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## Counsellors Respond to the DSM-IV-TR Les conseillers répondent au DSM-IV-TR

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### ABSTRACT

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) is an administrative fact for many counsellors. This psychiatric approach to formulating client concerns runs counter to those used by counsellors of many approaches (e.g., systemic, feminist). Using an online survey of counsellors ( $N = 116$ ), invited contributions to a website blog, and in-depth interviews of 10 counsellors, we sought to better understand how the DSM-IV-TR influenced counsellors' practice, and their responses to its expected use. From our situational analyses, we relate our findings to tensions experienced by counsellors when practicing from non-psychiatric approaches to practice.

### RÉSUMÉ

Le Manuel diagnostique et statistique des troubles mentaux, texte révisé (DSM-IV-TR), est devenu un fait administratif pour beaucoup de conseillers. Cette approche psychiatrique à la formulation des préoccupations des clients va à l'encontre du style de thérapie adopté souvent par des conseillers (e.g., systémique, féministe). Nous sommes servi d'un sondage en ligne de praticiens ( $N = 116$ ), des soumissions sollicitées à un blogue Web, et des entrevues en profondeur avec dix conseillers dans le but de mieux comprendre l'influence du DSM-IV-TR sur la pratique des conseillers, et leurs réponses à son utilisation attendue. Les constatations de nos analyses situationnelles sont reliées aux tensions ressenties par les conseillers dont la pratique se base sur des approches non psychiatriques.

The conversational work of counselling is inescapably shaped by the other conversations that engage clients and counsellors. At the heart of this work are specific words and ways of talking that counsellors and clients use to make differences in clients' lives. Counselling is somewhat unique as a helping profession for having so many discourses as reflected in its many theoretical approaches. Tensions can emerge over whether the field should move toward an integrated discourse and approach to practice or whether it should stay pluralistic (Cooper & McLeod, 2010). *The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - Text Revised* (DSM-IV-TR; American Psychiatric Association, 2000) arguably offers such an integrated language for talking about clients' concerns. Not only

is it used by other mental health professionals but its terminology is increasingly known by clients for having been widely circulated by the media.

However, using the DSM-IV-TR, a symptom discourse, to discuss client concerns can seem at odds with other discourses counsellors use in talking with clients, such as when client concerns are discussed in social justice, or spiritual discourses. Our pluralistic interest is with counsellors' views of the influence of DSM-IV-TR on their preferred discourses for conversing with clients.

Increasingly, psychiatric discourse from DSM-IV-TR has become the expected norm. In many settings, institutionally, professionally, and culturally, the DSM-IV-TR is used to make sense of client concerns (e.g., Watters, 2010). However, in the words of Norwegian psychiatrist and family therapist, Tom Andersen (1996), "Language is not innocent" – particularly diagnostic language that locates client concerns in psychopathologies. To professionally use DSM-IV-TR discourse requires particular kinds of conversations in counselling, in a meaning-making and problem-solving focus that can be at odds with a number of counselling approaches (e.g., feminist, systemic, narrative). In the current research we report here, we surveyed over 100 counsellors and followed up with in-depth interviews with 10 Canadian graduate-trained counsellors (i.e., who would have exposure to the DSM in their training) on potential influences they saw DSM-IV-TR having on their conversational work with clients.

Seen one way, the efforts that will culminate in DSM-V by 2013 amount to a major accomplishment. They will show broad scientific and professional consensus on how to classify and diagnose the symptoms clients present as mental disorders. Clients' concerns become understandable in language familiar to medical as well as counselling professionals. Such a shared language also enables research to occur regarding clients' mental disorders and helps identify the interventions that can succeed in treating such disorders. From the perspective we are taking in this article, the DSM-IV-TR is one socially constructed discourse (Potter, 1996) among others, despite the science that has gone into its construction. However, the DSM-IV-TR is increasingly being taken up as the dominant discourse by administrators of counselling (e.g., Eriksen & Kress, 2005; Linton, Russett, & Taleff, 2008) while the profession continues its pluralistic tradition (Cooper & McLeod, 2010).

Consensus on what people need to talk about when they come to counsellors has been a source of considerable discourse itself. Discursively speaking, counselling can seem like a Tower of Babel, given its hundreds of approaches, each with a discourse for making sense of and addressing clients' concerns (Miller, Duncan, & Hubble, 1997). In a provocative reflection on a single therapeutic development at a videotaped case conference meeting, psychiatrist and early therapeutic discourse analyst, Albert Schefflen (1978), highlighted very different ways that counsellors described understanding and relating to a client's smile, reflecting their different theoretical approaches. Each participating counsellor accounted differently for the smile, with corresponding thoughts of how to intervene consistent with each account. For some, such anecdotes illustrate the downside of counselling's

diverse traditions and approaches, a downside that science could address. While some champion unitary languages, like the DSM, for counselling (e.g., Seligman, 2004), others advocate pluralism (Cooper & McLeod, 2010).

Despite considerable interdisciplinary effort to reflect contemporary concerns, the science of DSM development has been contested. Developing as a discourse for client symptoms largely within psychiatry, the science and politics of DSMs I (American Psychiatric Association, 1952), II (American Psychiatric Association, 1968), III (American Psychiatric Association, 1980), III-R (American Psychiatric Association, 1987), IV (American Psychiatric Association, 1994), IV-TR (American Psychiatric Association, 2000), and V (anticipated in 2013) has featured many controversies.

The Chair of the DSM-IV Task Force, Allen Frances (2011), has been an outspoken critic of the process that promises DSM-V. But, traced historically, huge debates have been resolved through votes on such things as replacing the presumed psychodynamic etiology of mental disorders, removal of homosexuality as a mental disorder, through to more contemporary efforts to advocate for inclusion of such concerns as “post-abortion” stress disorder.

Paula Caplan, a Canadian psychologist, wrote disparagingly in *They Say You're Crazy* (1996) of her insider experiences serving on one of the DSM-IV committees devoted to classifying personality disorders. Of course, people outside the counselling professions have put forward their views (mostly negative) as well, such as in two recent books, *Globalizing the American Psyche* (Watters, 2010) and Gary Greenberg's *Manufacturing Depression* (2010), in which Greenberg refers to the DSM as “a language tethered to itself” (p. 79). For a broader sense of how discourse and counselling become intertwined with cultural developments over time, readers will be well served by Philip Cushman's (1995) *Constructing the Self, Constructing America: A Cultural History of Psychotherapy*. The main concern raised by these critiques of the DSM's development relate to whether the conversational practice of counselling is actually better served by a single discourse, like DSM-IV-TR or DSM-V.

As the world's many languages demonstrate, there are different ways to understand, relate to, and talk about what, at first consideration, would be common experiences. This extends to how people within particular discourse communities make sense of such life phenomena as gun control, spirituality, and even depression. Inside counselling, systemic counsellors understand and approach their conversational work with clients quite differently than would psychodynamically trained counsellors, gestalt counsellors, or cognitive behavioural counsellors.

To a systemic counsellor, clients' presenting concerns arise in patterns between people, not inside them as expected in a DSM focus on psychopathology (Crews & Hill, 2005). Ethically and scientifically diagnosing a client's concern to arrive at a DSM-IV diagnosis is more than a semantic or descriptive exercise. A particular kind of conversational work is involved, conversational work that may be at odds with the kind needed, for example, to discuss social justice or problem-solving issues clients are facing (Eriksen & Kress, 2005; Townsend, 1998). For discourse

analysts, differences in and over language use are a feature of our cultural lives. What matters are discourses that come to dominate social interactions, and what therefore gets left out of such interactions (Fairclough, 1995).

Professionally and institutionally, the discourses used by counsellors can be important. Scientific controversies notwithstanding, the DSM-IV-TR offers mental health administrators a means to classify and compensate the conversational work of counsellors (Danzinger & Welfel, 2001; Linton et al., 2008). However, with these means come concerns about counsellors being able to converse about concerns in other ways with their clients (Miller, 2004), even to the point of deceiving administrators and fee payers (e.g., Moses, 2000). When the particular kind of conversational work required to diagnose problems is coupled with the protocols of manualized, evidence-supported interventions, counselling's conversations have the possibility of coming across as overly scripted (Hansen, 2005; Strong, 2008).

As yet, Canadian counsellors and psychotherapists have not found consensus on their discourses of practice, or on the DSM-IV-TR. South of the border, the American Counseling Association (ACA; 2011) recently struck its own task force on the DSM-5 and from a press release of November 28, 2011, indicated:

According to Rebecca Daniel-Burke, staff liaison on the ACA DSM task force, "in general, counselors are against pathologizing or 'medicalizing' clients with diagnoses as we prefer to view clients from a strength-based approach and avoid the stigma that is often associated with mental health diagnoses." (para. 7)

Similarly, the 2011 British Psychological Society Division of Counselling Psychology Conference was titled "Celebrating Pluralism in Counselling Psychology?," a title reflecting the ambivalence of its members on approaches to counselling. Currently, the Canadian Counselling and Psychotherapy Association (CCPA) makes no mention of diagnoses in either its Code of Ethics or in its Accreditation Standards document (CCPA, n.d.). Furthermore, CCPA (n.d.) cites no requirements for using DSM-IV-TR diagnostic categories, and instead advocates the following pluralistic stance:

counselling theories that provide the student with a consistent framework to conceptualize client issues and identify and select appropriate counselling strategies and interventions. Presentation of theories should include the foundations of their development; their cognitive, affective and behavioural components; research evidence for their effectiveness; and their application to practice. Theories presented should reflect current professional practice. (para. 12)

A lack of consensus among counsellors on discourses of practice, including on how a symptom discourse like the DSM-IV-TR should guide counselling, seems the norm for our profession.

However, while many counsellors persist with a pluralistic stance on practice, this stance is not always compatible with administrative and fee-payer requirements, as a growing literature attests. Counsellors have responded to these incompatibilities in various (and questionable) ways, including the following:

(a) by adapting dialogue with clients to include relevant gender, social justice, and cultural concerns (Crethar, Rivera, & Nash, 2008; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008); (b) “deconstructing” such diagnoses with clients (Parker, 1999); (c) colluding with clients to provide adequate diagnoses required for funded treatment (Moses, 2000); and (d) ignoring funder prescribed interventions (e.g., Wylie, 1995).

While the DSM-IV-TR has been increasingly featured in the discourse of counsellors and counselling administrators, and even in client discourse, our interest is with how counsellors have been influenced by and respond to possibly expected use of the DSM-IV-TR in their counselling. We were curious how counsellors manage possible tensions associated with different administrative, collegial, and client expectations regarding the use of DSM-IV-TR.

## METHOD

### *Recruitment*

We wanted to hear from counsellors beyond our anecdotal experiences and the positions on the DSM and counselling taken in the literature. To this end, and following ethics approval at the University of Calgary, we developed a website of resources for counsellors (<http://www.ucalgary.ca/ddsm/>) that included a discussion forum where visitors could share their experiences and responses to DSM. We also developed an electronically accessible survey (SurveyGizmo, see Appendix A) that we sent, embedded within an accompanying e-mail message, to members of the CCPA, the Canadian Psychological Association’s Counselling Psychology’s section, the Taos Institute Associates (<http://www.taosinstitute.net/>) electronic mailing list, and to colleagues of this article’s primary author. The survey included a mix of closed and open-ended questions.

Recipients of our e-mail recruitment message were encouraged to forward the e-mail and its survey link to other counsellors, an online equivalent to snowball sampling (Finlay & Evans, 2009). Finally, in the electronic survey itself, we included an item where Canadian counsellors interested in participating in a telephone interview of between 40 and 60 minutes could indicate their interest. We followed up by telephone with this smaller group of Canadian counsellors using a semistructured interview (see Appendix B). These latter interviews were audio-recorded and transcribed for analysis.

### *Sample*

Between November 2010 and February 2011, 116 counsellors responded to our electronic survey, 62% of whom were Canadian, 20% American, and 18% from other countries. Respondents came from a mix of counselling professions (6% identifying as social workers and family therapists), though they were predominantly master’s-level counsellors, with 36% holding doctoral degrees. The majority of respondents (68%) indicated more than five years of practice; 55%

of respondents indicated that they were in private practice, 26% practicing in educational contexts, 17% in public mental health facilities, 23% in not-for-profit agencies, and 17% in group practice arrangements. Survey respondents also self-identified as preferring to practice from a range of counselling approaches.

Counsellors identified over 15 counselling approaches; the top three mentioned were client-centred therapy, cognitive-behaviour therapy (CBT), and narrative therapy (listed in descending order). Most germane to our research were the responses about the extent to which counsellors were expected to use DSM diagnoses in their conversational work with clients. Only 8% of counsellors indicated expected use of DSM diagnoses, while over one third indicated that they were not expected to use DSM. Over one third indicated using these diagnoses “some of the time.” No assessment was done of participants’ prior training or supervision in the use of the DSM. Although all participants held master’s and doctorate degrees in psychology, social work, or family therapy, registration and licensing were not assessed.

Ten Canadian self-selected (i.e., on our electronic survey) counsellors participated in follow-up semistructured interviews to the electronic survey. Interviews were approximately 45–60 minutes long and took place over the phone. The aim of these interviews was to elicit participants’ elaborations on experiences and opinions related to the influence of the DSM on their conversational work with clients, and their responses to any expected uses of the DSM. The online discussion forum contributions were unstructured and took up a variety of themes of interest to contributors.

### *Procedures*

Survey respondents’ open-ended answers and website discussion forum comments were copy/pasted to a single Word document, and then were added to the transcribed interview responses that were also aggregated in a Word document. By including all our data—from website discussion forum postings, survey open answers, and interview responses—in an aggregate textual representation in one Word document, our aim was to “map out” the diverse experiences and responses of counsellors using Clarke’s (2005) situational analysis.

## ANALYSIS

Situational analysis is described by its developer, Adele Clarke (2005), as a post-modern response to the grounded theory method of research originally developed by Glaser and Strauss (1967). For postmodernists like Clarke, no single account can ultimately explain experiences or phenomena as complex and diverse as those, in our case, of counsellors’ experiences of and responses to DSM diagnoses. From this perspective, a “situation” can be described as an area of interest that “is always greater than the sum of its parts because it includes their relationality in a particular temporal and spatial moment” (Clarke, 2005, p. 23). Clarke’s approach is, therefore, focused on mapping out diverse elements relevant to situations of

research interest, avoiding a reductive, thematic account that purports to capture how things really are.

Our sense, in advance, was that counsellors' experiences and responses were anything but homogeneous when it came to the DSM. So, while we looked for commonalities in what our participants said across their survey responses, discussion forum comments, and interview answers, we also wanted to reflect the diverse positions counsellors take up with respect to the DSM in their counselling. We want to emphasize that we see these discursive positions as fluid and dynamic; counsellors can act from different discourses (or be of "different minds," Harré & van Langenhove, 1999) in how they relate to such aspects of their work with clients. What analytically matters for us are the tensions and degrees of tension counsellors indicated they experienced between these positions. Such tensions cannot be well captured by grounded theory analyses (e.g., Glaser & Strauss, 1967) that focus on common thematic elements in the data.

Another postmodern facet of situational analysis (SA) is the acknowledged role that interpretation and discourse play in researchers' accounts of any complex situation under study. Thus, a challenge for the situational analyst is to map out diverse elements of a situation, enough so that actors in that situation (in our case, counsellors) can recognize complexities in the situation as they experience it. This challenge extends to mapping, or making evident, relevant, yet taken for granted, features of the situation. Accordingly, SA was used in the present study to map the complexities associated with how DSM features in counsellors' conversational work with clients.

#### RESULTS: MAPPING THE DSM'S INFLUENCE ON COUNSELLORS

Aggregating all our textual data sources (e.g., website discussion forum, survey responses, transcribed semistructured interviews, and positions found in the counselling and research literatures) enabled a "messy" starting place from which we could map out details we and our respondents reported as relevant to how the DSM features in counselling. It was assumed that each one of those relevant details played a role within the "situation" our question was opening up. For Clarke (2005) a messy map of such details precedes an ordered map developed by the researchers, according to their interpretations of how details are initially best grouped or thematized. Metaphorically, each relevant detail that goes into a messy map is like a note placed in a box with the others, and once all details are in the box, the box itself is turned over on the floor to yield a mess of noted details awaiting some form of interpretive ordering. For example, our messy map contained certain professions as elements having some influence within the situation: psychiatry, counselling, clinical psychology, and social work, among others. Hence, "professions" was one category we used to bring some order to the initial messiness. Other major human, nonhuman, discursive, and other elements were grouped into further categories (Appendix C). These ad hoc categories represented other sources of influence such as "Practices," "Legal Processes," "Academic/

Professional Discourses,” or “Moral/Cultural Issues.” From our initial messy, and then ordered, situational map, we developed two relational maps: a map of how counsellors’ practices were influenced by the DSM and a map of how counsellors creatively responded to expected uses of the DSM (Appendix D). We move next to describe how we constructed these relational maps as a middle analytical step toward developing positional maps.

Our situational map (Appendix C) spatially and thematically depicts the relevant factors we could identify from our different data sources. However, mapping out the relevant factors influencing DSM use was only a step toward better understanding the complex relations between such factors as they related to counsellors’ practice. Knowing, for example, that a counsellor’s use of DSM is shaped by such factors as their theoretical orientation, their legal or administrative responsibilities, or their moral or cultural views says little about the interplay of these factors with respect to their DSM use. In using this postmodern research method, we were also interested in getting a better sense of that complex interplay, including tensions, between such factors.

Our relational maps aimed to describe such complexity by depicting connections (represented in lines) between elements talked about by participants in our data. We constructed two relational maps by drawing lines when any participant (at least one) connected two or more elements in their accounts of the following: (a) how DSM discourses influenced their practice (Relational Map 1), and (b) how counsellors creatively responded to such influences (Relational Map 2). A simplified version of our Relational Map 2 is shown in Appendix D. The lines between elements represent, for instance, how (one or more) participants talked about the relationship between the use of diagnosis and professional validation, or how participants noted the impact of diagnosis in professional efficiency.

Consistent with Clarke’s (2005) postmodern approach, we see participants’ ways of relating to the DSM-IV-TR as complex, and not worth reducing for obscuring those complexities. A counsellor could hold two or more positions on the DSM-IV-TR, for example: (a) that for some clients the DSM was a good thing for enabling medical service, and (b) that DSM was generally problematic for offering a medicalized language of counselling. Therefore, we developed what Clarke calls *positional maps* to portray such differences in positions—differences a participant might voice, or differences across all our participants. Again, our aim was not to reduce or homogenize the voices of our participants into a thematically coherent account, but to convey differences in positions on a complex topic. Hence, our interest was to map discursive positions and tensions counsellors reported with respect to the DSM-IV-TR: (a) its influence on their conversations with clients, and (b) how they responded to these influences. Participating counsellors indicated feeling torn between such positions, but to varying degrees. We present two positional maps to depict these two aspects mentioned above (Appendix E for DSM-IV-TR influences on practice; Appendix F for counsellors’ responses to those influences). Each positional map is indicated by the question shown in the centre of the map. The rectangular boxes indicate discernible positions counsel-

lors reported to us. In the Influences Positional Map (Appendix E), readers find a range of these positions:

1. “Detrimental influence” refers to how using the DSM can be potentially harmful for clients.
2. “Helping clients understand medical/psychiatric discourse” refers to how the DSM represents a psychiatric discourse that needs to be understood in clients’ own terms.
3. “Sidestepping” and “Minimal influence” speak to using DSM diagnoses minimally.
4. The positions “Complying with administrative requirements,” “Coordinating care services,” and “Legitimizing resources” describe how diagnoses help administrators and practitioners legitimize and respond to client concerns with appropriate psychiatric and other resources.
5. “Planning treatment” refers to a diagnosis seen as an organizing construct for the interventions that followed.
6. “Part of the assessment process” points to how DSM diagnosing was an expected part of how counsellors were to articulate client concerns.
7. “Accepting mainstream ideas on mental health” refers to accepting and working with clients’ self-diagnoses in DSM-IV-TR terms, that clients adopted from mass media or past work with mental health professionals.

The Responses Positional Map (Appendix F) is similarly configured. We articulated various positions we saw participants engaged in, which we list below:

1. “Stating theoretical/practice orientation” refers to how counsellors would describe their ways of practice vis-à-vis expected use of DSM diagnoses (e.g., a narrative therapist seeing this as a dominant, problem-saturated story).
2. “Exploring and choosing diagnoses” refers to a collaborative practice of relating clients’ symptoms to plausible diagnoses agreeable to client and counsellor.
3. “Being part of collaborative communities” speaks to counsellors using DSM diagnoses to interact with psychiatrically oriented colleagues, while perhaps relating to this formulation of the client’s concern differently in other contexts of practice.
4. “Parts of the puzzle” indicates a position whereby a psychiatric diagnosis becomes one piece of a more comprehensive understanding of a client’s concern.
5. “Being proficient” involved counsellors demonstrating competence with this discourse of practice (while not sticking exclusively with a psychiatric discourse of practice).
6. “Having multiple faces” exemplifies positioning (Harré & van Langenhove, 1999) insofar as counsellors reported having to “talk DSM” with their psychiatric colleagues, while using other discourses and ways of describing client concerns with colleagues and clients.

7. “Making space for clients’ voices” involved conversational input from clients on the aptness they felt with DSM diagnoses articulating their concerns and to gain their input on other articulations of those concerns.
8. “Elaborating on meaning” referred to going past the “thin description” (White & Epston, 1990) offered by a diagnostic label, to hear more from clients about the experiences behind such a way of naming their concerns.

As we illustrate below, both maps capture a range of positions with respect to how counsellors described being influenced by the DSM-IV-TR in their practice, and how they responded to such influences. Our arbitrary distinction of influences from responses brought lots of discussion, as there were clear overlaps between comments about “influence” and those about “response.”

The positional maps we have been describing not only map out the different positions we could thematically discern from counsellor comments; they can also be used to depict strong and weak tensions between such positions. For example, a counsellor presented with a child who is acting out may diagnose them with oppositional defiant disorder while systemically responding to such disorder by working with the family on problematic ways of relating (i.e., by parents as well as the child). In this case, the counsellor may be influenced by a variety of discourses on his or her practice that could represent very different perspectives on counselling. These different perspectives are presented in the Influences Positional Map (Appendix E), which shows some of these perspectives and how these played out in how participants talked about their practice.

In the Influences Positional Map, we organized the different positions we could discern from counsellors’ comments from the interviews, surveys, and blog according to how these related to each other with different degrees of tensions. We named “strong tensions” the relationships between positions that seemed to be further away from each other for what these positions seemed to represent for counsellors. A strong tension could be described as relating a position in agreement with the utilization of a DSM diagnosis to guide the relationship between a client and counsellor, with a position that would reject the idea of a predefined manual guiding a counselling practice.

In the Influences Positional Map, readers find two positions (“Planning treatment” and “Sidestepping”) with a bigger arrow indicating a stronger tension between them than found between other positions (e.g., between “Helping clients understand medical/psychiatric discourse” and “Minimal influence”). This bigger arrow refers to how a number of counsellors indicated feeling torn between being expected to use DSM-IV-TR to guide treatment planning and preferring to use approaches to treatment that did not follow this way of formulating client concerns. As an illustration, in one interview a participant indicated that s/he used the DSM because it helped him/her “to diagnose a patient and planning for treatment ... it guides decisions around orientations, narrows down focus more easily....” Such a position (i.e., “Planning treatment”) seemed in strong tension with the position “Detrimental influence” (e.g., an interviewee claiming that

while working at a mental health facility, s/he was supposed to diagnose clients in order to offer them treatment—a practice regarded as “detrimental to therapy”). Similarly, Appendix E illustrates how a position such as “Planning treatment” (e.g., in which practitioners are supposed to use dialectic behavioural therapy if they give a personality disorder diagnosis) is in tension with a position in which practitioners use a broad diagnosis (e.g., DSM-IV-TR 309.9) to assure that services are provided to clients (“Legitimizing resources”).

In our Responses Positional Map (Appendix F), we describe the tensions we saw between different positions in how participants creatively responded to DSM influences. For example, in the position we identified as “Parts of the puzzle” (i.e., being part of a bio-psycho-social team), a participant stated, “Everyone kind of knows what part of the healing practice we are in with the client.” This position seemed to be in strong tension with “Stating theoretical/practice orientation,” a position in which participants described their responses to DSM influences by taking a clear theoretical stance. For example, a participant indicated “my beliefs about the DSM often do not fit ... I have to find a way to practice ... and still respect the other professionals involved” (see Appendix F for further examples about counsellors’ embodied tensions between discursive positions).

#### DISCUSSION

“I work with clients to choose their own diagnoses ... we can call you a this or a this.” (Survey participant)

Our aim in this study has been to examine the diverse ways counsellors are influenced by and respond to the DSM-IV-TR in counselling. We do not claim a representative sample of counsellors in what we report, but we feel that the input of our participants, in the context of the general controversies stirred by the DSM-V’s development (e.g., Frances, 2011), merit reader consideration. From participants’ responses to surveys, our website discussion forum, and telephone interviews, we mapped out complexities associated with DSM use in participants’ conversations with clients in counselling. However, these conversations on using DSM-IV-TR diagnoses do not stop in the consulting room; they extend to counsellors’ conversations (sometimes through their paperwork) with administrators and funders, conversations with the public, and conversations in professional journals like this one. While expectations that counsellors use DSM diagnoses in this conversational work are growing (Eriksen & Kress, 2005), so too are concerns of practitioners who see their intended ways of counselling at odds with the psychiatric discourse of the DSM (Hansen, 2005; Strong, 2008). Therefore, in this study, we wanted to hear how counsellors viewed the DSM as a possible influence on their ways of practice, and to learn about their responses to the DSM when such use was expected.

Anticipating that there would be no single story to be told about counsellors and the DSM, we elected to map out differences and tensions in what they told

us, using Clarke's (2005) situational analysis (SA). The counsellors responding practiced in a variety of contexts using diverse approaches, so, unsurprisingly, they experienced and responded to the DSM in anything but a uniform manner. Using SA helped us to identify elements in what counsellors told us about how they were influenced by the DSM, and how they chose to respond to its influence. By mapping out those elements, and the relations between them, we were able to identify diverse positions and tensions between them, which might have gone obscured by a single account.

A range of positions on the DSM and counselling became evident to us through the kinds of self-identifications and comments that counsellors made in our survey, discussion forum threads, and interviews. Many respondents (36%) were not expected to use the DSM, and others found it unproblematic to reconcile their approaches to practice with expected use of DSM. However, for practitioners of some approaches (most notably systems, narrative, solution-focused, and feminist), the expected use of the DSM was problematic in a number of ways. Some counsellors even reported choosing to practice in ways inconsistent with the intent behind expected uses of DSM. The upshot, from our respondents, would be that DSM is neither expected across all contexts of practice, nor—when it is expected—adhered to, as a form of conversational work with clients. Despite an increasing medicalization of counselling (Hansen, 2005) reinforced by fee-paying and administrative requirements (e.g., Cushman & Gilford, 2000; Miller, 2004), our respondents mostly indicated that their conversations with clients had not been “hijacked,” or overtaken, by expected use of the DSM's psychiatric discourse (Strong, 2008).

Counsellors engage in quite varied conversations to formulate the concerns clients present to them, in ways consistent with their approaches. This kind of conversational work—such as narrative therapy's practice of reauthoring problem stories (e.g., White & Epston, 1990)—can be at odds with recent efforts to standardize conversations required to properly diagnose clients' psychiatric symptoms (Nienhuis, van de Willige, Rijnders, de Jonge, & Wiersma, 2010).

When expectations for DSM diagnoses are coupled with expectations to use evidence-based interventions, a counsellor's ability to practice according to models incompatible with such a conversational approach can pose ethical or administrative dilemmas (Danzinger & Welfel, 2001; Eriksen & Kress, 2005; Moses, 2000; Wylie, 1995). Hallward (2005) referred to this in an article titled “The politics of prescription” to underscore how selective views and practices of science can be used to delegitimize some forms of professional practice while exclusively legitimizing others (cf. Larner, 2004). So far, it would appear counselling has managed to avoid such politics of prescription, despite the seemingly rational and administrative order that using the DSM could bring to counselling (House, 2005).

There are different implications regarding what all of this means for counsellors and counsellor training. If the aim of the DSM-IV-TR was to move all mental health professionals toward a common language of practice—whether on scientific or administrative grounds—our results suggest that this aim is not being

met. Counsellors shared a diverse range of views on the DSM: everything from an enthusiastic embrace to dismissal or even subversion. Most of our counsellors were ambivalent, often on theoretical grounds or over concerns about stigmatizing clients.

Presently, students in graduate counsellor programs are exposed to theories or models of counselling (e.g., systemic, feminist, narrative) that are incompatible with a DSM formulation of client concerns. These same students do their practica in settings where expected use of the DSM may or may not be the practice norm. Seen one way, this is an issue of noncompliance, paralleling the kinds of concerns some counsellors have about resistant clients. Seen another way, it is a recognition that counselling is practiced in diverse ways for a diverse clientele—reflecting a pluralistic tradition of approaches seen as a strength by some in the field (Cooper & McLeod, 2010), and the field's undoing by others (Seligman, 2004). We take the former view and are concerned with where the latter view could take counselling as a profession.

Being informed by social constructionist theory, we do not feel that there can be a correct language for naming our clients' concerns. We see a language of health symptoms as one of the discourses we could engage clients from, but stopping there and failing to ask about issues of meaning, social context, and so on—for a focus on psychopathology—overlooks aspects of counselling we feel must be retained. Thus, we see our field as necessarily pluralist, while welcoming research and client voices on what clients find helpful.

By design and response this was a modest study that aimed to shed exploratory light on a recent development in counselling. Our situational analyses of 116 self-selecting respondents who fully responded to our survey, our discussion forum contributors, and 10 in-depth interviews offer glimmers of different positions and tensions arising as the DSM gains greater prominence in counselling's conversational work.

Our aim was not to achieve statistical representativeness but a sampling of those who wanted to speak out on the DSM. We analyzed their qualitative responses and therefore do not see our analyses as generalizable. We see these accounts as raising issues worthy of further quantitative analyses; the focus of our study was to start mapping these tensions and positions, to give readers a sense of counsellors' experiences and responses to a psychiatric diagnosis, proposed as central in evidence-based practice.

Counselling practiced from a single discourse of psychiatric symptoms, followed by scientifically supported interventions that correspond with each diagnosis, promised to modernize and unify mental health practice (Eriksen & Kress, 2005; House, 2005). However, counselling has always featured diverse ways to approach conversational work with clients, particularly with respect to how clients' concerns might be understood and addressed. As our exploratory study indicates, counsellors unsurprisingly have mixed feelings and responses to the DSM when its use is expected, and for many, DSM use is not (yet?) expected. If healthy debates about psychiatric discourse can occur about the development of the DSM-V, they can

also occur within counselling over increasing expectations that we use such psychiatric discourses of practice.

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## Appendix A

*Online Survey Questions*

- 
1. Please indicate your primary country as a counselor, therapist, or helping professional
  2. Please rank-order the three primary approaches to practice you use in helping clients.
    - Client-centered
    - Cognitive behavioral
    - Narrative therapy
    - Solution-focused therapy
    - Family systems
    - Collaborative therapy
    - Psychodynamic
    - Existential
    - Feminist
    - Hypnotherapy
    - Social therapy
    - Appreciative inquiry
  3. If you use an orientation that was not identified in the previous question, please identify it below and provide it a rank-ordering (e.g., Constructivist - 1).
  4. Since completing your graduate training how long have you practiced from the orientation(s) indicated above?
  5. What level of graduate or postgraduate training have you completed?
    - Masters plus further specialized training and supervision
    - Masters in Clinical Psychology
    - Masters in Counselling Psychology
    - Masters in Social Work
    - Masters in Family Therapy

- Doctoral degree  
Doctoral degree plus further specialized training and supervision
6. If your graduate training was not listed in the previous question, please identify it here.
  7. In what practice setting do you offer your helping services:  
Public mental health agency  
Educational setting  
Independent or Group Practice  
Private Counselling Practice or Firm  
Not-for-Profit or Community Organization
  8. If your practice setting was not identified in the last question, please identify your setting below.
  9. Please indicate the extent to which you are expected to use psychiatric (DSM) diagnoses (e.g., depression or ADHD) to meet administrative or fee-payers' requirements:  
Not at all  
Some of the time  
Most of the time  
All of the time
  10. With respect to expectations that you use DSM diagnoses in your practice, please share (in as much detail as you wish) your experiences of how these expectations have influenced practicing from your preferred orientations, if at all.
  11. With respect to expected use of evidence-supported interventions in your practice, please share (in as much detail as you wish) your experiences of how these expectations have influenced practicing from your preferred orientation, if at all.
  12. With respect to adapting to expectations that you use DSM diagnoses in helping clients, please indicate any creative ways you have adapted your approach to helping so as to remain consistent with your preferred orientation(s) to practice.
  13. Please share any further thoughts or ideas you may have about continuing to practice from your preferred orientation(s) to helping in the face of expected or anticipated requirements that you use DSM diagnoses and related evidence-supported interventions.
  14. If you practice from a social constructionist approach to practice, we are interested in hearing any further comments you might have to add to those offered above, as we would like to share your views and creative responses with other constructionist practitioners.
  15. If you are Canadian and interested in participating in a more in-depth follow-up telephone interview pertaining to the effects of DSM and evidence-supported interventions on your practice please indicate your interest by providing your e-mail address and a first name you want us to address you by below.

## Appendix B

### *Interview Questions Sample*

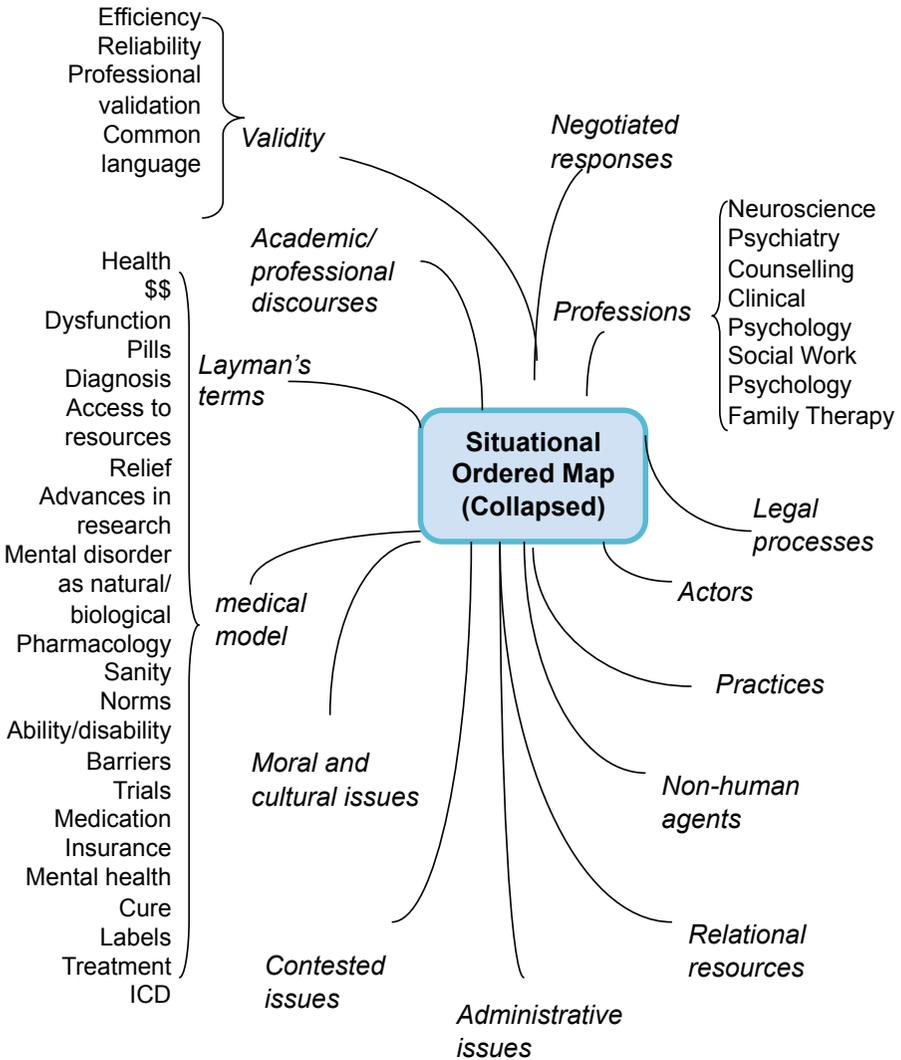
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Participants were interviewed over the phone, for approximately 30–45 minutes. A list of guiding questions was used during the semistructured telephone interviews with participants. These questions were created aiming to elicit rich descriptions from counsellors regarding their views on how the DSM and psychiatric discourses influenced (or not) their practice. The list of guiding questions is provided below.

1. Please provide a detailed sense of the context(s) in which you practice.
2. Describe the orientation from which you counsel clients. What aspects, if any, are at odds with a psychiatric discourse of practice?
3. If you have counselled for a number of years in your current context(s) of practice, what trends, if any, have you noticed toward a psychiatric discourse of practice in those contexts?
4. How, if at all, has your practice changed with those trends?
5. With respect to your orientation to counselling, how does your approach to formulating and talking about client concerns vary from, or is consistent with, the use of psychiatric diagnosing procedures?
6. Share how your practice is shaped by expected use of psychiatric discourse (e.g., diagnoses and evidence-based practices)?
7. Administratively, what specific requirements of you as a counsellor most feature in being expected to use psychiatric discourse in your work with clients (e.g., assigning clients a diagnosis, my case notes, participation in case management meetings, expected used of particular interventions)?
8. For what kinds of client concerns would you say a psychiatric approach is most/least appropriate? Explain your answer.
9. Where are your efforts to combine your preferred orientation(s) to practice most challenging? Why?
10. In what way does your employer or fee payer enable/prohibit you to practice your preferred approaches to counselling?
11. What are your views on how your professional organization, overseeing counselling practice, is addressing issues pertaining to the use of psychiatric discourse in counselling?

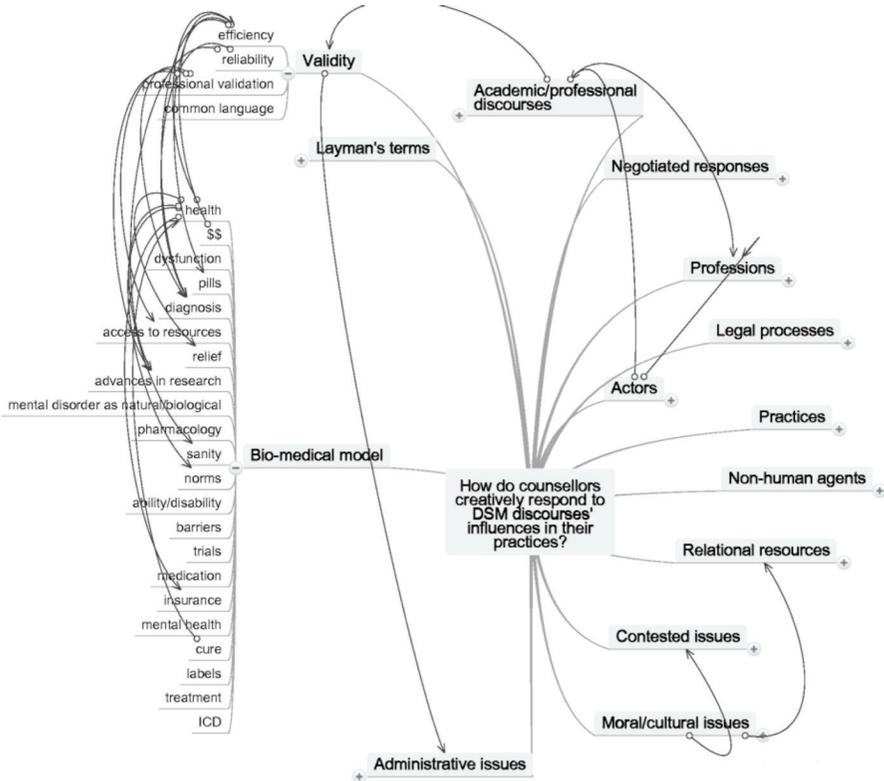
Appendix C

*Situational Map of Influences on Counsellors' Use of DSM*



Note: This is a simplified version of our situational ordered map. It shows all the categories or nodes used to group relevant elements from our textual data sources (website discussion forum, survey responses, transcribed semi-structured interviews, and positions found in the counselling and research literatures) within the situation that was previously represented in our messy map. To show the gist of our ordered map in a simplified manner, only three of these categories are expanded into their constituent elements.

### Appendix D *Responses Relational Map (Simplified)*



Note: This is a simplified version of one of our relational maps. It shows connections between categories and/or elements in the 'situation'. Such connections were made by participants/authors when addressing how they creatively respond to DSM discourses' influences in their practices. To show the gist of our relational maps in a simplified manner, only two of these categories are expanded into their constituent elements.

Appendix E  
*Influences Positional Map*

