Talking about the DSM-V

Tom Strong

University of Calgary

Abstract

The Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition; DSM-V) is nearing publication, despite considerable controversies over its development. In this paper I provide a critical historical review of developments associated with the DSM-V, particularly as these developments relate to the practices of narrative and other constructionist practitioners. I relate the findings of recently completed research in which practitioners shared how they responded to the influence of the current DSM-IV-TR on their conversations with clients, along with ways they creatively responded to that influence. I close with suggestions for practitioners who live with administrative expectations that they use DSM-V diagnoses in their conversational work.

Human beings are creators of culture, they develop beliefs and morals standards and

constantly transcend their own empirical human self which is the only self that scientific

research can recognise and grasp. Karl Jaspers, 1963, p. 8

The DSM-V will likely soon become a fact for those concerned about human

wellbeing. Many therapists find the direction taken in the DSM-V constraining how they

converse with clients. Originally a discourse about medical symptoms for researchers; the DSM

long ago escaped the laboratory and found its way into public, administrative and professional

discourses. Arguments against DSM have mounted since DSM-I's arrival in 1952. For therapists,

systems or constructionist discourses as well as social justice, existential or normal problem

solving discourses are inconsistent with a psychiatric discourse that exclusively locates client

concerns as deficits or pathologies *inside* them. Still, after considerable controversy within

psychiatry itself, the DSM-V is poised to become therapy's lingua franca. Yet this psychiatric

discourse doesn't stop with how our clients' concerns and sufferings are named; coupled with the

DSM discourse is a discourse of evidence-based interventions. A quintessentially modern

solution to human concerns seems attainable – one of mapping our clients' concerns onto a

single discourse of scientifically warranted names and practices. However, not all helping

professionals subscribe to this solution or the narrow science cited as supporting it.

Critically speaking, the DSM begs deconstruction for constraining how therapists and

clients do their conversational work. Whether clients present their concerns in DSM terms they

found in online and other media, or the administrative procedures therapists work by require

DSM diagnoses, talking without reference to the DSM is becoming difficult. My comments

which follow are primarily aimed at narrative and other constructionist therapists, whose work is

increasingly constrained by a DSM and medicalized discourse of practice. After a history and

contemporary overview of DSM's presence, I will identify tensions these therapists can face, while suggesting critically generative ways of talking with, around, and beyond DSM as a discourse of practice.

<div align="center">Background</div>

It was after a narrative therapy conference in the early 1990s that my concerns about the DSM as a discourse of practice first peaked. At the time, I worked as a community psychologist in the beautiful and isolated community of Smithers, in northwestern British Columbia. My earlier training had been in systemic forms of family therapy, which also have little compatibility with a DSM view of practice (cf., Strong, 1993). I had eagerly embraced the resourceful and conversational ways of practice I associate with the narrative, solution-focused, and collaborative therapies. The notion that clients' concerns and experiences were to be mapped on to a language and logic stripped from clients' contexts of living and meaning felt increasingly weird and unethical to me. But, this notion was my institutional reality, since practice in public mental health was becoming increasingly articulated and rationed on DSM terms. These were the days before evidence-based practice, however. So, at the time, I might use catch-all diagnoses like adjustment, depressive or anxiety disorders, then go back to doing my thing as a narrative and systemic therapist – coming up with experience-near names for solvable problems that clients played a role in co-constructing. Then, as now, I welcomed whatever name clients brought in for what was concerning them – DSM names included. Welcoming such names, however, should not be confused with staying with and tethering therapeutic dialogue to them.

Interest in what I now call the discursive therapies (e.g., Lock & Strong, 2012) seemed to partly wane in the 1990s at about the same time as evidence-based practice hit stride (Busch, 2012). Listening and talking in counselling seemingly needed to be done by the book – literally,

from manuals or scripts for diagnosing and treating clients' concerns. The evidence-based

approach to practice has, itself, been hugely controversial within organizations like the American

Psychological Association (e.g., Levant, 2005). It wouldn't be possible without the use of DSM

diagnoses. Some of the contention has been over what evidence should count and how evidence

should be obtained. Well-controlled, randomized clinical trials, like those done in university

clinics, in no way resemble frontline practice. Still, a view persists that how therapists talk with

clients can be evaluated in the same way one would test the efficacy of a trial of drugs for a

medical condition (Stiles & Shapiro, 1989). Properly practicing this way means adhering to

manuals or scripts of practice (e.g., Wilson, 2007), and that therapeutic dialogue be monitored to

ensure "treatment fidelity" (e.g., Tucker & Blythe, 2008). For researchers of therapy, there is

little evidence to support this kind of "methodolatry" (e.g., Hubble, Duncan & Miller, 1999).

This medicalized view of practice has been growing, despite very vocal opposition to

the DSM-V's role in enabling a Foucaultian nightmare of over-determined and micro-

dynamically administered therapeutic dialogue (House, 2005). Whole Divisions of the American

Psychological Association, the American Counseling Association, the American Family Therapy

Association, not to mention the Chairs of DSM-III and DSM-IV development, have protested the

science and over-reach of DSM-V with respect to the helping professions.

<div align="center">Why scientifically classify human concerns?</div>

Though symptom talk has always been an idiom of therapy, therapy itself is a relatively

recent, modern construction (e.g., Cushman, 1995; Miller & Strong, 2007). Understandably, the

same thinking and science that had helped to put people on the moon and eradicate diseases was

applied to human concerns about wellbeing. First needed, from this perspective, is a scientific

language for identifying and classifying the concerns to be addressed. However, humans and

their concerns cannot be known and classified in the same manner as minerals and microbes; they can object to how they are objectified (Latour, 1999). Still modern social science seemed to promise that human concerns could be correctly known and addressed - a promise that, perhaps coincidentally, fits contemporary managerialist practice for governing therapy (House, 2005).

Postmodern therapists can feel somewhat smug, dismissive, and disgusted with what Amundson and his colleagues (Amundson, Stewart & Valentine, 1993) referred to as modern 'temptations of certainty'. These temptations are rooted in survival, and their salience grew with successes in addressing bubonic plagues, community-destroying fires, and desires for improved transportation. Enlightenment science offered and continues to offer effective solutions to varied issues of survival and wellbeing. What it doesn't offer certainty. Nor, as poststructuralists or social constructionists make clear, can any social scientific outcome offer a final word on any human phenomenon or experience. Instead of correct answers to salient human concerns one finds potentially effective answers articulated in potentially effective vocabularies befitting people according to their changing circumstances. Still, determining what is effective has been a recent modern temptation: an evidence-based seduction or obsession borrowed from medicine. Establishing an evidence base for therapy has required the diagnostic language of DSM.

Giving names to human concerns so that such concerns can be recognized and addressed in ways communicable to others is as old as Zog telling the rest of his cavemates why Og, just eaten by a sabre toothed tiger, won't be joining them for dinner. We want names and understandings for what matters to us. However, it was often not enough to name things; seemingly needed were shared descriptions that enable shared prescriptions for action as well. For Wittgenstein (1953), languages, our varied ways of sharing meaning and coordinating action, enabled 'forms of life'. But, all human forms of life need to adapt as circumstances change.

Modern, well-intended, temptations of certainty continuously animate scientific efforts to end troubling aspects of being human. In this regard, humans pit their social constructions – languages and practices - against that which troubles them. However, as David Abram (1996) suggests, in using language humans can fall prey to the conceit that they can 'stake down' nature – human nature included. This human impulse to use language to make things understandable comes with a cost that some refer to as 'discursive capture' (Massumi, 2011) or 'narrative entrapment' (Shotter, 1993). The modern conceit is that the scientific names reflect phenomena 'as they are' in universally classifiable and applicable ways. Thus, territories like human misery can be seen as requiring scientific names and classifications with corresponding responses; or, conversely, as circumstances inviting endless re-territorialization (Rapley, Moncrieff, & Dillon, 2012). Witness Foucault's (2006) historical critique of the elusive construct named 'madness' - of which the DSM offers the latest articulation.

How is it that in over 60 years human troubles became so thoroughly medicalised in ways that concern even the Chair of the previous DSM-IV process, Allen Frances (e.g., 2011)? I think the answer has something to do with what Paul Ricoeur (1976) has described as our tendency to 'stake a wager' on meanings – in this case, on an unfulfillable wish to use medical diagnoses and interventions to make our human concerns go away. In medicine, to diagnose a concern means one is well on their way to addressing that concern. Naming or diagnosing the concerns of our clients, in terms of symptoms or deficits inside them, promises medical cures or health care management.

The history of what has been diagnosable in DSM terms is recent and part of what Grob (1991, p. 430) has referred to as a "yearning for omniscience". Terms like neurotic, moron, feeble-minded, neurasthenic, or simply 'mad' long dominated mental health discourse before

1952's DSM-I, enabling policies like eugenics or specialized deployment within the military.

Some see the increasingly nuanced vocabularies of the DSM-II, DSM-III, DSM-IIIR, DSM-IV,

DSM-IV-TR, and the forthcoming DSM-V as evidence of the triumphant march of science. Let

the evidence decide, they say, but evidence does not come to us by way of immaculate

conceptions. It is shot through and through with humanly constructed vocabularies, methods and

frames of reference. Look closely at the DSM process and you will find highly contentious

debates on such things as abandoning a psychodynamic framework and de-medicalizing

homosexuality through to contemporary debates on whether there should be such diagnoses as

post-abortion trauma syndrome, or if grief should be a category. Canadian psychologist, Paula

Caplan (1996), provides an instructive if not perplexing look at the politics of what goes on

inside the American Psychiatric Association committees that ultimately decide what goes into

the DSMs – in her case, the DSM-IV.

People get understandably vexed or anxious when science and politics are equated or

conflated. Science was to be above politics and value-free, despite central constructs like

objectivity morphing with the values and politics across eras (Daston & Galison, 2007). What

comes to pass as scientific fact has a very human trajectory (e.g., Fleck, 1979). Ian Hacking

(1998) has referred to this as 'looping effects' - providing actionable DSM self-identifications

for the people taking up such self descriptions. Standardized as human experience such language

and its applications become intertwined in institutional and cultural realities. There are up and

downsides of unquestioned yet humanly standardized practices (e.g., Turner, 2011), such as

timekeeping and the world clock (Galison, 2004).

Philip Cushman (1995) takes this line of analysis a step further suggesting that North

American therapeutic culture has been engaged in an ongoing dialogue with those who define the

self on normative and psychological terms. The self we want to become has a scientific stamp of approval, while the same science flags for us the self we must learn to diagnose and treat. Factoring Foucault into these observations, we arrive at what sociologist, Nikolas Rose (1990) has referred to as 'the psy complex', a normative enterprise whereby therapists using such science become complicit in maintaining an unjust societal status quo. An obvious beneficiary of the DSM developmental process has been 'big Pharma'. With each new diagnosed condition, new medications are seldom far behind (Angell, 2011; Greenberg, 2010). Of course, what is purportedly good for America is also ripe for the global market. Ethan Watters (2010) provides a scary account of what happens as the diagnoses and logic of the DSM gets taken up in cultures where, until recently, that logic has been foreign. Claiming that such developments are accomplished neutrally, thus scientifically warranted, is to overlook how the dialogues of science inescapably reify some human values and understandings over others (Aho & Guignon, 2011).

Part of the narrative therapists' angst over what I have been describing relates to recognizing that there are multiple discourses for making sense of human concerns. By default, the DSM has enabled a medicalization of misery (Rapley, et al., 2012), what Gergen (1990) provocatively referred to as a language of enfeeblement. The numerically coded diagnoses of the DSM were long ago recognized as furnishing the actuarial means necessary to ration therapy by diagnosed condition when coupled to evidence-based interventions (Sharfstein, 1987). One writer went so far as to refer to this coupling of diagnosis with evidence-based interventions as facilitating 'algorithms of practice' (Rush, 2001). Special Education services nowadays, for example, are almost impossible to fund or conceptualize without reference to diagnosable conditions and expected interventions (e.g., Linton, Russett, & Taleff, 2008).

The upshot of this view of practice is an abstract clinical landscape devoid of human contexts of living - abstract symptom clusters mapped onto abstract, if not idealized, interventions or scripts of practice. It arguably bring us closer to an aspiration of Lord Layard (2006), the British economic champion of happiness, that humans have conquered much of the world, though they have yet to 'conquer themselves'. However, such mapping isn't the sole province of mental health experts, others understandably use such expert ways of understanding to self-diagnose, or diagnose their children and partners, apprenticing themselves to this discourse of understanding and intervention (Strong, Lysack, & Sutherland, 2007; Watters, 2010). What I have been describing is a controversial context of help-providing and help-seeking that has become increasingly dominated by DSM thinking and practice (Eriksen & Kress, 2005).

What therapists have to say about the DSM

"I work with clients to choose their own diagnoses.(...) "we can call you a this or a this"

(Therapist respondent in Strong, Gaete Silva, Sametband, French & Eeson, 2012)

Over the past two years I have been talking to many therapists about the DSM on how the DSM influences their dialogues with clients, and how they creatively respond to the DSM as a feature of the clinical landscape, are diverse. While many practitioners describe helping clients, under administrative expectations they use DSM diagnoses, such expectations have not translated to the scripted algorithms of practice (Rush, 2001) referred to earlier. Indeed, behind the closed office doors of therapists, therapeutic dialogues vary in ways common to the pluralistic approaches of therapists and counselors (Cooper & McLeod, 2001). Mindful of such things as stigmatizing diagnoses, requirements for common understandings among helping professionals with particular 'cases', and administrative paperwork requirements, therapists talked about the many ways their practice was influenced by the DSM-IV-TR, and how they responded , often creatively, to its influence.

In a recent study (Strong, et al, 2012), some graduate students and I sought therapist responses on the DSM through an online survey, in telephone interviews, and at a discussion blog where different themes pertaining to the DSM and practice featured. The self-selecting respondents practiced from many approaches to practice; including approaches where DSM diagnoses and evidence-based practice were their identified approach. We were particularly interested in the tensions experienced by therapists on therapy's front lines; especially given how therapists using different approaches may talk about client concerns without making psychiatric symptoms focal. If therapy was to have become scientifically standardized, along DSM and evidence-based practice lines, the therapists responding to us had only partly bought in.

For me, somewhat reassuring was that the administration of practice had not tightened up to the extent that those concerned with diagnostic and treatment 'fidelity' (e.g., Sells, 2012) advocate. Instead, our respondents, practicing in publicly and privately funded contexts, reported that, while influenced by the DSM, they were only sometimes dominated by it. So, for example, it was quite common for therapists to be expected to administratively affix a DSM diagnosis, and then basically go on to practice in ways inconsistent with the DSM's psychiatric approach. This rhetorical move is not unlike Michael White (1984) famously re-naming a family's presenting concern about encopresis, as "sneaky poo". However, for other therapists, the conversational challenges were more substantial, as when some reported having to account for their practice in one 'official' language (the DSM) while talking very differently when with clients. Similarly, some described using 'cognitive therapy' for a DSM condition, despite practicing narrative therapy, since they could not be funded to see clients if they did not do so. This kind of practical and ethical dilemma has been hugely controversial and the *Journal of Contemporary Therapy* devoted a special issue to it a few years ago (Moses, 2000). Despite calls for tighter adherence to

diagnostic and evidence-based treatment protocols (e.g., Wilson, 2007), it would appear that

front line clinical practice has not achieved the nightmarish scenario Wylie (1994) described

years ago, as equating to having big brother oversee what goes on in the consulting room.

   Instead of the orderly clinical world envisioned by those wanting to systematize the

conversations of therapy according to DSM diagnoses and evidence-based treatment protocols,

therapists seem to negotiate the languages they used with clients, administrators, colleagues, and

others. To some that might sound like conversational anarchy; to most of our respondents it was

the hallmark of client centered dialogue. Many respondents, particularly narrative and other

strengths-focused practitioners, reported negotiating with clients who would present their

concerns to them in the language of the DSM. Their negotiating stance was often articulated

along lines link: 'well, that is how psychiatrists might talk about your concern, but what is left

out by such an account of your concern?' Then, the conversation could proceed down different

conversational pathways, than one tied solely to relieving DSM symptoms. Some respondents

were mindful of DSM symptom talk, regarding it as important when negotiating with other

professionals, to ensure a continuum of care inclusive of psychiatric treatment, or time away

from work. They negotiated the potential utility and stigma associated a DSM diagnosis with

clients (cf., Grunebaum & Chasin, 1978) as part of their conversational work. They also

negotiated it as a condition of their work: in supervisory and case meetings, in paperwork, in

ensuring that clients met the DSM criteria for service (e.g., working with a 'depressed' client and

his partner – instead of calling their work couples therapy), and in conversations with other

helping professionals. Some reported mechanically going through assessment procedures, for

paperwork or administrative procedure requirements, until they could move on to other ways of

talking about clients' concerns. In short, practitioners often negotiated their use of the DSM for institutional or fee-payer purposes. If this sets off pangs of ethical queasiness, perhaps it should.

What has prompted increased expectations that practitioners use the DSM have been decreases in funding for counseling that cannot be justified as medically warranted. The evidence-based movement arose, in part, so that scientific arguments could back up funding for 'mental health' services (Busch, 2012). Many therapists, particularly narrative and other constructionist therapists, have had to live with an uneasy ambivalence regarding this medical direction to their conversational work with clients. Currently, massive budget cuts to government funded mental health care in the US and UK have arrived well after focused efforts to better manage how therapy has been delivered (Buck, 2003). Efforts to better manage therapy were major motivators for developing and revising the DSMs, and for developing an evidence-base for therapeutic interventions – as forms of medical practice (Rapley, et al, 2011). In a sense, this was a case of therapists having to follow the money (Cushman & Guilford, 2000); or as Wylie (1994) crassly put it, of 'diagnosing for dollars'.

For narrative and family therapists, given this medical focus on individual symptomatology and decontextualized prescriptions for practice, how clients' concerns get named becomes even more critical to their conversational work. Locating problems inside clients, as deficits or symptoms to be treated, can obscure or make therapists complicit with unjust social and cultural realities giving rise to such deficits or symptoms (Rose, 1990). This direction also de-emphasizes clients' possible ways of conversationally working with therapists to address those circumstances Szasz (1961) long ago referred to as problems in living.

The 'diagnose and treat' discourse of the DSM-V and its evidence based interventions could approximate what Deleuze and Guattari (1987) referred to as a machinic assemblage, or

what Agamben (2009), building on Foucault, has referred to as an apparatus. Inside an

assemblage or apparatus is an enclosed and predictable way of making sense, and of responding

to experience – a potential predicament of 'discursive capture' (Massumi, 2011). An attractive

way to map human concerns and responses to them for health care financers and administrators,

the DSM-V, relative to previous versions of the DSM, is an expansionist discourse. More human

concerns, bereavement for example, have been targeted for DSM-V medicalization, prompting

widespread criticism, including vociferous opposition from former DSM-IV Chair, Allen

Frances (e.g., 2012). What makes DSM-V's ways of medicalizing human concerns apparatus-

like relates to how it dominates the understandings and practices of those taking up its discourse,

and the exclusory ways by which alternative understandings and practices can go intolerated. For

example, I once participated in a case management meeting where I commented on one clients'

resources and relations, only to be told by case manager that such suggestions put me in the same

league as geographers who similarly had no role to play in such circumstances. Inside such an

apparatus, particular understandings and practices are required; deviation from them seen as

being unscientific or in other circumstances, heretical.

　　Centuries ago, the philologist, Giambattista Vico (2001/1744) shared his concerns about

orthodoxies developing over a Newtonian/Cartesian (i.e., machinic) view of being human.

Where the latter view purportedly promised ultimate, God's-eye understandings of humanity,

Vico saw different forms of common sense, differently shared ways by which people lived and

understood. For Vico, any form of common sense can acquire what he called linguistic poverty

that could only be overcome by poetic wisdom; the kinds of resourceful and innovative uses of

language familiar to constructionist therapists. Many of us can empathize with Vico's position.

The zeitgeist of his time was animated by the promise of an Enlightenment science which could

properly name experience then run it like clockwork (Dolnick, 2012). While the DSM-V and its related evidence-based interventions don't offer 'clockwork', both purport to deliver on a similar promise; in this case, of scientifically addressing human concerns. For DSM-V advocates, alternatives to this discourse can seem unscientifically quaint; administratively subversive, professionally questionable, and so on. Narrative therapists talk in stories and discourses while science-informed therapists practice using calculable diagnoses and treatment protocols. Despite narrative and other constructionist therapists' empathy for Vico's concerns about overcoming linguistic poverty, it can seem daunting to propose poetic wisdom when the DSM and evidence-based discourse promises so much. The DSM discourse can also estrange language from people's lived experiences, as suggested by the critical historian of psychology, Kurt Danziger: "The more uncompromising psychologists became in their exclusive commitment to the requirements of scientific language the more impoverished their descriptions became, at least from the point of view of ordinary usage" (1997, p. 192).

Associated with linguistic poverty is a concern best expressed in a binary: are we users of, or used by language? For the most part people use the languages they live by in unquestioned ways, and these languages usually and effectively help us negotiate the circumstances and relationships where we put it to use. A kind of taken-for-granted inertia can develop as we use language over time – and this is precisely where language can use us, as we are swept along by past meanings or uses of language. Linguistic poverty occurs when language uses and fails us in our ongoing negotiations with new people and circumstances. It is also the case that words and what they are intended to represent invariably fail to capture any experience in its totality. There is always more to be said about an experience (Ricoeur, 1976). For dialogue theorist, Mikhail Bakhtin (1981), we have to 'people' our words with our intentions to keep them alive in the

negotiations and other dialogues where we put them to use. Of course, these negotiation

challenges and failures are not only about words; how we use words matters also. A scientific

language of bereavement would seem impoverished would it not? Yet, DSM-V will offer more

psychiatric terms, and corresponding evidence-based interventions (including drugs).

<div align="center">Responding to the DSM-V?</div>

whenever worlds are laid on, underlives develop (Erving Goffman, 1961, p. 305)

Therapists have not been quiet about the DSM-V. Official statements and petitions

have come from groups as varied as the American Counseling Association, the American Family

Therapy Academy, The Humanistic Psychology Division of the American Psychological

Association (see their widely circulated petition: http://www.ipetitions.com/petition/dsm5/) , and

others. Scientific concerns about DSM-V even merited comment in those most prestigious of

scientific journals, *Nature* (Ledford, 2011) and *Scientific American* (Jabr, 2012). The

professional responses have largely focused on the medicalized direction of DSM-V and its

associated evidence based interventions. Some of the concern relates to how moves in this

direction may further marginalize those approaches to therapy that are not consonant with the

medical assumptions associated with DSM-V. Certain approaches to therapy for concerns that

cannot be translated to a DSM-V formulation are frequently de-listed as fundable ways of

helping clients. As well, the coupling of DSM diagnoses with evidence based interventions has

translated to a new kind of micro-management or rationing of therapy: diagnosis X requires 3

sessions of treatment Y. A broad cross-section of the therapist community has been vocal about

the DSM-V and where it may take therapy.

This said, a common practitioner discourse (e.g., Strong, et al, 2012) is that DSM

diagnoses are helpful in translating clients' concerns into symptoms for publicly or privately

funded treatment. Behind such a discourse is an assumption that the DSM is benign, that

practitioners can continue to practice their various forms of therapy irrespective of diagnoses and

the treatments scientifically prescribed for addressing them. Seen this way, practitioners doubly

describe problems: 1) using DSM terms for supervisors and administrators, and 2) using

variations on descriptions such as 'sneaky poo' (White, 1984) for clients who seek plausible,

empowering names for their concerns. This is the kind of double-entry thinking and practice

warranted a special issue in the *Journal of Contemporary Psychotherapy* (Moses, 2000). What

are the professional and everyday ethics of such poetic practices when the systems and

institutions enabling such practices conduct their business in scientific prose?

   The DSM can be seen as a single discourse of helping among many provided that

administrators and fee-payers are fine with it being used that way. However, the DSM

terminology, and use of 'corresponding 'evidence-based interventions has always been seen as

enabling cost containment, training and supervision of therapeutic practice (Rogers &

Wupperman, 2007; Sharfstein, 1987). It also enables a kind of Foucaultian governance of

treatment fidelity (Tucker & Blythe, 2008) - that practitioners are diagnosing clients <u>correctly</u>

and following up with evidence based treatments <u>appropriately</u>. Such views of correctness and

appropriateness follow from DSM-V's prosaic assumptions, enabling therapy to be conducted

and administered 'by the book'.

   Narrative therapists practice from different assumptions, often seeing their conversational

work with clients as helping clients recognize, resist, and overcome forms of 'discursive capture'

(Deleuze & Guattari, 1987; Winslade, 2009). Any discourse affords some possibilities for living

and conversing while constraining others. DSM-III enabled recognition, treatment, and

compensation of Viet Nam war veterans who met the symptomatic criteria of Post Traumatic

Disorder, for example. 'Discursive capture' occurs when a single prescribed discourse affords linguistic poverty (Vico, 2001) for those living by its prose. Intercultural concerns also extend to the cultural over-reach of DSM-V as presumed universal discourse of mental health marginalizing local cultural helping practices (e.g., Watters, 2010). Constructionist (including narrative; Lock & Strong, 2012) therapists tend to engage clients in conversations that usurp any problem discourse's dominance; eliciting and mobilizing instead resourceful discourses of possibility.

At a minimum, narrative therapists can continue to converse with clients using Bateson's (1980) notions of 'double description' that were later adapted by Michael White (1986) in ways that informed narrative therapy. While clients typically present their concerns in one descriptive discourse, therapists have responded in others that, for the therapist, present more possibilities associated with their expertise. Narrative therapists, however, tend to converse from an ethic of collaboration as they do this double-describing of concerns. The names and discourses brought to defining and overcoming concerns are negotiated between therapists and clients in ways intentionally befitting the experiences and preferences of clients (e.g., Madsen, 1999). Therapists can also deconstruct diagnoses, along with diagnosis as a professional practice, with clients (e.g., Parker, 1999). They can also explore what any diagnosis leaves out of clients' understandings and yearnings (Strong, 2000). Whether continuing such conversational practices will be accepted by funders and administrators beg a different level of conversation.

The controversies associated with the development of DSM-V, and its coupling with evidence-based practice, have largely focused on the medical discourse it furthers. Less prominent in the discussions have been considerations of the DSM as an administrative discourse - particularly in a prolonged era of fiscal accountability (Johnson, 1995; Linton, et al, 2008).

Within academic and professional contexts there has been intense ambivalence over this medicalized direction; with many therapist-researchers embracing the evidence based direction DSM enables. Elsewhere, academics and practitioners have railed against the exclusory consequences of moving in this direction. Meanwhile, the public tries to make sense of DSM diagnoses and what they and professionals must do to address them (e.g., Greenberg, 2010). Whole traditions of practice (e.g., systemic, narrative, existential, feminist) are incompatible with the medicalised direction of the DSM and evidence-based practice (Eriksen & Kress, 2005). Seeing problems as occurring between people, or as problems outside of people to be overcome, is different than diagnosing deficits and pathologies for treatment inside them. Different kinds of science and evaluation are called for with these non-medicalised approaches (e.g., Harper & Thompson, 2012), despite traditional science and evaluation repeatedly showing that clients' concerns are best addressed by a good quality relationship with helping professionals (e.g., Hubble, et al, 1999). As the professional and scientific communities cry out about DSM-V, the coziness between its developers and 'big Pharma' still grows (cf., Angell, 2011).

It is unlikely that the pluralism evident across our many forms of professional helping will be overtaken by a single medical discourse for diagnosing and treating human concerns (Cooper & McLeod, 2010). This is despite the strong rhetorical and administrative pull of such a medical discourse promising to minimize and manage the intrusion of concerns into human existence. Therapists continue to talk their ways around the DSM and evidence-based practice. They also go underground in their conversations with clients as therapy becomes increasingly rationed according to diagnosed condition and use of evidence based treatments (Cushman & Gilford, 2000). What therapists have inadequately responded to, however, are expectations to justify their services to their fee-payers – for using other discourses of practice.

Part of my choosing to return to academic life was based on the medicalized direction in therapy that I have raised concerns about here. While perhaps a convenient yet politically divisive prescription (see Hallward, 2005) for rationally administering therapists' dialogues with clients, the DSM-V, like its DSM predecessors, invariably becomes linguistically impoverished. The chief responses to it have been to find ways to ignore it, or take it on in charged professional and scientific politics. The presumption that social science or its perceived applications (like therapy) is best practiced in a single discourse evaluated by a single set of criteria strikes the average constructionist or poststructuralist therapist as outrageously outdated. However, countering the DSM, while it continues to dominate many aspects of professional helping, seems beyond contest. Therapists feel impotent to challenge the science that purportedly supports the dominance of the DSM and its evidence-based interventions. They also can be intensely ambivalent about still being able to be paid for using DSM diagnoses (cf., Wylie, 1995). Meanwhile, other ways to understand and respond to human concerns lose their currency.

My hope, as therapists go forward, is to respond to the same kinds of concerns that have animated DSM development. How can we better show clients that their conversations with us – those that don't use DSM diagnoses – can succeed in addressing their concerns? What is it that we want the public to better understand about our conversational work with clients, so as not to default back to a medicalized idea of what we do? How can we get fee-payers to recognize that our work can make differences in clients' lives? Presently, questions such as these have seemed best addressed by DSM kinds of science, while narrative and other constructionist therapists resist or at least struggle with the results. We need to better make our case using our poststructuralist science and ways of practice.

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