PSYCHIATRIC DIAGNOSIS AS SIGN AND SYMBOL:

NOMENCLATURE AS AN ORGANIZING AND LEGITIMATING STRATEGY

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ABSTRACT

Focusing on professional knowledge and occupations and drawing on institutional, resource dependence, and ecological theories, reasons why psychiatric nomenclature has changed are postulated. The effects that these changes may have on the division of labor among mental health professionals and organizational forms of service delivery are conceptualized. Through the development and control of knowledge and belief systems, professions gain power by resituating whose professional competence becomes most relevant. In highly institutional environments such as mental health services settings, where etiology, technology, and outcomes can be intangible and unclear, attempts to standardize rules of classification and practice according to a scientific model of medicine reduce uncertainty and enhance professional and organizational legitimacy. With increasing pressure to rationalize health care, diagnoses can be viewed as a

Perspectives on Social Problems, Volume 4, pages 155-176.

ISBN: 1-55938-559-6

resource and a commodity that administrators negotiate with funding environments and regulatory agencies. Treatment organizations operating in conflicting institutional environments will "decouple" their research, clinical, and administrative organizational structures.

The *Diagnostic and Statistical Manual* (DSM), published by the American Psychiatric Association, codifies the rules for making patient diagnostic and treatment decisions. Since 1980, with the third revision of the manual (DSM-III), it has been the focus of increasing controversy in the professional and scholarly literature. The DSM-III and III-R debates have been characterized by both refutation and polemics among the mental health disciplines of psychiatry (Klerman, Vaillant, Spitzer, and Michels 1984; Klerman 1989), psychology (Garfield 1986; Meehl 1986; Millon and Klerman 1986), social work (Kutchins and Kirk 1988), and sociology (Mirowsky and Ross 1989).

Although these debates span several disciplines, they focus on three themes: the philosophy of science, paradigm revolution, and measurement theory. This literature portrays discussions of the tension between the practice of science versus professional politics as the basis of how DSM-III is conceptually constructed. Second, there are the descriptions of the professional pushing and shoving in a paradigm shift from the psychodynamic to the biopsychiatric model. And last, there is a literature on measurement theory, with most notably the issue of making continuous phenomenon into discrete events and the concomitant trade-off between validity and the quest for reliability. In all, this literature has the flavor of evaluating the DSM-III as a tool rather than as an explanation for its existence and continuing development.[1] These discussions describe and critique the development of the DSM, but not the institutional determinants and organizational consequences.

Given the focus of this literature as well as the ongoing work in developing the DSM-IV,[2] it is important to extend the questioning of the DSM revisions beyond asking if the proliferation and rationalization of the psychiatric nomenclature has been substantiated by real growth in scientific knowledge. It is also crucial to ask what else, on a rational as well as a symbolic and institutional level, might drive the continuing development and expansion of the DSM?

This paper will draw upon institutional, resource dependence, and ecological theories to lend insights about how the DSM-III may be viewed as a set of rules (Meyer and Rowan 1977; DiMaggio and Powell 1983), as a resource (Pfeffer and Salancik 1978), as a commodity and marketing strategy (Abbott 1989), and as an organizing strategy for the mental health sector. An attempt will be made to focus upon this subject in terms of the implication for the professions as well as the effects on the organizational forms of the service delivery system.[3]

REVIEW OF THE DSM-III AND III-R

First, a brief overview of the classification system (DSM-III and III-R) is useful here. This nomenclature has become the official classification system of mental disorders used by most all mental health professionals in the United States. It has been translated into thirteen foreign languages. It has organized the boundaries and methods of classifying mental illness differently from its predecessors (DSM II-R, 1974, DSM-II, 1968 and DSM I, 1952) in a number of significant ways.

In DSM I, II, and II-R, explicit criteria are not provided. The clinician is largely on his or her own in individually defining the content and boundaries of diagnostic categories. In DSM-III and III-R, intangible psychodynamic concepts such as neurosis are no longer used as definitional and classifying principles. To improve interjudge reliability, mental disorder is defined by categorical criteria consisting of observable and reported symptoms.

A multiaxial system, to obtain information of value in planning treatment and predicting clinical outcome and prognosis, includes axes for describing psychological (mental disorders), biological (physical disorders and conditions), and social factors (severity of psychosocial stressors and highest level of adaptive functioning) (Spitzer and Williams 1982).

The DSM-III and III-R include a set of hierarchical decision trees and rules for differential diagnosis whereby those cases with co-occurrence of symptoms and syndromes (characteristic of many cases) can be assigned to a dominant disorder, that is, a single diagnosis (Boyd et al. 1984). For example, a diagnosis of major depression would rule out a diagnosis of obsessive compulsive disorder, although the patient may experience symptoms that indicate either diagnosis.

The DSM-III was designed to be atheoretic with regard to the etiology of mental disorders so as to encourage clinicians of varying theoretical orientations (e.g., social learning, cognitive, behavioral, and biological) to use the classification system. By avoiding claims concerning etiology, the DSM-III attempts to get around the problem of a lack of consensus among professionals in the mental health field. The DSM-III and subsequent revisions are embodied in an underlying philosophy of positivism; which as a unifying framework is compatible with several theoretical and disciplinary orientations in the mental health professions. The DSM-III and III-R revisions also appear to model the scientific paradigm of medicine.

The classification system has been designed by committees and subcommittees of the American Psychiatric Association with some liaison from other professional associations. DSM-III lists 18 such committees and DSM-III-R refers to 28. Eighty to ninety percent of the committees have been composed of psychiatrists or members with medical degrees representing recognized expertise in diagnosis of specific disorders. For the most part,

proposals for revision of the DSM-III and III-R and the subdivision of each diagnostic class into specific disorders were not empirically based on known etiology but are constructed on the best judgment of these advisory subcommittees. The authors view the DSM as a "still frame" and an ongoing process of attempting to better understand and define mental disorders. They view the goal of future revisions as increasing the utility of the classification categories for making treatment and patient management decisions.

Unlike the DSM-III, the development process of the DSM-IV is attempting to base changes in diagnostic categories on systematic literature reviews and empirical research when available. The "rationalizing" changes made in the DSM in 1980 have facilitated the growth of empirical research. The National Institute of Mental Health and private research foundations have funded not only empirical work on mental disorders, but also research on the reliability and validity of the DSM diagnostic categories.

Psychiatric diagnoses have diverse, latent, and sometimes conflicting roles and functions. Using an institutional theory perspective, this discussion will focus first on the DSM's role in rationalizing, legitimating, and providing an "account" of mental health work. Second, using a set of resource dependence arguments, the connection between diagnostic records and reimbursement systems, where the product of the DSM can be viewed as an organization resource, commodity, and marketing strategy will be made. And finally, through an ecological lens, the implications of the development of the DSM will be viewed as an organizing strategy for the mental health professions and the service delivery system.[4]

MANAGING THE ENVIRONMENT: DIAGNOSIS AS REDUCING TECHNOLOGICAL UNCERTAINTY

Institutional theory takes account of how symbols, ideologies, and rules may shape organizational forms. It provides an alternative or complementary explanation for organizational forms aside from technical production and exchange. Organizations are characterized as highly institutionalized environments when work is less technical and tangible and organizations incorporate rational institutionalized rules to gain legitimacy, resources, stability, and enhanced survival prospects.

Institutional theory follows two lines of argument. Rooted in the work of Selznick (1957), Berger and Luckmann (1967), Meyer and Rowan (1977), and Scott (1987), the first branch focuses on the cognitive processes that construct a shared definition of practices that over time become infused with value. The second vein focuses on a macro level with the impact of organizations, agencies of the state and professional associations. The origins of rational institutional rules are (1) the elaboration of complex relational networks, for example,

institutions and values that make it advantageous for organizations to incorporate new structures; (2) the degree of collective organization of the environment, for example, the development of legal and regulatory entities, licensing requirements, and professional organizations that have the capacity to generate and enforce cognitive and normative belief systems and reward professions and organizations for conformance to rules; and (3) leadership efforts of organizational actors, for example, managing the institutional environment among key organizations such as the American Psychiatric Association (APA), the Health Care Financing Administration (HCFA), and the National Institute of Mental Health (NIMH) (Meyer and Rowan 1977).

Mental health service delivery settings have been described as having a strong institutional and a weak technical environment (Meyer 1986; Scott 1987). Organizations theory argues that there is a continuum of organization environments from those structured by technical criteria (e.g., manufacturing) to those dominated by institutional criteria (e.g., schools, mental health centers) (Meyer and Scott 1983). Technical organizations are evaluated by their product or service being exchanged in a market setting that rewards effective or efficient performance. Institutional organizations are assessed by their conformity to socially legitimate forms. For technical organizations, work processes follow structure and can be concretely evaluated. For institutional organizations only structure can be assessed and the work and output are assumed to be appropriate (Perrow 1985).

Mental health service settings as an institutional environment in an increasingly "rationalizing" world are dependent on a strong set of rules and beliefs. The DSM as a symbol of professional knowledge is a powerful set of rules for understanding and managing a highly institutional environment. Mental health treatment technologies are uncertain and work activities often are not visible. Through the DSM as sign and symbol, meaning, form, and continuity are given to uncertain and less tangible work activities where performance criteria are not always clear. Even though a diagnosed problem may remain ambiguous, by identifying an appropriate professional category for it, the ambiguity is at least professionally contained (Abbott 1988).

For example as Brown (1987) states, "Clinicians take the DSM very seriously and believe in its reality. It provides positive functions of reducing uncertainty around imprecise treatment technologies ... it gives you the sense that psychiatric diagnosis is so accurate that you have to use five digits." One might then expect that:

Hypothesis 1. As mental health organizations attempt to "manage uncertainty" they will increasingly adopt visible evidence of professionally codified forms of providing service such as use of the DSM.

Hypothesis 2. As societal pressure increases toward "rationalizing" institutional environments (e.g., demonstrate technology and outcomes), then there will be continued effort toward tangible codification of mental disorders.

DIAGNOSIS AS CREATING PROFESSIONAL LEGITIMACY

Legitimacy and uncertainty are inversely connected. "What legitimates institutionalized organizations, enabling them to appear useful in spite of the lack of technical validation, is the confidence and good faith of their internal participants and their external constituents" (Meyer and Rowan 1977).

Particularly since the work of Goffman's *Asylum* (1961), Szasz's *The Myth of Mental Illness* (1974), and the British and American cross-cultural studies on schizophrenia, there have been attacks on the legitimacy of the mental health profession and a crisis in public sentiments over individual versus collective responsibility for mental health (Meyer 1986).

Koran and Sharfstein (1986) have noted that there is disagreement on what mental illness is and on the approaches to treating it. Klerman (1989) states that in the past, when the preferred treatment was individual psychoanalysis, it didn't matter what diagnostic category was assigned to the patient because the treatment was not recognized as legitimately treating an illness, but instead an individual's intrapsychic conflicts.

Meyer (1986) has noted that a prominent aspect of the mental health system has been the lack of consensually agreed upon rules for defining people as healthy or sick, better or worse, or for differentiating between successful and unsuccessful treatment. The construction of a more reliable diagnostic system (DSM-III, III-R) allows mental illness to be visible to the public and external organizations. It fosters a "logic of confidence" that mental health as a profession has a scientific method that can do something about mental illness. Thus one might expect that:

Hypothesis 3. As concerns for professional legitimacy increase, the DSM will become increasingly developed and adopted as the standard technology for diagnosis.

DSM AS A RATIONALIZING FORCE

There are growing environmental pressures to institutionalize rationality and efficiency in the health and mental health sectors (Meyer 1986; Bittker 1985; Freedman 1985; Scott 1983). Organizational forms of service delivery are increasingly coalescing into systems of large organized purchasers and private multi-system corporate providers that value standardization and devalue

professional status and individuality (Light 1988; Bittker 1985; Relman 1987). There is an increased trend to rationalize the system by corporate planners (Scott 1983; Siegrist 1983) and professional managers.

If one looks at the history of the development of the DSM one can also see a concomitant trend. In 1952, with the publication of the first edition, there was virtually little standardization. Subsequent editions required that diagnosis be only theoretically informed. And as later editions have developed, they have become increasingly rationalized by the dominance of decision rules for manipulating atheoretic lists of categories and criteria.[5] The institutionalization of the DSM in clinics and in training physicians, psychologists, and social workers can function to reduce the cost of clinical staff supervision and coordination. It can be thought of as increasing the efficiency of collective diagnostic work.[6]

DIAGNOSIS AS AN ORGANIZATION RESOURCE AND COMMODITY

Resource dependence theory states that organizations are not self-sufficient, but survive and adapt their forms by exchanging resources with their environment (Pfeffer and Salancik 1978). The need to acquire resources creates dependencies among organizations and outside units. To ensure organizational survival, managers act to aggressively acquire and maintain resources from their environments, while at the same time attempting to minimize threatening dependencies (Scott 1987).

It seems important to draw the link between the formalization of diagnostic categories and the notion of organizational resources and the role of records in human service organizations. Diagnostic records can be viewed as social products that become intra- and interorganizational resources. Relationships with other organizations produce demands for records and record production influences the day-to-day form of providing services and interacting with patients. The clinic and the clinician are dependent on a variety of other agencies, such as health care and social service agencies, as well as funding bodies. Until the clinic has created the records, it has not done any identifiable work activity that can be exchanged for resources or transferred to other agencies (Olson and Gordon 1984).[7]

Reimbursement systems in mental health have changed dramatically in recent years and these changes have altered the consequences of diagnosis (Dorwart and Schlesinger 1988; Kirk and Kutchins 1988). Beginning in the late 1970s, the funding of mental health services shifted from public policy-driven "programs" to reimbursement-driven clinical services. During the era of public policy-driven programs, services were provided based on professional and program treatment ideologies (e.g., prevention, accessibility, continuity of

care, community care, and minimizing use of inpatient services), rather than on the basis of their marketability as "unbundled" commodities and "product lines" that are perceived as clinically legitimate or cost efficient to administrators and third party payors. In an increasingly privatizing and professionalizing delivery system, diagnosis takes on a new meaning of providing certification of need for services in the health care marketplace. Diagnosis as a tangible certification for funding by third party payors can be viewed as an important organizational resource and commodity. As Brown's (1987) study indicated, "we have to come up with a billable diagnosis on the first day.... Insurance coverage can lead to both the minimization and inflation of diagnosis." Following this line of thinking, then one might expect:

Hypothesis 4. If resources are contingent on the treatment of certain diagnostic categories, then growth of diagnoses will tend to be toward those categories.

For example, patients with differential diagnoses may be given the one that is most likely to be reimbursable.

Hypothesis 5. As connections with reimbursement sources in the environment shift, organizational forms will change.

Hypothesis 6. As environmental pressures for efficiency increase (reducing costs), then the work of individual therapists or professionals will become increasingly dependent on standardized commodities (such as the DSM) and organizations (i.e., administrative systems and economies of scale).

DSM AS A MARKETING STRATEGY

Professionals regularly impart chunks of routinized knowledge when they produce guidebooks of practice. Although this pattern of commodification is less prevalent in the medical and psychotherapy realms than for other professional arens such as law, engineering, and architecture (Abbott 1989), it still seems exemplified by the development of medical manuals and the DSM. If one makes the argument that the DSM defines, and publicly legitimates categories of mental disorders and an array of treatments, then the DSM can be viewed as defining an ongoing market for new experts and new services (Abbott 1989).

There may seem to be an inconsistency in the linking of diagnosis and treatment. Such a matching simplifies professional work and makes it more easily marketable to the public by health care entrepreneurs; but it also may

make professional work vulnerable to downgrading and deskilling. One way to view this phenomenon is through the notion of "elite professionalism" (Abbott 1989) where by the professions become increasingly stratified or "decoupled" and a smaller group of expert researchers regularly produce new knowledge that is accepted with a "logic of confidence" (Meyer and Rowan 1977) and used to "order, assess, and direct the work of the rank and file" practitioner in the health care marketplace (Freidson 1984).

For example, the subdivision of psychosexual dysfunctions into seven specific disorders by the committees in charge of the revision of the DSM-III is in response to the expressed needs of clinicians who specialize in the treatment of these conditions (DSM III-R, 1987). The DSM also includes conditions that are not mental disorders, but are considered the "appropriate jurisdiction of professional attention and treatment" (Spitzer and Williams 1982). The DSM makes socially visible problems of living that are not previously codified or formally recognized as such (e.g., developing a classification of relational problems and disturbed family units, or a section on disorders under study for inclusion into ongoing revisions of the DSM, or the development of a DSM-IV manual for primary care physicians). As such, the institutionalization of the DSM ensures that there must be experts to do ongoing revisions and that the realm of mental health work is expansive.[8]

The DSM can be viewed as a prerequisite to the development of a marketing strategy. It can be thought of as expert knowledge transformed into a "capital good" that is potentially at the disposal of allied professionals, the public, and health care entrepreneurs. Specifications of new disorders allow for entrepreneurs to expansively create distinctive service "product lines" and marketing strategies that in turn lead to competition among health care organizations for product service markets.[9] The DSM facilitates growth in the mental health market share by legitimating diagnoses and thereby generating pressure on payors to expand the number of billable diagnoses. Given this, one might expect:

Hypothesis 7. As the system of classification of mental disorders (DSM) expands or contracts, markets for new clinical services will also expand or contract.

For example, professional processes act to expand diagnostic categories and administrators act to narrow them. The government has conflicting constituents in that it is caught between groups interested in expanding and interest groups concerned with contracting diagnostic categories, for example, the NIMH and the HCFA.[10] The NIMH funds empirical research and professional work groups to revise old and consider new diagnostic categories for the DSM. These work groups include collaborative processes with administrators from HCFA.[11]

THE DSM AS AN ORGANIZING STRATEGY FOR THE MENTAL HEALTH PROFESSIONS AND THE SERVICE DELIVERY SYSTEM

A central question that has been asked about the mental health sector is: Why is it so disorganized (Meyer 1986; Scott and Black 1986)? In less clear domains such as mental health, the usual means by which technical problems become organized is to professionalize them. But unlike medicine, where physicians are more clearly the specialty that sets the rules for order (Freidson 1970), in the mental health domain there are overlapping authority rules among professionals that do similar types of mental health work (Meyer 1986).

Abbott (1989) adds to the conceptualization of how social order comes about by describing three ways to institutionalize expertise and organize work: through commodities, organizations, and professions. Commodities are products and materials that simplify and rationalize expert work such as machines, forms, software, and manuals. Organizational forms of expertise would be exemplified by organizations that house professional work such as hospitals and mental health clinics. Professions represent the institutionalization of expert knowledge in individuals. Professionals handle the esoteric, complex, and intellectual aspects of expert knowledge best. According to Abbott (1989), changes in the professions are shaped by the transformation and relegation of professional knowledge to alternative forms such as organizations and commodities.

Historically, professionals have been viewed within the context of independent and often powerful associations operating outside the boundaries of clinical organizations. More current depictions view the role of organizations as increasingly powerful and reciprocally intertwined with the role of professionals (Scott 1983). The professions are subject to control by organizations, as well as by professional associations that transcend and operate autonomously of the organization. As Scott (1989) points out, the open systems paradigm locates the professions in the organizations' environment and suggests that changes in the way professional associations organize their expertise produce changes in organizations' structures.

Abbott (1988) extends our understanding of the historical power and authority relationships of the mental health professions through an ecological analysis. The professions are viewed as dynamically and competitively interdependent and their relative "problem jurisdictions" are shaped by environmental forces that both help and hinder their position. He argues that internal differentiation in the work place, changes in knowledge, and new organizations and technology create professional jurisdictions vulnerable to invasion and succession. "Diagnosis, treatment, inference and academic work provide the cultural machinery of legitimate jurisdiction." It is through the control of knowledge that professions retain their power in a competitive

system of professions. If the knowledge is too abstract, the profession is vulnerable to claims of illegitimacy because of an unconvinced public, and if the knowledge is not abstract enough, the profession is akin to a craft and is susceptible to task encroachment by subordinate or invading groups. Similarly, if expert knowledge is codified into commodities such as manuals, like the DSM, it can be subject to deskilling and encroachment by lower-level professionals (Abbott 1989).

The history of the mental health professions has demonstrated an active ecology and a recurrent underlying theme of dominance and submission in relation to competing specialty professions (Abbott 1988). During the period of large, primarily biologically oriented mental hospitals and psychoanalytically oriented outpatient treatment (Koran and Sharfstein 1986) psychiatry was aligned with medicine and was clearly the dominant mental health profession. In the subsequent era of the community mental health movement, when the dominant theories of causation were social and environmental factors, psychologists and social workers greatly encroached upon psychiatry's professional boundaries. At that time psychiatry had fallen prey to overextending its claim to social concerns and an area of tasks that could not be easily remedied by a medical model (Mechanic 1989). Psychiatry then, was left with a precarious jurisdiction among competing professions and an uncertain knowledge base. Now as the legitimacy of social experiments have waned and as brain sciences and biopsychiatric research make remarkable advances (Holden 1988), psychiatry aligned again with medicine is gaining renewed dominance.[12]

A number of authors have recognized the development of the DSM-III as a mechanism for restructuring the knowledge claims and work tasks of the mental health professions. The DSM-III has been touted as Psychiatry's attempt to once again assume dominance in the mental health profession and reclaim the field as a specialty of medicine (Brown 1987; Mirowsky and Ross 1989; Klerman 1989).

The revision of the diagnostic classification system in 1980 and 1987 (DSM-III and III-R) delegitimized some problems and areas of professional jurisdiction. For example the changing criteria of "caseness" for such classifications as antisocial behavior (Koran and Sharfstein 1986) or substance abuse and dependence. Changes from DSM-III to III-R "broadened the boundaries of substance dependence and narrowed the borders around substance abuse so that abuse has become a residual category without specific defining features" (DSM-IV Update 1990). This placed groups that specialized in treatment programs of those (residual) problems at a disadvantage in competing for reimbursement and professional legitimacy (Abbott 1988).[13] Michels (1984) for example, points out how the changes in DSM-III retained the biological and social, but shut out the psychological aspects of mental illness. Similarly, Mirowsky and Ross (1989) admit in their critique of DSM-

III, that if depression, alcoholism, panic disorder, and antisocial personality have become illnesses, then only physicians have the right to say what should be done about it. Such changes may have the effect of constraining psychologists to practice and compete in organizational settings traditionally dominated by physicians (Freidson 1970) and in medical environments where they are at a disadvantage in terms of authority structures and the hierarchy of staff privileges.[14] Thus, psychiatric diagnoses as a sign of professional knowledge may serve to define the hierarchy of professionals and to set organizational boundaries within the service delivery system.

The obverse may also be true as well. DSM-III may function to expand the jurisdiction of some professionals in a symbolic sense (Meyer and Rowan 1977). As Kutchins and Kirk (1988) found in their survey of registered clinical social workers, the professionally democratic use of DSM-III gives the impression that social workers' understanding of mental disorder may be greater than it really is. In a latent sense, the DSM may provide an expanded jurisdiction for psychiatry's non-physician members. Thus, the DSM may function to reduce or expand autonomy of allied mental health professionals by redefining clinical work and the legitimate competencies and organizational settings of competing mental health service providers.

Hypothesis 8. If control of the boundaries of the knowledge base weakens, then internal attempts by professional constituencies to structure the knowledge base will increase.

For example, the dissemination of new knowledge or the selective inclusion of certain knowledge into official manuals may weaken or strengthen the jurisdiction of one specialty profession to another. Expert knowledge and concomitant treatment activities may be shed to other or lower-level practitioners and resituate whose professional competency is most valued or legitimate. Such interdependency effects (Abbott 1988) may increase activity to revise what knowledge is ordained legitimate or to generate new knowledge. One might think about this in terms of why the DSM-III-R was released in 1987, when the original plans for revisions were to be timed every 10 years with the revision schedule of the International Classification of Diseases (ICD-9). Did a real growth in science, technology, or new knowledge justify an additional revision? Or, why were the psychological defense mechanisms (not observable) returned to the glossary in the DSM-III-R in 1987? Was this an attempt to shore up the knowledge base by the psychodynamic camp? Such examples indicate the instability of the "official" cognitive base of professional mental health knowledge. Such a notion is similar to that of professional dominance (Freidson 1970), at an organizational level of analysis, and is exemplified by the jockeying for position by organizations such as American

Psychiatric Association, American Psychological Association, National Association of Social Workers, the World Health Organization, and so on.

Hypothesis 9. As the form of professional knowledge changes, the form of professional organizations will also change. A case for the converse might also be made (Zucker, 1988).[15]

For example, if the DSM continues to institutionalize mental disorders within the biological domain, then mental health service configurations around a hospital setting or medical culture will increase. And as changes in the institutional environment (reimbursement policy, perceptions of legitimacy) force mental health professionals into hospital settings, the DSM will become isomorphic with medical nomenclature.

ORGANIZATIONAL CONSTRAINTS ON DIAGNOSIS

A case for a nonrecursive model might also be made. As Byrd's (1981) study indicated, the structure of the service delivery system can have an influence on diagnoses. In her analysis of outpatient clinic records in a university teaching hospital she found that in slack times intake staff will alter patient characteristics so that therapists can utilize their technical expertise more efficiently. Conversely, when caseloads were larger, patients were more likely to be diagnosed as psychotic and therefore inappropriate for outpatient treatment. She found evidence that available treatment openings affected diagnosis and patients were redefined based on organizational structural characteristics.

Brown's research (1987) at a university hospital walk-in clinic demonstrated parallel results. After taping and observing interviews between patients and therapists and therapists and supervisors, he found that "creative diagnoses" were given to allow for a better fit between organizational constraints and professional autonomy.[16]

Given Brown's and Byrd's findings one might hypothesize:

Hypothesis 10. The greater the diversity of treatment goals of "valued" (e.g., funding, prestige associations, etc.) external referral organizations the greater the diagnostic conflict and pressure to use "creative diagnoses."

Hypothesis 11. If conformity to institutionalized rules of therapy conflict with the "efficiency criteria" used in the DSM, then organizations will become loosely coupled building gaps between their formal administrative structure and actual clinical work activities (Meyer and Rowan 1977).[17]

CONCLUSION

What then might organization theory predict about the structure of the service delivery system from viewing diagnosis as the codification of professional knowledge and as an organizational resource? Diagnosis serves different functions for the various organizational constituencies, organizations on the periphery of the delivery system, patients, professional groups, government agencies, and private and public insurers. Treatment organizations forced to operate in heterogeneous environments with multiple referral agencies representing conflicting goals and with restrictive external funding constraints might "decouple" (Meyer and Rowan 1977) their diagnostic procedures and organizational structures. Under the most diverse conditions, treatment organizations might structure a three-tier system of diagnostic and administrative work activities—administrative, clinical, and research.[18] The administrative component would link to the exterior environment and make sure that diagnostic activities in the clinical core were transformed into the proper form of exchange with the environment. This organizational level could also serve to buffer and protect ongoing therapeutic work activities from the diagnostic surveillance of external institutions. The clinical component would represent those constructions that allow for the best fit between available therapist and patients within the confines of the organizations' treatment goals. The research component would be most closely allied with academic institutions and values and would represent the least externally constrained classification of patient pathology. The research level would also be the genesis of formalized changes in the classification of professional knowledge, that is, the revision of the DSM (Koran and Sharfstein 1986; Abbott 1988). "This decoupling enables organizations to maintain standardized, legitimating, formal structures while their activities vary in response to practical considerations" (Meyer and Rowan 1977).

RESEARCH IMPLICATIONS

The arguments presented here generate implications for several lines of research. One approach might view the growth of the DSM as a dependent variable and link it with a set of covariates or explanatory variables that would represent changes in the institutional environment. This could be conceptualized along the lines of Hypothesis 8 and use network analysis to look at the factors contributing to the weakening of the knowledge base and the "pushing and shoving" among various constituencies to shape and clarify overlapping "problem jurisdictions."

A second line of research might attempt to link changes in professional knowledge (DSM) with changes in organizational forms. This approach would

view changes, death, and survival of organizational forms in the mental health sector as a dependent variable and link it with a set of independent variables, one of which would be the potential explanatory effect of the DSM. In this set of equations, independent variables might be both endogenous and exogenous and represent changes in the internal organizational environment as well as the external organizations environment. This approach stems from Hypotheses 9 and 5, where one would expect that as the form of professional knowledge (DSM) and funding sources change, one would expect the form of professional organizations to change.

One might conceptualize the DSM as a measure of external legitimacy and combined with other external and internal structural change measures describe mental health organizational change, death, and survival over time. Other measures of external legitimacy might be changes in access to environmental resources such as referral networks and endorsement by powerful collective actors such as licensing, accreditation, regulatory, reimbursement, and program policy making bodies, for example, the Joint Commission on Accreditation of Hospitals (JCAH), NIMH, HCFA, APA, and so on

Measures of internal organizational change might be conceptualized as changes in the organizational director, organizational goals, structure, client or patient groups served, and domain in which services are offered, for example, satellite street clinics to Community Mental Health Centers (CMHCSs) to multi-service medical centers.

One also could test for the effect of "loose coupling" on organizational survival and persistence (D'Aunno and Price 1988). As Hypothesis 11 indicates, one would expect that loose coupling would enable organizational survival under conditions of conflicting institutional environments. One could develop measures such as the degree of conflict in the "efficiency criteria" of the DSM and actual clinical activities, informed from participant observation work like that of Brown (1987). Measures of loose coupling might also be developed from survey and secondary sources such as comparisons of grant application or administrative program descriptions with actual clinical training and self-referent ideology of first line clinical staff.

In future studies it would be interesting to understand how the processes of internal organization change may be systematically related to external legitimacy and organizational survival. Along the lines of the work of Singh et al. (1986), who attempt to link internal structural changes and the notion of external legitimacy to predict survival of social service organizations; and Tolbert and Zucker (1983), who have looked at diffusion and institutionalization of change in formal organization structure, where early adoption of innovation is related to internal organizational requirements, and later adoptions are related to institutional definitions of legitimate structural form. First adoptions of change are for efficiency and as the practice becomes institutionalized later adoptions are for legitimacy.

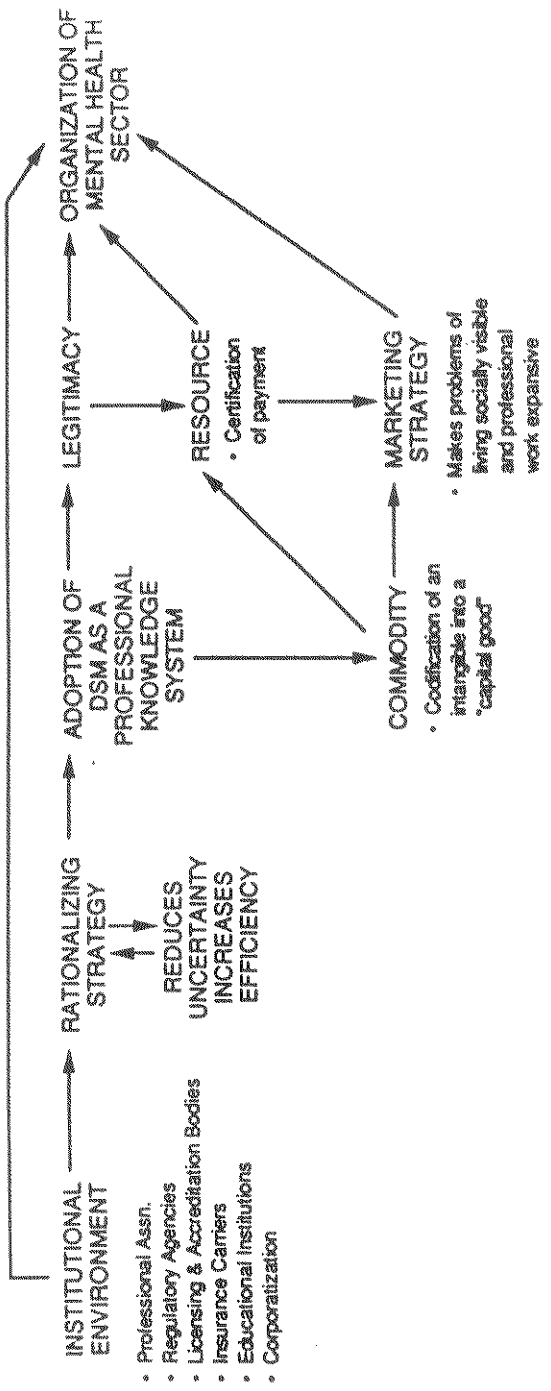

Figure 1. Summary of Arguments

Source: Adapted from Meyer and Rowan (1977).

It would be interesting to investigate how the growth of the DSM is first rooted in the internal needs of organizations and the professions, and second, how over time adoption of the DSM becomes mimetic and explained by conformity to institutional definitions for legitimacy.[19] As a greater number of mental health workers and organizations adopt the use of the DSM it becomes increasingly understood to be a necessary component of the proper way to do mental health business. The symbolic legitimacy of DSM diagnostic procedures themselves serve as the impetus for later development and adoption of the DSM.

These hypotheses and arguments suggest the need for both historical and comparative approaches in research methods. Analyses could be done comparatively across different organizational fields in the mental health sector, for example, those dominated by the NIMH, state policy, and the Veterans Administration, since they represent different chunks of the service delivery system and have a history of formal record keeping.

Quantitative event history approaches[20] (Tuma and Hannan 1984), as well as validating qualitative data, could be constructed from content analysis of archival sources such as mental health program policy journals, newsletters, public correspondence, grant reporting documents, and ongoing participant observation in clinical settings.

Such analyses are not without caveats. Causal paths are complex and nonrecursive. And indeed, several difficult boundary problems make murky the methods of investigation of the origins and change of any social structure: the distinction between the professional and organizational; between the internal and the external environment; and the rational versus the symbolic.

SUMMARY

Some of the key arguments in the literature on the development and uses of psychiatric diagnosis and the DSM have been summarized very briefly. This paper, however, has taken a different direction from these arguments by demonstrating a reasoning and set of hypotheses to explain the growth and adoption of the DSM from an institutional and organizational perspective. Using insights from institutional, resource dependence, and ecological theories, Figure 1 summarizes the set of arguments presented here. Indeed, it is interesting that, given the controversy over the DSM, it continues to be developed and widely adopted.

NOTES

1. As Robert Michels (1984, p. 548) notes, "I am disturbed to see the proliferation of textbooks, courses, and training programs that are not about people or diseases but rather about the nomenclature. There is something wrong with a field that has turned away from its subject matter in order to study its tools, instead of using those tools to study the world."

2. The DSM-IV is to be published in 1993 in coordination with the revision of the *International Classification of Diseases*, ICD-X.

3. This paper was presented at the section on medical sociology, American Sociological Association, Washington, D.C., August 1990. I would like to acknowledge the helpful advice and comments of Dick Scott, John Meyer, Howard Goldman, Lorrin Koran, Ruth Cronkite, Elizabeth Ozer, Lynne Zucker, Bernice Pescosolido, and Eliot Freidson.

4. It should be noted early on that this discussion operates at several levels of analysis, the social psychological and the structural. The effects of diagnosis can be conceptualized from the standpoint of internal and external constraints. This view also takes an open systems approach (Scott 1987) such that although the organization may have its insulated internal realities in the "technical core" (Thompson 1967) the organization is also "mapping," i.e., conforming to environmental constraints (Lawrence and Lorsch 1967; Scott, 1989). Second, as Scott (1989) notes, professions are not located structurally at the same level as individual organizations. Professional structures operate both internal to the organizaton as well as trans-organizationally through powerful external associations independent of the employing organization. Additonally, to paraphrase Lynne Zucker, the boundary definitions between professions and organizations are ambiguous. This points to an important problem that should be addressed in institutional theory research, and that is boundary definitions, what is inside and what is outside the organization (Discussant, Stanford Conference on Organizations, Asilomar, Ca., April, 1990).

5. According to Bayer and Spitzer (1985), "The proposed nomenclature displays a generous measure of linguistic and conceptual sterility. DSM-III gets rid of the castles of neurosis and replaces it with a diagnositc Levittown." And the developmental process for DSM-IV requires formally documented literature reviews, reanalysis of existing data, field trials, the development of a source book for any changes, and the formal documentation of the arguments for inclusion, if empirical evidence is absent.

6. This is probably most true in homogeneous treatment environments where there are not conflicting demands on clinical staff by referral and funding sources such that resolving ambiguities lead to "creative diagnoses."

7. "Records are the clinic's most important product. Other agencies do not want the "whole patient," the entire messy chart; they want information that is readily identifiable and conforms to their standards of "fact," things that can be checked and redone, are the products that are reimbursed, not the service" (Olson and Gordon 1984).

8. See Spitzer and Williams (1988) "Having a Dream: A Research Strategy for DSM-IV," *Archives of General Psychiatry*, vol. 45, September, on the DSM III R's new section on "proposed diagnostic categories needing further study" for new diagnostic categories that were not approved by the DSM subcommittees prior to press time. Or the development of a version of DSM-IV for primary care physicians who see patients with "sub-threshold" conditions that do not meet full criteria for specific DSM diagnostic categories so as to encourage better communication and specification in clinical settings (DSM-IV Update newsletter, American Psychiatric Association).

9. Marketing strategies are characteristic of the privatization of mental health services. Under an older public model, service organizations competed in response to requests for proposals (RFPs) driven by public policy-oriented professionals and bureaucrats. This system was more removed from market conditions and lay public view.

10. Comments and discussion from Eliot Freidson, session on medical sociology, American Sociological Association, August 1990.

11. Correspondence among organizations involved in the development of DSM-IV.

12. According to a discussion with a NIMH staff person, "Psychiatry is becoming increasingly medicalized. It used to be that to become a chairman of the department of psychiatry, one had to also have the credentials of an analyst. Now these kind of credentials would be the kiss of death. In addition to the M.D. to assume this type of position today, one has to have credentials as a clinical scientist."

13. For example, residential programs are now thought of as "housing," and are described with terms such as "clustered apartment projects" that are developed and run by "real estate magnates," rather than as social psychiatry, therapeutic communities, and residential treatment as Lamb et al. (1969) and others had originally written about it. There is a beginning counter movement to separate housing from treatment since successful residential treatment leads to housing transitions that are too stressful for chronic populations to accommodate. This notion of enduring communities or subcultures shares some similarities to a prior era of long-term institutionalization in state mental hospitals (per discussion with Ken Meinhardt, M.D. and Larry Telles, Ph.D., Santa Clara County Mental Health). One could make the point that as diagnoses are described more in medical nomenclature there is also growth of local inpatient treatment services and outpatient mental health services that are centered around a hosptial culture. Dorwart and Schlesinger (1988) note the conversion of medical surgical beds to psychiatry beds in general hospitals. During the community mental health era, medical surgical beds often encroached on psychiatry beds and there were incentives to not use inpatient psychiatric services.

14. When professional expertise and work in the mental health sector become institutionalized by medical oganizations, then private practice psychologists without "full hospital privileges" may lose their patients at the hospital door when inpatient services are indicated. Such examples are evidenced by the current restraint of trade complaints to the Federal Trade Commission by Psychological Associations as well as a recent surge of interest in the literature on psychologists' role in hospitals (Enright, Resnick, Deleon, Sciara, and Tanney 1990; Enright, Walsh, Newman and Perry 1990). In some states, psychologists may avoid conflicts with hospitals and their psychiatric neighbors by having professional autonomy in private outpatient practice, but this may have the impact of disorganizing occupational identity, professional power, and service delivery. Conversely, for psychologists to work in an organized hospital or medical setting may relegate their professional autonomy to that of an employee or make them subservient to psychiatrists in the treatment planning process. At the 1990 annual convention of the American Psychological Association, the Council of Representatives voted 118 to 2 to establish a task force on prescription privileges. It will be interesting to follow the psychologists' attempts to gain prescription privileges, since not being able to prescribe medications handicaps their status in medical organizations.

15. Lynne Zucker has noted that her idea presents a potentially unsolvable problem of disentangling the causal paths between the professions and organizational structure. She reminds us of an old problem and analogy from anthropology (Sapir Whorf), i.e., is culture defining language or vice versa? Are changes in the professions defining organizational structure or is organizational structure defining changes in the professions? We need measures of how changes in professional terminology produce changes in organizations. This problem is further confounded by mistaking labels for concepts, a critique that Mirowsky and Ross have made.

16. Brown found the use of "creative diagnoses" was greatest when the organization was dependent on accepting (e.g., through contracts, social responsibility, etc.) patients from referring agencies with conflicting goals, such as the courts and social service. These patients did not easily fit into organizational treatment goals and the professional nomenclature practiced in the hospital clinic.

17. Refer to Weick (1976) Orton and Weick (1990) for a definition of loose coupling. Just briefly, the term accounts for the existence of nonrational organizational structures. Rational is meant in the sense that organizational structures reflect intentional plans. When an organization is loosely coupled there may be a relative lack of coordination or there may be an absence of linkages that should be present, or an organization's structure may not be coterminous with its activity. Given conflicting elements in organizational environments, loose coupling may be an adaptive mechanism to enhance organizational survival.

18. This idea stems from Parson's (1956) functional analysis of organizational adaptation to the environment and larger social systems; and from Cook et al. (1983) the theory on organizational response to regulation.

19. Mimetic isomorphism is a notion developed by DiMaggio and Powell (1983) where organizations tend to model themselves after similar organizations in their field that they perceive as more legitimate and successful.

20. An event history is a data record containing information on the timing of the birth and death of an organizational form along with a set of explanatory variables.

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PART III.

STUDIES IN SOCIAL PROBLEMS