Carnegie Mellon University

ACHIEVING MENTAL HEALTH PARITY:

A RHETORICAL ANALYSIS OF A SOCIAL CHANGE

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Doctor of Philosophy in Rhetoric

By Julia G. Deems

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Dissertation Committee:

Dr. Linda Flower, Chair
Dr. Andreea Deciu Ritivoi
Dr. James Wynn

ABSTRACT

Congressional rhetoric has commonly taken one of two forms: studies of political leaders or studies of the settling of political argument. Our understanding of other components of congressional rhetoric, including the role of public testimony, is less well developed. Further study of congressional rhetoric is critical to our understanding of political decision-making. Public testimony is central to deliberative democracy, in which an engaged citizenry provides reasons for policy decisions. I examine public testimony, the written response to legislation prepared in advance and presented orally before congressional committee.

Public testimony benefits the public as a forum in which to express support or concerns and as a public record of congressional reasoning; it simultaneously benefits legislators, in that testimony clarifies problems, identifies goals, suggests solutions, and provides a source for rhetorical strategy. Public testimony on mental health parity legislation, including the Mental Health Parity Act of 1996 and legislation integrated into the Affordable Care Act, and was considered by Congress for more than two decades and offers a rich site for investigation. In part, this research examines claims made by stakeholder groups as they define the policy problem. Findings suggest that public testimony does more than respond to the legislation: it expands the policy issue and sets the agenda for additional legislative change. Better understanding the role of public testimony can expand and strengthen its use.

Mental health parity legislation aims to address discrepancies between insurance provisions for mental health care relative to medical care. While public opinion polls have long demonstrated support for parity, enacting legislation proved challenging. Legislation was introduced repeatedly, and much legislation was sent to committee for public response. The most

direct beneficiaries, the mentally ill and their families, testify. This dissertation asks: Do the

mentally ill and their supporters have rhetorical agency? If so, what strategies do they employ?

Findings suggest that those that focus on mental illness employ one set of rhetorical strategies,

including personal narratives of tragedy and luck, while those that focus on mental wellness

employ other strategies. This research has significance for congressional rhetoric, public

deliberation, and deliberative democracy.

Key words: Congressional rhetoric, Public deliberation, Deliberative democracy, Toulmin

analysis, Rhetoric of civic engagement, Public testimony, Congressional hearings

DEDICATION

To all those who have made my life better as I worked and wrote: to James and Claire, who bring

joy and a constant faith. To my parents, Ray and Dorothy, who always have known the right

time to push and the right time to offer a soft place to land, and to my brothers, Norwood and

Bart, who helped me see the world through their eyes. I am the better for your insights and

inspirations. And to the many great teachers who have inspired, challenged, and encouraged me.

I am better for your direction, guidance, and counsel.

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Chapter 1. RHETORICAL ANALYSIS OF PUBLIC POLICY ARGUMENTS:

ASSESSING PUBLIC LEGISLATIVE TESTIMONY ON MENTAL HEALTH PARITY

Overview

This dissertation examines the rhetorical construction of mental health parity legislation, through a rhetorical analysis of public testimony offered before congressional committees and subcommittees (House and Senate) during the period from 1991 to 2008, inclusive of the 102nd Congress through the 110th Congress. This period includes all legislation cited in *The Mental Health Parity Act: A Legislative History* (Sundararaman and Redhead, 2008), a report prepared for members of Congress that identifies relevant legislative proposals, committee hearings, votes, and legislative outcomes on mental health parity proposals. The legislation has significant financial implications for both those with a mental illness as well as those with a family member with a mental illness: it increased parity between coverage for medical services and coverage for mental health services; further, it closed loopholes, by reducing out-of-pocket costs (co-pay amounts) and increasing the total annual days of care covered for inpatient stays and outpatient visits, as well as lifetime caps on coverage and total numbers of covered days, among other changes. The financial benefits of this legislation accrue to a greater extent to those requiring more intensive or longer-term treatment.

Changes to mental health parity coverage occurred incrementally as a result of two major legislative initiatives. In the first push, beginning in the 102nd Congress (January 3, 1991 through January 3, 1993), the goal was to achieve parity for lifetime limits (number of days and

total dollar amounts). Following passage of the Mental Health Parity Act in 1996 (during the

104th Congress), which implemented lifetime parity, the goal of new legislation shifted to

addressing parity 1) for co-pay amounts (changing the out-of-pocket cost for office visits to

mental health professionals so that they were on par with out-of-pocket costs for office visits to

medical professionals) as well as 2) for total *annual* dollar and day limits for inpatient and

outpatient coverage. These two new provisions were eventually implemented as part of the

Affordable Care Act (ACA), which passed in 2010 (106th Congress) and was implemented in

2014 (108th Congress).

Mental health parity in the context of the Affordable Care Act

The Affordable Care Act had three primary goals: 1) to ensure the availability of

affordable health care to more individuals and families, 2) to expand the Medicaid program to

include adults with incomes of less than 138% of the federal poverty level, and 3) to support

innovations in delivery of medical care delivery methods in order to lower the overall costs of

health care.

Starting in 2014, as a result of the ACA, all new small group and individual market plans

were required to cover ten Essential Health Benefit categories. These benefit categories ensured

that individuals gaining access to insurance coverage through insurance packages available

within the government-subsidized marketplace would receive comparable benefits for: outpatient

services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental

health and substance abuse disorder services, as well as behavioral services; prescription drugs;

rehabilitative and habilitative services and devices; laboratory services; preventive and wellness

services as well as chronic disease management; and pediatric services. For mental health and

substance use disorder services, parity was required between these benefits and those for medical and surgical benefits. This change in policy led to extended mental health and substance abuse coverage for 62 million Americans.[1] Lifetime limits have greater impact on those with a chronic mental illness, typically defined to include schizophrenia, bipolar disorder, and major depressive disorder, while co-pay and annual limits impact both those with chronic conditions as well as those who have more short-lived mental health problems (as an example, imagine someone with rapid-onset depression as a result of a personal tragedy, such as divorce or a major illness, who recovers within a few months).

To provide additional context for the policy change, it is useful to remember that in the United States both at the beginning of this research period (1991) and continuing through today, health insurance, or coverage for medical conditions, is a piecemeal affair. Individuals may have insurance through private plans (employer-sponsored or direct purchase) or through government plans (Medicaid, Medicare, or military health care benefits). Still other individuals have no insurance. In part because of the way that insurance is provided, adults aged 65 and older are more likely to have insurance coverage than any other group (typically provided or supplemented by Medicare), followed by children (either provided by parental coverage, Medicare, or through the Children's Health Insurance Program (CHIP)). Working-age adults (aged 18-65) are the least likely to have insurance, with the highest incidence of no coverage occurring around age 27.[2] While employer-sponsored insurance plans are not identical, with some offering better coverage than others, federal legislation sets the regulatory "floor" for the

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[1] For additional information, see the Health and Human Services web site: https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans. Note that some grandfathered plans were not required to extend coverage to include the Essential Health Benefit categories.

[2] For more information, see Barnett and Vornovitsky (2016):
https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf

minimum coverage that should be included in qualified health plans; this floor can then be raised by state legislation but it cannot be lowered. Mental health parity legislation did not guarantee access to mental health services, instead it sought to increase insurance protections by requiring that insurance providers "match" those lifetime dollar and day limits that already existed in individual plans (whether employer-sponsored or government-sponsored) for physical illness, limits that across the board were superior to and exceeded those in place for mental illness and substance abuse. Prior to passage of the Mental Health Parity and Addiction Equity (MHPAE) Act in 2008, 74 percent of workers in employer-sponsored health plans with mental health benefits faced annual outpatient visit limits, 64 percent faced inpatient day limits, and 22 percent faced higher cost sharing for mental health benefits than for general medical benefits (Barry et al., 2003). Mental health parity legislation impacted insurance providers, employers and the government (primarily the federal government) through potential increases in cost of services; it also impacted service providers, particularly mental health professionals, by making mental health care more accessible. Representatives from these groups participated in the hearings and offered testimony.

Context: Mental Health Parity Legislation

Defining mental health parity

Before going further, it is important to understand mental health parity as a policy issue. Mental health parity itself is complex; this brief introduction aims to provide sufficient context to see its importance as a public policy goal. To begin, the goal of mental health parity legislation is to ensure parity between health care coverage, which only provides coverage for physical health, and mental health care coverage. The section that follows begins with a description of the ways that health care coverage (typically, but not exclusively, in the form of insurance) is

available to consumers. Then the same kind of information will be provided for insurance for mental health care.

Access to medical care coverage in the U.S.

In the United States, health care coverage with a defined benefit is available in a variety of forms: as insurance provided as an employer-sponsored benefit, as privately-purchased insurance (for example, the current health care exchanges, but also other supplemental forms of insurance, such as for self-employed individuals), or as a government-provided benefit (through Medicare or Medicaid). Health care benefits vary enormously from organization to organization and from plan to plan. And even among individual employers, different plans are typically available, making it possible for employers to make choices about what health care will be covered; similarly, individuals making contributions to health care plans may also have choices, for instance, about preferred provider (PPO) plans or health maintenance (HMO) plans. As a consumer attempts to choose among available plans, one difficulty is that the consumer may find it challenging to weigh not only current needs but also future needs against the cost. This difficulty may result in the consumer (or family member) failing to anticipate insurance needs and therefore the consumer may face unanticipated needs and concurrent costs. Fortunately, as more and more consumers become insured, these unanticipated, and often catastrophic, costs can be alleviated.

In this brief description of health care coverage access, notice the decision points: employers (or other providers) make decisions about what benefits to include in offered plans, then consumers (or their family members) make decisions about what benefit levels to select (to make contributions to or to pay for out of pocket) – and these decisions result in limits on access

to care. If the consumer has anticipated future needs wisely, and no unexpected needs emerge,

the consumer should have neither too much nor too little insurance coverage. In the event that

the consumer needs supplemental or uninsured care, say, for a life-threatening illness, the

consumer will typically pay out of pocket, be expected to pay in cash or provide a credit card up

front, or will need to search for a provider with the resources that is willing to provide for the

care without charge. In the event of a non-life-threatening illness or wound, there may still be

options, but they become onerous; the consumer (or family members) will need to make

arrangements for payment, whether in the short term or the long.

Access to mental health coverage in the U.S.

In contrast to access to medical care coverage, access to mental health coverage, prior to

the passage of mental health parity legislation, was more limited. Mental health care here

includes mental health, behavioral health, and substance abuse treatments. Employers, seeking to

limit health care costs, could choose to "carve out" mental health, behavioral health, and

substance abuse treatments or choose to include in their offered plans mental health care

coverage with different types of caps and limits. This meant that, even for consumers who had

an ongoing need, mental health care of any sort might be unavailable at any cost through their

employment-based insurance coverage. Similarly, consumers with an emergent need might

discover, once they sought care at a treatment facility, that their (perhaps otherwise excellent)

health care coverage did not provide for care for any mental illness, or might only provide care at

a minimal level. As will be heard later in the testimony, this meant that sometimes a consumer's

need for care would prove catastrophic for the family: a lifelong, debilitating mental health

condition (such as a major depressive disorder, bipolar disorder, or schizophrenia) might

bankrupt a family as they sought care for a loved one.

Because of inconsistencies in the coverage included within a particular plan, when employees moved from one job to the next, or from one state to another, they might lose access to much-needed services. Employers too were free to change their policies and to reduce the amount of mental health coverage that they had included in the past. In sum, prior to mental health parity legislation, the approach to providing access to mental health care, behavioral health care, and substance abuse treatment took a patchy, scattershot approach.

Parity as a goal

Speaking broadly, the naming of mental health parity legislation, with its focus on "parity," demonstrates a conscious act on the part of bill sponsors to promote equity between physical and mental health insurance benefits provided to employees. Expanding on this idea, mental health parity legislation was designed to ensure the provision of insurance coverage for mental health problems such that the coverage would be "on par" with coverage offered for physical health problems. While this goal can be stated in a condensed way, it helps to understand that for insurance coverage (focusing here on health insurance) there may be several ways that insurance either meets, or fails to meet, the needs of consumers. First, there is the issue of availability of insurance: for employed individuals, is health coverage available, either as part of an employer benefits package, or such that employees can purchase health insurance directly at a negotiated rate? Second, what limits and copays are placed on particular health services, such as routine care and non-standard or emergency care?

Individuals in the U.S. covered by insurance will likely know that insurance companies, in negotiation with employers or other organizations, negotiate *limits on coverage* in a myriad of ways: in total *annual* inpatient and outpatient days, total *annual* dollar limits, and total *lifetime*

expenditures, but also in other ways, such as copay amounts and defined patient contributions to

coverage costs as a percentage of total care. These limits on coverage are designed to spread the

cost of care across the insured population, but also, in some sense, evaluate the relative value of

types of care received and the likely outcome of a particular type of care. Insurers can choose to

cover some types of care, but fail to cover others. Similarly, insurers might choose to cover

certain generic medications but not cover brand name medications. Insurers make choices like

these because they must balance the cost of services with potential benefit to consumers,

employers, and insurers alike and as a result, insurance represents a sharing of risk. In providing

coverage, insurance providers cannot provide all care to all individuals: insurance coverage

makes coverage available in a way intended to distribute the benefit fairly across the pool of

participating individuals.

Mental health parity legislation sought to redress existing preferences, which prioritized

physical health, by ensuring that limits for mental health coverage closely approximated those

for health coverage. For instance, in the 104th Congress, S. 298 (Equitable Health Care for

Severe Mental Illnesses Act of 1995), introduced by Senators Domenici and Wellstone, included

the following language:

> [P]ersons with severe mental illnesses must not be discriminated against in the
> health care system, and health care coverage ... must provide for the treatment of
> severe mental illnesses in a manner that is equitable and commensurate with that
> provided for other major physical illnesses.

Similarly, the synopsis of the Mental Health Equitable Treatment Act of 2001 (S. 543,

107th Congress) describes its function as follows:

> Amends the Employee Retirement Income Security Act of 1974 and the Public
> Health Service Act, respectively, to prohibit certain employee group health plans
> or related insurances providing both medical-surgical and mental health benefits
> from imposing mental health treatment limitations or financial requirements

unless comparable limitations and requirements are imposed upon medical-surgical benefits. States that the foregoing shall not be construed as requiring a group health plan (or related insurances): (1) to provide any mental health benefits; (2) preventing the medical management of mental health benefits; or (3) requiring the provision of specific mental health services, except to the extent that failure to provide such services would result in a disparity between the coverage of mental health and medical-surgical benefits.

Exempts specified small employers from such requirements (any employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year).

Insurance providers also set limits of the types described above for a range of medical services, such as for cancer or heart disease. Setting limits on care, of course, is not exclusive to mental health conditions. What has differed, however, is that insurance providers have typically set much tighter limits (including lifetime, annual, day, and co-pay amounts) for coverage of mental health conditions than for physical health conditions. Such limits made it possible for insurance providers to claim that they offered mental health coverage, only to have consumers learn that, when care was needed, the care that was offered did not meet their needs. While the size and scope of unmet need is described in the public testimony, consumers often did not know they needed mental health coverage until they knew they sought care – or a family member sought care – at which point, the cost of care had to be borne by family members. Prior to the passage of mental health parity legislation, two lifelong diagnoses, such as schizophrenia and leukemia, would result in different caps on services, both annually and as total expenditures over time. As reported in the testimony, these differences in annual and lifetime limits financially devastated some families as they sought care for loved ones.

Beyond the kinds of limits placed on coverage, mental health parity legislation also aimed to ensure parity in terms of *availability* of insurance coverage, meaning that if a major company or organization offered medical insurance coverage as part of its benefits package for its employees, then it would also be required to offer similar levels of mental health coverage.

This does not mandate that an employer provide any insurance, but it does mandate that if medical coverage is available, then mental health coverage should also be available. Prior to this legislation, "carve outs" of mental health coverage meant that employees might not even realize that they did not have coverage for mental health until they needed it. Given the rapid onset of some mental health problems, this left individuals and families scrambling for solutions.

While a number of different bills were introduced over several decades to achieve passage of mental health parity legislation, the final version of mental health parity legislation included in this analysis was the prototype for the policies included in the Affordable Care Act. The political decision to roll mental health parity into the ACA as one component may have simplified and streamlined the passage of mental health parity. As a component, it represented a small fraction of the total cost of the proposed ACA legislation.

The role of states

States emerged as leaders in the support of mental health parity legislation, by implementing changes at the state level that demonstrated that costs could be contained while still providing improved support for the mentally ill. When mental health parity legislation was first introduced, there was no legal requirement for parity at the federal level. Some states however, had already begun to implement parity legislation within their states. In fact, by 2007, 49 states and the District of Columbia had enacted legislation to strengthen mental health coverage; of these, 26 states had enacted full mental health parity (Sundararaman & Redhead, 2007). Individual states played a pivotal role in supporting passage of federal mental health parity legislation, serving as a testbed to determine cost implications of full parity. As expressed in the testimony, state implementation of different parity policies provided strong evidence that

the cost of implementation would be less than had been determined by business consultants and actuarial accountants. Similarly, when companies and organizations independently chose to implement mental health parity as part of their employee benefits package, their outcomes were included in the testimony as a way to counteract predictions about cost. Individual states, which typically bear the cost of mental health issues in the form of additional costs for other social services required by the mentally ill should they not be able to work, demonstrated that costs to the state and the individual were reduced for states implementing full parity; states were also critical in testing managed care and other cost control mechanisms (Barry, Frank, & McGuire, 2006). Given this context, states deserve significant credit in pushing for reform of mental health parity laws. Their role is described in parts of the testimony, and representatives from states with experience in implementing mental health parity legislation testimony state-wide were invited to speak about their own experiences.

Definitions of key terms

Mental health parity legislation addressed, at various points, behavioral health, mental health, and substance abuse. These concepts have definitions that occasionally are used, within the professions and in specific contexts, to refer to similar problems; the meanings of the terms also shifted in the culture over time. To reduce confusion, here I define how I use these expressions and outline, if relevant, when the terminology shifted in the testimony. *Behavioral health* is commonly used within the mental health profession as an umbrella term that incorporates behavioral problems, ranging from anger management issues to anorexia nervosa. The focus in the term is on behavior rather than the underlying causal mechanism of the behavior. Someone with an anger management issue might or might not have an underlying mental health problem. *Mental illness* and *mental health* are often used interchangeably in the

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testimony and in the legislation, although mental illness is more typically defined in terms of an underlying psychiatric condition. Over time in the testimony, this type of underlying psychiatric condition came to be referred to as a *brain disorder*. The increased use of the term brain disorder marked increased acceptance of the idea that an underlying physiological state accompanies mental illness and that there is a biological basis for defining mental illness. *Mental illness* can be differentiated from mental health because of its goal of treating symptoms. The term *mental health* is also considered to be less stigmatizing than the term mental illness. In the testimony the term *mental health* is often used as a differentiating term, with mental health more typically focused on the prevention of mental health problems while mental illness more typically focused on the treatment of existing mental health problems. *Substance abuse* refers to an addiction, whether to alcohol or to drugs. Some early legislation focused exclusively on mental illness rather than incorporating substance abuse into the same bill or amendments. For example, the National Mental Health Parity Act of 1997 (H.R. 621) only addressed mental health; during the same congressional session, the Mental Health and Substance Abuse Parity Amendments of 1998 (H.R. 3568) included parity for treatment for substance abuse. Parity for substance abuse was included in the Mental Health Parity and Addiction Equity Act of 2008. While the focus in this dissertation is on mental health parity, substance abuse is addressed in some, but not all, of the testimony.

Context: Legislative Hearings

Process of testimony

Testimony was prepared in advance, prior to the hearing, and then presented orally at the time of the hearing; the Congressional Record provides written documentation of both what had been prepared (which was submitted to the committee) and what was actually said (which was

delivered before the committee). The prepared texts constitute the data analyzed in this

dissertation. Providers of public testimony for the hearings on mental health parity can be

categorized into two groups, *insiders* and *outsiders*, according to their formal responsibilities

within the congressional committee organizing the hearing. This work examines public

testimony presented by *outsiders*, where *insiders* are defined as members of Congress presenting

to their colleagues (Senators appearing before a Senate committee, House members appearing

before a House committee) and *outsiders* are defined as all others: anyone not elected to

Congress *or* members of Congress testifying outside of their congressional responsibilities

(Senators testifying before the House, House members testifying before the Senate). This work

asks what rhetorical strategies outsiders use in their testimony as they attempt to influence policy

outcomes, focusing specifically on the mentally ill and their advocates.

Significance of testimony

Understanding the rhetorical strategies outsiders use as they advance their position,

whether in support of or in opposition to mental health parity legislation, is an important

endeavor. First, public testimony is a practical example of the Habermasian notion of

communicative rationality, an example of the public display of reasons, here in support of

legislative decision-making, where the aim is to come to consensus. This is a study of the role of

public testimony as a rhetorical practice that engages the public in decision-making about an

important policy issue. Second, this is an example of research that follows the argumentative turn

(Fischer & Forester, 1993) in public policy studies. The argumentative turn stands in contrast to

what Stone (2001) refers to as the "rationality project". The rationality project, according to

Stone, followed from the neo-positivist tradition that assumes logical rules are universal and

generalizable; given this assumption, policy decisions should be based on the right data in order

determine the best course of action. In contrast, the argumentative approach follows from the belief that sociocultural practices and their symbolic systems of meaning shape policy outcomes, that is, policy decisions are made in the world within specific decision-making contexts. The rules are not readily generalizable, outcomes are only partially determined by data, and what matters is understanding how ideas come to be seen problems, how some problems are prioritized over others, and how language and rhetorical choices make these changes possible. In legislative hearings, policies are shaped by language, by rhetorical choice, and the sociocultural frames brought to bear in this venue for legislative decision-making. In fact, this is one of the few sites where individuals can directly impact the legislative decision-making process.

Additionally, there are practical consequences to gaining a more complete understanding of how ideas move from problem to policy. In practical terms, this matters because full parity has not yet been achieved. While the mental health parity legislation examined in this study led to passage of the Mental Health Parity Act of 1996 and was included in the Affordable Care Act of 2010, loopholes remain: first, while insurance plans must now have parity between mental and physical health coverage if they offer both types of coverage, insurance providers can choose to only cover physical health and omit mental health entirely. Second, employers with fewer than 50 employees are exempt from existing laws and therefore are not required to provide plans that include mental health coverage. The U.S. Department of Commerce reported that in 2012 17.6% of all employees were employed by companies with fewer than 20 employees; another 16.7% were employed by companies with 20-99 employees.[3] Taken together, these figures suggest that

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[3] Source: Statistics of U.S. Businesses Employment and Payroll Summary: 2012.
https://www.census.gov/content/dam/Census/library/publications/2015/econ/g12-susb.pdf
Note that the Patient Protection and Affordable Care Act excludes employers with 50 or fewer employers, but this data groups employers into "very small" (fewer than 20 employees) and "small" (20-99 employees). Because this data does not use "For other current data on the breakdown of insurance coverage in the United States, including data on coverage by employer, Medicaid, Medicare and other forms, see the Kaiser Family Foundation website:

at least 20% of all employees (and probably more) work for employers exempt from this legislation. A third loophole limits employer responsibility should costs increase: if a plan's costs increase by more than 1% as a result of including mental health coverage, then employers too are exempt from the legislation. While some employers voluntarily include coverage for mental health and substance abuse treatment, without the legal mandate they can drop coverage at any point. These loopholes collectively leave many Americans without insurance coverage for either mental health or substance abuse. Articulating the arguments about mental health parity, both pro and con, has real world consequences in terms of erecting or removing barriers that limit access to mental health coverage; rhetorically analyzing arguments that are employed and when they are employed provides a landscape view of the arguments used to date and should prove useful to the ongoing debate.

The legislative process

Public testimony is offered before legislative committees and subcommittees in the US House and Senate. Individuals may provide testimony by one of two paths: invitation or request. In both cases, those who provide testimony help legislators understand the current need, provide the perspective of individuals or organizations affected directly or indirectly, and may explain potential implications of the proposed legislation. For congressional hearings on mental health parity legislation, most speakers either represent or are employed by a large organization or have standing within a professional organization, business, or lobbying group that represents special interests.

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http://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Public testimony may be heard before committees or subcommittees. When public testimony occurs, it is because legislation has already been introduced and the legislation has been referred to a committee for further discussion. After the committee hearing, the legislation may remain in committee (thereby preventing a vote, and resulting in the legislation dying in committee), be referred to a second committee, or be brought up for a vote on the floor. If legislation does not pass out of committee during a congressional session, then it must be reintroduced in the subsequent congressional session (beginning the process anew). Failing this, the proposed legislation will be abandoned. Each congressional session may therefore hold multiple opportunities for testimony: testimony on proposed mental health parity legislation was often heard before multiple committees in the House and multiple committees in the Senate within a single congressional session. The testimony being analyzed shows this trend: for some congressional sessions, there is extensive testimony, while for others there is little. Committees may also eschew public testimony entirely. Committee members and their staff will often work behind the scenes to gather support for legislation; legislative staff members typically do additional work to understand the initiative, to determine potential costs and impacts, and to assess support for the legislation. Thus, public testimony represents only a small part of the policy process, but it is one way in which those outside the process may potentially impact outcomes. Legislators also report that committee hearings are a valuable source of new information (Bradley, 1980). It is clear that hearings are integral to the work of congressional committees (Brasher, 2006). Despite these perceived benefits, no consensus exists about the function of hearings, a point that will be elaborated on in Chapter 4. For the present argument, the key point is simply that hearings may function differently than expected.

The policy arguments being assessed in this dissertation are interwoven with the legislation itself. This is because when new mental health parity legislation was introduced, there was also an opportunity for new testimony. In some cases, this new testimony was provided by organizations that, or individuals who, had presented during earlier committee hearings.

To provide context for the testimony, Chapter 2 includes a brief outline of the legislation pending at the time of the testimony. While one might assume that each of the testimonies would, of necessity, speak directly about the pending legislation, another possibility is that a disconnect exists between the existing legislation and the goals of those called upon to provide testimony. The analytical portion of the dissertation answers two questions: Chapter 3 asks how the policy problem is negotiated and defined in the public testimony and whether consensus forms about what the problem is. Then, focusing more narrowly, Chapter 4 asks whether the mentally ill and their supporters, one particular group of stakeholders participating in this deliberation, achieve agentic power as they advocate for mental health parity.   Beyond the scope of this dissertation, later work can then examine: how are goals and solutions negotiated and defined?   How other stakeholders aim to achieve agentic power? Does their use of appeals differ from the appeals employed by the mentally ill and their advocates? The next section describes some of the strategic moves that scholars of rhetoric and political science see as typical when gaining this support.

Research Questions

This work aims to understand both the *product* of public testimony as embodied in the written texts presented by outsiders to House and Senate committees and subcommittees as well as the *function* of public testimony as a tool in gathering broad perspectives on current mental

health parity legislation. The first broad goal, with its focus on the analysis of written texts, clearly operates in the realm of rhetoric. The second goal, understanding the function of public testimony, is made possible by the rhetorical analysis. This dual focus, on both product and process, is reflected in the research questions. In terms of the written arguments, key questions include:

1) Is there consensus about the problem? How do outsiders providing public testimony describe the current state and/or the problem of mental health insurance coverage?

2) What arguments do they use to argue for or against mental health parity?

3) What types of evidence do they incorporate into their testimony?

4) Do these arguments change over time? If so, how?

The work also aims to understand the function of public testimony, and to consider the value of public testimony, in its current form, as one method of engaging the public on important policy issues, examining participation, representation, use of arguments, claims, and evidence, and the function of testimony overall. In its totality, this examination, of arguments, process, stakeholders, and function of testimony, offers insights and raises questions about the value of public testimony and its role in the subsequent passage of this legislation.

The study of policy argumentation sits at the intersection of rhetoric, public policy, and political science. This dissertation takes rhetoric as its framework, uses a rhetorical lens, and constructs a rhetorical analysis. At the same time, this work examines a public policy debate, and is therefore simultaneously entrenched in public debate and policy issues. The section that follows describes these connections.

Scholarly and Theoretical Framework

The roots of rhetoric are in Aristotle's conceptualization of deliberation.   In *Nicomachean Ethics*, Aristotle writes, "We deliberate about things that are in our power and can be done" (1112a). The phrasing here creates strong limits for deliberation: limits to what is within our power and even stronger limits to what can also be done. Kock (2014) argues that politics requires rhetoric, and deliberation *(proairesis)* and deliberate choice are central to Aristotelian definitions of ethics, politics, and rhetoric:

> Ethics is about deliberate choices by individuals. Politics and rhetoric are about the collective deliberate choices by the polity: politics is about making these choices well so that the good life of all citizens is optimally secured; rhetoric is one of the principal means to do this. (p. 14)

Deliberation thus requires collective decision-making, and rhetoric scaffolds and enables deliberation. Kock, following an argument by Kenny (1979), identifies plurality of values as a condition that makes deliberation complex. In practical reasoning, we begin with a goal in mind, and then search for reasons to support that goal. While epistemic reasoning seeks to preserve truth, deliberation seeks to preserve goodness under the condition of plurality of values. Rhetoric seeks to reconcile this plurality of values so as to best preserve goodness.

In the service of this end, Aristotle argued for a definition of rhetoric as "the power of perceiving the available persuasives (*pisteis*)" (Conley, 1990, p.14). A skilled rhetorician, according to this view, is one who is skilled at "perceiving" – that is, one who understands that what works in one situation and for one individual or one audience may not work for another, and using that knowledge to see the range of possible approaches that are likely to be persuasive for a given issue. He or she should be able to tease out group interests and perspectives on

particular issues – but also be skilled at "the available persuasives" – that is, not only matching

but also crafting and constructing the available arguments to be persuasive for these particular

individuals or groups. Following this tradition, rhetoric here does not look for, or expect to find,

truth, but instead aims to persuade. For Aristotle, persuasion should include logos, ethos, and

pathos, the triad of proofs that remain foundational.

Aristotle's *Rhetoric* identifies categories of speech to include deliberative, judicial or

forensic, and epideictic or demonstrative (Remer, 1999, p. 41). In this schema, judicial or

forensic rhetoric can be thought of as drawing connections between existing laws to past actions

and events in order to assess the rightness or injustice of these past actions. Epideictic, or

ceremonial, rhetoric functions to assign praise or blame in the present, whether to a person or a

thing; in short, ceremonial rhetoric builds community by describing shared values as they relate

to a specific person or event. Deliberative speech, in contrast, is appropriate when the right

answer is not already known, when existing solutions are not a perfect fit for old or new

problems, when the goal is not to assign praise or blame, but instead to come to a well-reasoned

response that will determine future actions by establishing goals, identifying shared beliefs, and

weighing the tradeoffs of different interest groups. The focus in this dissertation is on

deliberation during public testimony in a public policy context.

Deliberation is a form of argument where "[t]he whole point…is usually to make our

decision processes more 'reflective': to help us *choose* a course of action, after due

consideration, rather than merely *picking* some course of action after hardly a moment's

thought, with scant regard to evidence or argument" (Goodin, 2008, p. 41). Deliberation, in

other words, does not take as a goal the permanent settling of disagreements, but does aim

toward a course of action instead is bound both by chronological time and exigence (Bitzer,

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1992). Moreover, deliberation has been shown to result in a range of individual outcomes: attitudinal change, tolerance of opposing views, higher levels of generalized trust, increased political knowledge, civic engagement, and other forms of political participation (Delli Carpini, Cook, & Jacobs, 2004).

An essential part of deliberation is delineating what the negative or positive consequences of future action or inaction are and who will be impacted so that the full range of interests are taken into account. Thus deliberation, in which different perspectives are shared and voices heard, is central to models of public debate, although in reality this may not occur. Because deliberation is future-oriented, it is perhaps the most complex of these three types of rhetoric: while individuals can readily understand what they want now, given their current circumstances, or wanted in the past, during those circumstances, it is more difficult to predict future wants since the circumstances remain unclear.

Deliberation thus offers enormous challenges and opportunities to speakers – what future outcomes are worth further consideration? What future needs should be anticipated? What unintended consequences might be anticipated? This research asks how different stakeholders participating in hearings on mental health parity legislation argued for or against the problem, identified goals, and described acceptable solutions; for the dissertation, the focus is on one stakeholder group, the mentally ill and their advocates, and asks whether this group, historically marginalized and stigmatized, can, and if so how, achieve agency. It further examines how different stakeholder groups as they deliberate on the problem of mental health parity.

Work in the rhetorics of community and civic engagement (Ackerman & Coogan, 2013; Flower, 2008; Kahn & Lee, 2011) and in deliberative democracy (Bessette, 1980; Bohman, 1996; Chambers, 2009; Elstub & McLaverty, 2014; Vitale, 2006) provide insight into the equally

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important roles of participants and process. These two areas of study begin with a similar assumption: that individuals and groups can be agents of change. Scholars in the rhetoric of civic engagement take a micro-level approach to supporting individuals or groups as they aim for increased civic engagement; scholars of deliberative democracy approach a similar goal from the macro-level by designing and implementing procedures and processes for community and civic engagement. These groups share two primary goals: 1) to provide supports for community and civic engagement, and 2) to develop improved tools, strategies, and venues where policy positions can be more clearly articulated. Scholars in the rhetoric of community and civic engagement attend primarily to opportunities at the individual or group level: guiding community members, and sometimes disengaged or marginalized individuals or groups, as they articulate their own policy problems and solutions, and either train and/or support the efforts of those individuals to a) engage in discussion of policy issues and/or 2) propose and/or develop a response to policy initiatives. In this sense, scholars of the rhetorics of community and civic engagement are engaging in an educational mission to prepare individuals and groups for civic engagement and social change. Projects have addressed community literacy, public health, and community revival (Eble & Gaillet, 2009; Flower, Long, & Higgins, 2000; Higgins, Long, & Flower, 2006; Jolliffe, Paganelli-Marin, Cunningham, & Peters, 2018; Kuehl, Drury, & Anderson, 2015; Young & Flower, 2002). In contrast, researchers in deliberative democracy have worked at the macro-level, aiming to improve design of programs at the institutional level (Chambers, 2009), by developing, testing and refining large-scale interventions. Projects include work on mini-publics (Calvert & Warren, 2014; Elstub, 2014; Goodin & Dryzek, 2006; Lafont, 2015; Niemeyer, 2011, 2014; Ryan & Smith, 2014; Setälä, 2014) as well as Fung's (2003) survey of "recipes" for the public sphere. This dissertation draws inspiration from both sources,

recognizing that the individual or group engaging in the hearing process and institutional design

of process (how testimony is gathered, by whom, for what purpose, under what conditions) both

impact the testimony. These two areas of scholarship provide an essential framework for those

who participate by providing testimony and the material conditions of the hearings process.

Deliberative democracy and the rhetorics of community and civic engagement draw

heavily from the theories put forward by the American philosopher and educational reformer

John Dewey (1927) in his philosophy of pragmatism and the German sociologist and philosopher

Jürgen Habermas (1984) in his philosophy of communicative rationality. John Dewey's

pragmatic philosophy calls for inquiry-based social action, following a process of identifying or

recognizing difficulties, generating potential paths forward, and testing those paths against

desired outcomes.[4] For Dewey,

> [D]emocracy as an ethical ideal calls upon men and women to build communities in
> which the necessary opportunities and resources are available for every individual to
> realize fully his or her particular capacities and powers through participation in political,
> social and cultural life. (Westbrook, 1991, p. xv)

Thus, Dewey valorizes the democratic principle of participation as a centerpiece of a life well

lived. Gastil (2000) elaborates on the process Dewey advocates:

> Following the writings of John Dewey, full deliberation includes a careful examination of
> a problem or issue, the identification of possible solutions, the establishment or
> reaffirmation of evaluative criteria, and the use of these criteria in identifying an optimal
> solution. Within a specific policy debate or in the context of an election, deliberation
> sometimes starts with a given set of solutions, but it always involves problem analysis,
> criteria specification, and evaluation. (p. 22)

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[4] For more, on this view see, for instance, Festenstein (1997).

This call to action, to create communities that allow for and welcome participation in all aspects of community life, highlights Dewey's optimistic take on existing democratic principles.

While Dewey identifies a compelling goal, communities where participants have the resources and opportunities to engage politically, culturally, and socially, Habermas complements this goal, describing the importance of the articulating of reasons in achieving similar aims:

> [C]ommunicative action is coordinated not through the egocentric calculations of the success of the actor as an individual, but through the mutual and co-operative achievement of understanding among participants. It is directed toward achieving a genuine agreement based on the intersubjective recognition of 'validity claims" (i.e. the claims raised in speech acts such as truth, rightness, sincerity, comprehensibility). It thus has a "rational basis" which Habermas approaches through a consideration of communicative rationality" (Roderick, 1985, pp. 207-08).

Within the broad category of social action, Habermas distinguishes five types, some that aim toward understanding and others that aim toward success: instrumental, social, communicative, normatively regulated, and dramaturgical. "Validity claims" for each of these types of action can be used to assess the rationality of each. Those engaged in communicative action can employ validity claims drawn from all types: claims of truth, effectiveness, rightness, sincerity, and authenticity. Communicative action engages participants in "cooperative negotiation of common definitions of the situation" (Habermas, 1984, p. 127).

He writes,

> I speak of communicative actions when the action orientations of the participating actors are not coordinated via egocentric calculations of success, but through acts of understanding. Participants are not primarily oriented toward their own success in communicative action; they pursue their individual goals under the condition that they can coordinate their action plans on the basis of shared definitions of the situation. (1984, p. 385, cited in Risse, 2000; translation by Risse)

This "process of mutual interpretation" becomes explicit in argument or discourse, with the aim of reaching a point where it is possible to "admit of consensus" (Johnson, 1991, p. 184).

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Consensus can then drive action; without consensus, parties can either return to discourse to work out disagreements (perhaps through courts of appeal) or through strategic action, which may entail force. The aim of communicative action is *consent* on the part of participants, achieved once participants employ and assess discursive validity claims to negotiate a common understanding of the situation. For the purposes of this dissertation, Habermas' theory draws our attention both to the role of language in establishing consensus, but also to the importance of establishing shared definitions. In this work, I seek to understand how different stakeholder groups seek to establish, and shape, shared definitions, specifically around definitions of the problem of mental health parity.

Drawing on the work of Habermas and others, those interested in deliberative democracy and the rhetorics of community and civic engagement have seen value in moving away from consensus and toward the more modest but perhaps also more realistic goal of mutual understanding and a willingness to work collectively for mutual benefit. Both have offered a shared critique: that contemporary democratic forms make it increasingly difficult for those being governed to feel connected to the government itself or to sense that their own concerns, values, and goals are reflected in policy and law. Habermas attributes this in part to the fact that "the rationality of science and technology is immanently one of control: the rationality of domination" (Habermas, 1971, p. 85); in other words, the government places its emphasis on establishing and maintaining a rational process rather than on the articulation of positions.

These concerns, according to Habermas, have collectively led to the public's increasing sense of disengagement from the state, and a willingness to question "[h]ow the public, or civil society in general, relates to the state" (Chambers 2009, p. 324). In this sense, Habermas offers a counterpoint to Dewey's optimism: a recognition that current political practices have not yet met

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their mark. Habermas argues, in fact, that more typically public participation is deployed simply

as a sign of consent rather than as a form of active engagement. Habermas argues,

> The contradiction is obvious: a proliferation of the social conditions that make
> private existence [here, referencing social security reform] that are maintained and
> secured by public authority, and therefore ought to be clarified within the communication
> process of politically autonomous public citizens, that is, should be made a topic for
> public opinion. Although objectively greater demands are placed on this authority, it
> operates less as a *public* opinion giving a rational foundation to the exercise of political
> and social authority, the more it is generated for the purpose of an abstract vote that
> amounts to no more than an act of acclamation within a public sphere temporarily
> manufactured for show or manipulation. (1989, p. 222)

This results in a "gap between public opinion as a fiction of constitutional law and

the social-psychological decomposition of its concept" (p. 244). For Habermas, communicative

action must be tied to validity claims that test public opinion in order to achieve systems that

reflect human goals.

Communicative rationality should be our aim: to focus our efforts on the use language

and human reasoning to achieve a communal goal, to achieve rationality not based solely on

quantitative and economic reasoning, which strips away context and values, but a rationality

based on shared communication. Successful communication is rational communication, willing

to tackle the incongruity and complexity of policy arguments where a range of perspectives are

heard.

This dissertation exists in the space between the traditions of the rhetorics of community

and civic engagement and deliberative democracy, building from conceptualizations of the role

of discourse in democracy to support decision-making that acts in the public good.   Its goal is to

examine public testimony before Congress, and to assess how effectively the existing forum

works in bringing in new voices. Some might argue that it is unfair to assess public testimony

using this lens – but what if a valid goal of public testimony is, in fact, to bring in new voices

that can test validity claims? The function of the question does not come from a desire to assign blame, but instead to simply ask: what happens now in public hearings? Does public testimony serve to bring in new voices and test central claims? And then perhaps we might ask: Might existing forms of representation be strengthened if deliberation was more clearly articulated as a goal? In this dissertation, one goal is to examine public testimony as an existing form of public participation and to assess, to some degree, how successfully it functions as a path for public deliberation, and second, to assess, using a rhetorical framework, how successfully those providing testimony are able to shape the discussion. These scholarly and theoretical lenses are employed to shape questions and to frame observations and outcomes.

Some might argue that testimony lacks the element of deliberation, because congressional testimony is most often one-way communication, with little opportunity for the back-and-forth that often marks deliberation. But as Goodin (2008, p. 41) argues, deliberation requires "an *internal* process of weighing of reasons [emphasis mine]"; it is this internal process that is captured in public testimony, where speakers know that their testimony will be heard in the context of the testimony of others. As will be seen in the testimony, these speakers recognize that alternative paths exist and they are careful to articulate their best reasons

Characteristics of Policy Arguments in Action

Policy arguments sit at the nexus of public norms and values, technical expertise and experience, political goals and moral choices, individual judgment and collective action. Policy arguments are "a complex blend of factual statements, interpretations, opinions, and evaluations" (Majone, 1989, p. 63): it can be challenging to differentiate fact from interpretation, opinion from evaluation.   Policy arguments incorporate values and constraints, but also require that

participants assess whether the claims being made are, in fact, are reasonable and legitimate (Gasper, 1996).   Additionally, policy arguments require moral choices about "who we are and who we aspire to be" (Stone, 2001). All of this means that participants in policy arguments may take varied approaches to crafting and interpreting them and must balance a number of different goals. Any rhetorical analysis of policy arguments must begin with an awareness of their complexity.

Stone's (2001) influential model of public policy discourse, which examines legislative decision-making, suggests that policymaking typically involves three stages in the (1) statement of goals, (2) consideration of problems, and (3) selection of solutions. Stone argues that the setting of goals and definition of problems are critical, in that the decisions about what goals problem solvers are aiming to address and how problems are defined will frame and constrain possible solutions: understanding. Having a strong leader, Stone argues, is also essential in getting a policy problem on the agenda.

The strategic moves that typically observed as policies advance include: identifying a strong champion, getting the policy issue on the agenda, defining a policy problem as amenable to *human* intervention, gaining agreement that the problem should be solved by *government* intervention, asking decision makers to weight the relative merits of the policy according to costs and benefits, and incorporating stakeholder perspectives.[5]

 Notice that the first two items are about the champion – having someone with the political will and political know-how. A champion gathers political will, uses personal connections, calls in political chits, and brings attention to an issue they see as in the public's

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[5] For extended descriptions of this process see Sabatier (1991); Stone (2001).

interest. Mental health parity had been championed by John F. Kennedy, Paul Wellstone, Pete

Domenici, Rosalynn Carter, and Betty Ford.[6] Many of its champions had an insider track to

understanding the key issues, with family members and personal understanding of the toll of

mental health and substance abuse issues. These champions gained credibility and had the

political know how to get mental health parity on the political agenda. Such champions are

critical because they make it possible to build political strength and promote change. And this in

turn makes it possible for an idea to become more than an idea. For the purposes of this work,

the issue of leadership refers to something beyond the testimony itself will be largely excluded.[7]

The role of the leader does come up within the testimony on occasion and it will be discussed

when it is explicitly addressed in the testimony. Agenda setting matters because there will

always be more ideas than there will capital to produce results – getting a policy goal on the

agenda requires changing the signal-to-noise ratio so that the signal comes through. While

agenda setting is clearly important, it precedes the gathering of public testimony and will be

excluded from this analysis, however it is clear from the amount of legislation introduced on

mental health parity and the number of hearings conducted, as well as the repeated ability to

continue the process of introducing legislation, that there was an agenda around mental health

parity.

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[6] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAE) Act, a provision of
the Emergency Economic Stabilization Act of 2008, was the first major mental health parity legislation and bore the
names of the legislators who worked to generate support for the legislation. Rosalynn Carter and Betty Ford, the
wives of former Presidents Jimmy Carter and Gerald Ford, testified before Congress regarding the importance of
mental health parity and coverage for substance abuse. Former President John F. Kennedy was an early leader in the
fight for mental health protections.
[7] Others have previously made the point that there were champions for mental health parity legislation, and that
these champions often had personal, family experience with mental illness. See Barry, Huskamp, & Goldman
(2010).

In contrast, the next two, defining as amenable to human intervention and gaining agreement that the policy is appropriate for government intervention, can be more immediately assessed in the testimony. Stone asserts that these promote success, and they continue to be debated throughout the testimony. Notice also that much of this analysis of strategic moves may appear to be describing what happens *prior* to a bill being introduced on the floor: however, as will be shown in the testimony, these questions of the problem of mental health parity being amenable to both human and governmental intervention recur throughout the testimony. This will be seen in the testimony through discussions of how we should think about mental illness (as a brain disorder, as having a biological basis) and through debate about the role of the states, employers, and the individual, which addresses ideas about ownership of the problem of mental health parity. As will be seen in the analysis, however, individuals providing testimony continued to return to questions of *whether* mental illness and substance abuse *was amenable to human intervention* and *whether it was the government's responsibility to do so* (see Chapter 3). These issues were not settled, resolved after a single victory, but instead continued to be points of disputation. This is another key feature of political change – issues are not resolved quickly, and even when they are resolved for the moment, disagreements are likely to reemerge at another point and in a new guise because moral disagreements, incompatible values, and incomplete understanding likely remain (Gutmann & Thompson, 1998). Other researchers examining mental health parity have similarly focused on the role of legislative leaders in pushing for mental health parity legislation (Barry, Huskamp, & Goldman, 2010; Levinson & Druss, 2000) and in pushing policy agendas in general (Stone, 1989).

The issues of human and government intervention warrant further discussion. Returning to the idea of gaining agreement that a problem is amenable to human intervention, the first goal

then is to demonstrate that human action and human know how has developed sufficiently to at least begin to address the problem. While humans can intervene in any number of situations, there must be some possibility of an action that might affect change. Similarly, the cost and the benefit must be aligned so that the potential benefit is seen to outweigh the likely cost. Next is the question of whether it is something that the government *should* address and who should take action. To choose a neutral example, one might argue about whether the government should be responsible for the building and maintenance of roads. As a public good, many would argue that roads should be the responsibility of the government. But there was a time when most major roads were toll roads, and toll roads were privately, rather than publicly, held.

Gaining agreement about the responsibilities of the government is tied, too, to political party, with Republicans and Independents more inclined to place less responsibility on the government's plate. Even from these more neutral examples, however, it should be clear that the question of public good is complicated. Toll roads still exist: should the state bear the cost of a road that benefits those outside of the state? Should the federal government bear the cost of a road that benefits some individuals and corporations more than others? National monuments incur costs: the land on which they sit is not available for development, the land on which they sit may hold natural resources. Even choices that today are seen as decided were once issues of controversy, and may be yet again.

The final two, incorporating perspectives from stakeholders and having decision makers weight relative merits according to costs and benefits, both focus on contributors to the deliberation. While it is certainly possible to create political change without involving stakeholder groups, having this input helps to build acceptance of new policies (McConnell, 2010) Further, the weighting of merits encourages participants to not simply push their own

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goals but to account for their relative worth (for an example, see Bayley & French, 2008). For this reason, the analysis examines the contribution and arguments made by different stakeholder groups. This work aims to shine a light on what happens in these committees by focusing on public testimony.

In public testimony on mental health parity, participants assessed the value of the policy and the impact of the legislation, evaluated who will be impacted positively and negatively and to what degree, and simultaneously showed how they weighed the tradeoffs between cost and social good. By employing both rhetorical and stakeholder analysis, the present research unveils how the meanings of problems, goals, and solutions are negotiated and thus provides insight into legislative hearings and rhetorical appeals employed by outsiders, specifically the mentally ill and their advocates. These arguments operate within a complex space of stakeholders' prior experiences and histories and are further constrained by an existing healthcare system, insurance programs and requirements, and financial and governmental commitments; within existing and prior definitions and understandings of what mental illness is, as described by the DSM-IV; and within beliefs and goals about the role of government. Collectively these constitute "unstated background assumptions" (Carrow, Churchill, & Cordes, 1998) that color these arguments and limit what participants may see as both reasonable and optimal outcomes. To fail to consider these existing systems would be to fail to fully grasp the arguments. As a consequence, this dissertation also draws on research and concepts from a range of fields: rhetoric first and foremost, but also public policy and political science, philosophy, history, and medicine. To isolate this work from that in these other fields would be a disservice to the complexity of public policy. Any brief digressions will, it is hoped, provide context and provide a richer understanding of political discourse.

There are also a number of challenges associated with policy arguments, and these difficulties may become even more challenging when choices and associated outcomes affect the public. These include: 1) an increasing tendency to turn to experts to resolve policy issues (Goodnight, 2012) using only an economic framework to assess outcomes (Stone, 2001); and engaging stakeholders in policy decision-making (Fung, 2003).

Congressional Hearings as a Unique Site for Public Deliberation

Public testimony presented during congressional hearings offers one type of "institutionally defined and bounded deliberation" (Chambers, 2009, p. 332). Testimony is institutionally defined and bounded in a number of ways. First, legislators control who speaks. Individuals speak before Congress either because they have been directly invited or because they requested the opportunity to present. But who speaks, and before which committee, is determined by the committee itself. This suggests that the committees themselves have some control of the narrative by deciding who is invited to testify. Second, legislators control when speakers present. The order of speakers is determined in advance and this appears to control the flow, and perhaps framing, of information. The flow of information is further controlled because testimony is one-way communication. The speaker delivers a prepared document, and this written document is then incorporated into the Congressional Record. There is very little deviation from the written testimony, and it appears rare for legislators to even ask follow-up questions. It does happen occasionally, but only when a legislator asks for additional information or for clarification.8 There is little opportunity for speakers to respond to earlier speakers. In this sense, then, public testimony doesn't typically emulate the deliberation model.

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8 The Congressional Record includes a transcript of the discussion within the committees and thus it is possible to confirm this.

Finally, the testimonies themselves are typically time bound. Speakers can include supplemental information (that is, information that they do not present during the meeting), however most simply provide a written record of their testimony.

Testimony also represents one form of "the institutionalized discourses at the center of the political system" (Habermas, 2006, p. 415). The fact that public testimony is institutionally defined and bounded matters – while individuals can ask to be included, it is more common for political leaders to invite individuals to testify, suggesting that the perspectives that are included have already been selected. Understanding who is invited provides insight into what perspectives are seen to be relevant to the debate. The fact that they are "institutionalized discourses" matters because, as with any discourse, there are expectations about what should and should not be said and rules about how the testimony will be presented. There is a pattern to much of the testimony. Often the testimony opens with a politeness move: the speaker describes how much he or she appreciates being asked to speak. Next the speaker introduces him or herself and provides information about his or her background (typically professional background). During this opening, most speakers will explain why they have a unique perspective on the proposed legislation. Sometimes this includes describing their experiences with someone with a mental health or substance abuse issue, but not always. Then the speaker provides information relevant to the legislation and their position on the legislation. They provide their best reasons, express concerns, and cite data and sources. Most close with a politeness move: expressing gratitude or appreciation, offering to provide additional information if needed. In short, there is a typical flow to the testimonies. Most testimony is two or three typed double spaced pages, although some are considerably longer. The length typically increases substantially when the speaker is providing estimates of the cost of parity.

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The case of mental health parity is a rich site for investigation. While the testimony consists of both technical experts and non-experts, most of the testimony comes from experts. They include program managers, consultants, medical professionals, and others. Non-experts, in contrast, are individuals facing mental health or substance abuse challenges, they have another kind of expertise: knowledge of how their conditions have impacted their lives and knowledge of how existing policies have impacted them financially. As is made clear in the testimony, members of this group have experienced stigma as a result of public response to their mental health conditions, and might be expected to experience further stigma by publicly detailing their condition. Thus, the existing system for participation expects that those affected by legislation with participate, but the issue itself makes this less likely. In short, mental health parity is a policy for which there is a profound need for representation, but enormous hurdles to full participation.

Currently little is known about the role of legislative hearings in the legislative process (Brasher, 2006) or, more specifically, the function of public testimony within the process. This lack of understanding about the rhetorical function of public testimony, its potential value, and its forms, has real world consequences. Public testimony is one of the few ways in which the public engages in the political process at its highest levels. Additionally, while there may exist a general belief that public testimony *should* enhance policy decision-making, it is important to test whether public testimony actually fulfills our expectations. Further, if public testimony does serve as a way in which the public alters the course of policy decision-making, by bringing in the perspective of those impacted by legislation, it would be useful to know *what kinds of arguments are made and the kinds of evidence that are used*. This study, then, also attempts to begin to answer these questions for the policy of mental health parity.

It seems possible that public testimony may serve a number of different functions. One possibility is that public testimony serves primarily an internal educational function, bringing new views to congressional leaders, or expanding their understanding of public views. Another possibility is that it serves an external function, allowing the public at large to gain insight into the issues in order to become better informed. A third possibility is that it serves a different external function, to demonstrate to other legislators that there exists broad support for a legislative solution to a public issue. Finally, public testimony may also serve yet another, more judicial, function, when the public can decide whether to exonerate or assign blame. As an example, Mary Barra, the CEO of General Motors Company, testified before Congress to address problems with a faulty ignition switch that led to over 100 deaths. Members of Congress asked what GM knew and when in order to assess responsibility and take corrective action to avoid future events[9]. The function of public testimony in mental health parity legislation remains poorly understood (Brasher, 2006).

Significance of this Work

As of 2018, there is again uncertainty about whether mental health parity will be removed from future health care legislation. By understanding the arguments being made in favor of reform or in favor of maintaining the status quo, as well as the role of public testimony in the legislative process, this dissertation aims to leverage the strengths of rhetorical analysis to understand the policy arguments, to tease out how different stakeholders weigh issues, to consider how arguments and stakeholders change over time, and to begin to develop a rhetorical

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[9] For more information, see: https://www.nytimes.com/2014/07/18/business/senate-hearing-on-general-motors.html

theory of the role of public testimony in the democratic legislative process. In this sense, this work builds on work in the rhetoric of civic engagement.

Understanding the rhetorical construction of this particular legislation has real world consequences. First, millions of Americans and their family members are impacted by the legislation, both financially and in terms of access to care. Better understanding what makes an argument about mental health parity compelling has impact in the world. Possibilities include: recommendations for those arguing for mental health parity legislation, those seeking to understand congressional rhetoric, and those studying policy formation. This work is tied to activist rhetoric, seeking to understand how rhetoricians can use rhetorical tools to better understand complex problems and political change.

Ensuring participation from those most affected by mental health parity policies is particularly challenging because of the stigma of mental illness. The existing assumption is that public engagement with policy issues happens readily. But those with the most severe forms of mental illness may be unable to contribute fully to this deliberation, while those with less severe forms of mental illness may be constrained by perceived stigma, leaving them unwilling to share their private struggles, and leaving family members unwilling to bare the challenges they face, in order to protect their loved ones. Given the possibility that a public "outing" of one's mental state might leave outspoken proponents of mental health legislation particularly vulnerable, this is completely understandable.

The mental health parity debate demonstrates the complexity of policy arguments in general, requiring that choices be made at the intersection of growing technical knowledge in both medical and scientific understanding, public preferences, moral choice, and economic cost. The debate also distinguishes itself from many other debates over public policy as a result of the

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role of stigma, which may have limited the public's willingness to acknowledge the size and

scope of the issue and may also have limited the willingness of those most impacted to come

forward and participate in the policy making process. In this sense, the debate tests the limits of

stakeholder participation.

Better understanding how policy arguments are rhetorically constructed has the potential

to expand our knowledge of how language works in the institutionally defined and constrained

setting of congressional hearings as well as understanding the role of language in policy

formation. Many studies of congressional rhetoric have focused on congressional rhetoric within

the context of a larger public discussion, with a focus on the policy goal. For instance, Miller

(1999), in an analysis of consent formation in midwifery legislation, has argued that

> [I]n the present fragmented political climate legislative debate may be
> increasingly regarded as generative, constructing policy which can depart in
> important respects from mediated public consensus, however that is denned or
> under whatever conditions it is produced. (p. 361)

Rhetoric can also provide insights into the policy formation process, which is still poorly

understood:

> Despite several studies on public policy debates and legislation, communication
> scholars have not yet examined the negotiation and construction of public policy
> as a rhetorical process beginning with bill proposals, congressional hearings, and
> congressional debates. (Gring-Pemble, 2001, p. 342)

While little is known about the rhetorical process of congressional hearings, research has shown

that witness affiliation and the Congress in which witnesses submitted testimony were effective

predictors of their level of influence (Edwards, Bryant, & Bent-Goodley, 2011, p. 145).

This work first aims to enrich the field's understanding of argumentation in congressional

rhetoric as well as the function of public testimony; second, it provides insight that should prove

useful to novice and expert practitioners -- how those who provided public testimony modified their rhetorical appeals over time, the function of public testimony as a way to expand current understanding of problems, and a method for the rhetorical analysis of congressional testimony. Because this research aims to be descriptive of the arguments used by stakeholders in the public testimony, it may also lead to normative recommendations useful to those providing testimony. Additionally, this research provides a Toulmin-based research strategy for approaching a large corpus: here the testimony extends over hundreds of documents as well as over decades. By examining a policy argument as it unfolds over time, this research offers a glimpse of how constructions of policy problems are contested and evolve over time. Finally, this work aims to assess the value of public testimony in decision making regarding public policy. Political theorists have increasingly focused on concerns about the democratic process in an age of ever-growing specialization, and deliberation is seen as a great hope for the continued sustainability of democracy. This type of "communicative rationality", of employing public testimony as a stand in for the public voice, is one highly visible site where public concerns are shared: rhetorical analysis can unpack what happens in public testimony. This rhetorical analysis of public testimony deepens our understanding of how public testimony functions and suggests modifications to strengthen its outcomes. This dissertation contributes to the literature on the passage of mental health parity legislation, suggesting contributions made by the mentally ill and their supporters. In addition, it demonstrates that public testimony functions in ways that differ from expectations. Finally, this identifies a coding process for the analysis of legislative testimony. This work has potential application to studies of deliberative democracy.

The remaining chapters will develop these ideas as follows. Chapter 2 describes the research methodology. Chapter 3 describes how stakeholder groups define the problems facing

the mentally ill and how these key concerns evolve over time. Chapter 4 describes how the

mentally ill and their supporters build coalition through the testimony. Chapter 5 concludes.

Chapter 2. A FRAMEWORK FOR ANALYZING CONGRESSIONAL TESTIMONY

This chapter details the corpus, context, and methods used to analyze public testimony in the mental health parity debate. The first section begins with a description of the argumentative turn in public policy, at which point a number of scholars of public policy began to recognize that policy issues came to be seen as problems not simply through analysis but largely through rhetorical arguments (Fischer & Forester, 1993; Stone, 2001). The second section describes the corpus of public congressional testimony on mental health and substance abuse parity legislation. The third section situates the corpus in three ways: historically, by offering a synopsis of the legislative history, and detailing legislation milestones by Congressional session; contextually, by describing connections between the speakers and events occurring outside of the congressional hearings; and by participant type, clustering testimony by stakeholder groups in preparation for stakeholder analysis. The goal in providing this rich context for the corpus is to recognize both the strengths and limitations of public testimony in addressing the full range of conditions impacting the mental health and substance abuse funding parity policy. The fourth section describes the coding process used in the analysis. Following a process for the analysis of policy arguments proposed by Gasper and George (1997), the coding process examines claims and data, taking a Toulmin-based approach, subsequently clustering claims according to categories proposed by Stone (2001), namely problems, goals, and solutions, and clustering warrants or grounds following common rhetorical topoi, or topics, as defined by Corbett and Connors (1999, p. 87). Employing Toulmin's model as the foundation of this work, argument analysis is the primary method of assessment and public testimony the central focus. The Toulmin model centers on a central distinction between data and claims. The Toulmin model

also recognizes that arguments do not exist only in the words themselves, but also in what the reader brings to the text – in the implicit assumptions that the reader should understand in order to make a text "work".

Argument analysis using the Toulmin model thus makes it possible to tease out underlying arguments, using data and claims to determine warrants of individual speakers. In addition to the Toulmin analysis, a stakeholder analysis (Brugha & Varvasovszky, 2000; Grimble & Wellard, 1997) made it possible to examine the alignment between arguments and stakeholders, and subsequently to construct overarching narratives for each stakeholder group. Following analysis of how each stakeholder group defines central arguments (e.g., what is the policy problem? what are its components?), it is then possible to comparatively examine how different stakeholder groups used rhetorical arguments to reframe the problem and to make an argument for who ought to be responsible for solving the problem. This comparison of stakeholder groups makes possible further analysis of points of agreement or disagreement among the groups.

While the stakeholder analysis defines five unique stakeholder groups, this dissertation examines only one of the groups, namely, the mentally ill and their advocates. However, the process for coding all subsequent stakeholder groups would proceed in the same manner. As a result, the dissertation serves as a starting point for further analysis. Similarly, the dissertation analyzes one of the categories for analysis proposed by Stone, problem definition. The process described in this chapter can be used for other categories identified by Stone, including goals and solutions. The method used here can be used systematically to extend the findings described in subsequent chapters.

Content analysis is used to supplement the Toulmin-based analysis, adding information about the frequency of key argumentative themes; here, it also made it possible to assess how different types of arguments were employed, and by which stakeholder groups, at different moments in time. Because the debate over mental health parity extended for several decades, content analysis is a useful tool to diachronically capture which arguments (for instance, about how the problem is described) are robust or less robust as well as whether arguments eventually disappear (and perhaps reappear). Understanding the relative strength of arguments can provide insight into the rhetorical nature of public policy and more specifically to identify components of the argument that are more contentious. These points of contention may indicate the places in the argument that led to the protracted debate over mental health parity.

The chapter concludes with a description of the computer assisted qualitative data analysis software (CAQDAS) tool employed in coding, *Atlas.ti*, and identifies its strengths and limitations in terms of this project. Atlas.ti was valuable in this analysis for a number of reasons. First, it makes it possible to include hundreds of texts in the same analytical frame. Second, it allows for texts to be assigned to "code families". In this case, it made it possible to conduct analyses of coded texts that examined the corpus either by Congressional session or by participant group. Additionally, it enables visual representation of the data through "maps", which can then be modified to add relationships. This ability to visualize the data in multiple ways is an asset to the researcher, simplifying the process of drawing connections across the coded testimonies.

Research Framework

Two competing theories of policy politics

What should be the unit of analysis when we study competing positions on policy arguments occurring in public testimony? Does the individual text, or individual testimony, provide insight? Or should we take as our unit of analysis something other than the individual? Stone (2001) asserts that we should examine groups or organizations. Her reasoning supports the choice to conduct a stakeholder analysis and I detail her argument next.

According to Stone (2001), two competing theories of policy politics exist, and these theories rest on opposing models of political society. The traditional model of policy politics, which Stone refers to as the *market* model, rests on a model of rationality, favored in economics, in which individuals are thought make decisions so as to maximize personal gain and information is symmetric -- accessible to all, accurate and complete. If we take the individual as the unit of analysis, the driving force in the market model, then each individual is seeking their own goals and decisions should only be made when information is complete and publicly shared. Stone refers to this rational/technical approach as "the rationality project". Her critique is that this does not capture what happens in the world of public policy making.

The competing possibility, and the better descriptor of what is observed in policy making, Stone argues, is that interest groups may come together temporarily to pursue shared goals, such as power, collective welfare, or public interest, but must make decisions based on asymmetric, incomplete, and even inaccurate information.   Stone contends that in policy politics the building blocks of social action are *groups and organizations* and information is "ambiguous, interpretive, incomplete, [and] strategically manipulated" (p. 33).   She refers to this as the *polis* model. In

the polis model, there are debates not only about the right solution, but about community preferences, goals, and values and the heart of action is in the ongoing negotiations about whether we are solving the right problem, what our goals should be, and what a good solution looks like. This dissertation takes the polis model as a starting point and takes the view that interest groups consist of stakeholder groups, assuming that stakeholder groups providing testimony are likely to have more shared interests over time than do interest groups.

The argumentative turn in public policy

Stone's view connects to similar observations in public policy. Since at least the 1970s, and building from Habermas' (1984) theory of communicative rationality, public policy analysts and political scientists have increasingly questioned what is omitted from a rational, technocratic assessment of policy issues and whether, instead, data-driven assessments might reflect a skewed model of a "good" solution. In research on public policy and public planning, this led to a renewal in the values of the community and a renewed interest in rhetoric; Forester & Fischer (1993) termed this shift the "argumentative turn". Following Fischer (2003), this work begins from the position that there exists "a constant discursive struggle over the definitions of problems, the boundaries of categories used to describe them, the criteria for their classification and assessment, and the meanings of ideals that guide particular actions" (p. 60). Following the argumentative turn, a number of theorists have argued for a more rhetorical, probabilistic, and community-driven view of policy inquiry (Dryzek, 1994; Fischer, 2003; Gottweis, 2006; Hajer & Wagenaar, 2003; Majone, 1989), contending that what actually happens in policy arguments is the constant tension over community preferences, goals, and values. Loyalties shift and dissolve, communities grow and disperse, values become salient and then give way under pressure of new demands. Following similar reasoning, Greenhalgh and Russell (2006) argue that,

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Policy making -- which might be defined as the authoritative exposition of values – is about defining and pursuing the right course of action in a particular context, at a particular time, for a particular group of people and with a particular allocation of resources. Policy making is about making and implementing collective ethical judgments. Most of us are painfully aware that "evidence" … fits obliquely and sometimes very marginally into this process. But if evidence is marginal, what is central? (pp. 35-36)

Rhetoric and rhetorical tools enable the exploration of these critical, but often implicit, agreements and disagreements. By incorporating rhetorical analysis and stakeholder analysis, I contend, it becomes possible to study how arguments are made and remade by groups and diachronically.

Rhetorical analysis of public policy arguments

Policy analysts and planners have turned to rhetorical tools and strategies to assess policy arguments. Gasper and George (1997) have argued for the importance of "the move away from simple instrumental rationality and towards use of improved processes of public discourse for identifying significant problematic situations and appropriate ways to addressing them" (p. 367). In studying policy arguments rhetorically, researchers (including Attride-Stirling, 2001; Gasper & George, 1997; Greenhalgh & Russell, 2006) have used the Toulmin model (1958/2003) as a starting point for rhetorical analysis of policy arguments. Toulmin's approach to argumentation runs parallel to those of the argumentative turn taken by policy analysts: Toulmin argues that the use of formal, deductive logic as the primary basis for teaching and analyzing argumentation fails to account for how language is used in practice. Brockriede and Ehninger (1960) describe the value of the Toulmin model, asserting, "Toulmin has provided a structural model which promises to be of greater use in laying out rhetorical arguments for dissection and testing than the methods of traditional logic" (p. 47). As a second primary benefit, they note, "Toulmin's analysis and terminology…suggest a system for classifying artistic proofs which employs

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argument as a central and unifying construct" (p. 44). While the Toulmin model holds great promise for the analysis of challenging policy arguments, there are also challenges to its implementation as an analytical tool. Understanding both the promise of the model and challenges in its use are essential to its successful use.

Corpus

Defining the corpus

The corpus of public testimony on mental health and substance abuse parity analyzed in this work consists of 90 documents. Each of these documents represents the written version of the testimony delivered before a Congressional committee or subcommittee by an invited speaker, that is, someone with a stake in the proposed legislation. While testimony was presented orally, each speaker also provided a written document for the record, and the documents themselves (rather than the oral testimony) are analyzed. The decision to analyze the documents rather than the oral arguments is two-fold: first, many of the written documents appear to be verbatim to the delivered oral testimony; second, should any differences exist, the assumption made is that the written document best captures the planned-for and intended meaning.

The hearing process allows for individuals providing public testimony to be asked questions, either orally or in writing, regarding their testimony, however only the written testimony is included in the corpus. There are two reasons for this decision. First, it simplifies the analysis, and second, it avoids the complexity of tracking all questions asked – both inside and outside of the hearing room. In cases where visuals (most commonly tables of numbers, such as cost estimates or projections) are part of the testimony, they are included in the analysis

only in so far that they are referenced in the text itself. Although such tables could potentially be analyzed rhetorically, they were most often provided by consultants aiming to provide additional details about their cost estimates and the text itself highlighted the key points from those tables. Additionally, the interpretation of such tables requires significant understanding of financial accounting procedures and therefore is beyond the scope of this work. Each included document is available, through the Government Printing Office (GPO), as part of the public record for its respective Congressional hearing.

The testimony analyzed includes the period from 1993 to 2009, incorporating eight Congressional sessions, beginning with the 103rd and concluding with the 110th Congress. Testimony was selected for inclusion by having been identified in a written report produced by the Congressional Research Service (CRS), entitled *The Mental Health Parity Act: A Legislative History* (Sundararaman and Redhead, 2008). The Congressional Research Service provides policy and legal analysis to members of Congress and to committees as whole and is funded by the federal government – its goal is to provide unbiased assessment of legislation. This report focuses on all legislation relevant to the mental health parity policy discussion for this period and therefore serves as an indicator of the most relevant legislation. Once the relevant legislation was identified, the next step was to determine whether hearings had been held. The CRS report also simplified this step by identifying dates of hearings. Without this report, conducting this research would have been significantly more difficult.[10] Given the volume of legislation that is proposed for any single Congressional session and the number of hearings held, the available data can be overwhelming.

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[10]   Other legislation also focused on mental health issues too and not all providers of testimony referred to "mental health parity".

Narrowing the corpus

The hearings used in this analysis are the result of two broad types of legislative proposals: legislation that focuses more generally on health care reform, and legislation that focuses narrowly on the issue of mental health parity and/or substance abuse parity.[11] While the CRS report tagged specific hearings as including testimony relevant to mental health parity, the bulk of those hearings addressed health care reform in general. Mental health parity was the primary focus for only a small portion of the total. In all cases, only testimony with a primary focus on mental health parity or substance abuse parity legislation was included in the analysis. Finally, because the goal of this analysis is to focus on how the public engages in the political process through testimony, testimony provided by elected officials speaking before their peers (House members speaking before House committees, Senate members speaking before Senate committees) is excluded.

Situating the corpus historically

Mental health parity legislation did not immediately gain broad support, rather it grew incrementally, with two legislative acts advancing the cause of mental health parity. While significant headway has been achieved in providing mental health parity as of this writing, parity still has not been fully institutionalized and achieving full mental health parity is an ongoing concern. Without a doubt there has been forward momentum, and that forward momentum has been sustained over time, but there are still many reasons to believe the existing law may be

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[11] Initially, the legislation focused exclusively on how to provide coverage for mental health needs – substance abuse was excluded from consideration. Over time, substance abuse was incorporated into the mental health parity legislation, presumably because the odds of passing legislation focused on substance abuse exclusively was not likely to see success.

repealed. This section will detail, albeit in broad strokes, some of the historical events that preceded the legislation's broader political acceptance.

An overview of key dates from the legislative history is provided in Appendix A. The Mental Health Parity Act of 1996 was an early milestone because it guaranteed partial parity. It required that insurance plans that offered any mental health coverage would be required to have parity in annual and lifetime limits for mental health and medical coverage[12], but this legislation left a number of other limits, such as co-pays and deductibles, unchanged. Over a decade later, the Mental Health Parity Act of 2007 further increased parity, but left in place exclusions, or "outs", for companies that could document increases in costs that exceeded 1% and small businesses.[13] One key sticking point throughout these legislative efforts has been potential cost increases.

Testimony regarding mental health parity legislation was heard before various House and Senate committees during 14 unique hearings, some of which were heard over multiple dates. (For a complete listing, see Figure 1. Source of Congressional Testimony (including Excluded Testimony.) During these public hearings, the number of speakers ranged from a single speaker to 18 individuals.

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[12] As an example, if an insurer limited total annual coverage to $50,000 for medical coverage, then the same coverage limit would also apply to mental health coverage. An insurer could not set a cap on coverage for one without having the same cap on coverage for the other.

[13] Small businesses are defined as companies employing 50 or fewer employees.

Congressional Session (in bold) and Legislation (not in bold)	Dates of Testimony	Committee Name (including Branch)	Testimony by Elected Officials (excluded)	Testimony by Others (included)
103rd Session				
Coverage for Mental and Addictive Disorders in Health Care Reform	*May 13, 1993*	*Senate Committee on Labor and Human Resources*	9	6
Health Care Reform	*Oct. 26, 1993*	*House Committee on Ways and Means; Subcommittee on Health*	0	4
Health Security Act of 1993	*Nov. 8, 1993*	*Senate Committee on Labor and Human Resources*	3	5
Health Care Reform	*Dec. 8, 1993*	*House Committee on Energy and Commerce; Subcommittee on Health and Environment*	0	4
Hearing on the Impact of Health Care Reform on Individuals with Disabilities	*Feb. 3, 1994*	*House Committee on Education and Labor; Subcommittee on Select Education and Civil Rights*	0	1
Health Security Act of 1993	*Mar. 8, 1994*	*Senate Committee on Labor and Human Resources*	9	2
104th Session		*None*	None	None
105th Session		*None*	None	None
106th Session				
Mental Health Parity	*May 18, 2000*	*Senate Committee on Health, Education, Labor and Pensions*	3	10
107th Session				
Achieving Parity for Mental Health Treatment	*July 11, 2001*	*Senate Committee on Health, Education, Labor and Pensions*	1	10
Assessing Mental Health Parity	*Mar. 13, 2002*	*House Committee on Education and the Workforce; Subcommittee on Employer-Employee Relations*	3	13
Insurance Coverage of Mental Health Benefits	*July 23, 2002*	*House Committee on Energy and Commerce; Subcommittee on Health*	0	5
108th Session				
Recommendations to Improve Mental Health Care in America	*Nov. 4, 2003*	*Senate Committee on Health, Education, Labor and Pensions*	3	6
109th Session		*None*	None	None
110th Session				
Mental Health and Substance Abuse Parity	*Mar. 27, 2007*	*House Ways and Means; Subcommittee on Health*	2	16
Paul Wellstone Mental Health and Addiction Equity Act of 2007	*June 15, 2007*	*House Energy and Commerce; Subcommittee on Health*	2	5
Paul Wellstone Mental Health and Addiction Equity Act of 2007	*July 10, 2007*	*House Committee on Education and Labor; Subcommittee on Health, Employment, Labor and Pensions*	0	3
Totals			35 documents	90 documents

Figure 1. Source of Congressional Testimony (including Excluded Testimony)

Figure 1 provides insight into the role testimony plays in the legislative process. First, note that much (35 out of 125 documents, or a little more than one-quarter) of the testimony on mental health parity legislation consists of elected officials speaking directly to other elected officials. Given that elected officials develop expertise through their affiliations with particular committees (Gilligan and Krehbiel, 1990; Krehbiel, 2004), it seems likely that these are speakers who have gathered expertise by serving on one committee, and now are sharing their expertise with others.[14] Next, note the broad range of committees that appear on this list. This suggests the broad impact expected from the legislation, in terms of financial and societal impacts on insurers, employers, and consumers, as well as on government services, including services such as Medicare and Medicaid -- and perhaps that different committees wanted the opportunity to make their own determination about those impacts. It may also be that testimony is offered before multiple committees as a way to more broadly disseminate information about the legislation and its impact. Finally, note that, no single committee dominated in soliciting testimony, perhaps indicating that legislators knew that their constituents wanted to offer testimony. Despite how little we know about the value and function of testimony, it is clear that gathering public testimony is a regular feature of the legislative information gathering process and that both House and Senate devote substantial resources to collecting and saving this testimony.

As may be clear from the committees referenced in the Figure 1, committees in the House and the Senate have distinct, rather than shared, names and committees are formulated by each

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[14] Further research might examine how testimony provided by legislators to other legislators differs from the testimony provided by those who are not legislators.

group (House or Senate) to suit their own needs – there is no common committee structure. Additionally, some committees are standing, or long-lived, while others are ad hoc, existing only for a short duration. This makes it challenging to draw conclusions about the hearing process in general and why hearings were held before these specific committees. However, the fact that hearings on mental health parity were heard before so many different committees in both the House and Senate appears to suggest how seriously the legislation was being considered over the two decade period. The 103rd session (1993-1994) marks the final hearings prior to the passage of the Mental Health Parity Act of 1996 and it may be that this flurry of activity is the direct result of increased pressure to pass the legislation.

Figure 1 shows each of the 125 testimonies, sorted to identify testimony provided by those who are providing testimony as an outside witness.[15] During these 14 committee hearings, which typically run over several days, there were 125 instances in which individuals provided testimony. Of these, 35 individuals (28%) were members of Congress (House or Senate) presenting before members of their own group (that is, elected Representatives presenting before other Representatives *or* Senators presenting before other Senators). These 35 prepared statements were excluded from the analysis but could be used for additional contrastive analysis later. The rationale for excluding these documents is based, at least in part, on priority: the goal of this research is to focus on the arguments used by outsiders to influence the outcome of mental health parity legislation. The remaining 90 documents constitute the corpus for both the rhetorical and content analyses.

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[15] The testimony is divided into senators or house members testifying before their peers (penultimate right-most column) and testimony provided by others (right-most column).

Contextualizing the corpus: Inputs to congressional decision-making

Hearings appear to be an important part of the legislative process. Congressional

hearings, Brasher (2006) observes,

> consume a significant amount of the time and attention of members of Congress. They
> are also a large component of the information that the public receives about the activity
> and behavior of Congress. Hearings are often the focus of media coverage...and are
> frequently designed to specifically to [sic] attract this attention. (p. 583)

Hoffman (2008) suggests that the "formal rationale" of public hearings may be described as

information-gathering (p. 92), but also recognizes that

> Organizers [...] stress the importance of political work prior to hearings; some political
> skeptics and participants disappointed by legislative outcomes take hearings to be *entirely*
> public rituals, considerably at a distance from the less visible spaces where decisions are
> reached. Nevertheless, without diminishing the importance of external organization,
> most participants also agree that what happens at hearings *matters* to the outcome. (p.
> 108)

Hearings have been used as a measure of whether legislation is being seriously considered

(Edwards, Barrett, and Peake, 1997). Hearings "are grouped with other indicators of forward

progress such as referral committee, being reported out of committee, or receiving a vote in the

chamber" (Brasher, 2006, p. 584). Yet, as Brasher explains, "A lack of consensus [exists] about

the purpose of hearings" (p. 584) and this results in 'the lack of understanding of their role in the

legislative process" (p. 584). Brasher continues,

> In sum, the previous studies that identify hearings as a distinct part of the legislative
> process have proposed that they may serve to provide information, sooth conflict,
> develop consensus, advocate preferences, communicate with constituents, support the
> chairman's position, manipulate outcomes, and signal to fellow legislators… [T]hey may
> also provide an opportunity to challenge the testimony of the participants, please
> constituents, or satisfy organized interests.... Given these disparate claims, we should not
> assume that hearings automatically signal forward progress for a bill. (p. 585)

In fact, "it is possible that the information produced by a hearing identifies problems *without*

producing solutions" (Brasher, p. 585). It appears, then, that hearings and the testimony

provided are assumed to have an important role in legislative decision-making, but exactly what that function is is poorly understood, and it may be that providers of testimony create their own rules for how to approach the testimony process.

Official documents, such as legislative testimony, "are a site of claims to power, legitimacy, and reality" (Lindlof & Taylor, 2011, p. 232). The context around such texts forms "interpretive domains…which structure, but do not determine, how institutional texts are assembled and interpreted" (Miller, 1997, p. 78). By constructing interpretive categories and frameworks, institutions "think" for participants (Douglas, 1986). The congressional hearing process is an example of a framework aimed to structure thought. Additionally, as Hoffman (2008) explains,

> As a democratic space, interested parties seeking to establish their expertise must translate these concerns to *lay members of the public* -- namely legislators who often lack scientific understanding and, as public representations, may possess different standards for scientific evaluation. As a legal space, legislators must in principle show concern *for the legitimacy of the law and the legislative process* vis-a-vis interested parties. (p. 93)

Having a deep understanding of this context can – and should – inform any interpretation. For this research, this included gathering information about the individual, the legislation, the legislative process and external events outside of the congressional hearing room. For those providing testimony, important context includes affiliations and memberships, professional roles, personal experience with mental illness (often experienced as a family member). Testimony itself operated within a specific context. While the testimonies rarely referenced recent events, they did often refer to recent publications, such as reports by the U.S. Surgeon General or the New President's Freedom Commission on Mental Health. When the testimony included references to external sources, and particularly when an external source was referenced more than once, or by more than one speaker, additional research was conducted to assess its impact.

To provide a landscape view of Congressional decision-making, testimony provided before Congress is one of many sources of information used in Congressional decision-making. While any of these sources of information might be analyzed rhetorically, public testimony represents one of the rare sites where the public can have sustained engagement in decision-making about public issues. This section provides context for the kinds of information that Congress considers in decision-making as a whole by sketching sources of information and makes the argument that testimony can offer unique insight into the decision-making process. By describing the sources of information of information considered by Congress, the goal in this chapter is to develop a coding methodology for assessing public testimony employed in congressional hearings. Ultimately, understanding the existing role of Congressional testimony may open the possibility of rethinking, and possibly expanding, its role in public engagement, specifically, as a way to engage the public in political decision-making.

Understanding potential sources of information is also important, as having too many inputs can present other challenges, specifically in terms of information processing. Individuals, including members of Congress, are limited in their cognitive processing capacities and, more specifically, by their serial processing of information (Simon, 1978); this means that "we tend to focus on the problem at hand, ignoring other problems that could be as important -- unless we have a mechanism for alerting us to the importance of those other potential issues we should address" (Baumgartner & Jones, 2015). Congress must organize these often-competing sources of information, and simultaneously respond to public concerns. As Jones (1994) observes, the same cognitive processing limits that exist in individuals are also observed in institutions as a whole, such as Congress when trying to identify priorities -- and this matters because "in setting priorities, we need diversity" (Baumgartner & Jones, 2015, p. 47). Without allowing, and indeed

creating a space for diversity in the problem identification phase, the wrong problems may be

solved. The legislative process is complex: testimony is given before congressional committees

in response to legislation, providers of testimony are called to briefly present their strongest

arguments. Legislators must, at the very least, give the appearance of inclusion, but may have

their own agenda behind who is invited to speak. Being aware of the complexity of the

legislative process provides critical context for this rhetorical analysis: the formal hearing

process, the potential for questions following a prepared speech, the inclusion of different

stakeholders, and the public nature of the event.

 In this analysis I use a simplified model of decision-making inputs that US legislators

use. Broadly speaking, inputs can be classified as internal or external. Internal inputs refer to

documents and information generated in-house.. They include assessments and reports

generated by Congressional staff members, legislative analysts, and members of the

Congressional Budget Office, to name a few. These inputs consolidate information, offer

assessments of potential policy impacts and costs, and provide legislative histories.

 External inputs, in contrast, come from outside sources of both public and private

interests. The distinction between private interests and public interests is, in some sense, well-

established, with private interests focusing on the good of a particular group of individuals and

public interests focusing on the good of the public at large. These distinctions can by murky,

however, as evidenced by the fact the most health insurers might claim to serve the public good

(and certainly they do that as well), and yet have a financial incentive to ensure their

organization's own well-being and continued success. Similarly, lobbyists have the reputation

for largely serving at the behest of private interests, yet some clients may come from the public

services sector. At the more public end of the public-private spectrum, one might think

specifically of public opinion polls and media coverage as system inputs that are primarily public in nature. Some media coverage, however, is more ideologically-biased, pushing such inputs further along on the continuum. Public opinion polls are another input source, and a source that appears to have strong impact on political decisions (Burstein, 2003).

As can be seen in Figure 2, this simplified model of system inputs to legislative decision-making model incorporates three primary sources of information: internal sources (including legislative analysts and cost analysts from the Congressional Budget Office), external sources (including public opinion polls and media reporting as well as individuals), as well as special interest groups (represented by party affiliations, lobbying groups as well as through professional or trade organizations and associations). While this model has limits, and may not capture all sources of inputs, one takeaway is that often information presented before Congressional decision-makers may represent a single side of a position. Often information has been filtered before it reaches legislative decision-makers. In contrast, public testimony represents one important avenue through which multiple stakeholders, who may possess little expertise in speaking before Congress, can publicly share their perspectives.

While congressional staff members and members of Congress develop specialized expertise in solving problems (Krehbiel, 1992), a different types of expertise is needed in order to evaluate what problems should be prioritized to be resolved. Members of the public, on the other hand, may have less experience in solving policy problems but more experience at understanding their own priorities. For this reason, the role of the public is crucial in the ability to recognize problems as well as recognizing specific features that should be addressed.

Additionally, public testimony also constitutes "a large component of the information that the public receives about the activity and behavior of Congress" (Brasher, 2006, p. 58).
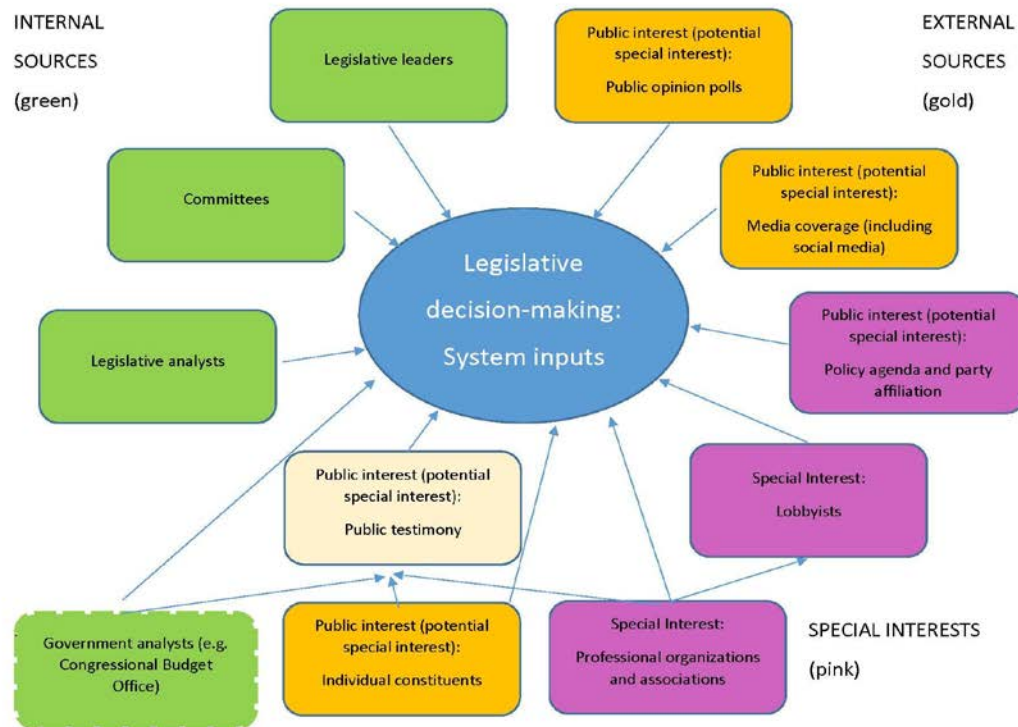
Figure 2. System Inputs to Legislative Decision-Making

Because "legislative committee hearings are defined as events in which new information is received, weighed, and ultimately judged by legislators" (Hoffman, 2008, p. 92), legislative staff members and committee members may seek to have broad representation. In business settings, stakeholder approaches are associated with a number of positive outcomes: "higher 10-year rates of return, sales growth and market share, talent retention, CEO salaries, bonuses, and stock options, and share price" (Young, 2016, p. 92). In policy settings, stakeholder approaches "improve[e] the selection, efficiency, effectiveness and evaluation of policies and projects… and

improve[e] assessment of the distributional, social and political impacts of policies and projects" (Grimble & Wellard, 1997, p. 177). In part, this is because decision-makers and audience members alike are likely to consider their own affiliations and special interests when making decisions (Bonham, Shapiro, & Heradstveit, 1988). In contrast, when stakeholders lack salience, they receive less attention and less effort is made to accommodate their concerns (Reynolds, Schultz, & Hekman, 2006). As a first step in assessing the testimony, the goal was initially to simply confirm whether or not there was broad representation. From the initial analysis of the speakers, it appears that broad representation of different stakeholder groups was intentional.

Certainly there are other sites where multiple stakeholders are brought into conversation, but often this happens through a filter. Legislative analysts, for instance, are responsible for creating reports and recommendations to help legislators answer questions about pending legislation. Baumgartner and Jones (1993), in drawing on observations of legislative processes, argue that this legislative process constitutes one type of institutional decision-making. Further, they argue that this type of institutional decision-making suffers from the same kinds of biases and limitations that are found in other type of human decision-making. Using this as a general framework, Fig. 2 provides a visual representation of what may happen in testimony, focusing specifically on the types of system inputs, or knowledge inputs, that might be expected. By articulating this hypothesis, we can then test against what happens in this specific set of hearings and assess how effectively this hypothesized view is mirrored in our observations. We might expect, for instance that testimony has, as its primary function, fact-finding, but little agreement exists about the purpose of hearings and this lack of clarity results in a poor understanding of their role in the legislative process (Brasher, 2006).

By providing context for the different sources of information used by Congress in their decision-making, it becomes clear that public testimony offers a unique view of the decision-making process, with scholars from rhetoric and political science calling for further studies of policy-making and the congressional hearing process (Asen, 2010a, 2010b; Brasher, 2006; Gring-Pemble, 2001). First, public testimony is one institutionally accepted method for systematically gathering information and this information can be classified by stakeholders. This systematic process gathers perspectives from multiple stakeholders, and as a result will likely provide a path for understanding sites of tension within an argument. Second, public testimony offers a shared and transparent record. In contrast, few other sources of information are transparent, and most are not shared. Public testimony, I suggest, offers a unique window into the complexities of policy arguments. Third, public testimony provides an historical record, allowing the researcher to examine whether, and if so how, arguments change over time. Given that complex policy arguments may take years (and in the case of mental health parity, decades) to resolve, being able to map these changes over time should provide insight into how the policy process evolves and the role of rhetoric in that process. Fourth, public testimony is one way that the public can provide input into critical legislative decision-making. And finally, public testimony engages the public in a national public forum. While many other fora exist, such as town halls or grass roots meetings, it is important to have shared discussion at the national level. Public testimony provides one such opportunity. For all of these reasons, it is important to have a better understanding of how public testimony functions in the policy-making process as problems, goals, and solutions are shared and negotiated.

Categorizing the corpus: Stakeholder analysis

A stakeholder in a policy setting can be defined "as persons or groups whose interests and activities strongly affect and are affected by the issues concerned, who have a 'stake' in a change, who control relevant information and resources, and whose support is needed in order to implement the change" (Morgan & Taschereau, 1996, cited in Aligica, 2006). Stakeholder analysis is "an approach for understanding a system, and changes in it, by identifying key actors or stakeholders and assessing their respective interests in that system" (Grimble & Wellard, 1997, p. 173). Stakeholder analysis has been broadly used in health care, public policy, and development (see Brugha & Varvasovszky, 2000 for a review) as well as in business (Cooper, 2017; Fleisher & Bensoussan, 2003; Goodpaster, 1991; Gupta, 1995) and in rhetoric (Coppola, 1997; Flower & Deems, 2002). Stakeholder analysis is of particular benefit when understanding the process of building coalition (Baumgartner and Jones, 1993) and has been used to ensure the viability of policies and programs (Baumgartner and Jones 1993; Crosby & Bryson, 1992; Roberts & King, 1996). Key stakeholders must be at least minimally satisfied to reduce the risk of failure (André, Enserink, Connor, & Croal, 2006; Mintzberg, Ahlstrand, & Lampel, 1998) and therefore understanding the goals of stakeholder groups is essential Identifying key stakeholders provides insight into stakeholder goals and values. A rhetorical analysis that examines individual stakeholder groups can provide insight into: 1) representation across stakeholder groups, 2) strategies employed by stakeholder groups, 3) diachronic changes to the argument over time (including whether some arguments hold sway across groups), and 4) by comparison, where points of disagreement or difference arise.

While the individuals who provided testimony and the organizations they represented are diverse, in my data set I clustered the individuals who provided testimony into five primary

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stakeholder groups. These include: 1) **Consumer advocates** ; 2) **Care providers** (doctors, psychologists, psychiatrists, and professional associations); 3) **Business solutions providers** (insurance providers, supply chain consultants, actuarial accountants, etc.); 4) **Government officials** (federal, state, or local); and 5) **Employers** (individual business owners and trade associations). Because the various legislative proposals had exempted employers having 50 or fewer employees from having to implement mental health parity within their businesses, no individual or organization provided testimony about the potential impact on small businesses. As identified above, stakeholders were clustered into five groups. These include: consumer advocates, care providers, business solutions providers, government officials, and employers. It is useful to understand the distinctions between these groups and to have a more specific sense of the individuals within each of these groups. Additional details follow.

> *Consumer advocates*. While there were several individuals who spoke about their personal experiences with mental illness, the majority of individuals were in leadership positions for consumer advocacy groups, such as the National Alliance for the Mentally Ill (NAMI) or the National Mental Health Association (NMHA).

> *Care providers*. Care providers included individuals who represented a range of different professional interests: physicians, psychiatrists, nursing staff, physical therapists, researchers, and more. This group also included organizations charged with treatment and care, such as hospitals and specialized treatment clinics, such as for addiction or eating disorders.

> *Business solutions providers*. Insurance association groups and insurance providers (such as Wausau Insurance) are typical examples. Beyond insurance providers and

associations, consulting groups that provided cost estimates were included in this category.

Government officials. Elected representatives were typically excluded from consideration. Exceptions were made in the case of elected representatives who were presenting before members of the opposing chamber (Representatives presenting before a Senate subcommittee, or Senators presenting before a House committee, for instance); the goal here was to focus on outsiders. Others who served to represent the government in some way, for instance, a commissioner from the President's New Freedom Commission on Mental Health, a government official representing an individual state, or a government official representing a state agency, were also given this designation.

Employers. Employer groups included associations (such as the American Manufacturing Association or groups representing small business) as well as individual employers (such as Weingarten Realty). One interesting observation about employers is that some employers were supportive of mental health parity legislation while others were less supportive. This is the only stakeholder group where the desired outcome was presented in stark and opposing terms from within the cluster.

In cases where the individual providing testimony could have been categorized into more than one stakeholder group, the testimony was used to determine best "fit" into one of these five categories. As an example, Howard H. Goldman, MD provided testimony during the 110th Congressional session as a psychiatrist, but had also served as the senior scientific editor of the Surgeon General's Report on Mental Health. In his testimony, he reported not on his own professional experience, but instead on the findings from the Surgeon General's report. As a member of the task force, he was reporting on the findings from a governmental group and the

analysis reflects this. Similarly, John P. Docherty, MD, who provided testimony in the 103rd Congressional session, opens by describing his own family's experience with mental illness but the bulk of his testimony is based on knowledge he acquired as a Clinical Professor of Psychiatry. As a result, his testimony is classified into the category "Care providers" rather than "Consumer advocates."

The classification of individuals providing testimony into stakeholder groups is represented in Figure 3. Care providers have the largest share (27%), followed by government officials (21%), business solutions providers (20%), and consumer advocates and advocacy groups (19%), and finally employers (13%). Given that these individuals are invited to testify by committee leadership, this may be an indicator of presumed interest or presumed expertise.

The incentives of government officials (providing testimony to other elected officials) and the role of business providers at this point, however, seem less clear. Their significant involvement in the testimony raises several questions: Do their testimonies represent a range of different governmental concerns? Do they serve to promote or work against the legislation? Or, more neutrally, to simply share information across Congressional lines? Remember that this is about instances, or opportunities, to gain the ear of Congressional leaders.

Having conducted this categorization of stakeholders, it is possible to see how many opportunities each group had to advance their message before committee members. This analysis suggests that 1) committee leadership considered representation of various groups in inviting testimony; 2) committee leadership may have allocated time to hear from different stakeholder groups according to an assessment of their potential value or contribution to the hearing process. From Fig. 3, it is clear that care providers presented testimony before Congress with more frequently than any other group. Care providers represent a diverse set of interests,

and testimony was provided by a broad range of professional organizations, from the American Association for Marriage and Family Therapy to the American Occupational Therapy Association to the American Association for Geriatric Psychiatry, as well as groups focused on mental health and substance abuse.

contribute

Figure 3. Overall Stakeholder Group Representation in Corpus

By examining testimony over time, it is possible to consider testimony for each individual Congressional session. This is represented in Fig. 4. As can be observed here, most groups were represented in each of the Congressional sessions. This suggests that committee leadership consistently sought to include specific stakeholder groups. For almost all of the congressional sessions, multiple committees gathered testimony across multiple stakeholder groups. In the 108th session, when only one committee, the Committee on Health, Education, Labor and Pensions, held hearings. For this congressional session, six individuals provided testimony; of these testimonies, half were from the government; consumer advocates andexam care providers rounded out the list.
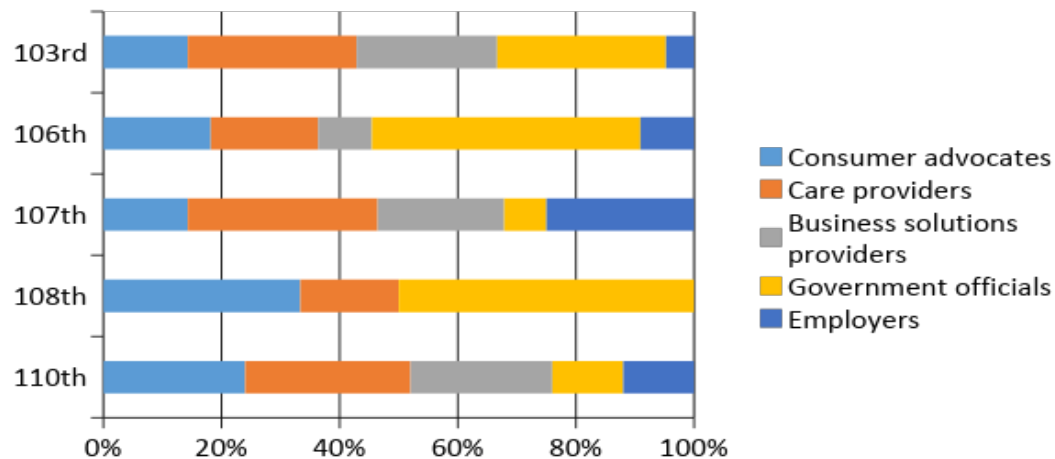
Figure 4. Stakeholder Group Representation by Congressional Session

Conducting a stakeholder analysis allows the researchers to observe patterns in the testimony that would otherwise be obscured. If one goal of the testimony is to ensure broad participation, stakeholder analysis also makes it possible to assess whether this goal is being met. Stakeholder analysis becomes the foundation for the rhetorical analysis, making it possible to connect specific rhetorical appeals and patterns in the argument to specific stakeholder groups.

Coding

Coding methodology and process

This section describes the methodology employed to analyze the public testimony. The dissertation takes a mixed method approach that incorporates both rhetorical and content analysis. The distinction here is that content analysis attends to information without attending to the rhetorical situation (Bitzer, 1992) while rhetorical analysis includes qualitative analysis. Based on Tashakkori and Creswell (2007), a mixed methods approach in research can be defined as "research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study

or program of inquiry" (p. 4) The power of a mixed methods approach comes from its ability to deepen understanding, yield additional evidence, and be more rigorous; such an approach is appropriate when examining complex phenomenon (Haines, 2011). This work benefits from both rhetorical analysis, which centers its analysis on the qualitative assessment of written arguments, and from content analysis, which complements the rhetorical analysis by identifying changes in arguments over time.

Developing the coding scheme

One of the goals of this research was to assess to what extent public testimony, specifically the public testimony about mental health parity, captures a complex argument and to determine whether various stakeholders, particularly the mentally ill and their advocates, are able to contribute to the provision of testimony. To conduct this kind of rhetorical analysis, and rhetorical analysis of dozens of texts, it was important to develop a robust yet flexible coding method. The coding method would need to support analysis at multiple levels, but a common set of codes should adequately capture concepts from a broad range of texts. Additionally, the coding method should allow for the field-dependent particularities of public policy argumentation. The coding scheme should also be reasonably simple to use. While this research will only test a subset of these capabilities, the goal was additionally to have a coding scheme that would support ongoing research and a rich examination of the rhetorical features of public testimonies and policy arguments in general. Given that previous research in public policy has built from the Toulmin model, this was a strong starting point. Next I provide a brief introduction to the Toulmin model, followed by some of the known challenges when using the Toulmin model to analyze arguments overall, as well as public policy arguments in particular.

Toulmin et al. (1979, p. 25) identifies six components that should be present in any explicit argument. These include 1) a claim, which is a conclusion, 2) grounds (also referred to as "data" in Toulmin, 1958/2003), 3) a warrant, necessary when the validity of the conclusion is not apparent from the grounds, 4) backing, which supports the legitimacy of the warrant, 5) a qualifier, used to temper the degree of certainty in the claim, and 6) a rebuttal, which may consist of doubts or counterarguments about the claim. These components can often be field-dependent (Toulmin, 1992), and as a consequence it may be useful to extend or limit the model to better capture qualities within particular fields.

In identifying these six components within arguments, several complexities arise: the components may be implicit or absent (Gasper and George, 1997), it can be difficult to accurately identify the warrant (Warren, 2010), the field-dependent nature of warrants (Goldstein, 1984), and difficulties in coding (Gasper and George, 1997). Despite these difficulties, Gasper and George (1997) also recognize the contributions of the Toulmin model:

> Toulmin's model advances practical argumentation in several ways: by establishing that arguments have structures; by identifying argument components and relationships among components; by demonstrating that the nature of argument components varies among and within fields; and by demonstrating how the same information can be used in very different arguments. (p. 369).

While seeing many advantages to the Toulmin model, given difficulties in its application, Gasper and George (1997) suggest that rather than conceptualizing Toulmin's contribution to argumentation as a "model", which assumes a standardized, universal layout, it may be more valuable to consider it as a heuristic. Claims and grounds, they note, are "always necessary… [but the other components] may be implicit, trivial or not required at all" (p. 380).

This leads Gasper and George to the following recommended steps in the analysis of policy arguments, following Fletcher and Huff (1990a, 1990b): first, identify "topic blocks" or

continuous segments of text that address a single issue; second, within topic blocks, identify claims, including both primary (central focus) and secondary (supporting, digressions, etc.) claims; third, identify grounds/data; fourth, identify other components (qualifiers, rebuttals), except warrants; fifth, identify explicit warrants; finally, identify implicit warrants. In moving through this process, they further recommend that each step be completed for the documents in full before moving on to the next step, so by the completion of coding, each document will have been reviewed at least six times. By completing each step in turn, the coder can concentrate on one process at a time, thereby eliminating the cognitive strain of approaching multiple steps simultaneously. Note too that Fletcher and Huff (1990a, cited in Gasper & George, 1997) eliminate "backing" as a separate category, arguing that it can be difficult to separate warrants and backing. Others have suggested that it can be difficult to determine how to separate grounds (also referred to as data) from warrants (Gasper & George, 1997; van Eemeren, Grootendorst, & Henkemans, 1996, pp. 158-159). Because of this difficulty, I opted not to code for warrants, but instead to use a simplified coding scheme. The primary objects of interest, then are claims and data/grounds.

Two other goals led to additional modifications of this process. First, one primary concern of researchers of the policy process has been how to best adapt the Toulmin heuristic to policy arguments: as Toulmin has acknowledged, arguments are field-dependent and categories of interest vary from one field to another (Toulmin, 1992). In *Policy Paradox* (2001), Stone argues that three clusters of ideas represent areas where points of contention may emerge: goals, problems and solutions. Stone (2001) offers examples for each of these, suggesting that common themes emerge. For goals, typical themes include equity, efficiency, security and liberty offer opportunities; for problems, the use of symbols, numbers, and identification of causes, interests,

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and decisions may shape understanding; and for solution, themes include inducements, rules, facts, rights and powers. While I did not assume that I would identify such themes in the coded documents, this framework was a useful starting point and was integrated into the coding process. As a result, after identifying claims, I then identified three specific claim codes: problems, goals, and solutions. In practice, this meant that claims could be coded as Problems, Goals, Solutions or Other (for claims that did not belong to these categories). Additionally, I added coding categories that identified sub-claims related to each of these. These sub-codes represent supporting claims.

Additionally, because policy arguments are artistic proofs (Brockriede & Ehninger, 1960) in that

> the data are not immediately conclusive, so that the role of the warrant in carrying them to the claim becomes of crucial importance. In this sort of argument the proof is directly dependent on the inventive powers of the arguer… (pp. 47-48)

I added categories that would further specify the types of grounds or data being employed in order to more closely analyze the kinds of appeals that were employed by differing stakeholder groups.

In the final coding, codes for data/grounds included three types of appeals. The first set, following Brockriede and Ehninger (1960) includes descriptions of the current state, the past state (historical state), existing or pending legislation, other context and definitions but also include appeals based on language (generalizations, parallel case, analogy and classification); these can be described as logical or substantive arguments (Brockriede & Ehninger, p. 48). The second set examines "the quality of the source" and consists of ethical appeals based on experience (personal narratives told in the first person; case examples about a person or a business, told in the third person), appeals based on authority (research cited, authority figure

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cited), appeals based on data (numeric, data-driven appeals), and statements of position (we

support, we do not support, what we support); these can also be described as authoritative

arguments (Brockriede & Ehninger, p. 48). The third set examines "the inner drives, values or

aspirations which impel the behavior of those persons to whom the argument is addressed"

(Brockriede & Ehninger, p. 48) and include appeals based on value or motivational appeals.

These constitute the three modes of artistic proof and provide the foundation for the coding

categories for data/grounds.

For the rhetorician, much of the action happens in the use of data/grounds and warrants,

whether explicit or implicit. By developing a robust and systematic method to assess the use of

data/grounds, it becomes possible to see how the claims, and specifically claims about problems,

goals, and solutions, are supported through data/grounds to accomplish their objectives. The

general coding process can be represented in this way:

1. Following Toulmin (1958/2003), code for claims.
2. Following Toulmin, code for data/grounds.
3. Following Stone (2001), code claims for:
   a. Problem
   b. Goal
   c. Solution
   d. Other
4. Following Corbett and Connors (1999, p. 87), code data/grounds for common topics:
   a. Definition (genus, division)
   b. Comparison (similarity, difference, degree)
   c. Relationship (cause/effect, antecedent/consequence, contraries, contradictions)
   d. Circumstance (possible/impossible, past fact and future fact)
   e. Testimony (authority, testimonial, statistics, maxims, laws, precedents/examples)

During the coding process, some of these common topics emerged as more prevalent. Those topics will be described in the chapters that follow and serve as the basis for the rhetorical analysis.

Rhetorical analysis

Rhetorical analysis examines the effect of language, language choices, and the reasoning that those choices are made within the rhetorical situation, which incorporates audience, context, and goals. The audience or listener may use a variety of sources to aid in this interpretation: who the speaker is and how they perceive the speaker, an assessment of the speaker's goals, and assessment of the context, including shared prior knowledge, and perhaps to even examine what is not said and what perspectives are not included. This rhetorical analysis will examine features that include agency, ethos, and rhetorical appeals following the topics (Corbett & Connors, 1999).

Quantitative analysis of linguistic features complements this understanding by making it possible to trace the frequency of particular arguments, including, as will be described in Chapter 3, increased use of the phrase "mental health parity" to capture a complex goal. Frequency of arguments, especially frequency over time, may indicate that consensus is forming around how to best frame and capture aspects of the mental health parity argument as well as acceptance, within specific stakeholder groups, of what matters most to them. As a result, these frequency counts can be used to complement the rhetorical analysis.

Rhetorical analysis can take many forms and address a variety of questions about discourse. My work relies on the Toulmin model (2003) of argument. Using the Toulmin model, the researcher begins by examining the data and claims and extends to the analysis of

warrants. Warrants are "general, hypothetical statements, which can act as bridges, and authorize the sort of step to which our particular argument commits us"; they are "the practical standards or canons of argument" (Toulmin, 2003, p.91). According to Toulmin, warrants may not be explicitly stated, but instead supplied by the reader. Assessing warrants is essential because:

> [U]nless, in any particular field of argument, we are prepared to work with warrants of *some* kind, it will become impossible in that field to subject arguments to rational assessment. The data we cite if a claim is challenged depend on the warrants we are prepared to operate with in that field, and the warrants to which we commit ourselves are implicit in the particular steps from data to claims we are prepared to take and to admit. (Toulmin, p. 93)

We might expect that different stakeholder groups, having different backgrounds and different goals, will employ different sets of warrants more appealing. These warrants constitute the available … In short, "the warrant assesses whether or not the trip from grounds to claim is a legitimate one" given institutional and disciplinary pressures (Foss, Foss & Trapp, 2014, p. 131). According to Loobuyck (2005, p. 390), "There are different modes of reasoning, which are dependent on different human practices. The nature of the activities and interests that are at stake determine the kind of rationality" (cited in Keith & Beard, 2008, p. 24). Warrants have been described as holding three qualities:

> First, warrants link data and claims, in a substantial way, one that is relative to what Toulmin calls a field, roughly a domain of knowledge. Second, they are typically implicit, as opposed to the required explicitness of a formal argument (such as a syllogism), so warrants may have to be supplied by the interpreter of the argument.11 Third, their strength (or lack thereof) is transferred to the strength of the conclusion, as marked by the "modal qualifier" attached to it, typically a sentential adjective of the familiar type: probably, possibility, almost certainly, etc. (Keith & Beard, 2008, p. 31)

They go on to identify a number of problems with the interpretation of warrants, recognizing that many authors have sought to tease out the role of warrants:

Bates, Lynch, Bevan, and Condit draw upon Toulmin's work to generate a "non-exclusive list of warrants that are generally accepted across speech communities" (pp. 331-44). These include "reasoning from needs and interests, applying 'natural laws' of ethics or morality, appealing to the text of legislation, providing statements of duty that devolve from a person's official or social role, employing appeals to authority, or reasoning through analogy, scientific methodologies, or logical deduction." They add to that "experiential understanding, and the deployment of cultural narratives" as other forms of warrants (331-44). (Keith & Beard, 2008, p. 39)

Ultimately, Keith and Beard argue Bates et al.'s list approximates *topoi* and argue instead for a "non-monotonic reasoning", referring to situations in which inferences are drawn tentatively, and can be withdrawn should new information come to light that makes these inferences infeasible, a situation described as "defeasible". For the present, however, they acknowledge the complexity of advancing non-monotonic reasoning. Their premise, that it should be possible to withdraw inferences, is reasonable. At the present, however, treating warrants as drawing from topoi continues to be an appropriate method.

For the researcher, the Toulmin framework encourages rhetorical analysis grounded in the text (through explicit data and claims) while also supporting the examination of the implicit common grounds that make the prospect of persuasion realizable. Best (1987) has also examined claims as a way to better understand social problems, arguing that:

Just as people's decisions to make claims emerge from a larger social context, so do their rhetorical choices. Claims-makers articulate their claims in ways which they find (and believe their audiences will find) persuasive. The larger cultural context-the weight assigned to various sorts of evidence, the relative importance given to different values, current standards for appropriate social policies, and the degree of consensus about these various judgments-,affects rhetorical work. Would-be claims-makers may rely on their own sense of what ought to be said, or they may learn from watching what happens to other claims-makers. These links between rhetoric and its cultural context deserve systematic attention. (p. 117)

Spector and Kitsuse (1977) define social problems as "the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions" (p. 75). Claims, they argue further, "exert the existence of some condition, define it as offensive,

harmful, and otherwise undesirable [...and] create a public or political issue over the matter"

(1987, p. 147). Best (1987), examining claims-making to understand the construction of the

missing child problem, concluded that

> [T]he most straightforward claims emphasize rectitude, arguing that values or morality
> require that a problem receive attention. The rhetoric of rectitude… tends to be adopted
> by relatively inexperienced claims-makers during the early stages of social problems
> construction…[and] is more likely to be associated with demands for reinterpretation,
> because moral considerations can justify viewing a problem in a different way. (p. 116)

More experienced claims-makers, he continues, are likely to move on to other social problems

DeYoung (1996), studying claims in the satanic ritual abuse problem, found that the data to

support the existence of the problem was "weak, contradictory, unsubstantiated and

uncorroborated by external evidence … [and its] conclusions appear unimaginative and

ineffectual" (p. 67), yet belief in the problem persisted. She found that warrants, including the

value of children, of believing in them, and the value of social order, led to the persistence of

claims. Coltrane and Adams (2003), examining divorce as a social problem, noted that "those

advancing claims are typically motivated by a desire to affirm the correctness of their own values

and to seek validation that their issue is worthy of widespread public attention" (p. 366).

Similarly, Coltrane and Hickman (1992) claims making in the moral discourse of child custody

and child support laws, finding that warrants that resonated with public perceptions led to the

identification of social problems critical to the enactment of new legislation.

Data, claims, and warrants are not the extent of the full Toulmin model,[16] but these three

initial components of data, claims, and warrants form the backbone along which other features

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[16] The full Toulmin model includes 1) qualifiers, 2) conditions for exception or rebuttal, and 3) backing (of
warrants).

hang. Because warrants are often implicit and hard to identify without first identifying claims and rebuttals the initial stage of the coding process will be dedicated to identifying these features.

The coding process proceeds according to the following steps. First, following the Toulmin framework, code for data and claims. After identifying these major coding categories, apply the conduct open coding to identify themes within the categories (Strauss and Corbin, 1990). Open coding requires multiple passes through the data to inductively identify themes and systematically analyze the data set following grounded theory (Glaser and Strauss, 1967). Grounded theory has been described as a "systematic, qualitative process used to generate a theory that explains, at a broad conceptual level, a process, an action, or interaction about a substantive topic" (Creswell, 2002, p.439). Grounded theory aims to use categories from respondents (in this case, those providing testimony) to "mak[e] implicit belief systems explicit" (Moghaddam, 2006) and typically proceeds through coding stages that include open coding, axial coding, and selective coding (Bohm, 2004). In this process, the researcher begins with the data itself to determine the earliest coding categories. They then create clusters of thematically related codes focusing on those codes identified as essential to theory building.

Next, categorize claims according to their primary function. Wood (2007), extending the Toulmin framework, argues for five major *stases*, or types of claims: those of fact, definition, cause, value, and policy (pp. 158-172). For this analysis, claim categories were further refined according to specific lines of argument within the stasis (or stance) of value: definition of the problem and evaluation of consequences (who is positively or negatively impacted and how by current state and proposed future state). Similarly, data, defined as evidence used to support a claim, was categorized into types. Here types included various types of evidence: quantitative data, research-based findings, and expert opinions as well as storytelling and metaphors. Some

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argue that storytelling and metaphors might be better categorized as backing (Xu and Yicheng, 2014); in this case, however, storytelling, or the telling of one's experience with mental illness, takes on the status of fact, a point that will be clarified further in Chapter 4. Finally, claims were identified in terms of stance, or perspective on the issue of parity: supporting the legislation, opposed to the legislation, and/or neutral and accordingly marked as + (positive), - (negative), or / (neutral). While some might argue that those providing testimony are likely to always take a stance of support or opposition, it was not always clear from the testimony what their position was.

Content analysis

Content analysis, employed broadly in the social sciences, is a technique for systematically describing content, including textual content. It focusing narrowly on observable features, without allowing for interpretation. Content analysis is conducted systematically, resulting in quantitative (numerical) counts based on clearly defined linguistic features that can then be used to assess the frequency of particular types of arguments. As an example, content analysis can be used to determine whether the definition of the problem is revisited repeatedly, across time, throughout the testimony, either as a whole or by certain stakeholder groups. Content analysis can be described in terms of either *manifest* content or *latent* content (Downe-Wamboldt, 1992; Kondracki, Wellman, & Amundson, 2002), with manifest content referring to the "visible, obvious components" (Graneheim and Lundman, 2004, p. 106). For the purposes of this work, the focus is on manifest content. Rather than simply identifying the existence of themes, content analysis can connect rhetorical forms (for instance, imperatives, analogies, etc.) and their frequency to their occurrence in time. One example is the use of examples that compare and contrast the parity in insurance between specific medical and mental health

problems, as well as the efficacy of treatment between common medical and mental health

problems.

Computer assisted qualitative data analysis software: Atlas.ti

Computer assisted qualitative data analysis software (CASDAQ), a term introduced by

Lee and Fielding (1991), refers to software that supports a wide range of functions useful in

qualitative analysis. Such software has been used extensively in the humanities and social

sciences. Such software allows the researcher to code and label items, write memos, attach

variables or attributes, and group codes into larger categories.

Atlas.ti is one type of CASDAQ software. While Atlas.ti was designed to support

grounded theory, it can also be used to support many other types of qualitative analysis,

including rhetorical analysis. Broadly, it supports analysis of primary materials (here, text-based

only, but Atlas.ti can also support analysis of audio, video, and geographical data), allows for the

production and linking of various types of annotations, and provides analytical and visualization

tools to support analysis. Some of its notable features include text retrieval, text coding and

labeling, internal production of concept maps and diagrams, as well as memo writing and

universal export.

Atlas.ti was a valuable tool in conducting the coding for at least four reasons. First,

Atlas.ti, as a computer-assisted qualitative data analysis software (CAQDAS), enabled dozens of

documents to be uploaded, coded independently, and tagged according to family groups;

subsequent analysis could thus assess trends within families of tests. This meant that, for

instance, it was possible to examine a particular congressional session of interest, such as the

110th Congress. It was also possible to create family groups consisting of specific stakeholders,

in order to identify trends in codes both within and across stakeholder groups. This simplifies

the process of examining changes in arguments over time, in that the researcher can retrieve only

codes (or documents, etc.) that are relevant to a particular question.

Second, the tool allows for codes to be generated by the coder in situ. This meant that as

new observations occurred, it was possible to not only add codes to segments of text, but also to

add additional observations. As an example, after identifying major claims, it was possible to

take a code category representing similar claims, such as about efficiency, and to add tags ("+"

or "/"or "-") to indicate whether a particular claim was favorable, neutral, or opposed to mental

health parity. This made it possible to flag areas of active disagreement as well as places where

agreement appeared to be well established.

Third, it is possible to double-code in Atlas.ti. This meant, specifically, that

"discrimination" and concepts related to discrimination could be coded separately – bringing

together claims and data, and without the concern that concepts related to discrimination might

be lost. Because discrimination had emerged early on as a potential code of interest, the ability

to bridge coding categories was valuable.

Finally, Atlas.ti supports visual representations of the data. Because Atlas.ti also allows

for the creation of concept maps, for the phase of the coding previously described as "axial

coding", it was possible to create maps of key concepts for particular Congressional sessions,

simplifying the process of visualizing changes over time according to particular rhetorical

features. As will be seen in Chapter 3, this meant that it was possible to take complex

representations (concepts clustered under the Problem code, for instance) and to create a visual

representation that allowed the coder to cluster concepts and evaluate possible interactions.

Taken together, the coding scheme and use of Atlas.ti made it possible to systematically examine

specific rhetorical features of public testimonies and to examine trends over time and by stakeholder group.

The next chapter employs this coding process to examine how the problem of mental health parity was defined by different stakeholder groups across time. In future research, this method will be extended to examine goals and solutions across stakeholder groups and across time.

Chapter 3. PROBLEM FORMULATION IN PUBLIC TESTIMONY ON MENTAL HEALTH PARITY: A RHETORICAL ANALYSIS

This chapter asks what a rhetorical analysis of problem formulation tell us about the function of congressional testimony. The chapter begins by describing the function and role of congressional committees and hearings in legislative decision-making as well as the role of public testimony within the hearing process. It then describes how the problem of mental health parity was formulated early in the hearings, how it shifted over time, and the role of various stakeholder groups in shaping the understanding of the problem.

Features of Congressional Committees

Because mental health parity legislation was heard before a number of different committees, it is important to understand how committees function and the importance of their role in legislative decision-making. This section describes features of legislative committees as important context.

Congressional committees are essential to legislative decision-making.   Bessette (1994) argues that "by design it is in [congressional] committees and subcommittees that the most detailed and extensive policy deliberation occurs within Congress" (p. 156). Committees are sites for understanding and debate, as well as sites where those outside the policy process can provide input. Committees are the workhorses of Congress, sites where problems become more clearly defined and solutions are hammered out. Because committees are essential to legislative decision-making, significant time, energy, and resources are devoted to committees and their work (Brasher, 2006).

Committees create opportunities for focused attention. As Jones and Baumgartner (2004) argue, "The range of issues pressing on government and the public is huge, but the attention capacities of both the general public and government are constrained, and constrained quite severely" (p. 2). Attention, as a limited resource, constrains public and legislative agendas. This constraint arises because of how humans process information. Jones (1994) argues that humans -- and organizations -- are subject to information "bottlenecks" (p. 238) in that we can only attend to information serially. While the policy preferences of individuals are fairly static,

> People have contradictory preferences and because they process information
> serially, they have a strong tendency to "cognitive twoness"--that is, to focus on
> one evaluative dimension at a time, sometimes shifting back and forth between
> two foci but seldom fully integrating them. (Jones, 1994, p. 238)

Incoming information, he contends, can either be put into existing frames, or ways of seeing issues, or cause agenda shifts. Thus agenda shifts, or abrupt shifts in policy, are typically the result of new ways of framing old issues. Rhetorical analysis, with its sharp focus on language, is a strong tool to assess this reframing.

Committee members focus in depth on a limited number of issues. Legislators may be expected to vote on a range of proposed legislation, but they will often cast their votes based on the recommendations of committee members from their own political parties. By participating on committees, researching and championing legislation, and sharing their findings with other elected officials, committee members become part of a complex web that contributes to legislative decision-making.

Committees allow legislators to develop expertise. Members of congressional committees gain expertise within specific knowledge domains and this domain expertise is intentional (Gilligan & Krehbiel 1987, 1990; Krehbiel, 2010; Hamm, Hedlund, & Post,

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2011). Krehbiel (1992), describing the information-gathering role of legislative committees, writes, "Committees, as agents of their parent chambers, exist to investigate, deliberate, apply specialized knowledge, and recommend action" (p. 105). Serving on a legislative committee allows legislators to deepen their knowledge about specific types of policy problems and to acquire the specialization that allows them to provide critical insights. This expertise subsequently benefits legislators as it contributes to their ability to move into leadership roles. Committee members tend to remain on the same committees for an extended period of time and, when listening to testimony, should be expected to come to the testimony with some understanding of problem and possible solutions. Further, given that providers of testimony are often invited to speak as a result of personal connections (DeGregorio, 1992), it seems probable that speakers would have some knowledge of legislators' key concerns and might incorporate that knowledge into their testimony.

Committees are also broadly charged with understanding the implications of legislation within their areas of expertise. This means that committee members are responsible not only for acquiring significant expertise in a subset of all possible legislation, but also for assessing likely impacts from other legislation on their own area of expertise. This matters in particular for mental health parity legislation because such legislation was heard before a number of different committees, and it seems safe to assume that committee members from each of these different committees would have their own key concerns. From about the 1980s, according to Baumgartner and Jones (2015), "[committee] jurisdictions increasingly began to overlap. For any given issue, more committees were involved" (p. 110). They attribute this change to governmental expansion and the increasing complexity of legislation. The idea that proposed legislation will be heard by more committees, and a broader range of committees, appears to be

borne out in the case of mental health parity. It seems possible, however, that different

committees may bring different frames for evaluating solutions. A rhetorical analysis can help

assess whether this is true.

The Role of Public Hearings

Hearings are an integral part of the work of congressional committees. Legislators report

that committee hearings are a valuable source of new information (Bradley, 1980). Yet there is

no consensus about the function of hearings and "A lack of consensus about the purpose of

hearings contributes to the lack of understanding of their role in legislative progress" (Brasher,

2006, p. 584). Researchers have suggested that hearings play a number of different roles: as a

place to gather new information (Bradley, 1980) or broaden legislative understanding

(Moreland-Russell et al., 2015; DeGregorio, 1992); as a way to publicize issues and gather

support (Dear & Patti, 1981); as a place to advance the legislator's own position (DeGregorio,

1992); as a place to develop the rhetorical resources that can be used in floor speeches (Brouwer

in Asen & Brouwer, 2001); but perhaps also as a way to signal that the legislation is not yet

ready to come up for a vote (Brasher, 2006). When congressional staffers were asked how they

determined would be invited to provide testimony, only 25% said that they sought to provide

balance in testimony coverage; further, when staffers were asked their motivation in choosing to

provide a full range of perspectives, they identified three reasons: first, because of demands from

the committee chair; second, to provide political cover; and third, because "a sound decision

process necessitates all the facts" (DeGregorio, 1992, p. 980). Balancing perspectives does not

appear to be a key goal; the mental health parity testimony corpus is an outlier, at least at first

glance, in providing a range of different perspectives, as can be seen from Fig. 3 (Overall

Stakeholder Group Representation in Corpus).

While testimony is often included as part of the rhetorical analysis of many public policy issues, it remains less common for a rhetorical analysis to focus exclusively on testimony. As has previously been argued, little is known about congressional rhetoric as a whole. One fundamental component of congressional rhetoric is public testimony. In order to have a more complete understanding of congressional rhetoric, we need a more complete understanding of the rhetorical function of public testimony as well as how participants see their own role. Additionally, rhetorical analysis can provide insight into whether incorporating greater diversity of stakeholders may contribute to a richer understanding of the problem by providing the "new information" sought by legislators. Finally, rhetorical analysis of testimony may help us identify strategies providers of testimony use to help shape legislative outcomes. This chapter focuses more narrowly on problems identified in the public testimony. This chapter undertakes this work by focusing on how different stakeholder groups describe problems and issues in the mental health parity testimony and how these descriptions shift over time, if at all. By understanding these descriptions and shifts, this chapter aims to elucidate our understanding of public testimony and the role of issue framing.

Issues and Problems in Public Hearings

While legislative committees may be where important legislative work gets done, that does not yet explain the forces that shape understanding of problems in congressional testimony. The argument in this chapter is that the core issue of mental health parity came to be seen as a different problem from the onset of its legislative process (when the proposed legislation was introduced and subsequently sent to committee) through the final legislation, and that rhetorical analysis can provide insights into these shifts. This ability to explore the rhetorical process by which problems are shaped in legislative testimony is important, both to an

understanding of the legislative process and to deliberative democracy. This analysis has the potential to expand the understanding of those rhetorical strategies used in public policies on mental health.

Many of the problems that Congress addresses are complex social problems. Because of their complexity, "too much 'clarity' can be a sign of too little information, too much orthodoxy, or too little willingness to look at those parts of the problem where the information is unpleasant" (Baumgartner & Jones, 2015, p. 47). We should, it seems, expect social problems to be messy. This messiness can be read as a sign of a willingness to engage with the problem fully. In studying the rise and fall of social problems, Hilgartner and Bosk (1988) argue that such problems come to be seen as social ones as a result of feedback that drives their growth. Social problems are social constructs: "projections of collective sentiments rather than simple mirrors of objective conditions in society" (pp. 53-54). But with so many pressing problems, the ability to gain -- and retain -- attention is critical.

When problems are complex, as most social problems are, it is desirable to have multiple perspectives on how to solve them and what a good solution looks like. As Page (2007) has argued, expert problem solvers are likely bring similar approaches to solving problems; diverse groups of problem solvers, in contrast, are more likely to identify a broader range of more creative solutions. This suggests that having too many individuals (here, legislators) with the same kind of experiences with and similar expertise in problem solving will result in predictable solutions and similar assessments of what a good solution looks like. It follows then that rather than relying on their own problem-solving strategies, it may be that legislators use congressional hearings as a way to enrich their own understanding of problems and to bring fresh eyes and way to seeing in order to identify a full range of potential solutions. However it may be instead that

more time in committee, and more time gathering testimony, is instead an indicator that there is not yet sufficient support for the legislation; in fact, hearings may represent an opportunity to put a placeholder in the process so that the proposed legislation does not drop out of the deliberative process entirely.

Although problem definition is typically thought of as preceding legislation, Weiss (1989) contends that problem definition in a policy setting can work in three different ways: creating "an intellectual framework for further action, [...] as a weapon of advocacy and consensus and as an outcome of policymaking" (p. 117). Focusing further on the role of problem definition, she offers a striking comparison: "Unlike the one-way picture in which problem definition sets the political process in motion and then fades from view, this perspective highlights the ongoing power of problem definition" (p. 113). Problem definition (and redefinition) occurs throughout the policymaking process. Should a new definition be accepted, it can change the direction of policy.

Are congressional hearings beneficial to the process by which problems and issues are described and defined? Baumgartner and Jones (2015) argue that the skills required to *solve* problems are quite different from the skills required to *identify* problems. While legislators are skilled at taking complex problems and articulating solutions, they are far less effective at identifying and prioritizing problems. They point out that "the focused expertise that allows a fuller understanding of the potential solutions to a given problem can render experts inept at making choices across problems" (p. 46). They further argue that two kinds of information are required to make legislative decisions: "information as diversity", which brings different perspectives to bear on an issue or problem, and "information as expertise", which brings to bear the tools and knowledge required to solve problems (p. 47). When legislative committees invite

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individuals to provide testimony, especially those individuals who contribute new knowledge and new understanding of the key problem and its priorities, they want -- and in fact need -- both diverse information (from public testimony) and expert knowledge (from both legislators and public testimony) to effectively solve complex problems.

So far the argument has been that public testimony can be used to 1) clarify and flesh out problems, 2) acquire new information, and 3) gain insights into potential approaches to problem resolution. However, because so little is known about congressional rhetoric, we still know very little about how providers of testimony approach their task as they provide testimony: Does this testimony serve to clarify problems? To expand or enrich understanding of the problem? To limit the size and scope of the problem? Given that the shape and boundaries of problems are constantly being renegotiated (Stone, 2001) and the insight that extensive public testimony may signal something other than forward momentum (Brasher, 2006), we might expect that when the hearing process is prolonged this may indicate the definition of the problem is unacceptable to key stakeholders: that the problem is too broad or too diffuse, too narrow, or simply not supportable in its current form. Additionally, given the prolonged period during which mental health parity legislation was debated, it would be interesting to know whether the problem definition experiences shifts diachronically. If it does, does this shift suggest a narrowing or broadening that enabled passage of the legislation? Can we infer anything about the acceptance or rejection of political goals by the current state of the problem definition? By understanding the role of problem definition in the testimony, we will gain insight into how providers of congressional testimony defined the rhetorical situation (Bitzer, 1992) and may be able to provide additional insights into the legislative process, of roughly two decades, through which

sufficient support emerged so that passage became possible. Given public support for protections for the mentally ill, it might appear surprising that passage took so long.

We next turn to the rhetorical analysis to examine how problems are defined in the testimony and to consider their impact and function in the legislative debate.

Problem Dimensions and Features: 103rd Congress

On May 12, 1992, Senators Domenici (R-NM) and John Danforth (R-MO) introduced the Equitable Health Care for Severe Mental Illnesses Act of 1992 (S. 2696). The bill was read twice and subsequently referred to the Committee on Labor and Human Resources; however, it never moved out of committee. Later that year, the Senate Appropriations Committee "instructed the National Advisory Mental Health Council to prepare a report on the cost of mental health parity" (Sundararaman & Redhead, 2008). Results from the Council's report were published in the *American Journal of Psychiatry* the following year. Their key findings were that mental health was both treatable and cost-effective.

In May of 1993, the first hearing on newly proposed mental health parity legislation began. In the 103rd Congress, 22 individuals provided public testimony. The goal of the legislation, as its title suggests, was to provide equity for those with severe mental illnesses. The policy portion of the proposed legislation reads:

> SEC. 3. STATEMENT OF POLICY.
> (a) IN GENERAL- It is the policy of the United States that--
> (1) persons with severe mental illnesses must not be discriminated against
> in the health care system; and
> (2) health care coverage, whether provided through public or private health
> insurance or any other means of financing, must provide for the treatment
> of severe mental illnesses in a manner that is equitable and commensurate
> with that provided for other major physical illnesses.

(b) CONSTRUCTION- Subsection (a) shall not be construed to preclude the
adoption of laws or policies requiring or providing for appropriate and
equitable coverage for other mental health services.

Of note here are three key issues: the current situation is described as discriminatory; the focus is

on those with "severe mental illnesses" -- as described earlier, a narrow subset of those with a

mental illness; and the goal is described in terms "equitable and commensurate" care. While

other mental health services should not be "preclude[d]", the focus is on outcomes for one

particular group: those with severe mental illnesses.

While the bulk of the legislation focused on those with severe mental illnesses, Section 5

added another consideration -- that the legislation was "intended to improve access to or control

the costs of health care"; however, all specific recommendations were more narrowly focused,

addressing benefits administered through private and public health insurance. After conducting

interviews with legislative leaders and staffers, Barry et al. (2010) suggest that three factors were

key to passage of mental health parity legislation: new ways to control costs, leaders' personal

experiences with mental illness, and political strategies employed by champions of the

legislation. This can be read to suggest that hearings had little impact on the eventual passage of

the legislation, but I argue that testimony played an important role.

Using this as a backdrop, let's now turn to the testimony provided by outsiders during the

103rd Congress. This represents 22 (out of a total of 90; the remaining 68 will be discussed in

the next section) testimonies and the entire corpus of public testimonies from the introduction of

S. 2696 to the 1996 passage of the Mental Health Parity Act. As a reminder, the 1996 MHPA

enacted *partial* parity: it required equity in annual and lifetime dollar limits, but exempted

employers with 50 or fewer employees. It made no change to other ways parity would later be

implemented, such as parity in number of covered visits or total number of inpatient days

covered per year or per covered life. Knowing the stated purpose of the introduced legislation,

what function does the public testimony serve: it is a response or rejoinder to this legislation?

Does offer new ways to think about the problem or to temper the existing legislation? To

address this question, we will next turn to the public testimony and explore how the problem --

or problems -- are defined in those testimonies.

Problems from a distance

The rhetorical analysis of the problems described in the congressional testimony enriches

our understanding here. In the testimony as a whole, 11 different major problem categories were

introduced, as assessed by being identified in the coding more than 10 times and across more

than one congressional session.   All of these problem categories were also identified within the

testimonies provided following S. 2696. For a visual representation of these clusters of

problems, see Appendix B (Map of Problem Formulation).

They include (ranked here according to frequency in the *overall* testimony) that: 1) the

existing benefit design drives inefficiencies and results in fragmentation of services; 2) too many

resources are devoted to inpatient care, at the expense of outpatient care; 3) treatment for the

mentally ill is often inadequate, poorly timed and without case management; 4) sites of care are

often inappropriate (emergency rooms, jails, juvenile detention centers, the "overburdened"

public system); 5) the population of mentally ill is large and growing, thus requiring additional

resources; 6) many barriers to care exist (particularly barriers to initial access, recognizing that

primary care doctors often serve as the gatekeeper in directing consumers to appropriate care); 7)

existing coverage is patchy and reimbursement, whether for providers or consumers, is not

guaranteed; 8) a lag exists between new medical knowledge and its dissemination and in turn

treatment appropriateness and efficacy; 9) the severe mentally ill face unique challenges, with disenfranchisement a large concern; 10) public perceptions and attitudes about the mentally ill result in stigma and discrimination; and 11) treatment outcomes for the mentally ill are often poor.

I offer this list for two reasons: first, to acknowledge that providers of testimony have a complex and nuanced understanding of the impediments to improving the lives of the mentally ill; and second, to suggest that many of the problems being defined within the public testimony were not intended to be addressed by the proposed legislation. This in turn suggests that some providers of testimony defined their goal in providing testimony as framing new opportunities for additional legislation, using the congressional hearing room as a site to broaden the legislative agenda. But many of the problems identified here also seem to be outside the scope of any previously-proposed federal solution. If we consider these items one by one, it is difficult to imagine a legislative solution that could respond to this range of problems. Taken together, they suggest a radical overhaul of the existing mental health care system is required; equity in insurance will not resolve the full complement of problems.

In terms of providing new information to legislators, the providers of testimony do a thorough job of explaining the legions of impediments that stand in the way of ensuring that the mentally ill will receive appropriate care. Unlike the proposed legislation, the providers of testimony only rarely speak about the current state as discriminatory, and thus it appears that the sense of the problem by those providing testimony differs from that of legislative sponsors. In terms of providing *new* information to legislators *about the proposed legislation*, then, the picture is somewhat murky. The legislation proposes changes to ensure that equity in coverage exists, that coverage "is not more restrictive than coverage provided for other major physical

illnesses", and "provides adequate financial protection to the person requiring the medical

treatment for a severe mental illness" (S. 2696). These changes to a single industry are

regulatory in nature and fall within the purview of the government. Many of the problems

identified in the testimony, however, cannot be fixed by the legislation as it existed then (or now)

and may, in fact, be outside the scope of legislative powers.

In alignment with the goals of the proposed legislation, this early testimony does identify

cost, and cost increases borne by employers, as a primary concern. Veronica Goff, of the

Washington Business Group on Health (WBGH, now known as National Business Group on

Health), reported that

> Between 1986 and 1990, employers saw their costs for mental health services
> increase by an average of 50 percent, with 65-70 percent of the spending on
> inpatient care The most generous indemnity (fee-for-service) plans were those
> that experienced the most dramatic increases (IB, Goff).

In other words, in the years prior to the testimony, employers had seen inefficiencies and

problems in the existing system, and had ideas about where those problems were most

severe. The single employer that testified during the 103rd Congress, BellSouth, described their

experiences with rising costs:

> The 1980's saw a proliferation of proprietary hospitals and substance abuse
> facilities that aggressively marketed to the general public, including corporations.
> The marketing strategy was to recruit patients, especially adolescents, whose
> treatment cost would be absorbed by the company's benefit plan...As a result, by
> 1986, BellSouth's mental health medical services were 23 percent of all hospital
> days… and 17 percent of total health care expenditures. (1C, Finch)

In this way, BellSouth described not only their cost concerns, but also laid out their reasoning

about cost drivers that included not only inpatient care but more specifically inpatient care for

substance abuse. BellSouth's purpose in providing this perspective, however, was not to reject

the idea of equity in insurance, but instead to raise concerns about continuing these specific

practices of aggressive marketers. We might think of their experience as a cautionary

tale. Other providers of testimony also saw opportunities for cost savings: not only through a

reduction the over-reliance on inpatient care and increased use of new psychopharmacology, but

also as a result of cost savings to employers through improved worker productivity. They also

agreed about the goals of access to care, appropriateness of care, and quality of care.

The testimony appears to function in several ways. First, the testimony aligns the goals

of these providers of testimony and legislative leaders on some issues. Second, the public

testimony moves the discussion away from the narrow focus on the severe mentally ill (not a

primary focus for those providing testimony) and instead widens the lens to focus on benefits to

a broader population, which includes not only those who have other kinds of less-severe mental

illness, but also including benefits to employers and to providers. The problem becomes

reconstituted here primarily as an issue of cost management and misuse of funds (by providing

better benefits for inpatient care, patients are more likely to use inpatient care), rather than

discrimination, with the goal of addressing employer needs for increased productivity and fewer

lost work days.

While providers of services agreed broadly that goals should incorporate improving

access to services and reducing fragmentation of services, those goals would be difficult to

achieve through a legislative solution. In this sense, then, the testimony appears to serve as a

way to caution others about potential problems with benefit design, to identify cost drivers, and

to disseminate best practices, or at least best recommendations, however provided no path for

enforcing these recommendations. In order to address problems with benefit design, providers of

care would need to have better control of costs, and this industry-wide expansion of cost

concerns led to the broad acceptance of managed care, which was not a legislative solution

except to the extent that these practices were adopted by government providers of insurance coverage, including Medicare, Medicaid, and the Federal Employee Health Benefits Program (FEHBP), the federal program that provides civilian government employees with health benefits. This suggests a second goal of the testimony was to help both insurance providers and providers of care (such as hospital systems and individual practitioners) understand that this complex social problem would require that providers of care independently implement administrative changes.

New Frames for Problems: 2000-2007

Most issues identified at any point in the public testimony were identified in the 103rd Congress (1993-1994) and then mentioned less frequently in subsequent congressional sessions. However, two specific issues violate this rule. Following the 1996 passage of the Mental Health Parity Act, which provided partial parity in terms of annual and lifetime limits, new legislation was introduced in every congressional session except the 109th (2005-2006). All of this legislation served to, at the very least, keep the goal of broader mental health and substance abuse parity on the agenda. Beyond this, the fact that the legislation brought sponsors from both political parties suggests that the expanded goal of parity in co-pay amounts and day limits, while reducing exemptions, was gaining traction.

Problem 1: Fragmentation of services

Fragmentation of services came to defined more clearly as a problem in the 108th Congress. The public testimony from the 108th Congress was presented before the Senate Committee on Health, Education, Labor and Pensions and was largely presented by those with governmental affiliation: of the six who provided public testimony, three were employed by the

government at the federal or state level. The exceptions were Ann Buchanan, who spoke as the

parent of a child with a mental illness; Michael M. Faenza, President and CEO of the National

Mental Health Association (Washington DC), speaking on behalf of Campaign for Mental

Health Reform; and Paul Appelbaum, M.D., who was then president of the American Psychiatric

Association. These speakers appeared to coordinate their efforts to ensure a consistent message

around the issue of fragmentation, a core message from *Achieving the Promise: Transforming

Mental Health Care in America*, a report commissioned by then-president George W. Bush's

New Freedom Commission on Mental Health. The 105-page report identified six broad goals

with a number of recommendations associated with each of the goals.

Then-President George W. Bush had convened a commission to assess the U.S.mental

health delivery system and make recommendations. These recommendations were formalized in

a report entitled *Achieving the Promise: Transforming Mental Health Care in America.* Stephen

Mayberg, then Commissioner of the President's New Freedom Commission on Mental Health,

was the first to provide testimony. In his testimony, Mayberg reported that "for too long, any

efforts to address mental illness in America have been [a] piecemeal, patchwork affair"

(11A). Pulling from the commission's report, he testified,

> That interim report clearly stated the "system is in a shambles", care is
> fragmented for adults and children, older adults do not receive adequate care, and
> we have unacceptably high levels of unemployment and disability for persons
> with serious mental illness. (Mayberg, 11A)

Others followed with similar concerns about fragmentation. Appelbaum continued with similar

concerns, putting a human face to the outcomes when continuity of care is compromised:

> [A]s it becomes clear that she'll need longer-term care in one of the few
> remaining state hospitals, she waits for more than a month before the transfer can
> take place. And once she's discharged into the community, the continuum of
> services that she needs -- housing, job training, treatment for substance abuse -- is

stretched so thin that there is no guarantee that she can access any of
them. (Appelbaum, 11C)

Others document "paralyzing fragmentation" (Faenza, 11D) and "fragmentation of services and

financing as central barriers to the effective delivery of comprehensive mental health services"

(Brandenburg, 11E). In speaking about personal experience with Medicare, Buchanan reported

"more needs to be done to address the fragmentation in both funding streams and eligibility

standards for these very complicated programs" (11F).

While the majority of speakers in the 108th Congress identified fragmentation as a

serious problem, the issue was not subsequently used as a way to define the problem in the 109th

Congress. Instead individuals who testified returned to earlier language, describing problems in

terms of access to care and continuity of care. The focused use of *fragmentation* language in the

Commission's report was used intentionally to create a new frame for the problem.

If we return to the New Commission's report, it's also clear that the language of

fragmentation is tied to who should take ownership of the problem. It reads:

> The underlying premise of the Commission's support for Comprehensive State
> Mental Health Plans is consistent with the principles of Federalism — providing
> incentives to States by granting increased flexibility in exchange for greater
> accountability and improved outcomes. (p. 44)

and culminates with,

> The Commission recommends that each State, Territory, and the District of
> Columbia develop a Comprehensive State Mental Health Plan. The plans will
> have a powerful impact on *overcoming the problems of fragmentation* in the
> system and will provide important opportunities for States to leverage resources
> across multiple agencies that administer both State and Federal dollars. The
> Office of the Governor should coordinate each plan. The planning process should
> support a dialogue among all stakeholders and reach beyond the traditional State
> mental health agency to address the full range of treatment and support service
> programs that consumers and families need. The final result should be an
> extensive and coordinated State system of services and supports that work to

> foster consumer independence and their ability to live, work, learn, and participate
> fully in their communities. (New Commission report, p. 44, italics mine)

In short, the testimony here supported that a problem, and a serious problem, existed and that problem was fragmentation rather than parity; the goal was to redefine who should take ownership of addressing the problem. While the label *fragmentation* captured an essential problem, it called for state leadership, and state funds to complement federal funds, to address the problem. Also telling, the word "parity" appears only once in the New Commission's 100-plus page report, and the word "equity" (often used as a parallel to parity in this context) appears only once, when describing the goal of having a electronic medical record system.

Those who testified identified "state planning" as a goal in resolving fragmentation (Buchanan, 11F), arguing that "all levels of government [are needed] to correct this problem by ultimately establishing in each 'an extensive and coordinated State system of services and supports'" (Brandenburg, 11E). The term *fragmentation* appears in roughly one-third of all instances in which the problem is described during the 108th Congress. It receives 17 mentions during the 108th Congress, out of a total of 21 uses of the term throughout the nearly two decades of testimony.

The term *fragmentation* appears to be used both as a way to claim ownership of the problem, to move away from the idea of *parity*, and to locate responsibility for solving the problem with the states. The New Freedom Commission report in fact has a section entitled "Fragmentation Is a Serious Problem at the State Level" and uses the phrase fragmentation or its variants 24 times within the report. The New Freedom Commission report is not mentioned in later public testimonies, so it appears to have strong impact within the hearings for one hearing before a single committee.

Problem 2: Prevalence and unmet need

Another external document also supported providers of testimony as they sought to redefine how the legislators thought about the problem. Providers of testimony referenced *Mental Health: A Report of the Surgeon General* repeatedly during the congressional session in which it was published. As with the New Freedom Commission report, however, its primary impact occurred during a single congressional session. When Surgeon General David Satcher published *Mental Health* in 1999, however, it had a major impact throughout the 107th Congress on the way providers of testimony described the problem in terms of prevalence. Having the Surgeon General offers his assessment appeared to validate the problem of prevalence.

The numbers are overwhelming. One provider of testimony stated "20% of our population suffer from a diagnosable mental disorder with only one-third receiving any treatment by health care providers" (American Psychiatric Institute for Research and Education, 8D). This number was repeated in testimony by others (Magellan, 9C). Referring to children, the American Academy of Child and Adolescent Psychiatry referred to the Surgeon General's report as well: "The Surgeon General's 2000 report of children's mental health estimated that 20% of American children and adolescents have a diagnosable mental or emotional illness. Of this number, fewer than one in five receive treatment" (8H). Referencing the surgeon general's report, another argued, "at least one in five Americans will have some form of mental illness in their life" (Weingarten Realty Investors, 8G). Even those who thought a different statistics was more accurate referenced the 20% figure and then revised down (American Psychiatric Association, 9J). Similarly, the American Medical Association cited the surgeon general's report, here referencing "15% of all adults use mental health services each year" (9L).

Often the providers of testimony seemed more reluctant to use numbers to indicate prevalence. Once the surgeon general's report had been published, however, it became the de facto way to describe the prevalence of mental illness in the United States.

Problem 3: Cost to society

The Surgeon General's report had broad impacts elsewhere. Testimony provided by the Health Insurance Association of America noted that "One thing is clear: Mental illness takes a tremendous toll on our society" (7G). This speaker also drew from the Surgeon General's report, acknowledging that direct and indirect costs to society total "nearly $200 billion a year" (7G). The American Psychological Association (APA reported that "we can no longer afford to continue to ignore what is wrong" with the health care system (2A). Trachtenberg argued that "Beyond the economic costs are devastating human costs" (2D); others described the existing state as "a national disgrace" (3C). The problem is described as "not tolerable in an advanced society" (3C), placing the U.S. within the context of other advanced societies.

Problems by Stakeholder Group

Perhaps not surprisingly, the five different stakeholder groups highlighted different aspects of the problem as they provided testimony.

Advocacy groups

By ranking, advocacy groups for the mentally ill, and the mentally ill who provided testimony, identified a number of key concerns: fragmentation of services, number and prevalence of mentally ill, cost of care, benefit design, government services, and public attitudes that promote discrimination and stigma. In describing the problem in this way, they highlighted difficulties in how the mentally ill access care.

Providers of care

Providers of care gave the most detailed and richest sense of the problem. By ranking, they identified the following as concerns: costs (including both problems with reimbursement for the providers and cost to consumers), access to care, number and prevalence of mentally ill, the existence of wrong incentives, problems with insurance, benefit design, government services problems unique to providers, and sites of care. As can be observed from this list, providers identified more problems than any other group.

Providers of business solutions

Providers of business solutions identified many problems that were shared with other groups. They identified cost as their top concern, followed by benefit design. So far their key concerns are similar to those of others. But now new patterns start to emerge: uncertainty about the value or appropriateness of treatment, concerns that the wrong treatments are offered. Following these two outliers, then their key concerns return to shared concerns: concerns with insurance providers, providers of care, and number and prevalence of mentally ill.

Governmental agencies and groups

Representatives of state and federal government also had a unique take on key problems. Their ranking: fragmentation of services, public attitudes including stigma and discrimination, impact on government services (Medicare, Medicaid), cost, benefit design, and number and prevalence of mentally ill. Note that the problems identified are more contained than the other lists, suggesting that government concerns are somewhat limited, suggesting that bringing in other stakeholder groups does have a positive effect on broadening understanding of the problem.

Employers

Employers had the narrowest list of key concerns of all of the groups. In part this is likely due to the fact that few businesses provided testimony. But it may also be suggestive that employers had little incentive to broaden the definition or description of the problem. Their list of key concerns included: cost of increased coverage as well as number and prevalence of mentally ill.

Observations on the Function of Problems in the Public Testimony

Public testimony adds value to the committee process, in principle, by ensuring diversity of perspective in problem articulation and increased creativity in problem solving as a result of that diversity. This chapter described how problems are defined in the public testimony on mental health parity as a way to understand how providers of testimony defined their goal in providing testimony. This rhetorical analysis offers a number of observations. First, the problem and its characteristics were most debated earlier in the congressional process, but continued to be defined and refined throughout the congressional hearings. As introduced earlier in the chapter, here the problem definition does appear to function as an "intellectual framework for future action" (Weiss, 1989, p 117). It seems unlikely that there was much effort to control the demarcations of the problems. There was also no attempt made early on to limit the number of different descriptions of problem features. Second, at least some of the problems being defined (e.g., fragmentation of services) were outside the scope of the proposed legislation, suggesting that some stakeholder groups defined their goal as framing new opportunities for additional legislation or using testimony as a way to broaden the legislative agenda or to coordinate outcomes with other groups, including state governments. This view is further supported by the New Freedom Commission report and its recommendations for state

governments. Third, other governmental groups (such as the office of the Surgeon General and the President Bush's New Freedom Commission on Mental Health) were instrumental in shaping how those who provided testimony described the problem. Whether providers of testimony came to this new framing independently or whether they were encouraged to reference these external documents -- or something else entirely -- is unclear. If providers of testimony took up the cause independently or as part of a coordinated effort, the outcome remains that these external documents seem quite important to the testimony for a relatively brief period of time but then the conversation continues where it will. Finally, different stakeholder groups defined the problem in quite different ways. Business stakeholders largely opted out of describing or defining the problem. Having described the proposed legislation as costly, they often appeared to have less sense of the problem and less interest in defining problematic features. This suggests that there may be a mismatch between what legislators hope to achieve through testimony (diverse opinions, creative solutions, recognition of other external governmental recommendations) and what providers of testimony hope to achieve (broaden the agenda, deny that a problem exists, etc.). By continuing to consider how testimony might best serve legislators, participants, and the public, as well as how testimony seems to function in the legislative process, it may be possible to improve outcomes.

The testimony provides a sprawling look at the complexity and challenges of improving outcomes for the mentally ill. By providing testimony and allowing stakeholders to describe their key concerns and challenges, legislators have the opportunity to see problems from the perspectives of those who have lived with these issues.

Chapter 4. THE MAKING OF MENTAL HEALTH PARITY

Studies of the rhetoric of *mental* disability are informed by studies of the rhetoric of disability *as a whole*. Similarly, studies of the rhetoric of disability are informed by sociological models of disability. This chapter begins by describing research in the rhetoric of disability and then connecting this research to sociological studies of disability and subsequently to sociological models of disability. It then draws connections to the rhetoric of mental disability. The experiences of the mentally ill, as one type of disabled, are in many ways effectively represented in the literature on the rhetoric of disability more generally; the mentally ill, however, face unique challenges. In the literature on the rhetoric of mental disability, those with a severe mental illness have been described as existing in a state where they may "lack rhetoricity" as a result of being "defined as nonhuman, by dint of their failure to *make sense*" (Price, 2011, p. 39). I argue, however, that this is not the case for the mentally ill and their advocates providing testimony on mental health parity.

While earlier rhetorical studies ask how existing sociocultural and discursive practices constrain the lives of the disabled, I ask whether the mentally ill, a perhaps even more marginalized subset of the (often) marginalized disabled, enact, in the context of congressional hearings on mental health parity, rhetorical strategies as they influence legislative decision-making. Employing contemporary conceptions of rhetorical agency and ethos, I argue that the mentally ill and their advocates demonstrate agentic power in these hearings. These strategies, I argue further, demonstrate that the mentally ill and their advocates implicitly draw from the existing sociological models as a source for rhetorical invention. Recognizing that agency comes from a complex interplay of contextual features, I identify sources that either strengthen or

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suppress their agentic power. The testimony from the mentally ill and their advocates suggests

that they aim to increase their own credibility by, in their testimony, reconfiguring the ethos that

they are assumed to hold and instead implicitly refuting that false ethos, that is, by demonstrating

through concrete examples the ethos of these mentally ill speakers. Given the frequency with

which providers of testimony speak about their own character and their own life choices, it

seems likely that these are active and intentional strategies by which the mentally ill seek to

increase their agentic power.

Situating the Rhetoric of Mental Illness

Over the course of the last several decades, rhetoric has begun to attend to disability as a

site for investigation, using a critical lens to observe how language is employed to define the

disabled, limit agency, and, all too often, deny rights. In studies of the rhetoric of disability, I

contend that two paths of inquiry are common: one path aims to articulate "the persuasion

surrounding the construction and maintenance of disability" (Brueggemann & Fredal, 1999, p.

133) by examining how language practices, as a core component of other sociocultural practices,

construct and reinforce conceptions of disability; the second examines how the disabled

experience this construction and maintenance. This twin focus follows from the view that

disability arises not from the individual alone but from "a relationship between a person with a

physical or mental impairment and the social and physical environment around him or her"

(Gadacz, 1994, p. 5). Exemplars of this first path include studies of how disability becomes a

force that delimits how the disabled are seen, such as Barton's (2001) study of representations of

disability in United Way fundraising campaigns or Brett's (2002) analysis of how parents of

disabled children "can be 'initiated' into 'tragedy talk' from the moment of diagnosis" (p.

829). Such work highlights the powerful sociocultural forces at work that shape responses to

disability. Exemplars that follow the second path include studies of how disabled individuals respond to the persuasion that surrounds disability, including Wilkerson's (2011) description of (in this case, her daughter's) rejection of a psychiatric diagnosis as well as "readings" of the material (here, disabled) body. Examples of such readings include Moe's (2012) description of Michael J. Fox, actor and Parkinson's disease advocate, who chose to deliver his testimony requesting additional federal funding without having taken the medication that would have suppressed his tremors; Brueggemann's (1999) description of Bob Dole's initial decision to hide his maimed arm during the 1996 presidential race and later decision to use it as "a badge of honor"; or Houck and Kiewe's (2003) description of Franklin Delano Roosevelt's concealment of his disability and deployment of rhetorical strategies so as to be seen as healthy and capable of leading the nation. These studies highlight the active role the disabled individual can take as they negotiate sociocultural expectations and pressures.

What constitutes disability?

The concept of disability is contentious and the construct of disability incorporates a broad range of conditions and experiences. Brueggemann & Fredal (1999) argue, as an example. that disability can be defined "medically, aesthetically, linguistically, socially, economically, sexually (to name but a few)" (p. 133).   Disability encompasses a broad range of conditions, although differences in societal perceptions -- imagine, for instance, the differences between a disabled individual with a cognitive impairment and one without -- result in unique pressures on those with certain disabilities. As a result, the rhetoric of disability offers a rich site for investigation.

As disability researchers have demonstrated, the label "disability" creates separate rules and procedures for the able-bodied and the disabled. This difficulty is exacerbated by language

practices by which "disabled people are constructed as de-authorized subjects" (Erevelles, 2001).

Examples of separate rules and procedures extend to separate physical accommodations (or lack

thereof), school and work accommodations, as well as perceived limits on what the disabled are

capable of. Beyond this, paradigms of disability impact resource provision, such as here the

provision of insurance parity for the mentally ill. And these differences in the provision of

health care impact not only the individual, but also extend to those in relationship with the

mentally ill, including family and caregivers, who often assume primary responsibility,

physically and financially, for their care.

While the disabled may be *treated* as a single monolithic group, as Wilson and Lewiecki-

Wilson (2001) have eloquently argued, "disability is not a universal category but a strategic

name marking diverse differences" (p. 10). The use of the monolithic label "disability"

accomplishes two actions: it draws a line between the disabled and the able-bodied and

aggregates those with dissimilar forms and degrees of disability.

Rhetoric of disability

Taken as a whole, rhetoric of disability researchers contend that the acts of labelling and

aggregating the disabled into a single category promote a situation in which external cultural and

social forces define the lived experience of the disabled, thereby reducing the their agentic

power. Rhetoric of disability researchers have also promoted the view that the disabled deserve

autonomy in controlling how they choose to be viewed. Studies of physical disability have taken

various forms: physical disability has been examined through works on deafness (Brueggemann,

1999), disease states such as AIDS (Nye, 2001) and multiple sclerosis (Krummel, 2001), and

other physical forms (Corker & French, 1999; Brueggemann & Fredal, 1999). Studies of the

disabled mentally ill have examined the critical role of diagnosis, observing that the use of the

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primary diagnostic tool for mental disorders, the Diagnostic and Statistical Manual for Mental

Disorders 4th ed. (DSM-IV), has led to "perceptual distortion" (Prendergast, 1999, p. 48), where

"the client becomes the sum of his or her symptoms" (Berkenkotter & Ravotas, 1997, p. 271).

Similarly, McCarthy and Gerring (1994) contend that revisions to the DSM-IV led to another

kind of distortion, where the goal of revisions to the manual aimed to strengthen the primacy of

psychiatry over other areas of knowledge and to solidify the primacy of the biomedical model of

mental disorder rather than to improve outcomes for the mentally ill. The moral purpose of the

DSM has also been questioned, with Sarbin (1997) arguing that

> [O]ur society has conveniently borrowed the power and prestige of the medical
> profession to pursue a moral enterprise -- the task of sorting out those people who
> must be marginalized because they engage in conduct that disrupts the smooth
> functioning of social life. (p. 233)

Thus, the primary diagnostic tool of mental illness, the DSM, has become part and parcel of the

cultural and social construction and maintenance of mental disability, resulting in two primary

outcomes: 1) a perpetuated justification for disparity between the mentally ill and their able-

bodied peers and 2) weakened agency on the part of the mentally ill as these outside forces

circumscribe what disability means and is. At the *moment* of diagnosis, agency is attenuated. As

Lewiecki-Wilson (2003) describes,

> This received tradition creates a barrier excluding the severely mentally disabled not only
> from rhetoricity but also from full citizenship, tied as traditional rhetoric is to the liberal
> ideology of the public forum, where good men (sic), speaking well, engage in civic
> debate. (p. 158)

As the mentally ill enter the public forum, here the congressional hearing room, they enter as

members of a marginalized group, a group often seen as lacking rhetoricity. While the power of

the congressional hearing grants them an audience, the legislative process alone does not ensure

agentic power. The mentally ill and their advocates must still establish themselves as "good

men, speaking well" to engage in the debate. This requires that they craft a message to demonstrate ethos, a process that will be outlined next.

Constructing ethos

Ethos is tightly located in the individual: not the individual as a constant, but the individual as instantiated at the moment and in a particular text. This can be thought of in terms of the differences between the "true" self and the "verbally constructed appearance" of self (Baumlin and Baumlin, 1994, p. xxvi). Ethos, part of the Aristotelian triumvirate of ethos, logos, and pathos, incorporates good sense, good will, and good moral character (Fahnestock & Secor, 2003). Beyond the qualities of the individual, Baumlin and Baumlin (1994) argue that "there is ethos precisely because there is a body, because there is a material presence that 'stands before' the texts that it speaks or writes" (p. xxiiv).

If those providing testimony are required to demonstrate "good sense, good will, and good moral character," one might expect that the mentally ill may struggle to establish ethos. In fact, one might argue, they enter the hearing room with a diminished ethos, given their identified mental illness and concurrent doubts about good sense, good will, and good moral character. While some might believe that the stigma surrounds mental illness is declining, Pescosolido et al. (2010) found that while the public has broadly accepted that mental illness has a neurobiological basis, attitudes about having a neighbor with severe mental illness remain largely unchanged and negative. There is ongoing stigma that results in distrust and, extending this argument, uncertainty about ethos. To have the reasoning of the mentally ill and their advocates gain traction, they must respond to this imagined lack of ethos, must take as a critical first step a response to how others might mistrust, or at least be agnostic, about their intentions and morals.

While others have sought to understand how disability is constructed, one goal of this chapter is to examine how the mentally ill and their advocates seek to *reconstruct* how others see the mentally ill who testify on their own behalf and their advocates -- not to be defined by their mental illness, but as individuals with rich and full lives, and thus regain rhetoricity. Through the stories that the mentally ill tell during their public testimony, more specifically, the details of their lives that they choose to incorporate, they suggest how they believe others are likely to imagine their lives and their abilities. In describing their accomplishments in the face of their mental illness, they enact personal and collective agency and demonstrate who they are, employing ethos to reduce the barriers that exist between the mentally ill and those who hear their testimony.

Before advancing these ideas, however, an overview of work from disability studies will provide additional context.

Disability studies and political change

Disability studies, as the field of study that "explores the critical divisions our society makes in creating the normal versus the pathological, the insider versus the outsider, or the competent citizen versus the ward of the state" (Linton, 1998, p. 2), has been responsible for "refusing the medicalization of disability and [...] reframing disability as a designation having primarily social and political significance" (p. 2). Disability studies arose as a way to further grow the community and political activism that emerged in the United Kingdom during the 1970s to urge changes that would improve the lives of the disabled. One of the most influential and earliest advocacy groups, the Union of the Physically Impaired against Segregation, distinguished between impairment and disability in their union's Fundamental Principles of Disability (1976):

Thus we define *impairment* as lacking part of or all of a limb, or having a defective limb, or organ or mechanism of the body; and *disability* as the disadvantage of restriction of activity caused by a contemporary social organization which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression. (cited in Finkelstein, 1980, p. 22)

This framing of disability as "social oppression" clearly shifts responsibility for solving the problem from the individual to the society as a whole. Using this lens, impairment is part of the natural world in much the same way as the curvature of the earth or the seasons exist – we don't blame the natural world for such features, but we work to accommodate those features into what we build and the way we think. In the same way, we as a society can build to accommodate a range of impairments.

Sociological models of disability

Sociological models of disability inform rhetorical studies of disability. This section outlines three models of disability in depth and briefly identifies several others. These sociological models matter because there exist, side-by-side, competing models for how to view the disabled; understanding that different models exist provides a broader perspective on how we might think about disability, in the same way that learning a new language provides a new way to think about how the world might be organized. In several of these models, the disabled themselves are described in terms of tragedy (and therefore deserving of charity), with rights granted through largesse; in others, the disabled claim rights as full members of society. While these models offer different interpretations, they share common features: they articulate who decides what counts as disability and what disability means within the culture, and in the process stake claims about the rights and responsibilities of the disabled and the non-disabled. Thus,

sociological models, as cultural frames for disability, inform how disability is viewed within the culture. And as Stone (2001) argues,

> In politics, we look for causes not only to understand how the world works but to assign responsibility for problems. Once we think we know the cause of a problem, we use the knowledge to prevent people from causing the problem, to make them compensate other people for bearing the problem, and to punish them for having caused suffering. (p. 189)

Among the existing sociological models of disability are: a medical model, a charity/tragedy model, and a social model. These models frame responsibility for disability in strikingly different ways, but all assume disability includes forms of physical disability (loss of one or more of the senses, loss of one or more of the limbs) as well as other types of mental difference (such as autism spectrum disorders (see Jurecic, 2007) and mental retardation). Of these, perhaps the most recognizable to the non-disabled is the medical model, which locates disability in the individual. In its simplest form, the medical model situates disability in the body and in the individual and takes as its highest goal the return of the body to "normal" functioning and, as lesser goals, a move toward recovery and rehabilitation. As Beaudry (2016) describes, the medical model "conceptualize[s] disability as a tragedy or problem localized in an individual body or mind, the definition and solution of which [is] to be provided by medical experts" (p. 211). Because the medical model takes treatment and recovery, to the extent possible, as the desired end state, accommodations become an afterthought. The onus for solving any challenges or difficulties falls on the disabled.

In contrast, the charity/tragedy model conceptualizes disability as a problem, "as tragedy that must be erased by generous giving" (Clare, 2001, p. 360). Through generous giving, the lives of the disabled are thought to naturally improve, and the collective guilt of their benefactors

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is expiated. The goal is not to create a space in the community for those with a disability but instead to reduce guilt and to give benefactors the opportunity to feel good about their largesse.

The social model, which has taken on a number of different forms, posits that disability exists as a result of poor supports, of not adequately understanding the existing features of the natural world. Described differently, the social model localizes the problem in a society or system that erects barriers which prevent the impaired from living rich and full lives and hence the goal in the social model is to ensure appropriate supports exist to support each individual. While most forms of the social model do not discount that the individual may willingly accept treatment to improve functioning, they (typically) do not locate responsibility for disability in the human body or the willingness of the individual to accept treatment. Instead the social model sees restrictions on the lives of those with a disability as "caused by a contemporary social organization which takes little or no account of people who have … impairments and thus excludes them from the mainstream of social activities" (Oliver & Barnes, 1998, p. 18). This framing has led to important outcomes, including increased political dissatisfaction and community activism:

> By redefining the disability problem, it enabled people who had felt in-valid, incompetent and dependent to relocate the problem of disability from themselves to the discriminatory society in which they lived. Rather than feeling shame, self-pity and frustration, people with impairments could legitimately feel anger, resentment and solidarity with others. (Shakespeare, 2004, p. 11)

Other models have continued to evolve. Among these is the affirmative model, described by Swain and French (2010) as "a non-tragic view of disability and impairment which encompasses positive social identities...for disabled people grounded in the benefits of lifestyle and life experience of being impaired and disabled" (200, p. 569) and the socio-relational model, which assigns primary difficulty to "barriers to doing (material), barriers to being (psycho-

emotional) and the effects of impairment (bio-social) as creating the experience of disability"

(Cologon, 2016, n.p.). As can be seen, these varied models offer alternative ways to think about

disability and to think about who has responsibility for addressing the rights and needs of the

disabled. This forms important context for the analysis.

Disability and agency

The possibility that an individual actor can effect change, that is, have agency, has been

broadly challenged (Spivak, 1988; Gaonkar, 1993); subsequent contemporary work in rhetoric

has sought to salvage the concept of agency. The central issue is that cultural theorists grant

significant power to cultural formations that diminish individual power, while rhetorical scholars

aim to continue their premise that "rhetors effect social change" (Herndl & Licona, 2006, p.

134). As reported by Geisler (2004), a number of working groups at an Alliance of Rhetoric

Societies meeting sought to address the problematic question of agency. One conclusion from

this meeting was that "rhetoric *as an interpretive theory* describes a variety of rhetorical

positions, some with more and some with less rhetorical agency" (p. 9). From this meeting, too,

came the observation that rhetorical agency does exist, under certain conditions, but it should not

be assumed to exist. Under what circumstances does rhetorical agency emerge?

Herndl and Licona (2006) begin to answer this question, arguing that agency is

constrained, "emerg[ing] at the intersection of agentive opportunities and the regulatory power of

authority" (p. 133). They continue: "If we define agency as self-conscious action that effects

change in the social world, then agency is contingent on a matrix of material and social

conditions" (p. 138). Miller (2007), locating agency within the rhetorical event:

> the kinetic energy of performance that is generated through a process of mutual
> attribution between rhetor and audience. Agency is thus a property of the
> rhetorical event, not of agents, and can best be located between the two traditional

ways of defining agency: as rhetorical capacity and as rhetorical effectivity. (p. 137)

If we think of agency as rhetorical capacity, then this suggests that every rhetorical situation has a maximum capacity,where rhetorical *capacity* is bounded in two ways: by the capacity of the situation and the capacity of the rhetor. In contrast, rhetorical *effectivity* asks about the likely outcome of a particular rhetorical strategy. While neither capacity nor effectivity can be adequately captured, agency can be thought to exist in their proximate orbit.

More recently, Cooper (2011), drawing from complex systems theory and neurophenomenology, has argued for a definition of agency that grants conscious intentions, plans and goals, but recognizes that the path from cause to effect is not linear: "change arises not as the effect of a direct cause, but from the dance of perturbation and response as agents interact" (p. 421). Current understanding of agency suggests that it is not a strong, directive force but instead a weak and poorly controlled one, a force she describes as "emergent and enacted" (p. 420), suggesting outcomes will be difficult to predict and context-specific.

Finally, agency requires that the speaker adapt to his or her audience. Leff (2012) has argued that agency has not traditionally been simply about "the power of the orator", by which he means the rhetor's strong physical presence, but that power also arises from "humility before the audience, because the power to move and persuade an audience requires accommodation and adaptation to its sentiments" (p. 216). This seems reasonable, if the audience is already favorably inclined to the speaker. In the case of those representing the mentally ill, however, humility may be less important than asserting similarity. Speakers can achieve agency both by leading the listener and also by being attentive to the audience's existing beliefs and ways of thinking. In this sense, "tradition can function as a mediating force between individual and

collective identities, and once viewed from this angle, tradition emerges as the primary resource for rhetorical invention" (Leff, 2012, p. 213).

How are we to think of agency given the ongoing debate? Conceptually, agency retains its potential to effect change, but existing social and material conditions may constrain its impact. In the case of the mentally ill and their advocates, these social and material conditions include the setting (congressional hearings), the stigma of mental illness, the invitation to testify, and the differential power relations that exist between the mentally ill and elected members of Congress as well as between the mentally ill and other speakers. Rhetors may be intentional in their aims, and may have an effective strategy, but that is not enough to guarantee the desired or intended outcome, given agency's sometimes non-linear and unintentional path. As a result, the analysis that follows should be seen as asserting potential agency rather than agency as taken-for granted. Rhetors can achieve agency by recognizing tradition and its value as a mediating force. It is within this context that agency should be understood.

The issue of tradition warrants additional discussion. In the context of studies on the rhetoric of disability, tradition may be thought of in terms of existing modes of thought about disability: existing labels and categories, but perhaps also existing systems and modes of separating and isolating the disabled from the able-bodied. It may also be thought of in terms of how the audience is likely to perceive of the mentally ill. Are they seen as similar to or dissimilar to the members of Congress? If the perception is that they are dissimilar, and if those who represent the mentally ill perceive that this places them at a disadvantage, then how might these speakers respond? As can be seen in this chapter, one goal seems to be to reduce the distance by showing similarity and reducing dissimilarity.

This theme of tradition and its value to rhetorical invention in arguments about how we should think about the mentally ill resonate throughout this analysis particularly in reference to the use of models of disability throughout the testimony.

Constraints on agentic power during congressional hearings

Like others, I argue that the disabled face a number of difficult challenges as they attempt to effect change through their testimony, and that as the mentally ill disabled and their advocates aim to enact agency they face a greater challenge than would face the able-bodied. Given that institutional power may limit the personal agency of the mentally ill once they have been hospitalized or have received a diagnosis (Wilkerson, 2011), that the stigma of mental illness remains (Pescosolido, 2010), and of ongoing marginalization, can the mentally ill have agency?

Despite these individual challenges, from the perspective of political power and political change, the term "disability" has power, in its ability to create a political bloc, and thus a constituency for change. As Stone (2001) and many others have argued, political change is more likely when affected groups have political agency and political strength. Political strength is typically reflected in having more political clout, more numbers at the polls, and greater consensus about the need for change. Rather than seeing the label of disability as problematic, the monolithic label of "disability" can also be seen as generating tremendous power -- if it can help create a community with bargaining strength and collective, more than individual, agency.

Mental illness, one type of disability, presents an interesting test case for the power of the label of disability. When the label is applied by outside forces, it limits personal agency; however, it may be that it is possible to construct a collective, or shared, agency, one assembled with the help of those with a mental illness as well as their supporters, and through this construction to expand the common understanding of mental illness to accommodate a much

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wider, and more broadly universal, understanding of disease. This chapter asks a central

question: what rhetorical appeals are employed by the mentally ill and their advocates in the

public testimony on mental health parity?

Taking the perspective that rhetoric can act to examine "the function of power within

language" (Dolmage, 2014, p. 93), studies on the rhetoric of disability examine the ways that

institutional and cultural forces constrain the power of those with a disability. The central

observation in this stream of research is that "common contemporary ideas about disability are

always prefaced by, always circumscribe, and always interact with our contemporary ideas of the

norm" (Dolmage, 2014, p. 19), where the contemporary norm requires "the cultivation and

perfection of performative, expressive control over oneself and others" (Brueggemann & Fredal,

1999, p.129). To frame in Aristotelian terms, the ability to identify the available means of

persuasion may be diminished when control over oneself is not possible. The inability to achieve

such control may lead to not only attenuated political and cultural power but also shrinking

rhetorical capacity.

The disability label does more than hide differences or craft a false narrative of the

disabled. Price (2010) suggests that "mental disabilities are shaped and lived through rhetorical

processes including diagnosis and resistance; that they appear unpredictably and are not always

legible; and that, above all, *coalition is essential among people who live under the rubric of the*

disabled mind [italics mine]" (p. 122). Linton (1988) too focuses on the power of the category:

> When medical definitions of *disability* are dominant, it is logical to separate people
> according to biomedical condition through the use of diagnostic categories and to
> forefront medical perspectives on human variation. When disability is redefined
> as a social/political category, people with a variety of conditions are identified as
> *people with disabilities or disabled* people, a group bound by common social and
> political experience. These designations, as reclaimed by the community, are used
> to identify us as a constituency, to serve our needs for unity and identity, and to
> function as a basis for political activism. (p. 12)

Public testimony on mental health parity has the potential to be a site for coalition, for those affected by the disabled mind to be represented, for a constituency to emerge; in fact, if not here, then where? These themes of agency, coalition building, and reconfiguring the boundaries that capture and contain disability culminate in new questions, ones that can be examined in public testimony. Brueggemann and Fredal (1999) capture the complexity of these issues when they ask:

> What are the '*available* means of persuasion' when disability is argued about? How do these differ from the *existing* means or the *effective* means? How is persuasion used to 'form attitudes' or 'induce actions' or 'gain the adherence of minds' concerning disability? (p. 133)

At the broadest level, this chapter examines the available means of persuasion when those with a mental disorder aim to induce action, that is, a policy change, and gain the adherence of minds of the members of the U.S. Congress. More narrowly, this chapter aims to understand not how disability is constructed and maintained, but a related series of questions: 1) How do those with a mental disability and their supporters rhetorically construct the mentally ill? 2) Do those with a mental disorder have agentic power in crafting the argument for mental health parity? If so, how? And finally, 3) Is it possible to build coalition for those with a mental disorder? If so, how is coalition achieved in the mental health parity testimony? This chapter addresses these three questions.

In conducting this analysis, this work also connects with disability studies more broadly. As Lindblom and Dunn (2003) argue, "Disability studies has taken 'disability' out of the category of 'physical defect' and put it into the category of 'socially constructed unfairness'" (p. 169). From a close reading of the testimony, it is clear that this is the goal of proponents of mental health parity legislation, who argue that creating a separate construct for mental illness, as

opposed to medical illness, has led to socially constructed unfairness, and that existing policy has

been built on the back of this unfairness. As will be clear in this chapter, proponents' central

argument is that crafting legislation to provide mental health parity is an important first step

toward eliminating this socially constructed unfairness.

Owning Disability

Researchers in disability studies have increasingly expressed dissatisfaction with the

models of disability identified here as well as with others (Shakespeare, 2004; Shakespeare &

Watson, 2001; Clare, 2001). Models provide pared-down representations of social and cultural

processes. As a result, models do not fully capture the complement of ways that the disabled

interact with the material world and the challenges posed by their interactions.   While in some

ways, the needs of those with a disability are similar (such as a desire for community, a lowering

of barriers to inclusion, a desire to work and be productive, the need for appropriate supports),

the material conditions required to meet these goals largely differ by disability type. As a

consequence, models of disability reflect current practices but also open a space to reflect on the

evolution of practice as models are tested against practice and needs. Because of this twinned

testing and revising of models, models of disability can serve as a source for rhetorical invention:

while models frame particular goals, lived experience locates new challenges, thereby

identifying the limitations of each model. Nonetheless, the models suggest new ways to think

about disability. When those with a specific disability, and their advocates, argue for change,

their efforts to craft strong policy messages must address two concerns: the specific needs of

the existing disabled and the material conditions that impact their lives.

In this chapter I identify appeals employed by the mentally ill and their advocates

throughout the public testimony on mental health parity. I subsequently argue that many of their

appeals map on to three early models of disability, reflecting medical, social, and charity/tragedy models; further, I argue that both the stigma surrounding mental illness and the specific material conditions that impact the mentally ill create opportunities for rhetorical invention, requiring that providers of testimony, recognizing that listeners may hold models of disability that differ from their own, create appeals that stretch between medical, social, and charity/tragedy models to accomplish their own goals.

Models of disability reflect perceptual frames who should take primary responsibility for solving, or addressing, disability. To garner support, providers of testimony draw from existing models, but their ways of defining disability also reflect mental illness and its stigma. As a consequence, the mentally ill and their advocates craft appeals that demonstrate an awareness of how others might locate responsibility for and ownership of the needs of the mentally ill; they then employ this knowledge to re-negotiate ownership.

This work builds on work by Manago, Davis, and Goar (2017), who find evidence of both social and medical models of disability in the discursive framing described by parents of disabled children, who were a asked to report on stigmatizing moments. Manago et al. report finding "a distinct flexibility in the ways that stigmatized persons pull from their cultural toolkits (Swidler, 1986, 2001)" (2017, p. 177), selectively challenging or deflecting stigma. It also builds on earlier work (Landsman, 1998, 2005; Blum, 2015) showing that parents of disabled children use medical and social model-based explanations in daily interactions to shape discursive responses to disability and stigma.

Several differences exist between earlier studies and this one. First, while the earlier work examined discursive practices used in daily life, here I examine rhetorical appeals in written public testimony. Additionally, this work focuses on mental illness specifically, while

earlier work focused on disability more generally. The studies and the testimony both

incorporate the views of parents of children with disabilities; in the testimony, however, the

children are adults (over the age of 18). Finally, goals differ: in earlier studies, parents sought to

reduce and deflect stigma in everyday conversations; those providing testimony not only aim to

gain support for the proposed legislation, but they also seek to reduce stigma by shaping

understanding of the mentally ill population. Acknowledging these differences, the providers of

testimony draw from arguments that reflect social, medical, and charity/tragedy models as they

craft their appeals. I argue, however, that these appeals also selectively challenge and deflect

stigma, calling out social conditions as discriminatory while simultaneously crafting an image of

those who benefit, notably including women and mothers as well as those who aim to work, be

productive, and have lives fully integrated in their communities.

Rhetorical appeals employed by consumers and their advocates

Consumers and their advocates provide 17 of the 89 testimonies (19%). Among these, 10

testimonies (59% of testimonies provided by consumers and their advocates; 11% of all

testimonies) are provided by individuals affiliated with two organizations: the National Alliance

for the Mentally Ill (NAMI) and Mental Health America (MHA). In this chapter, I will examine

trends in appeals employed by consumers in general, but I'll also focus more narrowly on

appeals employed by NAMI and MHA. All other consumer groups presented only once. These

include: Federation for Families with Children with Mental Illness (4D); Bazelon Center for

Mental Health Law (5A); National Depressive and Manic Depressive Association (7J); Eating

Disorders Coalition for Research, Policy and Action (12B); and the Carter Center Mental Health

Task Force (14B).   Two individuals (Ann Buchanan, Amy Kuehn) also presented without

identifying specific ties to any consumer group. Ann Buchanan's testimony (11F) is a response

to the President's New Freedom Commission report. Amy Kuehn speaks twice in the testimony: once representing the Eating Disorders Coalition for Research, Policy and Action (12B) and once speaking about her experience raising a son with autism and ADHD diagnoses (12J).

Throughout the testimony, stakeholders employed a range of rhetorical appeals. Types of appeals found throughout the testimony as a whole include appeals based on comparison, based on language, based on person (authority or experience), as well as appeals providing evidence (case/story or data/quantitative) or drawing from authority (referencing an external source), and claims to experience, representation, urgency, and value (value judgments or appeals to who we aspire to be). Within each of these broad categories, I subsequently identified themes. (See Appendix C, Table of Personal Narratives and Case Examples.)

The coding process identified seven major types of appeals employed by mental health consumers and their advocates. These include (by rank order, with total observations indicated in parentheses): appeal -- based on personal experience (46), appeal -- to evidence -- data/quantitative (25), appeal -- based on comparison (not parity) (23), appeal -- based on person (qualifications, personal commitment) (21), appeal -- to representation (16), appeal -- to value (who we are and what we value) (13), and appeal -- to evidence -- case or story (9). The cutoff for inclusion on this list was 10 observations. An exception was made in the case of appeal -- to evidence -- case or story (the last category) because the use of cases shares much with the use of personal stories. Personal narratives tell of one person's experience directly; case examples describe one person's experience in the third person. Case examples are also typically short (five or six sentences) but they serve the same function: to describe the lived experience of mental health consumers and their families. For an example, see Appendix D, Case Example.

By defining the appeals employed by consumers of mental health services and their advocates, we gain additional insight into the rhetorical tools consumers and advocates select as they aim to persuade policy makers and others. They also, I suggest, offer insight into how mental illness maps to to current models of disability. Understanding these issues is critical to the debate that remains over mental health parity. In addition, the deliberation over models of disability, whether grassroots or research-driven, are critical to shaping public understanding of disability and legislative decision-making about the rights of the disabled. This work contributes to both.

Luck and Anguish: Stories of Mental Illness

While Lewiecki-Wilson (2003) suggests that those with a severe mental illness may lack rhetorical agency, and she is almost certainly right for the most severe cases, those who testify about their own experiences with mental illness clearly do have agency. Three individuals describe themselves as "fortunate" or "lucky": not fortunate to be ill, but fortunate to have received care at all. They describe how the received care because of a sacrifice made by their parents, because they supplemented their employer's insurance with their own supplemental insurance or cash payments, that they left employment and turned to public aid when all else failed. The implicit message, in Toulmin's terms, a warrant, is that most mentally ill consumers are less fortunate and less likely to receive care. Other consumers describe less favorable outcomes: what happens when lifetime limits are exceeded, what happens when states are allowed to determine appropriate parity levels, what happens when there is a delay in receiving appropriate treatment.

Parent-advocates also tell their own stories and describe their experiences, but theirs are stories of anguish and tragedy exclusively. One parent, a founder a group for individuals with

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eating disorders, describes founding the group after it was "too late" to help her child. Others describe how their children received care only after suicidal ideation. Another reports being told that his child would be removed from a treatment program if he was unable to pay $1000 per day for continued treatment; after removing the child from treatment, the child soon experienced a relapse and required a 3-week inpatient stay. One mother describes that she had to shut down her own business in order to care for her child. Taken together, these are stories of tragedy that locate the tragedy not with the individual but with the system that fails to provide care and offer claims that mental illness disrupts not only the individual but the family as well.

Other advocates, typically leaders of advocacy groups (who sometimes also have a mental illness), use short case examples to identify specific problematic features of the existing system for accessing care. They describe consumers who work and want to work, but who cannot cover needed services using insurance provided by their employers. These brief sketches highlight different problems within the existing mental health system: differences in state systems of care, the gap in care due to small business exemptions, differences in care between chronic medical illness and chronic mental illness, the burden borne by families, the burden of lifetime caps, and on and on. These speakers use the narrative form to describe the lives and aspirations of mental health consumers, and to highlight disparities between physical health and mental health in terms of access, treatment, and costs incurred by the consumer.

Claiming experience: Personal narratives and case examples

In the testimony, the primary function of mental health consumers is to tell their story. Altogether, there are 24 unique narratives or cases, as defined as a personal experience or case descriptions delivered in a single testimony. As seen in Appendix C, nearly half of the 24 narratives and case descriptions (43%) provide personal accounts of the speaker's own mental

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illness, while others offer the perspective of the mother (39%) or father (7%); the remainder describe a friend, an employee, or a constituent (8%) . A large percentage describe individuals integrated into education and employment. Nine (32%) describe consumers who attended college; eight (25%) report being employed -- despite the fact that several of these cases describe children. Men are underrepresented in consumer self-reports while women are overrepresented, compared to the general population. Only one male describes himself as a consumer (8% of the sample of self-identified consumers); in contrast, women constitute 11 of the 12 (roughly 92%) who describe themselves as consumers. This suggests that stigma is less of a concern for women than it is for men and aligns with research that women are more likely to seek out mental health support than are men (Chandra and Minkovitz, 2006; Leong and Zachar, 1999).

These narratives and case examples construct an image of who benefits. Taken as a whole, whether speaking for themselves or their children, the majority of speakers are female (83%). Speakers report on their own experiences as mental health consumers (43%). These stories paint the picture of beneficiaries of mental health parity: individuals who pursue lives with meaning and connection, desire to work, and aim to be productive members of society. In telling these stories, the mentally ill and their advocates aim to establish ethos. Not only do these stories humanize those with mental disabilities, but they show the toll on families, suggesting that women carry more of the burden -- both of illness and of care. Of the 24 narratives or case examples, 13 are provided by parents (54%); of these 11 are presented by mothers (85%) and 2 are presented by fathers (15%). The other side is, of course, that these accounts serve to minimize that men too have mental disabilities, that mental disabilities may be so severe as to preclude any ability to participate in the workforce, and that chronic and relapsing conditions may require ongoing care. This further suggests that the stigma associated with mental illness is

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sufficient, particularly for men, to place employment, and future prospects of employment, at risk. Women who provide testimony, in several cases, describe having employment and describe how the lack of parity places their continued employment at risk.

It seems likely that these narratives and case examples were chosen for impact. What may be more surprising is how many of these narratives and case examples were relayed more than once to the legislators. Of the 24 testimonies with a narrative or case example, six women presented before different committees, or had their experience presented for them, twice. Among these, three women were mothers; two women were consumers; and one was both a consumer and a mother of a child with a mental health issue (in this case, she presented once about her own condition and once about her experience with her child). These cases constitute 50% of the personal narrative or case examples heard by members of Congress.

Sample Narrative: Lisa Cohen

Some of the most powerful personal stories, in fact, are those that describe the individual having parallel, or comorbid, health issues (that is, both physical and mental health existing side by side) while experiencing good access to treatment for a medical condition but poor access for a mental health condition. To provide context, in Appendix E I include a sample text from one individual, Lisa Cohen, who spoke during a hearing in support of the legislation.

In the testimony, Cohen describes her experience as a person with both medical and mental health conditions. Her testimony is included here in full to provide a deeper understanding of the entirety of the corpus but also because it demonstrates how rhetorical agency is enacted in the testimony. While the testimony that follows describes the lived

experience of one individual, it also functions to demonstrate the experience of those individuals (and there are many) with concurrent medical and mental health problems.

Cohen writes (and presumably speaks) eloquently; her testimony is a compelling exemplar, demonstrating the key strategies employed by supporters of mental health parity: 1) a personal narrative of someone who aspires to work and be productive, 2) who has been afforded a full range of family and social supports, 3) who calls out the existing policy as discriminatory and stigmatizing and 4) draws in stark terms the differences between those policies that support medical health in contrast to those for mental health -- and the impact of these policies on her own life.

Two issues complicate Cohen's testimony. The first time she speaks she indicates no group affiliation. The second time she speaks, however, she speaks on behalf on Mental Health America (formerly National Mental Health Association). The first issue is simply the fact that she speaks twice. The second issue is that Mental Health America receives (as does the National Alliance for the Mentally Ill) funding from a number of pharmaceutical companies. Paragraph marks have been introduced into the testimony for ease of reference. An elaboration of these key themes follows the testimony. The full text of the testimony is provided in Appendix E, Testimony Example: Lisa Cohen.

Constructing the personal narrative

Cohen achieves personal agency through four key rhetorical arguments, crafting a narrative that addresses three questions:

1. Who is the speaker (ethos)?
2. How did this situation come about (pathos)?
3. Is this a problem amenable to human intervention (logos)?

Argument 1: The speaker is just like us. Cohen is eminently relatable. The central message is that she has aspirations similar to our own: to work, to be productive, to be independent. She has been successful by the metric of education: in college when her illness first emerged, by the time of her testimony, she has completed a Master's degree. She is also successful in terms of employment, maintaining full-time employment "despite the fact that I still contend with occasional bouts of depression and hypo-manic episodes, continued medication changes (22 and counting), and all kinds of side effects..." (para. 10). She describes herself according to broadly shared metrics: education, employment, relationship, independence, and happiness (para. 10). But equally important, Cohen has taken ownership and responsibility for her illness. She describes herself as having medical insurance through her work, but purchasing supplemental insurance to provide for her needs. She takes responsibility for her own care, too, by ensuring that she "monitor[s] my psychiatric illness very carefully in order to stay out of the hospital" (para. 15), thereby "sav[ing] the insurance company not to mention the government lots of money" (para. 15).

Argument 2: Misfortune led to the current state. Cohen's central message is that she is supported by family and social supports and that she is "lucky" to have the supports that she does. When her illness first manifested itself, she was "lucky" to have a family to return to (after she dropped out of college). Receiving a diagnosis was both "a blessing and a curse" (para. 4): A blessing because being able to name her illness opened up the possibility of treatment and "the possibility of a return to 'a normal life'" (para. 4), but a curse because of the chronic nature of her illness, the fact that her treatment would be "expensive and uncovered" and the stigma of mental illness.

Argument 3: The values of the U.S. Congress demand change. Cohen also makes arguments

that are driven by both ethos and by logos. Cohen blames "the insurance industry" (para. 2) but

she makes it clear that she also blames "stigma, greed and the lack of proper Federal legislation"

(para. 16). She describes the current situation as "discriminatory" (para. 2) and "unjust" (para.

18), explaining that "[r]eceiving coverage for my mental illness has not been easy, fair or

complete" (para. 8). But she also questions the logic of the current policy, arguing that it

"makes no sense, since the costs to society of untreated mental illness are greater than the costs

of providing treatment" (para. 2). She offers no data to support this final observation, apparently

leaving it to other experts to provide further support.

Argument 4: Change is necessary. By comparing support for medical health with support for

mental health, Cohen reinforces the central message that change is possible. She notes that

"[M]y insurance company had no trouble paying for any and all care for my blood disorder,

including more tests than I care to count. No questions asked, no limits on doctor's visits or

hospital stays" (para. 9). If this kind of care is possible for medical illness, then it is also possible

for mental illness. She concludes, "As members of the United States Senate you have a great

opportunity before you to put an end to an unjust system and enable millions of people to receive

the mental health coverage they desperately need" (para. 18). In this final statement, she does

not say that this change will result in less cost for those with mental illness and their families

(although it will), or that it will result in better treatment (although it may), instead she focuses

on a single outcome: that this will enable care. Individuals who need care fail to receive the care

they need because of the existing system.

Speaking for the mentally ill: Appeals to person

Appeals based on person described the individual in terms of their personal commitment, affiliations, and leadership roles. These appeals came early in the testimony and included in 53% of testimonies provided by mental health consumers and their advocates. In providing this background information, they established credibility and identified characteristics that set them apart. For family members advocating on behalf of the mental health consumers, this meant identifying themselves as parent of a mental health consumer; it often also meant identifying the particulars of their experience: where they lived, what specific disease state, how long they or their child had been diagnosed and at what age. In this way, they situated themselves as experts and established their *bona fides*. This was a common appeal (46 instances) for the stakeholder group consisting of the mentally ill and their advocates as well as a common appeal for all stakeholders.

Appeals to representativeness, in contrast, described the ways in which speakers were representative of a larger group: often in terms of the numbers of constituents in their affiliated group or the length of time that their organizations had existed. These were appeals based on the organizations or groups that they represented, in contrast to appeals based on the individual, and were observed 16 times, yet they were present in 10 of 17 testimonies (59%) provided by mental health consumers and their advocates. These appeals explicitly identified the ways in which they were representative: "I am one of many persons who either have no health insurance coverage… or insurance coverage that restricts access to treatment for my life-threatening conditions" (12M National Association of Anorexia Nervosa and Associated Disorders). They framed their personal experiences as representative, imploring, "I ask you to consider my testimony not solely as one person's story, but as a microcosm of millions of Americans" (13C Mental Health

America). They situated their affiliated consumer groups as representative given the size of their

memberships: "As the nation's largest organization representing individuals with serious brain

disorders and their families with 220,000 members and over 1,200 affiliates, we know why a

minimum standard for parity in insurance coverage is desperately needed" (8I NAMI). Appeals

to representation sought to establish that their experiences were not unique, but were

representative of the challenges faced by those seeking mental health care and their families.

Stories trump numbers

Of the appeals using numbers (total of 25 for consumers and their advocates), the most

common quantitative appeal, observed in seven cases (23%), was *enumerating the population of*

mentally ill as a whole or a sub-population of the mentally ill (notably categories of severe

mental illness). The next cluster of quantitative appeals, each seen three times (10% for each)

included: rates of *public support* for parity; rates of *employer support* for parity; rates of plan

compliance following parity requirements (without cost offsets); and data on *cost savings*

through managed care. Next, seen twice, was *estimation of annual indirect costs* for not treating

mental illness. Finally, there were a number of quantitative appeals observed a single time:

treatment success rates, *percentage of plans limiting inpatient or outpatient care* prior to

implementation of parity, the *number of mentally ill not receiving appropriate treatment*,

estimates of the cost of full parity (at a cost of 1%), the *life expectancy of the mentally ill*

compared to those without a mental illness, *high school dropout rates* for the mentally ill, the

number of mentally ill in prisons, the *number of mentally ill in emergency rooms*, and the *number*

of individuals who stand to benefit from parity. Appeals using quantitative data were observed in

9 of the 17 testimonies (53%) provided by mental health consumers and their advocates,

however 2 testimonies (by Michael Fitzpatrick and Jacqueline Shannon) constituted 15 of the 25

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instances (Shannon, testifying for her second time (8I), offered 8 unique quantitative appeals; Fitzpatrick offered 7 (12L)). These two testimonies represent 60% of all uses of quantitative data across all 17 testimonies. In both cases, the speakers had experience testifying before the legislature.

Examining who used numbers to support their argument, perhaps not surprisingly, leaders of advocacy groups were more likely to use data to support their arguments than were individuals not in leadership roles. The National Alliance for the Mentally Ill supported their testimony using quantitative data more often than other groups, but they were also well represented in the testimony as a whole. What is most interesting, however, is how NAMI speakers employed quantitative data to support their position and how their practices shifted over time and from speaker to speaker. The next section examines how NAMI speakers employed both data and narratives or case examples, and contrasts these findings with how a similar advocacy group, Mental Health America (MHA), employed similar types of appeals. NAMI presented five times before Congress on mental health parity, while MHA presented four times. NAMI is the nation's largest grassroots organization dedicated to helping consumers and their families; MHA "is dedicated to promoting mental health, preventing mental and substance use conditions and achieving victory over mental illnesses and addictions through advocacy, education, research and service."

In Fig. 5. Advocacy Strategies of NAMI and MHA, it is clear that speakers for two major advocacy groups, representing NAMI and MHA, employed different strategies as they advocated for mental health parity. While those representing NAMI frequently incorporated personal stories and case examples, and tended to use data to support their argument, MHA used these strategies far less often. The average number of case stories or personal narratives in NAMI

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testimony was 3.8 with quantitative data employed in each testimony four times on average. MHA, in contrast, used case stories or personal narrative .75 times on average across the four sessions; they employed quantitative data on average once every time they offered testimony. While both groups sought to influence the mental health parity policy, their use of appeals varied widely and warrants further investigation.
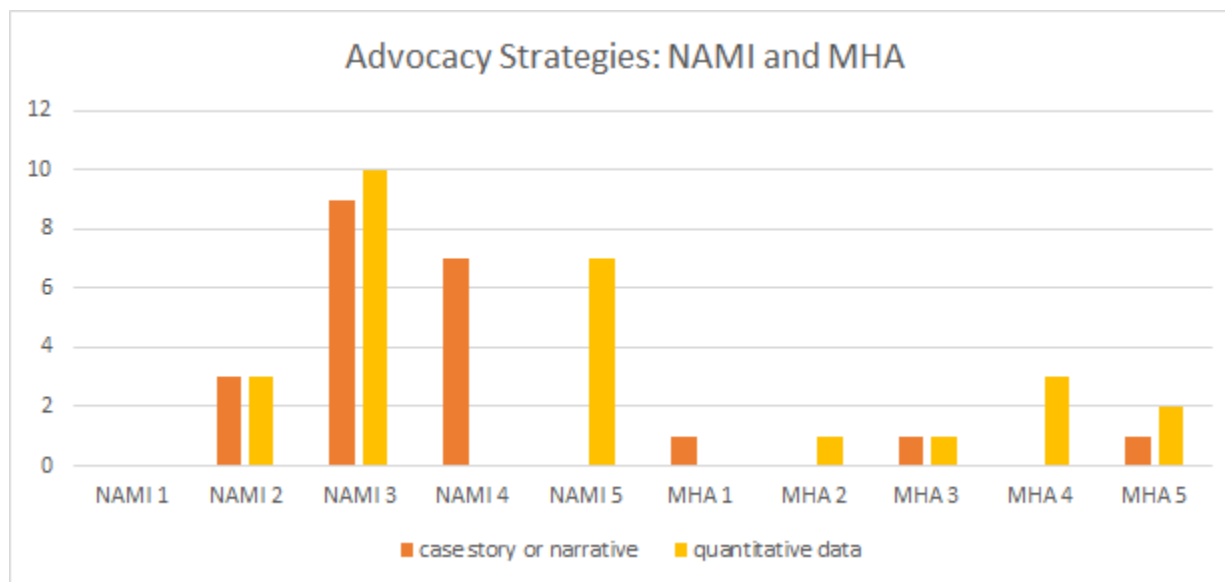
Figure 5. Advocacy Strategies: NAMI and MHA

Examining the differences behind the organizations and their speakers yields further clues. To begin, however, I first examine NAMI's use of appeals. In NAMI 1 (the first time NAMI presents on mental health parity, represented by Mary Ann Beall, a NAMI board member), there are no personal narratives, case examples or quantitative data. In all other cases (both NAMI and MHA), providers of testimony draw on either case story/narrative or quantitative data, and typically both, to present their argument. As NAMI presenters gain experience, they, in general, more regularly use personal narratives or case examples to support their argument. The single exception is NAMI 5 (Michael Fitzpatrick, Executive Director of NAMI), when quantitative appeals are employed while personal narratives or case examples are

omitted. We can learn more by considering the background and role of each of the speakers. Understanding more about NAMI is important to the understanding of NAMI's role in providing testimony.

NAMI, a grassroots advocacy group representing the interests of those with severe mental illness and their family members, is often led by a family member of a mental health consumer, serving as president. In NAMI 1, a NAMI board member speaks; in NAMI 2, 3, and 4, the then-president of NAMI speaks; and in NAMI 5, the executive director for NAMI speaks. NAMI 5 is unusual in terms of use of quantitative appeals. As an executive director, Fitzpatrick's charge is to effectively manage and direct the organization's strategy and overall direction, and unlike the other NAMI testimonies, Fitzpatrick does not identify himself as having personal experience with mental illness. Further, and perhaps more suggestively, he had previously served in the legislature for the state of Maine and had previously held senior management positions in state government and in the nonprofit sector. Given these previous work experiences, it seems reasonable to assume that Fitzpatrick had had far more experience with testimony, both observing it and providing it.   While the evidence is thin, it suggests that Fitzpatrick's strategy may have differed as a result of his personal experience: he only delivers quantitative, data-driven appeals. Additionally, Fitzpatrick continued to serve as NAMI's executive director for years, retiring as recently as 2013, so it is clear that NAMI leadership recognizes his skills. It is not simply that he used quantitative appeals, however; the specific quantitative appeals are even more interesting.

Examining Fitzpatrick's selection of quantitative appeals illustrates his persuasive approach. Not only does he prioritize appeals based on numbers, but he employs numbers that speak to other challenges facing other governmental agencies and groups. While other speakers

representing NAMI (for instance, Jacqueline Shannon) include the source of their data,

Fitzpatrick identifies no sources. He offers striking contrasts ("A man with a serious mental

illness is likely to die by age 53, compared with the average male life expectancy of 78 years"

and enumerates that 130 million will benefit from expanded parity benefits (12L). Beyond these

numbers, he uses data to identify impacts on other legislative endeavors: education

("Approximately 50 percent of students with a mental disorder age 14 and older drop out...the

highest dropout rate of any disability group"), the criminal justice system ("Twenty-four percent

of state prison and 21 percent of local jail inmates have a recent history of a mental health

disorder"), health care systems ("Between 2000 and 2003, emergency department (ED) visits

with a primary diagnosis of mental illness increased at four times the rates of other ED visits"),

annual indirect costs of mental illness ($79 billion), and annual productivity losses due to mental

illness ($63 billion) (all in 12L). While those with personal experience with mental illness use

personal narratives and case examples to persuade, this suggests that those with legislative

experience may persuade instead through data, including impacts on other systems funded,

whether partially or fully, by the government, as well as cost estimates identifying productivity

losses and other economic losses.

Returning to the remaining NAMI testimonies, the trend seen in the figure suggests a

learning curve. Jacqueline Shannon (then-president of NAMI, designated NAMI 2 and 3 in the

figure above) presents twice. The first time she includes three examples of case stories or

personal narratives and three examples of quantitative data; the second time she presents, she

employs more of both (9 case stories or personal narratives; 10 quantitative data), tripling her use

of both appeals. Shannon also incorporates the source of her data the second time she presents.

Again, the evidence is thin but suggestive: testifying the second time, Shannon finds greater

value in using personal narratives and case examples as well as quantitative, data-driven appeals. That she details her data sources may indicate that she does not see herself as having the authority to get by without detailing her sources.

Three of the NAMI testimonies are delivered by NAMI presidents (Jacqueline Shannon in NAMI 2 and 3; Jim McNulty in NAMI 4). Of these, Jim McNulty relies on personal narratives or case examples (total of 7) but uses no data (0). He offers a counterbalance to earlier emphasis on mothers and their children, instead describing the experiences of fathers and sons. While it is impossible to know with certainty why McNulty chose not to include any quantitative data, it seems reasonable to attribute it to his relative lack of experience.

What appears to be happening, then, is that those with more experience (Shannon in NAMI 3, Fitzpatrick in NAMI 5) rely more heavily on quantitative data. It seems possible too that those with a close experience of mental illness, whether through lived experience or through that of a family member, see the telling of these personal stories as persuasive. Yet when Fitzpatrick presents, in his role as executive director and having experience speaking before legislature, he includes no case examples. This seems surprising, given that he certainly has heard many narratives in his role as executive director. Given his prior experience, his choice suggests that he sees quantitative appeals will have greater impact on committee members.

The other major group represented in the testimony is Mental Health America (MHA), which is represented in five testimonies (as many as NAMI, they often seem to be paired in the congressional hearings). The strategies employed by those providing testimony on behalf of MHA strongly contrast with those employed by NAMI. Given their missions, these two organizations have some agreement in objectives, however MHA focuses on mental wellness whereas NAMI represents those with severe mental illness and their families; in other words,

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while one focuses primarily on prevention and recovery, the other focuses largely on the long-term needs of individuals unlikely to ever fully recover. This divide in the mental health community, setting recovery as the prize or supports for chronic illness, for which recovery may not be realistic, is deep and pervasive, and reflected in how NAMI and MHA representatives provide testimony. When MHA incorporates data, it is to report on suicide statistics (many forms of depression are short-lived) or to report on results from an MHA-funded survey:

> [T]he survey data showed that nearly all Americans (96%) think health insurance should include coverage of mental health care (with only 2 percent responding that health insurance should not cover it), and a large majority (74%) responding that insurance plans should cover substance abuse treatments at the same levels as treatments for general health issues. Significantly, the public's views on mental health and addiction equity is bipartisan -- 83% of Republicans and 92% of Democrats support equitable health insurance. (12A, Mental Health America)

They aim to establish their own expertise and to support those with mental illness for whom recovery is more likely. The lack of other quantitative appeals seems surprising. MHA was then headed by Dr. David Shern, a trained research psychologist and former professor at the University of South Florida, yet the only quantitative appeals he employs are from MHA's own survey.

While testimony on behalf of NAMI focuses on the myriad difficulties faced by those with severe mental illness, and testimony centers on personal narrative and case examples, MHA testimony only uses personal narrative or case examples three times, each time focusing on a single individual: Lisa Cohen (who presents twice), "Ruth" (the single case example), and Marley Prunty-Lara. Lisa Cohen's testimony has already been described in depth; her original diagnosis was depression and later bipolar disorder; "Ruth", described only briefly, has a diagnosis of severe depression; Marley Prunty-Lara has a diagnosis of bipolar disorder. Three women, three "treatable" diagnoses, and three stories of an upending of the American dream.

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"Ruth" is described as the spouse of a Fortune 500 employee who, despite her husband's better-than-average insurance, cannot get the care she needs. Marley Prunty-Lara describes her CPA mother who, facing a months-long waiting list for her daughter's treatment, dropped everything and drove Marley 350 miles to find a therapeutic program because no spaces were available in her region, and who subsequently took out a second mortgage to finance Marley's two-month inpatient stay. Their stories are powerful; the speakers are eloquent and call for an end to "sanctioned discrimination" (13C Prunty-Lara).

The data from mental health consumers and their advocates suggest that most advocates believe that personal stories are more persuasive than quantitative data; an alternative hypothesis is that they have personal stories more readily to hand than they have quantitative data. Personal stories paint an empathetic picture of parents, mostly women, in anguish as they aim to gain treatment for their children. Further, when those with a mental illness diagnosis speak for themselves rather than their children, they are typically women too. Despite this, the most widely cited data from around the time of the hearings suggested that women were only slightly more likely than men to have a mental illness (Regier et al., 1993; Regier et al., 1988). More current data suggests a somewhat different picture. Substance Abuse and Mental Health Services Administration (SAMSHA) data from 2016 suggests that the past-year prevalence for *any* mental illness was 21.7% for women and 14.5% for men; in contrast, past year prevalence for *severe* mental illness was 5.3% for women and 3.5% for men.[17] However, these numbers are complicated by the fact that women are more likely to seek out treatment, either from a primary care doctor or from a specialist (Leong and Zachar, 1999). Further, while the testimony includes speakers with diagnoses of bipolar disorder (for which rates between men and women are nearly

[17] For more, see the National Institute for Mental Health website link:
https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

identical) and depression (for which women are more likely to receive a diagnosis), it does not

include alcohol dependence (for which men are twice as likely to receive a diagnosis) or

antisocial personality disorder (for which men are three times as likely as women to receive a

diagnosis). It cannot be determined whether depression and bipolar disorder are more prominent

in the testimony simply because women are testifying or whether women testify because they are

thought to be more sympathetic and as a result the testimony includes more descriptions of

bipolar disorder and depression.

Those speakers with more experience, particularly more legislative experience, appear

more likely to employ quantitative appeals, sometimes framing the problem of mental health

parity as an issue that has repercussions throughout multiple government-subsidized programs

and having far-reaching economic impacts. The sample here however is small, and it would be

valuable to determine whether former legislators who provide testimony at other congressional

hearings are more likely (than co-testifiers without such experience) to include impacts on other

government functions. This might lead to improved recommendations for those who intend to

testify before a congressional committee. These initial findings are enriched and complicated by

examining other appeals, those based on comparisons and values.

Socially Constructing Fairness

Constructing illness: Appeals based on comparison

Speakers advocating on behalf of mental health consumers employed comparisons in

65% of all testimonies (11 out of 17 testimonies). In these eleven testimonies, 22 comparisons

were employed. Within these comparisons, half (11 of 22) directly compare coverage for mental

illness to coverage for physical illness. In the testimonies, comparisons are drawn between

mental illness and diabetes, rheumatoid arthritis, multiple sclerosis, cardiac or pulmonary care,

angioplasty, atherectomy, hypertension, or spinal cord injury. One speaker suggest that if

coverage is not available for mental health coverage, it could be made available by scaling back

on medical coverage for heart, kidney, lung, liver, or musculoskeletal systems (2C

NAMI/Beall). This is asked as a rhetorical question, but highlights the marked contrast in

coverage for mental illness and disorders of any other part of the body.

One-third of those who use comparisons do so using dollar and lifetime limits for mental

illness and medical illness; another one-third compare treatment success rates, noting that

success rates for schizophrenia and depression are better than rates for other standard treatments

for heart disease. Other types of comparisons include comparing copayment rates for mental

illness and other medical illness and teasing out how proposed legislation offers differential

benefits. These comparisons ask that the listener reflect on the qualities they attach to mental

illness and to other disease states. If as a chronic disease, insurance covers other chronic

diseases such as diabetes, multiple sclerosis, and rheumatoid arthritis. If as a disorder of an

organ, insurance covers other organs, such as heart disease or kidney failure. If as a disorder

with poor treatment success, disorders with worse treatment success are already covered,

including atherectomy and angioplasty. The implicit argument is that yes, we understand that

there must limits to how much is covered, but existing limits are applied inequitably.

NAMI employs appeals to comparisons in all of their five testimonies (100%), while

MHA employs such appeals 80% of the time (four out of five). Other mental health consumers

and advocates, who testified a single time, provided comparative appeals in 2 of 7 testimonies

(29%); for the Federation of Families with Children with Mental Illness (one comparison) and

for Bazelon Center for Mental Health Law (two comparisons). The first time NAMI offers

testimony (Beall 2C), five such comparisons are made; the first time MHA offers testimony

(Cohen 8B) there are six comparisons. In subsequent testimonies, NAMI and MHA both dramatically reduce the number of comparisons, but they continue to offer comparisons every single time they present, including the last. It appears that the first time they present, respectively, they are forcefully establishing a new persuasive appeal; later they appear to be simply reinforcing the appeal. The use of comparative appeals that connect treatment for mental disorders with treatment for other medical disorders is compelling.

Framing current practices as discriminatory: Appeals to values

Providers of testimony speaking for the mentally ill and their advocates appealed to values in 53% of testimonies (frequency count of 12; employed in 9 of 17 testimonies by the mentally ill and their advocates). Most typically, the value of fairness was expressed in value-based appeals to fairness, primarily avoiding discriminatory actions. This frequency count does not include more implicit arguments; implicit arguments included describing the current state as discriminatory in 71% (12 of 17) of the testimonies delivered by the mentally ill and their advocates. In February, 1993, Chris Koyanagi, Co-Director of Governmental Relations for the Bazelon Center for Mental Health Law, argued, "While individual responsibility is a valuable principle, it should not become a mantra invoked to legitimize continued discrimination against low-income citizens, regardless of their disability or diagnosis" (Bazelon Center for Mental Health Law 5A). This focus on the socioeconomically disadvantaged is rare in the testimony; more typically, speakers addressed benefits to the population as a whole. In March 2007 testimony proffered by Mental Health America, the speaker argued,

> That disparate coverage of behavioral health should be both routine and lawful is
> not only morally offensive, but -- in our view-- fosters a climate that tolerates other
> forms of discrimination and tends to weaken the fabric of equal opportunity laws.
> (12A)

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Here President and CEO David Shern connects one type of discrimination with other forms, and reminds the listeners of their earlier commitments to equal opportunity laws. As we saw earlier with speakers offering personal narratives, current practices are described as discriminatory: speakers call for "an end to an unjust system" (Cohen 8B) and urge the ending of "unjust [limits that] … apply only to illnesses of the brain, and not to any other organ or system of the body" (NAMI 9M). Throughout the testimony by the mentally ill and their advocates, the current situation is case as discriminatory. In one testimony, the term discrimination and its variants are used 24 times. Yet for much of the testimony by the stakeholder group representing the mentally ill, the rhetorical move is not to make claims about the rightness or wrongness of discrimination. Instead the phrasing is used as a silent witness to describe an ongoing and pervasive state.

Agency and the Mentally Ill

This chapter addresses three questions regarding the mentally ill who testify before Congress regarding mental health parity legislation: 1) How do those with a mental disability and their supporters rhetorically construct the mentally ill? 2) Do those with a mental disorder have agentic power in crafting the argument for mental health parity? If so, how? And finally, 3) Is it possible to build coalition for those with a mental disorder? If so, how is coalition achieved in the mental health parity testimony?

The mentally ill are rhetorically constructed within the testimony as a portrait in contrasts. While the stigmatizing expectation might be that the mentally ill are not be full members of society, these speakers show themselves to be working and to want to work, to be educated, to be connected with family and friends, to live full and rich lives. These rhetorical appeals are revealed through personal narratives and vignettes that highlight their actions and

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attitudes. While their ethos, as defined by good sense, good will, and good moral character, might be initially questioned by their audience, their stories appear crafted to address pre-existing concerns and stigma.

The mentally ill and their advocates demonstrate agentic power. Recognizing that this power comes in part from the rhetorical situation, the invitation to speak before Congress, their affiliation with recognized mental health advocacy organizations, and their status within those organizations, the mentally ill demonstrate individual agency as they shape understanding of mental health parity by drawing on the values and beliefs shared by their audience, and by connecting their appeals to sociological models of disability, most notably the social and medical models.

While the speakers draw from both social and medical models, they at least partially reject the charity/tragedy model. In rejecting the charity/tragedy model, speakers describe themselves as having been lucky or fortunate; they describe parents who took out second mortgages to finance their care; they describe how their child was about to be kicked out of a residential program because the family couldn't afford the $1K per day treatment, until suddenly someone had a change of heart. These stories of near-misses are offset by the stories that remain to be written: Bonnie Putnam who waits to see whether she can keep her job, depending on what happens with her insurance; "Ruth" who isn't sure whether the generic medication, as the only medication that her insurance company will agree to cover, will result in more severe depressive symptoms and an increasingly tenuous purchase on life. These are stories of tragedies waiting to happen. The charity/tragedy model is an underlying appeal, hidden in the shadows and right around the corner, waiting for when luck runs out. It is also present in the stories of parents, who describe their anguish over children for whom treatment is "too late", who raise alarms about

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children who will soon age out of the juvenile system, and who see that their children will require long-term care.

The medical and social models structure and guide the testimony as well. The medical model, with its focus on treatment and recovery, drives the comparative appeals: the comparisons of treatment efficacy, the descriptions of similarities between different kinds of medical and mental disease, and how those with medical conditions are treated relative to their peers with mental health conditions. The medical model appears most fully in the testimony of those whose focus is on recovery, rather than on chronic mental illness: on the suicides that can be avoided and the depression that can be eased. The social model is reflected too: in the broader impacts that mental illness causes throughout families, communities, and society as well as its ancillary costs.

The mentally ill and their advocates have agency by positioning their arguments in terms of values shared by their listeners. In providing public testimony, advocates craft rhetorical appeals that position women and children as the primary beneficiaries. Men are underrepresented in the testimonies, particularly in terms of those who self-identify as mentally ill, perhaps suggesting that the speakers believe having men present their arguments would gain less traction, although this stigma does not seem to extend to male children in the same way that it does to men in general. Additionally, some disease states are more likely to be described in the personal narratives, such as depression and bipolar disorder. Other severe and chronic illnesses, such as schizophrenia, are described less frequently. Supporters position beneficiaries as individuals who want to participate in their communities, who seek to work and to have fulfilled lives, and who have diseases for which recovery is possible. These descriptions appear to offer a

counter-argument to a stigmatizing accepted perception that the mentally ill are malingerers who have little interest in work.

Mental health consumers and their advocates employ a range of rhetorical appeals, including personal narratives and case examples, appeals to representation, quantitative appeals, comparative appeals, value-based appeals, and ethical appeals based on the speaker. While some of these appeals are employed broadly, those speakers with more experience are more likely to offer comparative appeals. Further, as as advocacy organizations gain experience in providing testimony, the rhetorical strategies they employ seem to shift. This does not, however, mean that greater numbers of one kind of appeal are employed more frequently. As seen in the case of comparative appeals, speakers continued to use comparative appeals, but used such appeals sparingly, suggesting that their goal was to nurture an idea that had previously been fostered and had taken hold. Additionally, speakers with experience testifying were less likely to rely exclusively on personal narratives or case examples and far more likely to include quantitative data. The individual with the most experience employed quantitative data to demonstrate impacts on other governmental agencies and groups and chose to exclude personal or case narratives. There is a learning curve to testimony and those with more experience use that experience to shape future testimony.

Consumers of mental health and their advocates achieve agency through the testimony as they shape comparative appeals that draw connections between mental and medical disorders. They reject notions of the mentally ill as tragic figures who require sympathy while simultaneously acknowledging that fortune has played an important role. Yet stigma remains: in the overrepresentation of women and underrepresentation of men, in the overrepresentation of depression and bipolar disorder and underrepresentation of disorders more common among men,

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such as substance abuse and antisocial disorders. The rhetorical analysis of these appeals grants insight into how consumers of mental health services, and their advocates, make a persuasive case for mental health parity.

Finally, the mentally ill and their advocates achieve coalition. They signal the scope of the problem by describing the numbers of mentally ill and the numbers of those with substance abuse disorders. They demonstrate that they have built coalitions that represent not only those with mental or substance abuse disorders, but their family members as well. They coordinate their appeals to present a consistent argument that brings together advocacy groups whose primary concerns differ. In building coalition, they further demonstrate their ability to have agentic power.

Chapter 5. CONCLUSION

Since at least the 1970s the purely rational approach to decision-making has been challenged. As described in this dissertation, this has been reflected in the concepts of communicative rationality (Habermas, 1984), the argumentative turn (Fischer & Forester, 1993) and the polis model (Stone, 2001). These theorists reject the idea that policy decisions can, or should, be limited to purely rational approaches. Having identified the many problems with strongly rationalist and technical approaches, these theorists confirm the importance of argumentation and rhetoric in policy decision-making.

Building from these observations, in political science there has been growing concern for the state of our democracy. Deliberative democracy takes as a central premise that public deliberation should be at the core of policy decision-making; the deliberative process adds to our collective trust and establishes the legitimacy of decisions. As Stone (2001) has argued, constituencies are not innate, but are called into being in the process of arguing for and deliberating about critical policy decisions. The public should not turn over political decision-making to technical experts alone. Relying on technical experts assumes that they understand problems deeply and fully, know how to fairly and efficiently allocate resources, and can effectively represent the complexities of the public interest. While technical experts do bring to bear important expertise, they cannot reliably predict public will, the creation of constituencies, or the potential arguments that may be brought to bear. In addition to wanting to engage the public and reduce our willingness to turn over critical decisions to technical experts, government and policy decision-making continue to become increasingly complex, making it more and more

challenging for the public to engage deeply in policy choices. Research in deliberative

democracy continues to search for new ways to engage the public in such policy choices and to

document the ways that the public seems to influence policy outcomes (Fung, 2003). In doing

so, research in deliberative democracy seeks to reinvigorate the deliberative process, arguing that

democracy as an institution is worth saving.

In order for deliberative democracy to flourish, the public requires spaces in which to

deeply participate in policy making. Some have advocated for designing new paths for public

deliberation. As a parallel recommendation, I argue that procedures already exist that support

public deliberation to support policy decision-making, and that one procedure with longstanding

recognition and support is public testimony. The common understanding of public testimony is

that it brings to bear the perspectives of the public. This is not decision-making per se, but it is a

critical stage in information gathering. In the common, perhaps idealized, understanding of

public testimony, individuals representing broad interests and concerns come together to share

their unique perspectives so as to better inform the policy process. Research from Brasher

(2006), however, suggests that congressional hearings are sites for more than the simple sharing

of information.

While congressional hearings are one of the primary existing sites where the public can

participate at the highest levels of government, we still have a poor grasp on how public

testimony functions within congressional hearings. This lack of understanding matters because

without a full grasp, it's impossible to know whether testimony contributes in the ways that we

expect and whether the possibility exists to improve the functioning of both testimony and the

hearing process more generally. This work contributes to our growing understanding of public

testimony, which plays a central role in the hearing process. As we have seen, however, while

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public testimony holds the promise of engaged deliberation, the deliberative value of public testimony may differ from our expectations.

New tools and strategies are required to understand the process of deliberation. Like many others, my argument has been that rhetorical tools and strategies are the most appropriate way to assess what happens in the policy making process. Researchers such as Brasher (2006) have examined public testimony from a rationalist perspective. However, as scholars of rhetoric have shown, while formal arguments follow a simple formula of deduction from known principles, informal arguments, the arguments of the everyday, instead require inductive reasoning, which asks what is probable given the available arguments (Perelman & Olbrechts-Tyteca, 1969; Toulmin, 1958/2003). In inductive reasoning, arguments need not be stated explicitly, with all components included, as in a formal proof; instead much remains implicit. Rhetorical scholars have tools to examine these implicit arguments and to consider the available means of persuasion.

In this research, I examined a test case on mental health parity legislation. This case is particularly interesting and important: interesting because those affected by the proposed legislation, the mentally ill, seem likely to have reduced agency as a result of the stigma around mental illness; important because this legislation was debated before Congress for more than 20 years, in various forms, and therefore offers a rich set of testimonies from which to examine deliberation. At a broad level, this dissertation sought to understand what happens in public testimony and whether and how one particular stakeholder group, the mentally ill and their supporters, achieve agency in the congressional hearings on mental health parity -- whether they do more, in fact, than simply providing new information. In conducting this work, I developed a coding scheme appropriate for the analysis of public testimony. This coding scheme builds from

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Toulmin's model of argumentation, as adapted by Gasper and George (1997). In order to better assess important rhetorical components, I elaborated on their process by incorporating concepts from Stone (2001), which allowed me to focus on key points of likely disagreement: problems, goals, and solutions. I further elaborated to better understand the role of grounds and data, drawing from recommendations by Brockriede and Ehninger (1960). The resulting analysis supports the value of this coding scheme. Additionally, I completed the coding in Atlas.ti, a computer-assisted qualitative data analysis software (CAQDAS) program and demonstrate that this program can be successfully employed for this type of rhetorical analysis and suggest some benefits, including the ability to create visual maps that complement the rhetorical analysis -- a value given the complexity of the argument.

The findings from this research also offer evidence that public testimony offers a useful site for rhetorical studies of deliberative processes. While a more generous interpretation might suggest that public testimony offers an opportunity for inclusion and problem-solving about a particular legislative issue, and a less generous interpretation might suggest that public testimony is simply for show, something far more complicated was observed in the public testimony on mental health parity. Given the resources devoted to congressional hearings, there is strong evidence that legislators value the inputs from the testimony, yet we also know that legislative staff do not always seek breadth in diversity when calling individuals to testify. While legislators have significant expertise in solving problems, their ability to assess new problems is strongly tied to outside inputs. As a result, we expected to find that providers of testimony would help legislators identify particular aspects of the specific problem of mental health parity. Yet what we found was quite different.

Results show that those providing testimony used the congressional hearing room as a site in which to lay out a broader set of concerns, reframing the issue to go beyond mental health parity and instead broadening the lens to incorporate issues that go beyond the ability of the legislature to respond. Here the picture seen in the testimony addresses not only *challenges* confronting the mentally ill as they aim to receive treatment, including concerns about access and continuity of care, but even more broadly on how the mentally ill are integrated, or fail to be integrated, into American society. While some groups, including business owners and their representatives, were disinclined to engage in framing the problem, others (most notably the mentally ill and their advocates as well as providers of care) described a rich and nuanced problem, with many contingencies and complexities, that can only be addressed by a more large-scale overhaul of the system in which the mentally ill receive treatment. This understanding of how the mentally ill and their advocates view their role in providing testimony suggests that they aspire to engage the legislature more broadly in meeting the needs of the mentally ill. Further, the rhetorical analysis demonstrates that the mentally ill, despite the stigma that surrounds mental illness, draw from a rich set of rhetorical strategies, including the use of models of disability and other types of rhetorical appeals, to construct and reconstruct how they wish to be send. In the testimony, they are agents of change in support of the legislation, and also agents of change in redrawing how they wish others to see them. This is a prime example of public deliberation and demonstrates the success in this process of providing a deep and broad framing of the problem.

The analysis of the testimony also reveals that a broad range of stakeholders contributed testimony, suggesting the some care was taken to ensure broad representation. Because of this broad representation, it was possible to analyze the testimony according to stakeholder group, and this provided additional insight into how different groups defined their primary goal in

providing testimony. While many studies of testimony capture the central arguments, by

connecting arguments back to particular stakeholder groups, I argue, it is possible to more clearly

identify points of resistance. Future research might continue to examine whether broad

stakeholder representation is more common in hearings of some issues. This knowledge is

critical to the strengthening of deliberative democratic processes.

This work was made possible by a number of technological changes. First, the access to

government archives in PDF form has simplified the process of researching legislative

testimony. Additionally, the development of computer-assisted qualitative data analysis software

such as Atlas.ti simplifies the process of examining arguments from the perspective of different

stakeholder groups as well as by time period. While this work could have been done without the

use of such software, Atlas.ti simplifies the process enormously. In the era of big data, the

ability to examine ever-larger data sets is appealing. By conducting research that covers, in this

case, decades allows the scholar of rhetoric to examine changes in the use of arguments over

time, or, in this case, to document that few changes occurred. The ability to add memos in situ

on research observations and to retrieve those observations within a subset of the corpus or from

the highest level view of the corpus further supports the researcher in her aims. Further, the

ability to generate visual representations of the data (as seen here in the representation of the

problem in Chapter 4) and to create counts of codes provides a robust way to support those

observations.

As with all research, there are a number of limitations. First, the public testimonies

examined here reflect one particular stakeholder group and focuses on one policy issue: the

mentally ill and their supporters arguing for mental health parity legislation. This means that

more research will be needed to determine whether the results here are generalizable. Additional

research on the role of public testimony would help us understand its function. Second, the arguments on mental health parity were particularly contentious -- choosing other, less contentious, arguments may yield markedly different results.

This research, as a test of the coding scheme, has examined only one stakeholder group and one of three major claims codes (problems, but not goals or solutions). Future research can usefully examine these remaining claims codes and stakeholder groups. This would allow for a more robust test of the coding scheme but would allow for more comparisons of employed strategies. As a test of agency, this research demonstrates that the mentally ill and their supporters successfully achieved agency, but that, as suggested in research from the sociology of disability, a number of challenges remain for the severe mentally ill. Finally, this research suggests that providers of testimony may have goals that differ from simply "providing testimony" and they use the opportunity to present before Congress to meet their own goals.

Finally, this research suggests that much remains unknown about the role of public testimony in the legislative decision-making process. Additional research might fruitfully examine the role of testimony in decision-making about other policy issues, what stakeholder analysis may reveal about what parties are brought into policy discussions, and the role of groups and organizations in constructing and reconstructing problems, goals, and solutions. With this deeper understanding of the legislative hearing process, rhetorical studies of public policy issues can continue to support and promote deliberative decision-making.

APPENDICES

APPENDIX A. LEGISLATIVE HISTORY: KEY DATES

102ND CONGRESS

*1992***:** First mental health parity legislation introduced.

104TH CONGRESS

*1996***: Mental Health Parity Act** enacted**.** This required partial parity requiring that group plans offering health care benefits would set equivalent annual and lifetime dollar limits for mental health benefits.

107TH, 108TH, 109TH CONGRESSES

 Full parity legislation introduced, but does not pass. (Exemptions remain in place for small businesses and "excessive" cost increases.)

110TH CONGRESS

*February 12, 2007***:** Sen. Pete Domenici introduces **Mental Health Parity Act of 2007 (MHPA).** Congressional Budget Office (CBO) estimates legislation will increase premiums by 0.4%.

*March 9, 2007***:** Rep. Patrick Kennedy introduces **Paul Wellstone Mental Health and Addiction Equity Act.**

*March 5, 2008***:** House version passes (with sunset clause).

*June 17, 2008***: MHPA** extended through the end of 2008.

*Oct. 3, 2008***:** Expanded parity legislation (**Mental Health Parity and Addiction Equity Act of 2008** or **MHPAEA**) passes in House and Senate as part of House **Resolution (HR 1424)** and became effective Oct. 3, 2009**.** This legislation extends parity to include copays and deductibles and visit limits are no more restrictive than requirements or limitations for medical benefits. Medical management standards should also be on par with those for medical benefits.

APPENDIX B. CONCEPT MAP OF PROBLEM FORMULATION
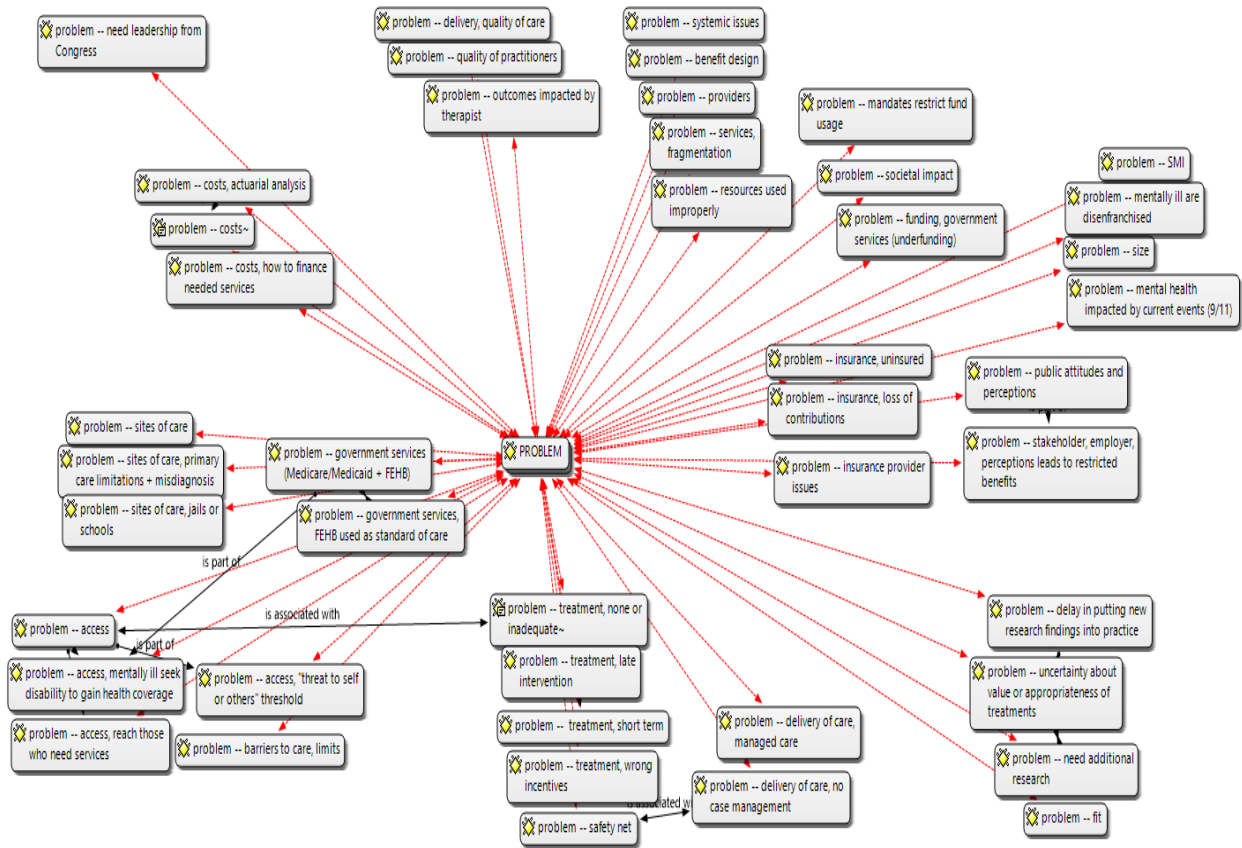
APPENDIX C. TABLE OF PERSONAL NARRATIVES AND CASE EXAMPLES

T	Speaker	Gender	Relationship	Diagnosis and Features
4D	Carol Obrochta, *Federation for Families with Children*	F	mother of consumer	see next (daughter presents too)
4D	Betsy Obrochta	F	consumer	**bipolar disorder** **substance abuse** desire to be part of community maintain independence intensive day treatment req'd
6A	Betty Ford, former First Lady, speaking on behalf of *Carter Center*	F	consumer	**substance abuse**
7I	Jacqueline Shannon, *NAMI President*	F	mother	**schizophrenia**; son exhausted $6K lifetime cap on mental health treatment in first (of many) hospitalizations
7I	Bonnie (no last name)	F	consumer	**major depression** worked for same company for 25 years; SC parity limits result in inadequate coverage; contemplating leaving employer
8B	Lisa Cohen	F	consumer	**depression → bipolar** college graduate medical diagnosis: idiopathic thrombocythemia (disparity in coverage)
8I+	Jacqueline Shannon, *NAMI President*	F	mother	son has **schizophrenia;** exhausted $6K lifetime cap on mental health treatment in first (of several) hospitalizations
8I	Suzette Scheele	F	mother	single parent with 3 children; oldest has **bipolar and ADHD diagnoses**. Had own business; now cannot work.
8I	Anne Renee Hansard	F	mother	daughter diagnosed with **bipolar disorder** age 19; had been honor

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				student at U Virginia; left job market and has been unable to re-enter
8I	Clare Cross	F	consumer	**depression**; had been working towards PhD in English at U Michigan; insurance forcing switch to generic
8I	Bonnie Putnam	F	consumer	**major depression**; SC parity made things worse; may lose job
8I	Christine Phillips	F	consumer	**bipolar diagnosis** elementary school teacher husband w/diabetes has no trouble with his medical coverage
8I	Susan Delaney	F	mother	daughter has **bipolar diagnosis**; age 18 but already used $20K lifetime mental health coverage limit; placed in state psychiatric facility after health deteriorated
9H+	Lisa Cohen	F	consumer	**depression → bipolar** college graduate medical diagnosis: idiopathic thrombocythemia (disparity in coverage); "lucky"
9M	Jim McNulty, *NAMI President*	**M**	consumer	**bipolar disorder**; diagnosed as college sophomore; "fortunate"
9M	Martin Stanley	**M**	father	son has **bipolar diagnosis**; exhausted coverage when son had suicidal ideation; potential $1K per day out of pocket
9M	Stephen Bacallao	**M**	father	son has **schizophrenia** and **anxiety disorder**; when insurance ran out, son removed from program → led to 3 week inpatient stay
9M+	Anne Renee Hansard	F	mother	daughter diagnosed with **bipolar disorder** age 19; had been honor student at U Virginia; left job market and has been unable to re-enter
9M+	Bonnie Putnam	F	consumer	**major depression**; SC parity made things worse; may lose job

9M+	Susan Delaney	F	mother	daughter has **bipolar diagnosis**; age 18 but already used $20K lifetime mental health coverage limit; placed in state psychiatric facility after health deteriorated
11E	Ann Buchanan	F	mother	son developed **depression** after father died unexpectedly; eventually diagnosed as **schizophrenic**; appropriate treatment only following **suicidal ideation**
12A	David Shern, President and CEO, *Mental Health America*	**M**	relationship not defined ("Ruth" F)	**major depression**; 20+ years; exhausted lifetime benefits from husband's Fortune 500 employer; discontinued therapy and left "floundering"
12B	Kathryne L. Westin	F	mother	**anorexia nervosa**; treatment deemed "not medically necessary"; daughter died
12J	Amy Kuehn	F	mother	son has **autism** and **ADHD** diagnoses; programs to treat do not accept Medicaid; unclear whether son can live independently without sufficient social skill training
12M	Amy Kuehn, *National Association of Anorexia Nervosa*	F	consumer	**anorexia nervosa**; **suicidal ideation**; college graduate
13C	Marley Prunty-Lara, *Board of Directors, Mental Health America*	F	consumer	**bipolar diagnosis** age 15; "lucky and privileged" to have received care
14B	Rosalynn Carter, *Carter Center*	F	former employer	former intern with **obsessive-compulsive disorder** and **depression**; college graduate; Phi Beta Kappa; employed in DC
14B	Rosalynn Carter, *Carter Center*	F	friend	Tom Johnson, former publisher LA Times; former CEO, CNN; **depression**

APPENDIX D. CASE EXAMPLE

Bonnie Putnam of Florence, South Carolina has been diagnosed with major depression since 1979. Even though she has worked for the same company for more than 25 years, she is on the verge of losing her job because she cannot afford to pay for the treatment she needs on her own. Her employer qualifies for the small business exemption under the MHPA. South Carolina's parity law is of little benefit to Bonnie because it still allows her health plan to strictly limit coverage for outpatient medication and therapy -- limits she long ago exceeded. Passage of South Carolina's law actually made things worse for Bonnie since her health plan responded by further limiting outpatient coverage. Bonnie Putnam needs parity.

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PREPARED STATEMENT OF LISA COHEN

¶ **1**. My name is Lisa Cohen and I am here today as one of the lucky ones. Why might I call myself lucky? I am certainly not lucky to have a mental illness, nor am I lucky to have a physical illness; I am, however, extremely lucky that I have been able to receive the treatment I need despite the roadblocks of unequal insurance coverage and stigma that I have had to cross in the process of learning to live successfully with chronic illness since 1988.

'¶ **2**. The insurance industry's discriminatory practice of providing far less coverage of mental than of "physical" illnesses has made my struggle to live a healthy and productive life much more difficult. And it makes no sense, since the costs to society of untreated mental illness are greater than the costs of providing treatment. You've already heard this morning eloquent testimony to back this up; but I have offered to tell my story, which is difficult to do, because I hope you will think of me and others far less fortunate as you consider this very important legislation.

¶ **3**. Thirteen years ago, I dropped out of college in Ohio and returned home to Philadelphia in a cloud of severe depression. At the time, I did not know what I was suffering from or why. All I knew was that I could no longer function and all I felt was futility, failure and hopelessness. With the support of my family, I was soon in the care of a psychiatrist.

¶ **4**. The diagnosis of clinical depression and later bipolar illness, or manic-depression, was a blessing and a curse. Finally, I knew that I had an actual illness, with available treatments and the possibility of a return to a "normal" life. What I didn't realize at the time was that along with this diagnosis came the need for long-term treatment, expensive and uncovered care, and, of course, the stigma of having a mental disorder.

¶ **5**. A few months later, in October of 1988, I was diagnosed with a rare blood disorder called Idiopathic Thrombocythemia. In simple terms, this means that I have too many platelets in my blood. The result of such a condition is the high risk of clotting diseases such as strokes and heart attacks. Just as my mental illness does, this disease demanded immediate treatment as well as continued medical attention. This included bone marrow testing, frequent blood tests, monitoring of side effects and numerous doctor's visits.

¶ **6**. For three very long years, I struggled to maintain a semblance of order in my life as I went from psychiatrist to hematologist, from therapy to medication and eventually numerous hospitalizations.

¶ **7**. To me, the two illnesses I have do not seem to be that different; one affects my blood the other my brain chemistry. Untreated, either illness can be fatal but with continued care and careful vigilance on the part of myself and my doctors, both can be treated successfully.

¶ **8**. Unfortunately, my insurance company chooses to view these illnesses with an unequal eye. Receiving coverage for my mental illness has not been easy, fair or complete.

¶ **9**. I learned this lesson early on when I was hospitalized for the third time for bipolar disorder. My stay exceeded the 30 days allotted to me by my insurance company, by one day. While I was in the midst of a severe episode, the insurance company was essentially kicking me out of the hospital. It was a horrific experience. I can only liken it to being three quarter's of the way through surgery, and the insurance company coming in and saying they won't pay for you to be stitched

up. Here again, I was lucky. My family stepped in. They made an arrangement with the hospital to pay them directly for any extra days needed. That is the only way I got the care I needed. However, with the fear of further hospitalizations, upon discharge I applied for Medicaid so that I would not be refused future mental health treatment. Meanwhile, my insurance company had no trouble paying for any and all care for my blood disorder, including more tests than I care to count. No questions asked, no limits on doctor's visits or hospital stays.

¶ **10**. Over the last five years, my life has been more stable with newer medications that have yielded better and more consistent results. This has allowed me to maintain full-time employment, despite the fact that I still contend with occasional bouts of depression and hypo-manic episodes, continued medication changes (22 and counting) and all kinds of side effects to go along with both illnesses. However, through careful monitoring and continued doctor's care, I have managed to remain out of the hospital, complete college, pursue a Master's degree in Social Work, maintain a job in Philadelphia's public behavioral health system, manage a relationship, live independently, and, overall, happily. For this, I can say I am very lucky.

¶ **11**. Currently I am under an insurance plan through my employer which affords me complete coverage for my hematologic condition but limits the amount of outpatient doctor's visits I may have, the amount of days I can be hospitalized for, and the

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maximum amount of money they will put out for my psychiatric care. And, by the way, I pay extra ($68.91 per month) for the privilege of enrolling in this health plan. The standard plan provided by my employer offers fewer benefits.

¶ **12**. In addition to the extra monthly fee I pay, I also pay out of pocket to see an out of network psychiatrist. My insurance plan reimburses physical out of network doctors and services at a rate of 80%, that is, of the total fees incurred. However, mental health professionals are reimbursed at a lesser rate of 50%. Now, don't be mistaken here, I won't be reimbursed for 50% of the total fees incurred; I will only be reimbursed for 50% of what the supposed "going rate" for a psychiatrist is, as determined by the insurance company. According to my insurance company, the going rate for a psychiatrist is about $80.00 (I don't know anyone who gets that rate), so I receive about $40.00 per visit. In reality that barely covers one third of my actual cost.   ·   .

¶ **13**. On the other hand, my insurance company affords me complete care from my hematologist, who is in-network. All I must do is pay a $10.00 co-pay at each visit. If I need to go into the hospital for psychiatric reasons, I can go in for 30 days per year. That is it. If I become severely depressed and need hospitalization for more than 30 days per year, I am, essentially, sunk. I will have to quit my very decent job that I have had for nearly 7 years and go on Medicaid to cover the hospital bill.

¶ **14**. On the other hand, if I have to go into the hospital for hematologic reasons, I can go in for as many days as needed. No lengthy arguments with the company over the phone trying to justify my stay, or the reality of my illness. After all, a blood disorder is a real medical condition in the eyes of my insurance company.

¶ **15**. In short, the reality of my life is this: I need to monitor my psychiatric illness very carefully in order to stay out of the hospital. For me, this means frequent doctor's visits and medication monitoring. To do so means that I stay out of the hospital and keep my job, and incidentally save the insurance company not to mention the government lots of money. However, I must do so

almost entirely at my own cost, regardless of the fact (or the myth) that I have a health care policy. And, I repeat, I am one of the lucky ones. I have been able to afford to do so.

¶ **16**. I present this testimony because I want you to understand how outrageous it is that there is no mental health insurance parity -- that because of stigma, greed and lack of proper Federal legislation, I am denied equal and adequate coverage solely based on the fact that I have a mental illness.

¶ **17**. I see no difference between my physical illness and my mental illness. My physical disorder can be fatal and requires long-term monitoring and continued care for the rest of my life. My mental disorder can be fatal and requires long-term monitoring and continued care for the rest of my life. Right now, the only difference is in the blatantly unequal and inadequate insurance coverage.

¶ **18**. As members of the United States Senate you have a great opportunity before you to put an end to an unjust system and enable millions of people to receive the mental health coverage they desperately need by enacting the Mental Health Equitable Treatment Act of 2001 (8. 543) I implore you to do so, for people like myself and those who have not been so lucky, for those who do not have the means on their own, or the family to help them pay for the mental health care that they need in order to live healthy and productive lives. Thank you.

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