover, a trainee's gender shapes the primary diagnosis she assigns. Being a female trainee is associated with a higher likelihood of assigning a diagnosis of Generalized Anxiety Disorder (GAD) rather than Major Depressive Disorder (MDD). Thus, in the case of a

client presenting an amorphous combination of depressive and anxious symptoms, female respondents are more likely than male respondents to choose the less-severe (according to DSM's decision trees) diagnosis over the more-severe diagnosis.

In an effort to contextualize trainees' diagnostic decisions, as well as to gain a richer understanding of the ways trainees use diagnosis in their clinical work, I conducted semi-structured interviews with a subset of thirty-three trainees, eleven from each professional program. The following section details interviewees' responses to questions regarding their use of diagnosis. Throughout the following section I continue to pay special attention to variations in trainees' approach to diagnosis, and investigate both intra- and inter-professional differences in the use of diagnosis in trainees' clinical work.

INTERVIEW RESULTS: THE ROLE OF DIAGNOSIS IN CLINICAL WORK

I asked interviewees from each of the three professional groups what role, if any, diagnosis plays in trainees' work with clients or patients. All interviewees agree that diagnosis has *some* place in clinical work. Moreover, each and every interviewee interprets diagnosis as synonymous with DSM diagnosis. The DSM-IV classification system is the only system these trainees use to diagnose patients' mental health problems, despite the fact that other diagnostic classification systems exist and are in use in certain other countries (e.g., The International Classification of Diseases, 9th Revision, Clinical Modification, or ICD-9-CM). Nevertheless, three distinct views emerge from the qualitative data regarding the role and consequence that diagnostic classification plays in working with patients or clients – a separate view held by each of the three professions. The psychiatry interviewees view establishing a patient's correct diagnosis as the first and most important piece in providing quality care, because diagnoses inform treatment

decisions. The psychiatry interviewees explain that fine diagnostic distinctions may make important differences in treatment planning. Alternatively, the clinical psychology interviewees consider diagnosis important, but do not view diagnosis as the *most* important piece of clinical work. Instead, the clinical psychology interviewees emphasize the relative importance of fully understanding a client's unique symptom profile over being able to make fine-grained diagnostic distinctions based on DSM criteria. The social work interviewees view diagnosis as one of a number of important pieces to consider when working with clients, but, similar to the clinical psychology interviewees, they feel a client's unique presentation and situation, rather than a client's diagnosis, should be paramount in planning treatment. Additionally, social workers, unlike the other two professional groups, voice wariness over the potential harm that may accompany the application of a psychiatric diagnostic label.

Psychiatry Residents

The psychiatry interviewees are emphatic about the importance of establishing the most accurate working DSM diagnosis possible for their patients before planning treatment. The reason that establishing a patient's DSM diagnosis is critical and foremost in residents' minds is that medical doctors treat diseases and disorders, not symptoms, and diagnoses determine treatment options. When asked what role diagnosis plays in residents' work with patients, one resident responds:

> Psychiatry Interviewee_C: It's *really* important, in my opinion, because without a diagnosis, what are you really treating? A lot of times, and again, you know, in the ER [Emergency Room] you wind up with people who are on medication from every class of medications. And you have to say to yourself: 'What are you treating? What's going on here?' You can't, in my opinion, really treat someone well without establishing a good working diagnosis.

A number of other psychiatry interviewees emphasize the importance of treating a diagnosed DSM disorder rather than treating a patient's symptoms. For example, Psychiatry Interviewee_D notes: "There are diagnoses and there are criteria and you treat a diagnosis, not a symptom." When asked why you treat a diagnosis rather than a symptom, this respondent explains: "Well, because if you're clearly treating symptoms then you're not really getting to the root cause [of a patient's problems]." Psychiatry Interviewee_C also warns against treating a symptom rather than treating a diagnosis:

> So often, people [i.e., mental health providers] don't have a diagnosis; people are just sort of working with someone on a mood swing – why are they having these mood swings? Or, you know, panic is one. People will have panic attacks for a hundred different reasons. Well, you know, you could give them Xanax every time they have a panic attack but it seems like you might want to figure out *why* they're having panic attacks before you just treat that symptom.

Other residents explain that psychiatrists focus on diagnoses rather than symptoms because they are *medical doctors*, and doctors plan treatments based on diagnoses. One notes: "If I don't know what disease entity I'm treating then I'm not really being a good doctor" (Psychiatry Interviewee_D). Another clarifies:

> Psychiatry Interviewee_B: In this day and age, it would not be right to be treating somebody with a medication or therapy when you don't have a diagnosis. It shouldn't work backwards. Like, you shouldn't throw medicine at a problem and say 'Oh, it worked, therefore, this is what they had.' You should work forwards like you would with any medical diagnosis. This is *medicine*.

Each of the psychiatry interviewees explains that the role of diagnosis in patient care is straightforward. Put simply, a patient's diagnosis informs his/her treatments, and even subtle or seemingly small diagnostic differences may have an effect on treatment planning. Asked what role diagnosis plays in the work psychiatrists do, Psychiatry Interviewee_F responds: "Probably the most important. Often the subtleties in like

diagnosing one illness or another has a huge impact in the long run as far as treatments are concerned." Diagnostic differences in terms of the severity of the condition, the presence or absence of psychosis, and in the type of condition (for example, between a mood and an anxiety disorder) determine which, if any, medications to prescribe, whether or not to hospitalize a patient, and whether to provide or refer for therapy or not: "Based on the diagnosis you base your decision off of what medications to use, if you hospitalize somebody or not, if somebody's clearly responsible for their acts or not, if they can—are competent to refuse a treatment or not" (Psychiatry Interviewee_I). When asked how diagnostic differences affect treatment decisions, Psychiatry Interviewee_E uses the example of a patient with a major vs. minor depressive disorder: "For treatment it would probably mean -- if it wasn't a Major Depressive Disorder I would not be thinking about medicines. I would be thinking mostly of some sort of therapy. But if it was a Major Depressive Disorder then I would consider it -- I would suggest to the patient the idea of medicines but it wouldn't be the only -- it wouldn't be the only thing that would help them. I would also consider therapy at that point." Thus, both therapy and medication would be offered to the patient with Major Depressive Disorder, while only therapy would be suggested for a patient with a similar symptom profile that does not meet some of the criteria for Major Depressive Disorder.

A few of the psychiatry interviewees (3 of 11, or 27.2%) offer spontaneous critiques of the DSM. For example, Psychiatry Interviewee_C notes that "some of the diagnoses in psychiatry are somewhat arbitrary, and made up by a committee, and that's the DSM," while Psychiatry Interviewee_E comments that in a few instances "the DSM falls short" due to some criteria being too strict. Nevertheless, the psychiatry

interviewees' views of the DSM are largely favorable. Psychiatry Interviewee_C, who notes that there is some arbitrariness in the DSM, explains that an accurate differential diagnosis is important to treatment planning because "although it [DSM] is arbitrary, I think it's arbitrary at the edges." This interviewee goes on to give an example of why it is important to treat a diagnosis rather than a symptom:

> Psychiatry Interviewee_C: If you have somebody who comes in and is impulsive and maybe mean, or things like that, you really want to figure out what their diagnosis is because maybe it's a personality disorder. And, you know, you wouldn't want to give medication to that, necessarily, whereas if they're mean because they're psychotic, then, you'd want to treat their psychosis or maybe, you know, they're having seizures and you'd want to get them an EKG and get a neurological work-up, so it's important in that regard.

To the psychiatry interviewees, then, diagnosis is critical because of its central role in treatment planning. While the DSM may not be flawless, its flaws appear at the edges, while the majority of the manual is a sound reflection of patients' conditions. Psychiatry Interviewee_B captures residents' relationship with the DSM aptly in the following quotation: "I think we're pretty bent on you must figure out what's wrong with the patient as described by our current instruments in order to treat the patient or you're not doing your job as a physician." Thus, to treat a patient without having first established that patient's accurate DSM diagnosis is tantamount to medical negligence for the psychiatry interviewees.

Clinical Psychologists

The psychiatry interviewees, then, view a patient's diagnosis as critical to clinical work because diagnoses determine treatment options. Members of each of the other two professional groups afford diagnosis less sway over treatment planning than do the psychiatry interviewees, offering conditions under which diagnosis matters more and less

for treatment planning and offering up other factors that matter as much, if not more, to treatment planning. Nevertheless, unlike the majority of the psychiatry residents who strictly discuss diagnosis in terms of treatment planning, most members of each of the other two professional groups also mention a number of other uses for diagnosis *besides* treatment planning. The clinical psychology interviewees mention, for example, the use of diagnosis as a type of linguistic shorthand between practitioners, its role in psychoeducation – in teaching clients about their conditions – and the role that a diagnostic label may play in ensuring that clients' care is covered under their insurance plans.

With respect to treatment planning, the clinical psychology interviewees acknowledge that a client's diagnosis may help narrow down treatment options, emphasizing the importance of going to the research literature to look up best practices and contraindicated practices for particular diagnoses. Thus, knowing a client's preliminary diagnosis is important for evidence-based practice because in order to search the research literature one needs to know a client's preliminary diagnosis. Clinical Psychology Interviewee_D notes: "In general it [diagnosis] provides a frame of hypotheses of directions to take. In some ways it narrows rather than saying that there are all these different things we can do. It sort of narrows the scope of things that we might choose to do." With certain diagnostic conditions, moreover, such as bipolar disorder and disorders involving psychosis, the clinical psychologists agree with the psychiatrists that knowing an individual's diagnosis is critical for treatment planning, because their treatments will likely include medication, which will necessitate a referral to a psychiatrist or another medical doctor with prescribing privileges.

Unlike the psychiatry interviewees, however, the clinical psychology interviewees hold that for treatment planning more generally, fully understanding an individual client's unique symptom profile is *more* important than arriving at a client's specific differential diagnosis. Clinical Psychology Interviewee_B explains that "rather than pay attention to specific labels, it's the symptoms that are important." Clinical Psychology Interviewee_D, who speaks above about how diagnosis helps to narrow down treatment options, goes on to explain that while a diagnosis may narrow options, it is actually a client's individual symptom profile that will have the most effect on treatment planning:

> In the beginning, when you are first learning about a person, what you have is their symptoms, and what they are experiencing. That would be, for me, what would drive the treatment. And then as you continue to work with the person the treatment would be modified based on their *individual* characteristics and on what's going to work best for *them* (emphasis added).

Clinical Psychology Interviewee_D goes on to explain why a client's individual symptoms and characteristics would trump that client's DSM diagnosis with respect to treatment planning: "One depression or one anxiety disorder is not going to always look the same across individuals, and so there might be reasons why you might have two depressed patients and take two very different courses of action."

The clinical psychology interviewees acknowledge the importance of knowing what class of disorders (e.g., anxiety vs. mood disorders; psychotic vs. non-psychotic disorders) the client presents with because this helps to focus their assessment of the client and is a piece of the larger case conceptualization, but they are less concerned than the psychiatry interviewees with arriving at their client's precise diagnosis based on specific criteria sets contained in the DSM. As one clinical psychology interviewee explains:

> Clinical Psychology Interviewee_A: I think that it's [diagnosis] an important factor. To get an idea and at least a preliminary diagnosis of kind of what's going on. I'm not sure that it's essential to know that [a client] has three specific phobias and Generalized Anxiety Disorder. It's *very* important to know that [the client] has pervasive problems with anxiety.

Another clinical psychology interviewee explains that "it's the diagnostic picture, not the diagnosis itself" that makes a difference for treatment planning (Clinical Psychology Interviewee_E). This interviewee goes on to say:

> Understanding the case, having a case conceptualization, understanding the symptomatology is, in a lot of ways, more important than being able to say, well, is this X vs. Y? Even though, I would still say, diagnosis is still important. Somewhat it is central, but it's not the end-all, be-all, and it's not, in my view, the most important thing.

Thus, with respect to treatment planning, the psychiatry interviewees view a patient's diagnosis as critical regardless of what type of problem a patient presents with, while the clinical psychology interviewees feel that understanding a particular client's individualized symptom profile is more important than being able to identify a client's specific DSM diagnosis. As one clinical psychology interviewee puts it: "Categories can be messy and you just--it's not as important as a richer understanding of the individual with us [clinical psychologists]" (Clinical Psychology Interviewee_H).

Clinical psychology interviewees appear to grant a client's unique symptom profile greater consequence for treatment planning than they do a client's precise DSM diagnosis at least partly due to the skepticism with which they regard the DSM as a classification system. A majority of clinical psychology interviewees (7 out of 11, or 63.6%) mention what they consider to be the problematic nature of the DSM during the course of their interview, compared to just a handful of interviewees from psychiatry (3 of 11, or 27.2%) and social work (1 of 11, or 9%). The clinical psychology interviewees

discuss two fundamental problems with the DSM, both of which are related to how well the DSM reflects their clients' realities. The first is that the DSM conceptualizes all mental disorders as categorical rather than dimensional, and sets aside a predetermined set of criteria for each disorder. That is, you either have a particular disorder or you do not, based on particular criteria such as the length of time a person has exhibited certain symptoms and the number of symptoms a person exhibits. While all interviewees seem to agree that a categorical classification system accurately represents disorders such as bipolar disorder and disorders with psychotic symptoms (e.g., you either have or do not have psychotic symptoms), a number of the clinical psychology interviewees suggest that non-psychotic conditions – for example, depressive, anxiety, and personality problems — are dimensional, rather than categorical. That is, everyone experiences depression and anxiety to some degree; only when depression or anxiety begins to impede an individual's ability to function does it become a problem that merits professional intervention. Thus, because the same symptoms may cause one person minimal distress while greatly inhibiting another's functioning, a diagnostic system such as the DSM that classifies people based on independent criteria will be problematic for practitioners who focus on an individual's intersubjective experience of particular symptoms. Several of the clinical psychology interviewees call into question the discrete or categorical nature of many DSM diagnoses by pointing to the fact that many people who qualify for one mental disorder diagnosis simultaneously qualify for other diagnoses as well. One clinical psychology interviewee explains:

> Clinical Psychology Interviewee_J: There's a fuzzy distinction between the two [personality disorders and Axis-I disorders such as anxiety disorders]. I'll let you know that. Most of the research says so. There's so much they -- and this is a problem with the DSM-IV, or our diagnostic system -- they call it

> comorbidity. There are so many people that are anxious are also depressed and may have the symptoms of personality disorders. Many people with one personality disorder can meet criteria for multiple ones. There's so much overlap with all these things that they do kind of get enmeshed in each other.

Thus, while the DSM presents a world where those with mental disorders are clearly distinguishable from those without disorders, and where hierarchical criteria sets clearly distinguish between different disorders, the clinical psychology interviewees question whether the DSM accurately captures their clients' messy realities.

The second concern that the clinical psychology interviewees raise is about the degree to which some of DSM's criteria are arbitrarily decided upon rather than based on solid scientific research that seeks to determine which criteria are associated with clinically-relevant distinctions. One clinical psychology interviewee, for example, notes that the arbitrary nature of some of the DSM criteria makes it more useful to focus on an individual's unique symptom profile rather than on his/her official differential diagnosis:

> Clinical Psychology Interviewee_I: Because really the DSM was written by committee, the reason why the cut-off was three instead of two is because they had a vote on it. So it [a DSM diagnosis] could be a useful heuristic for communicating with other clinicians but it's not going to communicate the depth of the individuality of a case; it's not going to necessarily inform the particular approach to treatment. But I know it [diagnosis] is a necessary thing, and I think that the DSM can be helpful in helping inform what to look for.

Clinical Psychology Interviewee_G helps to explain psychologists' ambivalence over the DSM by noting that some of the DSM criteria may not be clinically relevant. This interviewee states:

> I believe the reason why it [diagnosis] is a thorny issue is because we're still trying to figure out what diagnoses are real, you know, what's real? Like what's helpful to know? Is there a meaningful distinction between schizoaffective disorder and schizophrenia or a mood disorder with psychotic features? A lot of those fine-grained distinctions, are those helpful in the case conceptualization, are they helpful in the treatment? And would it lead to better outcomes if you know it's one versus the other? So that's a

> controversy. We don't know enough about that yet for a lot of these diagnoses. For some of them we do know.

Thus, for the clinical psychology interviewees, DSM diagnoses have a number of uses for clinical work, including informing treatment planning. Nevertheless, with respect to treatment planning, it is more important to the clinical psychology interviewees to fully understand a client's distinctive symptom profile than it is to identify a client's very specific DSM differential diagnosis. This relative emphasis on an individual's symptoms over that individual's DSM diagnosis seems due, in part, to the clinical psychology interviewees' concern that many DSM diagnoses do not adequately reflect their clients' individual realities, and that some DSM criteria do not offer clinically-relevant distinctions. The finding that the psychiatry interviewees emphasize a DSM diagnosis' crucial role in treatment planning while the clinical psychology interviewees consider diagnosis important but are ambivalent about using a classification system developed by psychiatrists to direct their own treatment planning echoes Kingsbury's (1987) personal reflections on the differences in training between the two professions.

Social Workers

The social work interviewees align with the clinical psychologists on some diagnostic issues and take a unique position on others. The social work interviewees agree with the clinical psychology interviewees, for instance, that diagnosis plays a role – although not the most important role – in working with clients. Social work interviewees, for instance, hold that diagnosis can be helpful in focusing assessments of clients, in helping practitioners become "more aware or attuned to what the client might be experiencing" (Social Work Interviewee_D). A diagnostic label can also help the client access important resources. One social work interviewee explains that at a social service

agency a client's diagnosis "doesn't really change the way we work with the clients but it does change the services available to them" (Social Work Interviewee_J).

Moreover, when a client presents with a severe-enough condition, especially when the client exhibits symptoms of mania or psychosis, a diagnosis can be very important for treatment planning. Social Work Interviewee_C explains that symptoms of mania or psychosis would typically rule out therapy as a treatment option: "with schizophrenia, therapy can't stop hallucinations. It can't stop delusions." A number of social work interviewees also mention that knowing a client's diagnosis is important if you want to search the research literature to learn about the current best therapeutic practices for particular diagnostic conditions. As with the clinical psychologists, however, the social work interviewees emphasize that when using a client's DSM diagnosis to help guide treatment planning, it is paramount to take an individual's unique characteristics and situation into account because not everyone experiences the same mental disorder in the same way. Social Work Interviewee_F notes that while the DSM "can be a great guiding tool," it can also be too narrowing: "I also find some of the DSM, I mean, I've not… it just seems so methodic and just not personalized. Just to slot somebody into that diagnosis and this is what you do and this is what they are going to be like." Social Work Interviewee_D echoes this thought by discussing "the idiosyncratic nature, from my perspective, of mental diagnoses with particular patients because it manifests themselves and people have different experiences. Like one person with bipolar is gonna have perhaps a much different experience than another person with bipolar." This interviewee goes on to explain that a clinical social worker's job is to "examin[e] kind of what their [clients'] meaning is…like their idiosyncratic, subjective

meaning of their particular mental diagnosis. And translating that into the particular situations in which, I guess, that diagnosis is manifested in their lives, and looking at the specific reactions to certain stimuli, be them persons or situations." Implicit in these quotes is the idea that while DSM diagnoses may be a good guide to help practitioners understand a client, a diagnosis may simultaneously strip information from a case conceptualization that would be helpful in understanding and planning treatment for a client. Both the clinical psychology and the social work interviewees emphasize the importance of not focusing on a diagnosis so exclusively that one overlooks important characteristics unique to a particular client that may be important in planning treatment.

The social work interviewees stand apart from the other two professional groups in that a number of them reference how diagnosis is important to another professional group planning treatment, namely the psychiatrists. These social workers talk about how an accurate diagnosis is important to psychiatrists who are prescribing medication for their patients. Two social work interviewees went on to say that for social workers working as a part of an interdisciplinary treatment team on an inpatient unit run by a psychiatrist, it is essential that they understand the language of the DSM if they are to be an integral part of that team. Social Work Interviewee_A explains that when working as a part of an interdisciplinary team at a hospital "The social workers really had to understand the diagnosis because they were being diagnosed by – we weren't diagnosing -- the psychiatrist was diagnosing them – but we had to understand that diagnosis in order to work from that perspective." Another social work interviewee clarifies that while diagnosis may not be a very important piece of lone therapeutic work done by social

workers, diagnosis becomes important when working as a part of an interdisciplinary team:

> Social Work Interviewee_E: From my perspective, I'm going to be more of a talk therapist and I don't feel like I need a big diagnosis. Because really we're dealing with symptoms and functioning and those kind of things. However, as part of an interdisciplinary team, especially in the [psychiatric hospital] setting I'm in, medication is a part of it, and so we have the psychiatrists. And also managed care is a part of it and they require the diagnosis.

Thus, to the social work interviewees, the use of diagnosis in clinical work depends on whether or not they are working alone, where a diagnosis is less important, or on an interdisciplinary team, where understanding the language of DSM and being able to navigate the DSM becomes important for communicating and working with other providers.

While the clinical psychology interviewees' ambivalence regarding using DSM to inform their clinical work stems in large part from their critiques over DSM's validity [i.e., does DSM adequately capture clients' realities?], the social work interviewees express caution in applying DSM diagnoses to their clients because of the potential harm that accompanies a diagnostic label of any kind. That is, while the clinical psychology interviewees are concerned with the DSM in particular, the social work interviewees are concerned with psychiatric labeling in general. Only one social work interviewee (Social Work Interviewee_B) makes a critical remark about the DSM specifically, and it is to explain that during the "Assessment in Psychopathology" course they briefly discussed that "DSM is not perfect."

While less likely than the clinical psychology interviewees and even than the psychiatry residents to critique the DSM, the social work interviewees are much more likely than the other two professional groups to mention the potential harm associated

with assigning clients a diagnostic label. Nine of eleven social work interviewees (81.8%) express concern over labeling their clients, compared to just one clinical psychologist trainee (9%) and none of the psychiatric residents. Social work interviewees raise two main concerns regarding diagnostic labels. First, diagnostic labels may be stigmatizing. People who interact with someone diagnosed with a DSM diagnosis may react negatively to those diagnosed because the label carries a connotation of insanity or instability. Second, a diagnostic label may narrow a clinicians' focus too severely, such that clinicians focus only on the aspects of a client that align with the diagnosis, and overlook a client's other symptoms, strengths, and the aspects of a client's life that make him or her unique. To that end, a number of social work students warn of the dangers of paying so much attention to a diagnostic label that you end up "putting them [your clients] in a box" – Social Work Interviewee_J. Indeed, the label may inhibit clinicians from thinking creatively, prohibiting them from, as Social Work Interviewee_F put it, "Thinking outside of the box" with respect to treatment options. The following quote from a social work interviewee captures social workers' ambivalence regarding diagnostic labels:

> Social Work Interviewee_E: I remember like one guy [student] in class said that… "I have a bipolar friend." Well, he's not a bipolar friend. He's a person who suffers from—or has—bipolar disorder. Just, it's a person who has this. If you start labeling all you see is the label. And so, I mean, I might have that slant that the labeling is bad and, I don't know, I guess I haven't really integrated that, my thoughts on that yet. I've kind of mixed feelings about it. I see the good, I see the bad.

Thus, all three professional groups agree that mental health diagnoses have some utility in clinical work. The interviewed psychiatry residents discuss their use in shaping treatment decisions, granting a patient's diagnosis the principal role in treatment decisions. Clinical psychology interviewees and social work interviewees suggest a

client's diagnosis can help shape treatment decisions, but feel that a client's individual circumstances and symptom profile should be more salient factors in treatment planning than diagnosis. While psychiatry interviewees focus almost exclusively on diagnosis' role in treatment planning, however, clinical psychology and social work interviewees discuss how a client's diagnosis may be useful in other ways such as operating as linguistic shorthand between providers, and in securing resources for clients. Moreover, while clinical psychology interviewees and social work interviewees both express ambivalence over using diagnoses in treatment planning, they do so for different reasons. The clinical psychologists question whether the DSM reflects their clients' realities and whether some of the DSM criteria help providers make clinically-relevant distinctions between clients. The social workers worry about the lasting detrimental effects that a diagnostic label may have on their clients, noting that such labels have the power to pigeonhole or stigmatize clients. Finally, the social work interviewees are unique in their reference to the importance of diagnoses to other types of providers' treatment decisions, and in their distinction between the importance of diagnoses for social workers working on interdisciplinary teams versus those working alone.

Other Factors Shaping Trainees' Use of Diagnosis

The role of diagnosis in outpatient vs. inpatient clinical work

The in-depth interviews, in addition to illuminating differences in the use and value trainees place on diagnosis by trainees' professional affiliation, also uncovered differences based on the setting in which care is provided. Diagnosis appears to play a greater role in treatment planning on inpatient units than it does in outpatient clinics. On inpatient units, providers tend to see a greater number of patients daily, patients will only

remain under a provider's care for the length of time they remain on the inpatient unit, patients' problems are acute, and patients are attended to by a number of different types of providers. This means that providers have less time to get to know and evaluate patients, so providers must learn to evaluate and plan treatment for patients quickly. Additionally, in order to maximize the quality of care provided, providers must coordinate their efforts with other providers. In outpatient settings, patients or clients are stable and remain under a provider's care for months or years at a time. There also tends to be less coordination that goes on between providers treating the same client on an outpatient basis. As a result, the process of assessing and planning treatment in outpatient settings is gradual and ongoing, and there is less of a need for a shorthand method of describing a patient to other providers. A patient's differential diagnosis offers a snapshot of the patient's problems and points to different treatment options. In an outpatient setting, there is less need for such a snapshot, because there is time to gain a richer, more complete picture of the individual, time to try multiple treatment options, and less need to communicate succinctly with other providers about a patient. Asked about the degree to which diagnosis is central to clinical work, Psychiatry Interviewee_J says:

> See, it really depends on the setting. If you're in an outpatient clinic where you're presumably seeing someone consistently weekly, I think coming to a final diagnosis is less important because the patients are more stable, and that way you can kind of take your time and talk with them and find out is this depression, is this anxiety, is this stress, is this related to trauma? You have time to spend with them.

Psychiatry Interviewee_C, likewise, implicitly suggests in the following quote that arriving at a diagnosis matters more when practicing on inpatient settings:

> I spend a lot of time working in the emergency room and so I've gotten used to just kind of getting the quick ten, fifteen minute, put-out-the-fire snapshot of someone. And that has its place and can be useful, so that would be the more

> quick, problem-focused assessment. But when you do therapy with someone, when you establish a longer-term working relationship with someone, you really need to take a few sessions to do as thorough an assessment as possible because a lot of times someone's problems are very complicated and go back a long ways. It's not just about, you know, about like one of the very common things is 'my spouse or loved one won't have sex with me.' Well, there's a lot to that, and, so, in the assessment you are going to try to bring out what else is going on. And you want to keep assessing as you work with somebody.

When asked what role, if any, diagnosis plays in clinical work, Social Work Interviewee_A likewise distinguished between outpatient and inpatient settings:

> I think, again, it depends on the setting. I guess like an LCSW [licensed clinical social worker] with a private practice is going to diagnose but they're not necessarily going to tell their client what they've diagnosed them with. Because I don't - in my experience with social work, diagnosing isn't something that is a priority as far as – it may be [A PRIORITY/IMPORTANT] for us to kind of get a picture of a person but it's not like [A PRIORITY/IMPORTANT] for treatment, like okay, I'm going to diagnosis you with this and this is how we're going to work, kind of thing, like a psychiatrist or something would do. And so that's been my experience with private practice…however, in my experience with the [inpatient setting], it was a lot about diagnosing and the psychiatric setting on inpatient.

Thus, in addition to differences in the use and value of diagnosis based on a provider's professional affiliation, there also appears to be differences based on the type of setting in which care is provided – at least for the psychiatry and social work interviewees. Given that only one of the clinical psychology interviewees discussed working on an inpatient unit, it is not possible to determine if the clinical psychology interviewees place greater emphasis on diagnosis in inpatient settings than they do in outpatient settings.

Psychodynamic orientation

In addition to looking at the effects of professional affiliation and type of setting I also explored whether trainees' gender, race, or primary theoretical orientations shaped

the way interviewees talked about diagnosis. Of these factors, only designating the psychodynamic orientation as primary influenced views of diagnosis in clinical work. Psychodynamic interviewees tended to consider diagnosis fairly important and no interviewees who endorsed a psychodynamic orientation spoke about diagnosis or DSM in negative terms. That is, none of the psychodynamic interviewees talked about the need to revise DSM, the arbitrary cut-offs for some of the diagnoses, or the potential for stigma that accompanies diagnosis.

Section Summary

As with the survey data the interviews demonstrate that trainees from different professional groups agree on some diagnostic-related decisions and part ways on others. When asked open-ended questions about diagnosis, all interviewees describe working exclusively with the DSM. That is, the DSM is the default diagnostic classification system for the trainees. Moreover, interviewees from each of the three professional groups acknowledge that diagnosis plays some role in the work they do with patients or clients.

The interviews, however, uncovered interesting differences in how trainees from the three professional groups view and work with diagnosis. The psychiatry residents place the greatest value on using a patient's differential diagnosis to shape treatment decisions for the large majority of patients they see. The clinical psychology and social work interviewees, while acknowledging that certain types of broad diagnostic distinctions will matter for treatment planning, emphasize paying attention to an individual's symptom profile, unique social circumstances, and personal experience with symptoms over an individual's very specific differential diagnosis when planning

treatment. Clinical psychology interviewees note that diagnosis matters more with particular clients (e.g., those exhibiting psychotic or manic symptoms) than with others, while social work interviewees mention that diagnosis matters more when working under particular conditions (on an interdisciplinary team headed by a psychiatrist) than under other conditions (practicing alone), and raise concerns over the possible detrimental effects that assigning a psychiatric label may have on patients.

The three professional groups also differ with respect to their attitude toward the DSM as a classification system. Social work interviewees, on the whole, voice neither criticism nor praise of the DSM. Social workers are instead concerned with the possible lasting pernicious effects of diagnostic labels more generally. The psychiatry residents, while acknowledging that some of DSM's criteria may need to be revised slightly in the future, view DSM diagnoses as the solid foundation on which their treatment decisions rest. Clinical psychology interviewees believe that the DSM accurately captures certain types of disorders (e.g., psychotic disorders) but not others (e.g., personality disorders), and that more research needs to be done to identify which criteria correspond to important clinical distinctions.

In addition to professional differences in the use of diagnosis, the setting in which care is provided and the psychodynamic orientation both shape the role that diagnosis plays in trainees' clinical work. On inpatient settings where multiple professionals provide care to patients in crisis for short periods of time, a patient's diagnosis tends to act as a critical snapshot that guides treatment decisions. In outpatient settings where providers treat stable help-seekers over longer periods of time and have a chance to conduct ongoing assessments, a definitive diagnosis is less important for treatment

planning. Finally, those who consider the psychodynamic orientation their primary orientation tend to have a more favorable impression of diagnosis than those who do not. Indeed, none of the psychodynamic interviewees spoke about diagnosis or the DSM in negative terms.

CONCLUSION

Let us now consider these findings in light of the relevant hypotheses drawn out in Chapter 2. Hypothesis 1 predicted trainees would demonstrate unanimity in some aspects of diagnosing patients, and divergence in other aspects of diagnosing patients. Hypothesis 2 predicted that some of the variability in diagnostic decisions and practices could be attributed to a trainee's professional affiliation. The findings support both Hypotheses 1 and 2. All of the trainees, for example, conceptualize Jessica's problems as representing a *mental health* problem that necessitates intervention from a mental health provider. Moreover, on the question of which diagnostic classification system trainees use to diagnose patients or clients, every interviewee referred solely to the DSM. Thus, for each and every interviewee 'diagnosis' was essentially synonymous with *DSM* diagnosis. Finally, all interviewees acknowledged that diagnosis has some value in working with patients. No one, for example, said that diagnosis had no place in their clinical work. Trainees' unanimity on diagnostic practices, however, ended here. When asked whether the woman from the case study was suffering from a diagnosable mental disorder, when asked to choose a primary DSM diagnosis, when asked to indicate how important selecting an accurate DSM diagnosis would be for treatment planning, and when asked specifically how they use diagnosis in their clinical work trainees' responses diverge along professional lines.

Based on each discipline's professional logic and status ranking within the mental health field, Hypotheses 3a and 3b predicted the ways in which trainees' diagnostic judgments would differ based on trainees' professional affiliation. Hypothesis 3a predicted that psychiatry residents would be the most likely, social work trainees the least likely and clinical psychology trainees would fall in between the other professional trainees on the issue of mental disorder attribution, and I find support for this hypothesis. Hypothesis 3b relates to the severity of the diagnostic label that trainees from each professional discipline would apply and predicted that psychiatry residents would apply more severe diagnostic labels than would trainees from the other two professions. This hypothesis receives only partial support. While a larger percentage of psychiatry residents than clinical psychology trainees or social work trainees do endorse the most severe diagnosis (i.e., Major Depressive Disorder), the differences between psychiatry residents and clinical psychology trainees are small and the difference between psychiatry residents and social work trainees is not statistically significant.

While professional differences in diagnostic judgments are not overwhelming, the interviews uncover important differences in how trainees view and work with diagnosis more generally. Psychiatry residents consider diagnosis the cornerstone of their clinical work and view planning treatment for any patient without first establishing a patient's DSM diagnosis tantamount to malfeasance. Clinical psychologists and social workers, alternatively, believe that arriving at a diagnosis is critical with certain help-seekers (e.g., those with psychotic disorders) but relatively unimportant with others (e.g., those suffering primarily from personality disorders) and that, in general, understanding a client's unique profile is more important than establishing her precise differential

diagnosis. Furthermore, clinical psychology and social work interviewees are both ambivalent about diagnosis, but for different reasons. Clinical psychology interviewees stress the flawed nature of some DSM diagnostic categories while social work interviewees point to the stigmatizing effect that applying any diagnosis can have on a client.

That the differences in survey respondents' diagnostic judgments are sometimes greatest between clinical psychologists and psychiatrists rather than between social workers and psychiatrists was unexpected. The interviews suggest two interrelated reasons that psychiatrists' and social workers' judgments sometimes overlap. First, social workers work as subordinate members of mental health teams run by psychiatrists and their utility on these teams is contingent upon their ability to understand and work from psychiatrists' perspective. Clinical psychologists, alternatively, tend to work independent of psychiatrists. Second, both psychiatrists and social workers (but not clinical psychologists) often work on inpatient settings. Interviewees suggest that establishing an accurate DSM diagnosis is more important on inpatient settings than outpatient settings due to the limited amount of time that any one provider spends with a patient. Thus, diagnosis acts as tool on inpatient settings to coordinate the ways different types of providers view and work with a patient. I now turn (in Chapter 5) to comparing trainees' treatment decisions and their approach to working with clients or patients.

Table 4-A: Percentage who Identify "Jessica" as Having a Disorder, by Professional Program, Race, Gender, and Theoretical Orientations

	Has a Disorder	Does Not Have a Disorder or Respondent "Not Comfortable" with Term Mental Disorder	(n)	χ^2 (*df*)	Φ	*p*
Full Sample	90.4%	9.6%	104			
Professional Program				6.0 (2)	.240	.051
Psychiatry	100	0	32			
Clinical Psychology	91.3	8.7	23			
Social Work	83.7	16.3	49			
Race				0.6 (1)	.078	ns
White/Caucasian	88.7	11.3	71			
Minority	93.8	6.3	32			
Gender				3.1 (1)	-.174	ns
Women	87.7	12.3	81			
Men	100	0	23			
Theoretical Orientations						
Medical/biological	92.9	7.1	101	1.2 (1)	.107	ns
Psychodynamic	94.5	5.5	101	2.8 (1)	.168	ns
Cognitive-behavioral	90.2	9.8	101	0.03 (1)	.017	ns
Interpersonal	86.8	13.2	101	1.2 (1)	.114	ns
Family Systems	82.4	17.6	101	6.8 (1)	-.260	.009
Strengths	80.5	19.5	101	7.0 (1)	-.264	.008
Person-in-environment/ Ecosystems	86.1	13.9	101	1.0 (1)	.097	ns
Humanistic/Existentialist/ Gestalt	85.0	15	101	0.7 (1)	.083	ns
Integrative/Eclectic	96.2	3.8	101	1.5 (1)	.122	ns

Table 4-B: Primary Diagnosis by Professional Program, Race, Gender, and Theoretical Orientations

	Major Depressive Disorder	Generalized Anxiety Disorder	Panic Disorder	Other Disorders[a]	(n)	χ^2 (*df*)	*p*
Full Sample	27.2%	39.8%	10.7%	22.3%	103		
Professional Program						11.6 (6)	.079
Psychiatry	40.6%	40.6%	12.5%	6.3%	32		
Clinical Psychology	13.0%	34.8%	13.0%	39.1%	23		
Social Work	25.0%	41.7%	8.3%	25.0%	48		
Race							
White/Caucasian	26.1%	47.8%	7.2%	18.8%	69	6.1 (3)	ns
Minority	31.3%	25.0%	18.8%	25.0%	32		
Gender						7.5 (3)	.058
Women	21.0%	43.2%	11.1%	24.7%	81		
Men	50.0%	27.3%	9.1%	13.6%	22		
Theoretical Orientations							
Medical/biological	27.3%	43.6%	9.1%	20.0%	98	1.1 (3)	ns
Psychodynamic	29.1%	43.6%	7.3%	20.0%	98	2.4 (3)	ns
Cognitive-Behavioral	27.2%	43.2%	9.9%	19.8%	98	2.8 (3)	ns
Interpersonal	15.4%	44.2%	11.5%	28.8%	98	9.4 (3)	.025
Family Systems	22.4%	44.9%	6.1%	26.5%	98	5.0 (3)	ns
Strengths	20.5%	51.3%	7.7%	20.5%	98	4.1 (3)	ns
Person-in-environment/ Ecosystems	23.5%	50.0%	5.9%	20.6%	98	3.0 (3)	ns
Humanistic/Existentialist/Gestalt	21.1%	42.1%	10.5%	26.3%	98	0.7 (3)	ns
Integrative/Eclectic	36.0%	36.0%	8.0%	20.0%	98	1.3 (3)	ns

[a] "Other disorders" include all disorders endorsed by less than 10% of respondents. They include major depressive episode, dysthymia, social anxiety disorder, and 'other.' Respondents who left the diagnosis field blank (*n* = 2), as well as the one respondent who indicated that 'Jessica does not have a mental disorder' have been excluded from these analyses.

Table 4-C: Multinomial Logistic Regression Results for Primary Diagnosis

	Generalized Anxiety Disorder				Panic Disorder				Other Disorders[a]			
	B	**SE**	**OR**	**95% CI**	***B***	**SE**	**OR**	**95% CI**	***B***	**SE**	**OR**	**95% CI**
Professional Program[b]												
Psychiatry (Reference)												
Clinical Psychology	-0.3	1.0	0.8	0.1 – 5.8	0.8	1.3	2.2	0.2 – 29.2	2.3	1.3	10.2*	0.8 – 123.3
Social Work	-0.5	0.7	0.6	0.2 – 2.3	-0.2	1.0	0.8	0.1 – 5.3	1.2	1.0	3.4	0.5 – 23.9
Race												
White (Reference)												
Minority	-1.0	0.7	0.4	0.1 – 1.4	0.8	0.9	2.2	0.4 – 11.9	0.5	0.8	1.7	0.4 – 7.2
Gender												
Women	1.7	0.7	5.3*	1.3 – 20.9	1.1	1.0	3.0	0.4 – 21.5	1.4	0.9	3.9	0.6 – 23.1
Men (Reference)												
Subscribes to Particular Theoretical Orientations[c] (0 = No, 1 = Yes)												
Interpersonal Orientation	1.1	0.7	3.0	0.8 – 11.1	0.9	1.0	2.5	0.4 – 17.1	1.0	0.8	2.6	0.5 – 13.2
Constant	-0.8	0.6			-2.5*	1.0			-3.2**	1.1		
n	39				11				20			
χ^2 (df)	28.8 (15)*											
Pseudo R^2 (*Nagelkerke R^2*)	.278											

Total N = 97

Note: Reference category for the analysis is a primary diagnosis of Major Depressive Disorder.

[a] "Other disorders" include all disorders endorsed by less than 10% of respondents. They include major depressive episode, dysthymia, social anxiety disorder, and 'other'. Respondents who left the diagnosis field blank (*n* = 2), as well as the one respondent who indicated that 'Jessica does not have a mental disorder' have been excluded from these analyses.

[b] Given that Hypothesis 3b is directional – the odds of trainees endorsing a diagnosis of Major Depressive Disorder should be lower for trainees in clinical psychology and in social work than for psychiatry residents, while the odds of trainees endorsing any of the less-severe diagnoses should be higher for trainees in clinical psychology and in social work than for psychiatry residents – the p values associated with the coefficients for clinical psychology and social work correspond to one-tailed tests of significance.

[c] Due to high associations between some of the theoretical orientations only those theoretical orientations that are significantly associated with the dependent variable in bivariate analyses are included in the multivariate analysis.

*$p < .05$; **$p < .01$.

Table 4-D: Average Importance[a] of Determining "Accurate DSM Diagnosis" to Treatment Planning, by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

	Importance of Accurate DSM Diagnosis *Mean (SD)*	*(n)*	*F*-Ratio from ANOVA[b]	Significant Post-hoc Differences[b,c,d]	*t (df)* [b]
Full Sample	7.1 (1.6)	104			
Professional Program			*F(2,101)* = 6.8**	PR, SW > CP*	
Psychiatry	7.4 (1.1)	32			
Clinical Psychology	6.0 (2.0)	23			
Social Work	7.3 (1.5)	49			
Primary Diagnosis			*F(3,98)* = 0.5		
Major Depressive Disorder	7.3 (1.9)	28			
Generalized Anxiety Disorder	7.2 (1.1)	41			
Panic Disorder	6.7 (1.6)	11			
Other Diagnosis	6.8 (2.1)	22			
Race					-2.0 (101)
White/Caucasian	6.9 (1.7)	71			
Minority	7.5 (1.4)	32			
Gender					-1.8 (102)
Women	7.2 (1.5)	82			
Men	6.5 (1.9)	22			
Theoretical Orientations					
Medical/biological	7.2 (1.2)	100			-1.1 (67.2)
Psychodynamic	7.3 (1.2)	100			-1.9 (71.5)
Cognitive-behavioral	7.1 (1.6)	100			-0.9 (98)
Interpersonal	6.6 (1.8)	100			2.8 (91.5)**
Family Systems	7.3 (1.5)	100			-1.7 (98)
Strengths	7.3 (1.4)	100			-1.3 (98)
Person-in-environment/ Ecosystems	7.2 (1.5)	100			-0.6 (98)
Humanistic/Existentialist/ Gestalt	7.4 (1.1)	100			-1.1 (98)
Integrative/Eclectic	6.6 (2.0)	100			1.4 (32.5)

[a] Values range from 1 (Not at all Important) to 9 (Extremely Important).

[b] *F*-ratio and Significant Post-hoc Differences are associated with a One-Way ANOVA model and apply only to the analyses related to *Professional Program* and *Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and *Theoretical Orientations*.

[c] *P* values corresponding to post-hoc differences are measured by Tamhane's T2.

[d] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.

$*p < .05$; $**p < .01$.

Table 4-E: ANCOVA Results[a] for Importance of Determining "Accurate DSM Diagnosis" to Treatment Planning

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	5.4	2.3	.050	.224
Primary Diagnosis	3	1.1	0.5	.015	.123
Race	1	6.2	2.6	.029	.170
Gender	1	2.4	1.0	.011	.105
Interpersonal Orientation	1	2.2	0.9	.010	.100
Error	88	2.4			
Adjusted R^2	.120				
R	.346				

[a]Due to high associations between some of the theoretical orientations only those theoretical orientations that are significantly associated with the dependent variable in bivariate analyses are included in the multivariate analysis.

$*p < .05$; $**p < .01$.

Chapter 5: Trainees' Treatment Decisions and Approach to Care

This chapter focuses on mental health trainees' treatment decisions and their approach to care. As in the previous chapter, I compare trainees in psychiatry, clinical psychology, and social work. The chapter begins with a summary of existing research, followed by a review of the trainees' survey and interview responses regarding their treatment choices. These responses include the number and types of theoretical orientations trainees draw on, trainees' beliefs about the efficacy of various types of treatment, the specific interventions trainees would recommend, and the type of relationship trainees attempt to cultivate with their patients or clients. The chapter closes with a discussion of the amount and source of variation in trainees' treatment decisions and therapeutic approaches.

PRIOR MENTAL HEALTH TREATMENT RESEARCH FEATURING MULTIPLE PROFESSIONAL GROUPS

I was able to locate only ten studies that directly compare the treatment decisions made by mental health providers from different professional disciplines, and only eight of them involve mental health professionals in the United States. These studies looked at a range of dimensions of treatment planning using varied methodological approaches and patients in both outpatient and inpatient settings. Taken together, the studies considered four dimensions of treatment planning: 1) providers' therapeutic approaches, 2) providers' means of gathering information to plan treatment, and the type of information they deemed most relevant for treatment planning, 3) the treatment recommendations themselves, and 4) the patient's role in treatment planning.

Strauss and colleagues (1964), in their classic sociological study of health care professionals working with psychiatric patients in two hospitals in Chicago during the

late 1950s and early 1960s, identified three therapeutic approaches used to guide clinical work. These approaches include a biological ('somatic') approach, a psychotherapeutic approach, and a sociotherapeutic approach. The biological approach presupposes malfunctioning of the central nervous system due to biological or genetic aberrations; treatment under this approach takes the form of drug-based interventions and electroshock therapy. The psychotherapeutic approach views mental illness as the result of psychological trauma, thus favoring treatment through individual psychotherapy. The sociotherapeutic approach focuses on the social environment's effects on individual well-being, leading to milieu therapy, or psychotherapy involving entire therapeutic communities—including other patients—as the favored method of treatment. Strauss and colleagues conducted their fieldwork at a time when psychiatry ruled the U.S. mental health field, and psychiatry was dominated by a psychodynamic approach to care. It is unsurprising, therefore, that the majority of each of the professional groups (psychiatrists, nurses, psychologists, and social workers) listed a psychotherapeutic approach to care as their "most preferred" clinical orientation. Nevertheless, as Strauss et al. (1964: 362) noted, "professional affiliation strongly influences the professional's ideological position." They found that psychiatrists were significantly more likely than psychologists or social workers to endorse a biological approach, while psychologists were likely to endorse a psychotherapeutic approach and social workers leaned toward a sociotherapeutic approach to care.

Most of the professionals Strauss et al. (1964) interviewed expressed the belief that multiple types of causes underlie mental illness, ergo multiple types of interventions may be helpful. Thus, as early as the late 1950s, Strauss and colleagues uncovered the

precursor to what is now widely considered the dominant viewpoint among mental health providers, the biopsychosocial approach to mental health (USDHHS 1999). This approach posits that mental health is affected by biological, psychological, and social factors simultaneously. However, though the professionals in those Chicago psychiatric hospitals agreed that mental health and illness were determined by a number of varied factors, the providers' professional affiliation shaped how providers ranked the relative importance of each factor.

Two more recent studies offer further confirmation that professional affiliation shapes a provider's therapeutic approach to care. Davies et al. (2006) studied the various types of professionals working in a medium/low security forensic mental health care unit in the United Kingdom. They found that professional affiliation strongly influences providers' approach to care and the roles that they play in the mental health care unit. For example, psychiatrists focus mainly on the diagnosis of mental disorders and pharmacotherapy, psychologists are mainly interested in service users' insights into their personal histories and problems (elicited through talk therapy), and social workers are primarily concerned with post-discharge living and working conditions. Wright (1997) studied the psychiatric staff's professional involvement with client families at the two largest hospitals in Indianapolis in the early 1990s. One organizational factor that affected how involved the staff related to client families was the staff member's professional affiliation. Social workers reported more contact with clients' families than did psychiatrists, nurses, and occupational and recreational therapists.[15]

Each of the studies discussed above focused on different professionals working alongside one another in the same organizational context. It may well be that approaches

[15] Psychologists were not among the types of professionals represented in Wright (1997).

to care differ because of a division of labor built into each organization's structure. For example, in inpatient settings psychiatrists typically are expected to diagnose patients and offer psychopharmacology while social workers focus on post-discharge living and working arrangements. My study attempts to control for the effect of organizational setting on trainees' approaches to care by keeping the organizational setting in which trainees are to treat the hypothetical "Jessica" purposefully vague. Respondents were told only that Jessica was seen in "a clinical setting" (see Question #12, page 8 of the survey instrument, Appendix 3-C).

Besides variation in therapeutic approaches to care, a number of studies have compared the types of information professionals deem important when planning treatment, or how providers from different professions gather and synthesize information during treatment planning. Plaud et al. (1993), for example, found that social workers are less likely to use research to guide treatment planning than psychiatrists and psychologists. Clavelle and Turner (1980) and Falvey (2001) found that, compared with other types of mental health providers, social workers are less consistent and focused in their manner of collecting and evaluating information when planning treatment.[16] In contrast, Falvey et al. (2005) found that clinicians follow one of four patterns of clinical decision making, and that clinicians from each of the three mental health professions included in the study – clinical social work, psychology, and mental health counseling – are represented among each of the four categories of decision-making. That is, the authors did not find professional differences in clinicians' patterns of decision making.

[16] Clavelle and Turner (1980) compared social workers, psychologists, and paraprofessionals, while Falvey (2001) compared social workers, psychologists and mental health counselors.

Three studies compared the types of services and referrals different types of providers recommended for treatment. While Clavelle and Turner (1980) found that the manner in which providers make treatment decisions differs by professional affiliation, they found no differences in the actual treatment recommendations of the social work, psychology, and paraprofessional providers in their study. In contrast, Turner and Kofoed (1984) and Wyatt and Livson 1994) found substantial differences, primarily between psychiatrists and psychologists. Turner and Kofoed (1984) asked participants from a Veterans Administration medical center to read a hypothetical, but typical, case report of a patient presenting with comorbid symptoms of both mental illness and substance abuse. Participants were to refer the case to either the general psychiatry unit or the alcohol/drug inpatient treatment unit. Psychiatrists and social workers more often chose the general psychiatric unit, while psychologists were equally as likely to refer the patient to the alcohol/drug treatment unit as to general psychiatry. Wyatt and Livson (1994) surveyed licensed psychiatrists and psychologists in five counties in the San Francisco Bay Area about their general positions on the etiology and treatment of mental illness. Psychiatrists and psychologists differ in their positions on the importance of psychotherapy and on the importance of drug therapy and other medical interventions in the treatment of mental illness. Not surprisingly, given the type of work in which each profession specializes, psychiatrists place greater importance on drug therapies than do psychologists, and psychologists place greater importance on psychotherapy than do psychiatrists.

Finally, two studies looked at providers' preferences regarding the role that patients or clients should play in their own care. Kent and Read (1998) surveyed the

mental health providers in a New Zealand Crown Health Enterprise[17] on their knowledge about and attitude toward client involvement in mental health care. They found psychiatrists know less than other types of professionals do about clients' rights within their agency, rights such as whether they are informed of confidentiality, whether their agency has a complaints procedure, whether clients are told they have a right to see and correct their records, and whether their agency solicits consumer input for planning services. Moreover, psychiatrists and other professionals who share a biomedical orientation to care are less likely than other groups of professionals to believe that mental health service delivery would improve if clients were involved in service planning or delivery, and are also less likely to favor clients being involved in the diagnosis and evaluation of their own presenting problems. In contrast, Wyatt and Livson (1994), in their survey of psychiatrists and psychologists in the San Francisco area, found that the professional groups do not differ from one another in terms of their preference for egalitarian vs. unilateral relations with their clients or patients. Survey respondents heavily favor egalitarian relations with clients, regardless of professional affiliation.

The findings from previous studies are, therefore, mixed on the impact that professional affiliation has on a provider's therapeutic approach and treatment decisions. With respect to multiple types of mental health professionals working alongside one another in a given organizational context, past studies suggest that professional affiliation does shape a provider's approach. Psychiatrists are more likely to favor a biological explanation for the emergence of mental disorders and to engage in medically-oriented interventions such as medication management than are the other groups. Psychologists

[17] A Crown Health Enterprise is type of organizational entity that provides mental health services within a specific locality in New Zealand.

are more likely than the other two professional disciplines to favor engaging a client in individual psychotherapy. Social workers are more likely than providers from other professions to focus on and engage people from a client's social network to aid in a client's care. These findings are in line with the idea that each discipline's unique professional logic shapes its providers' ideas about mental health and illness as well as its providers' notions regarding the types of clinical roles in which they should engage.

Prior studies are more mixed on the effect that professional affiliation has on other dimensions of mental health treatment planning and delivery. A number of studies found that social workers may not be as consistent or focused as other groups when evaluating clients or planning treatment, and the one study that looked at different professions' reliance on research found social workers less likely to use research to inform treatment decisions than are psychiatrists or psychologists (Plaud et al. 1993). Providers' treatment recommendations themselves, however, do not always split along professional lines. When professional affiliation does predict treatment decisions the greatest differences exist between psychiatrists' and psychologists' recommendations. Finally, the two studies that surveyed professionals about the ideal amount of involvement that clients should have in treatment planning and delivery present divergent findings. The New Zealand study (Kent and Read 1998) found psychiatrists less receptive to the idea of client involvement than other professional groups, while the U.S. study that surveyed psychiatrists and psychologists (Wyatt and Livson 1994) found both groups favor collaboration between providers and clients over more authoritarian provider-patient relationships.

TRAINEES' USE OF DIFFERENT THEORETICAL ORIENTATIONS IN CLIENT CARE

Number of Theoretical Orientations Used in Clinical Practice

One of my central arguments is that each profession's unique overarching professional logic shapes its members' clinical judgments and the way members approach care. At a slightly lower level of abstraction, however, clinicians have a range of cross-disciplinary theoretical orientations available to them to guide their day-to-day dealings with clients or patients. These theoretical orientations are available to all who work within the mental health field, and include, for example, a biomedical orientation, a psychodynamic orientation, a cognitive-behavioral orientation, and a family-systems orientation. Additionally, providers may regularly combine orientations in what is referred to as theoretical integration or eclecticism. Theoretical integration generally refers to the synthesis of the same mutually-compatible orientations for each client, while eclecticism is associated with picking and choosing among various theoretical orientations and techniques based on each individual client's profile (Garfield 1994). Additionally, regardless of which orientations a provider chooses to combine, theoretical integration or eclecticism is sometimes considered a broad theoretical orientation in its own right (ibid). Thus, many studies (e.g., O'Donohue et al. 1990; Wyatt and Livson 1994), including this one, offer providers the option of reporting their orientation as integrated or eclectic, either alone or in combination with other orientations.

Hypotheses 4a through 4e regard the number and type of theoretical orientations trainees use to guide their work with patients or clients, based on a trainee's professional affiliation. Hypothesis 4a concerns the average number of theoretical orientations trainees report using in clinical practice. Psychiatry's unifying professional logic, the biomedical

model of mental disorders (Horwitz 2002), with its singular focus on the genetic and biochemical determinants of mental disorder, is also a theoretical orientation in its own right. Given the fact that psychiatry's current professional logic is biomedical and that psychiatrists are trained as medical doctors, psychiatrists are highly likely to report using a biomedical orientation in practice. Unlike the other orientations that explain mental health and illness largely as a function of psychological or social factors, the biomedical orientation stands alone in conceptualizing mental illness in medical terms, as a function of a diseased brain (ibid). As such, the biomedical model and the providers that logically should prefer it (i.e., psychiatrists) are more likely than other professional groups to use a *single* orientation (the biomedical orientation) rather than to combine the biomedical orientation with other approaches that have different views on the origins of mental illness.

Clinical psychology's professional logic or unifying model is the scientist-practitioner model, which advocates hypothesis-testing in evaluating and treating clients to determine what plagues them and what research-backed intervention(s) would best serve each client (Petersen 2007). The scientist-practitioner model encourages skepticism toward accepting any one orientation or intervention as the one solution to a client's recovery, and clinical psychology has historically not been dominated by a single orientation (Strauman 2001). Similarly, social work's ecological or person-in-environment logic, which focuses on how an individual is embedded in multiple social systems that have the potential to affect her well-being, also encourages a broad focus on multiple determinants of mental disorder (Simpson et al. 2007). Social work's tradition of borrowing theoretically from multiple disciplines such as psychiatry, psychology, and

sociology (Grob 1991) also points to a willingness to embrace multiple orientations to practice. Therefore, Hypothesis 4A predicts that psychiatry residents will report using fewer orientations on average than will trainees in clinical psychology and social work.[18]

The number of theoretical orientations that trainees report using (see Table 5-A) is significantly associated with professional affiliation ($F(2,98) = 6.3$; $n = 101$; $p < .01$). Psychiatry residents use the fewest ($M = 4.1$, $sd = 1.8$), social work trainees the most ($M = 6.2$, $sd = 3.0$), with clinical psychology trainees in between ($M = 5.2$, $sd = 2.4$). A multiple comparisons/post-hoc test was run to isolate which professional programs significantly differ from one another on the average number of orientations used. Psychiatry residents report using significantly fewer orientations, on average, than do social work trainees ($p = .001$). Neither psychiatry residents nor social work trainees significantly differ from clinical psychologists in the number of theoretical orientations they reported using. Thus, Hypothesis 4a is partially confirmed. Psychiatry residents report using fewer orientations than either of the other two professional groups, but the difference is statistically significant only between psychiatrists and social workers.

Of additional interest with respect to the number of theoretical orientations respondents report using is the fact that every respondent reports using at least two theoretical orientations, despite the fact that only a quarter of respondents indicate that they endorse an integrative or eclectic approach to practice. While a number of studies (e.g., Garfield 1994; Morant 2006; Siporin 1985) have pointed to the fact that many clinicians take a pluralistic approach to practice, drawing from manifold theories and

[18] Only bivariate analyses are used to explore the relationship between trainees' professional affiliation and use of theoretical orientation(s). This is because it is strictly the intersection of trainees' professional affiliation and theoretical orientation(s) that is of interest here. It is beyond the scope of this study to develop or test a complete model of factors that may affect choice of theoretical orientation, a topic that has its own voluminous literature (e.g., Ogunfowara and Drapeau 2008).

using multiple types of interventions in their work with clients, it is truly notable that not a single respondent from any of the professional groups reported using only one orientation. This pluralism speaks to the relatively weak nature of the institutional environment in mental health, where multiple approaches are available and problems are understood to have several possible solutions. This finding also throws into question the validity of research that measures a respondent's theoretical orientation by using a single, close-ended question where the respondent is asked to choose only one theoretical orientation.

Types of Theoretical Orientations Used by Trainees from Each of the Professional Groups

In addition to shaping the number of theoretical orientations, a provider's professional affiliation may also shape the type of orientations used in clinical sessions, due to the historical backgrounds of the theoretical orientations and different orientations' compatibility with each profession's distinct professional logic. Hypotheses 4b through 4e predict the orientation(s) too which each profession adheres. Two types of survey questions address this issue. First, trainees were offered a list of theoretical orientations and asked to select all of the orientations they used to guide "the majority of [their] treatment sessions" (Survey Question #23, Appendix 3-C). Second, trainees were asked, via an open-ended question (Survey Question #24, Appendix 3-C), to indicate which one or two orientations they consider "primary" in their "work with most clients." Table 5-B presents the results of the crosstabulation analyses for professional affiliation by theoretical orientations used, while Table 5-C presents the results of the crosstabulation analyses for professional affiliation by *primary* theoretical orientation(s) used. That is,

refer to Tables 5-B and 5-C when reading the following sections that pertain to Hypotheses 4b through 4e.

Hypothesis 4b predicts that psychiatry residents will be significantly more likely to endorse a biomedical orientation than will either social work or clinical psychology trainees. The biomedical model, which emphasizes biological and genetic causes of mental disorder and medically-oriented treatments (such as psychopharmacology) for mental disorder, doubles as both an orientation and as psychiatry's current professional logic. As such, it would be surprising if psychiatry residents were *not* more likely than other trainees to use this orientation in practice. Indeed, as predicted, analyses demonstrate that psychiatry residents are more likely than the other two professional groups to use a medical or biological orientation to guide practice, with all psychiatry residents, compared to thirty-eight percent of social work trainees and twenty-seven percent of clinical psychology trainees endorsing this orientation ($\chi^2 = 38.4$, $df = 2$, $n = 101$, $\varphi = .616$, $p < .001$). The difference between psychiatry residents and other trainees on the question of the use of a biomedical orientation is even greater when respondents were asked to indicate which one or two orientations serves as their *primary* orientation(s). Ninety-four percent of psychiatry residents list a medical or biological orientation as primary, compared to just four percent of social workers and no clinical psychologists ($\chi^2 = 82.6$, $df = 2$, $n = 100$, $\varphi = .929$, $p < .001$).

Hypothesis 4c concerns the psychodynamic or psychoanalytic orientation to practice. A psychodynamic or analytic approach dominated American psychiatry for much of the twentieth century (Hale 1995), and out of all of the approaches that social work drew from in formulating their own disciplinary knowledge base, social work is

perhaps most indebted to a psychodynamically-oriented psychiatry (Danto 2009). Clinical psychology, in contrast, developed largely as a competitor to psychiatry (Grob 1991; Fancher 1995), and clinical psychology gained ascendancy over psychiatry in the area of psychotherapy in the late 1950s and 1960s (Benjamin 2005). During this "Golden Age" of clinical psychology (ibid), the dominant orientation guiding clinical psychology was behaviorism, an orientation that gave birth to behavioral therapy, which was developed largely to "repudiate psychoanalysis" (Fancher 1995:184). Thus, Hypothesis 4c predicts that both psychiatry residents and social work trainees will be more likely to use a psychoanalytic or psychodynamic orientation than will clinical psychology trainees.

The data partially confirm Hypothesis 4c. Psychiatry residents use a psychodynamic orientation more than do clinical psychology trainees. Social work trainees, however, do not use a psychodynamic orientation significantly more often than do clinical psychology trainees, although a slightly higher percentage of social work trainees report using a psychodynamic orientation compared to clinical psychology trainees. Seventy-five percent of psychiatry residents report using a psychodynamic orientation, compared to just forty-seven percent of social work trainees and forty-one percent of clinical psychology trainees ($\chi^2 = 8.2$, $df = 2$, $n = 101$, $\varphi = .285$, $p = .017$). In fact, when asked to list the one or two *primary* orientations they use with clients, clinical psychology trainees are *more* likely (22.7%) than social work trainees (6.5%) to list a psychodynamic orientation. Both psychology and social work trainees are less likely than psychiatry residents (37.5%), however, to list the psychodynamic orientation as one of their primary orientations ($\chi^2 = 11.5$, $df = 2$, $n = 100$, $\varphi = .338$, $p = .003$).

Hypothesis 4d concerns the use of the cognitive-behavioral orientation with patients or clients. Behavioral therapy in the U.S. developed out of American psychologist B. F. Skinner's radical behaviorism, and originated during the 1950s in large part as an alternative to psychiatry's favored psychotherapeutic approach at that time: psychoanalysis (Fancher 1995). Fancher (1995) goes on to explain that when pure behavioral therapy, which focused on a patient's behaviors and paid little or no heed to a patient's thoughts or feelings, started to lose ground in the 1960s, many psychologists turned to cognitive therapy, which focused on thoughts and cognitions. Cognitive therapy was developed by a psychiatrist, Aaron Beck, who was expounding on the work of American psychologist Albert Ellis. As with behavioral therapy, cognitive therapy developed largely as an alternative to psychoanalysis (ibid). In the 1980s and 1990s, cognitive and behavioral techniques were merged to produce cognitive-behavioral therapy, a blanket term used to describe therapies such as dialectical behavior therapy and rational emotive behavioral therapy – therapies that emphasize the important role that both thoughts and behaviors play in how we approach life (Rachman 1996). Given that both cognitive and behavioral therapies developed largely as an alternative to psychiatry-dominated psychoanalysis (Fancher 1995), and that many ideas in cognitive-behavioral therapy come from psychologists such as Albert Ellis and Michael Mahoney (Dobson and Dozois 2002), Hypothesis 4d predicts that clinical psychology trainees will report using a cognitive-behavioral orientation more than will psychiatry residents.

The data partially confirm Hypothesis 4d. With respect to the percentage of each group that lists cognitive-behavioral as one of the orientations that guides their clinical work, Hypothesis 4d is not upheld. A larger percentage of clinical psychology trainees

(90.9%) compared to social work trainees (85.1%) and psychiatry residents (71.9%) reports using a cognitive-behavioral orientation with clients; however, the differences are not statistically significant (χ^2 =3.7, df = 2, n = 101, φ = .192, p = .154). Instead, a large majority of *each* professional group of trainees reports using a cognitive-behavioral orientation. The differences between clinical psychology trainees and psychiatry trainees are significant, however, in terms of the percentage of each group that lists cognitive-behavioral as an orientation that is or will be *primary* in working with patients or clients. Nearly three-quarters of clinical psychology trainees (72.7%), compared to just nineteen percent of psychiatry residents and forty-eight percent of social work trainees name cognitive-behavioral as a primary orientation (χ^2 = 15.9, df = 2, n = 101, φ = .399, p < .001). Thus, Hypothesis 4d is confirmed with respect to which professional groups consider cognitive-behavioral a *primary* orientation, but not with respect to the percentage of each group that reports sometimes using a cognitive-behavioral orientation.

Hypothesis 4e concerns the three orientations – a person-in-environment or ecological orientation, a family-systems orientation, and a strengths orientation – that are most compatible with the tenets of social work. The main tenet of a person-in-environment approach is that every individual is embedded in sometimes-overlapping social environments (e.g. community, family, school, work) that affect an individual's well-being (Dorfman 1988). The person-in-environment (also known as person-in-situation or ecological) approach functions both as a theoretical orientation and as social work's organizing professional logic. As such, Hypothesis 4e predicts that social work trainees will favor this orientation more than will the other professional groups. A family-systems orientation is remarkably similar to a person-in-environment orientation. The

difference lies in the large amount of focus a family-systems orientation places on one particular realm of social life in which an individual is embedded – namely, one's family (Minuchin 1985). This focus on an individual's external environment playing a role in an individual's well-being remains consistent with social work's premises. As such Hypothesis 4e predicts that social work trainees will also favor a family-systems orientation more than will trainees from other professional groups. Finally, the strengths perspective, an orientation that favors focusing on an individual's assets more than on her deficits (Allison et al. 2004), is more consistent with social work's holistic, client-centered focus (Kutchins and Kirk 1995) than it is with psychiatry's (Light 1980) and clinical psychology's (Ganzach 1997) relative focus on psychopathology. Thus, Hypothesis 4e predicts that social work trainees will also favor the strengths orientation more than will trainees in psychiatry and clinical psychology.

The data confirm Hypothesis 4e. With respect to a person-in-environment orientation, more social work trainees (68.1%) than clinical psychology trainees (4.5%) or psychiatry residents (12.5%) report using this orientation to guide clinical practice (χ^2 = 37.8, df = 2, n = 101, φ = .612, p < .001). The same is true for a family-systems orientation (χ^2 = 22.9, df = 2, n = 101, φ = .476, p < .001), and for a strengths orientation (χ^2 = 44.4, df = 2, n = 101, φ = .663, p < .001). This pattern also holds when considering which orientations different professional groups list as primary. For example, twenty-eight percent of social work trainees list the person-in-environment orientation as primary, compared to no clinical psychology trainees or psychiatry residents (χ^2 = 17.5, df = 2, n = 100, φ = .419, p < .001); thirty-three percent of social work trainees list the strengths perspective as one of their primary orientations, compared to no clinical

psychology trainees or psychiatry residents (χ^2 =20.7, df = 2, n = 100, φ = .455, p < .001); and thirty percent of social work trainees list the family-systems orientation as primary, compared to just five percent of clinical psychology trainees and six percent of psychiatry residents (χ^2 = 10.9, df = 2, n = 100, φ = .331, p = .004).

While no hypothesis was made regarding trainees' preference for using an interpersonal orientation, the difference between the three professional groups in their use of this orientation is marked, especially between clinical psychology trainees and psychiatry residents. Interpersonal theory was developed by a psychodynamically-trained psychiatrist, Henry Stack Sullivan (Evans III, 1996). Sullivan combined ideas from psychodynamic psychiatry with ideas from social science. An interpersonal orientation focuses on the way an individual relates to other people. That is, it focuses on an individual's patterns of interactions with significant others throughout the life course. Unlike a strict psychodynamic approach which places greatest emphasis on childhood experiences and relationships, an interpersonal orientation places more emphasis on the here-and-now (ibid).

One hundred percent of clinical psychology trainees report using an interpersonal orientation, compared to fifty-one percent of social work trainees and just twenty-two percent of psychiatry residents (χ^2 = 32.0, df = 2, n = 101, φ = .563, p < .001). When asked to name the one or two orientations they consider primary in their clinical practice, fifty-five percent of clinical psychology trainees write in 'interpersonal,' compared to just six percent of psychiatry residents and two percent of social workers (χ^2 = 34.8, df = 2, n = 100, φ = .590, p < .001). Thus, despite the fact that the interpersonal orientation was developed by a psychodynamically-trained psychiatrist, it provides another

psychotherapeutic alternative to a strict psychodynamic approach besides cognitive-behavioral therapies. As such, it is the clinical psychology trainees rather than the psychiatry trainees that favor an interpersonal approach.

A final way to compare the theoretical orientation preferences of the three professional groups is to consider each group's top-ranked theoretical orientation choices. When asked which one or two theoretical orientations they consider primary, psychiatry residents most frequently list biomedical (93.8%), followed by psychodynamic (37.5%). Clinical psychology trainees, on the other hand, most frequently list cognitive-behavioral (72.7%), followed by interpersonal (54.5%). Social work trainees, like the clinical psychology trainees, most frequently list cognitive-behavioral (47.8%). Unlike the clinical psychology trainees, however, social work trainees' next preference is the strengths orientation (32.6%). Thus, different ways of measuring trainees' theoretical orientation preferences yield the same result. Professional affiliation is strongly associated with a trainee's choice of theoretical orientation(s).

Section Summary

Both in terms of the number of orientations trainees report using and the brand of orientations they favor, the survey data clearly demonstrate a relationship between a trainee's professional affiliation and her use of theory in clinical work. Social work trainees use more theoretical orientations on average than do clinical psychology trainees, who use more than do psychiatry residents. All trainees, however, take a pluralistic approach to care, in that the minimum number of theoretical orientation trainees report is two.

While some orientations are used more frequently (e.g., cognitive-behavioral) than others (e.g., humanistic/existentialist/gestalt) by the majority of trainees (see Tables

5-B and 5-C), trainees from different mental health disciplines favor the use of different theoretical orientations. In particular, psychiatry residents favor the biomedical orientation and psychodynamic orientations, clinical psychology trainees favor the cognitive-behavioral and interpersonal orientations, and social work trainees favor the cognitive-behavioral and strengths perspectives. Thus, the different disciplines favor orientations that are in line with their overarching professional logics, as well as orientations that historically have allowed the professions to maintain and/or expand their jurisdictions within the U.S. mental health arena.

EFFICACY AND TREATMENT RECOMMENDATIONS[19]

Beliefs about Intervention Efficacy

I predict trainees faced with the same patient or client will rate the efficacy of treatment interventions differently based on their professional affiliations. Efficacy ratings should depend on how well a particular intervention fits with the respective discipline's professional logic, and on the frequency with which members of the profession generally tend to offer a particular intervention. In general, the arguments I made in the previous section on which professions are likely to favor particular orientations hold here as well. Table 5-D depicts which interventions match up with particular theoretical orientations. Specifically, the following section considers trainees' efficacy ratings of psychopharmacology or drug treatment, psychodynamic psychotherapy, cognitive-behavioral therapy, family/couples therapy, inpatient hospitalization, and interpersonal psychotherapy for Jessica.

As noted in Chapter 3, for each intervention I begin by presenting the bivariate relationships between the intervention and various independent variables. The

[19] Interested readers can turn to Table 5-AB for a summary of findings from Section II.

independent variables include: professional affiliation, primary diagnosis, race, gender, and whether or not a trainee reports regularly using particular theoretical orientations (Survey Question #23) in clinical work[20]. I then report the results of a multivariate analysis with the intervention as the dependent variable and the independent variables listed above as predictors. For the likely effectiveness outcome variables I conduct ANCOVAs. For the treatment recommendation outcome variables I conduct binary logistic regressions. Due to relatively low N's for each multivariate analysis[21] I include only those theoretical orientations in the multivariate analyses that are significantly associated with the intervention in a bivariate analysis.

Bivariate results for beliefs about efficacy of psychopharmacology

Hypothesis 4f predicts that psychiatry trainees will rate the efficacy of psychopharmacology higher than will either of the other two professional groups, while clinical psychology trainees will rate pyschopharmacology's efficacy higher than will social work trainees. Table 5-E presents the results of the bivariate analyses for trainees' rating of psychopharmacology's efficacy. A trainee's belief about how efficacious psychopharmacology would be is associated with professional affiliation ($F(2,101) = 12.6$; $n = 104$; $p < .001$). Psychiatry residents rate the likely efficacy of psychopharmacology higher ($M = 8.3$; $sd = 0.8$) than do both clinical psychology trainees

[20] Survey Question #23 asks that respondents select all theoretical orientations that they regularly use to guide their clinical work. I recoded this question into a series of dichotomous variables for use in multivariate analyses. For example: respondent regularly uses psychodynamic orientation, yes or no.

[21] That is, by including only those orientations that are significantly associated with the intervention in a bivariate analysis, I allow for more degrees of freedom in each multivariate analysis and reduce multicollinearity due to strong associations between certain theoretical orientations. Due to particularly strong associations among the family-systems, strengths, and person-in-environment orientations, these three orientations have been combined in multivariate analyses. Thus, respondents who indicate that they subscribe to one or more of these orientations are counted as 1 (yes), while respondents who subscribe to none of these orientations are counted as 0 (no).

(M = 6.9; sd = 1.3; p < .001) and social work trainees (M = 6.8; sd = 1.6; p < .001). There is no significant difference between clinical psychology trainees' and social work trainees' rating of the likely efficacy of psychopharmacology.

A trainee's belief about the efficacy of psychopharmacology is also associated with race (t = -2.5; df = 101; n = 103; p = .02), and with the biomedical (t = -5.2; df = 73.3; n = 101; p < .001), family-systems (t = 2.4; df = 99; n = 101; p = .02), person-in-environment (t = 2.4; df = 99; n = 101; p = .02), and humanistic/existentialist/gestalt (t = 2.5; df = 99; n = 101; p = .014) orientations. Minority respondents rate the likely efficacy of psychopharmacology higher than do white respondents; also, trainees who report using a biomedical orientation rate the efficacy of psychopharmacology higher than others. Conversely, using a family-systems orientation, a person-in-environment orientation, and a humanistic/existentialist/gestalt orientation are all associated with significantly lower efficacy scores for psychopharmacology.

Multivariate results for beliefs about the efficacy of psychopharmacology

Table 5-F presents the ANCOVA results for trainees' ratings of the likely effectiveness of pharmacotherapy or psychopharmacology. The model explains twenty-six percent of the variance. Using a biomedical orientation (F(1,86) = 9.7; p < .01; partial η = .318) is significantly associated with efficacy ratings of pharmacotherapy when other independent variables are included in the model; no other independent variables predict trainees' effectiveness score for pharmacotherapy. Trainees who report using a biomedical orientation rate the likely efficacy of pharmacotherapy higher than do others. Once endorsement (or lack of endorsement) for the biomedical orientation is accounted for, professional affiliation is no longer significantly associated with ratings of

pharmacotherapy's efficacy. Thus, the data do not support Hypothesis 4f once multiple factors that may affect a trainee's rating of the likely effectiveness of pharmacotherapy are taken into account.

Bivariate results for beliefs about efficacy of psychodynamic psychotherapy

Hypothesis 4h predicts that psychiatry residents and social work trainees will rate the likely efficacy of psychodynamic psychotherapy higher than will clinical psychology trainees. Table 5-G presents the results of the bivariate analyses for trainees' rating of psychodynamic psychotherapy's likely efficacy. A trainee's belief about how efficacious psychodynamic psychotherapy would be is associated with a trainee's professional affiliation ($F(2,101) = 17.1$; $n = 104$; $p < .001$) in the ways hypothesized. Clinical psychology trainees rate the likely efficacy of psychodynamic psychotherapy lower ($M = 4.6$; $sd = 2.2$) than do both social work trainees ($M = 7.3$; $sd = 1.9$; $p < .001$) and psychiatry residents ($M = 6.7$; $sd = 1.5$; $p = .001$).

A trainee's belief about the efficacy of psychodynamic psychotherapy is also associated with the psychodynamic ($t = -3.4$; $df = 65$; $n = 100$; $p = .001$), strengths ($t = -3.2$; $df = 98$; $n = 100$; $p < .01$), person-in-environment ($t = -2.8$; $df = 98$; $n = 100$; $p < .01$), interpersonal ($t = 2.1$; $df = 98$; $n = 100$; $p = .038$), and integrative/eclectic ($t = 2.2$; $df = 98$; $n = 100$; $p = .034$) orientations. Trainees who report using a psychodynamic, strengths, or person-in-environment orientation rate the likely efficacy of psychodynamic psychotherapy higher than do trainees who do not report using these orientations. Conversely, those trainees who report using an interpersonal or an integrative/eclectic orientation rate the likely efficacy of psychodynamic psychotherapy lower than do those who do not endorse these orientations.

Multivariate results for beliefs about the efficacy of psychodynamic psychotherapy

Table 5-H presents the ANCOVA results for trainees' rating of the likely effectiveness of psychodynamic psychotherapy. The model explains thirty-two percent of the variance in trainees' beliefs regarding the efficacy of psychodynamic psychotherapy. Using a psychodynamic orientation is (unsurprisingly) significantly associated with a higher effectiveness rating for psychodynamic psychotherapy. Results indicate that after controlling for other trainee characteristics, professional affiliation continues to be associated with trainees' efficacy ratings for psychodynamic psychotherapy ($F(2,85) = 7.1$; $p = .001$; partial $\eta = .378$). I ran a multiple comparisons/post-hoc test to determine which professional groups had significant mean differences. Clinical psychology trainees rate the likely efficacy of psychodynamic psychotherapy significantly lower than do social work trainees ($p < .001$) and psychiatry residents ($p < .01$). Thus, the data confirm Hypothesis 4h.

Bivariate results for beliefs about efficacy of cognitive-behavioral therapy

Hypothesis 4j predicts that clinical psychology trainees will rate the likely effectiveness of cognitive-behavioral therapy higher than will psychiatry residents. Table 5-I presents the results of the bivariate analyses for trainees' rating of cognitive-behavioral therapy's likely efficacy. The only independent variable associated with trainees' rating of cognitive behavioral therapy's likely effectiveness is race. Minority trainees rate the likely efficacy of cognitive-behavioral therapy slightly higher than do white trainees ($t = -2.2$; $df = 101$; $n = 103$; $p = .03$). Somewhat surprisingly, neither professional affiliation nor cognitive-behavioral orientation are associated with how trainees rate the likely effectiveness of cognitive-behavioral therapy in bivariate analyses.

Instead, trainees tend to give cognitive-behavioral therapy high efficacy marks regardless of their professional affiliation and theoretical orientation(s). Indeed, of all the interventions that trainees were asked to rate, trainees as a whole grant cognitive-behavioral therapy the highest likely efficacy rating, an average score of 7.9 out of 9, where a score of 9 indicates an intervention is likely to be "extremely effective."

Multivariate results for beliefs about the efficacy of cognitive-behavioral therapy

Table 5-J presents the ANCOVA results for trainees' rating of the likely effectiveness of psychodynamic psychotherapy. The model predicts only two percent of the variance in trainees' ratings, and none of the independent variables are significantly associated with trainees' cognitive-behavioral therapy ratings. Thus, the data do not support Hypothesis 4j. Clinical psychology trainees do not rate the likely effectiveness of cognitive-behavioral therapy higher than do psychiatry residents.

Bivariate results for beliefs about efficacy of family and couples therapy[22]

Hypothesis 4l predicts that social work trainees will rate the likely efficacy of family or couples therapy higher than will clinical psychology trainees and psychiatry residents. Table 5-K presents the results of the bivariate analyses for trainees' rating of family/couples therapy's likely efficacy. A trainee's belief about how efficacious family/couples therapy would be is significantly associated with a trainee's professional affiliation ($F(2,99) = 19.2$; $n = 102$; $p < .001$). Social work trainees rate the likely efficacy of family/couples therapy considerably higher ($M = 7.0$; $sd = 1.7$) than do both

[22] On the survey (see Appendix 3-C), trainees were asked to rate the likely effectiveness of family therapy and couples therapy separately (Questions 11e and 11f). For purposes of analysis, trainees' ratings of the effectiveness of family therapy and couples therapy have been combined. That is, a trainee's family/couples therapy efficacy score represents the average of a trainee's score on Survey Question 11e and Survey Question 11f.

clinical psychology trainees (M = 4.4; sd = 1.6; $p < .001$) and psychiatry residents (M = 5.6; sd = 1.7; p = .002). Additionally, psychiatry residents rate the likely efficacy of family/couples therapy higher than do clinical psychology trainees (p = .028).

A trainee's belief about the efficacy of family/couples therapy is also associated with gender (t = -2.4; df = 100; n = 102; p = .017), and with the family-systems (t = -2.8; df = 96; n = 98; p = .007), strengths (t = -2.9; df = 96; n = 98; p = .004), person-in-environment (t = -3.7; df = 96; n = 98; $p < .001$), and integrative/eclectic (t = 2.1; df = 96; n = 98; p = .041) orientations. Female trainees rate the likely efficacy of family/couples therapy higher than do male trainees. Also those who report using the family-systems, strengths, or person-in-environment orientation rate the likely efficacy of family/couples therapy higher than do trainees who do not report using these orientations. In contrast, trainees who report using an integrative/eclectic orientation to care rate the likely efficacy of family/couples therapy lower than do those who do not report using an integrative orientation.

Multivariate results for beliefs about the efficacy of family/couples therapy

Table 5-L presents the ANCOVA results for trainees' rating of the likely effectiveness of family/couples therapy. The model explains thirty-one percent of the variance in trainees' beliefs regarding family/couples therapy's efficacy. Neither gender, an integrative/eclectic orientation, nor the family-systems, strengths, or person-in-environment orientation predict trainees' efficacy ratings for family/couples therapy once other independent variables are taken into account. A trainee's race, however, proves a significant predictor of her rating of the likely efficacy of family/couples therapy; minority respondents rate the likely efficacy of family/couples therapy higher than do white respondents.

Results indicate that after controlling for other trainee characteristics, professional affiliation continues to be associated with trainees' efficacy ratings for family/couples therapy ($F(2,85) = 9.8$; $p < .001$; partial $\eta = .432$). A multiple comparisons/post-hoc test uncovers the same pattern of differences that the bivariate analysis reveals. That is, social work trainees rate the likely efficacy of group therapy significantly higher than do both clinical psychology trainees ($p < .001$) and psychiatry residents ($p = .001$). Additionally, psychiatry trainees rate the likely efficacy of family/couples therapy higher than do clinical psychology trainees ($p = .021$). Thus, the data confirm Hypothesis 4l: social work trainees rate the likely efficacy of family/couples therapy higher than do their counterparts from other professional groups.

Bivariate results for beliefs about efficacy of inpatient hospitalization

Hypothesis 4n predicts that psychiatry residents will rate the likely efficacy of inpatient hospitalization for Jessica higher than will their equivalents in clinical psychology and social work. Table 5-M presents the results of the bivariate analyses for trainees' rating of inpatient hospitalization's likely efficacy. Psychiatry residents ($M = 2.7$; $sd = 1.5$) rate inpatient hospitalization's likely efficacy slightly higher than do both social work ($M = 2.4$; $sd = 1.4$; $p = n.s.$) and clinical psychology ($M = 1.7$; $sd = 1.4$; $p = .03$) trainees ($F(2,100) = 3.5$; $n = 103$; $p = .035$), although the difference is only significant between psychiatry residents and clinical psychology trainees. Thus, the bivariate analysis of inpatient hospitalization rating by professional affiliation partially supports Hypothesis 4n.

In addition to professional affiliation, trainees' efficacy scores for inpatient hospitalization are also associated with the primary diagnosis trainees assign Jessica ($F(3,97) = 3.5$; $n = 101$; $p = .018$), as well as whether or not a trainee regularly uses the

medical/biological (t = -3.3; df = 97; n = 99; p = .001) and psychodynamic (t = -3.9; df = 91; n = 99; p < .001) orientations. Specifically, those trainees that assign Jessica a panic disorder diagnosis (M = 1.3; sd = 0.5) offer a significantly lower likely efficacy score for inpatient hospitalization than do those trainees that assign Jessica a major depressive disorder (M = 2.9; sd = 1.7; p < .001) or a generalized anxiety disorder (M = 2.3; sd = 1.3; p = .002) diagnosis. Conversely, those trainees who regularly use the medical/biological (M = 2.7; sd = 1.6; p = .001) and the psychodynamic (M = 2.8; sd = 1.6; p < .001) orientations rate the likely efficacy of inpatient hospitalization higher than do those trainees who do not use these orientations.

Multivariate results for beliefs about efficacy of inpatient hospitalization

Table 5-N presents the ANCOVA results for trainees' rating of the likely effectiveness of inpatient hospitalization. The model explains twenty percent of the variance in trainees' beliefs regarding inpatient hospitalization's efficacy. After controlling for the effect of multiple predictors, neither professional affiliation nor a medical/biological orientation continue to be significantly associated with the likely efficacy score trainees give inpatient hospitalization. Thus, the data do not uphold hypothesis 4n. The primary diagnosis a trainee assigns (F(3,86) = 3.1; p = .031; partial η = .313), however, as well as a trainee's use of the psychodynamic orientation (F(1,86) = 4.3; p = .042; partial η = .217), do continue to be significantly associated with the likely efficacy rating a trainee gives inpatient hospitalization. The regular use of the psychodynamic orientation is associated with a higher likely efficacy score for inpatient hospitalization. Compared to those trainees who assign a major depressive disorder diagnosis, trainees who assign a panic disorder diagnosis tend to consider inpatient hospitalization less beneficial (p = .004).

Bivariate results for beliefs about efficacy of interpersonal psychotherapy

I made no predictions about how one's professional affiliation would affect trainees' likely efficacy ratings for interpersonal psychotherapy. Nevertheless, I report on which trainee characteristics are associated with the efficacy ratings for this intervention below. Trainees gave interpersonal psychotherapy relatively high average efficacy marks overall. Table 5-O presents the results of the bivariate analyses for trainees' rating of the likely efficacy of interpersonal psychotherapy. A trainee's belief about how efficacious interpersonal psychotherapy would be is significantly associated with a trainee's professional affiliation ($F(2,101) = 10.1$; $n = 104$; $p < .001$). Social work trainees ($M = 8.0$; $sd = 1.3$) give interpersonal psychotherapy significantly higher likely efficacy ratings than do psychiatry residents ($M = 6.5$; $sd = 1.5$; $p < .001$) or clinical psychology trainees ($M = 6.8$; $sd = 2.0$; $p = .04$).

Trainees' efficacy ratings for interpersonal psychotherapy are also associated with the primary diagnosis a trainee assigns Jessica ($F(3,98) = 2.8$; $n = 102$; $p = .04$), as well as with the family-systems ($t = -2.1$; $df = 98$; $n = 100$; $p = .04$), strengths ($t = -3.2$; $df = 98$; $n = 100$; $p = .002$), and person-in-environment orientations ($t = -2.8$; $df = 93$; $n = 100$; $p = .006$). With respect to primary diagnosis, those trainees who assign Jessica a panic disorder diagnosis rate the likely efficacy of interpersonal psychotherapy lower than do those who assign Jessica one of the less-severe diagnoses (such as dysthymia) that have been combined into the 'other diagnosis' category. With respect to theoretical orientations, those trainees who endorse the family-systems orientation, strengths orientation, or person-in-environment orientation rate the likely efficacy of interpersonal therapy higher than do those who do not endorse these orientations.

Multivariate results for beliefs about the efficacy of interpersonal psychotherapy

Table 5-P presents the ANCOVA results for trainees' ratings of the likely efficacy of interpersonal therapy. The model explains seventeen percent of the variance in trainees' beliefs regarding interpersonal psychotherapy's efficacy. After controlling for the effects of other variables on a trainee's ratings, a trainee's professional affiliation ($F(2,88) = 4.5$; $p = .014$; partial $\eta = .305$) and the diagnosis she assigned Jessica ($F(3,88) = 2.7$; $p = .05$; partial $\eta = .292$) continue to significantly predict her score of the likely efficacy of interpersonal psychotherapy. A family-systems, strengths, or person-in-environment orientation, however, no longer significantly predict a trainee's interpersonal efficacy rating once other factors are taken into account. Once other factors were controlled for, a multiple comparisons/post-hoc test reveals that social workers' and psychiatrists' efficacy scores for interpersonal psychotherapy differ significantly ($p < .001$). A post-hoc test, however, does not uncover significant differences between efficacy scores based on the diagnosis trainees assign.

Trainees' Treatment Recommendations

In line with the predictions I made about how trainees would rate the likely efficacy of various interventions, I also predict that the type of interventions that trainees plan to provide or refer to will differ along professional lines. That is, trainees will be more likely to steer towards interventions that fit well with their occupation's professional logic, and towards interventions that members of their profession have historically done and/or been trained to do. Specifically, the following section examines what proportion of trainees recommend psychopharmacology, psychodynamic psychotherapy, cognitive-behavioral therapy, family or couples therapy, inpatient hospitalization, and interpersonal psychotherapy.

Bivariate results for psychopharmacology recommendation

Psychopharmacology or drug treatment is a particularly popular recommendation – second only to cognitive-behavioral therapy – with three-quarters of trainees recommending a medication consult (n = 105). Hypothesis 4g predicts that psychiatry residents will be more likely to provide or refer[23] for psychopharmacology than will clinical psychology trainees; moreover, Hypothesis 4g predicts clinical psychology trainees will be more likely to refer for psychopharmacology than will social workers. Table 5-Q presents the bivariate crosstabulation analyses for the provision or referral of psychopharmacology. The psychopharmacology-recommendation-by-professional-program crosstabulation supports Hypothesis 4g[24]. Psychiatry residents are nearly unanimous (96.9%) in their recommendation for a medication consult, compared to about three-quarters (73.9%) of clinical psychology trainees and three-fifths (62.0%) of social work trainees (χ^2 = 12.8, df = 2, n = 105, φ = .349, p = .002). A recommendation for psychopharmacology is also associated with the biomedical (χ^2 = 11.5, df = 1, n = 101, φ = .338, p = .001), psychodynamic (χ^2 = 7.9, df = 1, n = 101, φ = .280, p = .005), family-systems (χ^2 = 6.5, df = 1, n = 101, φ = -.254, p = .011), and person-in-environment (χ^2 = 4.5, df = 1, n = 101, φ = -.210, p = .035) orientations. Endorsing the biomedical (87.5%) or psychodynamic (85.5%) orientations is associated with a higher likelihood of a

[23] Respondents answered an open-ended question about referral(s) (Q. #13a) that I then coded into binary referral variables such as 'refer for psychopharmacology,' yes or no. Throughout this section on treatment recommendations, respondents who indicated that they would personally provide a particular service (e.g., psychopharmacology), and those who indicated that they would refer Jessica for that service are both counted as recommending that particular treatment intervention. Certain services (psychodynamic psychotherapy, cognitive behavioral therapy, and interpersonal psychotherapy) did not merit a mention by any of the respondents when they were asked about types of services to which they would refer Jessica. In those cases, the section on that particular intervention discusses treatment *provision* rather than treatment *recommendation or treatment referral.*

[24] A chi-square-crosstabulation analysis, however, does not indicate which categories of the independent variable (professional program) significantly differ from one another on the dependent variable (recommendation for psychopharmacology).

recommendation for psychopharmacology. Conversely, endorsing the family-systems (63.5%) or person-in-environment (62.2%) orientations is associated with a lower likelihood of a recommendation for psychopharmacology.

Multivariate results for psychopharmacology recommendation

Table 5-R presents the results of the logistic regression analysis for a psychopharmacology recommendation. The model, which estimates the impact of individual predictors on the dependent variable while simultaneously controlling for the effects of other predictors, explains forty-four percent of the variance in the decision to recommend a medication consult or not ($\chi^2 = 34.1$, $df = 10$, $n = 97$, $p < .001$). Once multiple factors are accounted for, professional affiliation is no longer significantly associated with trainees' decision to recommend psychopharmacology. Thus, the data do not support Hypothesis 4g.

Compared to a diagnosis of major depressive disorder, a diagnosis of panic disorder ($B = -2.4$, *s.e.* = 1.1, $OR = 0.09$, $p = .034$) is associated with a lower likelihood that a trainee recommends a medication consult. Similarly, endorsing either the family-systems, strengths, or person-in-environment orientations ($B = -2.2$, *s.e.* = 1.0, $OR = 0.1$, $p = .025$) is also associated with a lower likelihood of a psychopharmacology recommendation. In contrast, endorsing the psychodynamic orientation is associated with a greater likelihood of a psychopharmacological recommendation ($B = 1.5$, *s.e.* = 0.7, $OR = 4.6$, $p = .032$).

Bivariate results for psychodynamic psychotherapy provision

Hypothesis 4i predicts that psychiatry residents and social work trainees will be more likely to recommend psychodynamic psychotherapy than will clinical psychology trainees. Table 5-S presents the results of the bivariate analyses predicting

psychodynamic psychotherapy *provision* (please see footnote 7; while some respondents indicate that they would personally provide psychodynamic psychotherapy, none of the respondents indicate that they would *refer* for psychodynamic psychotherapy). Just over 1-in-4 trainees (27.9%; $n = 104$) indicate that they would provide psychodynamic psychotherapy. While a smaller percentage of clinical psychology trainees (17.4%) than psychiatry residents (25.0%) or social work trainees (34.7%) plan to provide psychodynamic psychotherapy, the relationship between professional affiliation and psychodynamic psychotherapy provision does not reach significance ($\chi^2 = 2.5$, $df = 2$, $n = 104$, $\varphi = .156$, $p = .28$). Thus, the bivariate data do not uphold Hypothesis 4i.

In contrast, being a male respondent ($\chi^2 = 5.8$, $df = 1$, $n = 104$, $\varphi = -.237$, $p = .016$), and endorsing a psychodynamic ($\chi^2 = 10.5$, $df = 1$, $n = 100$, $\varphi = .324$, $p = .001$), family-systems ($\chi^2 = 7.9$, $df = 1$, $n = 100$, $\varphi = .281$, $p = .005$), person-in-environment ($\chi^2 = 4.0$, $df = 1$, $n = 100$, $\varphi = .201$, $p = .045$), or humanistic/existentialist/gestalt ($\chi^2 = 6.7$, $df = 1$, $n = 100$, $\varphi = .259$, $p = .01$) orientation are each significantly associated with the provision of psychodynamic psychotherapy. Male trainees, as well as trainees that endorse a psychodynamic, family-systems, person-in-environment, or humanistic/existentialist/gestalt orientation, are significantly more likely to provide psychodynamic psychotherapy.

Multivariate results for psychodynamic psychotherapy provision

Table 5-T presents the results of the multivariate logistic regression performed on psychodynamic psychotherapy provision. The model explains thirty-three percent of the variance in psychodynamic psychotherapy provision ($\chi^2 = 24.6$, $df = 10$, $n = 97$, $p = .006$). A trainee's professional affiliation is not significantly associated with her decision to provide psychodynamic psychotherapy or not. Thus, the data do not support

Hypothesis 4i. Unsurprisingly, reporting the regular use of the psychodynamic theoretical orientation with clients is significantly associated with a greater likelihood that a trainee provides psychodynamic psychotherapy (B = 1.7, *s.e.* = 0.7, OR = 5.5, p = .011). Additionally, being a male provider is associated with a greater likelihood that a trainee provides psychodynamic psychotherapy (B = -1.8, *s.e.* = 0.7, OR = 0.2, p = .019).

Bivariate results for cognitive-behavioral therapy provision

More than three-in-four trainees (76.9%, n = 104) report that they would provide cognitive-behavioral therapy, just surpassing the proportion who recommend psychopharmacology (75.2, n = 105), making it the treatment recommendation endorsed most often by respondents. Hypothesis 4k predicts that clinical psychology trainees will be more likely to recommend cognitive-behavioral therapy than will psychiatry residents. Table 5-U presents the results of the bivariate crosstabulation analyses with the provision of cognitive-behavioral therapy as the dependent variable. While a greater percentage of clinical psychology trainees (91.3%) than psychiatry residents (71.9%) report that they would provide cognitive-behavioral therapy, professional affiliation is not significantly associated with the provision of cognitive-behavioral therapy. Thus, the bivariate analysis of cognitive-behavioral-therapy-provision by professional affiliation does not support Hypothesis 4k. Providing cognitive-behavioral therapy is, however, associated with regularly using a cognitive-behavioral orientation (χ^2 = 11.5, df = 1, n = 100, φ = .338, p = .01) and with regularly using an integrative/eclectic orientation (χ^2 = 6.7, df = 1, n = 100, φ = .260, p = .009). The use of these orientations is associated with a higher likelihood of providing cognitive-behavioral therapy.

Multivariate results for cognitive-behavioral therapy provision

Table 5-V presents the results of the logistic-regression analysis for the provision of cognitive-behavioral therapy. The model (χ^2 = 22.5, *df* = 9, *n* = 97, *p* = .007) explains thirty-two percent of the variance in cognitive-behavioral therapy provision. Only choosing the cognitive-behavioral orientation as one of the orientations that guides the majority of treatment sessions is associated with the provision of cognitive-behavioral therapy. Specifically, the cognitive-behavioral orientation is associated (again, unsurprisingly) with a greater likelihood of providing cognitive-behavioral therapy (*B* = -1.8, *s.e.* = 0.7, *OR* = 0.2, *p* = .019). None of the other independent variables are significantly associated with providing cognitive-behavioral therapy. Therefore, Hypothesis 4k, which predicts that clinical psychology trainees will recommend cognitive-behavioral therapy more often than psychiatry residents will, is not supported by the data.

Bivariate results for family/couples therapy recommendation

Hypothesis 4o predicts that social work trainees will be more likely to provide or refer to family or couples therapy than will clinical psychology trainees or psychiatry residents. Table 5-W presents the results of the bivariate analyses for family/couples therapy recommendation. A third of trainees recommend family/couples therapy (35.8%, *n* = 106). The recommendation for family/couples therapy, however, is associated with a trainee's professional affiliation in the manner hypothesized (χ^2 = 17.1, *df* = 2, *n* = 106, φ = .401, *p* < .001). More than half of social work trainees (54.9%) recommend family/couples therapy, compared to only one-in-four psychiatry residents (25%) and less than one-in-ten clinical psychology trainees (8.7%). Thus, the bivariate analysis between professional affiliation and family/couples therapy recommendation supports Hypothesis

4o. Additionally, using a person-in-environment orientation is positively associated with a recommendation for family/couples therapy ($\chi^2 = 6.7$, $df = 1$, $n = 101$, $\varphi = .258$, $p = .01$).

Multivariate results for family/couples therapy recommendation

The results of the logistic regression analysis for family/couples therapy recommendation are presented in Table 5-X. The model predicts thirty-five percent of the variance in family/couples therapy recommendation ($\chi^2 = 28.8$, $df = 8$, $n = 97$, $p < .001$). Professional affiliation remains significantly related to the decision to provide or refer to family/couples therapy after accounting for the effects of multiple covariates. Compared to being enrolled in the social work program, enrollment in the clinical psychology program reduces the odds of a family/couples therapy recommendation by ninety-five percent ($B = -3.1$, *s.e.* = 1.0, $OR = 0.05$, $p = .002$), while enrollment as a resident in the psychiatry program reduces the odds of a family/couples therapy recommendation by eighty-nine percent ($B = -2.2$, *s.e.* = 0.8, $OR = 0.11$, $p = .005$). Thus, the data support Hypothesis 4o. The other significant predictor of a family/couples therapy recommendation is primary diagnosis. Compared to choosing a diagnosis of major depressive disorder, choosing panic disorder ($B = -2.6$, *s.e.* = 1.2, $OR = 0.08$, $p = .033$) reduces the odds of a trainee prescribing family/couples therapy by ninety-two percent.

Bivariate results of inpatient hospitalization recommendation

Hypothesis 4n predicts that psychiatry residents will be more likely to recommend inpatient hospitalization than will clinical psychology or social work trainees. Table 5-Y presents the bivariate analyses for a recommendation of inpatient hospitalization. Inpatient hospitalization is a particularly unpopular option among the mental health trainees. Only two respondents (1.9%, $n = 106$) indicate that they would recommend a

hospital stay. Neither of the two respondents were psychiatry residents; thus, the data do not support Hypothesis 4n. While a recommendation of inpatient hospitalization is unpopular among all groups of trainees, a number of trainee characteristics *are* associated with a greater likelihood of recommending an inpatient stay. Specifically, male trainees compared to female trainees ($\chi^2 = 7.4$, $df = 1$, $n = 106$, $\varphi = -.263$, $p = .007$), and trainees who regularly employ the humanistic/existentialist/gestalt orientation ($\chi^2 = 8.3$, $df = 1$, $n = 106$, $\varphi = .286$, $p = .004$), in addition to those who employ an integrative or eclectic orientation ($\chi^2 = 5.9$, $df = 1$, $n = 106$, $\varphi = .241$, $p = .015$) are more likely than trainees who do not employ these orientations to recommend inpatient hospitalization.

The near-unanimity among trainees in their decision not to recommend inpatient hospitalization makes it impossible to perform a multivariate-logistic-regression analysis for this variable. Thus, it is not possible to determine which – if any – trainee characteristics would be significantly associated with an inpatient hospitalization recommendation while simultaneously controlling for other factors that may affect this decision. The cogent point, however, is that very few trainees would recommend an inpatient stay given the information contained in the case study.

Bivariate results of interpersonal psychotherapy provision

Just as I made no predictions in Chapter 2 about how trainees would rate the likely effectiveness of interpersonal psychotherapy, I likewise made no predictions about which groups of trainees would be more likely to recommend this type of therapy. Just as I reported trainees' responses regarding the likely effectiveness of interpersonal psychotherapy, however, so too do I report trainees' responses regarding the possible recommendation of this intervention in the section that follows.

Table 5-Z presents the results of the bivariate analyses for interpersonal psychotherapy provision. A trainee's professional affiliation is significantly associated with her decision to provide Jessica with interpersonal psychotherapy or not ($\chi^2 = 22.9$, $df = 2$, $n = 104$, $\varphi = .469$, $p < .001$). Less than one-in-five psychiatry residents indicate that they would provide interpersonal psychotherapy, compared to more than two-in-three clinical psychology (69.6%) and social work (69.4%) trainees. Providing interpersonal psychotherapy is also associated with the use of the interpersonal theoretical orientation ($\chi^2 = 14.2$, $df = 1$, $n = 100$, $\varphi = .377$, $p < .001$), the person-in-environment orientation ($\chi^2 = 7.5$, $df = 1$, $n = 100$, $\varphi = .274$, $p = .006$), and the humanistic/existentialist/gestalt orientation ($\chi^2 = 4.4$, $df = 1$, $n = 100$, $\varphi = .211$, $p = .035$). Trainees using each of these orientations are more likely to provide interpersonal psychotherapy than those trainees who do not report the regular use of these orientations.

Multivariate results for interpersonal psychotherapy provision

Table 5-AA presents the results of the logistic-regression analyses for interpersonal psychotherapy provision. The model explains forty-two percent of the variance in trainees' decision about whether or not to provide interpersonal psychotherapy ($\chi^2 = 36.2$, $df = 10$, $n = 97$, $p < .001$). After controlling for multiple factors that may affect interpersonal psychotherapy provision, a trainee's reported use of the interpersonal orientation and a trainee's professional affiliation both continue to be significantly associated with a trainee's choice to provide interpersonal psychotherapy or not. Unsurprisingly, those trainees with an interpersonal theoretical orientation are more likely to provide interpersonal psychotherapy ($B = 1.4$, $s.e. = 0.6$, $OR = 4.1$, $p = .028$) than are those trainees who do not regularly use the interpersonal orientation in their clinical work. Compared to psychiatry residents, clinical psychology trainees are more

than five times as likely ($B = 1.7$, *s.e.* = 0.9, $OR = 5.2$, $p = .059$), and social work trainees are more than seven times as likely ($B = 2.0$, *s.e.* = 0.7, $OR = 7.6$, $p = .006$) to provide interpersonal psychotherapy.

Section Summary

The amount of consensus in trainees' treatment decisions and beliefs regarding the efficacy of various interventions varies by the type of intervention in question. That is, the degree of institutionalization varies by the type of intervention. Trainees tend to agree about the value of some interventions, yet vary considerably in their views of other interventions based on trainee characteristics such as professional affiliation, theoretical orientation(s), gender, and the primary diagnosis a trainee assigns. Table 5-AB provides an overview of the findings related to trainees' views of the likely efficacy of various treatment and their treatment recommendations.

Trainees largely agree with one another regarding their views of and recommendations for inpatient hospitalization and cognitive-behavioral therapy. That is, given the particulars of Jessica's case history, trainees generally do not see much benefit in a hospital stay, while the vast majority of trainees would provide cognitive-behavioral therapy and believe it would be effective. Both of these interventions, then, represent highly-institutionalized types of treatment. American mental health care since the 1970s has been characterized by deinstitutionalization, or the treatment of the majority of mental health problems in outpatient settings in the community, outside of hospitals or other institutions (Mechanic 2008). Thus, trainees' judgment that the level of severity described in the case study does not meet the threshold for an inpatient stay reflects the trend in mental health care to treat the majority of mental health complaints on an outpatient basis. Cognitive-behavioral therapy, a brand of therapy that is shorter (and thus

more cost-effective) than traditional psychodynamic psychotherapy, and whose manual-based nature (and, thus, replicability) makes it a more suitable candidate for appraisal via randomized clinical trials than more individually-tailored psychotherapy approaches, has become increasingly popular in the mental health field in the last two decades (Dobson and Dozois 2002), especially for use in the treatment of mood and anxiety disorders (Gaudiano 2008). Trainees' judgment that a patient struggling with depression and anxiety would benefit from cognitive-behavioral therapy, then, is a reflection of the widespread belief in the American mental health field that cognitive-behavioral approaches are effective in treating mood and anxiety disorders.

In comparison, the level of institutionalization of psychodynamic psychotherapy and family or couples therapy is low to medium. About twenty-eight percent of respondents (n = 104) recommend psychodynamic psychotherapy and thirty-six percent recommend family/couples therapy (n = 106). Thus, more than a handful but less than a majority recommend these interventions, and professional affiliation shapes trainees' efficacy ratings (with both types of interventions) and recommendations (with family/couples therapy). The following paragraph considers the role of professional affiliation in treatment decisions in more detail.

Professional affiliation shapes trainees' opinions of and recommendations for family/couples therapy and interpersonal psychotherapy, and shapes trainees' opinions of psychodynamic psychotherapy. Social work trainees are more favorable toward and more likely to recommend family/couples therapy than are psychiatry residents and clinical psychology trainees. Social workers' professional logic, a logic that sees individuals' well-being as highly contingent on the health of their relationships with people in their

social networks, is particularly amenable to helping clients navigate their relationships in one of their most central social networks – the family – through family or couples therapy. Psychiatrists' lower endorsement of interpersonal therapy relative to their clinical psychology and social work counterparts seems counterintuitive initially, given that interpersonal psychotherapy was developed by a psychiatrist, Harry Stack Sullivan (Evans 1996). Nevertheless, interpersonal psychotherapy, like behavioral therapy, emerged as an alternative to traditional psychodynamic psychotherapies (Sundberg 2001) which were closely associated in the U.S. with mainstream psychiatry in the middle of the twentieth century (Hirshbein 2004). It is, therefore, understandable that it would be psychiatry's competitors – clinical psychology and, to a lesser extent, social work – rather than the psychiatric profession that would be more likely to adopt the use of interpersonal psychotherapy. Relatedly, given that psychodynamic psychotherapy – developed by a psychiatrist (Freud) and heavily borrowed from by social work (Danto 2009) – was the dominant brand of talk therapy in the mid-twentieth century, it also follows that psychiatry's most formidable challenger (i.e., clinical psychology) would rate the effectiveness of psychodynamic psychotherapy lower than would the other two professional groups of trainees.

Trainees' use of particular theoretical orientations in their clinical work is another factor that shapes trainees' treatment decisions and attitudes toward particular interventions. For example, a trainee's attitude about psychopharmacology's likely efficacy is related to whether or not a trainee takes a biomedical approach to treatment, regardless of that trainee's professional affiliation. Similarly, the decision to recommend for a psychopharmacology consult is also associated with a trainee's choice of theoretical

orientations. It is the use of the psychodynamic and either the family-systems, strengths, or person-in-environment orientations, however, rather than the biomedical orientation that predicts whether or not a trainee recommends that receive a psychopharmacology consult. Indeed, whether or not a trainee uses the psychodynamic orientation is a particular strong predictor of trainees' treatment decisions and beliefs about various treatments' likely effectiveness. The psychodynamic orientation is a significant predictor of the likely effectiveness score and/or recommendation for psychopharmacology, psychodynamic psychotherapy, and inpatient hospitalization.

A trainee's gender also helps predict treatment decisions in the case of particular interventions. Male trainees are more likely than female trainees to recommend psychodynamic psychotherapy and inpatient hospitalization[25]. Psychodynamic psychotherapy tends to be longer-term and more intensive than other brands of psychotherapy such as cognitive-behavioral therapy (Cutler et al. 2004), and inpatient hospitalization is by its nature more restrictive than outpatient interventions. Thus, male trainees may be more likely than female trainees to judge Jessica as needing more intensive, longer-term help. This finding adds to the literature on the impact of mental health clinicians' gender and client/clinician gender matching on treatment approaches and treatment outcomes, a literature characterized by nuanced findings (Barak and Fisher 1989; Beutler et al. 2004). Despite a considerable literature examining potential differences in the mental health field in treatment outcomes and in clinicians' approach by gender, I could find no studies that looked at the possible effect of clinician gender on

[25] I was only able to test the significance of predictors on the recommendation for inpatient hospitalization via a bivariate analysis. Thus, it is unclear whether a trainee's gender and a psychodynamic orientation would still predict a trainee's decision to recommend inpatient hospitalization after other potentially mitigating factors are taken into account.

choice of intervention. The current study finds that a clinician's gender has an effect on certain intervention choices – such as on the decision about whether or not to provide psychodynamic psychotherapy – but not on others, such as on the decision about whether or not to refer for a psychopharmacology consult.

Finally, the primary diagnosis trainees choose is associated with a number of their treatment decisions. Given that a professional's diagnosis of a client's problem is ideally supposed to point to a range of possible treatments and away from other treatments (Abbott 1988), it is not surprising that trainees who arrive at different diagnoses sometimes arrive at different treatment decisions as well. The largest divergence appears between trainees who assign major depressive disorder and those who assign panic disorder. For example, trainees who diagnose major depressive disorder rate the likely efficacy of inpatient hospitalization higher, and are more likely to recommend psychopharmacology and family therapy than are those trainees who diagnose panic disorder. It is unclear why the largest differences in treatment decisions exist between major depressive disorder and panic disorder. If the differences in treatment decisions are due to the fact that one disorder is a mood disorder while the other is an anxiety disorder, then there should be a similar divide between major depressive disorder and generalized anxiety disorder, yet this does not emerge. If the differences are due to the severity of a major depressive disorder diagnosis compared to a panic disorder diagnosis then there should be a similar divide between major depressive disorder and the "other disorder" category which combines a number of less severe diagnoses. Again, this divide also fails to appear. Regardless of the reason behind the specific divergence in some of the treatment decisions for panic disorder and major depressive disorder, however, these

results reinforce the idea that practitioners who see the same patient but identify different salient features in that patient's case history will also – periodically – arrive at different treatment decisions.

TRAINEE-CLIENT RELATIONSHIPS AND TRAINEES' APPROACH TO CARE

In an effort to elicit a more complete picture of the kind of clinical work that trainees routinely engage in, as well as to better understand trainees' approach to treating their patients or clients, I conducted in-depth interviews with a subset of eleven interviewees from each professional program ($N = 33$). Interviewees were asked to describe the "core work" that members of their profession did with clients, and were then asked what that work might entail for a typical client or patient who presented to them with symptoms of depression or anxiety. As trainees described their clinical work, a picture emerged of trainees' relationships with and approach to caring for help-seekers. As was the case when trainees described their use of diagnosis in clinical work, trainees' descriptions of their day-to-day clinical realities and their interactions with help-seekers revealed both points of commonality and points of dissension between the three professional groups.

Commonalities

With respect to commonalities, trainees from all three professional groups a) emphasized the importance of developing a working or therapeutic alliance between clinician and client, b) stressed the necessity of listening, validating, and supporting their clients, c) described the use of psychotherapy in mental health professionals' clinical work, and d) emphasized that treatment plans are not one-size-fits-all; instead, the course of treatment always depends on factors such as the help-seeker's needs and preferences,

the help-seeker's presenting problem(s), and the organizational setting(s) in which care is being provided.

Trainees from each of the three professional groups explained that clinician-client rapport and a common sense of purpose are critical components to therapeutic effectiveness. The following quotes illustrate trainees' estimation of the centrality of a strong therapeutic alliance between clinician and client:

> Social Work Interviewee_F: The majority of the time by building a positive rapport you're going to get more results. And it's something…I just think they feel safer, more comfortable, and these are people even though I've just met them for the first time I actually really care about and so I feel like establishing that bond and trust is pretty paramount to the whole process 'cause if you don't have it, your ability to be effective is pretty compromised.
>
> Psychiatry Interviewee_F: One of the first [objectives I have when I start working with a patient] is always to build a good rapport with the patient, regardless if I'm gonna do therapy or medications, I feel like if the patient can't really trust me or doesn't see me as someone who can be helpful then I start off wrong. So I always try to keep that as my first priority.
>
> Clinical Psychology Interviewee_I: Just as much as [those first few sessions represent] a chance for me to get to know the client, it's a chance for the client to become comfortable with me. In order for the work to proceed there has to be that therapeutic alliance. There has to be that relationship. There are researchers out there that claim that the majority of what is transformative about help therapy is simply that therapeutic alliance. It's these non-specific factors. I don't know if I would go that far, but I think that the non-specific factors are definitely hugely important and that therapy cannot proceed without them.

Thus, trainees from each of the professions stress that building a strong therapeutic alliance based on trust is a necessary first step in working with a client.

According to trainees from each of the professions, a key rapport-building element is compassionate listening on the part of the clinician, also referred to as supportive therapy. Compassionate listening refers to making the client feel heard, validated, and generally supported. When asked to describe the core work that clinical

social workers engage in, for instance, Social Work Interviewee_A responds: "I think it is the ability to listen and validate and empathize with people." Asked to describe the core work psychiatrists do, Psychiatry Interviewee_C describes two separate patient populations, and refers to listening and supporting patients as a critical piece of the work with the less-severe population:

> I think psychiatrists do two things: psychiatrists treat severe, terrible, chronic mental illness like schizophrenia and bipolar disorder and then psychiatrists also do a service to people who, I would say, are more of the walking wounded. Listen to people, make people feel heard, make people feel better, be supportive, offer treatment to people with less severe mental illness who are still having trouble. So I think psychiatrists do two things that are sometimes related but a lot of the times very separate.

Clinical Psychology Interviewee_K likewise describes the role of supportive therapy when beginning work with a client:

> The first few sessions are also largely supportive therapy more than anything. So supportive—my understanding thus far from the supervisors I've had— is helping, being very empathic and letting the client know you're hearing what they say. That you want them to do well and that you care, but also helping them to identify good coping behaviors and what they can do. So, what their resources are right now to maximize whatever they can do to make themselves feel better, and then also identifying things that may be more maladaptive, and things that they should avoid right now.

In addition to the importance of a therapeutic alliance between clinician and client, an alliance dependent on the clinician practicing compassionate listening with her client, the majority of trainees from each of the professions discussed psychotherapy as an integral part of the mental health clinician's repertoire.[26]

Finally, the last point on which virtually all trainees agreed was that a clinician's approach to patient care could not be fully standardized. Instead, the types of

[26] Not every trainee who mentioned talk therapy as a piece of the "core work" that their profession engages in plans to practice psychotherapy once graduating. However, virtually all trainees identified psychotherapy as a popular and useful intervention in the treatment of patients or clients presenting with symptoms of depression and anxiety.

interventions used and focus of care depends on patient characteristics and on the type of setting (e.g., inpatient vs. outpatient) in which care is provided. When asked to describe what "typically" would take place between clinician and client when a client presented for mental health care, the trainees explained that treatment plans are contingent both on the individual seeking help, and on the treatment setting and the role the clinician is expected to play in that treatment setting. Clinical Psychology Interviewee_B, for example, explains that the client's objectives are paramount:

> Well, first thing I would need to know is what they are in for. Or what their goal is. Because someone might walk into the therapy office or whatever, and I might see, you know, fifteen things that seem to be the problem for them, and they might say, "Yeah, I've got that in my family relationships, but what I really want to do is work on my test anxiety." They seem really separate to me, you know the client can say, "I can talk about my mom but I don't want to." You know, and they say "I want help with the test," then, you know, I can't make that person talk about something they don't want to talk about… so a client's goal, what they want to get out of therapy is the most important thing to me.

Psychiatry Interviewee_H similarly explains that what the patient wants is going to affect treatment recommendations:

> So, basically, I'm going to determine after a couple of evaluation sessions whether the patient is someone who would benefit from therapy and whether they're interested in investing the time and money to come weekly or biweekly. And if they're not, I'll probably end up seeing them once a month for medication management. Most people, you see, can benefit from therapy. So, you know, it's usually more based on what they want and not the fact that I wouldn't be recommending it. If the person's invested in wanting to get therapy, wanting to come in every week and can afford it, then I'd be willing to see most people for, you know, weekly sessions, and probably several of those people, you know, some percentage I really don't know what, will end up on both medications and seeing me for therapy.

In addition to the patient's goals for treatment, treatment recommendations are also going to depend on the patient's circumstances, including the patient's diagnosis:

> Psychiatry Interviewee_B: Part of it is what they want, but the majority of it is based on what they have, what their DSM criteria is, their diagnosis is, and what the evidence, good standards of clinical practice indicate is the treatment. And

> then I will offer that treatment in all of its variations, whether it's meds and therapy, therapy only, meds only, you know whatever it is I will say these are the accepted treatment practices. You know, "I would recommend X, Y, Z, or a combination. What, if any of these, are you comfortable with?"

Finally, the organizational setting in which care is to be provided and the role that a clinician is expected to play in that setting both determine a trainee's approach to clinical care. Social Work Interviewee_D, for example, explains that the treatment goals for the same patient or client depend on the organizational setting in which they are receiving care:

> You have to take the policy of the organization for whom you're working into account…my goals in an inpatient mental health facility are gonna be very different from my goals as, say, an outpatient therapist… with the inpatient mental health facility, the goal is stabilization, whether it's getting clean from alcohol or drugs or stabilizing a person's, the symptoms that are borne out of a particular diagnosis…[in an outpatient setting] the goals then differ because you can focus more in-depth on resolving the issues surrounding depression, relationship issues, anxiety, on a longer-term basis. It's really contingent on how long the patient can see you. I mean you have to take that into account. Because the last thing you want to do – the goals are, the goals that you come… are not only for the client's best interest but it's also how many times are you gonna be meeting with this client? What is the setting? What is the organization? I mean, you have to take all of that into account if you're going to be ethical about it. And mainly you don't want to open up something you can't close up.

Psychiatry Interviewee_C similarly discusses the difference between treating a depressed person in an inpatient unit versus treating that same person on an outpatient basis:

> So a depressed patient in an inpatient, you don't get to be on an inpatient unit for depression unless you're a danger to yourself or others. It's very, an inpatient unit is very focused on 'are you a danger to yourself?' You know, how can we transition this patient out of the hospital such that they will be safe and into the care of another professional? So, typically if I'm seeing someone as an outpatient, I'm not working on their suicidality. They're not suicidal. Or if they are, it's like this chronic suicidality and they're not going to do anything imminently but we're dealing with issues of how hard life is. But when someone gets to be acutely suicidal and going to do something that minute then that's when they have to be in the inpatient hospital until that passes. So if you're on the inpatient unit, you want to establish a good relationship with somebody, but it's very focused on 'are you a danger?' Once they're not a danger, they're out.

Thus, a number of trainees from each of the professions discussed the use of psychotherapy in clinical work, discussed the importance of a therapeutic alliance borne out of compassionate listening on the part of the clinician, and explained that treatment plans are always dependent on factors such as a patient's individual characteristics and the setting in which care is provided. On a number of aspects of care, however, a trainee's professional affiliation strongly shapes her clinical approach. I now turn to the aspects of care that differ based on professional affiliation.

Differences by Professional Affiliation

Four aspects of trainees' approach to care differ based on professional affiliation. These include a) whether trainees view psychotherapy or medication as the primary treatment intervention for most of their patients; b) the amount of focus they place on bolstering a client's strengths versus alleviating a client's negative symptoms and behaviors; c) whether they view linking a client or patient up with community resources as part of their clinical mandate; and d) the appropriate tenor of the relationship between clinicians and their clients/patients.

Centrality of medication vs. centrality of psychotherapy

While many trainees from each of the professional schools mentioned psychotherapy as a type of the core clinical work done by members of their profession, professional affiliation shapes whether a trainee considers psychotherapy or psychopharmacology as more important to the progress of a patient exhibiting signs of depression and anxiety. When asked to compare the approach taken by different types of mental health professionals, trainees from all three professions stated that typically psychiatrists' main focus is on psychiatric medications, rather than on psychotherapy,

while clinicians from the other professions consider medication as secondary to psychotherapy:

> Psychiatry Interviewee_K: Obviously psychologists are focusing more on -- I mean, their primary focus is gonna be therapy -- as opposed to psychiatrists it's gonna be primarily medications. Social workers are more focused on therapy as well as other aspects of the patient's life, like their housing, their finances, helping provide resources for the patient, things like that.
>
> Social Work Interviewee_B: I found that in my experience and exposure to psychiatrists that they - I almost want to say that psychiatrists are more dedicated to the DSM, meaning that they want to go after "Okay, what are your symptoms? What are you struggling with?" Because that helps them know what medications they need to use. And that's pretty much all they care about is: "What are you presenting with? Okay. This medication works." They really don't want to get into the reasoning behind it or how you're feeling. I mean, they want to know how you're feeling once you're on medication. "Are you feeling less depressed? Are you feeling less anxious?" if they're giving you medication to target that. That's been my experience. They want to go straight for, "I want to get the information I need to know whether or not you're on the right medication."
>
> Clinical Psychology Interviewee_I: One of the big differences between clinical psychologists and psychiatrists, the psychiatrists are more focused on more the medical stuff, the medication, that kind of thing. They're more focused on that kind of stuff and any sort of talk therapy, that's kind of a little bonus but it's not the important part, it's more about check-in, "Okay, how are the symptoms? The symptoms are okay, fine." Clinical psychologists are more about talking to people, they're more into the therapy aspect of things. So in my view therapy is the key, medication may be a catalyst to that, but therapy really has something going for it. Now the psychiatrist is probably going to say okay, medication is the key, medication is the crux of it, that's what we're going to fix and then the talking part of it, that's more secondary.

Thus, while psychiatrists tend to focus more on medication management than they do on psychotherapy, clinical psychologists and social workers place greater emphasis on psychotherapy than on psychoactive medication.

Focus on client strengths vs. focus on alleviating psychopathology

The mental health professions also differ in the amount of emphasis they place on bolstering a client's strengths or positive attributes versus alleviating a client's problems.

Some trainees from each of the professions discuss targeting and relieving maladaptve thoughts and behaviors as a focus of their clinical work. A greater percentage of social work interviewees, however, discuss bolstering client strengths (7 of 11, or 63.6%) than discuss alleviating problems (3 of 11, or 27.2%). Conversely, a greater percentage of clinical psychology trainees (8 of 11, or 72.7%) and psychiatry residents (6 of 11, or 54.5%) discuss alleviating and preventing negative symptoms than discuss shoring up assets (3 of 11, or 27.2% of clinical psychology trainees and 2 of 11, or 18.2% of psychiatry residents). The following quotes from social workers are examples of their focus on bolstering clients' strengths:

> Social Work Interviewee_E: Yeah, I personally am very strengths-based… there are a lot of people with just depression and feeling beaten down and, you know, especially in the setting I see them –they're just in crisis. Like even in talking with the family members, doing a family contact and sessions and stuff. Just, you know, they're just so down, they've dealt with this problem so much and they see it as this huge overwhelming problem. I then come in and say: "Oh my gosh, you have a stable place to live, you have X, Y, and Z, that's great!" and really just kind of focusing more on all those things they *do* have. I just like to do that. But I think that's also very social-workery.

Similarly, Social Work Interviewee_B, when asked to compare the approaches taken by different mental health professions, had this to say:

> Clinical psychologists, for me, I guess just my exposure to them, and I'm not saying all of them are like this, because I know some that aren't. But they tend to be a little more problem-focused, versus social work education puts a big emphasis on, like, rights, the right of clients to have a part in their treatment and in their goal planning. And talks a lot about, you know, salutes strengths-based perspective, solution-focused. Not focusing on pathology but on positive things and how that can really affect a person's mindset and view of themselves and just not slapping a diagnosis on someone and then start defining themselves as "I'm a schizophrenic," or whatever it is.

In contrast, psychiatry residents and clinical psychology trainees tend to refer to their core work in terms that stress reducing pathology, symptoms, and unhealthy thoughts and behaviors rather than building on help-seekers' existing assets. Examples of psychiatry

and clinical psychology interviewees' description of their core work include "reduc(ing) the pain of mental illness" (Psychiatry Interviewee_E), "provid(ing) something for their problems there in the moment" (Psychiatry Interviewee_C), and "preventing more maladaptive behaviors. So finding ways to stop sort of the train wrecks that we really often see" (Clinical Psychology Interviewee_C).

Helping clients access community resources

While psychiatry residents stand out from the other two groups by stressing the centrality of medication over psychotherapy, and social work trainees stand apart by more often taking a strengths-based perspective versus focusing on the reduction of psychopathology, clinical psychology trainees stand apart due to their relative *lack* of focus on helping clients access community resources. Connecting clients with resources is a large part of a social worker's job, as Social Work Interviewee_F asserts:

> A part of being a social worker is being aware of all the different types of agencies that can help them in various ways, resources that are available, connections with other social service agencies in the area.

Social Work Interviewee_H describes the core work that clinical social workers do in the following way:

> We are supposed to do the individual counseling, the skill-building groups and things like that, but also really cater towards the meso- and macro-levels. Make sure that all of their other needs are being met. Like I said earlier, if they're in a domestic-violence situation get them connections or resources to kind of get out of that. If they're complaining about lack of food or health care, get them connections to that. That's what I think clinical social work really is. It's the individual counseling but it's also connecting through resources and kind of networking for the client or giving them the opportunity to do that.

A number of psychiatry residents also mentioned how connecting patients with community resources constitutes a large part of their job as residents:

> Psychiatry Interviewee_H: I think I probably underestimated how much, I mean, I hesitate to call it social work, but in a sense social work, that we do. You know,

> helping people with housing, helping people with financial resources, helping people engage support in their, you know, environment in terms of family and friends that can help them. All kinds of sort of plans that don't necessarily, aren't necessarily specifically related to what their mental illness might be, but that affect it. You know, so helping them decide things that are going on outside of just their mental illness, that are going on in their life, that will help or hurt them -- I think becomes a lot of what we do.

Similarly, Psychiatry Interviewee_G explains that treating children with mental health problems frequently involves linking the child and her family up with community resources:

> So that would include, essentially, medication, therapy, and I think therapy in the broad sense of both kind of working with the individual kid, working with the family, working with the environment within which they function and for kids, that's school. But if they're involved with DFACS [Department of Family and Children's Services] or DJJ [Department of Juvenile Justice], working with those agencies. That would also, I think, include giving them -- arming them with coping skills and other social outlets, whether that's kind of sports, church, other community kind of groups in support of their overall functioning.

Thus, both social work and psychiatry interviewees refer to helping patients or clients access needed resources. While social work interviewees seemed to consider this a key piece of their work with clients, however, psychiatry residents spoke about resource referrals as a subsidiary part of their jobs.

In contrast, the only mentions the clinical psychology interviewees made of linking their clients up with resources came when they were asked to compare the work clinical psychologists do with that of other mental health professionals. In both instances, the interviewees explained that clinical psychologists were not as adept at helping clients access community resources as are social workers:

> Clinical Psychology Interviewee_H: I think for the clinical social workers they have to, they get into the client's environment whereas our clients come to us. Whereas social workers would really take a systems perspective in being able to use the community resources to help their clients.
>
> Interviewer: And you don't feel that clinical psychologists do the same?

> Clinical Psychology Interviewee_H: I think they do but that their adeptness is probably less.

> Clinical Psychology Interviewee_E: The clinical social workers, they, they have, I think, and I don't know exactly the ins- and outs- of what they do, but I think that they are, they have more talent and training in general social issues, transitional housing. You know, we had something come up the other day where someone [a client] was very distressed and had basically lost their housing and didn't know what to do and we really had to think about what information to look up. Whereas I think a clinical social worker would have had like, you know, "Here are shelters, here's what you do, you go here first and then after this…" you know, I think that's more of what they do. They have more, you know, in terms of working with child protective agencies and things like that, but they really do more kind of social work in terms of housing, in terms of working with the government agencies and things like that.

Thus, the clinical psychology trainees stand apart from the other two groups in their relative lack of training and experience in helping their clients access external resources.

Relationship between clinician and help-seeker

The type of relationship that trainees forge with their clients or patients ranges in terms of trainees' conceptualization of the proper roles to be played by both clinician and help-seeker. On one end of the spectrum the client is the expert, in that the client holds the answers to his/her problems and is the one doing the heavy lifting, while the clinician acts as a facilitator to this process. On this end of the spectrum, clients' treatment goals and preferences are paramount. On the opposite end of the spectrum, the clinician is the expert, offering the client access to her professional knowledge and skills, without which the client cannot begin to move forward and feel better. On this end of the spectrum, client preferences are taken into account, but the clinician holds sway over the client in that only she has the qualifications to make final treatment decisions. In the middle of the spectrum, both client and clinician are involved in a partnership where both parties contribute evidence, preferences, and insight equally.

The three points discussed above on this relationship continuum – client as expert, equal client-clinician partnership, and clinician as expert – are ideal types, meaning that in reality most trainees' relationships with their clients or patients tend to fall somewhere in between these positions. Nevertheless, it is instructive to pinpoint where on the continuum social work trainees, clinical psychology trainees, and psychiatry residents tend. Social workers' descriptions of their relationships with clients place this group between the client-as-guide position and the equal client-clinician partnership positions, with a tendency to fall closer to the client-as-guide position. The following quotes illustrate the sense conveyed by social work trainees that the client is paramount, and that the clinician's job is to empower the client to solve his or her own problems:

> Social Work Interviewee_D: I think that clinical social workers are very adept at -- what I think they have been trained to, not necessarily *do for others*, although some theoretical perspectives dictate that you do, but to – how to enhance motivation in other people in order to empower individuals so they may *do for themselves*. Clinical social workers focus more on being facilitators as opposed to doers I would think. Generally speaking.

Social Work Interviewee_D goes on to explain:

> I'm not interested in, I mean I don't sit there and be like "Whoa, you know, I have ultimate insight into your problem. Let me give you the benefit of my wisdom, what I've learned in Social Work." It's not really like what I do… my responsibility as a social worker is to empower them. Not to give advice. And I'm a big advocate of social learning as far as I think they have the answers to help themselves. It's just a question of facilitating, helping them realize that they have the answers.

Social Work Interviewee_K also notes that a social worker's job is to empower a client to make

positive changes, rather than simply telling a client what to do or think:

> I like to see myself as – I know it's kind of cliché, but maybe see myself as an 'agent of change,' not necessarily, you know, kind of be more that person that's there to help guide the individual rather than to provide the answers and tell them what to do. Something that I kind of ran into a lot with some of my clients. Always asking me "What should I do, what should I do," you know? But I'm not

> about giving advice, it's more – at the end of our sessions or you know, whenever my client figures something out and they say "Thank you for helping" -- I'm like, "No, you were the one that really figured it out, I was just kind of here working with you." Really empower them for that.

Clinical psychology trainees, in contrast, place themselves closest to the equal-client-clinician-partnership position, discussing how the relationship is a collaboration to which both players contribute, and emphasized how each member of the dyad is responsible for the pair's progress. When asked what takes place in the first sessions when a client exhibiting symptoms of depression and anxiety presents for help, Clinical Psychology Interviewee_I explains:

> What I'm going to do is probably, well, I mean, we're going to work together to mutually come up with, to figure out what the problems are. To figure out what the goals are, even, because you can't do all that much unless you know what it is you want to accomplish.

Clinical Psychology Interviewee_D likewise explains that client and clinician work together to develop treatment goals:

> I think, if I understand your question correctly, you are asking me what happens when they come into the therapy room and we're faced with the task that we need to develop their goals. I like to -- I generally like to take a pretty direct approach. I generally start hearing about their story. I like to know a little bit about the client so I can understand what their experience is like. I think that's very important before we start ironing out goals. Generally from that the goals will come out - a lot of times their goal will come out. Oftentimes people will tell you and if they don't then you have to ask "So what brings you in, why are you here, what do you want to get from this?" And people can generally give you an answer and if they can't then we work together to try to figure out what's not working so well and what we can change. In my work I try to use that as a basis for establishing goals. Sometimes the goals come more from the client, sometimes they come more from me, but in the end it's a constant tweaking in the collaboration to make sure that the goals that we are working on are ultimately helpful for them and consistent with why they came in.

In contrast to social work trainees who lean toward the client-as-expert model, and the clinical psychology trainees who strive for a collaborative partnership, psychiatry residents favor the clinician-as-expert model. The psychiatry residents stress their

physician status and note that their medical backgrounds qualify them to make treatment decisions on a patient's behalf. Indeed, a number of psychiatry residents emphasize that it can be dangerous when patients unilaterally make treatment decisions, such as when patients adjust their medication without consulting their physicians:

> Psychiatry Interviewee_H: I find myself spending a lot of time on those first couple of appointments trying to decrease the stigma about taking medication. Some people come in willing to take it but a lot of people come in with these preconceived notions about it, particularly people that are getting that first-time or second-time treatment, about medications, you know, being something for "crazy people," about the side effects of what the medications are going to do to them, about not realizing even what their illness is and that feeling like they need to just suck it up and deal with it. That it's not an illness, it's just "I'm being weak, I'm going through a rough patch, I'm going to get over it on my own." So, you know, you tend to, of course this is so patient-specific, some people don't have that issue at all, but those first couple sessions I end up, I think, doing a lot with that. Doing a lot with explaining what the medication's for, how it's going to work, how quickly they can expect to see results. The importance of compliance and adherence to the doses and taking it every day, which is *always* a challenge. Despite the highest functioning of people, no one ever really listens to what you're saying, and just goes home and says: "Okay, I'll just take my medication every day as directed." I mean, people tinker with it, people stop taking it, people take it at the wrong time, they miss doses, they up their own doses. So that's a constant battle.

Asked about the type of factors that affect treatment decisions, Psychiatry Interviewee_B notes that patient preferences are secondary to standards of medical practice tied to specific DSM diagnoses:

> Part of [making treatment decisions] is what [patients] want, but the *majority* of it is based on what they have, what their DSM criteria is, their diagnosis is, and what the evidence, good standards of clinical practice, indicate is the treatment.

Psychiatry Interviewee_D echoes the notion that while patient preferences may be taken into account, it is up to the doctor to make final treatment decisions:

> My patients aren't going to dictate to me what kind of treatment I recommend. There have been times when I have told patients "I'm not going to do that," and then they've gone and found another doctor. And that's probably one of the most

> important lessons – another great, important lesson – to learn as a doctor, is that you can say no to your patients. Once you realize that it makes life a lot easier.

Thus, the psychiatry residents view the appropriate clinician-patient relationship as hierarchical, with the psychiatrist's expertise taking precedence over patient preferences, should the two conflict.

Patients or clients?

The terminology trainees use to refer to help-seekers is an indicator of the way trainees view and conceptualize the relationship between themselves and help-seekers. The term 'patient' connotes illness or disease and suggests a distance between the help-seeker and the clinician. The term 'client' suggests a mutual and more egalitarian relationship between help-seeker and clinician. The psychiatry residents exclusively refer to help-seekers as patients. In contrast, five of the eleven clinical psychology interviewees (45.5%) refer to help-seekers both as patients and as clients during the course of their interview, while the remainder of the clinical psychology interviewees (54.5%, or 6 respondents) refer exclusively to help-seekers as clients. Eight of the eleven social work interviewees refer to help-seekers as both patients and clients (72.7%), while the remainder use the term 'client' in interviews.

In the course of their in-depth interviews, social work and clinical psychology trainees use the term 'patient' under two circumstances. Only when describing help-seekers receiving care in hospital settings or when referring to care jointly provided by psychiatrists and other medical doctors do these two groups revert to the term 'patient.' The default term for these two professional groups, however, is 'client.' The following quotes explain social work trainees' preference for the term 'client,' as well as the impact

that the *setting* in which care is provided has on their language. Asked what term s/he uses to describe help-seekers, one social work interviewee has the following to say:

> Social Work Interviewee_B: I say client. I think it depends on the setting that you're in. One of my internships was in a nursing home and I referred to them as residents. And I think that if it was more of, like, an inpatient treatment facility then I would say probably patients. But I see 'clients' - it's more, I guess, *voluntary* versus 'patients' being more – I don't know – patients has more of a negative connotation to it I think. In my mind patient is correlated to hospitals, and when you think mental illness and you think patient, then sometimes, like, inpatient psychiatric facilities and stuff don't have the best reputations.

Social Work Interviewee_D explains:

> Patient is the language that we use at [inpatient practicum site]. But I like client just because I feel it humanizes them more. I go back and forth. It's just mainly due to the fact that I used [the term] 'client' in my classes and used 'patient' in my practicum.
>
> Interviewer: When you say it humanizes them, can you just say a little more about that?
>
> Social Work Interviewee_D: Yeah. Just not seeing people in terms of their illnesses. Not defining them. And I know that they're [other non-social-work mental health professionals working at inpatient site] not doing that but in a sense I guess they are. 'Cause you know at an inpatient mental health facility the emphasis is on *medical* treatment.

Social Work Interviewee_F explains some reservations about using the term 'patient':

> I think 'patients' just has a cold feel to it. It also, for me, kind of implies that there's something wrong with them… that they need to be fixed.
>
> Interviewer: I mean, don't they essentially have some kind of a problem, though, if they're coming in to see you?
>
> Social Work Interviewee_F: More than likely, but it's not, I guess it's not a, I guess 'patient' I feel like has kind of a stigma attached to it. That there's something that they can't control and there's something wrong in the sense that it's bad and negative. Whereas 'clients' I kind of feel like, well, clients I like because there's many fields that use the term client. It implies a relationship and it does not necessarily mean an imbalance of power.

The clinical psychology interviewees also favor the term client over patient. Clinical

Psychology Interviewee_K explains that the clinical psychology trainees prefer the term client over patient because client signifies a mutual, collaborative relationship between clinician and help-seeker, while patient implies that the help-seeker is merely a passive recipient of the clinician's professional expertise:

> Yeah we [fellow classmates] talked a lot about it, patients, clients--when you say patient you typically think of more of a medical model, and there's something more passive about using the word patient…often when you say patient there's something sort of reminiscent of some of the older models of therapy where it was believed that therapy sort of, the relationship between a therapist and a client was uneven, and the therapist was someone who had knowledge, who had more power, and the patient needed the therapist more, and things have certainly changed to make things more egalitarian. So I think we all came to the conclusion that client was the better term to use although we also were a little uncomfortable with the term client because often when you think of the word client you think of, you know, hooker. A hooker with a client. So we were like hmm…the lesser of two evils, okay. But I think there is something slightly less passive in using the term client. Client -- I think patient evokes, at least the imagery in my mind, when I think patient, I think sick. I think something wrong. Client implies more of a collaborative relationship. I think the term patient implies some passivity. Like when you say patient, for me at least, the term patient evokes a passivity in that the patient needs me to get better. I think for me when I use the term client it sets up more of – you're clearly struggling, things are not going well and I'm going help you through this—but, I mean, I like that term better because it immediately gets me thinking more in terms of an even relationship and you're [the client] going to do work too. It's not that I'm just going to give you this medicine and you're going to get better. It's a collaborative effort and you've got to be right there with me for things to get better.

In contrast to social work and clinical psychology trainees' preference for the term 'client,' psychiatry residents will only refer to help-seekers as patients. Indeed, a few psychiatry interviewees actually recoiled when I inadvertently referred to help-seekers as clients.[12] The psychiatry interviewees explain their use of the term 'patient' via two arguments. One explanation concerns issues of professional identity. Psychiatrists are medical doctors, and as a result, the people who seek their help are, without exception, patients. The psychiatry residents are quick to note that they, just like other types of

doctors, successfully completed medical school. The use of the term patient, then, links psychiatrists with other medical doctors at the same time that it helps distinguish psychiatrists from other mental health professionals who have not earned medical degrees. Asked about the term 'client,' Psychiatry Interviewee_D responds with vigor:

> Yeah, I hate that [term client]. They're patients, I'm a doctor and they're patients. I'm not a lawyer, I'm not an accountant, I'm not working the corner at Macy's. I understand that 'client, consumer' is trying to remove the stigma from 'patient,' but I don't see why mental health has to be different. I'm a doctor first and a psychiatrist second. I think there's already too much in my specialty of separating us from the rest of medicine. We should be just as much a part of it. You definitely don't hear a cardiologist say "I'm doing a catheterization on a client." If I were a massage therapist, sure. But no, it's a doctor-patient relationship. If you come to see me, you're a patient…There are psychiatrists and psychologists. So damn if my grandfather still doesn't say that I'm a psychologist. He just doesn't get it. Most people don't realize that we went to four years of medical school. That I went to the same medical school that their fancy-schmancy surgeon did. They think I played with rats or did a PhD, which is perfectly valid, but that's not what I did. Patients will even say "Now, are you the medical doctor or the psychiatrist?" And I say, "I'm both!"

Relatedly, Psychiatry Interviewee_B, who wrote in the margins of the survey instrument: "Please do not call patients clients"[27] notes: "I can't stand that when patients are called clients. Yeah, I'm a doctor, they're my patients." Psychiatry Interviewee_H similarly notes that people seeking help from doctors of any ilk are patients, and psychiatrists are doctors:

> If you are trained as a physician first and a psychiatrist second, then you will always be coming from a place being a physician and the other side of that is always a patient. Every other field of medicine it's a patient, not a client. Cardiologists don't see clients. They see patients. In every field of medicine, they're called a patient. So why would it be any different for a psychiatric patient? They're patients too.

[27] Originally I used the term 'client' throughout the survey instrument for trainees from each of the three professions. Once I realized that psychiatrists respond negatively to the term 'client' I changed the language from client to patient for the psychiatry residents' version of the survey. This respondent, one of the first psychiatry interviewees, received a version of the survey instrument that used the term 'client' rather than 'patient'.

The second argument the psychiatric interviewees made for the use of the term patient over client concerned the nature of the conditions that mental health professionals treat. The psychiatry residents see themselves as treating mental *illnesses* – serious chronic diseases that have a biological basis. The use of the term 'client,' to them, implies that mental disorders are not real diseases; it perpetuates the stigma that mental 'illnesses' can be controlled by virtue of mind over matter, and that they do not merit medical attention. Indeed, psychiatry residents view the use of the term client as undermining the importance of the services they provide and the seriousness of the conditions from which their patients suffer:

> Psychiatry Interviewee_E: What you lose by using the term client is the fact that these are serious illnesses. You know, client makes it almost sound like a business arrangement or something, which again could be helpful for the patient to feel empowered like that. But on the other hand, we can't forget that some of these people, not the ones who have -- who are really upset about the break-up or whatever and they're pissed off -- I'm talking about the ones with major depressive disorder, the ones with generalized anxiety sort of like full syndromal, you know schizophrenia or whatever. You know, those are serious illnesses and I don't know, I guess by holding on to that term patient, maybe it helps -- maybe it helps people sort of realize the seriousness of what they're suffering with and that they really *should* maintain a relationship with the doctor.

> Psychiatry Interviewee_B: I feel like clients are people who go to the mall to buy something or you go to your hair dresser and you're their client or you're her client. But, I mean, I know that with health care as it is in this country it's like a consumer good, but I don't feel like I'm offering an optional service. You know, or a luxury service. That there would be clients. I don't know, I'm a doctor and the people who see me are patients, and it's not a stigma, I'm a patient, too, of my own doctor.

Psychiatry Interviewee_H explains that psychiatrists work from the medical model of mental disorders, and that a good number of the people seeking their help are suffering from debilitating chronic diseases. As such, it is only fitting that these people are referred to as patients:

> When you're looking at it through the lens of a medical model, an illness model, and you're saying what you have is an illness, that makes you a patient. You're a patient with an illness. Folks that don't come from a physician's training, from a medical model, tend to see it as I said before, I think psychologists in general are trained more, and there is some positives to seeing it this way, to not label people, to not look at it as an illness, but to look at it as these are traits of your personality. This is stress that you're dealing with. These are things that are going on in your life, social life, etc., we need to work on but why give it a label, per se. And if you come at it from that direction, then the stigma of being a patient is a negative thing and rather than stigmatizing someone and calling them a patient, I can see why it would be easier to call them a client and to make it seem like I'm just providing a service like a masseuse provides a service, just like a salesperson provides a service, you know, just like someone fixes your car. I'm here to talk to you about your psychological issues and you're here to, you know, to pay me to do so, but you're just a client of mine. You know, like a lawyer, whatever, etc. I've never called a patient a client. I don't think there's anything wrong with doing it that way, but it's solely a basis of where you start your training and I think if psychologists saw all schizophrenic patients, they'd be more likely to call them patients and less likely to call them clients. I could be wrong about that, but that's what I think. Because when you start to see people in more of a biological-like model like where you're: "This is an illness, you have a very serious chronic mental illness that's never going to go away that requires medication," it's pretty hard to convince yourself that that person is not a patient.

Thus, clinical psychology trainees and social work trainees *prefer* the term client because it deemphasizes the degree to which help-seekers are ill or sick and also because it suggests a non-hierarchical relationship with an actively-involved help-seeker, yet they will sometimes use the term patient in particular organizational settings (e.g., inpatient facilities) or when working alongside medical doctors. The psychiatry residents, alternatively, will only use the term patient. The residents reason that a) as they are doctors, those who come to see them are patients; and b) shying away from the term patient reinforces the stigma afforded to mental illnesses – namely that they are not true diseases requiring medical attention, and that people with such problems should simply be able to overcome their troubles without the assistance of a doctor or another type of mental health professional.

Other Factors Shaping Trainees' Approach to Care

In addition to examining interviewees' approach to care by professional affiliation, I also explored the degree to which the type of intervention proffered as well as an interviewee's gender, race, and primary theoretical orientation(s) were associated with her clinical approach. With respect to gender and race, women and minority interviewees were more likely to focus on bolstering a client's strengths than were men and white interviewees. Gender also shaped social work and psychiatry interviewees' relationships with their clients or patients, although in different directions. Female social workers were somewhat more likely than male social workers to stress client rights and client self-determination. Female psychiatrists, in contrast, were more likely than male psychiatrists to emphasize the hierarchical nature of their relationships with patients. For example, women psychiatrists were more likely than male psychiatrists to speak about problems with patient non-compliance and the importance of maintaining proper boundaries, while male psychiatrists were more likely than female psychiatrists to highlight the collaborative nature of their relationships with patients.

The interview data also suggest that a trainee's approach to care is associated with the type of intervention in question as well as her primary theoretical orientation to practice. When discussing medication management interviewees highlighted the need to educate patients about the importance of medication and the value of taking their medication as directed. Discussions about psychotherapy, alternatively, were much more likely to focus on the collaborative nature of the clinician-client relationship. With respect to primary theoretical orientation, a psychodynamic orientation was associated with working to alleviate psychopathology whereas a cognitive-behavioral orientation

and the family-systems, strengths, and person-in-environment orientations were associated with bolstering client assets.

Section Summary

In sum, there are a number of professional differences in trainees' therapeutic approach to clinical care. Psychiatry residents, in general, focus on medication management more than on psychotherapy, focus on alleviating problems and symptoms more than on bolstering strengths, are frequently tasked with helping patients access community resources, and on the spectrum of clinician/help-seeker relationships they lean towards a model that identifies the clinician as the expert in the relationship. In a measure of the distance they maintain between themselves and those who seek their care, psychiatry residents will only refer to help-seekers as patients, regardless of the setting or the patients' individual characteristics.

Clinical psychology trainees, in contrast, consider psychotherapy the most beneficial type of intervention available to most help-seekers presenting with mental health problems, rarely are called upon to link clients up with community resources, and on the continuum of clinician/help-seeker relationships tend toward the middle, a model that emphasizes collaboration between equal parties. In an effort to minimize the hierarchy between clinician and help-seeker and to downplay the idea that those who seek their help are ill, clinical psychology trainees prefer the term client over patient. Like psychiatry residents, however, clinical psychology trainees focus on alleviating problems more than they do on bolstering client strengths.

Social work trainees, like clinical psychology trainees, emphasize psychotherapy more than they do psychopharmacology, and likewise prefer the term client over patient. Like psychiatry residents – in fact, to a greater degree – social work trainees spend a

large portion of their time and must be adept at linking clients with community resources. Social work trainees also focus on fostering positive attributes in their clients rather than strictly focusing on alleviating problems. On the clinician/client relationship spectrum social work trainees tend to view the client as the guide or expert in the relationship, and consider their role as facilitators in the process of helping clients become empowered.

Other factors influencing clinical approach include gender, race, theoretical orientation, and the type of intervention provided. Women and minorities are more likely to focus on client strengths than are men and white clinicians. Clinicians who favor a family systems, strengths, or person-in-environment orientation, as well as those favor a cognitive-behavioral approach are also more likely than those who do not to focus on bolstering client strengths. In contrast, those who consider the psychodynamic orientation primary are more likely to concentrate on alleviating psychopathology.

The type of treatment offered – medication vs. psychotherapy- and a clinician's gender both influence the clinician-help-seeker relationship. Medication management lends itself to the provider-as-expert model, while psychotherapy promotes a more collaborative relationship between provider and help-seeker. Finally, gender impacts respondents' views on the appropriate tenor of this relationship as well, although in different ways depending on professional affiliation. Women social workers were more likely than male social workers to discuss fostering client self-determination as a critical treatment goal, while women psychiatrists were more likely than their male counterparts to discuss physician-patient interactions in physician-as-expert terms.

CONCLUSION

As is the case with trainees' approach to diagnosis and their diagnostic judgments (see Chapter Four), trainees agree on certain aspects of patient care and vary on others. Areas of agreement likely represent areas that are highly institutionalized; areas of disagreement likely represent instances of weak institutionalization. Trainees from each of the professional programs emphasize the importance of creating and maintaining a therapeutic alliance between clinician and client based on trust in order to ensure client cooperation and optimize client outcomes. Likewise, certain interventions and orientations – such as a cognitive-behavioral orientation and the type of therapy that accompanies that orientation – enjoy widespread support from trainees for the treatment of depression and anxiety regardless of trainees' group affiliations. Other interventions and orientations – such as recommending inpatient hospitalization to a patient who is not clearly a danger to herself or others, or the use of a humanistic orientation – are largely dismissed, if they are considered at all. The focus on developing a therapeutic alliance, the use of both cognitive-behavioral therapy and inpatient hospitalization in the care of those suffering non-acute anxiety and depressive symptoms, and the conditions under which each is to be implemented are part of a shared cognitive script that is disseminated throughout the U.S. mental health field.

In contrast, trainees vary considerably in their views of and recommendations for certain interventions and in certain aspects of their approach to care. The use of family/couples therapy and psychodynamic psychotherapy for the treatment of depressive and anxious symptoms, and trainees' ideal model of a relationship between clinician and help-seeker, for instance, are all examples of weakly-institutionalized areas in the mental

health field. Other types of interventions, such as interpersonal psychotherapy, enjoy a modest amount of support from trainees. Support for interventions, orientations, and aspects of care that enjoy only low- to medium-levels of institutionalization is divided based on trainee characteristics such as trainees' professional affiliation, preferred theoretical orientations, race, and gender.

Professional affiliation shapes trainees' views of and recommendations for interventions such as psychodynamic psychotherapy and family/couples therapy, interventions that have historically been important to maintaining a profession's jurisdiction (e.g., psychiatry and psychodynamic psychotherapy) or that dovetail with a discipline's professional logic (e.g., social work and family/couples therapy). Additionally, professional affiliation shapes trainees' approach to care and treatment recommendations indirectly by guiding trainees from particular professions toward certain orientations and away from others.

Trainees' theoretical orientations also affect their treatment decisions and clinical approach. For example, the use of a biomedical orientation is associated with rating psychopharmacology's effectiveness higher, while the use of a psychodynamic orientation makes trainees more likely to recommend for a medication consult. Attitudes and treatment decisions towards interventions such as interpersonal psychotherapy depend on both a clinician's professional affiliation and theoretical orientation. An interpersonal psychotherapy recommendation is less likely to come from a psychiatry resident than from a trainee in social work or clinical psychology, while a trainee's endorsement of the interpersonal orientation makes her more likely to provide interpersonal psychotherapy regardless of her professional affiliation. With respect to

trainees' clinical approach, it is not possible to fully untangle the effects of theoretical orientation and professional affiliation from one another, but it is clear that both professional affiliation and theoretical orientation shape how trainees view and interact with clients.

A trainee's gender and race also affect the work she does with clients. For example, male trainees are more likely than female trainees to recommend psychodynamic psychotherapy, while female trainees are more likely than male trainees to discuss helping clients access resources as a piece of her core work. With respect to race, minority trainees rate the likely effectiveness of family/couples therapy higher than do white trainees, and minority trainees are more likely than white trainees to focus on bolstering client strengths rather than alleviating client problems.

Table 5-A: Average Number of Theoretical Orientations Subscribed to by Trainees from Each of the Professional Programs

	Full Sample	Psychiatry	Clinical Psychology	Social Work	(*n*)	*F*-Ratio from ANOVA[a]	Significant Post-hoc Differences[a,b,c]
Average # of Theoretical Orientations Used in Practice Mean (*SD*)	5.3 (*2.7*)	4.1 (*1.8*)	5.2 (*2.4*)	6.2 (*3.0*)	101	*F(2,98)* = 6.3**	PR < SW**

[a] $*p < .05$; $**p < .01$.

[b] *P* values corresponding to post-hoc differences are measured by Tamhane's T2.

[c] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.

Table 5-B: Percent of Each Professional Group that Subscribes to Various Theoretical Orientations in Practice[a]

Theoretical Orientations	Full Sample	Psychiatry	Clinical Psychology	Social Work	(*n*)	χ^2 (*df*)	Φ	*p*
Medical/biological	55.4%	100	27.3	38.3	101	38.4 (2)	.616	<.001
Psychodynamic	54.5%	75.0	40.9	46.8	101	8.2 (2)	.285	.017
Cognitive-behavioral	82.2%	71.9	90.9	85.1	101	3.7 (2)	.192	ns
Interpersonal	52.5%	21.9	100	51.1	101	32.0 (2)	.563	<.001
Family Systems	51.5%	25.0	36.4	76.6	101	22.9 (2)	.476	<.001
Strengths	41.6%	12.5	9.1	76.6	101	44.4 (2)	.663	<.001
Person-in-environment/ Ecosystems	36.6%	12.5	4.5	68.1	101	37.8 (2)	.612	<.001
Humanistic/Existentialist/ Gestalt	19.8%	3.1	31.8	25.5	101	8.6 (2)	.291	.014
Integrative/Eclectic	25.7%	21.9	54.5	14.9	101	12.7 (2)	.354	.002

[a]Respondents were asked to select *each* theoretical orientation that they use to guide clinical practice. Consequently, percentages do not add to 100 percent.

Table 5-C: Percent of Each Professional Group that Lists Various Theoretical Orientations as Their "Primary" Orientations to Practice[a]

Theoretical Orientations	Full Sample	Psychiatry	Clinical Psychology	Social Work	(*n*)	χ^2 (*df*)	ϕ	*p*
Medical/biological	32.0%	93.8	0	4.3	100	82.6 (2)	.929	< .001
Psychodynamic	20.0%	37.5	22.7	6.5	100	11.5 (2)	.338	.003
Cognitive-behavioral	44.0%	18.8	72.7	47.8	100	15.9 (2)	.399	< .001
Interpersonal	15.0%	6.3	54.5	2.2	100	34.8 (2)	.590	< .001
Family Systems	17.0%	6.3	4.5	30.4	100	10.9 (2)	.331	.004
Strengths	15.0%	0	0	32.6	100	20.7 (2)	.455	< .001
Person-in-environment/ Ecosystems	13.0%	0	0	28.3	100	17.5 (2)	.419	< .001
Humanistic/Existentialist/ Gestalt	2.0%	0	0	4.3	100	2.4 (2)	.155	ns
Integrative/Eclectic	8.1%	3.1	22.7	4.3	100	8.4 (2)	.289	.015

[a]Respondents were asked to write in which "one or two orientations" are "primary" in their clinical work. Consequently, percentages do not add to 100 percent.

Table 5-D: Treatment Interventions and their Corresponding Theoretical Orientations

Intervention	Corresponding Theoretical Orientation
Psychopharmacology/Drug Therapy	Medical/biological Orientation
Inpatient Hospitalization	
Psychodynamic Psychotherapy	Psychodynamic Orientation
Cognitive-Behavioral Therapy	Cognitive-Behavioral Orientation
Family/Couples Therapy	Family-Systems Orientation
Interpersonal Psychotherapy	Interpersonal Orientation

Table 5-E: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Psychopharmacology by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Psychopharmacology/Drug Therapy			
Full Sample Mean (SD)	7.3 (1.5)		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	8.3 (0.8)	**Medical/biological** (*n* = 101)	7.9 (1.1)
Clinical Psychology (*n* = 23)	6.9 (1.3)	*t (df)*[b]	-5.1 (99)**
Social Work (*n* = 49)	6.8 (1.6)		
F-Ratio from ANOVA[b,c]	*F (2,101)* = 12.6**	**Psychodynamic** (*n* = 101)	7.5 (1.3)
Significant Post-hoc Differences[e]	PR > CP, SW**	*t (df)*[b]	-2.0 (84)
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 101)	7.1 (1.6)
MDD (*n* = 28)	7.6 (1.1)	*t (df)*[b]	1.5 (99)
GAD (*n* = 40 - 41)	7.1 (1.6)		
Panic Disorder (*n* = 11)	7.5 (1.7)	**Interpersonal** (*n* = 101)	7.0 (1.5)
Other Diagnosis (*n* = 20 - 23)	7.2 (1.5)	*t (df)*[b]	2.0 (99)
F-Ratio from ANOVA[b,c]	*F (3,97)* = 0.9		
Significant Post-hoc Differences[e]		**Family Systems** (*n* = 101)	6.9 (1.5)
		t (df)[b]	2.3 (99)*
Race			
White/Caucasian (*n* = 71)	7.0 (1.5)	**Strengths** (*n* = 101)	6.9 (1.6)
Minority (*n* = 32)	7.8 (1.3)	*t (df)*[b]	1.8 (99)
t (df)[b]	-2.5 (101)*		
		Person-in-Environment (*n* = 101)	6.8 (1.5)
Gender		*t (df)*[b]	2.4 (99)*
Women (*n* = 81)	7.3 (1.5)		
Men (*n* = 23)	7.3 (1.5)	**Humanistic/Existentialist/ Gestalt** (*n* = 101)	6.5 (1.8)
t (df)[b]	0.005 (102)	*t (df)*[b]	2.5 (99)*
		Integrative/Eclectic (*n* = 101)	7.1 (1.7)
		t (df)[b]	0.6 (99)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.
[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.
[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.
[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).
[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.
$*P < .05$; $**P < .01$.

Table 5-F: ANCOVA Results for Likely Effectiveness of Psychopharmacology

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	1.0	0.6	.015	.123
Primary Diagnosis	3	1.0	0.7	.022	.148
Race	1	0.4	0.3	.003	.055
Gender	1	0.2	0.1	.001	.032
Medical/Biological Orientation	1	15.5	9.7**	.101	.318
Family Systems or Strengths or Person-in-Environment[a]	1	1.8	1.1	.013	.114
Humanistic /Existentialist/Gestalt Orientation	1	1.8	1.1	.013	.114
Error	86	1.6			
Adjusted R^2	.261				
R	.511				

[a]Due to high associations between the orientations *family systems*, *strengths*, and *person-in-environment*, the three orientations have been combined. Respondents who indicated that they subscribe to one or more of these orientations are counted as 1 (yes); respondents who subscribe to none of these orientations are counted as 0 (no).

$*p < .05$; $**p < .01$.

Table 5-G: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Psychodynamic Psychotherapy by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Psychodynamic Psychotherapy			
Full Sample Mean (SD)	6.5 (2.1)		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	6.7 (1.5)	**Medical/biological** (*n* = 100)	6.8 (1.8)
Clinical Psychology (*n* = 23)	4.6 (2.2)	*t (df)* [b]	-1.5 (98)
Social Work (*n* = 49)	7.3 (1.9)		
F-Ratio from ANOVA[b,c]	*F (2,101)* = 17.1**	**Psychodynamic** (*n* = 100)	7.1 (1.4)
Significant Post-hoc Differences[e]	CP < PR, SW**	*t (df)* [b]	-3.4 (65)**
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	6.3 (2.2)
MDD (*n* = 28)	7.2 (1.9)	*t (df)* [b]	1.7 (98)
GAD (*n* = 41)	6.2 (1.8)		
Panic Disorder (*n* = 11)	5.3 (2.9)	**Interpersonal** (*n* = 100)	6.1 (2.2)
Other Diagnosis (*n* = 22)	6.5 (2.3)	*t (df)* [b]	2.1 (98)*
F-Ratio from ANOVA[b,c]	*F (3,98)* = 2.5		
Significant Post-hoc Differences[e]		**Family Systems** (*n* = 100)	6.8 (2.1)
		t (df) [b]	-1.4 (98)
Race			
White/Caucasian (*n* = 71)	6.4 (2.0)	**Strengths** (*n* = 100)	7.2 (1.6)
Minority (*n* = 32)	6.8 (2.3)	*t (df)* [b]	-3.2 (98)**
t (df) [b]	-0.7 (101)		
		Person-in-Environment (*n* = 100)	7.3 (1.3)
Gender		*t (df)* [b]	-2.8 (98)**
Women (*n* = 81)	6.4 (2.3)		
Men (*n* = 23)	6.8 (1.2)	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	6.4 (1.9)
t (df) [b]	1.0 (67)	*t (df)* [b]	0.2 (98)
		Integrative/Eclectic (*n* = 100)	5.7 (2.0)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.
[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.
[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.
[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).
[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.
$*P < .05$; $**P < .01$.

Table 5-H: ANCOVA Results for Likely Effectiveness of Psychodynamic Psychotherapy

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	21.7	7.1**	.143	.378
Primary Diagnosis	3	6.0	2.0	.065	.255
Race	1	3.4	1.1	.013	.114
Gender	1	7.3	2.4	.027	.164
Psychodynamic Orientation	1	29.6	9.7**	.102	.319
Interpersonal Orientation	1	0.09	0.03	.000	.000
Family Systems or Strengths or Person-in-Environment[a]	1	0.5	0.2	.002	.045
Integrative Orientation	1	1.8	0.6	.007	.084
Error	85	3.1			
Adjusted R^2	.317				
R	.563				

[a]Due to high associations between the orientations *family systems*, *strengths*, and *person-in-environment*, the three orientations have been combined. Respondents who indicated that they subscribe to one or more of these orientations are counted as 1 (yes); respondents who subscribe to none of these orientations are counted as 0 (no).

$*p < .05$; $**p < .01$.

Table 5-I: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Cognitive-Behavioral Therapy by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Cognitive-Behavioral Therapy			
Full Sample Mean (SD)	7.9 (1.0)		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	7.9 (1.0)	**Medical/biological** (*n* = 100)	8.0 (1.0)
Clinical Psychology (*n* = 23)	8.1 (0.8)	*t (df)* [b]	-0.4 (98)
Social Work (*n* = 49)	7.9 (1.1)		
F-Ratio from ANOVA[b,c]	*F (2,101)* = 0.3	**Psychodynamic** (*n* = 100)	7.8 (0.9)
Significant Post-hoc Differences[e]		*t (df)* [b]	1.5 (98)
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	8.0 (0.9)
MDD (*n* = 28)	7.9 (1.0)	*t (df)* [b]	-1.8 (98)
GAD (*n* = 40)	7.7 (1.0)		
Panic Disorder (*n* = 11)	8.4 (0.9)	**Interpersonal** (*n* = 100)	7.9 (0.9)
Other Diagnosis (*n* = 22)	8.1 (0.9)	*t (df)* [b]	0.8 (98)
F-Ratio from ANOVA[b,c]	*F (3,97)* = 1.7		
Significant Post-hoc Differences[e]		**Family Systems** (*n* = 100)	7.9 (1.0)
		t (df) [b]	0.4 (98)
Race			
White/Caucasian (*n* = 71)	7.8 (1.1)	**Strengths** (*n* = 100)	7.9 (1.0)
Minority (*n* = 32)	8.3 (0.8)	*t (df)* [b]	0.5 (98)
t (df) [b]	-2.2 (101)*		
		Person-in-Environment (*n* = 100)	7.9 (1.0)
Gender		*t (df)* [b]	0.1 (98)
Women (*n* = 81)	8.0 (1.0)		
Men (*n* = 23)	7.9 (1.0)	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	7.8 (1.0)
t (df) [b]	-0.3 (102)	*t (df)* [b]	0.8 (98)
		Integrative/Eclectic (*n* = 100)	8.2 (0.6)
		t (df) [b]	-1.2 (98)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.
[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.
[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.
[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).
[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.
$*P < .05$; $**P < .01$.

Table 5-J: ANCOVA Results for Likely Effectiveness of Cognitive-Behavioral Therapy

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	0.4	0.4	.009	.095
Primary Diagnosis	3	0.8	0.8	.025	.158
Race	1	3.4	3.3	.035	.187
Gender	1	0.02	0.02	.000	.000
Error	92	1.0			
Adjusted R^2	.024				
R	.155				

$*P < .05$; $**P < .01$.

Table 5-K: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Family/Couples Therapy by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Family/Couples Therapy			
Full Sample Mean (SD)	6.0 (1.9)		
(*n*)	102		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	5.6 (1.7)	**Medical/biological** (*n* = 98)	5.9 (1.9)
Clinical Psychology (*n* = 22)	4.4 (1.6)	*t (df)* [b]	0.4 (96)
Social Work (*n* = 48)	7.0 (1.7)		
F-Ratio from ANOVA[b,c]	*F (2,99)* = 19.2**	**Psychodynamic** (*n* = 98)	6.0 (1.8)
Significant Post-hoc Differences[e]	SW > CP, PR** PR > CP*	*t (df)* [b]	0.1 (96)
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 98)	6.0 (2.0)
MDD (*n* = 28)	6.5 (1.7)	*t (df)* [b]	0.2 (96)
GAD (*n* = 40)	5.9 (1.8)		
Panic Disorder (*n* = 11)	5.2 (2.0)	**Interpersonal** (*n* = 98)	5.6 (2.0)
Other Diagnosis (*n* = 20)	5.7 (2.2)	*t (df)* [b]	1.9 (96)
F-Ratio from ANOVA[b,c]	*F (3,95)* = 1.5		
Significant Post-hoc Differences[e]		**Family Systems** (*n* = 98)	6.5 (2.1)
		t (df) [b]	-2.8 (96)**
Race			
White/Caucasian (*n* = 72)	5.8 (1.8)	**Strengths** (*n* = 98)	6.7 (1.8)
Minority (*n* = 30)	6.3 (2.2)	*t (df)* [b]	-2.9 (96)**
t (df) [b]	-1.1 (100)		
		Person-in-Environment (*n* = 98)	6.9 (1.6)
Gender		*t (df)* [b]	-3.7 (96)**
Women (*n* = 79)	6.2 (1.8)		
Men (*n* = 23)	5.1 (2.1)	**Humanistic/Existentialist/ Gestalt** (*n* = 98)	5.9 (2.1)
t (df) [b]	-2.4 (100)*	*t (df)* [b]	0.1 (96)
		Integrative/Eclectic (*n* = 98)	5.3(1.9)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.

[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.

[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.

[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).

[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.

$*P < .05$; $**P < .01$.

Table 5-L ANCOVA Results for Likely Effectiveness of Family/Couples Therapy

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	25.5	9.8**	.187	.432
Primary Diagnosis	3	4.9	1.9	.062	.249
Race	1	12.3	4.7*	.053	.230
Gender	1	0.7	0.3	.003	.055
Family Systems or Strengths or Person-in-Environment[a]	1	0.6	0.2	.003	.055
Integrative Orientation	1	0.2	0.09	.001	.032
Error	85	2.6			
Adjusted R^2	.311				
R	.558				

[a]Due to high associations between the orientations *family systems*, *strengths*, and *person-in-environment*, the three orientations have been combined. Respondents who indicated that they subscribe to one or more of these orientations are counted as 1 (yes); respondents who subscribe to none of these orientations are counted as 0 (no).

$*P < .05$; $**P < .01$.

Table 5-M: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Inpatient Hospitalization by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Inpatient Hospitalization			
Full Sample Mean (SD)	2.3 (1.5)		
(*n*)	103		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	2.7 (1.5)	**Medical/biological** (*n* = 99)	2.7 (1.6)
Clinical Psychology (*n* = 23)	1.7 (1.4)	*t (df)* [b]	-3.3 (97)**
Social Work (*n* = 48)	2.4 (1.4)		
F-Ratio from ANOVA[b,c]	*F (2,100)* = 3.5*	**Psychodynamic** (*n* = 99)	2.8 (1.6)
Significant Post-hoc Differences[e]	PR > CP*	*t (df)* [b]	-3.9 (91)**
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 99)	2.3 (1.5)
MDD (*n* = 28)	2.9 (1.7)	*t (df)* [b]	0.2 (97)
GAD (*n* = 40)	2.3 (1.3)		
Panic Disorder (*n* = 11)	1.3 (0.5)	**Interpersonal** (*n* = 99)	2.2 (1.5)
Other Diagnosis (*n* = 22)	2.1 (1.5)	*t (df)* [b]	0.9 (97)
F-Ratio from ANOVA[b,c]	*F (3,97)* = 3.5*		
Significant Post-hoc Differences[e]	MDD, GAD > Panic**	**Family Systems** (*n* = 99)	2.5 (1.5)
		t (df) [b]	-1.1 (97)
Race			
White/Caucasian (*n* = 71)	2.2 (1.4)	**Strengths** (*n* = 99)	2.6 (1.5)
Minority (*n* = 31)	2.5 (1.5)	*t (df)* [b]	-1.7 (97)
t (df) [b]	-0.9 (100)		
		Person-in-Environment (*n* = 99)	2.7 (1.5)
Gender		*t (df)* [b]	-1.8 (97)
Women (*n* = 80)	2.6 (1.9)		
Men (*n* = 23)	2.2 (1.3)	**Humanistic/Existentialist/ Gestalt** (*n* = 99)	2.5 (1.7)
t (df) [b]	0.9 (101)	*t (df)* [b]	-0.5 (97)
		Integrative/Eclectic (*n* = 99)	2.6 (1.9)
		t (df) [b]	-0.8 (32)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.

[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.

[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.

[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).

[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.

$*P < .05$; $**P < .01$.

Table 5-N ANCOVA Results for Likely Effectiveness of Inpatient Hospitalization

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	2.5	1.4	.032	.179
Primary Diagnosis	3	5.4	3.1*	.098	.313
Race	1	0.6	0.3	.004	.063
Gender	1	0.2	0.09	.001	.032
Medical/Biological Orientation	1	6.5	3.7	.041	.203
Psychodynamic Orientation	1	7.4	4.3*	.047	.217
Error	86	1.8			
Adjusted R^2	.197				
R	.444				

*$p < .05$; **$p < .01$.

Table 5-O: Bivariate Analyses[a,b,c] for Average Effectiveness[d] Rating of Interpersonal Psychotherapy by Professional Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Interpersonal Psychotherapy			
Full Sample Mean (SD)	7.3 (1.7)		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	6.5 (1.5)	**Medical/biological** (*n* = 100)	7.2 (1.5)
Clinical Psychology (*n* = 23)	6.8 (2.0)	*t (df)*[b]	0.6 (98)
Social Work (*n* = 49)	8.0 (1.3)		
F-Ratio from ANOVA[b,c]	*F (2,101)* = 10.1**	**Psychodynamic** (*n* = 100)	7.3 (1.4)
Significant Post-hoc Differences[f]	SW > CP* SW > PR**	*t (df)*[b]	0.2 (98)
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	7.2 (1.6)
MDD (*n* = 28)	7.5 (1.5)	*t (df)*[b]	1.0 (98)
GAD (*n* = 41)	7.2 (1.4)		
Panic Disorder (*n* = 11)	6.0 (2.6)	**Interpersonal** (*n* = 100)	7.4 (1.7)
Other Diagnosis (*n* = 22)	7.7 (1.6)	*t (df)*[b]	-0.4 (98)
F-Ratio from ANOVA[b,c]	*F (3,98)* = 2.8*		
Significant Post-hoc Differences[f]	Panic < Other*	**Family Systems** (*n* = 100)	7.7 (1.5)
		t (df)[b]	-2.1 (98)*
Race			
White/Caucasian (*n* = 71)	7.3 (1.6)	**Strengths** (*n* = 100)	7.9 (1.2)
Minority (*n* = 32)	7.2 (1.9)	*t (df)*[b]	-3.2 (98)**
t (df)[b]	0.3 (101)		
		Person-in-Environment (*n* = 100)	7.9 (1.3)
Gender		*t (df)*[b]	-2.8 (93)**
Women (*n* = 82)	7.4 (1.7)		
Men (*n* = 22)	6.9 (1.3)	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	7.6 (1.2)
t (df)[b]	-1.3 (102)	*t (df)*[b]	-0.8 (98)
		Integrative/Eclectic (*n* = 100)	7.2 (1.4)
		t (df)[b]	0.3 (98)

[a] One-Way ANOVA analyses were done for *Professional Program* and *Primary Diagnosis*. T-tests were done for the remaining independent variables in the table.
[b] *F*-ratio and Significant post-hoc Differences are associated with a One-Way ANOVA model, and thus apply only to the analyses related to *Professional Program and Primary Diagnosis*. *t* (df) is associated with a t-test and applies to the analyses related to *Race*, *Gender*, and the various *Theoretical Orientations*.
[c] *P* values corresponding to post-hoc differences are measured by Tukey's Honestly Significant Difference Test when variances are equal. *P* values corresponding to post-hoc differences are measured by Tamhane's T2 when variances are not equal.
[d] Values range from 1 (Not at all Effective) to 9 (Extremely Effective). Average is expressed in Mean (SD).
[e] PR = Psychiatry Residents; CP = Clinical Psychology Students; SW = Social Work Students.
$*P < .05$; $**P < .01$.

Table 5-P: ANCOVA Results for Likely Effectiveness of Interpersonal Psychotherapy

	df	*Mean Square*	*F*-value	η^2	η
Professional Program	2	10.8	4.5*	.093	.305
Primary Diagnosis	3	6.5	2.7*	.085	.292
Race	1	1.4	0.6	.006	.078
Gender	1	0.02	0.009	.000	.000
Family Systems or Strengths or Person-in-Environment[a]	1	0.4	0.2		
Error	88	2.4			
Adjusted R^2	.166				
R	.407				

[a]Due to high associations between the orientations *family systems*, *strengths*, and *person-in-environment*, the three orientations have been combined. Respondents who indicated that they subscribe to one or more of these orientations are counted as 1 (yes); respondents who subscribe to none of these orientations are counted as 0 (no).

$*P < .05$; $**P < .01$.

Table 5-Q: Percentage of Respondents Who Would Provide or Offer Referral for Psychopharmacology by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Psychopharmacology			
Full Sample	75.2%		
(*n*)	105		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	96.9%	**Medical/biological** (*n* = 101)	87.5%
Clinical Psychology (*n* = 23)	73.9%	χ^2 (*df*)	11.5 (1)**
Social Work (*n* = 50)	62.0%		
χ^2 (*df*)	12.8 (2)**	**Psychodynamic** (*n* = 101)	85.5%
		χ^2 (*df*)	7.9 (1)**
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 101)	73.5%
MDD (*n* = 28)	89.3%	χ^2 (*df*)	0.1 (1)
GAD (*n* = 41)	75.6%		
Panic Disorder (*n* = 11)	63.6%	**Interpersonal** (*n* = 101)	69.8%
Other Diagnosis (*n* = 22)	68.2%	χ^2 (*df*)	1.2 (1)
χ^2 (*df*)	4.4 (3)		
		Family Systems (*n* = 101)	63.5%
		χ^2 (*df*)	6.5 (1)*
Race			
White/Caucasian (*n* = 72)	75.0%	**Strengths** (*n* = 101)	66.7%
Minority (*n* = 32)	75.0%	χ^2 (*df*)	2.2 (1)
χ^2 (*df*)	0 (1)		
		Person-in-Environment (*n* = 101)	62.2%
Gender		χ^2 (*df*)	4.5 (1)*
Women (*n* = 82)	74.4%		
Men (*n* = 23)	78.3%	**Humanistic/Existentialist/ Gestalt** (*n* = 101)	65%
χ^2 (*df*)	0.1 (1)	χ^2 (*df*)	1.1 (1)
		Integrative/Eclectic (*n* = 101)	80.8%
		χ^2 (*df*)	0.8 (2)

*$p < .05$; **$p < .01$.

Table 5-R: Logistic Regression Results: Likelihood that Respondents Would Provide or Offer Referral for Medication Consult/Psychopharmacology

Predictors	Provide *or* Refer for Medication Consult/ Psychopharmacology			
	B	**SE**	**OR**	**95% CI**
Professional Program				
Psychiatry	(Reference)			
Clinical Psychology	-2.1	1.4	0.1	0.008 – 2.0
Social Work	-2.4	1.4	0.1	0.006 – 1.6
Primary Diagnosis				
Major Depressive Disorder (Reference)				
Generalized Anxiety Disorder	-1.6	0.9	0.2	0.04 – 1.2
Panic Disorder	-2.4	1.1	0.09*	0.01 – 0.8
Other Diagnosis	-1.4	1.0	0.3	0.04 – 1.8
Race				
White/Caucasian (Reference)				
Minority	-1.2	0.7	0.3	0.08 – 1.3
Gender				
Women	1.6	1.0	4.7	0.7 – 33.8
Men (Reference)				
Subscribes to Particular Theoretical Orientations[b] (0 = No, 1 = Yes)				
Medical/Biological	0.7	0.8	1.9	0.4 – 9.3
Psychodynamic	1.5	0.7	4.6*	1.1 – 18.3
Family Systems or Strengths or Person-in-Environment[c]	-2.2	1.0	0.1*	0.01 – 0.8
Constant	3.4	1.5	52.3**	
χ^2 (df)	34.1 (10)**			
Pseudo R^2 (Nagelkerke R^2)	.440			
N	97			

*$p < .05$; **$p < .01$.

Table 5-S: Percentage of Respondents Who Would Provide Psychodynamic Psychotherapy by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Psychodynamic Psychotherapy			
Full Sample	27.9%		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	25.0%	**Medical/biological** (*n* = 100)	28.6%
Clinical Psychology (*n* = 23)	17.4%	χ^2 (*df*)	0.2 (1)
Social Work (*n* = 49)	34.7%	φ	.04
χ^2 (*df*)	2.5 (2)	**Psychodynamic** (*n* = 100)	40%
φ	.156	χ^2 (*df*)	10.5 (1)**
		φ	.324
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	24.1%
MDD (*n* = 28)	25.0%	χ^2 (*df*)	2.1 (1)
GAD (*n* = 41)	29.3%	φ	-.145
Panic Disorder (*n* = 11)	18.2%	**Interpersonal** (*n* = 100)	32.1%
Other Diagnosis (*n* = 22)	31.8%	χ^2 (*df*)	1.5 (1)
χ^2 (*df*)	0.8 (3)	φ	.121
φ	.091	**Family Systems** (*n* = 100)	39.2%
		χ^2 (*df*)	7.9 (1)**
Race		φ	.281
White/Caucasian (*n* = 71)	25.0%	**Strengths** (*n* = 100)	29.3%
Minority (*n* = 32)	29.6%	χ^2 (*df*)	0.2 (1)
χ^2 (*df*)	0.2 (1)	φ	.043
φ	-.047	**Person-in-Environment** (*n* = 100)	38.9%
Gender		χ^2 (*df*)	4.0 (1)*
Women (*n* = 81)	22.2%	φ	.201
Men (*n* = 23)	47.8%	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	50.0%
χ^2 (*df*)	5.8 (1)*	χ^2 (*df*)	6.7 (1)*
φ	-.237	φ	.259
		Integrative/Eclectic (*n* = 100)	26.9%
		χ^2 (*df*)	0 (1)
		φ	.001

*$p < .05$; **$p < .01$.

Table 5-T: Logistic Regression Results: Likelihood that Respondents Would Provide Psychodynamic Psychotherapy as Part of an Initial Intervention

	Provide Psychodynamic Psychotherapy			
Predictors	***B***	**SE**	**OR**	**95% CI**
Professional Program				
Psychiatry	-0.8	0.8	0.5	0.09 – 2.3
Clinical Psychology	-0.2	0.9	0.4	0.07 – 2.1
Social Work (Reference)				
Primary Diagnosis				
Major Depressive Disorder (Reference)				
Generalized Anxiety Disorder	0.3	0.7	1.3	0.3 – 5.7
Panic Disorder	0.2	1.1	1.3	0.2 – 10.6
Other Diagnosis	0.5	0.9	1.7	0.3 – 8.8
Race				
White/Caucasian (Reference)				
Minority	0.3	0.6	1.4	0.4 – 4.8
Gender				
Women	-1.8	0.7	0.2*	0.04 – 0.8
Men (Reference)				
Subscribes to Particular Theoretical Orientations[a] (0 = No, 1 = Yes)				
Psychodynamic	1.7	0.7	5.5*	1.5 – 20.2
Humanistic/Existentialist/Gestalt	0.9	0.7	2.3	0.6 – 9.0
Family Systems or Strengths or Person-in-Environment[b]	0.7	0.8	2.1	0.5 – 9.3
Constant	-1.5	1.1	0.2	
χ^2 ***(df)***	24.6 (10)**			
Pseudo R^2 **(Nagelkerke** R^2***)***	.326			
N	97			

*$p < .05$; **$p < .01$.

Table 5-U: Percentage of Respondents Who Would Provide Cognitive-Behavioral Therapy by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Cognitive-Behavioral Therapy			
Full Sample	76.9%		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	71.9%	**Medical/biological** (*n* = 100)	73.2%
Clinical Psychology (*n* = 23)	91.3%	χ^2 (*df*)	1.7 (1)
Social Work (*n* = 49)	73.5%	φ	-.130
χ^2 (*df*)	3.5 (2)	**Psychodynamic** (*n* = 100)	74.5%
φ	.183	χ^2 (*df*)	0.9 (1)
		φ	-.092
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	84.3%
MDD (*n* = 28)	78.6%	χ^2 (*df*)	11.5 (1)**
GAD (*n* = 41)	68.3%	φ	.338
Panic Disorder (*n* = 11)	90.9%	**Interpersonal** (*n* = 100)	79.2%
Other Diagnosis (*n* = 22)	81.8%	χ^2 (*df*)	0.2 (1)
χ^2 (*df*)	3.2 (3)	φ	.032
φ	.178	**Family Systems** (*n* = 100)	74.5%
		χ^2 (*df*)	0.7 (1)
Race		φ	-.086
White/Caucasian (*n* = 71)	77.5%	**Strengths** (*n* = 100)	80.5%
Minority (*n* = 32)	75%	χ^2 (*df*)	0.3 (1)
χ^2 (*df*)	0.08 (1)	φ	.050
φ	-.027	**Person-in-Environment** (*n* = 100)	72.2%
Gender		χ^2 (*df*)	1.1 (1)
Women (*n* = 81)	75.3%	φ	-.105
Men (*n* = 23)	82.6%	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	85.0%
χ^2 (*df*)	0.5 (1)	χ^2 (*df*)	0.7 (1)
φ	-.072	φ	.084
		Integrative/Eclectic (*n* = 100)	96.2%
		χ^2 (*df*)	6.7 (1)**
		φ	.260

*$p < .05$; **$p < .01$.

Table 5-V: Logistic Regression Results: Likelihood that Respondents Would Provide Cognitive-Behavioral Therapy as Part of an Initial Intervention

	Provide Cognitive-Behavioral Therapy			
Predictors	***B***	**SE**	**OR**	**95% CI**
Professional Program				
Psychiatry (Reference)				
Clinical Psychology	0.07	1.0	1.1	0.2 – 7.6
Social Work	-0.1	0.7	0.9	0.2 – 3.4
Primary Diagnosis				
Major Depressive Disorder (Reference)				
Generalized Anxiety Disorder	-0.7	0.7	0.5	0.1 – 2.0
Panic Disorder	1.5	1.3	4.4	0.4 – 54.2
Other Diagnosis	0.9	1.0	2.4	0.4 – 15.7
Race				
White/Caucasian (Reference)				
Minority	-0.2	0.6	0.9	0.2 – 3.0
Gender				
Women	-0.06	0.9	0.9	0.2 – 5.2
Men (Reference)				
Subscribes to Particular Theoretical Orientations[3] (0 = No, 1 = Yes)				
Cognitive-Behavioral	2.1	0.7	8.3**	2.0 – 34.5
Integrative	1.9	1.1	6.8	0.8 – 60.7
Constant	-0.5	0.9	0.6	
χ^2 ***(df)***	22.5 (9)**			
Pseudo R^2 **(Nagelkerke** R^2***)***	.315			
N	97			

*$p < .05$; **$p < .01$.

Table 5-W: Percentage of Respondents Who Would Provide or Offer Referral for Family/Couples Therapy by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Family/Couples Therapy			
Full Sample	35.8%		
(*n*)	106		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	25%	**Medical/biological** (*n* = 101)	33.9%
Clinical Psychology (*n* = 23)	8.7%	χ^2 (*df*)	0.7 (1)
Social Work (*n* = 51)	54.9%	φ	-.085
χ^2 (*df*)	17.1 (2)**	**Psychodynamic** (*n* = 101)	34.5%
φ	.401	χ^2 (*df*)	0.5 (1)
		φ	-.069
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 101)	38.6%
MDD (*n* = 28)	46.4%	χ^2 (*df*)	0.2 (1)
GAD (*n* = 41)	36.6%	φ	.041
Panic Disorder (*n* = 11)	9.1%	**Interpersonal** (*n* = 101)	30.2%
Other Diagnosis (*n* = 23)	34.8%	χ^2 (*df*)	2.6 (1)
χ^2 (*df*)	4.8 (3)	φ	-.161
φ	.216	**Family Systems** (*n* = 101)	46.2%
		χ^2 (*df*)	3.3 (1)
Race		φ	.181
White/Caucasian (*n* = 72)	34.7%	**Strengths** (*n* = 101)	47.6%
Minority (*n* = 32)	40.6%	χ^2 (*df*)	3.1 (1)
χ^2 (*df*)	0.3 (1)	φ	.174
φ	.057	**Person-in-Environment** (*n* = 101)	54.1%
Gender		χ^2 (*df*)	6.7 (1)*
Women (*n* = 83)	38.6%	φ	.258
Men (*n* = 23)	26.1%	**Humanistic/Existentialist/ Gestalt** (*n* = 101)	40%
χ^2 (*df*)	1.2 (1)	χ^2 (*df*)	0.06 (1)
φ	.107	φ	.024
		Integrative/Eclectic (*n* = 101)	23.1%
		χ^2 (*df*)	3.2 (1)
		φ	-.177

*$p < .05$; **$p < .01$.

Table 5-X: Logistic Regression Results: Likelihood that Respondents Would Provide or Offer Referral for Family/Couples Therapy as Part of an Initial Intervention

	Provide *or* Refer for Family/ Couples Therapy			
Predictors	***B***	**SE**	**OR**	**95% CI**
Professional Program				
Psychiatry	-2.2	0.8	0.11**	0.025 – 0.520
Clinical Psychology	-3.1	1.0	0.05**	0.007 – 0.322
Social Work (Reference)				
Primary Diagnosis				
Major Depressive Disorder (Reference)				
Generalized Anxiety Disorder	-0.4	0.6	0.7	0.2 – 2.2
Panic Disorder	-2.6	1.2	0.08*	0.007 – 0.8
Other Diagnosis	-0.4	0.8	0.7	0.2 – 3.1
Race				
White/Caucasian (Reference)				
Minority	0.6	0.6	1.9	0.6 – 6.0
Gender				
Women	-0.2	0.7	0.9	0.2 – 3.4
Men (Reference)				
Subscribes to Particular Theoretical Orientations[b] (0 = No, 1 = Yes)				
Family Systems or Strengths or Person-in-Environment[c]	-0.5	0.7	0.6	0.2 – 2.6
Constant	1.4	1.0	4.0	
χ^2 ***(df)***	28.8 (8)**			
Pseudo R^2 **(Nagelkerke** R^2**)**	.349			
N	97			

*$p < .05$; **$p < .01$.

Table 5-Y: Percentage of Respondents Who Would Admit or Refer for Inpatient Hospitalization, by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

Inpatient Hospitalization			
Full Sample	1.9%		
(*n*)	106		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	0.0%	**Medical/biological** (*n* = 101)	1.8%
Clinical Psychology (*n* = 23)	0.0%	χ^2 (*df*)	.024 (1)
Social Work (*n* = 51)	3.9%	φ	-.016
χ^2 (*df*)	2.2(2)	**Psychodynamic** (*n* = 101)	3.6%
φ	.144	χ^2 (*df*)	1.7 (1)
		φ	.130
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 101)	2.4%
MDD (*n* = 28)	7.1%	χ^2 (*df*)	0.4 (1)
GAD (*n* = 41)	0.0%	φ	.066
Panic Disorder (*n* = 11)	0.0%	**Interpersonal** (*n* = 101)	3.8%
Other Diagnosis (*n* = 22)	0.0%	χ^2 (*df*)	1.8 (1)
χ^2 (*df*)	5.5 (3)	φ	.135
φ	.230	**Family Systems** (*n* = 101)	3.8%
		χ^2 (*df*)	1.9 (1)
Race		φ	.138
White/Caucasian (*n* = 72)	2.8%	**Strengths** (*n* = 101)	4.8%
Minority (*n* = 32)	0.0%	χ^2 (*df*)	2.9 (1)
χ^2 (*df*)	0.9 (1)	φ	.168
φ	-.093	**Person-in-Environment** (*n* = 101)	5.4%
Gender		χ^2 (*df*)	3.5 (1)
Women (*n* = 83)	0.0%	φ	.187
Men (*n* = 23)	8.7%	**Humanistic/Existentialist/ Gestalt** (*n* = 101)	10.0%
χ^2 (*df*)	7.4 (1)**	χ^2 (*df*)	8.3 (1)**
φ	-.263	φ	.286
		Integrative/Eclectic (*n* = 101)	7.7%
		χ^2 (*df*)	5.9 (1)*
		φ	.241

*$p < .05$; **$p < .01$.

Table 5-Z: Percentage of Respondents Who Would Provide Interpersonal Psychotherapy by Program, Primary Diagnosis, Race, Gender, and Theoretical Orientations

	Interpersonal Psychotherapy		
Full Sample	53.8%		
(*n*)	104		
Independent Variables			
Professional Program		***Theoretical Orientations***	
Psychiatry (*n* = 32)	18.8%	**Medical/biological** (*n* = 100)	46.4%
Clinical Psychology (*n* = 23)	69.6%	χ^2 (*df*)	2.9 (1)
Social Work (*n* = 49)	69.4%	φ	-.171
χ^2 (*df*)	22.9 (2)**	**Psychodynamic** (*n* = 100)	52.7%
φ	.469	χ^2 (*df*)	0.08 (1)
		φ	-.028
Primary Diagnosis		**Cognitive-Behavioral** (*n* = 100)	53.0%
MDD (*n* = 28)	50.0%	χ^2 (*df*)	0.2 (1)
GAD (*n* = 41)	53.7%	φ	-.044
Panic Disorder (*n* = 11)	45.5%	**Interpersonal** (*n* = 100)	71.7%
Other Diagnosis (*n* = 22)	63.6%	χ^2 (*df*)	14.2 (1)**
χ^2 (*df*)	1.3 (3)	φ	.377
φ	.114	**Family Systems** (*n* = 100)	62.7%
		χ^2 (*df*)	3.2 (1)
Race		φ	.179
White/Caucasian (*n* = 71)	60.6%	**Strengths** (*n* = 100)	63.4%
Minority (*n* = 32)	40.6%	χ^2 (*df*)	2.5 (1)
χ^2 (*df*)	3.5 (1)	φ	.157
φ	-.185	**Person-in-Environment** (*n* = 100)	72.2%
Gender		χ^2 (*df*)	7.5 (1)**
Women (*n* = 81)	55.6%	φ	.274
Men (*n* = 23)	47.8%	**Humanistic/Existentialist/ Gestalt** (*n* = 100)	75.0%
χ^2 (*df*)	0.4 (1)	χ^2 (*df*)	4.4 (1)*
φ	.064	φ	.211
		Integrative/Eclectic (*n* = 100)	61.5%
		χ^2 (*df*)	0.8 (1)
		φ	.090

*$p < .05$; **$p < .01$.

Table 5-AA: Logistic Regression Results: Likelihood that Respondents Would Provide Interpersonal Psychotherapy as Part of an Initial Intervention

Predictors	Provide Interpersonal Psychotherapy			
	B	SE	OR	95% CI
Professional Program				
Psychiatry (Reference)				
Clinical Psychology	1.7	0.9	5.2†	0.9 – 28.8
Social Work	2.0	0.7	7.6**	1.8 – 32.3
Primary Diagnosis				
Major Depressive Disorder (Reference)				
Generalized Anxiety Disorder	-0.4	0.7	0.7	0.2 – 2.7
Panic Disorder	-0.7	1.0	0.5	0.08 – 3.3
Other Diagnosis	-0.5	0.8	0.6	0.1 – 2.8
Race				
White/Caucasian (Reference)				
Minority	-0.2	0.6	0.9	0.3 – 2.7
Gender				
Women	-0.5	0.8	0.6	0.1 – 2.7
Men (Reference)				
Subscribes to Particular Theoretical Orientations[a] (0 = No, 1 = Yes)				
Humanistic/Existentialist/Gestalt	0.8	0.7	2.3	0.5 – 9.7
Family Systems or Strengths or Person-in-Environment[b]	0.4	0.7	1.4	0.4 – 5.4
Interpersonal	1.4	0.6	4.1*	1.2 – 14.7
Constant	-1.4	0.7	0.2	
χ^2 *(df)*	36.2 (10)**			
Pseudo R^2 (Nagelkerke R^2)	.417			
N	97			

†$p < 0.09$; *$p < .05$; **$p < .01$.

Table 5-AB: Summary of Results on Treatment Effectiveness and Treatment Recommendations

Intervention Type	Hypothesis	Variables that Predict Likely Treatment Effectiveness	Variables that Predict Recommendation	Degree of Institutionalization of Intervention	Support for Hypothesis?
Psychopharmacology	Hyp. 4f/4g: PR > CP > SW	Biomed OR = ↑ effectiveness	Panic diagnosis = ↓ likelihood; Fam/Strength/Eco = ↓ likelihood; Psychodynamic = ↑ likelihood	Medium to High	4f: Not supported 4g: Not supported
Psychodynamic Psychotherapy	Hyp. 4h/4i: PR, SW > CP	Profession – PR, SW > CP; Psychodynamic OR = ↑ effectiveness	Psychodynamic = ↑ likelihood; Male trainees = ↑ likelihood	Low to Medium	4h: Supported 4i: Not supported
Cognitive-behavioral Therapy	Hyp. 4j/4k: CP > PR	None	Cog-beh OR = ↑ likelihood	High	4j: Not supported 4k: Not supported
Family/Couples Therapy	Hyp. 4l/4m: SW > PR, CP	Profession – SW > PR > CP; Minority trainees = ↑ effectiveness;	Profession – SW > PR, CP; Panic diagnosis = ↓ likelihood;	Low to Medium	4l: Supported 4m: Supported
Inpatient Hospitalization	Hyp. 4n/4o: PR > CP, SW	In bivariate analyses – Panic diagnosis = ↓ likelihood; Psychodynamic OR = ↑ likelihood	In bivariate analyses - Male trainees = ↑ likelihood; Humanistic OR = ↑ likelihood Integrative OR = ↑ likelihood	High	4n: Not Supported 4o: Not Supported
Interpersonal Psychotherapy	No hypotheses offered	Profession – SW > PR	Profession – SW, CP > PR; Interpersonal OR = ↑ likelihood	Medium	No hypotheses offered

Note: Hyp. = Hypothesis; Profession = Professional Affiliation; PR = Psychiatry Residents, CP = Clinical Psychology Students, SW = Social Work Students; Biomed OR = Endorsed Medical/Biological Orientation; Panic Diagnosis = Diagnosis of Panic Disorder compared to a diagnosis of Major Depressive Disorder; Fam/Strength/Eco = Endorsed one or more of the Family/Systems, Strengths, or Person-in-Environment orientations; Psychodynamic OR = Endorsed Psychodynamic Orientation; Cog-beh OR = Endorsed Cognitive-behavioral Orientation; Interpersonal OR = Endorsed Interpersonal Orientation

Chapter 6: Conclusion

Recent reports point to and disparage the uneven nature of U.S. mental health service provision (e.g., Institute of Medicine 2006). For example, Wang et al. (2005) find that only thirty-three percent of those receiving services are offered treatment consistent with evidence-based clinical guidelines. Inconsistent clinical practices suggest that the U.S. mental health field is incompletely institutionalized, or that there are multiple sets of acceptable rules, beliefs, and blueprints for action that exist to shape providers' practice patterns.

I devised this study of trainees from the top programs in psychiatry, clinical psychology and social work in Georgia to a) determine the extent to which trainees' diagnostic- and treatment-related judgments and approaches converge; b) determine which aspects of diagnosis and treatment trainees agree and disagree on; and c) uncover factors that account for divergences. DiMaggio and Powell's (1991) writing on professions as a source of uniformity within organizational fields coupled with Abbott's (1988) writing on professions' need to distinguish themselves from other professions in order to create and maintain their jurisdiction suggest an interesting proposition. Namely each profession should generate uniformity among its members but in an organizational field that contains multiple competing disciplines professional affiliation will be a source of variation for the field as a whole. This proposition led me to focus on the impact that professional affiliation has on trainees' work with patients, while also exploring the impact that trainees' gender, race and theoretical orientations may have independent of professional affiliation.

DIAGNOSIS

Some aspects of trainees' use of diagnosis are widely shared while others are variable. All of the trainees conceptualize the issues contained in the case study as evidence of a mental health problem that necessitates intervention from a mental health provider. More generally, all interviewees agree that diagnosis has some place in their clinical work. Most notably, on the question of which diagnostic classification system trainees use to diagnose patients or clients, all interviewees refer solely to the Diagnostic and Statistical Manual of Mental Disorders (APA 2000), or DSM, despite being prompted about alternative classification systems. That is, for each and every interview respondent 'diagnosis' is synonymous with DSM diagnosis*,* although multiple diagnostic classifications systems (e.g., ICD-9 (National Center for Health Statistics 2009)) are available and in wide usage for mental health conditions in certain other countries (e.g., The Bahamas). This uniformity suggests DSM is highly institutionalized throughout the U.S. mental health field. Put another way, DSM as diagnosis is a part of the widely-shared cognitive script that binds the field together.

Trainees' unanimity on diagnosis, however, ends there. When asked whether the woman in the case study is suffering from a "mental disorder," when asked to assign a primary diagnosis, and when asked to discuss the role of diagnosis in their clinical work, trainees' answers diverge based on professional affiliation. Specifically, psychiatry residents stand apart from the other two groups in a number of respects. They consider DSM the foundation for their clinical work because an accurate diagnosis determines their treatment decisions. Additionally they are comfortable with assigning diagnoses – even severe diagnoses such as Major Depressive Disorder – quickly. In comparison,

social work trainees are more reluctant than psychiatry residents to make a disorder attribution, and clinical psychology trainees are more likely than psychiatry residents to assign a less-severe diagnosis. Clinical psychology trainees and social work trainees both consider arriving at a differential diagnosis secondary to understanding an individual's unique symptom profile (for the clinical psychologists) and social circumstances (for the social workers). Social workers stand apart from the other groups in stressing the potential stigma that psychiatric diagnoses can bring.

Intriguingly, with respect to the case study, social work and psychiatry trainees do not differ significantly in the primary diagnosis they assign or in the importance they place on rendering an accurate diagnosis. This unexpected uniformity may be due to the fact that the social work trainees frequently work on mental health teams headed by psychiatrists. Thus, they may have reservations about rendering a diagnosis but when asked to do so their judgments approximate those of the professionals in power. In contrast, clinical psychologists tend to work independent of psychiatrists. Perhaps as a result a number of their diagnostic judgments differ significantly from psychiatrists' judgments.

Preliminary data I gathered on training patterns offer potential insight into professional differences in the use of diagnosis. Social work trainees, for example, have the opportunity to take only a single class on psychopathology and diagnosis. Outside of this one *elective* class the social work faculty mention diagnosis and diagnostic labels infrequently. When social work faculty do mention psychiatric diagnoses, it is often to caution students about the lasting harmful effects that a diagnostic label may have. Interviewees from the other two groups report extensive training in diagnosing clients or

patients using the DSM classification system, and make no mention of their professors warning them of the possible long-term, detrimental effects of psychiatric diagnoses on their patients' lives. Given the scant training social workers receive on diagnosis, coupled with their professors' warnings about the potential for stigma associated with diagnostic labels, it is understandable that social workers may end up learning how to use the DSM on the job from psychiatrists yet remain reticent about assigning a diagnosis.

Both psychiatry and clinical psychology trainees, in contrast, receive substantial training on diagnosis, but of a different nature. Psychiatry residents' training focuses on learning the specific criteria necessary to make differential diagnoses for conditions contained within the DSM. Training begins with rote memorization of the diagnostic criteria and over time moves toward creating diagnosticians who combine efficiency with accurate precision. While clinical psychology trainees receive a broad grounding in DSM, their training focuses on broad rather than fine diagnostic distinctions and encourages them to view the DSM criteria sets with a critical eye (e.g., to ask which criteria are clinically relevant). Additionally it focuses more generally on errors in clinical judgment, identifying speed, the use of oversimplified heuristics, and errors of reasoning as causes of clinical errors. Moreover, clinical psychologists' training takes place exclusively in an outpatient setting with stable clients and emphasizes a slow, steady gathering of information over a series of hour-long outpatient visits with a client. In contrast psychiatry residents are pushed on the inpatient units (especially in emergency rooms) to learn to make diagnostic decisions quickly so that very ill patients are attended to in a timely manner. Given their different training it follows that psychiatry residents are the most comfortable rendering diagnostic judgments quickly based on limited

information while clinical psychology trainees assign diagnosis less importance in general and offer less severe diagnoses when asked to make diagnostic judgments quickly.

Other factors that influence trainees' diagnostic judgments and views on the role of diagnosis in clinical work include a trainee's gender, her theoretical orientations, and the setting in which care is provided. In the case of a client presenting with a mix of depressive and anxious symptoms male trainees are more likely than female trainees to assign the most-severe primary diagnosis option offered (Major Depressive Disorder). With respect to theoretical orientations, endorsing the strengths or family-systems orientation is associated with discomfort over labeling a client's condition a mental disorder, while endorsing the psychodynamic orientation is associated with an overall positive view of diagnosis' role in clinical work. Finally, trainees' use of diagnosis depends on the setting in which care is provided. Diagnosis is more prominent on inpatient settings where patients are critically ill, a provider's time with a patient is limited and multiple providers must coordinate treatments with one another. In outpatient settings – where clients are stable and clinicians have the ability to evaluate their clients over a series of sessions – arriving at a client's differential diagnosis becomes less important than gaining a thorough picture of a client's unique case history and symptom profile.

TREATMENT

As with diagnosis, trainees' treatment patterns and decisions reflect neither unanimity nor complete dissensus. Some aspects of care are widely shared among trainees from all professions (suggesting field-wide institutionalization), while others are

shared within but not between professions (suggesting institutionalization at the level of professions). All trainees, for example, support the use of psychotherapy to treat anxiety and depression despite the fact that not all trainees plan to offer psychotherapy after graduation. Likewise, many trainees from all professions speak of a focus on building and maintaining a relationship based on a patient's trust and cooperation as critical – regardless of the type of treatment (i.e., medication vs. psychotherapy) offered. That is, while not every interviewee independently mentions a therapeutic or working alliance as a key component of a successful clinician-patient relationship, no one discounts the importance of such an alliance. It is widely-held that treatment success is contingent on a patient's trust and buy-in.

Furthermore, trainees express widespread support for a number of treatment interventions for use with patients or clients exhibiting signs of anxiety and depression. Cognitive-behavioral therapy (CBT) and, to a somewhat lesser extent, drug therapy have the benefit of most trainees' endorsement. This runs counter to my hypotheses that CBT would be more popular with clinical psychologists and drug therapy more popular with psychiatrists. This widespread backing suggests that despite profession-specific origins these interventions now are institutionalized field-wide. Additionally, just as interventions that have widespread support likely represent areas of high institutionalization, interventions with very little or no support – such as recommending a person with depressive and anxious symptoms not in crisis be admitted to an inpatient unit – are also part of a broadly-shared cognitive script that governs the U.S. mental health field. Finally, and unexpectedly, trainees share an eclectic or integrative approach to the use of theory to guide their clinical work. That is, not a single trainee endorses (in

the survey) or discusses (in the interview) using only one orientation with clients. The way that trainees join orientations (e.g., always combining the same orientations in the same way vs. using different single or multiple orientations depending on the circumstances) varies but the act of drawing on multiple orientations does not. This suggests that despite the large number of theoretical orientations available for use among mental health clinicians – orientations enjoying varying levels of field-wide support – a pluralistic approach to care is part of the overarching script that governs beliefs and behaviors in the U.S. mental health arena.

While some aspects of care are widely shared, others are contingent on professional affiliation thanks to unique professional logics that govern professionals' beliefs and actions. For example, social work, emerging as it did out of concerns for social welfare and social justice, conceptualizes individuals as embedded within social systems (e.g., community, family) and emphasizes individual rights. Consequently social work trainees favor the family-systems and person-in-environment orientations, the use of family therapy, and consider resource referrals central in their work with clients more than do trainees from other professions. Social work's focus on individual welfare and self-determination translates to an egalitarian model of working with clients where clients are empowered and have the final say in treatment decisions.

Psychiatry maintained its prominence throughout a large part of the twentieth century due to the popularity of psychodynamic psychotherapy which, until recently, only psychiatrists could legally offer. In recent years psychiatry retained its jurisdiction due to the rise in popularity of psychoactive drug therapy, a type of intervention only medical doctors can legally offer in most states. Thus, psychiatry residents are more

likely than trainees from other professions to use a psychodynamic orientation. Additionally, despite the widespread support for drug therapy among trainees of all professions, it is the psychiatry residents with their medical backgrounds and prescription privileges who consider medication management the prime intervention to use in treating mental disorders. The other two professions see psychotherapy as primary and medication as secondary. Moreover, psychiatry residents' medical background, which emphasizes maintaining distance between patients and doctors in the interest of making objective diagnostic and treatment decisions, translates to a clinician-as-expert model of working with patients. That is, residents typically see themselves as teaching patients and have the final say in some treatment decisions such as whether or not to prescribe medication or recommend admittance to an inpatient unit.

Clinical psychology's legacy of scientific inquiry and standardized psychological testing leads its trainees to focus on research and evidence-based practice more than trainees from the other professional disciplines. Psychology's focus on psychopathology discourages a strengths-based approach to care (favored by social work trainees). Additionally its focus on individuals' symptoms and personalities means that clinical psychology trainees tend to emphasize individual-level interventions and deemphasize interventions like family and couples therapy and community referrals – interventions favored by their counterparts in social work and, to a lesser extent, psychiatry.

Finally, one of the most striking – and wholly unexpected - examples of professional affiliation shaping trainees' practice patterns is trainees' choice of theoretical orientations to guide clinical practice. Trainees who chose both the biomedical and psychodynamic orientations were psychiatry residents. Trainees who selected the

cognitive-behavioral and interpersonal orientations were clinical psychologists. Those who combined either the family-systems or strengths orientation with the cognitive-behavioral orientation were social workers.

Preliminary data analyses on profession-specific training patterns suggest ways in which university training shapes its members' decisions and clinical approach. Virtually every social work class offered to members on the individual-practice track (as opposed to the community track) contained the word 'family' in the title and interviewees talked about how each class emphasized how family development, familial interactions, and overall family well-being affects individuals. While social work trainees were introduced to a variety of theoretical orientations and their corresponding interventions in the one class offered on clinical interventions, all of their classes conveyed the importance of taking a strengths-based approach and of conceptualizing individuals as embedded in social networks. This translates to social work trainees favoring the family-systems, strengths, and person-in-environment orientations and in their belief about the effectiveness of family therapy.

Psychiatrists' first year of residency is spent exclusively working on inpatient units with very ill patients where they are primarily taught diagnosis and medication management. Training in outpatient psychotherapy – specifically in psychodynamic psychotherapy - begins part-time in their second year where it remains relegated to second-place compared to medication management. The two orientations stressed throughout their training are the biological or medical model of mental disorders (which translates to a focus on drug therapy) and the psychodynamic orientation (which translates to a focus on psychodynamic psychotherapy).

Clinical psychologists take an intensive research methods course in their first semester and are assigned to a research lab on their first day as graduate students. Conducting their own research is mandatory and receives the same emphasis as does training in psychotherapy. And while clinical psychology trainees receive extensive training in different types of individual psychotherapy the two orientations that receive the greatest emphasis are cognitive-behavioral and interpersonal approaches and trainees receive no training in family therapy. Consequently clinical psychology trainees are encouraged to use the research literature to guide their treatment decisions. They also favor the use of cognitive-behavioral and interpersonal therapies and discount the effectiveness of family therapy.

Trainees' theoretical orientations, gender, and race affect trainees' treatment decisions independently of trainees' professional affiliation. For example, those practicing from a psychodynamic orientation were more likely to rate drug therapy highly effective and to gear treatment toward alleviating psychopathology than were those who did not work from a psychodynamic orientation. Conversely, women, minorities, and those favoring the family-systems, strengths, or person-in-environment orientations were more likely to focus treatment on bolstering strengths than were men, whites, and trainees who did not endorse of these orientations.

CONCLUDING REMARKS AND DIRECTIONS FOR FUTURE RESEARCH

This project provides a glimpse into present and future diagnostic and treatment trends in the U.S. mental health field by focusing on advanced clinical trainees. It adds to our understanding about mental health providers' practice patterns by exploring a key source of variability in decision making and approach to care, namely professional

affiliation. I find that certain types of trainees' diagnostic and treatment-related judgments and approaches are widely shared (likely representing field-wide institutionalization) while others are strongly shaped by professional affiliation. Areas where trainees' decisions and general work patterns are shared within but not between professions likely represent institutionalization at the level of professions. That is, in these instances trainees' enact professional logics. Figure 6-A depicts the nested levels of institutionalization affecting trainees' clinical decisions and approach to care. For example, diagnosis is synonymous with DSM diagnosis field-wide based on the "rational myth" (Meyer and Rowan 1991) that DSM represents a scientifically-validated classification system, yet trainees' specific views on and use of diagnosis are contingent on professional affiliation. Put another way, different professional disciplines translate broad institutions in distinct ways. Additionally, trainees' views of diagnosis are shaped by their preferred theoretical orientations which cluster based on professional affiliation. Thus, the results of this study suggest that despite pressures toward uniformity in a given organizational field substantial differences will persist when the field contains multiple professions fighting over jurisdiction.

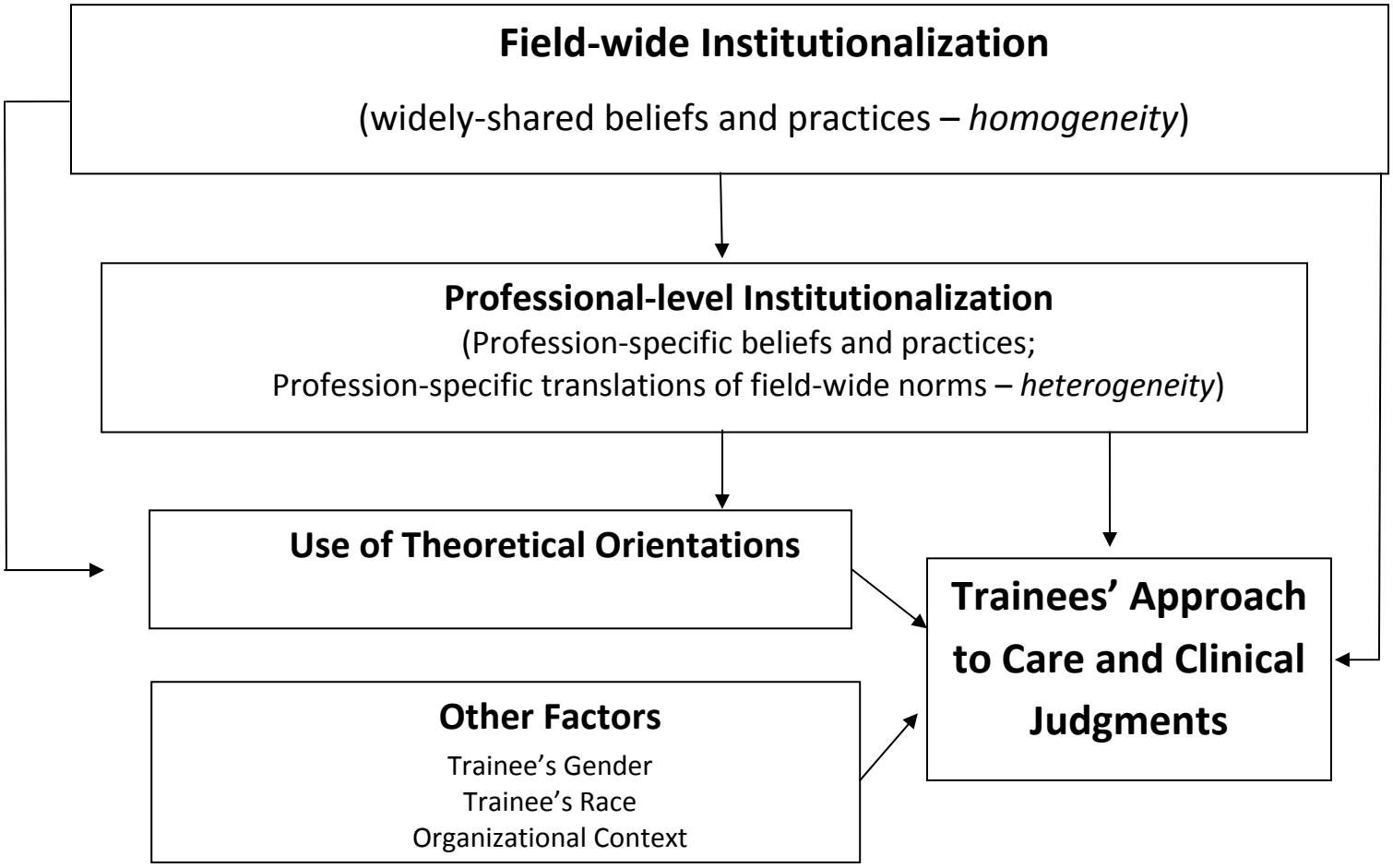
This project is limited in scope, however, and suggests a number of potential avenues for future research. First, the study is small and restricted to three professional programs in a single U.S. state. Future research should test the generalizability of this study's conclusions, either by replicating this study with a random sample of U.S. mental health trainees or by undertaking multiple case studies in various regions of the country to test for regional differences. It would also be interesting to broaden the scope of the project to include newer occupational groups working in the mental health field such as

clinical psychologists that receive the professional degree (PsyD) rather than the PhD (geared toward combining research and clinical practice) and mental health counselors.

Second, DiMaggio and Powell (1991) note two ways that professions generate isomorphism are university training and membership in professional associations. Future research should explore the ways in which professional training programs shape trainees' practice patterns. What are the mechanisms through which professions transmit their professional logics?

Third and finally, it would be interesting to see whether professional differences evident in advanced trainees calcify or dissipate over time. Does professional training put trainees on a path-dependent trajectory that membership in professional affiliations serves to solidify? Alternatively, do differences in work patterns among members of the same profession (e.g., different types of work, work in dissimilar organizational contexts, work with different patient populations, working alongside different types of providers) serve to enlarge differences within professions and narrow differences between professions over time? A longitudinal cohort study that began studying the work patterns of different types of mental health trainees and repeatedly observed these same individuals at various intervals during their careers would be especially instructive in uncovering the extent to which and the different mechanisms through which professional affiliation shapes providers' clinical practices over time.

Figure 6-A: Factors Shaping Mental Health Trainees' Clinical Judgments



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