Quality of Care for Depressed Medicaid Patients:

99 Problems and "Evidence-Based" Therapy is One

TSL

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Quality of Care for Medicaid Patients

The phrase "evidence-based" therapy by all appearances is used to indicate the scientific validity and therapeutic efficacy of a psychotherapeutic modality. In a perfect world, where "evidence" retains, as its footnote, the research that supports it, this phrase would indicate something of importance. Today, this does not seem to be the case. As Jonathan Shedler (2017) remarks, "The majority of patients who receive an 'evidence-based' therapy—more than 50%—seek treatment again within 6 to 12 months for the same condition" (p. 323). Additionally, citing the most prominent research on the use of CBT for depression—a modality considered the "gold standard" of "evidence-based" therapy—Shelder writes, "scientific research demonstrates that 'evidence-based' treatments are effective and have lasting benefits for approximately 5% of the patients who seek treatment" (p. 324).

What is one to make of the fact that in Washington state, CBT is the only therapeutic modality covered under Medicaid (Washington State Health Care Authority, 2020, p. 59)? Along with the mountain of evidence Shedler provides against "evidence-based" therapies as scientifically valid and therapeutically efficacious, this question of restricting payment for therapy to a modality that is shown to be ineffective raises a number of large questions of the relation between science and capitalism, the responsibility of therapists in reforming their own slice of the economic sector named "mental health," and for what purpose mental health therapy is given.

Medicaid expansion, as a provision of a more universalized healthcare system, is at present rolling out in several states. Meanwhile, studies of healthcare accessibility for low income populations have accrued, pointing to various conflicting results. Medicaid expansion has indeed, though very marginally, improved non-mental health outcomes, particularly for low

income populations (Ollive, 2020, January 07). However, when compared with subsidized private insurance, “Five of 12 secondary quality measures favored private insurance, and 1 favored Medicaid” (Allen H, et al., 2021). A study of mental health outcomes of Medicaid expansion for low income parents from 2010-2015 gave this concerning conclusion, “Together, our results suggest that the improvements in mental health status may be driven by reduced stress associated with improved financial security from insurance coverage” (McMorrow, et. al, 2017). When mental health outcomes of depressed patients are looked at in particular, a randomized-controlled study of over 12,000 respondents who were treated for depression while enrolled in Medicaid, found “The greatest relief in symptoms was seen primarily in feeling depressed, feeling tired, and having trouble sleeping—consistent with the increase observed not just in medications targeting depression but also those targeting sleep” (Baicker, K., et. al., 2018). In other words, a general feeling of well being was improved by the use of sleep medicine to obtain more sleep. The evidence for the scientific validity and therapeutic efficacy of CBT extends to scant evidence of good mental health outcomes when health coverage is extended to more people.

There are many issues of power and privilege entangled with Medicaid. There is inherent in manualized therapies, which is what, according to Shedler, “evidence-based” therapy really means, a philosophy of objectification. If human experience is categorized, interacted with, and “treated” as in and of itself mechanistic, then people begin to use objectifying language to understand their experience and themselves. Nancy McWilliams (2021) articulates this phenomenon well:

> People talk about themselves in acronyms oddly dissociated from their lived experience: “my OCD,” “my eating disorder,” “my bipolar.” There is an odd estrangement from one’s

> sense of an agentic self, including one's own behavior, body, emotional and spiritual life, and felt suffering, and consequently one's possibilities for solving a problem. There is a passive quality in many individuals currently seeking therapy, as if they feel that the prototype for making an internal psychological change is to describe their symptoms to an expert and wait to be told what medicine to take, what exercises to do, or what self-help manual to read. (p. 5)

The question of power and Medicaid patients includes the question of how the form of attention applied to human experience is determined by economic pressures that use human beings as commodities, and how our systems of health care utilize these forms of attention to reproduce the economy by shaping human experience to reproduce economic pressures. An example of this comes to mind immediately, from my experience in Infant Observation. Some families take their infants, just several weeks old, to daycares, without thinking about how this may shape the infant's emotional experience. What is the deciding factor for this move is the economic pressure of returning to work. Additionally these infants are oftentimes placed on strict sleeping and feeding schedules, not because they need fed at certain intervals consistently over long periods of time, nor because they require a sleep regimen imposed upon them in order to change their inability to sleep. Rather, these infants are treated, unconsciously, as if they are commodities within a commodity exchange—a "good" baby when sleeping through the night so that the parents can work, a "good" baby when tracked for developmental achievements compared with other infants in the same age range for future projections of abilities.. The baby looks at the mother not for attention but to feed, and when the feeding activity is over is ready to sleep: this is the economically efficient baby. The infant becomes managed by economic pressures and then internalizes these economic pressures to relate to their own experience.

Donald Winnicott (1960) spoke of how these pressures shape the developing personality of the infant in terms of a false self: “The mother who is not good enough is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infant gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant” (p. 145). Esther Bick (1986) observed similar phenomena in infants and points to the exteriorization of the psychic function in the development of a “second skin,”: “in the event of defective development of this containment function [of being held together by the skin] other ‘secondary skin’ devices may arise, in collaboration with particularities of the maternal care, such as muscular or vocal methods” (p. 146). Both Winnicott’s and Bick’s works point to the earliest consequences of external pressures disrupting the earliest phases of emotional development when the infant and mother, in a symbiotic relation, are from the infant’s perspective one being: the consequence is a compliance to external demands in conjunction with a repression or projection of internal needs, and the development of an exoskeleton to evade awareness of dependency needs while the internal life is locked and sealed away in the movements of the body or mind. These concepts, applied to the emotional atmosphere of our technological society, enforced by work requirements—the effects of which are targeted for anesthetization and then promoted as a cure by manualized mental health therapies—already stand at the beginning point for how power and privilege dynamics are then perpetuated by ineffective mental health therapy for Medicaid patients: the system creates problems it then advertises only it can solve, a logic inherent to addiction.

Compliance and exoskeletons, used to control and manage feelings and appearances of self, is the central issue with evidence-based modalities. To act out a feeling, to have words for a feeling, to apply a technique to control or manage a feeling is not equivalent to psychotherapy,

where the aim is psychological growth. But psychological growth is difficult to quantify, control, and manage. Adorno and Horkheimer (1947/2002) wrote about the epistemological underpinnings to our modern, scientific world of enlightenment, where all psychological insights are subject to the domination of techniques aimed at reducing subjective experience to objective behavior, "For enlightenment, anything which does not conform to the standard of calculability and utility must be viewed with suspicion" (p. 3). The problem with calculability and utility as the standard against which psychological growth is measured is that it assumes an identity of human phenomenon with conceptual phenomenon that, in order to be rational, must follow laws of noncontradiction. Again, Adorno and Horkheimer saw this point clearly:

> Human beings purchase the increase in their power with estrangement from that over which it is exerted. Enlightenment stands in the same relationship to things as the dictator to human beings. He knows them to the extent that he can manipulate them. The man of science knows things to the extent that he can make them. Their 'in-itself' becomes 'for him.' In their transformation the essence of things is revealed as always the same, a substrate of domination. This identity constitutes the unity of nature. (p. 6)

Put another way, the "unity," the equivalence, between affect, belief, and behavior drawn in CBT, is one where affect and behavior are joined together, not from a perspective of inner arrangement of the personality, but by the tokenization of language, where belief, formed and managed by social pressures and stock phrases, becomes the dictator of affect and behavior. Again, the internalization of economic pressures—an economically reliable, compliant, and productive person—becomes the end goal of therapy.

Any modality without a conception of the unconscious participates in the reification of economic pressures as "natural" psychological phenomena. At baseline the unconscious is a

concept about the existence of elements of human motivation that are not fully compliant with external pressures, and reveals itself in symptoms of defiance on one end and pathology on the other. This is the crux of conservative therapeutic modalities and how they become purveyors of social antagonisms.

The myth that resolving contradictions in the mind also resolves contradictions in the body, or vice versa, has promoted an obsession with conscious articulation and demoted the awareness of unconscious elements in human experience. The demands of conceptual rigor that when followed by the conscious mind lead to "truth"—such as the law of contradiction, the law of excluded middle, and the principle of identity—may not, when used as boundaries for legitimate experience, also lead to life. What is clean and domesticated about the grid plans of grammars and what is compelling about the austere simplicity of logic may say more about the desires and phantasies of human beings than it does about the nature of truth and reality and human experience. As Adorno (1973/2014) asks, "what is a cogitative law and what is real" (p. 6)? How do we parse what applies to the law of rationality and to the laws of feeling? We can point, with Horkheimer (1995), to an emerging feature of a different landscape for engaging with human experience: "Thought, and thus concepts and ideas, are modes of functioning of human beings, and not independent forces" (p. 116). A concept of responsibility emerges here, and a question of who is responsible for the thoughts that come to occupy the therapeutic session must be raised here.

That there are "modes of functioning of human beings" highlights what is forgotten in the modern myth of mind and body: other modes of functioning exist, in particular the unconscious. And for the unconscious, cogitative law has no authority. Freud (1917/1989) summarizes simple threads of the unconscious' contexture succinctly as the "mutual interference…[of] different

intentions" (p. 80). Not only is the rigid order of quantifiability absent from the unconscious, but its goal-oriented, means-to-an-end motivation is similarly nowhere to be found: "The brain's neuroplastic capacity for change doesn't differentiate good change from damaging change; habitual, repetitive practices rewire the brain without concern for values or goals" (Fishbane, 2013, p. 36). Whether a thought, memory, image, emotion, or any structure of perception comes to frame human experience one way or another has more to do with, like a sharp chisel, the kind of impression it makes, rather than if it is real or artificial, good or bad, true or false, beautiful or ugly, conducive to genuine human flourishing or irretrievably traumatic.

As to the exact relation between contradictions of the mind and the body, I can report, at least anecdotally, some incommensurability exists: I have come to know the experience of my thoughts disbelieving in phenomena my body wholly surrenders to. After all, if Freud (1917/1989) is correct that, "resistance is independent of…[a person's] theoretical conviction" (p. 142), then the status of the real may be more appropriately conceptualized as the presence of affect. Beliefs that manage and control affect have the status of truth, as Adorno and Horkheimer articulated, only insofar as domination of the interior space is realized.

Particularly troubling is the extent to which political fanaticism is driven by the same antagonisms that have ascended the conscious viewpoint in conservative therapeutic discourses to a "gold standard" of "evidence-based therapy," making "evidence-based" a conceptually dubious play on words, much like the linguistic play of an authoritarian government establishing a Ministry of Truth. Carl Jung (1921/1990) identifies this similarity:

> The more it [the conscious viewpoint] tries to fend of the [unconscious] doubt, the more fanatical the conscious attitude becomes, for fanaticism is nothing but over-compensated doubt. This development ultimately leads to an exaggerated defence of the conscious

> position and to the formation of a counter-position in the unconscious absolutely opposed to it. (p. 351)

What, then, of the many patients who will come into the therapy room for treatment of depression or anxiety who, on Medicaid, are looking for any salve to the economic pressures that blame them for problems produced by the economic system that ensnares them? What, then, of the objectifying language they will seek to manage and control their affect and behavior—of the doctrines they will want to memorize and repeat to prove they have become one of the dignitaries of the "evidence-based" creed?

This is a question that is inescapable for anybody in the modern world who wrestles with the incomprehensibility of suffering today, not just for the therapist. But for the therapist, it is an essential question. Encountering this in the therapeutic relationship, as it includes technique, frame, and theoretical orientation, has to do with working within a dialectical, rather than hierarchical, conception of therapy. Thomas Ogden (2022) names two dimensions that are relevant to this: "the epistemological dimension…involves arriving at understandings of previously unconscious thoughts, feelings, and bodily experience, which help the patient achieve psychic change" and the "ontological [dimension, which] involves providing an interpersonal context in which forms of experiencing, states of being, come to life in the analytic relationship that were previously unimaginable by the patient" (p. 15). I would include a third dimension, from Donald Meltzer (2018), called the "aesthetic," where separate feelings, identities, and ideas are not inherently perceived as *conflicting*, requiring a relation of hierarchy to resolve, but rather are viewed as *contrasting*, where the the tension of contrast promotes psychic growth by mobilizing love and hate under the need to understand rather than to act or repress.

In conclusion, the therapeutic space that utilizes a manualized approach to human suffering follows the science that is itself shaped by economic interests in merely manipulating empirical relations pre-established for it by its social context. “[T]heir apparatus express in turn the problems and interests of society as it is” (Horkheimer, 1947/1974, p. 33). On the other hand, I believe therapy to be a space that allows suffering to speak—and I take this as a condition of truth. Any system that manualizes human experience and determines beforehand what is positive and negative, as if *human thinking* itself does not determine this distinction in the first place, outlaws human suffering, for systems of domination are created to mediate and modulate human need in a way that never calls the system into question. Human suffering, and the truth of it that is shared in therapeutic spaces, is the mechanism that revolts against the system and, through this negation, establishes the possibility for new systems, by making space for pain.

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