Textual Standardization and the "Common Language" of the *Diagnostic and Statistical Manual of Mental Disorders*

by

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Abstract

This dissertation analyzes the textual standardization of discursive and pragmatic practices in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Specifically, this study examines psychiatrists' prescriptive and proscriptive discursive practices in the diagnostic manuals. This study claims psychiatrists' metadiscourse about the textual standardization of discursive and pragmatic practices in the *DSMs* as a distinct object of study. This project focuses on the textual standardization of a professional discourse community's communicative practices by asking about the ways in which the *DSMs* help to constitute psychiatric knowledge. In order to answer the question, the project examines psychiatrists' metadiscourse about style, standards, and standardization in the *DSMs* themselves, in psychiatric journals, and in journalistic coverage of the *DSMs*.

The three chapters of analysis focus on different processes and stages in the textual standardization of the *DSMs*. The analysis of psychiatrists' metadiscourse demonstrates that, in an effort to standardize disciplinary knowledge, sometimes the object of scientific inquiry in the *DSMs* is the discursive practices of psychiatrists. When this happens, the development of a professional style for American psychiatry contributes to knowledge-making because psychiatrists locate the evidence for knowledge claims in discourse structures. In addition to the many other purposes the diagnostic manuals fulfill (e.g., diagnostic, statistical, forensic, actuarial, and so on), the textual standardization of the professional style constitutes a handbook of usage, and in this sense, then, the *DSMs* are a rhetoric. A central claim of this project is that the professional style facilitates the cultural shareability and portability of the APA's "common language" across a range of rhetorical situations. The study concludes that the development of a professional style and the textual standardization of that style in the APA's diagnostic manuals are central to the discursive construction of the APA as a professional scientific society and to the discursive production of psychiatric knowledge.

Keywords: APA; common language; DSM; professional style; rhetoric of science; textual standardization

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Chapter 1.

The Development of a Professional Style for American Psychiatry

In 1999 the American Psychiatric Association (APA) began the revision process for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). *DSM-5* is slated for official release at the APA Annual Meeting in San Francisco in May 2013 (APA, 2012a). As part of the development process, in February 2010 the association published the proposed revisions to the organizational design of the classification system along with the draft diagnostic criteria for each classification on the *DSM-5* Development website and invited public feedback on those revisions (www.dsm5.org). APA President Alan Schatzberg, in his 2010 address to the membership, noted that "the website generated 41 million hits and over 8,700 substantive comments" (Schatzberg, 2010, p. 1163). On the website, under the heading "DSM-5: The Future of Psychiatric Diagnosis," the APA states that the publication of *DSM-5* "will mark one the most anticipated events in the mental health field" (APA, 2012a). The forthcoming edition of the APA's diagnostic manual provides the rhetorical exigence for this study.

This dissertation analyzes the textual standardization of discursive and pragmatic practices in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Specifically, this study examines psychiatrists' prescriptive and proscriptive discursive practices in the *DSMs.* This study claims psychiatrists' metadiscourse about the textual standardization of discursive and pragmatic practices in the *DSMs* as a distinct object of study. Thus the object of study distinguishes this project from existing studies of psychiatric discourse.

This study focuses on the textual standardization of the APA's communicative practices by asking the following question: In what ways do the *DSMs* help to constitute

psychiatric knowledge? To answer this question, I examine psychiatrists' metadiscursive and metapragmatic instructions about language standards and standardization in the *DSMs* themselves, in psychiatric journals, and in journalistic coverage of the *DSMs*. I analyze metadiscourse as a way to foreground some of the professional practices that create seemingly natural relationships among texts, contexts, and authors. These professional practices contribute to the textual standardization of the *DSMs* and the development of a professional style for American psychiatry.

I show how the textual standardization of the *DSMs* and the development of a professional style for American psychiatry results in a *handbook of usage*. In calling the *DSMs* a handbook of usage, I locate the diagnostic manuals within a tradition of texts that promote uptake of a circumscribed style that aims to resist stylistic, syntactic, lexical, and pragmatic variation. In the same way that dictionaries, grammar books, and style guides codify the written system of English, *DSM-III* and subsequent editions codify the written system of American psychiatry's professional style, which the APA calls the "common language" (APA, 1980, p. 1). In addition to the many other purposes the diagnostic manuals fulfill (e.g., diagnostic, statistical, forensic, actuarial, and so on), standardization of discursive and pragmatic practices in *DSM-III* and subsequent editions constitutes a *handbook of usage*, and in this sense, then, the *DSMs* are a rhetoric.

The analysis of psychiatrists' metadiscourse demonstrates that, in an effort to standardize disciplinary knowledge, sometimes the object of scientific inquiry in the *DSMs* is the discursive practices of psychiatrists. The data for this study show that psychiatrists' metadiscourse about the style, standards, and standardization of the classification system focus on discourse attributes as a way to constitute, circumscribe, and stabilize psychiatric knowledge in the *DSMs*. When this happens, the development of a professional style for American psychiatry contributes to knowledge-making because psychiatrists locate the evidence for knowledge claims in discourse structures. Furthermore, metadiscourse about standardization of APA discursive and pragmatic practices indexes the authority of psychiatry as a branch of medicine and the authority of psychiatrists as a community of medical specialists (clinicians and diagnosticians) engaged in standardized scientific practices. Thus, in part, the epistemic authority of the profession, that is, claims about knowledge structures, nosological principles, and

diagnostic practices derive from the textual standardization of the *DSMs* and the development of a professional style for the APA. A central claim of this project is that the development of a professional style for American psychiatry facilitates the cultural shareability and portability (Urban, 1996) of the APA's "common language" across a range of rhetorical situations.

This project contributes to research in rhetoric of health and medicine through a diachronic analysis of psychiatrists' metadiscourse about the textual standardization of the *DSMs*. The diachronic perspective forms a fundamental aspect of an analysis that accounts for context in terms of the manuals' history of discourse (Silverstein & Urban, 1996) or text trajectory (Blommaert, 2005), that is, how written discourse shapes and is shaped by prior discourse and shapes the possibilities for future discourse. Blommaert illustrates his concept with an example from psychiatric discourse that accounts for some of the ways that institutional and professional communicative processes facilitate the shifting of discourse across contexts and genres: "a patient's oral narrative is written down in scribbled notes by a psychiatrist, who then writes a (prose) summary of it and talks about it to colleagues, who in turn take notes and incorporates elements of the narrative into a published paper" (p. 255). This study uses an approach that foregrounds the *DSMs'* history of discourse and text trajectory as a way to highlight the rhetorical work of the psychiatrists who standardize the stylistic, syntactic, lexical, and pragmatic practices of a professional discourse community in published printed texts, and to show how the rhetorical acts of the psychiatrists who write and revise the *DSMs* help shape psychiatric knowledge through prescriptive and proscriptive literate practices.

This project contributes to existing scholarship in rhetorical studies of professional communication in healthcare settings, rhetorical studies examining the textual standardization of professional discursive and metapragmatic practices, and studies analyzing the entextualization and recontextualization of discourse in published printed texts. This project adopts an approach to rhetorical criticism that aims to link a systematic and fine-grained textual analysis of metadiscourse in the APA's diagnostic manuals to larger-scale claims about how psychiatrists' rhetorical acts, in this case, the textual standardization of a professional style for American psychiatry in the *DSMs*, indexes professional standards of practice and psychiatric knowledge. This study shows some of the ways that the writers and revisers of the *DSMs* create psychiatric

knowledge, in part, through the standardization of discursive and pragmatic practices and the development of a professional style for American psychiatry.

The present chapter introduces and contextualizes the project, describes the data for the study, outlines the rhetorical perspective and approach, and presents an overview of the chapters.

Historical Overview of the *DSMs*

The diagnostic manual is the American Psychiatric Association's (APA) official classification system for child, adolescent, and adult psychopathology in the United States and, increasingly, worldwide. Psychiatrists and other mental health professionals, for example, physicians, psychologists, clinical social workers, nurses, and so on, use the classification system as an assessment and diagnostic tool. To date, the APA has published four editions of the manual and two text revisions (indicated with "R" and "TR"): *DSM-I* (1952), *DSM-II* (1968), *DSM-III* (1980), *DSM-III-R* (1987), *DSM-IV* (1994), and *DSM-IV-TR* (2000). *DSM-I* contains 106 classifications of mental disorder (130 pages) and *DSM-II* (134 pages) contains 182 categories. The much expanded *DSM-III* (494 pages) contains 265 classifications, and the further expanded *DSM-III-R* (1987) includes 292 mental disorders (567 pages). Then, in 1994, the APA published *DSM-IV,* which defines 297 mental disorders (886 pages), and the current text revision *DSM-IV-TR* (2000) totals more than 900 pages with 365 classifications of mental disorder. (Mayes and Horwitz, 2005, p. 251).

In 1952, the American Psychiatric Association (APA) published *DSM-I* in response to the perceived need in the psychiatric community for a standardized classification system of mental disorders. In the Foreword to *DSM-I*, George Raines, Chairman of the Committee on Nomenclature and Statistics, notes that by 1948 there were at least three nomenclatures in general use, each with their own deficiencies, and the disparities among the three manuals "resulted in a polyglot of diagnostic labels and systems, effectively blocking communication and the collection of medical statistics" (p. V). *DSM-I*, then, was intended to resolve the confusions and disparities that multiple

nomenclatures produced within the psychiatric profession and better enable psychiatrists to accurately collect and record medical statistics.

In 1968, the APA published *DSM-II*, an edition that, for the most part, continued the biopsychosocial and psychoanalytic traditions of *DSM-I*. However, *DSM-II* reduced use of the term *reaction* in the classifications' names and definitions—a term closely associated with Adolf Meyer's view that mental disorders represented reactions of the personality to psychological, social, and biological factors—thus weakening the close relationship of the diagnostic manual to psychodynamic traditions. Historian of psychiatry Edward Shorter (1997) notes that, in *DSM-I,* "more in a bow to Adolf Meyer than Freud, the term 'reaction' was sprinkled liberally throughout, as in 'schizophrenic reaction' and 'antisocial reaction'" (p. 299). In the 1960s, however, and with the publication of *DSM-II*, the nomenclature reflected the predominance of psychoanalysis in American psychiatry: "psychoneurotic problems were no longer called 'reactions' but 'neuroses.' The sturdy Freudian term 'hysteria' appeared, replacing 'conversion reaction' and 'dissociative reaction'" (Shorter, 1997, p. 299). (See Appendix 1 for an example of a *DSM-I* classification that uses the term *reaction*; see Appendix 8 for a genealogy of the terms *reaction*, *neurosis*, and *disorder* across the first three editions of the manual.)

Then, in 1980, under the stewardship of Robert Spitzer, the APA adopted a classification system that replaced Meyerian and Freudian etiologically-defined, intrapsychic conflicts with neo-Kraepelinian categorical diseases. The term *neo-Kraepelinian* refers to a group of psychiatric researchers (John Feighner, Samuel Guze, Eli Robins, Robert Spitzer, George Winokur, among others), whose theoretical perspective derives from nineteenth-century German psychiatrist Emil Kraepelin's approach to the identification, division, and naming of psychopathology (Klerman, 1978). The publication of *DSM-III* and the neo-Kraepelinian approach is taken to mark the introduction of the biomedical model in the *DSMs*—a model borrowed from medicine. On these changes in theoretical orientation, Spitzer notes the following in his Introduction to *DSM-III*:

> BACKGROUND
> The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the

> diagnostic categories. The use of the term “reaction” throughout the classification reflected the influence of Adolf Meyer’s psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In the development of the second edition (DSM-II), a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases,* for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and ICD-8 went into effect in 1968. The DSM-II classification did not use the term “reaction” and used diagnostic terms that by and large did not imply a particular theoretical framework for understanding the nonorganic mental disorders. (pp. 1-2).

The current edition, *DSM-IV-TR* (2000), continues in the tradition of the neo-Kraepelinian model of psychiatry introduced in the third edition. The descriptive text annotates each disorder under the following headings: “Diagnostic Features”; “Subtypes and/or Specifiers”; “Recording Procedures”; “Associated Features and Disorders”; “Specific Culture, Age, and Gender Features”; “Prevalence”; “Course”; “Familial Pattern”; and “Differential Diagnosis.” The diagnostic criteria sets provide concise descriptions that summarize the signs and symptoms patients must exhibit in order to receive a particular diagnosis. Each classification of mental disorder comes with a corresponding five digit diagnostic code, for example, “309.81 Posttraumatic Stress Disorder” (APA, 2000, p. 463), that practitioners, hospitals, and institutions and government and private agencies use for epidemiology, statistics, and health insurance billing purposes.

During the 1970s, the reliability of the various nomenclatures in use became the focus of sustained attention. Many scholars who analyze the *DSMs* focus on single editions of the manual, post-*DSM-II*, to critique the scientific methods and claims of the nomenclatures. Neither *DSM-I* nor *DSM-II* resolved what psychiatrists describe as the reliability problem. According to *DSM-III* Task Force Chair Robert Spitzer, the primary strength of *DSM-III’s* “descriptive approach” (APA, 1980, pp. 6-8) and diagnostic criteria were “interjudge diagnostic reliability” (APA, 1980, p. 8)—improved diagnostic agreement among clinicians and researchers. However, many commentators suggest the classification system achieved diagnostic reliability at the cost of diagnostic *validity*—the intrinsic unity of a classification of mental disorder independent of the techniques used to identify and measure the disorder (Cooper & Michels, 1981, p. 128; Frances & Cooper, 1981, p. 1200; Horwitz & Wakefield, 2007, pp. 99-100; Kirk & Kutchins, 1992, pp.28-30; Kutchins & Kirk, 1997, pp. 28-32, pp. 249-252).

Some scholars who study the *DSMs* focus on the interrelationships between the diagnostic manual and pharmaceutical manufacturers: the use of psychopharmacological medications for specific mental disorders and the production and distribution of classifications, and, in some cases, the coconstitution of psychopharmacological medications and the classification for which the medication is designed (Angell, 2004; Graham, 2011; Moynihan & Cassels, 2005); the financial ties between the authors of the *DSMs* and pharmaceutical companies (Angell, 2004; Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006; Petersen, 2008); questions of medical ethics, often on the distinction between what constitutes normal human suffering and discomfort and the medicalization of normal human responses to life events (Aho, 2008; Conrad, 2007); questions about the grounds and rules of evidence: when do we intervene to relieve pain and suffering, whom do we authorize to intervene, and by what methods of intervention? (Elliott, 1998, 2003; Healy, 2000; Kramer, 2004, 2006); the ways in which pharmaceutical advertisements function as epideictic rhetoric through representations of socially sanctioned interactions and relationships (Segal, 2011); and the ways in which the scripted narratives of pharmaceutical advertisements promote gendered illness identities (Cosgrove & Riddle, 2003; Emmons, 2010; Greenslit, 2002; Figert, 1995; Metzl, 2003; Metzl & Angel, 2004).

Other studies of psychiatric discourse include analyses of psychiatrists' record-keeping activities, for example, the uses of repetition, reported speech, and joint productions in psychotherapeutic discourse (Antaki, Barnes, & Leudar, 2005; Berkenkotter & Ravotas, 2002; Buttny, 1998; Ferrara, 1994); analyses of psychiatric texts and classification systems other than the *DSMs* (Berkenkotter, 2008; Berkenkotter & Hanganu-Bresch, 2005; Bowker & Star, 2000; Reynolds, 2008; Reynolds, Mair, & Fischer, 1995; Stewart, 2008); and a corpus of scholarship offering accounts of single mental illnesses: anxiety (Horwitz & Wakefield, 2012; Tone, 2008), depression (Emmons, 2010; Horwitz & Wakefield, 2007), mania (Healy, 2008), postpartum depression (Godderis, 2011), and premenstrual dysphoric disorder (Caplan, 2004; Caplan, McCurdy-Myers, & Gans, 1992; Figert, 1995, 2005; Gold & Severino, 1994; Ussher, 2003, 2006). Lane (2007), for example, tracks the evolution of shyness from a normal behaviour to the mental disorder Social Phobia (Social Anxiety Disorder)—one of seven anxiety disorders that replaced the neuroses in *DSM-III*.

Studies from anthropology, history, philosophy, and psychology, among other disciplines, investigate the connections between the social construction of knowledge and the scientific knowledge structures in the *DSM*s (Caplan, 1991, 1995; Caplan & Cosgrove, 2004; Cooper, 2004; Crowe, 2000; Grob, 1985, 1991; Showalter, 1997). Psychologist Caplan (1991), for example, describes her first-hand experience as a consultant and advisor to two *DSM-IV* subcommittees. She explains how her requests for empirical studies to conduct a systematic literature review went unmet, and she concludes that the Work Group's commitments to adhere to sound scientific principles and to base decisions on empirical data were not met.

Other scholars map the spatial and temporal features of psychic distress and chart the trajectory of illness experiences and their expression as a cultural phenomenon (Healy, 2008; Martin, 2009; Micale, 1993; Shorter, 1992; Showalter, 1997; Tone, 2005). Hacking, (1998), for example provides a framework with four principle vectors for understanding transient mental illnesses (medical taxonomy is one such vector). According to Hacking, transient mental illnesses only appear in a particular time and place and the symptom repertoire or illness contours map onto "socially permissible combinations of symptoms and disease entities" (p. 10). The centuries-old ailment known as Melancholia may be a case in point. A group of seventeen experts, including David Healy, Edward Shorter, and Robert Spitzer submitted a position paper to the *DSM-5* Mood Disorders Work Group asking them to consider Melancholia as a discrete disorder and not simply as a specifier for Major Depressive Disorder (Parker, Fink, Shorter, Taylot, Akiskal et al., 2010).

Data

This project analyzes several types of published printed texts: specialist material written by psychiatrists for psychiatrists from 1952 to 2012, primarily metadiscourse about standardization of discursive practices from the *DSMs* themselves. This includes the usual types of Front and Back Matter found in texts, for example, the "Introduction" and "Foreward," and the types of material found in medical texts, for example, "Cautionary Statement," "Use of This Manual," and "Glossary of Technical Terms," as well as supporting and appended materials, for example, statistical cards, diagnostic

decision tress, and annotated tables of classificatory terms. The analysis extends to metadiscourse about standardization of the *DSMs* discursive practices in medical journals, for example, the *American Journal of Psychiatry*, *Archives of General Psychiatry*, *Canadian Medical Association Journal, Canadian Journal of Psychiatry, Psychiatric News, Psychiatric Times,* and *Schizophrenia Bulletin,* among others, and in print media, for example, *The New York Times* and *The New Yorker*.

When referring to the diagnostic manuals, I use the plural form "*DSMs*" whenever possible rather than the singular form "*DSM*" to individuate the editions from one another, and I indicate the edition/s to which I refer in each particular instance of use. The use of the singular form indexes an ideological position vis-à-vis language that privileges Western literate practices and the view of texts, particularly reference texts, as authoritative, stable, and objective: dictionaries (the *Oxford English Dictionary*), etiquette manuals (the *Blue Book*), rhetorical handbooks (the *Rhetorica ad Herennium*), theological texts (the *Bible*)—all of which have multiple authors and editions like the *DSMs*. In this sense, there are always a multiplicity of authors and a multiplicity of *DSM*s. This usage (of the plural) foregrounds the diachronic approach and theoretical perspective central to this project.

Rhetorical analysts and discourse analysts share an orientation to the particularities of discourse and discursive practices. Aristotle defines rhetoric as "the faculty of discovering in the particular case what are the available means of persuasion" (*Rhetoric*, 1355b). Attention to the particular case is also characteristic of the discourse analytic approach that focuses on "actual instances" of meaningful symbolic behaviour in the medium of language (Johnstone, 2008, p. 2). Thus, references to specific editions index the rhetorical perspective of the project: the study analyzes particular cases or actual instances of discourse, locates the editions in their sociohistorical contexts, and pays attention to their history of discourse. From this perspective, then, the diagnostic manual is not a single, coherent text; rather, each iteration (edition) represents the recontextualization of prior texts/discourse in a bound material form.

Whenever possible, I name the social actors, for example, "Robert Spitzer," "Allen Frances, "David Kupfer" and/or name the social category the actor represents or inhabits at a particular time and place, for example, "author," "writer," "Task Force Chair,"

"Work Group member." I do so in an attempt to foreground participants and participant roles, to identify participants as authors, principals, and animators (Goffman, 1981) of the *DSMs*, and to show how the textual standardization of psychiatry—authors' stylistic, syntactic, lexical, and pragmatic choices—indexes professional standards of practice, scientific methodologies, and scientific knowledge. Thus, use of the plural "*DSMs*," the naming of participants, and the identification of participant roles are attempts to counter the hegemonic status accorded "the DSM." This approach helps to foreground my own role as a participant by highlighting my stance and footing vis-à-vis other research on the *DSM*s and explicitly pointing to some of the ways that I intervene in the texts as researcher, analyst, and interpreter.

The Process of Textual Standardization

In this study, because I analyze written discourse not spoken discourse, and because this study focuses on the textual standardization of a professional style for American psychiatry in the *DSMs*, I use the term *standardization* somewhat differently than scholars who study phonetic forms and pronunciations associated with language standardization (for example, Agha, 2003; Milroy & Milroy, 1991; Crowley, 1989). However, I do use the term *standardization* to mean resistance to optional variation in discursive and pragmatic practices in the *DSM*s and this use retains the notion of "a standard" (albeit idealized and unattainable) that marks out difference and sameness among language varieties—in this case a professional style. According to Milroy and Milroy (1991), the process of standardization requires that persons of influence select language features as a way to single out a language variety from other varieties, stamp out equivalent variants, and assign the variety elevated status as the standard (pp. 27-28). Thus standardization discourages diversity and aims at uniformity of discourse features. Once the standard gains acceptance, the language variety often acquires prestige and undergoes codification in, for example, dictionaries, grammar books, and handbooks of usage, such as the *DSMs*. The written language system advanced in these types of books reinscribes the prescriptive norms of the standard (pp. 27). In the *DSMs*, then, textual standardization aims at developing a professional style for American psychiatry.

Metadiscourse and Context

The term *metadiscourse* (discourse about discourse) refers to the use of language to comment reflexively on discourse itself. Metadiscursive devices range along a continuum of self-reflexivity and self-referentiality: explicit framing devices such as discourse markers (*first*, *however*, *on the other hand*), contextualization cues (how participants introduce, foreground, and background knowledge in culturally relevant ways), and metacommunicative vocabularies (speech codes, argots), to name a few. There are many other explicit reflexive uses of language. Authors use an array of discourse features to intervene in the unfolding text for pragmatic purposes, for example, to produce coherence and cohesion for readers; to construct interactions with readers about propositions and claims about what counts as knowledge; to influence audience reception of the text; and to perform a variety of other functions in interaction (Barton, 1995; Johnstone, 2008, p. 165, p.238; Swales, 1990, pp. 188-189).

When a writer characterizes or comments on a regularity or pattern of language use (*pragmatic*), this type of reflexive comment can be called *metapragmatic*. Lucy (1993) writes that "metalinguistic activity, in this view, is fundamentally *metapragmatic*, that is, most reflexive activity deals with the appropriate *use* of language" (p. 17; emphasis original). In this project, I analyze some of the metapragmatic aspects of the *DSM*s' metadiscourse: the ways that Task Force members and Work Group members signal how these regularities or patterns of language use are to be interpreted. For example, instructions in *DSM-I* about how to accurately compile and record the movement of patient populations on a sample hospital statistical card; in *DSM-II*, ways to determine the combinations of diagnoses that can occur within a select group of disorders and instructions about how to tabulate multiple psychiatric diagnoses; and instructions in *DSM-III* about how to interpret a single brace or double brace in Appendix C: Annotated Comparative Listing of DSM-II and DSM-III).

Sometimes metadiscursive resources signal authorial attitudes toward textual material and audience reception of that material: writers' purposes, presuppositions about audiences, how writers persuade readers, galvanize support, and gain audience adherence to claims through the negotiation of participant relations, and the ways in which text producers describe their own authorship, work to establish authority and

credibility, and advance knowledge-making claims. Therefore, what seem to be typical or mundane metadiscursive devices meant to contribute to textual cohesion and coherence—that is, solely to textual relations—actually perform a number of extratextual functions (interpersonal, indexical, ideological, sociohistorical) that situate the writer vis-à-vis the propositions being advanced and enable the writer to adopt a particular stance and footing vis-à-vis the presentation of claims and counterclaims (Goffman, 1981).

In this study, the analysis of metadiscourse shows how even the most hegemonic, ideologically-saturated texts—the *DSM*s—exist in interaction with and in interdiscursive and intertextual relationship with real-world participants—individual subjects, collectives, and institutional structures—that orient toward and interact with the text/discourse. At times, in the *DSM*s, authorial metadiscourse interrupts the apparent seamlessness of the published printed text and foregrounds context as being constituted in interaction. During these metadiscursive interventions, when, for example, authors directly address readers, text producers provide evidence of their own authorship and agency in the text. Sometimes, metadiscourse shifts the focus from the immediate and local context of production (synchronic) to other, prior contexts and historical processes (diachronic). On this view, every utterance (spoken and written discourse) responds to prior utterances and carries the history of those prior texts and contexts in the current iteration and in future iterations and recontextualizations. Each new utterance positions itself in relation to the history of the prior utterance through an array of metadiscursive devices, for example, direct and indirect quotation (reported speech, constructed dialogue, joint productions), paraphrase, citation, and so forth. For example, in the context of psychotherapeutic discourse, Ferrara (1994) identifies the written record of highly-collaborative conversational interactions between therapist and patient as “joint productions” (p. 138). According to Ferrara (1994), joint productions occur when discrete contributions between active participants during the shaping of a stretch of discourse become difficult to identify (p. 165).

The study of discourse in context remains a central tenet of rhetorical studies. In this project, paying attention to psychiatrists’ metadiscourse helps to identify and delimit what counts as relevant sociohistorical context—a difficult task for a rhetorician researching highly stylized and edited published printed texts—and helps avoid the ethical and ideological pitfalls of “researcher as missionary,” whereby the rhetorician as

outsider critiques a practitioner or organization's discourse practices and the implications of those practices without due regard for what "*they perceive as problems*" (Segal, Paré, Brent, & Vipond, 1998, p. 79, emphasis original). I do not mean to suggest, however, that I uncritically accept participants' terms as objective depictions of events or that my rhetorical approach to discourse analysis eschews theoretical and ideological commitments. That is an impossibility. However, these kinds of top-level considerations or theoretical perspectives follow from close textual analysis rather than presuppose the terms of analysis (Schegloff, 1997, p. 170), and, if and when appropriate, theory contributes to and enriches discourse-based findings and conclusions (Eisenhart & Johnstone, 2008, p. 3).

Rhetorical Approach

This study takes a rhetorical approach to the analysis of the *DSMs* and uses methods from discourse analysis to investigate them. The theory and principles that inform this study derive from the neo-Aristotelian rhetorical tradition—the conversion of Aristotle's method for producing speeches to one of textual criticism—for example, three occasions for speeches (deliberative, forensic, epideictic), three modes of appeal (*ethos, pathos, logos*), thirty-two *topoi* or lines of argument, and two types of reasoning (deductive and inductive). Further, Aristotle identified two modes of reasoning in persuasion, deductive and inductive, with two corresponding argument structures, the enthymeme, which he calls a rhetorical syllogism, and the example. To reason inductively means to begin from the particular case, an example, and to work outward to the universal, whereas deductive reasoning moves from the universal to the particular. We attempt to persuade an audience, Aristotle says, only when we understand the terms under which the audience may be disposed toward action.

Contemporary scholars of rhetoric adapted what originated as a method of invention, that is, an art directed toward practice, to a way of reading texts (spoken and written discourse). Many contemporary rhetorical theorists point out, however, that Aristotle's classificatory system (the generic triad) is insufficient to account for the sorts of discourse that contemporary rhetoricians take as their objects of study (Jamieson, 1973, Miller, 1984). While frameworks from Classical rhetoric contribute to contemporary

rhetorical analyses, these frameworks have limitations when used for the analysis of contemporary texts and their complex sociohistorical and material contexts of production.

Rhetorical scholar Judy Segal suggests that rhetoricians of health and medicine, like all rhetorical scholars, concern themselves with persuasion in human discourse and action: who is persuading whom of what, by what methods of appeal, and to what ends? (Segal, 2005, p. 2). Rhetorical criticism, suggests Segal, is performed by "a person trained within a scholarly tradition on public discourse into a rhetorical subjectivity suggesting lines of inquiry and a procedure for thinking" (p. 7). For rhetoricians of health and medicine, Segal's research exemplifies, first, the importance of understanding principles from the rhetorical tradition, and, second, how contemporary rhetoricians can retool those principles from within the rhetorical tradition and from a rhetorical subjectivity for the analysis of contemporary texts.

Scholars in rhetoric of health and medicine acknowledge a debt to rhetoricians of science. Their research expands and builds upon the concepts and principles established in rhetoric of science (Leach & Dysart-Gale, 2011; Segal, 2005). For example, Gross (1990) suggests that rhetorical arguments differ from scientific arguments not in *kind* but in *degree* (p. 12). If we think of scientific knowledge as *invented*—knowledge as historically and discursively constructed and therefore uncertain rather than as *discovered*—knowledge as ahistorical and atemporal—always there waiting to be revealed and therefore certain, then scientific theories, those that are obsolete and those that form part of our current paradigm, can be said to be historically and culturally contingent (p. 12). Furthermore, according to Gross (1990), scientific experimentation, no matter how rigorous, illustrates reasoning by example, and scientific deduction, no matter how rigorous the logical chain, never represents universal rules applicable in all worlds (p. 12). From this perspective, then, scientific knowledge is the outcome of an intellectual and interpretive enterprise and thus the claims are rhetorical inventions (Vatz, 2006), and the interplay between scientific researcher (writer) and the scientific community (readers) can be viewed as a "rhetorical transaction" (Weimer, 1977, p. 23).

Research in rhetoric of health and medicine transcends disciplinary boundaries and researchers take a wide variety of spoken and written discourse as their objects of study, and researchers' theoretical frameworks and methods vary. Thus rhetoric of health and medicine is a transdisciplinary field, and landmark contributions come from theoretical perspectives and disciplinary traditions other than rhetorical theory. For example, physicist and philosopher of science Thomas Kuhn (1962) articulates how techniques of persuasion in argument are central to consensus-building and knowledge-making in scientific communities. Kuhn points to the role of persuasion in transactions between scientist and scientific community, and shows how the element of persuasion in scientific communities overthrows the notion of scientific knowledge as "a construction placed directly upon raw sense data by the mind" (p. 96). Sociologists Bruno Latour and Steve Woolgar (1986) also point to the role of persuasion in science. Their ethnography of scientists in the laboratory suggests that scientists are "writers and readers in the business of being convinced and convincing others" and, as writers, scientists must "persuade readers of papers (and constituent diagrams and figures) that its statements should be accepted as fact" (p. 88). Gross (1990) makes a similar point when he states that "rhetorically, the creation of knowledge is a task beginning with self-persuasion and ending with the persuasion of others" (p. 3). He suggests that this position admits of the possibility that "the claims of science are solely the products of persuasion (p. 3), and that the "chief vehicles through which scientific knowledge is created and disseminated" are texts (p. 20).

This study shows that one of the rhetorical accomplishments of the writers of the *DSMs* is that, through the development of a professional style for American psychiatry, the material processes of production become invisible, including the "descriptive" style and the writers themselves. Yet scientific writing, like all writing, occurs in the social world, and the ways in which members of a discipline write about their practices cannot be separated from those same practices. Therefore, the professional style of the *DSMs* reflects dynamic and intricate aspects of social, disciplinary, and institutional systems and the ways in which those systems organize and distribute knowledge. Bazerman (1988) notes that "scientific language is a particularly hard case for rhetoric" because the sciences have the reputation of reporting facts in language that "transcends symbolic trappings," for example, tropes and figures, and takes up, instead, a "purer symbolic

system" much closer in practice to mathematics (p. 6). Yet, scientific arguments remain the province of rhetoric because there is no certainty in science (p. 258).

This study builds on and contributes to rhetorical analyses of the *DSMs*, particularly studies that demonstrate the ways in which the *DSMs* mediate the communicative action of healthcare professionals and, in doing so, help shape and constrain professional identity. In a landmark case study on *DSM-III*, McCarthy (1991) investigates how the *DSM-III* shapes the discursive practices of one child psychiatrist. What McCarthy found was that the manual "shapes what she knows about mental illness and how she communicates that knowledge" (p. 359). She concludes that the diagnostic manual influences what the child psychiatrist was able to observe and recognize as data in the first place, what counts as relevant information, and how that information and data should be interpreted and presented (p. 375).

Other rhetorical analyses of the *DSMs* examine the recontextualization of patient reported speech in psychotherapeutic and psychiatric discourse to demonstrate the cultural portability of the standardized language of the *DSMs* across genres and the recontextualization of the professional style across different rhetorical situations. In her study of *DSM-IV,* Berkenkotter (2001) takes up Giltrow's (2002) term *meta-genre* to suggest that "*DSM-IV* (and its predecessors, *DSM-III* and *III-R*) can be seen to function as *meta-genres* around which a constellation of professional activities (and their genres) are organized. In this respect, it has become a mediational means, or tool for stabilizing practices" (p. 339). According to Giltrow (2001), a *meta-genre* is "situated language about situated language" (p. 190). Giltrow suggests that "guidelines" are an example of a meta-genre that provides "written regulations for the production of a genre, ruling out some kinds of expression, endorsing others" (p. 190). Berkenkotter uses the term *meta-genre* to demonstrate how the *DSM-IV* classification system has the ability to "create and sustain networks" that detach knowledge from local practices and transport it across contexts (p. 346, n. 10). Thus the concept of meta-genre demonstrates how standardized discursive practices can both constrain and shape professional health communication.

A study from Berkenkotter and Ravotas (1997) shows how *DSM-IV* diagnostic language provides an interpretive framework for psychotherapists that, while useful for

insurance billing purposes and necessary for institutional structures and professional practices, guide the therapeutic process in such a way that prevents the psychotherapist from providing a record of the client's insights about his or her own "lifeworld" that arise during the therapeutic process (p. 269). In a second study, Berkenkotter and Ravotas (2002) document the written transformation and recontextualization of patient reported speech across two institutional genres—from the session notes to the initial assessment. The authors conclude that the language of diagnosis disciplines the psychotherapist's writing practices such that the initial assessment effaces the client's point of view when the psychotherapist recontextualizes patient speech through paraphrase that references the standardized language of *DSM-IV*. These studies of the *DSMs* demonstrate some of the ways that psychiatrists and psychotherapists use the standardized diagnostic language to recontextualize patient reported speech so as to accomplish institutional and professional goals, and the authors' findings provide evidence of the uptake and transmission of reported speech within and across the sequentially linked communicative actions of psychiatrists and psychotherapists.

Many rhetoricians acknowledge the need for methods of analysis for planned and spontaneous discourse in public and private domains and the need for a supplemental vocabulary for describing the varied manifestations of contemporary persuasion (Eisenhart & Johnstone, 2008, p. 4). Some rhetoricians show how traditional rhetorical analytic tools—topoi, modes of appeal, occasions for speech, types of reasoning, invention and style—inform and are informed by a variety of discourse analytic methods. A rhetorical perspective and rhetorical criticism complement and contribute to the methods of discourse analysis, and rhetorical analysts and discourse analysts share substantive commonalities in their approach to close textual analysis. Both rhetoricians and discourse analysts attend to how the features of spoken and written discourse (metadiscursive markers, figurative language, argument structure, register, genre, audience) shape social interactions, relationships, and identities and constitute knowledge (Eisenhart & Johnstone, 2008).

In this project, the view of discourse and discourse analysis follows from Johnstone's (2008) heuristic approach to understanding how discourse shapes context and how context shapes discourse (p. 10). The analytic heuristic guides an approach that is particularistic, systematic, and interpretive and asks, "'Why is this stretch of

discourse the way it is? Why is it no other way? Why these particular words in this particular order?'" (p. 9). The heuristic suggests multiple ways of thinking about relevant context. Together with Johnstone's approach, the analysis of the *DSMs* proceeds through, primarily, a Bakhtinian theory of language that views discourse as dialogic and heteroglossic: each utterance responds to and supplements others' utterances on a particular topic or in a particular sphere of speech communication, demonstrating the permeability of author boundaries and imbuing the utterance with "*dialogic overtones*" (1986, p. 92, emphasis original).

Because discourse analysis is a collection of methods and not a discipline, this project makes use of a variety of discourse analytic resources. Following Johnstone, I describe my approach as data-driven rather than theory-driven. That is, my primary analytic commitment is at the level of text (data) and analysis proceeds upward from particular, situated instances of text and context rather than downward from a theoretical perspective or framework for which I seek evidence in the text. In this sense, the methods are empirical: proceeding from discourse-based observations; seeking to understand relevant context from the perspective of the participants engaged in the production of this particular stretch of discourse (Eisenhart & Johnstone, 2008, p. 3; Schegloff, 1997, p. 167, p. 180). Thus the emic or "insider" perspective focuses on cultural distinctions and descriptions in terms meaningful to insiders (Pike, 1967).

Discourse analysts use the term *discourse* rather than *language* to differentiate the former from analytic practices focused on language as an abstract system of rules, whose unit of analysis is often an isolated sentence rather than an utterance and whose aim is to arrive at a generalizable rule. Discourse analysts and rhetoricians derive their data from "living samples of spontaneous language" rather than rules-based, abstract constructions—"made-up introspective data" (Hopper, 2007, p. 238), and locate analysis in the details of discourse: a bottom-up approach (observation-based, data-driven) rather than a top-down approach (theory-driven) (Johnstone, 2008). Thus discourse analysis and rhetorical analysis are interpretive or hermeneutic endeavours that view the language practices of professional discourse communities as inherently dialogical, addressed, and purposive; both concern themselves with the communicative interactions of speakers/writers and their interlocutors, including aspects of social discourse such as audience, genre, and situation. Discourse analysts and rhetoricians attempt to connect

aspects of language-in-use to persons in the social realm and, in doing so, come to some conclusions about how language shapes and is shaped by human interactions.

This view of discourse differs somewhat from the Foucauldian notion that discourses (plural) are the medium through which power relations produce speaking subjects. Foucault (1972) posits discourse as an ordered system of macro-level social practices belonging to collectives and within which individuals act according to the rules of the particular "discursive formation": systems of available and familiar statements circulating in the discursive field, "which we call medicine, economics, or grammar" (p. 37). These discursive practices produce a speaking subject who takes up strategies of thinking, talking, and acting in accord with the dominant discourse (the discursive formation). In this way, individuals repeat and re-enact hegemonic representations of the world. In this sense, then, the discourse "speaks" the subject and thus produces ontological categories that appear natural and given. However, the principle of reciprocity in Johnstone's (2008) analytic heuristic shows how discourse not only responds to a given context (that is, constrained by) but also shapes context. This points to the idea that texts and contexts are interdiscursively and intertextually constructed in social interaction—individual human agents produce social knowledge at the micro-sociological level in interactional contexts and as such contexts are changing and changeable and may overlap.

Many rhetoricians and discourse analysts investigate the communicative and material processes involved in bounding a stretch of discourse as a text, and their analytic approaches share some common methods and principles to track the activities and agency of rhetors and follow the back and forth movement of spoken and written discourse across spatial, temporal, and generic borders (see, for example, Andrus, 2011 and Emmons, 2010). For example, during processes of recontextualization, the text-artifact (extracted, bounded discourse) proves more amenable to transmission across social, cultural, generic, and generational boundaries. Use of the term *text-artifact* highlights how spoken discourse becomes decontextualized and recontextualized in a bounded, stable, material object that humans write, edit, produce, distribute, read, interpret, and so on (Silverstein & Urban, 1996). The process of recontextualization links certain contexts to texts such that context becomes delimited—stable, durable, bounded, and objectified—and creates seemingly natural relationships between texts and

contexts. According to Silverstein and Urban (1996), the construction of the text-artifact, that is, the extraction of a bit of discourse "from its infinitely rich, exquisitely detailed context" in order to "draw a boundary around it, inquiring into its structure and meaning," marks it off as discrete and referential discourse and constructs and constricts context (p. 1).

Another way to think about how recontextualization circumscribes context is to consider what the recontextualized discourse indexes and fails to index. The concept of *indexicality* situates language (spoken and written) as an inherently social practice. An indexical form is a linguistic form that affirms and/or creates social meaning beyond the strictly denotational meaning. Indexical forms depend upon interactional context for meaning, providing a semiotic link between the linguistic form and the social meaning (Ochs, 1992; Silverstein, 1976, 2003). For example, phonological variants of the same word may share the identical reference yet index more than one meaning depending upon the interactional context (Ochs, 1992, p. 338). Furthermore, the resources of language—how participants use and evaluate others' language use in interaction—can index shared membership in a discourse community (Johnstone, 2008, pp. 133-134). For example, when psychiatrists use the standardized syntax, lexicon, and taxis of the diagnostic criteria they *index* shared professional membership, professional consensus in the form of interrater agreement and diagnostic reliability, and the status of the APA as a scientific community, and they *index* the classification system as methodologically objective, as the product of empirical methods derived from observation and data-collection, and, therefore, the status of the *DSMs* as scientific.

This study takes the view that contexts, like discourse, are flexible, changing, and negotiated rather than fixed, given, and objective and, therefore, difficult to delimit. That is, context is not a stable set of social conditions—"a rhetorical situation" (Bitzer, 1968)—nor is context reducible to any one aspect of a social interaction. Rather, contexts are made up of complex matrices of actions and events, prior utterances, prior texts, recontextualizations, and text trajectories, and the scope and level of context include higher-level events and actions that operate above the structural elements of discourse. Thus rhetors actively create meaning in social interaction: discourse structures and contexts co-construct each other, are subject to interpretation, and are understood differently by different participants (Van Dijk, 1997, pp. 14-15).

While scholars often disagree about how to delimit relevant context, there is agreement that analysts must not ignore context (for example, see the different approaches to context in Schegloff, 1997 and Fairclough & Wodak, 1996). One link between context and discourse is in the way participants represent the social situation (Van Dijk, 2008, p. 9). When participants orient to context, as they sometimes do metadiscursively, then context may be available in the text. This approach, paying attention to specific stretches of discourse—micro-rhetoric, rhetoric in detail, the micro-sociological—informs my research methodology.

Posttraumatic Stress Disorder as a Case Study

Rhetorical scholars of professional health communication sometimes use a case study approach to identify and examine discourse features linked to professional discourse communities and to draw conclusions about the ways in which texts accomplish the aims and goals of the discourse communities for whom and in which they function, to show the ways in which entextualized and recontextualized discourse contributes to professional identity formation, and to show how those texts function for readers in social interactions. For example, Spoel and James (2006) examine how the emerging profession of midwifery works within the constraints of established health policy to develop and articulate a professional identity that both conforms to and shapes some of the standard forms of professional healthcare regulation.

In this study, the example of a particular case helps anchor the analysis and interpretative claims. This project uses the example of Posttraumatic Stress Disorder (*DSM-III*, 1980, pp. 236-238; *DSM-III-R*, 1987, pp. 247-251; *DSM-IV*, 1994, pp. 424-429; *DSM-IV-TR*, 2000, pp. 463-468). In addition to these iterations, analysis includes the *DSM-5* draft diagnostic criteria for the forthcoming revised classification (APA, 2012b) and two earlier classifications Gross Stress Reaction (*DSM-I*, 1952, p. 40) and Adjustment Reaction of Adult Life (*DSM-II*, 1968, p. 49). While the reasons for the elimination of Gross Stress Reaction from *DSM-I* remain unclear, and while no *DSM-II* classification accounts for the traumatic war neuroses, many scholars point to Gross Stress Reaction and Adjustment Reaction of Adult Life as the nosological progenitors of

Posttraumatic Stress Disorder (Andreasen, 2004; Brett, Spitzer, & Williams 1998; Scott, 1990, 1993; Turnbull, 1998; Wilson, 1994).

Taken together, then, these classifications offer an historical overview of APA naming conventions and classificatory principles for what has historically been known as traumatic neurosis, traumatic stress, and the traumatic war neuroses (Freud, 1966; Kardiner, 1941; Keiser, 1968). The case study approach highlights the diachronic relations among the iterations of the classification and the editions of the manual, provides an opportunity to follow terms of art such as *transient*, *neurotic*, and *disorder* across editions, to follow the recontextualization of discourse as visual representations, for example, bracketed tables and diagnostic decision trees, and to follow the text trajectory of particular stretches of discourse such as the recontextualization of putative patient reported speech, for example, "The world is completely dangerous" (APA, 2012g), from a prior context of production (whatever that might be) onto the draft diagnostic criteria for *DSM-5*.

Sometimes research on the history of Posttraumatic Stress Disorder emphasizes the controversial status of the classification in *DSM-III* (the first iteration of this mental disorder) and subsequent editions. For example, Posttraumatic Stress Disorder is the only category to include etiology in the description (Summerfield, 2001, p. 97). In the past, the disorder generated debates both within the psychiatric profession (Buck & Walker, 1982; Brett, 2006; Brett, Spitzer, & Williams, 1988; Spitzer, First, & Wakefield, 2007; Wilson, 1994) and within stakeholder communities struggling for recognition of the disorder, notably members of the Vietnam Veterans Against the War (VVAW) and the Vietnam Veterans Working Group (VVWG), some of whom are mental healthcare professionals, (Haley, 1974; Lifton, 1973; Shatan, 1972, 1973; Shatan, Smith, & Haley, 1976), and children and women's rights activists advocating for a classification representative of non-combat related traumatic events and experiences, particularly domestic assault and sexual violence (Brown, 1991; Herman, 1992).

These debates continue to address questions about the origin, genealogy, and boundaries of the disorder (Andreasen, 2004; Foa, Keane, & Friedman, 2004; Foa & Rothbaum, 1999; Friedman, Resick, Bryant, & Brewin, 2011; Friedman, Resick, Bryant, Strain, Horowitz, & Spiegel, 2011; Rosen & Frueh, 2007). Some analyses question the

validity and clinical utility of the diagnostic criteria for this classification (Green, Lindy, & Grace, 1985; Moran, 2012; Spitzer, First, & Wakefield, 2007; Summerfield, 2001; Young, 1995). Much of the current research asks questions about what sorts of traumatic experiences the *DSMs'* descriptions privilege and silence, and researchers make the case for gender- and culture-appropriate definitions of trauma and traumatic expression (Breslau, 2000, 2004; Chakraborty, 1991; Hinton & Lewis-Fernández, 2011; Nichter, 2010; Phillips, Friedman, Stein, Craske, 2010; Watters, 2010). These considerations are particularly salient for non-Western populations whose cultural beliefs include alternative forms of diagnostics such as divination and shamanism and whose cultural practices include speaking and behaving in ways that the Euro-centric posttraumatic construct pathologizes: the non-linear representation of time and chronology in narratives, Western representations of cultural memory and personal memory, local conceptions of the nervous system and somatic complaints (e.g., *nervios* and *ataque de nervios* among Caribbean-Latino populations, *khyâl* attack among Cambodian refugees) (Guarnaccia, Lewis-Fernández, & Rivera Marano, 2003; Hinton, Hinton, Um, Chea, & Sak, 2002; Hinton & Lewis-Fernández, 2010), and other non-Western somatic and psychic idioms of distress (Bracken, Giller, & Summerfield, 1995; Eisenbruch, 1991, 1992; Frey, 2001; Marsella, Friedman, Gerrity, & Scurfield, 1996; Rasmussen, Katoni, Keller, & Wilkinson, 2011; Summerfield, 1999).

The classification continues to generate discussion; for example, *DSM-5* revisions include restructuring of the diagnostic manual such that the classification moves from the "Anxiety Disorders" section to the new "Trauma- and Stressor-Related Disorders" section (Zoellner, Rothbaum, & Feeny, 2011). The Chair and Vice Chair of the Task Force on Nomenclature and Statistics (henceforward, Task Force) report that the Work Group overseeing the revision of this classification, the "Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group," received more public feedback during the final (of three) open comment periods than any of the other 12 Work Groups: of the 2300 public comments submitted during June 2012, 545 comments were submitted to this Work Group (APA, 2012c). Thus the *DSM-5* iteration of the classification provides the rhetorical exigence for the case study and provides a generative site for rhetorical analysis.

Why DSM-III?

The third edition in the manual's publication history is of focal interest to this project; rather than limiting or excluding other concerns it orients them. With the development of the *DSM-III* classification system a new array of biomedical criteria and professional assessment practices were introduced to psychiatrists, psychotherapists, and other healthcare professionals for the diagnosis of mental disorders. In his Introduction to *DSM-III*, Task Force Chair Robert Spitzer names the new classification system's terms of art, descriptive text, and diagnostic criteria the "common language" of American psychiatry and he writes that "clinicians and research investigators must have a common language with which to communicate about the disorders for which they have professional responsibility" and to do so using "diagnostic terms that are clearly defined" (APA, 1980, p. 1). In this way, Spitzer connects the discourse features of the "common language" to the profession's communicative aims and goals: consensus among APA members about diagnostic terms and definitions, the usefulness of the classification system to clinicians and researchers of varying theoretical orientations, and the reliability and validity of the diagnostic categories to facilitate and enhance interrater agreement (APA, 1980, p. 2). The "common language" reflects the neo-Kraepelinian theoretical perspective and ideological stance toward the classification of mental illness and promotes the values of medicine and biomedicine.

DSM-III Task Force and Work Group members foreground their commitments to the "descriptive approach" and to the "common language." In much the same way that dictionaries, grammar books, and rhetorical handbooks attempt to authorize and circumscribe literate practices, *DSM-III* codifies and standardizes a professional style for American psychiatry. In the tradition of handbooks of usage, *DSM-III* addresses a variety of stylistic, syntactic, lexical, compositional, and pragmatic practices in many of the manual's sections and subsections. For example, the manual's glossary "Appendix B: Glossary of Technical Terms" (pp. 353-368) makes tacit and explicit distinctions between the "descriptive approach" of the current manual and the psychodynamic and biopsychosocial approaches of the earlier editions, particularly in the definitions for "Neurotic Disorder" (p. 364) and "Neurotic Process" (pp. 364-365). The introductory subsections "Descriptive Approach" (pp. 6-8), "Diagnostic Criteria" (p. 8), "Systematic

Description" (p. 9), "NEUROTIC DISORDERS" (pp. 9-10) make these types of distinctions as well. For example, the latter named section begins: "Throughout the development of *DSM-III* the omission of the *DSM-II* diagnostic class of Neuroses has been a matter of great concern to many clinicians, and requires an explanation" (p. 9). The subsection explains that, whereas Freud used the term *neurotic disorder* both "descriptively" and "to indicate an etiological process," *DSM-III* uses the term "descriptively" and "without any implication of a special etiological process" (p. 10). Thus much of Spitzer's Introduction establishes theoretical distance between the orientations of the earlier editions and the current edition's atheoretical stance through the introduction of new terms of art and, sometimes, through new definitions for old terms of art.

The authors and designers of *DSM-III* based the manual's classification system on the organizing principles of Emil Kraepelin's descriptive style (Kirk & Kutchins, 1992; Klerman, 1978; Kutchins & Kirk, 1997; Shorter, 1997). In the diagnostic manual, the APA aims to accomplish textual standardization through the "descriptive approach" to classification (APA, 1980, pp. 6-8), and *descriptive* becomes a key term of art in *DSM-III* and subsequent editions. The manual's "descriptive approach" arranges mental disorders according to collections of co-occurring, observable attributes and characteristics that comprise diagnostic classes subdivided into specific disorders (with further subdivisions when necessary) (APA, 1980, pp. 6-8), and diagnostic criteria follow the descriptive text for all classifications, and subsequent editions replicate and expand on these organizing principles.

This study shows how the textual standardization of discursive and pragmatic practices contributes to the portability of the *DSM-III* diagnostic criteria. These symptom repertoires become the most shareable or portable discursive attribute of American psychiatry's professional style. The uptake of the *DSM-III* "common language" beyond the borders of psychiatry comes about through the exportation of a repertoire of symptoms without accounting for an "idioms of distress" approach to psychic suffering. That is, an approach that values sociocultural diversity, local knowledge, and culture-specific expressions of that knowledge (Nichter, 1981, 2010). Individuals learn how to represent themselves through cultural archetypes and models of the ill self (Emmons, 2010), and because idioms vary across cultures, they convey the available and

appropriate ways in which sociocultural groups express psychic distress (Hinton & Lewis-Fernández, 2010; Nichter, 1981, 2010). This means that cultural groups express psychic illness and distress in the idiom of their time and place (Hacking, 1998; Shorter, 1992; Showalter, 1997; Summerfield, 2001; Young, 1997; Watters, 2010). Therefore, sometimes, individuals express psychic distress in the idiom of the *DSMs.* To speak in the idiom of *DSM-III*, for example, means to discursively construct mental *disorders* as discrete and bounded entities, identified through collections of *observable* signs and symptoms, and articulated in standardized repertoires of *diagnostic criteria*.

Many discussants write about the power and authority of the biomedical model in *DSM-III* (and subsequent editions) using epithets that highlight the demographic and geopolitical reach of the third edition's discourse conventions: "the *DSM*" (use of the singular form is widespread throughout academic scholarship and journalistic accounts); the "bible" or the "psychiatric bible" (Bower, 1989; Caplan, 2012; Kirk & Kutchins, 1997; Kutchins & Kirk, 1992; Lane, 2007, 2008; Shorter, 1997; Watters, 2010); the "encyclopedia of insanity" (Davis, 1997); the "lingua franca" of psychiatry (Berkenkotter, 2011; Young, 1997); a "charter document" (McCarthy, 1991); a "master genre" (Emmons, 2010); a "meta-genre" (Berkenkotter, 2001) an "atomic table of elements" (Martin, 2009). Most interlocutors, however, take up the APA's preferred term, the "common language," to describe *DSM-III's* standardization of discursive and diagnostic practices (while the list is long, some notable examples include First, 2010a; Frances & Cooper, 1981; Kendler, Muñoz, & Murphy, 2010; Kupfer, First, & Regier, 2002; Mayes & Horwitz, 2005; Millon, 1991; Schacht, 1985; Schatzberg, 2010; Sobel, 1979; Spiegel, 2005; Wilson, 1993). These terms—*bible*, *charter document*, *encyclopedia of insanity*, and so on—highlight the interplay between Western literate practices and the geopolitical expansion of American psychiatry.

Sometimes analysts talk and write about the *DSMs* using language that positions the manual (singular) as a mediating structure or as hegemonic discourse that perdures across time and place. For example, when scholars refer to "the *DSM*" (singular) they elide human agents—those psychiatrists who theorize, design, write, edit, and revise the *DSMs*. As well, situating "the *DSM*" as hegemonic discourse positions the manual as part of the macro-social order (Silverstein, 2003, p. 202), that is, as a mediating structure seemingly out of reach of speakers and readers engaged in particular and situated "real

world" speech events. Thus, treating "the *DSM*" (singular) as a mediating structure or transcendent construct naturalizes and essentializes the qualities and characteristics of the bounded discourse. In other words, differentiating the micro-contextual ("real world" speech events) from the macro-social (a transcendent construct) demonstrates that through particular, individual acts of speaking, writing, listening, reading and so on, such as treating the multiple editions of the manuals as singular, "the *DSM*" gains asymmetrical power and authority as a stable, transcendent construct.

To recast this discussion in concepts and principles from the rhetorical tradition, these distinctions between the macro-social order (use of transcendent constructs) and the micro-situational ("real world" speech events) bear some resemblance to distinctions between a view of "the rhetorical situation" (Bitzer, 1968) as generative of and controlling for persuasion: "the situation controls the rhetorical response " (Bitzer, 1968, p. 6, p. 9); and a view of rhetors as generating the grounds for persuasion: "meaning is not discovered in situations, but *created* by rhetors" (Vatz, 1973, p. 157, p. 160, emphasis original). The first perspective (Bitzer) tends to present situations as discrete and thus meaning resides in events (waiting to be discovered); that is, meaning exists separate from human agents in social interactions; the second perspective (Vatz) posits rhetors as actively engaged in creating meaning. Leff (2001) notes that "a more recent view" from within rhetorical studies of the interplay between contexts and text accounts for contexts as at least somewhat "rhetorical and interpretive constructs" and thus the relationship between text and context is necessarily fluid (p. 246).

The rhetorical principle *kairos*, translated variously as *fitness to occasion*, *timing*, or *opportunity*, may help to provide a nuanced view of the interrelationships among rhetor, audience, exigence, and the constraints of the rhetorical situation. As Miller (1992) notes in her discussion of this principle in scientific discourse, *kairos* "permits interplay between both objective and subjective dimensions of a moment in time" (p. 312). When we talk about *kairos*, Miller says, we talk in two types of metaphors: temporal and spatial. A common temporal metaphor relevant to scientific discourse is "moment in time," an objective metaphor that structures *kairos* as separate from rhetor; another perspective, in keeping with the temporal motif, suggests that any "moment in time" has a *kairos* that a rhetor may "grasp" or make use of (pp. 312-313). From this latter view, which Miller calls a "subjective construction" (p. 312), *kairos* is the site of

interaction between the situation and the rhetor who recognizes the available creative forces and mobilizes strategies to act. This view is consonant with the rhetorical approach of this project—paying attention to the contingent, situated particularities of the *DSMs*.

The Rhetoricity of Classification Systems and Acts of Classifying

Bowker and Star's (2000) analysis of the World Health Organization's (WHO) official classification system, the *International Classification of Diseases* (ICD) reveals some of the ways in which medical technologies join with social systems through a complex architecture of material and non-material layers: social, medical, and technological (p. 33). **T**he authors note, however, that in the case of medical information infrastructures, the primary medium and technology in which medical knowledge occurs is a material object—a text (p. 289). Furthermore, as these complex information/knowledge infrastructures become part of everyday social life, they tend toward invisibility without any loss of power (p. 319). Thus orthographic practices and the textual standardization of classification systems contribute to their everydayness and to their invisibility as taken for granted objects.

The *DSMs* have become the primary reference tool in the American mental healthcare system, and the discursive and pragmatic attributes of the *DSMs* circulate in an expanding social field: hospital billing, hospital statistics, epidemiological records, insurance billing, clinical research, clinical practice, textbooks, the classroom, public healthcare education, and public healthcare policy. The writers and revisers of the *DSMs* help shape the form that psychiatric knowledge takes, how, where, and to whom the knowledge circulates and for what purposes, and help constrain the situations and conditions under which audiences take up, interpret, and understand psychiatric knowledge. As instances of epideictic rhetoric, which, following Segal (2005), we might think of as "a rhetoric of values" (p. 69), classification systems operate as "rhetorical performatives" (Beale, 1978, p. 225) and participate in a "rhetoric of socialization" (Charland, 1987, p. 138), amplifying virtues to be praised or vices to be declaimed. That

is, acts of classifying or assigning diagnostic labels “do” something in their saying; they constitute rhetorical transactions, valourizing some behaviours and pathologizing others.

Scientific knowledge and scientific classification systems (knowledge structures), although produced in specialized communities, respond to the exigencies and constraints of the broader culture. Because scientific knowledge derives from members of a discourse community who presumably operate under the constraints of an orthodoxy or belief system, the communicative practices of specialized discourse communities cannot be exempt from the cultural values and beliefs of their historical period and their situational context (Burke, 1966, pp. 45-46; Perelman & Olbrechts-Tyteca, 1969, pp. 149-153; Sullivan, 1991, p. 232). Audiences uphold or denigrate cultural norms, beliefs, and values, and, through adherence to values held in common, audience members participate in the very discourse that seeks to persuade them (Charland, 1987; Perelman & Olbrechts-Tyteca, 1969).

The psychiatrists who design the classification system (e.g., collect, divide, and name pathological behaviours) aim to identify, describe, and codify in written form psychiatric pathology, and in doing so, index social and cultural norms, beliefs, and values in the categorical structure (e.g., the biomedical psychiatric model). Thus classification systems codify ways of being in the world anchored in these values (Sadler, 2002; Schacht, 1985), sanctioning some, dissuading others, and promoting an etiquette of behaviours in the public sphere (Goffman, 1963). This means that the interactional and communicative behaviours of patients and practitioners, in both spoken and written modes, shape and are shaped by psychiatric classification systems. A patient’s symptom repertoire, for example, must find a degree of discursive fit with one or more diagnostic criteria sets for a practitioner to confer or withhold a diagnosis; and, as the rhetorical analyses of the *DSMs* indicate, practitioners take up the classification system’s organizing principles, style protocols, diagnostic language, and pragmatic practices during diagnostic interviews and the transcriptions of those interactions.

The purported objectivity of scientific prose and the absence of emotional appeal in scientific nomenclatures are rhetorical strategies and as such do not represent a neutral stance on the part of the writer/s. Therefore, scientific nomenclatures like the *DSMs* are rhetorical, in part, because they strive for an absence of emotional appeal and

present themselves as objective and thus as referential discourse. The objective, neutral stance disguises writers' syntactic, substantive, and pragmatic practices. Scientific prose attempts to equate statements with facts in a style that aims at separating language from the description of a particular reality—a reality that exists separate from discourse and, therefore, is seen to be arhetorical (Bazerman, 1988; Gross, 1990; Kuhn, 1962; Latour & Woolgar, 1986).

Sometimes the authors and designers of the *DSMs* demonstrate the "reflectionist" or referential view of language as representing an accurate account of the world (Silverstein, 1979, p. 194). For example, psychiatrists describe the classification system and the visual schemas that diagram the arrangement, organization, and naming of classes and disorders in the structure (bracketed tables, decision trees, and lists) as "carving nature at the joints," a paraphrase of Socrates' view of taxonomy from Plato's *Phaedrus* (First, 2005, n. p.; Hempel, 1965, p. 145; Emil Kraepelin qtd. in Shorter, 1997, p. 355, n.116; Pickles & Angold, 2003; Skull, 2006, p. 149). When psychiatrists borrow the language of Plato to describe the organizing principles of the *DSMs*, they seem to borrow the Platonic view of the world as made up of cosmic absolutes or universal forms, and, in doing so, posit mental disorders as discrete and discernible disease entities existing separate and apart from discourse. Thus, psychiatrists connect the taxonomic endeavour to the pursuit of absolute knowledge.

Second, psychiatrists describe *DSM-III* as "atheoretical with regard to etiology" (APA, 1980, p. 7). The *DSM-III* authors who make this claim for the classification give primacy to "raw sense data" such as observable behaviors and biological signs (the empiricist position) and not to "experience-distant data" that require theoretical frameworks and inferences (Millon, 1991, p. 258). Theory, however, forms an integral and inseparable aspect of scientific observation and data-collection (Kuhn, 1962), and, in the case of psychiatric classification systems, etiological theory gives the taxonomy both scientific validity and clinical relevance (Hempel, 1965, Quine, 1977). Theory-based approaches (for example, Freudian, Jungian, and Meyerian) classify disorders according to comprehensive organizing principles common to category members and point to dynamic processes, proven and unproven theoretical constructs, inferred from these underlying principles.

Spitzer's and other Task Force members commitment to an atheoretical etiological position, descriptive language, and diagnostic criteria necessarily influences *DSM-III's* classificatory schema and discourse features. A model that claims causative neutrality for its descriptive approach requires terminology consonant with that model of psychopathology. For this reason, the *DSM-III* classification system requires new organizing principles, style, vocabulary, and metapragmatic instructions that follow the neo-Kraepelinian model of psychiatry. An assertion of theoretical neutrality vis-à-vis causation in-and-of-itself depends upon a particular view of psychopathology and as such articulates an ideological position that comes with normative beliefs about the observation, identification, naming, and organization of mental disorders and their written depictions derived from Kraepelin's descriptive approach (Blashfield & Livesley, 1991; Carson, 1991; Cooper, 2004; Faust & Miner, 1986; Klerman, 1978; Millon, 1991, Ritchie, 1989). The design, arrangement, and naming practices of classification systems direct attention to certain discursive attributes and characteristics and the hierarchical structure of lists, for example, determines how readers interpret relationships between and among categorical items (Bowker & Star, 2000; Goody, 1977; Schryer, 2012). The authors' naming conventions and writing and diagrammatic practices bely the atheoretical etiological argument. Thus, in these ways, the categorical arrangement and hierarchical structure of the APA's classification system constitute a theory about psychopathology based on the medical model of discrete disease entities.

Chapter Overviews

Chapter 2: Metapragmatic and Visualist Practices in the *DSM*s

In this chapter, I analyze psychiatrists' metadiscourse to show the development of the *DSM*s from, primarily, a statistical manual to a diagnostic manual, and the evolution of APA professional identity from that of *statisticians* engaged in uniform record-keeping of hospital data to that of *diagnosticians*: medical experts engaged in diagnosis and diagnostic research. I suggest that through the definition and separation of these two practices, *statistical* and *diagnostic*, the APA positions the professional body as a scientific community and connects the newly emerging identity of the APA as a scientific community to the terms *diagnostic* and *diagnostic criteria*. To do so, I draw on

research that shows how writing practices help shape disciplinary knowledge (Kuhn, 1962; Latour and Woolgar, 1986), and research on the hierarchical and organizing principles of visualist materials such as lists (Bowker & Star, 2000; Goody, 1977; Schryer, 2012) and tables (Gross, 1990; Ong, 1958) to demonstrate how scientists' orthographic practices bolster knowledge claims. Specifically, I demonstrate how Ramist and Porphyrian classification systems and the hierarchical organizational structure of lists influence the diagrammatic materials of the *DSMs*. I show how *DSM-III* uses diagrammatic methods to introduce new terms of art and eliminate old terms of art through organizing principles that make spatial relationships between member-terms appear as part of an unproblematic, logical progression in the classification system and as integral to the manual's scientific methods.

The analysis of metadiscourse from the first two editions of the *DSM* identifies the communicative acts and literate practices through which the APA connects professional identity formation to knowledge formation. Further, I connect these information structures (statistical manual versus diagnostic manual) to professional identity formation (statistician versus diagnostician) as a way to show how the APA indexes professional values through communicative practices. The analysis of metadiscourse from the third edition shows how three types of diagrammatic structures, bracketed tables, diagnostic decision trees, and lists, organize and summarize new information and help readers bring prior knowledge from *DSM-I* and *DSM-II* to bear on the new classification system. I document how the APA substitutes new terms of art (*disorder*, *diagnostic criteria* in *DSM-III*) for old terms of art (*reaction* in *DSM-I*, *neurosis* in *DSM-II*) across the three editions. I use the concept of prior discourse (Bakhtin, 1986; Becker, 1994; Vološinov, 1986) to account for the evolution of terms of art across editions and to demonstrate how professional metadiscourse and metapragmatic practices help shape the *DSM-III* revision process. Furthermore, the analysis of visualist materials shows how the APA comes to equate the organizational systems or methods used in the three kinds of diagrams with the scientific method of the *DSM-III* classification system. I conclude that while the organizational design contributes to their uptake (decision tree nodes and lists of diagnostic criteria lend themselves to memorization and recall), the cultural power of these literate artifacts lies in their material reproducibility and replicability.

Chapter 3: Textual Standardization and the Development of the *DSM-III* "Common Language"

This chapter analyzes psychiatrists' metadiscourse about the aim to standardize the style of the *DSMs*. I show how the textual standardization of discursive and pragmatic practices helps the APA to develop a professional style for American psychiatry, which they call the "common language." I note the evolution of arguments across the *DSM*s about the perceived exigencies, purposes, and audiences of the "common language" of American psychiatry. Along the way, I show how the textual standardization of the "common language" helps to accomplish different communicative aims and goals for the profession at particular junctures. Furthermore, I suggest that the "descriptive approach" to the "common language" aims to develop a professional style for American psychiatry and that textual standardization of the *DSMs* produces a handbook of usage.

I show how the *DSM-III* "descriptive approach" eliminates psychoanalytic and psychodynamic terms of art and substitutes terms of art that uphold the neo-Kraepelinian model of psychopathology. As a consequence, psychoanalytic terms and concepts—*neurosis*, *reaction*, *transient*, *situational*, *disturbance*, and so on—come to be associated with unscientific language and thus represent unscientific knowledge structures. Through a program of textual standardization, then, the professional style becomes the marker of a shared culture and aims to assimilate all minority affiliations into the neo-Kraepelinian paradigm in the interest of professional communication and interrater agreement—behaviourists, family-centered modalities, psychoanalysts, biopsychosocial practitioners. According to adherents and supporters of textual standardization, psychiatrists holding divergent theoretical perspectives will be able to use the "common language" to talk to one another about clinical matters, and in this way standardized discursive and pragmatic practices promote professional consensus—the pragmatic upshot of which is diagnostic reliability. Through claims to improved interrater agreement and diagnostic reliability, then, the association positions psychiatry as having scientific standards and scientific methods of practice and, in doing so, helps to establish American psychiatry as a scientific society.

Thus the chief style attributes of the diagnostic manuals help determine the chief professional attributes such that the textual standardization of the profession becomes inseparable from the standardization of psychiatric knowledge. One of the professional aims of the textual standardization of the diagnostic manuals is to align psychiatrists with the practice of medicine and to position psychiatrists as medical professionals who use scientific standards of practice and scientific research methods to make scientific discoveries and thus produce psychiatric knowledge. Thus, in part, the epistemic authority of the profession, that is, claims about knowledge structures, nosological principles, and diagnostic practices derive from the textual standardization of the *DSMs* and the development of a professional style for American psychiatry.

Chapter 4: *DSM-5* and the Community Speakers of the "Common Language"

In this chapter I analyze the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder (www.dsm5.org). The *DSM-5* revision marks the first time the APA has launched a public website dedicated to the development process (this technology was not available during previous revisions), and, more importantly, the first time the APA has solicited public review of the profession's official diagnostic manual. Given that *DSM-5* is a medical classification system developed and written by and for healthcare professionals, predominantly psychiatrists, how do publics come to be seen as exemplary speakers, writers, and revisers of a professional style developed to improve communication and interrater agreement within a professional discourse community? As a way to provide some evidence toward answering this question, I focus on five occurrences of reported speech on Criterion D2 of the diagnostic criteria for Posttraumatic Stress Disorder to suggest that publics recognize the "common language" through this discursive feature, and to show how the professional style facilitates the social transmission, public visibility, and public uptake of the *DSM* "common language."

Rather than considering the givenness of "audience," I consider the textual nature of social being—how the classification Posttraumatic Stress Disorder constitutes subject positions in a text—as the loci for experience and action—through their interpellation as subjects using the discursive resource of putative patient reported speech on the *DSM-5* draft diagnostic criteria. To do so, I draw on the scholarship of Charland (1987) whose term "constitutive rhetoric" suggests that in the act of addressing

auditors, the rhetor establishes the possible identity positions for audience members to inhabit and, in doing so, auditors participate in the rhetorical process—auditors recognize and acknowledge the address. Thus the "voice" and persona of the speech reports on Criterion D2 are produced through complex co-authoring practices that recontextualize putative patient reported speech.

The analysis of reported speech on Criterion D2 shows how the diagnostic criteria decontextualize and dehistoricize the characteristics and qualities of the items under consideration, in this case, the "voice" and persona of putative patient reported speech. I examine the stylistic design and the placement of reported speech on the diagnostic criteria to show how recontextualization severs utterance from speaker and assists the cultural portability of putative patient speech from the reported context (whatever that may be) to the reporting context (diagnostic criteria on dsm-5.org). I conclude that the placement of reported speech on the diagnostic criteria recontextualizes the reports such that putative patient speech becomes constitutive of psychiatry knowledge.

Chapter 5: The Discursive Construction of Psychiatric Knowledge in the *DSMs*

This project focused on the textual standardization of a professional discourse community's communicative practices by asking about the ways in which the *DSMs* help to constitute psychiatric knowledge. In order to answer the question, I examined psychiatrists' metadiscourse and metapragmatic instructions about language standards and standardization in the *DSMs* themselves, in psychiatric journals, and in journalistic coverage of the *DSMs*. I analyzed metadiscourse as a way to foreground some of the ways in which psychiatrists' prescriptive and proscriptive discursive practices create seemingly natural relationships among texts, contexts, and authors. I showed how these prescriptive and proscriptive practices contributed to the textual standardization of American psychiatry. A central claim of this project was that the development of a professional style facilitated the cultural shareability and portability of the APA's "common language" across a range of rhetorical situations.

The three chapters of analysis focused on different processes and stages in the textual standardization of American psychiatry. The analysis revealed that delimiting

discursive and pragmatic practices in the *DSMs*, particularly in *DSM-III*, became the means of delineating and delimiting psychiatric knowledge in the diagnostic manuals. The study concluded that the development of a professional style and the textual standardization of that style in the APA's diagnostic manuals were central to the discursive construction of the APA as a professional scientific society and to the discursive production of psychiatric knowledge.

Chapter 2.

Metapragmatic and Visualist Practices in the *DSMs*

In this chapter, I analyze metadiscourse in the *DSMs* to identify some of the institutional and professional practices through which the American Psychiatric Association (APA) introduces new terms of art in the first three editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*): the term *diagnostic* in *DSM-I* (1952) and *DSM-II* (1968) and the term *diagnostic criteria* in *DSM-III* (1980). The examination of metadiscursive and metapragmatic practices in the *DSMs* reveals some of the ways in which the APA's standardization of these practices contributes to identity formation. I connect metadiscourse in the *DSMs* to the development of the APA classification system from a *statistical* manual to a *diagnostic* manual, and to the development of the APA professional identity from that of *statisticians* engaged in uniform record-keeping of hospital data to that of *diagnosticians,* that is, a community of scientists engaged in data-collection for diagnosis and diagnostic research.

The metadiscursive interventions I analyze demonstrate the ways in which psychiatrists evaluate, interpret, and make sense of their own communicative events, negotiate meaning, and establish professional and institutional norms. Because APA metadiscourse provides evidence of how the professional association negotiates and intervenes in the social world, some of the professional practices that help shape the classification systems are recoverable through an analysis of metadiscourse. Furthermore, analysis of these socially situated and historically contingent practices offer a way to pay attention to and understand what the members of a discourse community say they are up to in their own terms (Schegloff, 1997; Swales, 1990). By this I mean, for example, the types of terms that Burke (1966) calls "tribal idioms," that is, terms developed by the tribe for their way of living (p. 44). As Burke (1966) points out, "we can't say anything without the use of terms. Whatever terms we use constitute a screen

that directs the attention to one thing and away from another" (p. 50). Thus paying attention to APA metadiscourse is one way to account for which practices the psychiatrists understand as meaningful and how the standardization of these situated practices contributes to professional identity formation.

To demonstrate how APA members engage in metapragmatic statements that express explicit concern for the discourse features of the *DSM*s, I analyze excerpts from *DSM-I* (1952), *DSM-II* (1968), and *DSM-III* (1980). In doing so, I show how APA metadiscourse results in the substitution of new terms of art (*disorder*, *diagnostic criteria* in *DSM-III*) for old terms of art (*reaction* in *DSM-I*, *neurosis* in *DSM-II*) across the three editions. I suggest that in each edition the terms of art index the sociohistorical processes that give rise to them (Ochs, 1992). I use the concept of *prior discourse* (Bakhtin, 1986; Becker, 1994; Vološinov, 1986) to demonstrate how professional metadiscourse and metapragmatic practices help shape the *DSM-III* revision process, and as a way to account for the evolution of terms of art across editions, for example, from *reaction* to *neurosis* to *disorder*. I argue that analysis of metadiscourse shows that psychiatrists describe *DSM-III* in language that naturalizes professional and institutional communicative practices. Furthermore, I suggest that the evolution of terms of art across editions results in consequential alterations in the third edition of the profession's classification system. Thus I focus the analysis on the production of the diagnostic manuals: the expert speech of the principals, authors, and animators (Goffman, 1981) of the *DSM*s themselves, and the expert speech of their interlocutors and commentators, primarily other APA members.

While one of the purposes of this chapter is to point out the different social constraints and exigencies that help shape the discourse features of the first two editions of the manual as compared with the third edition, I do not mean to suggest that no registerial similarities exist across these three editions. For example, each edition has an integrated textual structure, precise lexical choices, high lexical variety, frequent nouns, and careful editorial oversight. According to Biber's (1988) corpus-based analysis, these types of discourse features indicate that the primary purpose of the speaker/writer is to provide high informational content (p. 107). While Biber notes that no absolute distinction exists between spoken/written discourse modes, the discourse production conditions and constraints of this type of informational register indicate highly structured features:

published printed text; standard orthography; high occurrence of passive constructions; precise lexical choice; frequent use of nouns and nominalizations; an integrated textual structure (p. 107). Thus the features of the informational register and their production circumstances help identify the kinds of discourse features, textual attributes, and production circumstances that perdure across editions of the manual.

This chapter builds on and contributes to research about how writing practices help shape scientific knowledge (Kuhn, 1962; Latour and Woolgar, 1986), and, more specifically, how visualist materials, for example, lists, tables, and figures, and orthographic practices help bolster scientific claims (Bowker & Star, 2000; Goody, 1977; Gross, 1990; Ong, 1958; Schryer, 2012). Latour and Woolgar (1986), for example, show how scientific knowledge results from the daily activities and literate practices of working scientists. They suggest that working scientists use various sorts of "literary inscription" (p. 45) practices in the form of charts, coding, graphs, diagrams, and so on to help organize initial observations, construct an ordered document, present their findings to the larger community of scientists, and prove to the scientific community that the methods and findings are valid (p. 36). Their study shows how scientists use the technologies of writing and diagramming not simply to transfer information but that writing is "a material operation" that creates order out of disorder (p. 245), and it is these literate practices that underpin their account of the social construction of facts.

Kuhn (1962), too, comments on the ability of the literate practices of working scientists to make invisible the daily working processes that produce scientific revolutions and thereby render invisible the revolutions themselves. For example, he suggests that science textbooks disguise "not only the role but the very existence of the revolutions that produced them" (p. 137). Textbooks, Kuhn argues, address themselves to and articulate an established body of scientific knowledge—the current paradigm that scientists are committed to at the time the text is written, and they do so in "the vocabulary and syntax of a contemporary scientific language" (pp. 136-137). While I do not claim that the *DSMs* are textbooks, in the sense that Kuhn means, the *DSMs* do aim to communicate an established body of scientific knowledge in the vocabulary and syntax of a specialist scientific community, the neo-Kraepelinians, and persuade others, psychoanalysts, for example, of the value of their vocabulary and syntax.

This chapter has four sections. The first section briefly analyzes an excerpt from an APA manual that predates the *DSMs*, the *Statistical Manual for the Use of Institutions for the Insane* (1918), as a way to provide some historical background and context for the statistical orientation of the first two editions of the *DSMs*. In the second section, I analyze *DSM-I* and *DSM-II* discourse features to show how APA metadiscourse helps to constitute the APA's professional identity as medical specialists, that is, scientists engaged in the science of diagnosis. In these two editions, APA metadiscourse differentiates between the terms *diagnostic* and *statistical*, identifies *diagnostic* as the profession's preferred term of art, and connects that term with practices appropriate to members of a scientific community. Specifically, I show how in *DSM-I* and *DSM-II* the APA identifies *diagnostic* practices as appropriate to the aims and goals of the discourse community, while at the same time distancing themselves from *statistical* practices traditionally associated with the profession.

In the third section, I examine three types of diagrams in *DSM-III*: bracketed tables, decision trees, and lists. Specifically, I connect psychiatric metadiscourse to the development of two primary terms of art in *DSM-III*, *disorder* and *diagnostic criteria*, and I follow their recontextualization as visual representations, bracketed tables, decision trees, and lists. The analysis of these visualist materials shows how the APA comes to equate the organizational systems or methods used in the three kinds of diagrams with the scientific method of the *DSM-III* classification system. I show how the writers equate the organizational systems or methods used in the three types of diagrams with the scientific method of the *DSM-III* classification system in the absence of evidence to support such an equivalency.

In the final section, I draw some conclusions about the consequences of the recontextualization of psychiatric discourse in these diagrammatic forms on APA professional identity formation. I suggest that the evolution of terms of art across the first three editions of the diagnostic manual index the development of the professional from that of statisticians engaged in record-keeping practices and statistical methods to that of diagnosticians engaged in diagnostic practices and scientific methods. Through the definition and separation of these two practices, *statistical* and *diagnostic*, the APA positions the association as a branch of medicine engaged in scientific practices and

connects the developing identity of APA members as scientists to the terms *diagnostic* and *diagnostic criteria*.

In this chapter, data include psychiatrists' metadiscourse from the Front and Back Matter of the *DSM*s themselves, from the APA's first standardized classification system, the *Statistical Manual for the Use of Institutions for the Insane* (1918), and from professional journals. As a way to locate the argument about the evolution of terms of art in a particular case, I examine one example of a classification for traumatic stress from each of the first three editions of the diagnostic manual: from *DSM-I* (1952), Transient Situational Personality Disorders: Gross Stress Reaction (p. 40); from *DSM-II* (1968), Transient Situational Disturbances: Adjustment Reaction of Adult Life (p. 49); from *DSM-III* (1980), Anxiety Disorders: Post-traumatic Stress Disorder (pp. 236-238). I chose these three classifications because many scholars point to Gross Stress Reaction and Adjustment Reaction of Adult Life as the nosological progenitors of Post-traumatic Stress Disorder, the first iteration of which occurs in *DSM-III* (Andreasen, 2004; Brett, Spitzer, & Williams 1998; Scott, 1990, 1993; Turnbull, 1998; Wilson, 1994). Taken together, then, these three classifications offer a historical overview of APA naming conventions and classificatory principles for what has historically been known as traumatic stress or the traumatic war neuroses, during the latter half of the twentieth century. In doing so, one of my purposes is to point to the diachronic relations among the first three editions of the manual (see Appendix 1, Appendix 2, and Appendix 3 for an example of a classification from each of these three editions.)

The American Psychiatric Association's First Statistical Manual

Prior to the publication of *DSM-I* the Committee on Statistics of the American Medico-Psychological Association (now the APA) in collaboration with the Bureau of Statistics of the National Committee for Mental Hygiene prepared the APA's first standardized classification system, the *Statistical Manual for the Use of Institutions for the Insane* (1918). In addition to this collaboration, the APA participated in the development of the Mental Disorders section of the *Standard Nomenclature of Diseases and Operations* (first edition, 1933).

The *Statistical Manual* comprises 37 pages in total and includes 22 categories of classification of mental disorder, for example, the Traumatic Psychoses, Manic-depressive psychoses, Psychoneuroses and neuroses (pp. 12-29). The manual includes 4 sample statistical cards for compiling patient statistics in an institution (p. 7). Example statistical cards include instructions on how to record first admission, readmission, discharge, and death (pp. 7-12), as well as a series of 18 statistical tables (pp. 30-40), for example, "Table 1: General admission," "Table 5: Citizenship of first admissions," "Table 7: Race of first admissions classified with reference to principal psychoses," and "Table 18: Duration of hospital life of patients dying in hospital, classified with reference to principal psychoses." The tables assist "the systematic presentation of the data that should be annually compiled by every such institution and that should be available for use by everyone interested psychiatry or the treatment of mental diseases" (p. 30). Together with the Forward (pp. 3-4) and the Table of Contents (pp. 5-6), these sections on statistical compilation comprise the whole of the *Statistical Manual*.

Metadiscourse in the *Statistical Manual* addresses the importance of routine, systematized practices and accurate recording of institutional data. The *Statistical Manual* opens with the following recommendations:

> SUGGESTIONS FOR THE PREPARATION OF STATISTICS IN A
>
> STATE HOSPITAL FOR THE INSANE
>
> Statistics of mental disease, to be trustworthy, must be based on accurate original data. If the facts first ascertained concerning the patients are recorded in a haphazard way without a clear understanding of the purposes to be attained, the statistics compiled therefrom will probably be very defective, if not absolutely worthless. . . .
>
> To facilitate tabulation and filing, it is recommended that four distinct statistical cards be used, viz. . . .
>
> It is suggested that first admission cards be printed on white cardboard, readmission on yellow, discharge cards on salmon, and death on blue, and that in each instance cards for male patients be printed with black ink and cards for female patients with red. (pp. 7-8; emphasis in original)

In addition to microlevel instructions about the colour coding of statistical cards according to admission status, and the colour of ink according to sex—*black* ink for male

patients and *red* ink for female patients—instructions about how to standardize language and style accompany the sample cards. The section entitled “Filling in Cards” (pp. 11-12) directs psychiatrists to use standardized notations for abbreviations, punctuation, and lexical choices according to the following style guidelines:

> FILLING IN CARDS
>
> Fill in every caption on each card; if full or accurate information cannot possibly be obtained, enter “U” (symbol for “facts unascertained”).
>
> If the information is negative enter “none” or “no”.
>
> Do not use the interrogation point (?).
>
> Do not use the dash (—) for “unascertained” or for “negative”.
>
> Do not use the term “several”; as “several years”; enter rather “ less than 1 yr.,” “between 1 and 5 yrs.,” or “over 10 yrs.,” if exact figures cannot be obtained.
>
> Avoid round numbers; accept figures ending with 5 or with 0 with skepticism and only after close questioning. Avoid, e.g., “1 yr” for 11 mos., 12½ mos., etc., and “1 mo.” for 35 days, etc. Avoid “60 yrs.” for 59 or 61yrs.
>
> Avoid ambiguous abbreviations; as “lob. pneu.” (lobar or lobular?), “par.” (paranoic or paralytic?), etc., and use only standard abbreviations.
>
> If the place assigned to any caption of the schedule is too limited to enter all ascertained data, mark the blank “over”, and enter the data on the back of the card.
>
> Entries on all cards should be typewritten. Designate items on the cards by underscoring; as, single. Do not cross out items or use check marks. (APA, 1918, pp. 11-12)

The above examples show how the *Statistical Manual*’s professional commitments to the compilation of uniform, written data across multiple institutional sites, and the standardization of language and style on the colour-coded statistical cards become constitutive of and synonymous with psychiatric standards of practice in the institutional setting. The metadiscursive framing of the profession’s activities in the title, *Statistical Manual for the Use of Institutions for the Insane*, establish the profession as primarily concerned with practices involving statistical record-keeping on behalf of institutions and

governments. Thus, metadiscourse apportions professional responsibility to statistical practices in the first instance.

DSM-I and *DSM-II* Metapragmatic Practices

As the representative professional body, the APA became responsible for future editions of the *Statistical Manual.* The APA Committee on Nomenclature and Statistics revised *the Statistical Manual* and changed the name to the *Diagnostic and Statistical Manual Mental Disorders* (1952), now known as *DSM-I*. *DSM-I* replicates the section "Diseases of the Psychobiologic Unit" from the fourth edition of the *Standard Nomenclature of Diseases and Operations* (1952) (pp. v-vi). The *DSM-I* Forward describes the implications of the amalgamation of these two separate information systems and knowledge structures, one statistical and one diagnostic, on the profession:

> With the publication of the first edition of the *Standard*, a considerable revision in the *Statistical Manual* became necessary. This revision was accomplished in the Eighth Edition of the *Statistical Manual*, 1934. The classification system of the new *Standard Nomenclature* was included, together with a condensed list for statistical use. For the first time the difference in a system of nomenclature and a system of statistical classification was underscored. (APA, 1952, p. vi)

At this time, then, with the publication of *DSM-I*, American psychiatry begins to distinguish the design, function, and purpose of a statistical classification from those of a nomenclature. Despite acknowledging these distinctions, however, the metadiscursive instructions for the statistical cards show that the *Statistical Manual* demonstrates ongoing microlevel scrutiny of the profession's statistical practices.

In part, the development and publication of *DSM-I* constitutes a response to the intellectual and historical exigencies of American psychiatry in the early post-World War II period. The changing psychiatric needs of veterans and the developing knowledge about complex, neuropsychological conditions in the aftermath of trauma contributed to the proliferation of manuals in use and to the ensuing nosological confusion (Grob, 1991; Mayes & Horwitz, 2005). The Navy, the Armed Forces, and the Veterans Administration developed their own classification systems for use during World War II; however, when

service personnel returned to their communities, civilian psychiatrists found themselves ill-equipped to diagnose the types of disorders military psychiatrists encountered and became familiar with during war time, such as chronic brain syndromes and transient or situational reactions to traumatic stress, in part, because the available classification systems lacked relevant classificatory concepts and categories (APA, 1952, pp. v- xi).

According to the *DSM-I* Foreward, the *Standard Nomenclature* proved inadequate because "no provision existed for diagnosing psychological reactions to the stress of combat, and terms had to be invented to meet this need. The official system of nomenclature rapidly became untenable," in part, because "a high percentage of psychiatrists contacted felt that change in the nomenclature was urgently needed, with special attention to the areas of personality disorders and transient reactions to special stress" (APA, 1952, pp. vii-viii). In addition to these considerations, during this period, a whole complex of sociohistorical processes and practices contributed to the changing professional landscape in psychiatry, including but not limited to the need for a medical nomenclature for researchers (APA, 1952), the introduction of psychoactive medications to treat mental disorders (Mayes & Horwitz, 2005; Shorter, 1997), the financial interests of the pharmaceutical industrial complex (Healy, 1997, 2003; Rose, 2004), the marginalization of psychiatry within the medical profession (Grob, 1991), the changing locus of psychiatry from institutional facilities to private domains, such as clinical practice (APA, 1952; Grob, 1991; Mayes & Horwitz, 2005), the transition from a discipline concerned with the insane to one focused on normal persons (Lunbeck, 1994), and an increase in the types of professionals involved in mental health care, for example, social workers and clinical psychologists (Mayes & Horwitz, 2005). Thus the confluence of many social factors and professional and institutional practices led to the publication of the first two editions of the diagnostic manual and helped shape their discourse features.

DSM-I and *DSM-II*, small spiral-bound books of 132 pages and 134 pages respectively, provide short descriptions of each classification, varying in length from a single sentence to approximately half a page. This means that the complete nomenclature of mental diseases in *DSM-I* comprises 31 pages (pp. 12-43), while the *DSM-II* nomenclature totals 38 pages (pp. 14-52). The *DSM-III* nomenclature, "The Diagnostic Categories: Text and Criteria" (pp. 35-335), accounts for 300 pages. Several factors account for the increased size of the third edition: (1) the expansion of

categories: for example, *DSM-I* included 106 diagnoses, *DSM-II* increased to 182 diagnoses, and *DSM-III* expanded to 265 diagnoses (Grob, 1991; Mayes & Horwitz, 2005, p. 251); (2) the inclusion of introductions for each disorders' section; (3) lengthier text descriptions of approximately 3-5 pages for each classification; (4) the addition of diagnostic criteria for each classification.

DSM-I includes detailed instructions for mental hospitals and outpatient psychiatric clinics about how to accurately compile and record the movement of patient populations (first admission, readmission, transfer, trial visit, discharge, death), and the instructions include a sample hospital statistical reporting card. An additional three sections in *DSM-I* address themselves to the collection and recording of mental health data and demonstrate the historical role of American classification manuals as statistical tools: "Section III: Recording of Psychiatric Conditions"; "Section IV: Statistical Reporting"; "Section V: Statistical Classification of Mental Disorders" (*DSM-I*, 1952, pp. 52-86). George Raines, Chair of the Committee on Nomenclature and Statistics, makes clear the importance, historically, of statistical reporting to the professional commitments of the APA:

> The collection of statistics on mental illness morbidity has long been a stepchild of Federal Government. Delegated from year to year on a fiscal basis to the Bureau of the Census, morbidity statistics in this most important area perhaps would never have been collected had it not been for the untiring efforts of former Committees on Statistics of the American Psychiatric Association and the National Committee on Mental Hygiene. It has therefore been most important in the past that this manual devote most of its attention to statistics, as was indicated by its name.
>
> In 1946, an Act of Congress authorized the establishment of the National Institute of Mental Health, under the United States Public Health Service. A Biometrics Branch has been established in that Institute, and concerns itself with the operational features of statistical reporting. It is, therefore, no longer necessary for the American Psychiatric Association to remain in the operational field as far as statistics are concerned. In keeping with the status of this Association as a scientific professional society, it has seemed appropriate to limit the statistical section of this Manual to a statement of general principles and procedures, leaving the preparation of detailed operating manuals to the operational agency created for that purpose, this Committee acting in a consultant capacity to that agency. (*DSM-I*, 1952, p. x)

Thus, with the publication of *DSM-I*, the professional organization designates "the operational features of statistical reporting" to hospital administrators and government statisticians in the public health service sector and begins to delimit the types of activities that constitute the professional practices of the association. The APA reassigns statistical operational procedures to the Bureau of the Census and mental hygiene administrators. In doing so, the APA elevates "the status of this Association" to that of "a scientific professional society." Thus, while the manual retains the term *statistical* in the title, the APA begins to direct professional practices away from statistical tabulation and toward those practices associated with a scientific professional society.

At this time, diagnosis and classification come to the fore both in the manual's name and as appropriate professional practices for APA members. The first edition of the manual includes "Appendix A: Appendix to the Standard Nomenclature and International Standard Classification" (pp. 87-102) reprinted from both the American Medical Association's *Standard Nomenclature of Diseases and Operations* (1952) and the World Health Organization's *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* (1948), which in part outlines the differences in purpose and scope between a statistical classification and a medical nomenclature, and the different qualifications and expertise required of users of each type of system.

> The function of a nomenclature is to train the medical student and practicing physician to use the clearest and most acceptable diagnostic terms to describe a particular clinical case; the function of this coding manual is to aid a capable diagnosis coder or record librarian, with occasional medical advice, to assign the terms and disease names used by the attending physician to the proper category in the list for the purpose of statistical tabulations. The better the nomenclature the more accurate will be the assignment of diagnoses for statistical purposes. (pp. 88-89)

Thus the term *statistical* came to be associated with the collection and compilation of data by "a capable diagnosis coder or record librarian" rather than with a professional organization overseeing medical specialists. The pragmatic distinctions between statistician and diagnostician arise, in part, when the locus of psychiatric practice moves from state asylums, clinics, and hospitals, those sorts of institutions closely associated with and responsible for the compilation of regional, state, and national epidemiological

records, to clinicians in private practice. Once psychiatric practice becomes removed from the state institutional setting, the APA begins to reconfigure the profession as primarily concerned with “acceptable diagnostic terms,” to align themselves with science and medicine as diagnosticians, and to codify the re-visioning of their professional identity in *DSM-I*.

While American psychiatrists recognized the need for the national standardization of methods of statistical collection and recording of mental disorders, and supported the development of a uniform classification system toward that end, with the publication of *DSM-I* the APA begins to position members as specialists engaged in disciplinary practices distinct from those of statisticians. In doing so, the APA draws a disciplinary boundary between psychiatrists and other mental health care professionals engaged in related but distinct activities, such as statistical tabulation and diagnostic record-keeping, and APA members aligns with those activities associated with diagnostics and the science of nosology. Thus with *DSM-I, diagnostic* becomes the primary term and concept with which the APA Committee on Nomenclature and Statistics begins to reposition psychiatry as a scientific professional society.

Despite the express intent to move away from statistical practices and toward diagnostic practices, the first two editions include many metapragmatic instructions about statistical reporting. *DSM-II*, however, dispenses with the lengthy instructional sections and the sample reporting tables found in *DSM-I*. Instead, “Section 4: Statistical Tabulations” (pp. 53-63) includes a list of bibliographic references concerned with procedures for record-keeping and statistical tabulation, and directs psychiatrists who wish to pursue these methods to these publications and to the Biometry Branch of the National Institute of Mental Health (p. 53).

However, the existence of metapragmatic instructions and sample tables in “Section 4: Statistical Tabulations,” which illustrate how to tabulate multiple psychiatric diagnoses, for example, provide evidence that APA institutional and professional practices developed gradually during the 1950s and 1960s. The primary difference between the sample tables in *DSM-I* and those in *DSM-II* seems to be that the latter grapple with record-keeping related to diagnostics: how to record multiple diagnoses, ways to indicate first diagnosis and subsequent diagnoses, and ways to determine the

combinations of diagnoses that can occur within a select group of disorders, for example, with the diagnosis “300.0 Anxiety Neurosis,” the psychiatrist indicates which of the following criteria apply, “First Diagnosis, Alone, In Combination, Total Times Mentioned” (p. 61), and within which select population, for example, “White Males, White Females, Nonwhite Males, Nonwhite Females” (p. 61). In this case, then, metadiscursive instructions build on the discursive features of *DSM-I* that begin to reposition psychiatrists as medical specialists, that is, diagnosticians, in addition to the many other professional duties. Metapragmatic instructions accompanying the *DSM-II* sample tables address psychiatric *diagnostic* data compilation rather than statistical record-keeping as an appropriate professional practice. In doing so, the APA continues to shape the professional practices of the association’s membership through metapragmatic instructions directing them away from old knowledge structures (statistical manual), and the associated writing and diagramming practices (statistical record-keeping), and toward new knowledge structures and professional practices represented in the *diagnostic* tables of *DSM-II*.

DSM-III Diagrammatic Materials

In this section, I look at three types of diagrammatic materials in *DSM-III*: bracketed tables, decision tree, and lists. Writing about the role of tables and figures as persuasive resources for the scientist, Gross (1990), highlights the ways that scientists’ diagrammatic materials suggest relationships—“ideally causal relationships”—among the objects they summarize (p. 74). According to Gross, tables and figures “add semantic weight” to the claims (p. 75). Tables and figures, then, support scientific arguments “by bringing the reader closer to the experience that grounds the argument” (Gross, 1990, p 74) through the visual depiction of seemingly invariant and stable relationships among the summarized items.

This section also draws on the scholarship of Ong (1958) and Goody (1977) whose work on the effects of visualist, literate practices on theories of classification in the Renaissance and in “primitive” cultures, respectively, inform my findings about how the APA’s visualist practices contribute to the “logical” arrangement and organization of *DSM-III*. Specifically, I analyze two organizational diagrams from the *DSM-III*

supplemental materials, which follow the descriptive text and diagnostic criteria for each of the 265 classifications. In all there are six appendices: Appendix A: Decision Trees for Differential Diagnosis; Appendix B: Glossary of technical Terms; Appendix C: Annotated Comparative Listing of *DSM-II* and *DSM-III*; Appendix D: Historical Review, ICD-9 Glossary and Classification, and ICD-9-CM; Appendix E: Classification of Sleep and Arousal Disorders; Appendix F: *DSM-III* Filed Trials: Interrater Reliability and Listing of Participants. I show how Appendix C: Annotated Comparative Listing of *DSM-II* and *DSM-III* (see Appendix 4 for the Neuroses section of the comparative listing) and Appendix A: Decision Trees for Differential Diagnosis (see Appendix 5 for one such decision tree) derive their properties from Ramus' bracketed tables of dichotomies (see Appendix 10 for an example) and the Porphyrian Tree (see Appendix 11 for an example), respectively.

Next, I consider the list-like properties of the diagnostic criteria whose organizational and hierarchical features bear a close relationship to the classificatory principles of the bracketed table and decision tree. However, before considering the properties of lists, I enumerate the constitutive properties of the diagnostic criteria for Post-traumatic Stress Disorder in order to identify the ways in which the diagnostic criteria arrange, segment, and hierarchize knowledge in the form of a list. The analysis of *DSM-III* visualist materials in Appendix A and Appendix C, together with the analysis of the diagnostic criteria as a type of list, shows how these materials help position psychiatrists as medical specialists with a scientific methodology.

Goody (1977) and Ong (1958) suggest that these visualist modes of classifying, for example, fixed, two-dimensional tables, Porphyrian trees, and lists impoverish and silence a subtle, sophisticated oral system of communicative acts thereby decreasing understanding by focusing on knowing as a sort of "seeing" (concerned with surfaces), rather than intellectual understanding (concerned with interiors) (Goody, 1977, p. 102; Ong, 1958, p. 104). Thus the technologies of visualist, literate practices advance a system of knowledge rooted in formal "logic," and produce schemas directed at highlighting the spatial relationships among items, reducing the complexities of the aural channel to the arrangement of "things" on the page (Goody, 1977, p. 102). These visualist technologies, transported from highly literate cultures and overlain onto oral cultures to measure intellectual capacities and achievements, become normative

instruments with profound consequences. The reduction of dynamic process (the aural channel) to “thing” (static object) through literate practices such as lists and tables plays an important part in the transformation of terms of art from *DSM-I* to *DSM-II* to *DSM-III*.

For the most part, Ong and Goody’s analyses tend toward technological determinism. For example, Ong’s argument identifies the invention of the printing press and moveable type in the post-Gutenberg era as the driving force behind Ramus’ reconceptualizations of logic and method as they pertain to dialectic and rhetoric. That is, Ong sees communication technology as the principal determining factor that causes Ramus to make connections between a formal system of logic and the arrangement of words in space, rather than understanding technology as a human invention, and as such co-constitutive of historical change. From this latter perspective, Ramus’ uptake of diagrammatic genres, such as the bracketed table of dichotomies and the Porphyrian tree, and his interpretive strategies are indicative of the complexities of communicative interaction and his participation in situated social practices. For his part, Goody, too, explains social change in terms of the effects of technologies of communication, such as writing, on systems of classification.

Nevertheless, Ong’s (1958) explication of Ramus’ visualist practices and the influence of particular types of diagrams and tables prove relevant for the analysis of diagrams and tables used to support the “logical” arrangement of categorical knowledge in the *DSM*s. So, too, Goody’s (1977) analysis provides critical insights about the spatial, hierarchical arrangement of lists and the effects of the vertical organization on the relationships among neighbouring items, particularly how the spatial design elements of the list index the “logic” of the *DSM-III* diagnostic criteria themselves.

In the diagnostic manuals, the APA makes use of graphic representations with their own distinctive characteristics to organize phenomena and package knowledge in discrete chunks in ways that serve the professional aims and goals of the association. When scientists collect, arrange, and categorize phenomena on a two-dimensional surface, the diagramming practices and the classifying principles amplify each other and help ratify the knowledge claims (Gross, 1990, p. 75). In scientific communities such as the APA, graphic representations arrange disparate phenomena onto a single, visible surface to augment research claims and establish epistemic authority. For example,

scientists produce material representations in the form of coding, charts, graphs, and diagrams, to make sense of their observations, and to transmit their methods and findings to other scientists. These sorts of “inscription practices” (Latour & Woolgar, 1986) create the objects of knowledge that become the hallmarks of the profession and play a key role in the organization of scientific knowledge.

The Bracketed Tables of Dichotomies

According to Ong (1958), the bracketed tables of dichotomies seek to produce knowledge and to arrive at understanding through the visual arrangement of topical information into hierarchies that Ramus took to be “proof” of something—an attitude fashioned in the tradition of Rudolph Agricola’s topical logic. Agricola divorces dialectic from rhetoric, insisting that the *loci* or places belong to dialectic alone, while at the same time he eliminates the Aristotelian distinction between a dialectic of probabilities and scientific demonstration (p. 102). While in the Aristotelian tradition the commonplaces operated within an oral/aural economy, a list of topics *spoken* on a given subject—propositions, assertions, statements—the Agricolan-Ramist tradition shifts the auditory sensory and conceptual attention from *enunciations,* for example, utterances about something or the expression of a judgement, to a discourse of explanation via the visual field and the use of visualist analogies that underscore the relationship of the subject in a proposition to the world of objects, observable phenomena, and objective knowledge.

During the English Renaissance, physicians adopted Ramus’ dialectical method as a scientific method so as to establish medicine as a credible discipline with systematic and rigid procedures (Tebeaux, 1991, p. 424). In sixteenth century English medical texts, bracketed tables displayed the book’s contents and summarized the material of each chapter, and the classificatory approach structured the discourse: parts of the body, causes of disease, treatment protocols, kinds of medicines—all were subjected to collection and division. The bracketed table acted as a mnemonic technique to facilitate student learning and in this way physicians connected Ramus’ method to the production of scientific knowledge. Thus during the English Renaissance, medical texts acquired the Ramist proclivity for substituting the structural attributes of the diagram,

characteristics like clarity, concision, and precision, for scientific method (Tebeaux, 1991, pp. 417).

In the nineteenth century, the structural aesthetic of the bracketed table of dichotomies surfaces in German psychiatrist Emil Kraepelin's classification of mental diseases, *Compendium der Psychiatrie (1883).* Throughout his life Kraepelin (1856-1926) continued to refine his *Compendium,* publishing eight revised editions before his death. Kraepelin favoured a psychiatric model that understood mental disorders by analogy with physical diseases, and his approach proceeded from the belief that classification of disease based on careful observation and ordering of visible phenomena rather than on the search for their causes would further psychiatric knowledge. Therefore, classification was the first step toward determining the course and outcome of the disorder, and, given sufficient empirical research, the organic and biochemical origins of mental disorders would be discovered (Mayes & Horwitz, 2005; Young, 1995). For example, Kraepelin's system distinguished dementia praecox (schizophrenia) from maniacal-depressive conditions in the disorder's constellation of signs and symptoms, course of disease, and outcome. *DSM-III* and subsequent editions take up this Kraepelinian perspective of classification: diagnosis based on observable phenomena, co-occurring signs and symptoms (the diagnostic criteria), that unfold over time in somewhat predictable patterns, without recourse to theories of causation.

In his Preface to *Einführung in die Psychiatrische Klinik* (1901) (*Lectures on Clinical Psychiatry*), Kraepelin addresses some of the differences between the spoken and written mode and his reasons for transcribing clinical lectures, delivered during hospital rounds, into the written mode.

> All those who have at any time given clinical demonstrations on disease must have felt the desire to impress more firmly on their hearers the remembrance of what they have seen than is possible in an ordinary lecture. After many attempts to arrive at this in some other way, I have now tried to preserve, in a measure, the impressions of a term's clinical work in the form of the lectures contained in the following pages. In my descriptions I have endeavoured, as far as possible, to follow the actual course of the lectures. Naturally, not only must this work give up all claim to the actual presentation of the patients, for which the student can only be compensated by personal experience in the hospital, but we must also forego the great help to teaching afforded by the assistant's little awkwardnesses and blunders, which so often serve to point out to the

> teacher the right method of instruction. On the other hand, the material can in this way be worked up more concisely, more systematically, and more completely than is generally possible in the hospital. (p. vi)

In this excerpt, Kraepelin points to some of the changes that occur when a given instance of discourse becomes entextualized. He seems to be aware that repackaging the spoken lectures as written text detaches the lectures from their indexical surround (e.g., the remove of the clinical setting and the absence of patients) and that the recontextualization changes the spoken discourse into an idealized speech situation with highly stylized and standardized features. On this latter point, Kraepelin notes how the production of published printed texts eliminates the missteps and disfluencies of the spoken mode, those "little awkwardnesses and blunders," which he recognizes as a loss, and that the process of entextualization allows him to produce a more concise, more systematic, more complete product than the spoken mode.

Furthermore, editor Thomas Johnstone, "worked up" Kraepelin's lectures into an even more concise, systematic method when, in this role, he supplemented the English language edition of the *Lectures on Clinical Psychiatry* (1904) with the bracketed table he names "Classification of Mental Diseases" (Appendix 12). Johnstone inserted his tabular rearrangement of the lectures into the Front Matter of the text following the list of contents and preceding the lectures themselves. In his Editor's Preface, Johnstone explains his motives for creating the tabular representation:

> In order that the subjects dealt with might be studied in regular sequence, I have constructed a table, placing together the subdivisions of each disease and the lectures in which they occur, so as to facilitate their continuous study. [. . .]
>
> The nomenclature of the diseases adopted in the text differs widely from that met with in English books on the subject; but any little difficulty here will be easily understood by a study of the table where the contents are classified—for example, the phases of the disease termed "maniacal-depressive insanity" only groups together phenomena which have long been recognised. (pp. viii-ix)

Like the English Renaissance physicians before him, and the *DSM-III* psychiatrists after him, Johnstone draws on the spatial organizing principles of the bracketed table, making judicious use of white space, headings, partitions, and fonts to recontextualize

Kraepelin's lecture series as a logical method. He offers the bracketed table as a mnemonic device for students and physicians and as an "easily understood" teaching aid for English psychiatrists. That is, he aims to make information more readable and memorable for an audience unfamiliar with the divisions and collections of phenomena in Kraepelin's classification system. In doing so, Johnstone constructs the lecture series as a system with an internal organizing logic consistent with the scientific method. Johnstone's recontextualization of Kraepelin's classifying apparatus and his rearrangement of the numbered lectures onto the dichotomous and trichotomous branching schema serve to instantiate the sequential "logic" of the classification system. Thus Johnstone's recontextualization of Kraepelin's text in diagrammatic form comes to stand in for the scientific "method" when no such continuity of method holds for the classification itself.

In *DSM-III*, Appendix C: Annotated Comparative Listing of *DSM-II* and *DSM-III* (see Appendix 4) consists of a table that compares *DSM-II* and *DSM-III* categories and makes use of an extended bracketed table to diagram the change in the names of diagnostic categories and individual classifications from *DSM-II* to *DSM-III* in the order in which they occur in *DSM-III* (pp. 371-395). Spitzer twice addresses the purpose of Appendix C, first, in the Introduction and again in the appendix itself. I include Spitzer's remarks, in that same order, in the following two excerpts.

> The profession is entitled to know the rationale for all the major changes that have resulted in the *DSM-III* classification of mental disorders. For this reason, included in Appendix C is a table containing an explanation for each major change made and new category added, with references from the scientific literature. With the use of this table, the reader can more easily make the transition from the *DSM-II* to the *DSM-III* classification and understand the reasons for the changes. (p. 9)

And,

> This section lists all of the specific categories included in the previous manual (*DSM-II*) and the specific *DSM-III* categories that are equivalent to or subsumed by them. Because of the greater precision with which the *DSM-III* categories are described and because the diagnostic concepts have often been modified, the degree of equivalence varies. (For example, in *DSM-III* the category of Schizophrenia is more restrictive than the *DSM-II* category.) Whenever a category in one manual corresponds

> to several categories in the other, the latter categories are enclosed by one brace. In some instances, several categories from one manual are equivalent to several categories from the other manual. In such cases, a double brace is used. (p. 371)

Spitzer endorses a visualist approach in *DSM-III*: the bracketed table helps the reader bring old knowledge structures to bear on new knowledge structures and in doing so understand the organizing principles, that is, the method and logic of the new classification system. Through the visual representation of the *DSM-III* classification schema as a two-dimensional annotated table, Spitzer seeks to unproblematically "modify" or "subsume" complex, etiological psychiatric concepts with the "greater precision" of the *DSM-III* categories. The evidence Spitzer offers to substantiate the claim that, for example, "categories from one manual are equivalent to several categories from the other manual," however, consists in an explication of the tabular design features of the table; that is, how the uses of a single brace differ from the uses of a double brace. This sort of argumentative strategy, establishing relationships through spatial arrangement, became synonymous with logical method in *DSM-III*. Thus for the two psychiatric nosologists, Spitzer and Johnstone before him, the method of the visual representation becomes equivalent with the method of the classification system in the absence of evidence for such claims.

The *DSM-III* bracketed table establishes a genealogy that unproblematically links old terms of art to new terms of art thereby seamlessly connecting old knowledge structures, the *DSM-II* concept *neurosis*, to new knowledge structures, the *DSM-III* concept *disorder*. The dotted lines, brackets, and spatial organization of items on the table draw equivalencies between classifications in *DSM-II* and classifications in *DSM-III* that may not exist, and demonstrate how the bracketed table builds an internal logic through the extension of terms across the three editions, from *reaction* (*DSM-I*) to *neurosis* (*DSM-II*) to *disorder* (*DSM-III*) (see Appendix 6, Appendix 7, and Appendix 8). The evolution of terms of art diagrammed on the bracketed table highlights the change from terms that index dynamic processes associated with Adolf Meyer's psychobiologic theory of mental disorder (*reactions*) and Sigmund Freud's psychoanalytic perspective (*neuroses*), to the neo-Kraepelinian term *disorder*, which recontextualizes dynamic processes of the personality as stable states in the body and exemplified in a static

object—the diagnostic criteria. The bracketed table arranges *DSM-III* naming conventions and classificatory principles as a series of binary branches on a single, visible surface. Thus *DSM-III's* bracketed table, a listing that substitutes *neuroses* with *disorders*, provides a visually stable framework that adds "semantic weight" (p. 75), to borrow from Gross (1990), to Spitzer's claim that "the neuroses were still there, of course, they were just renamed and reorganized according to their symptoms" (Sobel, 1979, C6).

To recast the effects of Ramus' diagrammatic logic in Bakhtinian terms, the bracketed table reduces a heteroglossic sound world of sociolinguistic diversity to silenced (monologic) "things" on the page, while the schematic relationship imposes a fixed semantic relationship between words. The *DSM-III* diagrammatic materials demonstrate the drive to "tie down words" in simple geometric patterns, as Ong (1958) says (p. 89), as though doing so demonstrates the logic of the classification system and stands as proof of the nomenclature's scientific rigour. The placement of categorical terms on the bracketed table with the *DSM-III* terms in the far right (final) column imposes a natural and logical order between old and new classificatory concepts such that the whole system of classification inherits and integrates the terms of art that came before *DSM-III* and all the dynamic processes they indexed become subsumed and silenced along with them.

The Porphyrian Tree

The Porphyrian tree (Appendix 11), named for the Greek neo-Platonist Porphyry of Tyre, became known through Boethius's Latin translations of Porphyry's explications of the Aristotelian categories (Ong, 1958). The tree-like structure, which influences the Ramist and Agricolan tables of dichotomies, displays a single field of knowledge in a spatial scheme, such as a hierarchical relation of genus to species. The Porphyrian tree came into widespread use for the diagrammatic organization of logic during the Renaissance (Ong, 1958, pp. 78-79, 199). Ramus translated the Porphyrian trees into abstract tables of dichotomies while retaining the dualistic division of the qualities of any item under consideration. Thus the Ramist dichotomies arise from notions of bipolarity in being, for example, form and matter; the one and the many (Ong, 1958, p. 199).

The *DSM-III* authors, like the Renaissance physicians before them, offer the bracketed tables and decision trees as memory aids to facilitate learning and teaching the new *DSM-III* method of classification. *DSM-III* includes six Porphyrian-inspired "Decision Trees for Differential Diagnosis" (one for each of six major diagnostic categories, for example, Differential Diagnosis of Irrational Anxiety and Avoidance Behavior) (Appendix 5). The Introduction describes the hierarchical design of the manual and refers the clinician to the decision trees for a visual summary of the nosological method:

> The order in which diagnostic classes are listed represents, to some extent, a hierarchy in which a disorder high in the hierarchy may have features found in disorders lower in the hierarchy, but not the reverse. This hierarchical relationship makes it possible to present the differential diagnosis of major symptom areas in a series of decision trees (see Appendix A). (pp. 8-9)

In Appendix A, Spitzer and Janet Williams, designers of the decision trees, offer an outline for their intended use:

> The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or out various diagnostic categories. The questions are only approximations of the actual diagnostic criteria. The decision trees are not meant to replace the specific diagnostic criteria. (p. 339)

The following year, in the *American Journal of Psychiatry*, Skodal, Spitzer, and Williams (1981) publish their recommendations for teaching and learning the decision trees.

> In *DSM-III* a series of logical decision trees is presented in an appendix. Each tree follows the logic, according to *DSM-III* concepts, of the decision-making process in an important area of differential diagnosis such as psychotic features, mood disturbance, and physical complaints. (p. 1582)

And,

> With the classification arranged hierarchically, disorders listed first in the classification may have the clinical features of disorders listed later, although the reverse is not true. This principle is incorporated into the logic of the decision trees. (p. 1583)

While the stated purpose of the decision trees is to help the clinician understand the hierarchical structure of the new manual, that is, "each tree follows the logic" of the *DSM-III* concepts, Millon (1983, 1991) argues the nosology exhibits no such hierarchical structure in the first instance:

> A prime consequence of so carefully fashioned a sequential chain of categories would be the fact that successive syndromes in the classification invariably are more specific and convey more precisely differentiated information than those that precede them. This increasing distinctness and exactitude, necessary ingredients in a successful decision tree or branching procedure, assures that each successive category possesses authentic clinical features not found in categories previously listed. A serial pattern of this nature would be a remarkable nosological achievement for the *DSM-III*, were it so in fact. (1983, p. 809)

And,

> Sequential patterns of the decision-tree type would be a remarkable achievement for any hierarchical nosology, if they were naturally or logically justified. Not only is there no inherent structure to psychopathology that permits so rigorous an arrangement, but the various *DSM*s, for instance, impose only a modest degree of sequential rigor on the taxonomic organization. (1991, p.253)

As Millon (1991) notes, and Skodal, Spitzer, and Williams (1981) attest, *DSM-III* presents the decision trees as having a "natural" or "logical" sequential rigour. The tree provides a useful metaphor that depicts both a unified, closed structure from the natural world and a natural system with whole to part relationships between the trunk, branches, and leaves of the tree. In *DSM-III*, however, the decision trees do not depict a natural system but rather make information available to the viewer in the form of a static object. The tidy, fixed, two-dimensional diagrams sanitize and flatten evidence of real-world interactions: shared assumptions (social, cultural, historical); ideological positions (professional, institutional); interpretative and decision-making strategies and stances

(clinical, theoretical), and the decision trees naturalize the neo-Kraepelinian framework and the biomedical view of mental disorders as discrete disease entities.

The *DSM-III* diagnostic decision trees present a series of choices in the form of propositions that require a decision be made in a binary manner: "yes" or "no." For example, in the decision tree for "Differential Diagnosis of Irrational Anxiety and Avoidance Behavior," the first decision point reads "Irrational anxiety or avoidance behaviour is the predominant clinical feature," to which the clinician must respond to the proposition with a response in the form of a "yes" or "no" judgement. Goody (1977) makes an explicit connection between the binary construction of the decision tree and the limits of knowledge.

> I mean only that the decision to include or exclude from a field or a class often has to be carried out in a binary manner when graphic representations are constructed (though the Venn diagram offers a partial alternative), and that this process, while possibly raising important problems for the growth of knowledge, may be quite divorced from the situation of the (oral) actor, whose field of perception is less differentiated, more homogeneous, than the one forced upon the (literate) reader. (pp. 106-107)

Furthermore, the suggestion that as the clinician moves along the various branches of the tree diagnoses are ruled out goes against the multiaxial framework and multiple diagnosis evaluation system of the manual. That is, the hierarchical principles of the decision tree promote mutually exclusive diagnoses and direct the clinician through a series of binary moves toward a differential diagnosis in accord with a classificatory scheme of discrete disease entities (Millon, 1983, 1991). However, other psychiatrists argue that the *DSM-III* model, with diagnostic criteria as an integral organizing principle, derives its structure from a prototypical model (Wittgenstein, 1953) rather than from a classical approach (Aristotelian) to categorization (Cantor, Smith, French, & Mezzich, 1980). That is, according to Wittgenstein's prototypical model of family resemblances, members of a category do not all share a set of defining features; rather, the possession of different sets of features for different category members determines membership in the category based on the metaphor of *family resemblances* (on Wittgenstein,1953,). According to this metaphor, "a complicated network of similarities overlapping and criss-

crossing: sometimes overall similarities, sometimes similarities of detail" (p. 27) occur between various members of a family.

The diagnostic decision trees ask the clinician to make decisions according to an Aristotelian classificatory system: the person either does or does not present the necessary characteristics. The Aristotelian system requires homogeneity of features according to monothetic principles of classification: the use of a single set of individually necessary and collectively sufficient characteristics, whereas the prototypal model allows heterogeneity of features according to polythetic principles of classification: the use of a number of overlapping and criss-crossing, sometimes shared, characteristics. In this sense, then, the decision trees, which are loosely based on the diagnostic criteria (APA, 1980, p. 339) and many of which were monothetic in design in *DSM-III* (Kupfer, First, & Regier, 2002), compel the clinician to specify the defining features for category membership and thus undertake an exercise in identifying discrete disease entities—Post-traumatic Stress Disorder *or* Adjustment Disorder with Anxious Mood—and to record the differential decision using the corresponding *DSM-III* 5 digit code.

Whereas the *DSM-III* multiaxial system allows for and encourages the recognition and coding of occurrences of diagnostic overlap, for example, multiple diagnoses, the differential diagnosis decision trees, as their names indicate, compel the clinician to differentiate between diagnoses, whereby membership in one classification precludes membership in another classification: Post-traumatic Stress Disorder *not* Adjustment Disorder with Anxious Mood. Thus the decision trees establish a hierarchy of diagnostic classes through the implementation of a series of binary decisions ("yes" or "no"), thereby positing a rigorous and sequential organizational scheme between whole classes and subordinate members (individual disorders) that some scholars question. According to this reasoning, if *DSM-III* follows a prototypical organizing approach, this approach precludes the nosology itself from following any such sequential rigour as displayed in the decision trees, and disallows claims to hierarchical cohesion in the disorders sections of the classification (Millon, 1983, 1991).

The Diagnostic Criteria

The diagnostic criteria represent a unique formal marker of the classification system absent from *DSM-I* and *DSM-II*. The *DSM-III* diagnostic criteria drew upon, primarily, two prior texts: "Diagnostic Criteria for use in Psychiatric Research" (Feighner, Robins, Guze, Woodruff, Winokur, & Munoz, 1972), known as *the Feighner criteria*, and the "Research Diagnostic Criteria" (Spitzer, Endicott, & Robins, 1975b), known as *the RDC*. The Feighner criteria constituted psychiatry's first explicit set of diagnostic criteria for 15 psychiatric diagnoses (Feighner, 1989), the RDC modified and expanded the Feighner Criteria to provide diagnostic criteria for 25 major diagnostic categories with further subdivisions, for example, major depressive disorder has 11 subtypes while schizophrenia has 6 subtypes (Spitzer, Endicott, & Robins, 1978), and *DSM-III* modified and expanded the RDC (Feighner, 1989; Spitzer, 1989) to provide diagnostic criteria for 265 disorders (Mayes & Horwitz, 2005). In *DSM-III* (and all subsequent editions), the diagnostic criteria follow the descriptive text for each disorder, and, according to Spitzer's Introduction, guide and assist the clinician in making a diagnosis, and "enhance interjudge diagnostic reliability" (APA, 1980, p. 8).

Within psychiatric circles, the diagnostic criteria became an often discussed discursive convention of the *DSM-III* nosology (Buck & Walker, 1982; Cooper & Michels, 1981; Frances & Cooper, 1981; Klerman, Vaillant, Spitzer, & Michels, 1984; Millon, 1983, 1991). Spitzer's professional orchestration of the *DSM-III* neo-Kraepelinian approach casts the designers of the diagnostic criteria (Feighner and himself) as revolutionary thinkers. Some critics suggest that decisions on inclusion and exclusion of diagnostic criteria were made by individual experts, a practice that allowed data to be either overlooked or ignored according to the whim of the individual researcher (Lane, 2007; Spiegel, 2005). Kirk and Kutchins (1992) note that revisions to the *DSMs* do not originate with clinical practitioners; rather, revisions derive from the comparatively small number of practitioners on Task Force subcommittees (p. 28), and, at times, as Spiegel (2005) documents, the chair of the Task Force or Work Group, such as Spitzer, might single-handedly entrench changes (p. 60). Still other commentators note the lack of systematic literature reviews during the revision process (Kutchins & Kirk, 1997), a shortcoming Spitzer acknowledges in the *DSM-III* Introduction (APA, 1980, p. xx).

Many scholars point out that increased interrater reliability brought a potential decrease in validity of diagnosis because of the assumed homogeneity of classified persons without consideration for culture, gender, race, class, and so on (Caplan, 1991; Figert, 2005; Godderis, 2011; Kendell & Jablensky, 2003; Lane, 2007; Ussher, 2006; Watters, 2010). Still others observe that the diagnostic criteria not only limit diagnostic validity but represent a throwback to nineteenth century Kraepelinian descriptive psychiatry and as such are not a mark of paradigmatic science (Frances & Cooper, 1981, p. 1200).

The architects of the *DSMs* and their commentators disagree among themselves as to whether the various editions of the manual follow a monothetic, polythetic, or mixed monothetic-polythetic classificatory scheme. Furthermore, within an edition the criterial design varies depending on the particular disorder under consideration. Young (1995) makes the case for the *DSM-III* iteration of Post-traumatic Stress Disorder as a monothetic classification in a manual with two sets of rules: disorders with explicitly monothetic diagnostic criteria and those with explicitly polythetic diagnostic criteria (pp. 118-19), whereas, "when the text is put into practice, however, and we move from the system's formal requirements to the cognitive processes affecting actual diagnostic judgement, diagnosis turns out to be more complicated and less rule-driven" (p. 120). In diagnostic practice, then, Post-traumatic Stress Disorder becomes a "quasi-monothetic" or "quasi-polythetic" classification, following the rules of neither kind, because it expands "to include cases related through family resemblances only" (p. 119). Young assigns Post-traumatic Stress Disorder this "quasi" status through the identification of a "submerged feature: a tacitly understood element that allows diagnosis to include 'partial' cases of a disorder (cases lacking one or more criterial features) within the rule-defined classification" (p. 119). In this case, the submerged feature Young identifies is the "polymorphous" traumatic memory (p. 119); a feature intrinsic to the classification, in some cases expressed as an associated feature, such as "unexplained absences" or "unpredictable explosions of aggressive behavior" (APA, 1980, p. 237), but not explicitly named on the diagnostic criteria. In these cases, according to Young (1995), the "submerged feature" works to bind the classification together from within (p. 120).

According to Dell and O'Neil (2009), most disorders in *DSM-IV* have polythetic criteria or "monothetic/polythetic hybrids" (p. 390). For example, the authors note that the

diagnostic criteria for Post-traumatic Stress Disorder follow a mixed monothetic-polythetic model: “in PTSD, any one of five types of reexperiencing must be present; *and* any three of seven types of avoidance/numbing must be present; *and* any two of five kinds of hyperarousal must be present “(p. 390; emphasis original).

Some commentators refer to the mixed monothetic-polythetic model as the “Chinese menu” approach of *DSM-III* (Vaillant, 1984, p. 543). In defense of this hybrid approach, Spitzer, Endicott, and Robbins (1975a) counter, “these observers totally ignore the fact that the usual Chinese menu is in columns (‘two from Column A and one from Column B’), whereas the diagnostic symptoms in this approach are presented in rows” (p. 1188, n.1). However, Goody (1977) notes that both columns and rows hierarchize and classify items:

> One of the features of the graphic mode is the tendency to arrange items in (linear) rows and (hierarchical) columns in such a way that each item is allocated a single position, where it stands in a definite, permanent, and unambiguous relationship to the others. Assign a position, for example, to “black” and it then acquires a specific relationship to all the other elements in the “scheme of symbolic classification.” (p. 68)

While the authors point out differences in diagrammatic layout between the Chinese menu approach (columns) and the layout of the *DSM-III* diagnostic criteria (rows), both rows and columns compel the viewer to draw inferences between items that occupy fixed positions in a classificatory system. As well, the authors do not account for the differences in patient inclusion and exclusion rates between classifications whose diagnostic criteria reflect a monothetic, a polythetic model, or a mixed monothetic-polythetic model.

According to Allen Frances, Chair of the *DSM-IV* Task Force, this edition of the manual includes explicitly monothetic diagnostic criteria and some polythetic diagnostic criteria (APA, 1994, p. xxiii). In the Introduction to *DSM-IV,* he writes that the change in diagnostic criteria design in this edition compensates for the limitations of the traditional categorical method because “a categorical approach works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive” (APA, 1994, p. xxiii). Therefore, because *DSM-IV* makes no such assumptions about homogeneity of category

membership or discrete borders between disorders or between disorder and no disorder, the inclusion of polythetic criteria allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, then, *DSM-IV* often includes polythetic diagnostic criteria, in which the individual need only present with a subset of items from a longer list. (APA, 1994, p. xxii)

Frances' statement, that "*DSM-IV* often includes polythetic criteria sets," suggests a mixed model. One consequence that results from the mixed model is that polythetic elaboration of monothetic diagnostic criteria increases the categorical reach of the classification and contributes to "diagnostic bracket creep" (Kramer, 1993, p. 15). While Kramer locates the contributing factor for this phenomenon in the pharmaceutical industry, that is, the expansion of categories matches an expanding pharmacopeia, I draw connections between "diagnostic bracket creep" and two *DSM-III* features that work hand-in-hand to produce this effect: (1) the quantitative increase in available diagnostic criteria in individual classifications, for example, *DSM-III* (1980) lists 3 symptom clusters (A, B, and C, monothetic) with a possible 13 criteria (polythetic expressions) for Post-traumatic Stress Disorder, while *DSM-IV* (1994) lists 6 symptom clusters (A, B, C, D, E, and F, monothetic) with 21 possible criteria (polythetic expressions) (see Appendix 9); (2) the expansion in terms of art, for example, in *DSM-I* (1952) the Psychoneurotic Reactions section identifies 7 reactions that transmogrify into 24 disorders in the Anxiety States section in *DSM-III* (1980) (see Appendix 8 for a partial list).

The use of classificatory schemes for everyday purposes, objects such as tables and chairs, and what counts as a game (Wittgenstein, 1953), and specialist purposes, medical classification systems such as the *DSM*s, vary depending on the conditions and occasions under which knowledge of an object/person, and the motivations to classify an object/person as one thing and not another thing, come into play, for example, Posttraumatic Stress Disorder, not Adjustment Disorder with Anxious Mood. In the series of Aphorisms mentioned above, Wittgenstein (1953) makes a similar point about how situated practices influence our use of categorical schemes. For example, in Aphorisms 65-69, Wittgenstein poses a series of questions and answers about "language games,"

and in Aphorisms 68-69 he ruminates about local and provisional determinates of the category “game”:

> 68. For how is the concept of a game bounded? What still counts as a game and what no longer does? Can you give the boundary? No. You can *draw* one; for none has so far been drawn. (But that never troubled you before when you used the word “game.”)
>
> “But then the use of the word is unregulated, the ‘game’ we play with it is unregulated.”—It is not everywhere circumscribed by rules; but no more are there any rules for how high one throws the ball in tennis, or how hard; yet tennis is a game for all that and has rules too.
>
> 69. How should we explain to someone what a game is? I imagine that we should describe *games* to him, and we might add: “This *and similar things* are called ‘games.’” And do we know any more about it ourselves? Is it only other people whom we cannot tell exactly what a game is?—But this is not ignorance. We do not know the boundaries because none have been drawn. To repeat, we can draw a boundary—for a special purpose. Does it take that to make the concept usable? Not at all! (Except for that special purpose.) (p. 28; emphasis original)

His point about rules and boundaries, so far as what counts as a game, is that participants negotiate the language based on the particular situation for “a special purpose,” while choosing the prototypical characteristics that best fit the occasion.

In terms of the *DSMs*, one of the important differences between these two models (prototypical and classical) is the necessity in the classical model to identify and distinguish discrete borders or boundaries between categories of mental disorders. The differential diagnosis decision trees together with the recording of numerical codes for statistical and insurance purposes entail the drawing of boundaries and in doing so render invisible the messy “real world” decision-making processes and interpretive strategies involved in patient diagnosis, and erase what Wittgenstein calls the “complicated network of similarities overlapping and crisscrossing: sometimes overall similarities, sometimes similarities of detail” (p. 27) between categories.

The List

As the above discussion indicates, *DSM-III* and *DSM-IV* arrange diagnostic criteria into alpha-numeric lists that group together similar types of signs and symptoms (Criterion A, Criterion B, Criterion C, and so on). According to Goody (1977), like other diagrammatic classifying systems, lists arrange items according to hierarchical organizing principles (p. 68). He notes that lists occur in spoken discourse, for example, in rituals but he suggests that the types of characteristics he highlights rarely occur in ordinary speech (p. 80). In many ways, the defining characteristics and organizing principles of the list place it in close relationship with schematic tables and decision trees. The graphic mode arranges items in columns and rows in such a way that each listed item occupies a permanent, discrete position and acquires stable relationships between other items in the system of classification (p. 68). Goody (1977) describes the properties of lists in the following way:

> Lists can be read in different directions, both sideways and downwards, up and down, as well as left and right; it has a clear-cut beginning and a precise end, that is, a boundary, an edge, like a piece of cloth. Most importantly it encourages the ordering of the items, by number, by initial sound, by category, etc. And the existence of boundaries, external and internal, brings greater visibility to categories, at the same time as making them more abstract. (p. 81)

Lists position main points ahead of subordinate ideas, code and highlight the importance of dominant positions through various design features, such as alpha-numeric ranking, and facilitate the recall of knowledge marked for prominence. Like the bracketed table and the decision tree, the list, itself a classificatory system, treats items like “things” arranged on a two-dimensional surface, silences the flux, discontinuity, and ambiguity of oral communication, and produces a static, material object whose organizing principles, hierarchical structures, and spatial arrangement determine how readers pay attention to, interpret, and evaluate the text. The spatial, hierarchical arrangements of lists raise questions about what to include and what to exclude and about the relationships of consecutive entries and neighbouring items; however, the placing together of items in rows and columns does not necessarily provide evidence of any significance in those proximate relationships nor does spatial arrangement and proximity produce meaning-making (Goody, 1977, p. 102).

Beginning with *DSM-III*, the diagnostic criteria in the *DSM*s display many of the common features of lists: alpha-numeric designation and spatial position indicate primacy of position; for each disorder, diagnostic criteria are titled in bold and laid out on greyed background to differentiate them from the descriptive text; symptom clusters establish boundaries (for example, Criterion A, Criterion B, Criterion C and so on) as does the white space between them; individual criterion within clusters appear to have equivalent relations. For example, on Criterion D of the diagnostic criteria for Post-traumatic Stress Disorder (Appendix 3), *DSM-III* directs the reader to choose "at least two of the following symptoms" (p. 238) from a list of six consecutively numbered diagnostic criteria arranged vertically in space. And, as the greyed background and bolded border of the diagnostic criteria demonstrate, lists are easily turned into tables (Goody, 1977; Schryer, 2012).

While the instruction to choose "at least two of the following symptoms," indicates equivalent weight among the six symptoms, the alphabetic values and vertical arrangement indicate an implicit hierarchy within the constituent items that make up the cluster of symptoms on Criterion D. The numeric values and the vertical order of the list establish an implicit hierarchy: items with the highest weight appear at the top of the column, while those with the lowest weight appear at the bottom (Goody, 1977, p. 103). Furthermore, in terms of Criterion D, six constitutive items seems to be a sizeable enough number to compel further division, clustering, arrangement, and classifying.

In the Western rhetorical tradition, lists privilege systematic, logical language thereby deriving some of their rhetorical force from their form. Bowker and Star (2000) refer to the *International Classification of Diseases* (*ICD*) as a list (pp. 137-139), and they point out that lists are one of the simplest of technologies used for hierarchical organization and division (p. 137). The authors suggest that the visual elements of lists encourage readers to develop a narrative and from there develop an argument. They note that explicit narrative is absent from medical classification systems like the *ICD* yet the organization and arrangement of items compel readers to construct narratives. During the activity of reading, the authors suggest, the categorical structure of the *ICD* prompts questions about division and arrangement and, in turn, hypothetical answers prompt readers to look for embedded narratives and arguments in the structure (pp. 55-57). These types of classification systems, however, foreground the categorical

arrangement while "pragmatically bleaching," to borrow a term from Haviland (1996, p. 64), the narratives and arguments that gave rise to them. As the name of Haviland's term indicates, highly literate practices contribute to the "bleaching" of the pragmatic conditions of the rhetorical situation, for example, the contexts of production.

Furthermore, over time, readers of lists actively construct and negotiate the narrative and the claims, and through these readerly negotiations they participate in a "collective accomplishment" of contents and vocabularies (Schryer, 2012, n. p.). Readers, then, may use the list-like structure of the *DSMs'* diagnostic criteria to look for additional patterns and relationships between items to invent new arguments even in the absence of evidence that such relations among neighbouring items exist. Schryer's (2012) observation about readers' contributions to the contents and vocabularies of lists highlights the ways in which lists, including lists of signs and symptoms of mental disorder, may facilitate the reproducibility, replicability, and recontextualization of the diagnostic criteria.

Conclusion

In this chapter, I showed how *DSM-III* diagrammatic structures organize and summarize new information and help readers bring prior knowledge from the *Statistical Manual*, *DSM-I*, and *DSM-II* to bear on the new information scheme. I showed show some of the characteristics of the Ramist and Porphyrian classification systems, for example, division and distribution, influence the diagrammatic materials of the *DSM*s. While the organizational design contributes to their uptake (decision tree nodes and lists of diagnostic criteria lend themselves to memorization and recall), the cultural power of these literate artifacts lies in their material reproducibility and replicability.

The analysis of metadiscourse in the *DSMs* demonstrated how institutional and professional communicative practices contribute to the development of new terms of art across editions, and, how the development of new terms of art facilitates the replication and expansion of categories of mental disorder. Thus the analysis of metadiscursive and metapragmatic practices highlighted the cultural portability of the classifications. Further, I have shown how the entextualization of these diagrammatic schemas—diagnostic

decision trees, bracketed tables, and ranked lists of diagnostic criteria—serves to decontextualize and dehistoricize the qualities of the items under consideration, the relationships among interlocutors in speech events, and the production circumstances, and, as a consequence, how recontextualization facilitates the cultural transmission, shareability, and portability of the standardized discourse features of the *DSMs*.

Furthermore, I have shown how the "logic" of these graphocentric, literate practices, which Gross (1990) refers to as their "semantic weight" (p. 75) reinforces the structure of the classification system as "logical" and suggests causal relationships among the terms they summarize. Thus the *DSM-III* diagrammatic materials provide interpretive frameworks and organize ways of seeing with multiple and far reaching consequences. For example, I showed how the *DSM-III* diagnostic criteria transform complex phenomena, patients' apperceptions, cognitions, and behaviours, many of which are hidden from view, into material artifacts that mark specific phenomena as salient through visualist practises, thereby pointing them out for scrutiny and shaping future action. The diagnostic criteria establish an orientation that organizes the psychiatrist's perceptions and activities and structures their communicative action, Burke (1966) would say "selects, directs, and deflects" (p. 46). The classification schemes of the profession—diagnostic criteria, bracketed tables, and diagnostic decision trees—transform human cognitions, perceptions, behaviours, and experiences (for example, "fear," "loss," and "sadness" in the descriptive text for Post-traumatic Stress Disorder) into universal, disembodied states (for example, "sleep disturbance" and "constricted affect" on the diagnostic criteria for Post-traumatic Stress Disorder), and "impale" these static states on the spatial structures, to borrow Ong's (1958) language. Thus psychiatrists view the complex human individual through the abstract (monological) diagrammatic concepts of the *DSMs*' classificatory apparatus.

In the next chapter, I continue the analysis of psychiatrists' metadiscourse about the standardization of discursive and pragmatic practices in the diagnostic manuals. I show how the third edition introduces the "descriptive approach" (APA, 1980, pp. 6-8), whose discursive exemplar is the diagnostic criteria, and I suggest that the "descriptive approach" and the "common language" (APA, 1980, p. 1) represent the textual standardization of the *DSMs* and the development of a professional style for American psychiatry. I argue that the development of a professional style contributes to the APA's

identity as a scientific community and to the view of psychiatrists as medical specialists with a scientific methodology. Furthermore, I show how the textual standardization of the *DSMs* and the development of a professional style for American psychiatry help constitute psychiatric knowledge.

Chapter 3.

Textual Standardization: The "Common Language" of *DSM-III*

In 1980 the American Psychiatric Association (APA) published the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, commonly known as DSM-III. This edition of the manual is often taken to signal the transformation of American psychiatry from psychotherapeutic approaches based on Adolf Meyer's psychobiology and Sigmund Freud's psychoanalysis to a research- and evidence-based model (APA, 1980, pp. 1-2, p. 9). Whereas Meyerian- and Freudian-inflected models stressed the uniqueness of the individual in interaction with the social environment, the "neo-Kraepelinian" designers of *DSM-III* based the classification system on the organizing principles of Emil Kraepelin's "descriptive" style (Klerman, 1978, p. 104).

Kraepelin (1883) developed a classification system that understood mental disorders by analogy with physical diseases. Therefore, classification was the first step toward determining the course and outcome of the disorder, and, given sufficient empirical research, the organic and biochemical origins of mental disorders would be discovered (Mayes & Horwitz, 2005, p. 260). Of note, Kraepelin's system identified discrete mental disorders each existing separate from the others. For example, he identified dementia praecox (schizophrenia) as different from manic-depressive conditions in the disorder's constellation of symptoms, course of disease, and outcome (Shorter, 1997, p. 108). Thus Kraepelin's classification system posited mental disorders as discrete disease entities with characteristic features and boundaries (Frances & Cooper, 1981, p. 1198; Mayes & Horwitz, 2005, p. 251).

During the middle to late 1970s, the APA *DSM-III* Task Force, under the leadership of Robert Spitzer, revised the classification system to reflect the turn away from Freud's psychoanalytic perspective (APA, 1980, pp. 2-3). The psychoanalytic

tradition advanced a psychosocial model that emphasized the etiological process of mental disorders. Adherents of this model theorized the existence of unconscious pathogenic drives (often sexual), and the therapeutic techniques of analysis and the interpretation of patients' narratives proceeded according to theoretical constructs about psychopathology. Thus psychoanalysts directed their attention at resolving unconscious pathogenic drives, whereas the neo-Kraepelinians focused on the resolution of the observable manifestation of the pathology (Horwitz & Wakefield, 2007; Shorter, 1997).

DSM-III and subsequent editions of the manual (*DSM-III-R, 1987; DSM-IV, 1994; DSM-IV-TR, 2000*) take up the neo-Kraepelinian perspective of classification, basing diagnosis on "identifiable behavioral signs or symptoms" (APA, 1980, p.7) that unfold over time in somewhat predictable patterns without recourse to theories of causation (Blashfield, 1984; Hoff, 1995; Horwitz & Wakefield, 2007; Kirk & Kutchins, 1992; Klerman, 1978; Mayes & Horwitz, 2005). The third edition's "descriptive approach" (APA, 1980, pp. 6-8) attempted to be neutral with respect to theories of etiology even though 75% of *DSM-III* field trial participants identified themselves as dynamically-oriented psychiatrists (Cooper & Michels, 1981, p. 128).

In his Introduction to *DSM-III*, Spitzer names the "descriptive approach" of the third edition a "common language" (APA, 1980, p. 1) and all subsequent editions use the term *common language* (APA, 1987, p. xxviii; APA, 1994, p. xxiii; APA, 2000, p. xxx)—as does the *DSM-5* development website (APA, 2012a, n. p.). In *DSM-III*, the "descriptive approach" to classification organizes and arranges mental disorders according to collections of co-occurring, observable attributes and characteristics, which comprise diagnostic classes subdivided into specific disorders with further subdivisions as required (APA, 1980, p. 9, pp. 6-7). The "descriptive text" annotates each disorder in the following areas and in the following, standardized order as a way "to ensure consistency and comprehensiveness" (APA, 1980, p. 31): essential features, associated features, age at onset, course, impairment, complications, predisposing factors, sex ratio, familial pattern, differential diagnosis (APA, 1980, pp. 6-8). The diagnostic criteria—alpha-numeric lists of signs and symptoms—follow the descriptive text for each disorder (see, for example, Appendix 3 for the *DSM-III* diagnostic criteria for Posttraumatic Stress Disorder).

At the time of publication, the *DSM-III* "common language" was common to many Task Force members who revised this edition, some of whom, like Spitzer, were the researchers who developed the descriptive text and diagnostic criteria for psychiatry in two earlier studies (aspects of which I discuss later). However, at this time, the "common language" was not yet common to the APA general membership—that is, many of the 75% who self-identified as dynamically-oriented psychiatrists.

In this chapter, I suggest that the "common language" represents the development of a professional style for American psychiatry and the textual standardization of that style in the manual. I use the term *standardization* somewhat differently than scholars who study phonetic forms and pronunciations associated with language standardization (for example, Agha, 2003; Milroy & Milroy, 1991; and Crowley, 1989). According to Milroy and Milroy (1991), the process of standardization requires that persons of influence select language features as a way to single out a language variety from other varieties, stamp out equivalent variants, and assign the variety elevated status as the standard (pp. 27-28). However, as the authors note, "there is no such entity as a standard spoken language" (p. 27). Thus, the ideology of standardization discourages diversity and aims at uniformity of discourse features. Once the standard gains acceptance by influential people and geographically expands, the language variety often acquires prestige and undergoes codification in, for example, dictionaries, grammar books, and handbooks of usage, such as the *DSMs*. The written language system advanced in these types of books reinscribes the prescriptive norms of the standard (p. 27).

Following Milroy and Milroy (1991), however, I do use the term *standardization* to mean resistance to optional variation in discursive and pragmatic practices in the *DSM*s. Therefore, in this chapter, use of the term *standardization* retains the notion of "a standard" (albeit idealized and unattainable) that marks out difference and sameness among language varieties—in this case a professional style. Thus, I locate the diagnostic manuals within a tradition of texts that promote uptake of a circumscribed style that aims to resist stylistic, syntactic, lexical, and pragmatic variation, in this case, through textual standardization of a professional style for psychiatrists. In much the same way that dictionaries, grammar books, style guides, and etiquette manuals attempt

to standardize and codify spoken and written English, *DSM-III* and subsequent editions attempt to standardize and codify American psychiatry's "common language."

The *DSM-III* "descriptive approach" develops the "common language" through the institutional standardization of discursive and pragmatic practices and the codification of those standardized practices in a text-artifact. However, making an absolute distinction between language *prescription* and language *description* proves difficult and perhaps impossible (Cameron, 1995, p. 49), and the difficulties in making clear distinctions between types of interventionists has given rise to the term "descriptive prescriber" to refer to "a prescriber who uses descriptivist methods" (Garner, 2009, p. xliv). Garner's neologism, which he introduces in his own handbook of usage (*Garner's Modern American Usage*), attempts to bridge the binary gap between prescriptivism/descriptivism and establish an ideological middle ground vis-à-vis two positions that are often presented as polar opposites. In most cases, however, the ideology of prescriptivism aims to keep linguistic variation to a minimum and thus stabilize and codify, often in written form, the linguistic norms of the language and the language-users. This is the case with the institutional standardization of the APA's "descriptive approach" to the "common language," which does not sanction language diversity. For example, the Task Force eliminates psychodynamic and psychoanalytic terms and concepts from the manual, notably, terms associated with Adolf Meyer (*reaction*) and Sigmund Freud (*neurosis*). (I return to the topic of these terms of art in the discussion of the *DSM-III* professional style.) In the *DSMs*, then, textual standardization aims at developing a professional style. Furthermore, I suggest that the development of a professional style for American psychiatry and the textual standardization of that style in the *DSMs* results in a *handbook of usage*. In addition to the many other purposes the diagnostic manuals fulfill (e.g., diagnostic, statistical, forensic, actuarial, and so on), the textual standardization of discursive and pragmatic practices in *DSM-III* and subsequent editions constitutes a handbook of usage, and in this sense, then, the *DSMs* are a rhetoric.

The understanding of which discursive and pragmatic practices constitute the "common language," in what ways, if at all, the discourse features of the APA "common language" differ from vernacular English, and the types of arguments for and against textual standardization change across editions. For example, APA metadiscourse about

the textual standardization of the profession includes appeals for a "common language" to reduce and repair communication breakdown in the profession, appeals for a scientific style of prose through the elimination of obscure or ambiguous terminology associated with psychoanalysis, appeals for a professional style that represents the current state of knowledge in the profession, appeals for scientific language that establishes psychiatry as a branch of medicine, and appeals for a language that connects psychiatry to the pursuit of scientific methods and knowledge production through empirical observation and data collection.

The identification of the textual standardization of the *DSMs* contributes to scholarship on the communicative practices of professional discourse communities, specifically studies of psychiatric discourse and, more specifically, studies of the *DSM*s. This chapter builds on existing scholarship in rhetorical studies of professional communication in healthcare settings and rhetorical studies examining the discursive practices of scientists and physicians. The analysis of metadiscourse helps demonstrate how the development of a professional style for American psychiatrists and the textual standardization of that professional style in the *DSMs* index professional order (consensus, reliability, verifiability) and scientific rigour (logic and method). For these reasons, psychiatrists' own talk about the textual standardization of American psychiatry provides a generative site for humanities research on health and medicine.

This chapter analyzes several types of published printed texts: specialist material written by psychiatrists for psychiatrists from 1950 to 2012. Much of the data for this chapter come from the *DSMs* themselves. To date, the APA has published four editions of the manual with two additional text revisions (*-R* and *-TR*): *DSM-I* (1952), *DSM-II* (1968), *DSM-III* (1980), *DSM-III-R* (1987), *DSM-IV* (1994), and *DSM-IV-TR* (2000). *DSM-5* is currently under revision and the APA has announced a publication date of May 2013. In addition to metadiscourse about the textual standardization of discursive and pragmatic in the *DSMs* themselves, I analyze excerpts from psychiatric journals that discuss the communicative practices of psychiatrists, particularly as these practises pertain to the "common language," for example, articles in the *American Journal of Psychiatry*, the *Archives of General Psychiatry*, and the *Canadian Medical Association Journal*. In addition to these specialist materials, I include a journalistic report about American psychiatry's "common language" from *The New York Times*. I take this

approach for several reasons. Psychiatrists' metadiscourse provides a valuable linguistic resource with which to identify and analyze the textual standardization of American psychiatry in the *DSMs*. As a humanities researcher in Canada, and, therefore, an outsider to American psychiatry, I have chosen an "emic" approach to analysis that focuses on terms meaningful to insiders. (Pike, 1967). That is, I have chosen to analyze what the psychiatrists who write and revise the manuals say about their own communicative practices using their terms as data. In this sense, the methods are empirical: the methods proceed from discourse-based observations in an attempt to understand relevant context from the perspective of the participants engaged in the production of discourse (Eisenhart & Johnstone, 2008, p. 3; Schegloff, 1997, p. 167, p. 180). I take this approach as a way to document some of the professional and institutional practices through which American psychiatry, under the auspices of the APA, produces, maintains, and disseminates the profession's "common language," and to draw some conclusions about how the textual standardization of a professional association's official diagnostic manual helps shape the APA's identity as a scientific society and how textual standardization helps constitute psychiatric knowledge.

This chapter has five sections. First, I review some of the relevant scholarship on the communicative practices of scientists and how those practices help shape scientific knowledge. Second, I briefly refer to the handbook tradition as a way to point to some historical examples of prescriptive style manuals. I locate the *DSM*s alongside the handbook tradition as a way to show how the APA's prescriptive and proscriptive practices help shape and constrain a professional style for American psychiatry. In the third section, the analysis begins with the publication of *DSM-I*. I show how, at this early stage in the process of textual standardization, before the development of the "common language," psychiatrists focus on the uniformity and standardization of common methods of practice. Then, I identify the development of the "common language" in the third edition. I show how this edition introduces the "descriptive approach," whose discursive exemplar is the diagnostic criteria, and, in doing so, how *DSM-III* represents the textual standardization of the profession. I argue that, along with the many other purposes *DSM-III* fulfills, this edition functions for the profession as a handbook of usage (as do subsequent editions). Next, I look at the use of the term *common language* in *DSM-IV* and *DSM-5* to demonstrate how textual standardization facilitates the expansion of the

community of speakers of the professional style, that is, the uptake of the "common language" by speakers beyond APA borders. Finally, I offer some conclusions about the rhetorical effects of the textual standardization of American psychiatry. I suggest that the analysis of psychiatrists' self-reflexive talk reveals some of the rhetorical acts of the writers and revisers of the *DSMs*. More specifically, I suggest that the textual standardization of the *DSMs* and the development of a professional style for American psychiatry help to constitute psychiatric knowledge.

Sometimes psychiatrists position the classification system as the use of natural and given language structures to refer to natural and given structures in the world—the world "as it is" (Lewis, 2000, p. 74) or "reality out there" (Silverstein, 1979, p. 194). The view of discourse as referential, that is, referring to the world "as it is," positions the world as external to discourse. Thus, for the psychiatrists who write and revise the *DSMs*, the professional style consists of neutral or transparent language structures—*descriptive* language structures—that merely refer to or reflect structures in the world. In this way, the "descriptive approach" of the "common language" upholds the neo-Kraepelinian view of mental disorders as discrete disease entities in the world external to discourse. In so doing, *DSM-III* psychiatrists seem to take up the positivist perspective of empirical knowledge which holds that the advancement of science and the accuracy of scientific conclusions depend upon the accuracy of their literate practices. Bazerman (1988) points out that to write in a scientific style is to appear not to write but simply to record—to be "a transparent transmitter of natural facts" (p. 14). That is, paradoxically, scientists seek language that works to disguise and downplay the complexity of their task (passive voice hides agency; qualifiers and hedges minimize claims), and they seek language that appears to transmit and record disciplinary knowledge (p. 15).

Anderson (1989), writing about how the language of medicine appropriates the language of science, describes the medical textual space as "a static, uninhabited, past-tense verbal world" in which "the doctor-cum-experimental scientist" speaks and writes about patients as though they are experiments—"sets of facts to be mastered and controlled" (p. 12). He notes that late twentieth century physicians continued to use positivistic approaches to medicine adopted during the Renaissance such that the language of science became the language of medicine: "to become a physician was (and still is) necessarily to become something of an experimental scientist" (p. 8). The

language of experimental science became so deeply embedded in the reading and writing practices of medicine, in clinical practice with patients, and in the education of doctors that the borrowing of this linguistic, persuasive strategy from scientific discourse fell from view and became the language of medicine *in toto*: “From its vocabulary to its syntactic structures to its larger, more complex units of meaning—its articles, books, lectures, specialities, and subspecialties—the language of contemporary medicine argues and validates the view of physicians as experimental scientists” (p. 11). In late twentieth century America, psychiatry, too, aligns with medicine through the uptake of the language of scientific medicine and through this alignment develops for the profession a terminological field consistent with a view of psychiatrists as scientists.

Bazerman (1988) notes that the success of the scientific style for advancing arguments in the natural sciences, whereby the scientist-writer appears to be “a transparent transmitter of facts” (p. 14), holds appeal for other scientific disciplines and those communities of scientists who are concerned with issues of the human mind borrow the language of the natural sciences to organize and advance their knowledge claims (p. 257). For example, he shows how the official style of the American Psychological Association’s *Publication Manual* takes up the behaviourist model of experimental psychology and, he suggests, the manual’s style reflects behaviourist assumptions about writers, readers, the object of study, and the depiction of knowledge. Thus, experimental psychology developed its own specialized discourse and “became the model and set the standards” for all the psychological disciplines aspiring to the status of science (p. 259). He concludes that the codification of the social scientific style in the *Publication Manual* offered psychologists a way to discuss their object of study in a manner consistent with the research community’s beliefs about human behaviour at that time (p. 275). That the *Publication Manual* is prescriptive in the first place, however, is unsurprising. Writers seek out the *Publication Manual* for disciplinary rules, writerly decorum, and corrective advice about appropriate conventions for reporting research findings and recording knowledge claims. Unlike psychiatry’s diagnostic manual, however, the *Publication Manual* is first and foremost a style guide and, for this reason, readers consult the manual for prescriptive and proscriptive advice about disciplinary style and standards. Yet both disciplines, experimental psychology and “descriptive” psychiatry, develop a professional style and codify that style in a published printed

manual. As Bazerman shows, the *Publication Manual's* rhetorical accomplishments are many and this, too, is the case for the *DSMs*. For American psychiatry, the professional style becomes the model and sets the standards for all the psychiatric disciplines aspiring to the status of science. Thus the development and codification of a professional style for American psychiatry is one of the rhetorical accomplishments of the *DSMs*.

According to Latour and Woolgar (1989), scientific texts come to be seen as containing not statements but facts because the technologies of writing and diagramming make invisible "all traces of production" (p. 176). The authors were concerned with the processes by which scientists, in their daily activities, make sense out of the "apparent chaos" of their perceptions and observations (p. 32), and, more specifically, the ways in which those daily activities lead to the construction of facts (p. 40). They conclude that scientists use a collection of techniques and practices to bring "a disordered array of observations" into an ordered document, construct a pattern, make sense of these observations, and prove to members of the scientific community that the methods and findings are valid (p. 36). In large part, the authors suggest, scientific arguments come to us not as propositions for our consideration but as facts, and facts, have the status of "'out there-ness'" (p. 175). Thus, like other types of scientific knowledge, psychiatric knowledge is produced through an array of literate practices. However, the daily activities and material processes that produce the professional style in the *DSMs* become bleached such that depictions of psychiatric knowledge in the *DSMs* seem to have the status of facts.

In their study of the *DSM-IV* Binge Eating Disorder (BED) Work Group, McCarthy and Gerring (1994) suggest that the textual standardization of *DSM-IV* helps to broker the relations between knowledge hierarchies and standardized practices: "The *DSM*, in offering clearly bounded diagnoses based upon this knowledge, is central to this standardization process in psychiatry" (p. 179). The authors document some of the social factors that account for the decision-making process during the BED Work Group's deliberations about the status of the proposed *DSM-IV* disorder, and they point out how the members, including Allen Frances and Robert Spitzer, were concerned with establishing "a clear knowledge hierarchy" and promoting the profession's knowledge hierarchy through "the standardization of practice" (p. 179). The authors show that the

warrants members would accept for the inclusion of a proposed diagnosis depended on whether individual members valued “clinical experience” or “research data” as evidence for inclusion (p. 178). Many Work Group members used the term “data” and valued it more than clinical experience—including the clinicians. The authors conclude that Work Group members connected the term “data” to the standardization of the profession’s practices and to the status of the profession as scientific (pp. 178-179). Thus the textual standardization of professional practices in the *DSM*s helps to establish the status of the profession as scientific and codifies those scientific practices in a handbook of usage.

The Handbook Tradition

Some of the earliest writers of rhetorical handbooks are thought to be Corax and Tysias (Kennedy, 1959). Some scholars suggest that Socrates’ explication of the parts of judicial oratory in Plato’s *Phaedrus* (266d-267c) is a summary of the kinds of material found in these handbooks (Gaines, 2010; Kennedy, 1959). Teachers of rhetoric often recorded theoretical and practical material as a means of imparting rhetorical principles to students, and thus handbooks came to form part of the formal system of education in ancient Greece and Rome (Gaines, 2010; Kennedy, 1959). In late fifth century B.C E. Greece, there were numerous handbooks in existence, and Aristotle briefly refers to these in the *Rhetoric* (1354a, 1414b-1416a). In Book 3 of the *Rhetoric*, Aristotle discusses *lexis* (style) and *taxis* (arrangement), and some scholars point to these sections as a contribution to the handbook tradition (Kennedy, 1959). In addition to these texts, some historical exemplars concerned with prescriptive practices for speakers come from the Roman rhetorical tradition, for example, Cicero’s *De Inventione*, the anonymous *Rhetorica ad Herennium*, and Quintilian’s *Institutio Oratoria*.

Whereas rhetorical handbooks and style manuals standardize an array of spoken and written style protocols, some taxonomies, such as conduct manuals, focus on appropriate and inappropriate behaviours according to the norms of social groups. In this regard, psychiatric taxonomies, operate much like conduct manuals to compile prescriptive and proscriptive situational behaviours (Goffman, 1963, p. 232). Thus, while handbooks display a range of tastes and preferences about speech and behaviours and the purposes and audiences for particular handbooks vary (Emily Post directed her

etiquette advice to women; Quintilian was concerned with the education of boys), what they share is a focus on the abstract and formal dimensions of language systems such that pragmatic considerations sometimes give way to arbitrary and dogmatic rules-based approaches. While language attributes are both functional and aesthetic, style norms are also ideological and often have a moral element (Cameron, 1995, p. 67). Often, this means that the stylistic "qualities" or "virtues" of the writing become inseparable from the qualities or virtues of the writer. For example, Perelman and Olbrechts-Tyteca (1969), writing about neutral style, which as Bazerman (1988) notes is often associated with scientific prose, point out the propensity for this kind of analogical thinking when considering style attributes. A neutral style, they write, "suggests the transition from general approbation given to the language to approbation of the standards enunciated" (p. 152).

Some commentators note the deficiencies in the notion of language standardization advanced in grammar books, handbooks, and style guides (Cameron, 1995; Crowley, 1989; Milroy & Milroy, 1991). From Bakhtin's (1981) perspective, *centripetal* forces (centralizing, hierarchizing, homogenizing) and *centrifugal* forces (decentering, dispersing, diversifying) in a language or culture always compete (p. 272). Thus, the textual standardization of the "common language" is an example of centrifugal forces producing language stratification: the development of a professional style for American psychiatry.

Textual Standardization Begins: *DSM-I* and *DSM-II*

The textual standardization of a profession's discursive and pragmatic practices occurs within a matrix of overlapping and competing social forces. While standardization never entirely succeeds in supressing or resisting variation, standardization can succeed at establishing awareness and recognition of standard norms against which variants are measured, assessed, regulated and often found deficient. Furthermore, the speaking subject's linguistic consciousness of these centralizing forces (the self within the system) produces normalizing responses (Giltrow, 2003, p. 365), as exemplified by the "complaint tradition" (Milroy & Milroy, 1991), whereby complainers interpret variation as the decline of language standards, and by "verbal hygiene" practices, that is, the need to

"clean up" language and enforce "correct usage" through standardization (Cameron, 1995, p. 2). Furthermore, because verbal hygiene practices are not epiphenomenal, in the sense that everyone at one time or another practices verbal hygiene, these kinds of practices become difficult to separate from complex and overlapping beliefs about prescriptivism, standardization, and normalization (Cameron, 1995, p. 2).

One way to account for the centrality of the role of prescriptive and proscriptive metadiscourse in the development of the professional style may be the phase of historical development. American psychiatry's "common language" is a relatively new professional style for psychiatrists that develops during the latter half of the twentieth century in the United States. For the psychiatrists writing the first edition of the manual, *DSM-I*, standardization of discursive and pragmatic practices emerges as a topic of central concern. In 1950, American psychiatrist Daniel Blain addressed the annual meeting of the Canadian Medical Association in a talk entitled "Trends in Psychiatry" (subsequently published in the *Canadian Medical Association Journal*). In part, Blain updated the meeting attendees on the APA's development of the first edition of the diagnostic manual:

> There is demand today that we get our house in order and present our material in logical fashion. Delay in achieving an objective science has, I believe, been caused by a necessary period of experimentation, of individual case study in psychopathology; by difficulty of refining our tools for measurement of abstract ideas and in clarifying our concepts so that we can reach general agreement as to nomenclature and description of our major concepts. Clarification is coming about slowly. Revision of standard nomenclature is gaining a further step forward in the new nomenclature now being appraised, that sent out by the A.P.A. Committee on Nomenclature and Statistics. . . .
>
> Not only do we need to agree on description, naming and quantitative and qualitative degrees concerning our patients' illness, but we need a method of recording these indices and numbers-records that can be compared with each other by other people, that do not take too much time and that can be used statistically. It is a horrible thought that most of our statistics of the past are of little value for they give false information based on uncertain meanings of words. . . .
>
> The effort to agree, on nomenclature and concepts is before you now. . . . The Mental Hospital Service will make a drive at the next Mental Hospital Institute to obtain common language and items of agreement in material and form in all annual reports.

> Backed by the A.P.A. Committee on Nomenclature and Statistics, an effort will start at the October meeting to get every state and province to adopt a punch card system of recording data on every patient in state and provincial hospitals. One of these is the I.B.M. Hallerith card system. We hope in three biennial legislative sessions, or six years, to get this adopted. In the meantime we must come to an agreement on what data to put on the cards and I believe we can do that in six years also. It is hoped that all hospitals and clinics and private practitioners will in time have this common method at their disposal. Then we can study our cases, analyze our results and concentrate on any small or large subject we like.
>
> A paper was presented at a V.A. hospital seminar recently on the topic, "Administration in Every Day Psychiatry," advocating the admission of a little of the new science of administration into our medical practice as well as the operating of our organizations and institutions. . . .
>
> We need to get facts, see where they lead and make a plan, and we must have our objective clearly in mind. I see psychiatry going in the direction of clarity, precision, and objectivity, and I urge every co-operative effort to further this trend toward objectivity. (Blain, 1951, pp.17-18)

During the prepublication period for *DSM-I*, Blain expresses the APA concern for the development of a "common method" of statistical collection and recording using the I.B.M. Hallerith card system. At this time, the APA begins to differentiate between the design, function, and purpose of a system of nomenclature and a system of statistical classification. However, as Blain's interest in "adopting a punch card system of recording data" demonstrates, metadiscourse about statistical record-keeping continues to inform the practices around which the APA organizes the epistemic authority of the profession. Blain refers to the punch cards as "the admission of the new science of administration into our medical practice"—a new science that "logically" organizes data using a "common method." Furthermore, Blain suggests that "medical practice" will benefit from "the new science of administration." Thus standardized record-keeping practices become the "common method" of psychiatric practice and help the profession in their pursuit of "facts" and "objectivity." The "common method" facilitates the "measurement of abstract ideas" and helps with "clarifying concepts," while the future "hope" for the development of a "common language" provides a corrective to methods of the past "based on uncertain meanings of words." As early as 1950, then, an APA member ties scientific practices—the pursuit of "logic," "facts," and "objectivity" to the style qualities "clarity" and "precision" and the development of a "common language."

Then, with the publication of *DSM-I* (1952), George Raines, Chair of the Committee on Nomenclature and Statistics, addresses the need for a standardized classification system. He notes in the manual's Foreward that there are "a polyglot of diagnostic labels and systems" in use "effectively blocking communication and the collection of medical statistics" (p. v). However, the proliferation of diagnostic manuals continues through the 1950s and 1960s despite APA attempts to standardize the profession's methods and style in "a uniform nomenclature of disease" (p. v). At this time, APA members connect lack of consensus about diagnosis and treatment protocol to the lack of textual standardization:

> In most countries, there is a national network of mental hospitals. Here we have 48 state systems, plus 4 federal systems—a total of *52* different mental hospital administrations. Each state or federal system becomes a sort of laboratory, and we have one of the world's most magnificent opportunities at our finger tips. One state emphasizes lobotomy, one stresses shock, one gives little but custodial care, one highlights psychotherapy, one puts its faith in "total push." If words and figures were comparable, we would have a wonderful experiment here; a chance to compare different measures of therapy. What has stultified this to date is unwillingness to agree on terms and numbers—the lack of a common language. What I propose is the development of such generally accepted criteria that "improvement" in one state will eventually mean the same as "improvement" in another, and so for the rest of the vocabulary. (Sewall and Davidson, 1956, pp. 124-125)

Writing four years after the publication of *DSM-I*, the authors propose the development of a standardized "vocabulary" where "'improvement' in one state will eventually mean the same as 'improvement' in another" and thereby result in a "common language" for the profession. Like Blain (1951), Sewall and Davidson equate standardized methods or "measures" with a standardized vocabulary, and suggest that if psychiatrists working in different states could "agree on terms and numbers" they could overcome "the lack of a common language." As this example demonstrates, at times, psychiatrists draw comparisons between mathematical qualities and language qualities. The style attributes "clarity" and "precision" come to be associated not only with "the science of administration" and the "common method" of psychiatry but with mathematical attributes: "numbers," "measures," "figures," and "logic."

Thus the proponents of the "mathematical" style for American psychiatry sometimes position scientific prose as a neutral symbol system with no virtues of its own. In some ways, then, the values and qualities that Blain and Sewall and Davidson, separately, ascribe to scientific prose draw on what Thomas Sprat (1667) in his history of the Royal Society of London called "mathematical plainness" (p. 113), by which he meant unadorned speech or speech as found in nature. Therefore, the mathematical style is the type of prose most suited for writing about the natural sciences and most suited to developing an appropriate prose style for scientific discourse. Sewall and Davidson's statement that "if words and figures were comparable" expresses an ideology of language similar to Sprat's (1667) one-*thing* to one-*word* theory: "when men delivered so many *things*, almost in an equal number of *words*" (p. 113; emphasis original). This view of language purports a natural correspondence between world and word such that for each one thing being described there exists one appropriate word. From this perspective, the scientist/psychiatrist treats language as the neutral medium or "windowpane" through which the world becomes knowable to others as though the audience observes external reality through a clear pane of glass (Gusfield, 1976, p. 17; Lewis, 2000, p. 74). While the science writer may choose to present lexical choices as neutral, the writer's neutral stance serves to shore-up claims to descriptive objectivity and data collection, and, in this sense, term selection is purposive and has argumentative value (Perelman & Olbrechts-Tyteca, 1969, pp. 149-153; Burke, 1966, see "Terministic Screens," pp. 44-62).

During the *DSM-II* revision period, psychiatrists connect the discovery of a "common language" to the discovery of professional standards of practice and scientific knowledge:

> It seems as though we and our colleagues abroad speak different languages in more senses than one when it comes to diagnostic appellations of depressions; this situation needs to be rectified.
>
> It is our hope that with the advent of the new standard diagnostic nomenclature we all will be speaking a common language soon, and then through the efforts of the basic scientists we will gain still further understanding of the enigma which now confronts us. When these happy situations come to pass it is probable that we will find that we know much more about these illnesses than we thought we did, and our knowledge

> will be more skillfully applied to the relief of an illness “most difficult to bear.” (Braceland, 1968, p. 1571)

The recognition of “the lack of a common language” that occurs during the development of *DSM-I* becomes the “hope” for a common language in *DSM-II*. In the above example, Braceland “hopes” that language will solve “the enigma,” that is, the knowledge deficit, confronting psychiatrists. In doing so, he characterizes the “common language” as a research tool that, in the hands of “basic scientists,” will lead to “further understanding” and “knowledge” about mental disorders—knowledge currently beyond their grasp. While Braceland does not explicitly promote the virtues of the “mathematical” style as do Blain and Sewall and Davidson before him, he does present science as an “enigma” or mystery to be solved through the discovery of suitable language. Therefore, Braceland implies a logical correlation or equivalency between *word* to-be-discovered, a common language, and *thing* to-be-discovered, psychiatric knowledge. In this sense, then, if a standardized language is not exactly mathematical it is a tool of discovery in the service of psychiatric knowledge and a tool of measurement in the service of science.

The Development of a Professional Style for American Psychiatry

While *DSM-I* metadiscourse laments the “lack” of a common language, and *DSM-II* expresses the “hope” for a common language, *DSM-III* announces the arrival of the common language in the diagnostic manual. During the revision process for *DSM-III*, Task Force members introduce new terms of art representative of the neo-Kraepelinian perspective of psychopathology, for example, *descriptive*, *disorder* and *diagnostic criteria*—terms that present mental disorders as discrete and stable entities located in the body and visible to observers. At the same time, psychiatrists forego psychodynamic and psychoanalytic terms of art, for example, *neurosis*, *reaction*, *transient*, *situational*, *disturbance*—terms that present mental illnesses as dynamic processes and maladaptive responses to known and unknown stressors.

Throughout the 1970s and 1980s, the professional debate about psychodynamic terminology in *DSM-III*, particularly the exclusion of the term *neurosis*, played out in the pages of mainstream print media such as *the Boston Globe* (Duchovny, 1978), *The New York Times* (Clines, 1978; Lear, 1988; Sobel, 1979), and *Newsweek* (Gelman, 1979), in the trade publication *Medical World News* ("No more neuroses," 1978), an editorial in *The Lancet* ("Goodbye Neurosis?" 1982), and in medical journals such as the *American Journal of Psychiatry* (Cooper & Michels, 1981; Frances & Cooper, 1981; Masserman, 1979) and *Archives of General Psychiatry* (Bayer & Spitzer, 1985; Janulis, 1982; Spitzer, Skodal, & Gibbon, 1982). Scholars from disciplines other than psychiatry continue to document the effects of the nominal shift from *neurosis* to *disorder* (Berkenkotter, 2008; Emmons, 2010; Kutchins & Kirk, 1997; Lane, 2007; Luhrmann, 2001; Scott, 1990; Watters, 2010; Wilson, 1993; Young, 1995).

APA members on both sides of the debate about the status of *neurosis* in *DSM-III* understood the rhetorical force of that lexical choice because of its close association with the ideological underpinnings of the psychodynamic approach. Bayer and Spitzer (1985) sum up the intraprofessional discord in this way: "with its intellectual inspiration derived from Kraepelin, not Freud, the task force was viewed from the outset as unsympathetic to the interests of those whose theory and practice derived from the psychoanalytic tradition" (p. 188). At a meeting to decide whether or not to retain *neurosis* as a diagnostic class in *DSM-III,* disputes between the neo-Kraepelinians and the psychoanalysts about the organization of the new classification system sometimes focused on terms of art:

> The importance of maintaining the linguistic conventions of the profession also emerged as a critical matter. Because the controversy centered on what would and would not appear in a text, much of the encounter took on a terminological form and was concerned with what might appear to be an almost farcical attention to words. However, the form of the clash should not obscure its ultimate importance. It was, at base, a struggle over both the image and intellectual commitments of a profession seeking to fashion a paradigm for its discourse and work, a struggle over the relative status and authority of those working within distinct traditions. (p. 187)

And,

> Despite the importance of the issues, much of the meeting was taken up with disputes over the placement of words, the use of modifiers, and the capitalization of entries. In the context of negotiations among adversaries who were attempting to reach a terminological compromise, each adjustment, each attempt at fine tuning, carried with it symbolic importance to those engaged in a process that was at once political and scientific. (p. 193)

Whereas *neurosis* lay within the domain of psychodynamics, the theoretical field the neo-Kraepelinians were working hard to exclude from the *DSM-III* revision, the word *disorder* implied a biological connection that upheld the positivistic principles of Emil Kraepelin's descriptive psychiatry (Grob, 1991; Mayes & Horowitz, 2005). The *DSM-III* Task Force replaced the *DSM-II* division IV: Neuroses (APA, p. 9) with the division Anxiety Disorders consisting of three new subdivisions and seven new classifications, including Posttraumatic Stress Disorder. While the authors of *DSM-II* clarified the intrapsychic mechanisms of *neurosis* in the second edition's "Definitions of Terms" (APA, p. 39), the *DSM-III* Task Force sought to eliminate psychodynamic formulations altogether claiming that contemporary psychiatry had shifted focus from neuroses to personality disorders (Bayer & Spitzer, 1985, p. 189). As a compromise to the psychodynamic point of view, the *DSM-III* Task Force adjusted some entries to include *neuroses* in parentheses (Bayer & Spitzer, 1985), for example: "Phobic Disorders (or Phobic Neuroses)" (p. 225); and "Anxiety States (or Anxiety Neuroses)" (p. 230).

Because the *DSM-5* revision process is currently underway, American journalists sometimes remind readers that the APA eliminated the term *neurosis* from the diagnostic manual. For example, a science reporter for *The New York Times* writes that, because the diagnostic manual no longer uses the term *neurosis* or defines what it means to be "neurotic," a "cultural archetype" has disappeared from the collective imagination: "that it [neurotic] means little now, to most Americans, is evidence of how strongly language drives the perception of mental struggle" (Carey, 2012, p. SR1). Carey notes that over time the APA eliminated the diagnostic class *neurosis* from the diagnostic manual: "scientists working to define mental disorders began to slice neurosis into ever finer pieces, like panic disorder, social anxiety and obsessive-compulsive disorder—all evocative terms that percolated up into common usage" (p. SR1). By connecting the standardization of terms of art in the diagnostic manual to the demise of

the archetypal “neurotic” and to Americans’ cultural understanding of mental illness, Carey illustrates how the development of a professional style helps to discursively construct psychiatric knowledge.

The *DSM-III* revisers introduce the descriptive text and diagnostic criteria for each mental disorder as a way to improve diagnostic reliability (in the form of interrater agreement) within a professional association whose members held diverse, divergent, and sometimes conflicting theoretical and linguistic commitments. The *DSM-III* Introduction begins as follows:

> This is the third edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, better known simply as DSM-III. The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many.
>
> First of all, over the last decade there has been growing recognition of the importance of diagnosis for both clinical practice and research. Clinicians and research investigators must have a common language with which to communicate about the disorders for which they have professional responsibility. Planning a treatment program must begin with an accurate diagnostic assessment. The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined. (APA, *DSM-III*, 1980, p. 1)

At the outset, then, Spitzer identifies the “common language” as the means of communication for diverse sorts of practitioners within the profession (clinicians and research investigators). He includes an appeal to professional ethics, that is, for psychiatrists to use “the diagnostic terms that are clearly defined,” because members have a professional responsibility to communicate in the “common language.” The *DSM-III* revisers sought a professional style to help broker the communicative needs of researchers and clinicians from diverse theoretical perspectives with their own specialist terms of art: behavioural, psychoanalytic, biological, neurological, and so on. Thus the lack of a professional style becomes an impediment not only to communication but to social order: if we don’t all speak a common language, incommensurable differences in communication will lead to social fragmentation and to the decline or disintegration of the profession (disruption in the social order). Furthermore, in the Introduction, Spitzer

describes the communicative purpose of *DSM-III* according to the aims and goals of the Task Force members who produced the text. According to Spitzer, the *DSM-III* revisers identify improved communication as an aim of the Task Force, specifically "a shared commitment" to ten goals that include "reaching consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoiding the use of terms that have outlived their usefulness" (APA, 1980, p. 3).

Task Force members and proponents of the *DSM-III* "common language" suggest the descriptive text and diagnostic criteria aim to eliminate *ambiguous* and *vague* definitions and terms from the classification system . For example, Frances and Cooper (1981) write that the "descriptive taxonomy" of *DSM-III* "was chosen for two reasons: 1) descriptive criteria can be framed in relatively clear statements which achieve high reliability and 2) the etiologies of most psychiatric disorders are unknown" (p. 1199).

The *DSM-III* diagnostic criteria drew upon, primarily, two prior texts: "Diagnostic Criteria for use in Psychiatric Research" (Feighner, Robins, Guze, Woodruff, Winokur, & Munoz, 1972), known as the *Feighner criteria*, and the "Research Diagnostic Criteria" (Spitzer, Endicott, & Robins, 1975b), known as the *RDC*. The Feighner criteria constituted psychiatry's first diagnostic criteria for 15 psychiatric diagnoses, the RDC modified and expanded the Feighner Criteria for 25 major diagnostic categories, and *DSM-III* modified and expanded the RDC for 265 disorders (Mayes & Horwitz, 2005). In keeping with the linguistic conventions of *DSM-II*, Feighner et al. (1972) retained *neurosis* and offered diagnostic criteria for the following types of neuroses: Anxiety Neurosis, Obsessive Compulsive Neurosis, and Phobic Neurosis (p. 59). Spitzer, Endicott, and Robins, (1975b), however, modified the names of the Feighner criteria to eliminate *neurosis*. Thus, the RDC included diagnoses for Obsessive Compulsive Disorder, Phobic Disorder, and Generalized Anxiety Disorder.

In 1989, Eugene Garfield's Citation Classics commentary featured both the Feighner study with commentary from Feighner (Feighner, 1989) and the RDC study with commentary from Spitzer (Spitzer, 1989). Garfield's introduction to the Feighner research says, in part, "the SCI® [Science Citation Index] and the SSCI® [Social Science Citation Index] indicate that this paper has been cited in over 3,950 publications,

making it the most-cited paper ever published in a psychiatric journal" (Feighner, 1989, p. 14). The introduction to the Spitzer commentary notes, "the SSC1® and SCI® indicate that this book has been cited in over 570 publications" (Spitzer, 1989, p. 21). Researchers across disciplines continue to cite both studies. As well, many more scholars cite the Spitzer, Endicott, & Robins (1978) explication of the RDC study (originally published by the researchers' home institution) in the *Archives of General Psychiatry*. To date (21 September, 2012), the *Archives* article, which offers a history of the development of the RDC and highlights the "rationale" (pp. 775-776) and "reliability" (pp. 779-781) of the diagnostic criteria, has been cited 5,407 times (SCI); the Feighner study, also published in the *Archives*, has been cited 4,889 (SCI).

Of course, there are many types of citation practices. All citations do not bolster research and researchers through confirmation or extension of findings—some operate as negative mentions or negations, such as when an author wants to challenge findings (Gilbert, 1977; Swales, 1986). However, when a scientific community reaches some degree of consensus, scientific papers act as "tools of persuasion" and "research findings will become transformed into scientific knowledge" (Gilbert, 1977, p. 115). In scientific papers, citations help demonstrate the validity of claims (Gilbert, 1977, p. 116). Thus, the two studies that developed diagnostic criteria for psychiatry, and on which the *DSM-III* authors modeled the "common language," helped establish the classification system's research methodology and scientific validity, and as the citation counts indicate these two studies continue to influence the broader research community and bolster the *ethos* and *logos* of *DSM-III*.

This discussion of citation practices provides evidence that the "descriptive approach" and the development of the "common language" index the semiotic neutrality of unmediated, scientific language—exemplified in the "mathematical plainness" of the diagnostic criteria. As Cameron (1995) notes, "describing something in the 'objective' language of science automatically confers moral legitimacy on it" (p. 231). George Winokur, one of the authors of the *Feighner criteria,* said of their research methodology, "No new words without new data!" (Winokur qtd. in Bayer & Spitzer, 1982, p. 39). Winokur's mathematical or formulaic view of language expresses a one-*thing* to one-*word* referential theory of the world and, in doing so, evokes Sprat's (1667) adherence to the language of mathematical plainness "when men delivered so many *things*, almost in

an equal number of *words*" (p. 113; emphasis original), and Sewall and Davidson's (1956) proposition that "if words and figures were comparable" (p. 124) the world would become knowable through the plain style of scientific discourse.

In two sections of the manual's front matter, the "Introduction" and "Use of This Manual," Spitzer describes the design and purpose of the diagnostic criteria as follows:

> **Diagnostic Criteria.**
>
> Since in DSM-I, DSM-II, and ICD-9 explicit criteria are not provided, the clinician is largely on his or her own in defining the content and boundaries of the diagnostic categories. In contrast, DSM-III provides specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge diagnostic reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised. (APA, 1980, p. 8; emphasis original)

> **DIAGNOSTIC CRITERIA**
>
> Diagnostic criteria appear at the end of the text describing each specific diagnosis.
>
> These criteria are offered as useful guides for making the diagnosis, since it has been demonstrated that the use of such criteria enhances diagnostic agreement among clinicians. It should be understood, however, that for most of the categories the criteria are based on clinical judgment, and have not yet been fully validated; with further experience and study, the criteria will, in many cases, undoubtedly be revised.
>
> Designation by capital letters indicates multiple criteria the presence of *all* of which constitutes the guide to making the diagnosis. (APA, 1980, p. 31; emphasis original)

The development of a professional style and the textual standardization of that style help to establish the classification system as scientific and the APA as a scientific society through the uptake of a diagnostic language based in empirical evidence, particularly through the use of diagnostic criteria intended to "enhance interjudge diagnostic agreement" (APA, 1980, p. 8). Thus the diagnostic criteria provide evidence for the classification system's scientific methods. In the *DSM-III* model, diagnostic precision is

rooted in the value of scientific repeatability or replicability across multiple raters and institutional sites, and, despite Spitzer's disclaimer, interrater agreement among researchers and clinicians using standardized diagnostic criteria becomes a measure of the scientific reliability of the "common language." Thus the "descriptive approach" and the diagnostic criteria come to operate as an organizing principle in the manual and these style features become synonymous with the scientific method in psychiatry. Writing one year after the publication of *DSM-III*, Francis and Cooper (1981) connect adherence to the manual's descriptive language to the achievement of diagnostic reliability, no matter the clinician's theoretical perspective. They write:

> *Diagnostic Criteria*
>
> The dynamic psychiatrist will find the definition of several of the DSM-III disorders quite unfamiliar, and it is unclear whether patients who meet DSM-III criteria will be similar to those described previously under the same labels by psychodynamic contributors. For example, the DSM-III borderline and narcissistic personality disorders may or may not correspond closely to currently used psychoanalytic definitions. It must be noted that psychoanalytic authors rarely provide operational definitions and often use labels loosely. This has led to confusion in the psychoanalytic literature and has inhibited clinical discourse, theory building, and research. There have been many suggestions that psychodynamic concepts and hypotheses be restated in an operational form amenable to testing validation (14-16). The appearance of DSM-III makes timely a renewal of this plea. Although some psychodynamic observations are inherently more difficult to put into reliable statements than are psychiatric symptom complexes, psychodynamic language has often been unnecessarily unclear, untestable, and idiosyncratic. . . .
>
> To achieve reliability and acceptance by clinicians of diverse orientations, *DSM-III* contains simple descriptive language generally understood by all psychiatrists. . . . To facilitate communication, the profession must also learn to play by *DSM-III* rules—if classifications are arbitrary, and, to a degree, all of them must be, it is a major advance to have everyone following the same conventions and speaking the same language. (Frances and Cooper, 1981, pp. 1198-1202; emphasis original)

At this time, then, psychiatrists begin to associate the values of "mathematical plainness" (precision, clarity) with the "simple descriptive language" of the third edition. *DSM-III* proponents of textual standardization suggest that "descriptive" language ensures the recording of objective facts and represents the best choice for the language of twentieth century American psychiatry: set in place the building blocks of a professional style as a

way to achieve the building blocks of psychiatry. From this perspective, language and facts are both theory-neutral. If the investigator strips away all the embellishments, irregularities, vagaries, and abstractions of language, then all underlying scientific principles will be laid bare for the observer in the neutral style of scientific prose.

In the following example, Spitzer identifies the rhetorical exigence for the revision as "concern that the ICD-9 classification and glossary would not be suitable for use in the United States." Second, he connects the production of a new handbook—"a new classification and glossary"—to the production of new knowledge:

> In 1974 the American Psychiatric Association, through its Council on Research and Development, appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January 1979. By the time this new Task Force was constituted, the mental disorders section of ICD-9, which included its own glossary, was nearly completed. Although representatives of the American Psychiatric Association had worked closely with the World Health Organization in the development of ICD-9, there was some concern that the ICD-9 classification and glossary would not be suitable for use in the United States. Most importantly, many specific areas of the classification did not seem sufficiently detailed for clinical and research use. For example, the ICD-9 classification contains only one category for "frigidity and impotence"—despite the substantial work in the area of psychosexual dysfunctions that has identified several specific types with different clinical pictures and treatment implications. In addition, the glossary of ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodological developments as specified diagnostic criteria and the multiaxial approach to evaluation. For these reasons the Task Force was directed to prepare a new classification and glossary that would, as much as possible, reflect the most current state of knowledge regarding mental disorders while maintaining compatibility with ICD-9. (APA, 1980, p. 2)

Spitzer points to the substantive differences between the WHO's nomenclature and *DSM-III*. As Kuhn (1962) notes, when scientific knowledge undergoes revolutionary or paradigmatic change "the normal-scientific tradition that emerges from a scientific revolution is not only incompatible but often actually incommensurable with that which has gone before" (p. 103). Furthermore, as Kuhn suggests, "the reception of the new paradigm often necessitates a redefinition of the corresponding science" (p. 103). In this case, the discursive attributes that belong to the new paradigm *DSM-III*, for example, the diagnostic criteria and the descriptive text of the "common language," become

emblematic of the "redefinition of the corresponding science" of *DSM-III*. According to the *DSM-III* Task Force, then, *DSM-III* cannot maintain compatibility with *ICD-9* and, at the same time, "reflect the most current state of knowledge regarding mental disorders" because the two classification systems represent not only incompatible scientific traditions but incommensurable paradigms. Furthermore, Spitzer's repeated use of the term *glossary* (4 occurrences) provides evidence for the claim that, in addition to all the other purposes *DSM-III* serves, the diagnostic manual is also a handbook of usage for American psychiatry, that is, a handbook of the professional style.

One of Spitzer's primary arguments for textual standardization holds that descriptive language makes it possible for clinicians with different theoretical perspectives to use the same classification system, and he presents his intervention in the language of *DSM-III* as the development of a "common language" designed to facilitate communication within a diverse psychiatric community:

> The *DSM-III* assumption is that the diagnostic criteria will be most helpful to clinicians of varying perspectives if they use language at the lowest level of abstraction possible yet adequately describes the features of the condition that makes it a specific disorder. In some cases, for example, major depression, the characteristic symptoms (*e.g.*, depressed mood, loss of interest or pleasure, disturbance in appetite and sleep) can be described with little inference and at a low level of abstraction. (Spitzer, 2001, p. 355)

Spitzer characterizes the attributes of the "descriptive approach," particularly the diagnostic criteria, as, variously, "language at the lowest level of abstraction possible" and "with little inference and at a low level of abstraction." Thus the elimination of psychodynamic terminology and the textual standardization of the "common language" help ensure stability of meaning for the profession. At least now, the argument goes, psychiatrists holding divergent theoretical perspectives will be able to use the "common language" to talk to one another about clinical matters in a standardized vocabulary that leads to common understanding, which in turn achieves diagnostic reliability through interrater agreement. However, such descriptions are themselves value-laden and, as such, diminish the validity of approaches with commitments to other diagnostic models (Sadler, Hulgus, & Agich, 1994); the "descriptive" approach leaves little room for the interpretation of psychic phenomena from psychosocial perspectives.

While Spitzer makes his appeal for standardization using his preferred terms "lowest level of abstraction" and "lowest level of inference" to promote the descriptive neutrality of the *DSM-III* "common language," Task Force member Theodore Millon (1991) uses the phrase "anchored to the realm of observables" to characterize the descriptive approach. In a 17 page article, Millon uses the term *anchored* 9 times and derivatives of *observe* no less than 59 times (for example, observation, observable, observational, unobserved), and he includes quotations of others' use of derivatives of *observe* 10 times. For example, he writes:

> Many open and fully speculative concepts are formulated with minimal or no explicit reference. Their failure to be anchored to the realm of observables has led some to question their suitability in scientific contexts. No doubt, clarity gets muddled, and deductions are often tautological when a diagnosis is explained in terms of a series of such constructs. For example, statements such as "in the borderline the mechanisms of the ego become diffused when libidinous energies overwhelm superego introjections" are, at best, puzzling. Postulating connections between one set of open concepts and another may lead to facile but often confusing clinical statements, as any periodic reader of contemporary psychoanalytic literature can attest. Such use results in formulations that are difficult to decipher because one cannot specify observables by which the formulations can be anchored or evaluated. (Millon, 1991, p. 249)

Arguing against psychoanalytic terms of art ("superego introjections), Millon, like Spitzer, makes an argument in favour of the descriptive language. He suggests that when words and meanings "fail to be anchored to the realm of observables," that is, when they no longer operate as referential discourse, whereby natural and given language structures refer to natural and given structures in the world, the "open" and "speculative concepts" of psychoanalysis become "difficult to decipher." Further, when words and meanings fail to be transparent representations of the world, that is, "anchored to the world of observables," the "formulations" may lead to "facile" and "confusing clinical statements" because "clarity gets muddled." As evidence of muddled terminology and confused thinking, Millon includes prior discourse in the form of direct reported speech from, presumably, psychoanalytic writings on borderline personality—albeit an unattributed quotation. He does so to demonstrate the questionable "suitability in scientific contexts" of psychoanalytic theoretical constructs—"speculative concepts" in Millon's view. According to this argument, while these sorts of mediating structures may be acceptable

for psychoanalysis, without the transparency of referential discourse— language "anchored to the realm of observables"—the constructs have no place in scientific texts/contexts. However, as Kuhn (1962) notes, "a pure-observation language" has not been devised (p. 126).

As these examples attest, the *DSM-III* "common language" depends upon the acceptance of definitions and terms of art which, while presented as neutral, natural, and transparent, covertly represent the ideological standpoint of one group—the neo-Kraepelinians—within a culturally diverse APA. The *DSM-III* "descriptive approach" holds positive valences for Spitzer, Millon, and the neo-Kraepelinian Task Force members, while psychodynamic terms of art signal the corruption of scientific values. The language of psychoanalysis, that is, the "muddled," "facile," "confused" terminology, leads to communication breakdown and contributes to fragmentation within the APA.

Kuhn (1962) suggests that for scientists debating incompatible differences between successive scientific theories (incommensurability), the vocabularies they use to discuss such theories consist of predominantly the same terms (p. 198), and, therefore, their communication is only partial. When communication breaks down, "the superiority of one theory to another is something that cannot be proved in the debate," and, instead, "each party must try, by persuasion, to convert the other" (p. 198). Thus the ratification of the professional style is successful, in part, because the Task Force is able to persuade the general APA membership that the "common language" will elevate the profession from one with "muddled," "facile," and "confused" terminology to a profession with scientific terminology—the descriptive text and the diagnostic criteria. Thus recognition and status for the profession come about, in part, through prescriptive and proscriptive practices that help establish psychiatry as a scientific endeavour whose members use empirical methods to produce knowledge—methods anchored in the observable world and represented in the "common language" of the professional style.

Spitzer and Millon delineate and delimit discursive and pragmatic practices for the professional association as a means to constructing a professional identity for psychiatrists as discoverers and purveyors of medical-scientific knowledge of psychopathology. In this regard, the diagnostic manual becomes the material record of the objective findings of scientists and the textual repository of scientific knowledge. As a

result, *DSM-III* prescriptivists, such as Spitzer, tend to present the "common language" as value-free. However, the common language ideal "depends on everyone accepting definitions which are presented as neutral and universal" (Cameron, 1995, p. 161). While Spitzer's arguments for the development of a professional style for psychiatry in *DSM-III* appear to be a discourse of tolerance and pluralism, an argument of this sort, based in the liberal ideals of civility, rationality, and civil compromise, may really be about the repression of language variation and ideological difference through standardization (Cameron, 1994, p. 161).

Thus far examples of metadiscourse have come from the *DSMs* themselves and from psychiatrists writing about the need for standardization in professional journals. The examples of metadiscourse from within the psychiatric research community provide support for the argument that the writers and revisers of the *DSMs* develop a "common language" for the profession through the "descriptive approach" to textual standardization and thus the development of a professional style. The next example comes from a journalistic report about "the need for a common language" and provides evidence that discussions about the textual standardization of American psychiatry move beyond the psychiatric research community to a broader audience. In 1979, *The New York Times* published an article about the current *DSM-III* revision that includes an interview with Spitzer, a preview of terminological changes, and a table that compares *DSM-II* terms ("Old Term") with *DSM-III* terms ("New Terms"):

> **Need for Common Language**
>
> To establish a common language for psychologists and psychiatrists representing every school of thought from behavior modification to psychoanalysis, the new diagnostic manual avoids any talk about the causes or origins of mental illness. It is purely descriptive and nontheoretical, Dr. Spitzer points out, so that it can be used by people of different theoretical orientations.
>
> In fact, the task force went so far as to omit the whole category of "neuroses," originally named and described by Freud, from the first draft.
>
> "The neuroses were still there, of course," Dr. Spitzer said. "They were just renamed and reorganized according to their symptoms."

A Sample of How Terms Are Changing

Old Term	**New Terms**
Anxiety neurosis	Panic disorder
	Generalized anxiety disorder
Hysterical neurosis	Psychogenic amnesia (sudden loss of memory)
	Psychogenic fugue (sudden fleeing from a problem through actions of which one is later unaware)
	Somnambulism (sleep walking)
	Multiple personality
Phobic disorder	Agoraphobia (fear of open spaces with panic attacks)
	Agoraphobia without panic attacks
	Social phobia
	Simple phobia

(Sobel, 1979, C6; emphasis original)

Spitzer's assertion that "the neuroses were still there, of course, . . . they were just renamed and reorganized," demonstrates how diagrammatic structures draw on spatial organizing principles to facilitate the "logical" equation of old knowledge structures with new knowledge structures in the absence of evidence of any such equivalency. This table, which inaccurately reproduces a diagrammatic structure from *DSM-III* (the "old term" should read Phobic *neurosis*; the "new term" Phobic *disorder* names the class under which the four listed phobias are categorized; see Appendix 4 for the *DSM-III* annotated comparative listing), provides an example of the principle of *obliteration by incorporation*, whereby present knowledge structures anonymously incorporate the sources, methods, and background knowledge of earlier contributions (Merton, 1968, pp. 27-28). The equivalency relationship established in the Old Term to New Term columns shows this principle at work, and the insertion of the table in the article facilitates, for newspaper readers, the obliteration of the (singular) old term "originally named and described by Freud" and the knowledge structures the old terms index into the (plural)

new terms “representing every school of thought from behavior modification to psychoanalysis.” In the article, Sobel uncritically repeats Spitzer’s stance that the “new terms” represent the “common language” of psychiatrists from “different theoretical orientations.”

In providing the table, *The New York Times* reproduces the *DSM-III* chain of reasoning that presents the substitution of “New Terms” for “Old Terms” as a scientific advance derived from empirical methods (observation-gathering and data-collection), and thus that the “New Terms” equal new knowledge. That is, the “New Terms” organized and diagrammed on the table index the scientific methods of the classification system, the development of new knowledge structures, and professional consensus about the current state of psychiatric knowledge. Thus the “Old Term/New Term” table presents the “purely descriptive and nontheoretical” vocabulary of the “common language” as the organizing principle and unifying method that helps organize and standardize the new knowledge structure. Furthermore, this example helps to show how textual standardization facilitates uptake of the “common language” by communities of speakers beyond the borders of the professional discourse community.

Textual Standardization Beyond *DSM-III*

In the case of the *DSM*s, the community of speakers broadens over time such that the professional style facilitates awareness and recognition of the “common language.” That is, the “common language” becomes available for persons and purposes for which the professional style was not originally developed, and becomes part of speakers’ and readers’ linguistic repertoires across diverse (and often non-clinical/non-research) social situations. The introduction to *DSM-IV* (1994) begins with Allen Frances, Task Force Chair, addressing the “common language” attributes and the purposes of the manual as a way of delimiting professional boundaries:

> This is the fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders,* or DSM-IV. The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful

> for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication among clinicians and researchers. We were also mindful of the use of DSM-IV for improving the collection of clinical information and as an educational tool for teaching psychopathology.
>
> An official nomenclature must be applicable in a wide diversity of contexts. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. DSM-IV must be usable across settings—inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations. It is also a necessary tool for collecting and communicating accurate public health statistics. Fortunately, all these many uses are compatible with one another. (APA, 1994, p. xv)

Like his predecessor, Frances identifies "clarity of language" as one of the salient discourse features of the "common language," and he singles out the diagnostic criteria as the discursive exemplar. In DSM-IV, like DSM-III, these discursive features index professional communicative goals, for example, "utility and credibility" and "extensive empirical foundation." Frances acknowledges the "diversity of contexts," "settings," and "orientations" as well as the diversity of users, "clinicians and researchers of many different orientations," of the classification system. At this time, circumscription of the professional style for mental healthcare clinicians emerges as a topic of central concern for the DSM-IV Task Force. As "common language" boundaries expand to include a broad range of health and mental healthcare experts and settings, APA metadiscourse in this edition shifts to concerns about speakers/readers of the "common language" who lack clinical and diagnostic expertise:

> **Use of Clinical Judgment**
>
> DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not

> meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication. (APA, *DSM-IV*, 1994, p. xxiii; emphasis original)

As this excerpt shows, Frances recognizes the diversity of speakers, situations, and contexts of use of the *DSM-IV* "common language"; however, concerns about particular types of speakers/readers emerge. First, he differentiates his use of the term "common language" from Spitzer's use through professional boundary-drawing that aims to delimit the community of speakers to professionals. Frances makes clear that "clinical judgement" and "appropriate clinical training and expertise" guide use of the diagnostic criteria and he dissuades approaches "applied mechanically by untrained individuals." Thus Frances mobilizes arguments about the pragmatics of the professional style (those with clinical judgement and expertise) to address his concern that "lack of familiarity with *DSM-IV* or excessively flexible and idiosyncratic application" of the professional style "substantially reduces" its communicative effects. Thus, in this case, Frances delimits the professional style to professional practices.

Currently, the APA is revising the diagnostic manual and the Task Force continues to address the effectiveness and usefulness of the professional style for mental healthcare researchers and clinicians on their website "DSM-5 Development" (www.dsm5.org). Among other things, the website introduces Task Force and Work Group members and outlines the timeline for the revision process. As part of the development process, the Work Groups posted the draft diagnostic criteria for each of the classifications in February 2010. The *DSM-5* Task Force uses the term "common language" and they explain the purpose of the manual with reference to the clinical utility of the diagnostic criteria on the website under Frequently Asked Questions (FAQs):

> **What is *DSM* and how is it used?**
>
> DSM stands for Diagnostic and Statistical Manual of Mental Disorders. DSM is published by the American Psychiatric Association (APA) and contains descriptions, symptoms, and other criteria for diagnosing mental disorders. These criteria for diagnosis provide a common language

> among clinicians – professionals who treat patients with mental disorders. By clearly defining the criteria for a mental disorder, DSM helps to ensure that a diagnosis is both accurate and consistent; for example, that a diagnosis of schizophrenia is consistent from one clinician to another, and means the same thing to both of these clinicians, whether they reside in the U.S. or other international settings. It is important to understand that appropriately using the diagnostic criteria found in DSM requires clinical training and a thorough evaluation and examination of an individual patient. (2010c; emphasis original)

The answer to the "what" and "how" of the manual positions the diagnostic criteria, first and foremost, as the "common language" of clinicians— "whether they reside in the U.S. or other international settings." Note, however, that while the diagnostic criteria "ensure that a diagnosis is both accurate and consistent" and that a diagnosis "means the same thing" to clinicians no matter where they reside in the world, the APA circumscribes the speaker/reader of the "common language" to those with "clinical training." The use of the term "clinician" acknowledges the broad range of mental healthcare professionals, in addition to psychiatrists, who might use the *DSM*s in clinical practice, while, at the same time, the term connects professional pragmatic practices and experience to the professional style in much the same way as the "Use of Clinical Judgement" section in the Introduction to *DSM-IV*. In doing so, *DSM-5* aims to delimit the community of speakers of the "common language" to "clinicians—professionals who treat patients with mental disorders." Thus the development website ensures that readers who visit dsm-5.org do not misinterpret "common language" to mean common to all speakers and readers.

The uptake and spread of the professional style across diverse social situations produce miscomprehensions and apprehensions within the APA about speaker competence. During the revision process for *DSM-IV*, for example, psychiatrist Mark Zimmerman expresses concerns about miscomprehensions among APA members and the possibility that too frequent revisions to the "common language" will negatively affect the communicative practices of the membership. If *DSM-III* and subsequent editions provide a "common language" for the professions, he says, "then this language is spoken with many different accents. I fear that if the revision process does not slow down soon, the accents will eventually differentiate into separate languages" (Zimmerman qtd. in Bower, 1989, p. 121). Furthermore, apprehensions among members

about outsiders' communicative competence lead Alan F. Schatzberg in his Presidential address at the 163rd Annual Meeting of the APA in May 2010, to address "misperceptions" about the profession and to circumscribe the professional domain of the *DSM-5* "common language" through the importation of Latin and Greek terms, thereby bringing the language of psychiatry into closer alignment with other medical specialities. He suggests that "attacks" on the profession come from outsiders:

> Some of the attacks have been by English and history professors, and, my friends, this does present a problem we need to think about. Everyone feels emotions; everyone reads pop psychology articles or watches pop psychologists on TV; and many come to believe they are experts in psychiatry. Having been in the profession for over 40 years, I am only beginning to get a sense about the workings of the mind and the bases for psychopathology.
>
> What can we do about it? It is nice in some sense to be in a specialty that many believe they can understand. But that is a false impression, and we contribute to it in many ways—let us remember, these professors are not attacking cardiology or hematology or, for heavens sake [*sic*], otolaryngology. One major way, evident in the DSM, is our use of common language. Other medical specialties have disorders based on Latin and Greek terms that are complimented [*sic*] by lay terminology or descriptors. Take, for example, myocardial infarction and heart attack. When you look at psychiatry, you see disorders that are distinctly unmedical in sound in many ways—binge eating disorder, major depression, panic disorder, etc.—with no real parallel and more technical medical terminology. This may make disorders appear intelligible but also can make them seem trivial and less serious. . . .
>
> We need to be more medical to be taken seriously. (Schatzberg, 2010, p. 1163)

The APA President identifies attacks from outsiders on psychiatry's epistemic authority as a language problem: the profession sounds "distinctly unmedical" and therefore is subject to interlopers who see themselves as experts. Schatzberg's corrective to the profession's problem takes the form of language intervention: "be more medical" ; use "more technical medical terminology" derived from "Latin and Greek terms." From Schatzberg's perspective, lay terminology "may make disorders appear intelligible" to outsiders who "believe they can understand" the language of psychiatry, and therefore psychiatrists "need to be more medical to be taken seriously." Schatzberg says the APA "common language" contributes to the false impression that psychiatry is "a specialty

that many believe they can understand." While the APA developed the professional style to improve communication and interrater reliability within the professional discourse community, the use of common English terms like "binge eating disorder, major depression, panic disorder, etc.," produce communicative effects beyond the borders of the profession.

While psychiatrists laude the discourse features of the "common language" for the communicative aims and purposes of their scientific discourse community, at the same time, because the professional style does not sufficiently differentiate itself from vernacular English, the APA finds it necessary to circumscribe speaker competence. This sort of boundary-drawing between communities of speakers is not new. The appropriateness of vernacular versus learned language for different types of discourse recurs as a topic of discussion throughout the classical rhetorical tradition (Aristotle, *Rhetoric*, 1406a-1406b; Quintilian, *Institutes,* VIII. ii.1-24, VIII. iii.; Cicero, *Orator*, xxiii. 76-xxiv. 81; *Rhetorica ad Herennium*, IV. viii-x). In the hands and mouths of "untrained individuals," to use Frances' expression, the *DSM-III* language, sometimes referred to as the *lingua franca* of psychiatry (Berkenkotter, 2011; Berkenkotter & Ravotas, 2002b; Young, 1997) becomes, in some sense, undifferentiable from vernacular English when a broad community of readers of the *DSMs*, and genres that borrow the discourse conventions of the *DSMs*, take up the professional style. In some sense, then, the "common language" of psychiatry becomes too common, too plain, and too accessible. On the one hand, the development of the "common language" established the profession as a scientific discourse community and helped to advance the APA's communicative aims and goals, particularly improved interrater reliability. On the other hand, the discourse features of the professional style, particularly the "mathematical plainness" (precision, consistency) and the alpha-numeric organization (list-like logic) of the diagnostic criteria, facilitates uptake of the "common language" beyond the borders of the profession such that some APA members yearn for Latin and Greek terms distinctive of scientific and medical discourse communities.

Conclusion

In this chapter, I analyzed psychiatrists' metadiscourse about the aim to standardize the style of the *DSMs*. I showed how the textual standardization of discursive and pragmatic practices helped develop a professional style for American psychiatry. I noted the evolution of arguments across the *DSM*s about the perceived exigencies, purposes, and audiences of the "common language" of American psychiatry. Along the way, I showed how the textual standardization of the "common language" helped to accomplish different communicative aims and goals for the profession at particular junctures.

I showed how the *DSM-III* "descriptive approach" eliminates psychoanalytic and psychodynamic terms of art and substitutes terms of art that uphold the neo-Kraepelinian model of psychopathology. As a consequence, psychoanalytic terms and concepts—*neurosis*, *reaction*, *transient*, *situational*, *disturbance*, and so on—come to be associated with unscientific language and thus represent unscientific knowledge structures. Through a program of textual standardization, then, the professional style becomes the marker of a shared culture and aims to assimilate all minority affiliations into the neo-Kraepelinian paradigm in the interest of professional communication and interrater agreement—behaviourists, family-centered modalities, psychoanalysts, biopsychosocial practitioners. According to adherents and supporters of textual standardization, psychiatrists holding divergent theoretical perspectives will be able to use the "common language" to talk to one another about clinical matters, and in this way standardized discursive and pragmatic practices promote professional consensus—the pragmatic upshot of which is diagnostic reliability.

Furthermore, I suggested that the "descriptive approach" to the "common language" aims to develop a professional style for American psychiatry and that textual standardization of the *DSMs* produces a handbook of usage. The development of what amounts to a "house" style in the *DSMs* and attention to standardized practices, in and of themselves, might be viewed as unsurprising. Many professional associations, including medical and scientific associations, establish standards of practice and publish those practices in official manuals. Of note, however, is how the textual standardization of the diagnostic manuals and the professional style introduced to the APA in *DSM-III*

index scientific standards and scientific methods of practice and, in doing so, help establish American psychiatry as a scientific society.

The chief style attributes of the diagnostic manuals help determine the chief professional attributes such that the textual standardization of the profession becomes inseparable from the standardization of psychiatric knowledge. One of the professional aims of the textual standardization of the diagnostic manuals is to align psychiatrists with the practice of medicine and to position psychiatrists as medical professionals who use scientific standards of practice and scientific research methods to make scientific discoveries and thus produce psychiatric knowledge. Thus, in part, the epistemic authority of the profession, that is, claims about knowledge structures, nosological principles, and diagnostic practices derive from the textual standardization of the *DSMs* and the development of a professional style for American psychiatry.

In the next chapter, I continue to investigate questions of audience for the *DSM-5* "common language." Specifically, I look at five occurrences of reported speech on Criterion D2 of the draft diagnostic criteria for Posttraumatic Stress Disorder. I show how the institutional recontextualization of putative patient reported speech contributes to the expanded community of speakers of the *DSM-5* "common language." I suggest that the textual standardization of a professional style in the *DSMs*, particularly the discursive feature known as the diagnostic criteria, and the placement of putative patient speech on Criterion D2, contribute to the public visibility, shareability, and uptake of the "common language."

Chapter 4.

DSM-5 and the Community of Speakers of the "Common Language"

In February 2010 the American Psychiatric Association (APA) launched their *DSM-5* website with details about the development of the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-5*), due for publication in May 2013 (APA, 2012a). The DSM-5 Task Force posted the draft diagnostic criteria for each of the disorders on dsm5.org, and during three comment periods (February-April, 2010; May-July, 2011; May-June 2012), invited site visitors to review the draft diagnostic criteria and provide written comments and suggestions (www.dsm5.org). From February 2012 to July 2012, the website received more than 15,000 written comments (APA, 2012b). After the close of the final comment period, Task Force Chair, David Kupfer, and Vice-Chair, Darrel Regier write that "the *DSM-5* Task Force and Work Groups have updated draft *DSM-5* diagnostic criteria to reflect available results from the *DSM-5* Field Trials, ongoing reviews of the literature, data analyses, external peer reviews, and the input received from you, our readers" (APA, 2012a).

The *DSM-5* revision marks the first time the APA has launched a public website dedicated to the development process (this technology was not available during previous revisions), and more importantly, the first time the APA has solicited public review of the profession's official diagnostic manual. The diagnostic criteria are the discursive exemplar of the APA's "common language" introduced in *DSM-III* (1980) to improve communication and interrater agreement among clinicians (APA, 1980, p. 1), and as such they represent the "data" of American psychiatry's empirical approach. Given that the diagnostic criteria were developed for mental healthcare professionals, how, then, do readers of dsm5.org come to be seen as a community of speakers of this professional style? As a way to provide some evidence toward answering this question, I analyze the *DSM-5* draft diagnostic criteria to show how this discursive resource facilitates the public

visibility and uptake of the professional style. Specifically, I analyze the stylistic and syntactic design and placement of five occurrences of putative patient reported speech on Criterion D2 of the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder. Aspects of design include the identification of an amalgamation of prior texts and contexts of production that contribute to the co-construction and co-authoring of reported speech on Criterion D2. Elements of placement focus on the effects of institutional recontextualization on the authenticity and authority of the "voice" and persona of putative patient reported speech in the classification. I show how *DSM-5* establishes possible identity positions for audience members to inhabit, and, in doing so, provides "narratized" subject positions as the loci for experience and action. Rather than considering the givenness of audience for *DSM-5*, that is "audience" as a transcendent subject who pre-exists discourse and is, therefore, extra-rhetorical, for example, Kupfer and Regier's "general public," I consider the textual nature of social being.

To do so, I draw on Charland's (1987) concept of constitutive rhetoric. Charland calls into question the traditional rhetorical concept of audience as made up of transcendent subjects who exist prior to the speech to be judged and reconfigures audience as comprising those persons who, in acknowledging the address, participate in the very discourse that seeks to persuade them and who, paradoxically, are bounded by the very rhetoric that called them into being. Charland supplements an Aristotelian perspective of audience as extra-rhetorical—existing separate from and prior to discourse and thus having the freedom to judge.

Charland calls constitutive rhetoric a "rhetoric of identification" and a "rhetoric of socialization" (p. 138), not restricted to one "hailing" (Althusser's word), whereby an individual recognizes and acknowledges the address. Thus he joins Burke's term *identification* to Althusser's term *interpellation*—the ideological constitution of the individual as a subject through address. For Burke (1969), "identification" rather than "persuasion" is critical to his conception of the rhetorical process as motivated action. We persuade only in so far as we are able to convince people to *identify* their beliefs with our beliefs—to become *consubstantial*—thus inducing the auditor to participate in the rhetorical process (to recognize and acknowledge the address). In Charland's configuration, then, constitutive rhetoric forms part of the discursive background of social life: "constitutive rhetorics are ideological not merely because they provide individuals

with narratives to inhabit as subjects and motives to experience, but because they insert 'narratized' subjects-as-agents into the world" (p. 227). Thus social identity is a discursive effect and a rhetorical effect produced through identification with a textual position.

This chapter builds on and contributes to research on reported speech (Bakhtin, 1981, 1986; Vološinov, 1986), particularly rhetorical scholarship on the recontextualization of patient reported speech in psychotherapeutic and psychiatric discourse (Berkenkotter, 2001, 2008; Berkenkotter & Ravotas, 1997, 2002; McCarthy, 1991). For example, McCarthy (1991) conducts a case study of one child psychiatrist using *DSM-III* "to examine the epistemological and textual consequences" (p. 375) of the classification system on the practices of the psychiatrist. McCarthy concludes that *DSM-III's* diagnostic principles provide a framework for diagnosing that affects how psychiatrists collect data, what counts as relevant information, which language they use to depict and record diagnoses, and what they know about mental illness in the first instance.

In two studies on client reported speech in a clinical setting, Ravotas and Berkenkotter (1998) and Berkenkotter and Ravotas (2002) show how, during the initial written assessment of the client, the therapist reformulates the client's speech so as to make the client's account consistent with the vocabulary of the therapist, thereby subsuming the client's perspective into the institutional account. In the later study, the authors note that psychiatrists use the standardized syntax, grammar, and vocabulary of *DSM-IV* in their paperwork such that the professional style of *DSM-IV* recontextualizes patients' reported speech. These studies show some of the ways in which psychotherapists and psychiatrists recontextualize putative patient reported speech in clinical settings through the uptake of the standardized lexicon of the *DSMs*. This study aligns with and extends these findings by demonstrating how psychiatrists in research settings recontextualize putative patient reported speech on the *DSM-5* draft diagnostic criteria.

This chapter has five sections. First, I introduce the term *exemplary speaker* as one way to account for the evolving and expanding community of speakers of the "common language" and the cultural portability and shareability of the "common

language," specifically the diagnostic criteria, and, more specifically still, reported speech on the diagnostic criteria. Second, I review some of the existing research on reported speech and the main theoretical issues associated with that scholarship, and I connect this discursive resource to two concepts central to the methods of analysis: cultural portability and text trajectory. Third, I analyze an array of instances of reported speech in various editions of the diagnostic manual to demonstrate the robustness and diversity of this discursive resource. By way of example, I document the text trajectory and recontextualization of small stretches of discourse in three classifications across all editions of the manual (1952-2012). Fourth, I analyze reported speech on the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder (PTSD) within the context of those theoretical perspectives. Next, I identify and analyze an amalgamation of prior texts that contribute to the recontextualization of reported speech on the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder. Finally, I offer some conclusions about the effects of the institutional recontextualization of reported speech in the classification. I suggest that the textual standardization of the professional style contributes to the public visibility and cultural portability of the diagnostic criteria. I document the ways in which institutional and professional co-authoring practices recontextualize the patient "voice" and persona of putative patient reported speech according to the interests and commitments of the APA. On Criterion D2, spoken discourse in the form of reported speech becomes recontextualized as data: the product of scientific research and the organization of scientific knowledge. As a consequence, the institutional recontextualization of reported speech produces a resource for the discursive construction of psychiatric knowledge.

The Exemplary Speaker of the "Common Language"

Sometimes linguists and discourse analysts use the term *exemplary speaker* when discussing phonological and lexical variation among the dialects and registers of a given language, for example, the prestige English register Received Pronunciation (RP), which operates as a form of semiotic capital in England and whose speakers index social and economic advantage and advancement (Agha, 2003). Scholars suggest that exemplary speakers must exhibit the capacity to uphold a speech standard (albeit idealized and unattainable), that is, to use phonetic forms, lexical variations, and

grammatical structures in a manner congruent with the appropriate context of use (Agha, 2005, p. 48). However, because I analyze the textual standardization of a professional style, I use the term *exemplary speaker* without reference to phonetic forms and pronunciation, although, as with all language varieties, the "common language" of the *DSMs* depends upon a system of sameness and differences.

As with other variants of English, the exemplary speakers of the "common language" of the *DSMs* must exhibit the capacity to uphold the standard in a manner congruent with the appropriate context of use. In some discourse communities, proscriptions exist against teaching registerial forms to outsiders, for example, sacred or ritual language in religious communities. Furthermore, professional associations, for example, the APA, delimit speaker competence of the professional style to members of the discourse community thus establishing and maintaining asymmetries of speaker competence and circumscribing the community of speakers. At the same time, however, institutional practices facilitate distribution and awareness of the "common language" of the *DSMs* beyond professional borders to diverse populations. In part, this occurs because the genres that reproduce the competence to *recognize* the language variety have a wider demographic reach than those that reproduce the competence to *speak* the language variety (Agha, 2003, pp. 264-265). In the case of the professional style of American psychiatry, and as with all language varieties, the community of speakers of the "common language" changes over time and all members do not exhibit identical competence.

While the diagnostic criteria are the discursive feature of the "common language" most often associated with the nomenclature's scientific method, many commentators question the scientific status of the data-collection methods. For example, Kirk & Kutchins (1992) note the differences between interrater *verifiability* and diagnostic *validity*, suggesting that, while the *DSM-III* diagnostic criteria may improve interrater verifiability (agreement), they may reduce diagnostic validity (pp. 28-30). In addition, Frances (2009) and Kupfer (2010) point out design flaws in *DSM-IV*'s data-collection methods and they caution *DSM-5* Task Force members to design field trials and data-collection methods that uphold scientific principles. However, despite these concerns about the lack of scientific methods in *DSM-III* and *DSM-IV*, the subtitle of Kutchins and Kirk's (1997) *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental*

Disorders highlights the manual's status as a cultural icon and a paradigmatic scientific text.

Psychiatrist Mitchell Wilson (1993) attempts to reconcile the diagnostic manual's lack of scientific rigour with its revolutionary status. To do so, he identifies sociohistorical factors to account for the Task Force's reliance on the diagnostic criteria as an indicator of the nomenclature's scientific foundations:

> The question remains why a single document—a manual "full of hypotheses"—both promoted and represented a radical transformation within the profession. This is a complex question to which only a few tentative answers can be offered. As I have described, the shrinking of resource support, the problem of accountability in psychiatric practice, and the lack of progress in research made it imperative that the profession officially adopt a model of psychopathology that stressed what was *publicly visible* over what was privately inferred. This emphasis on public visibility through the methodology of explicit diagnostic criteria greatly facilitated communication for psychiatric clinicians and psychiatric investigators. With *DSM-III*, psychiatrists now had a common language with which to communicate. Further, American psychiatry now had a common language with which to map its professional jurisdiction. (p. 408; emphasis in original)

Mitchell connects the "radical transformation" of psychiatry to the visibility of the diagnostic criteria: lists of observable signs and symptoms. The imperative for better communication within the profession came to be seen as achievable through a lexicon of explicit diagnostic criteria and interlinked with a medical model of psychiatry that afforded greater interrater reliability through empirical observation—visible signs and symptoms of disorder. The "common language" brought about a shift in the production of knowledge in American psychiatry: biomedical researchers engaged in the collection of data directed at diagnostic replicability became the example par excellence for the profession, edging out clinicians engaged in biopsychosocial therapeutic models (Wilson, 1993, p. 408); the researcher's laboratory replaced the clinician's couch as the privileged sphere of activity for psychiatric practice. However, the desire for a "common language" that articulated observable, measurable signs and symptoms in the physical body, "what was *publicly visible*" rather than underlying etiologic theories hidden from view, "what was privately inferred," produced communicative effects that reverberated beyond the borders of the profession. There is another sense, different from Wilson's

use, in which we can think about the terms *common language, publicly visible,* and *public visibility*. The prescriptive imperative to develop a "common language" for American psychiatry coupled with the objective to adopt a scientific model based in what was *publicly visible* in patients resulted in *public visibility* for *DSM-III*. While professional practices delimit speaker competence of the "common language" to professional discourse communities, the social values interlinked with the discourse features promote circulation of the language across a range of social occasions such that many cultural members recognize and, in some cases, are able to describe and mimic the features of the profession style. As a result, the community of speakers expands and the "common language" is taken up by speakers outside the psychiatric discourse community.

An article in *The New Yorker* addresses uptake of the professional style by non-professionals and the writer suggests that Spitzer "not only revolutionized the practice of psychiatry but gave people all over the United States a new language with which to interpret their daily experiences and tame the anarchy of their emotional lives" (Spiegel, 2005, p. 56). Spiegel describes the new community of speakers of the "common language" as follows:

> Almost immediately, the book started to turn up everywhere. It was translated into thirteen languages. Insurance companies, which expanded their coverage as psychotherapy became more widespread in the nineteen-seventies, welcomed the *DSM-III* as a standard. But it was more than that: the *DSM* had become a cultural phenomenon. There were splashy stories in the press, and TV news magazines showcased several of the newly identified disorders. "It was a runaway success in terms of publicity," Allen Frances says. Spitzer, Williams, and the rest of the DOPs [data oriented people] were surprised and pleased by the reception. "For us it was kind of like being rock stars," Williams says. "Because everyone saw that it was the next big thing, everyone knew us and wanted to talk to us. It was like suddenly being the most popular kid on the block." (p. 60)

The audience for the "common language" expands— "everyone saw that it was the next big thing"—such that the diagnostic manual for a professional discourse community becomes "a cultural phenomenon." Whereas the originary exemplary speakers were "the DOPs" who designed the Feighner criteria and the RDC, with the publication of *DSM-III* the community of speakers of the "common language" expands to include the general APA membership and, over time, to other interactional professional domains such as

health care professionals (therapists, counselors, clinicians, and researchers), social workers, and insurance providers. Spiegel identifies several of the social processes through which the standardization of discourse features contributes to the expansion of the community of speakers of the professional style: codification of the published printed text—"the book started to turn up everywhere"; translation of the text "into thirteen languages"; designation of the text as an industry "standard"; newspaper and media coverage—"splashy stories in the press." The standardized discourse features circulate in the public sphere and readers of the diagnostic manuals themselves and readers of stories about the diagnostic manuals recognize the professional style as a prestige standard to be emulated, sometimes as no more than "cocktail party patter," but for others the diagnostic language "changed the way we see ourselves—many people previously preoccupied with understanding their unconscious motivations now focused on understanding their psychiatric disorder" (Frances, 2010, n. p.). Thus a whole complex of overlapping social processes assist the public visibility and uptake of the diagnostic language across an array of social situations. In the next section, I show how the discursive resource known as reported speech facilitates speaker/reader uptake of the "common language."

The Cultural Portability of Reported Speech

According to Vološinov (1986), reported speech points to a speech intersection between two authors, where one author reports the voice of another and provides an opportunity not only for two speech participants to come together but for two contexts to meet, the reported context (the prior discourse) and the reporting context (the current iteration). Vološinov's theory of reported speech accounts for the complex temporal trajectory of the utterance: how the prior utterance is understood, taken up, and reused (repeated) in future discourse. Vološinov writes, "reported speech is speech within speech, utterance within utterance, and at the same time also *speech about speech*, *utterance about utterance*" (p. 115; emphasis in original).

While, traditionally, scholars have distinguished between direct quotation and indirect quotation, recent research into reported speech questions the assumption that direct speech is more accurate than indirect speech. Many scholars now suggest that all

reported speech is recontextualized speech (Holt & Clift, 2007; Lucy, 1997; Tannen 1986, 1989). Rather than differentiating degrees of authenticity of types of reported speech, researchers (including those mentioned earlier) focus on the effects of recontextualization: the fundamental change that each report undergoes when it is repeated in the reporting context (Holt & Clift, 2007; Lucy, 1993; Tannen, 1986, 1989). Tannen (1989) suggests the term *reported speech* is a misnomer and she opts instead for the term *constructed dialogue* to reflect how in the reporting context the person is not so much reporting speech as engaging in a creative activity much like the author who constructs dialogue in a work of fiction (p. 311). Everyday ordinary speakers make use of strategies in conversation that heretofore have been thought to belong to literary discourse: the creative elements of constructed dialogue operate as a primary feature of repetition in conversational genres. This view reflects the duality of reported speech (and indeed of all language when language is viewed as indirect quotation): the report is a repetition and as such has a history for both speaker and listener, and the report is novel in the sense that the reporting context transforms (makes new) the report (Tannen, 1989, p. 132).

In the context of psychotherapeutic discourse, some research identifies the written record of highly-collaborative conversational interactions between therapist and patient as "joint productions" (Ferrara, 1994, p. 138). Joint productions occur when discrete contributions between active participants during the shaping of a stretch of discourse become difficult to identify (Ferrara, 1994, p. 165). Other researchers show how clinical therapists formulate clients' speech using different terms to make the speech consistent with the therapist's discourse (Buttny, 1998). The term *formulation* refers to how, in the clinical setting, therapists sometimes undertake joint productions of client speech to summarize for gist, draw out relevant implications, and seek ratification from clients. During formulations or *re*formulations of client talk, therapists delete client terms and select and substitute new terms in their stead (Davis, 1986). In interaction, the uptake of new terminology occurs with varying degrees of agreement, and tendentious formulations most often happen in institutional interactions (Heritage, 1985). Clinicians' reformulations of patient talk entail both creative and interpretive interventions so as to bring patient talk about their history and symptoms, for example, into alignment with diagnostic language (Antaki, Barnes, & Leudar , 2005). Clinicians and therapists employ

language from normative models and theories about the world, often in written, codified forms, which govern therapist-client interactions. Often therapists' reformulations of patient talk move the talk in a direction to which the therapist orients such that reformulations recontextualize the world view of the patient to align with the professional and institutional practices of the therapist (Peräklyä & Vehviläinen, 2003).

Every language community has a reservoir of texts from which they draw to shape old texts to new contexts (Becker, 1994), and speakers always borrow words from others to serve their own purposes, intentions, and contexts. From this point of view, reported speech represents a particular kind of repetition or prior text. The notion of prior discourse/prior text highlights the permeability of authorial boundaries and the dialogicality of the utterance, and points to the interconnectedness of texts, that is, how repertoires of prior texts make contributions to current iterations through repetitions of discourse conventions, features, and patterns (Bakhtin, 1981, 1986; Becker, 1994).

But all texts are not created equal. Some prior texts are more public than others and the degree of public-ness impacts the degree of availability to a community of speakers (Becker, 1994, p. 166). For example, Urban (1996) notes that the lack of uniqueness in a stretch of discourse contributes to its repeatability and shareability across genres and generations, and in certain contexts group efforts or co-operative ventures rather than individual efforts more readily produce shareable culture (p. 40), for example: myth-telling/myth-building in oral cultures; religious and ritualistic ceremonies; and, I suggest, diagnostic criteria.

Text-building strategies (for example, reported speech, paraphrase, citation, and so on) make the old text coherent with the current discourse in the current context and for the current audience. However, various processes of replication—moving parts of texts around in speech and writing—highlight the textual rather than the contextual aspects of the copied discourse. Johnstone et al. (1994) note, "the function of repetition in general is to point, to direct a hearer back to something and say, 'Pay attention to this again. This is still salient; this still has potential meaning; let's make use of it in some way'" (p. 13). On this view, reported speech serves metacommunicative functions, helping members of a professional discourse community interpret the discursive interactions surrounding the production of the reported speech, providing a link between

the social context and the original discourse, and assigning meaning to utterances (Johnstone, 2008; Urban, 1996). At the same time, the speech interaction provides the possibility during reporting (a type of repetition) for reaccentuation, recontextualization, and reinterpretation in the new speech situation. Depersonalized discourse detached from local context is more culturally portable and therefore more shareable than discourse whose formal properties and specificity of context contribute to its uniqueness (Urban, 1996, p. 21). The notion that some texts make for "better culture" (Urban, 1996, p. 42) than others, in the sense of being more transmittable or shareable, points to the text trajectory of reported speech, whereby the reports metamorphize through various iterations and recontextualizations.

The *DSM*s provide an interpretive framework that mediates the individual communicative action of psychiatrists and therapists and institutional structures. Studies from Berkenkotter & Ravotas (1997, 2002) and McCarthy (1991) show how psychotherapists' and psychiatrists' notes and reports, respectively, form part of the institutional and professional cycles of discourse. Reported speech on Criterion D2 of the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder provides another example of the recontextualization of the patient's oral narrative and evidence of the text trajectory of the classification and the diagnostic manual. Analysis of reported speech undertaken with a view to theories of prior discourse and text trajectory offers a way to identify professional, historical, and social formations (extralinguistic structures) outside the immediate, bounded text (linguistic structure). Any analysis of reported speech must account for the relations between reported context and reporting context and the complex temporal trajectory of the utterance—how the prior utterance is understood, taken up, and reused in future discourse (Vološinov, 1986, p. 115). On this view, even direct reported speech remains, to some degree, constructed speech because speakers and writers appropriate past speech for present purposes.

To better demonstrate the cultural portability and the life cycles of this professional style, in the next section I include examples of reported speech in various sections and editions of the diagnostic manual that demonstrate the diversity and frequency of this discursive resource in the nomenclature, including a brief diachronic analysis of reported speech in three classifications: Attention Deficit/Hyperactivity Disorder; Anorexia Nervosa; and Panic Disorder. Then, I review the uses of reported

speech in the descriptive text of the classification Posttraumatic Stress Disorder in *DSM-III*, *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR*.

Reported Speech in the Diagnostic Manuals

Reported speech is not a new discursive strategy in the diagnostic manuals. All editions make use of this resource for a variety of purposes in the introductions, forewords, and appendices, for example, as a metadiscursive device that frames the terms of art and the names of classifications. The example below shows two types of uses: (1) to emphasize metapragmatic instructions (2) to highlight symptom degrees:

> 4. Pre-Morbid Personality and Predisposition.
>
> The description of predisposition will consist of the patient's outstanding personality traits or weaknesses, which have resulted from inheritance and development, and an evaluation of the degree of this predisposition based on the patient's past history and personality traits. Frequently, the premorbid personality may be such that classification can be made as one of the personality disorders. When the predisposition cannot be determined, it will be recorded as "undetermined." The degree of predisposition will be reported as "none," "mild," "moderate," or "severe." (APA, 1952, p. 48)

The example below shows two instances of one type of use identified above: (2) to describe visual signs:

> **Neurofibromatosis (Neurofibroblastomatosis, von Recklinghausen's disease).**
>
> A disease transmitted by a dominant autosomal gene but with reduced penetrance and variable expressivity. It is characterized by cutaneous pigmentation ("cafe au lait" patches) and neurofibromas of nerve, skin and central nervous system with intellectual capacity varying from normal to severely retarded.
>
> **Trigeminal cerebral angiomatosis (Sturge-Weber-Dimitri's disease).**
>
> A condition characterized by a "port wine stain" or cutaneous angioma, usually in the distribution of the trigeminal nerve, accompanied by vascular malformation over the meninges of the parietal and occipital lobes with underlying cerebral maldevelopment. (APA, 1968, p. 18)

The following example from the "Glossary of Technical Terms" in *DSM-III* and *DSM-II-R* demonstrates some additional uses of reported speech in the manuals (the term does not appear in subsequent glossaries):

> PERSEVERATION. Persistent repetition of words, ideas, or subjects so that, once an individual begins speaking about a particular subject or uses a particular word, it continually recurs. Perseveration differs from the repetitive use of "stock words" or interjections such as "you know" or "like."
>
> Examples: "I think I'll put on my hat, my hat, my hat, my hat." Interviewer: "Tell me what you are like, what kind of person you are." Subject: "I'm from Marshalltown, Iowa. That's 60 miles northwest, northeast of Des Moines, Iowa. And I'm married at the present time. I'm 36 years old. My wife is 35. She lives in Garwin, Iowa. That's 15 miles southeast of Marshalltown, Iowa. I'm getting a divorce at the present time. And I am at present in a mental institution in Iowa City, Iowa, which is 100 miles southeast of Marshalltown, Iowa."
>
> Perseveration is most commonly seen in Organic Mental Disorders, Schizophrenia, and other psychotic disorders. (APA, 1980, pp. 365-366; APA, 1987, p. 403)

In the above example, the discursive device frames the colloquialisms "stock words," "you know," and "like" as well as marking turn taking in a dialogue between a subject and an interviewer. The glossary entry borrows discourse conventions from literary genres to present the interactants in the example as named characters in a play engaged in dialogue. The lack of disfluencies, hesitancies, and overlapping speech, that is, those discourse conventions typical of spontaneous speech, indicate constructed dialogue rather than the transcription of a stretch of discourse.

In addition, the diagnostic criteria for many classifications include reported speech in the form of colloquialisms, informal expressions, and conversational language that summarize patients' subjective experiences. Representative examples of putative patient speech on the diagnostic criteria for three classifications follow:

Example 1 Criterion 5/e for Attention Deficit/Hyperactivity Disorder (AD/HD) reads:

DSM-I (no such classification)

DSM-II (known as "Hyperkinetic reaction of childhood"; no diagnostic criteria)

DSM-III (5) is always “on the go” or acts as if “driven by a motor” (p. 44).

DSM-III-R (the Work Group removes this diagnostic criterion) (APA, 1987)

DSM-IV (e) is often “on the go” or often acts as if “driven by a motor” (p. 84)

DSM-IV-TR (e) is often “on the go” or often acts as if “driven by a motor” (p. 92)

DSM-5 e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable or uncomfortable being still for an extended time, as in restaurants, meetings, etc; may be experienced by others as being restless and difficult to keep up with) (APA, 2012e)

Example 2 Criterion B for Anorexia Nervosa reads:

DSM-I (known as “Psychophysiologic gastrointestinal reaction”; no diagnostic criteria)

DSM-II (known as “Feeding disturbance”; no diagnostic criteria)

DSM-III B. Disturbance of body image, e.g., claiming to “feel fat” even when emaciated (p. 69)

DSM-III-R B. Intense fear of gaining weight or becoming fat, even though underweight (p. 67)

DSM-IV B. Intense fear of gaining weight or becoming fat, even though underweight (p. 544)

DSM-IV-TR B. Intense fear of gaining weight or becoming fat, even though underweight (p. 589)

DSM-5 B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight. (APA, 2012d)

Example 3 Criterion for Panic Disorder reads (alpha-numeric ordering varies) :

DSM-I (known as “Anxiety reaction”; no diagnostic criteria)

DSM-II (known as “Anxiety neurosis”; no diagnostic criteria)

DSM-III B. (12) fear of dying, going crazy, or doing something uncontrolled during an attack (APA, 1980, p. 232)

DSM-III-R C. (12) fear of dying (13) fear of going crazy, or doing something uncontrolled during an attack (p. 238)

DSM-IV A. 2 (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”) (p. 402)

DSM-IV-TR A. 2 (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”) (p. 433)

DSM-5 1. Persistent concern or worry about additional Panic Attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”) (APA, 2012f)

Arranging the three sets of examples in chronological order indexes the history of discourse of the classifications and the diagnostic manuals, and the text trajectory of reported speech on the diagnostic criteria in these classifications. In Example 1, the two speech reports “on the go” and “driven by a motor” repeat across all editions with the exception of *DSM-III-R* . The revisers of this edition remove this criterion altogether (the reasons remain unclear) and the *DSM-IV* revisers reinstate the criterion with both speech reports intact but with a slight alteration in phrasing that reduces the level of certainty of the claim: the criterion includes two uses of the qualifier “often”; the first use replaces “always” and the second modifies the verb “acts.” In Example 2, the speech report “feel fat” in the *DSM-III* iteration is replaced in all subsequent editions with the collocation *becoming fat* as part of the phrase *Intense fear of gaining weight or becoming fat*. In this case, the verb “feel” takes the simple present tense and expresses the mental process of perception in an individual (Downing & Locke, 2006, pp. 139-140). The verb *becoming* takes the progressive form to express a dynamic process of transition or a way of being that calls attention to a resulting attribute (Downing & Locke, 2006, pp. 144-145), rather than to the current state of being suggested by the present tense “feel fat.” In Example 3, the *DSM-III* and *DSM-III-R* collocation *going crazy* takes the form of reported speech—“going crazy”—in the *DSM-IV* iteration and all subsequent editions. This latter recontextualization, which transforms a colloquialism into reported speech thereby pointing to a subjective patient experience (e.g., an individual speaking

subject), highlights the constructed nature of this discursive resource as representing the type of utterance a person diagnosed with Panic Disorder is expected to say thereby discursively constructing psychiatric knowledge.

The descriptive text for Posttraumatic Stress Disorder in *DSM-III* (the first edition to include this classification) does not include colloquialisms, informal expressions, or conversational language representative of patient speech or patients' subjective experiences in the form of reported speech. However, in later iterations, Task Force revisers introduce one colloquialism "flashbacks" in the descriptive text and the diagnostic criteria. I characterize "flashbacks" as a colloquialism to differentiate patient reported speech from expert reported speech in the classification. Shatan (1973) credits Vietnam veterans with the application of this term to describe some aspects of the syndrome (p. 645).

In this classification, the descriptive text for *DSM-IV-TR* transformed the colloquialism *flashbacks*, first included on Criterion B3 of the *DSM-III-R* iteration, into reported speech: "flashbacks." The first excerpt (below) shows the parenthetical designation of the term on Criterion B3 in *DSM-III-R*, the second shows the unmarked use, that is, absent quotation marks, on the diagnostic criteria in *DSM-IV*. In this iteration, the *DSM-III-R* parenthetical use, which designates the term as a synonym for or example of the term *dissociative*, recontextualizes the use as a collocation with the terms *dissociative* and *episode*, and the third and fourth excerpts, respectively, show the unmarked use on the diagnostic criteria (no change from *DSM-IV*) and the term's recontextualization as reported speech in the descriptive text in *DSM-IV-TR*:

> 1. B (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)(APA, 1987, p. 250).

> 2. B (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). (APA, 1994, p. 428)

> 3. B (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and

> dissociative flashback episodes, including those that occur on awakening or when intoxicated). (APA, 2000, p. 468)
>
> 4. In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. (APA, 2000, p. 464)

In addition, all iterations of this classification include two unattributed occurrences of expert reported speech from two psychiatrists who, separately, research and theorize the traumatic war neuroses: "psychic numbing" from Robert Lifton (1967) and "emotional anesthesia" ("l'anesthésie affective") from Eugène Minkowski (1946). These two instances of expert reported speech appear in the descriptive text in each edition of the manual as follows (the Task Force has not yet published the draft descriptive text for *DSM-5* classifications):

> Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. (APA, 1980, p. 236; APA, 1987, p. 248; APA, 1994, p. 425; APA, 2000, p. 464)

In the *DSM-III* descriptive text, "psychic numbing" occurs a second time under the section entitled "Impairments and complications":

> "Psychic numbing" may interfere with interpersonal relationships, such as marriage or family life. (APA, 1980, p. 237)

Although the descriptive text and the diagnostic criteria for the classification underwent substantial revisions in *DSM-III-R* (1987), *DSM-IV* (1994), and *DSM-IV-TR* (2000), each edition retains large unaltered portions of the *DSM-III* descriptive text and diagnostic criteria for this classification, including repetitions of the *DSM-III* sentence with the reported speech intact across editions. While all iterations of the classification to date include these two occurrences of expert reported speech, *DSM-5* marks the first time Posttraumatic Stress Disorder includes putative patient reported speech, the first time the diagnostic criteria for the classification includes reported speech of any variety, and

Criterion D7 includes the term *psychic numbing*; however, this repetition of the utterance occurs as a parenthetical example and without quotation marks:

> Persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing) (APA, 2012g).

Finally, the *DSM-III-R* descriptive text introduced one additional instance of expert reported speech, "omen formation" (Terr, 1983), in a new subsection of the classification, "Age specific features" in *DSM-III-R* and "Specific Culture and Age Features" in *DSM-IV* and *DSM-IV-TR*, as follows:

> A symptom of Post-traumatic Stress Disorder in children may be a marked change in orientation toward the future. This includes the sense of a foreshortened future, for example, a child may not expect to have a career or marriage. There may also be "omen formation," that is, belief in an ability to prophesy future untoward events. (APA, 1987, p. 249)

And,

> In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation"—that is, belief in an ability to foresee future untoward events. (APA, 1994, p. 426; APA, 2000, p. 465)

As the name indicates, this subsection of the descriptive text addresses manifestations of the disorder specific to children and culture-specific features. In the next section, when I analyze the recontextualization of what appear to be five occurrences of direct reported speech from patients on Criterion D2 of the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder, the culture-specific language of two of the speech reports become of central importance. Furthermore, analysis shows how the diagrammatic and hierarchical arrangement of the diagnostic criteria and the discursive resource known as reported speech contribute to the social transmission, cultural portability, and uptake of the "common language."

The *DSM-5* Draft Diagnostic Criteria for Posttraumatic Stress Disorder

DSM-III and subsequent editions arrange diagnostic criteria into alpha-numeric lists that group together similar types of signs and symptoms (Criterion A, Criterion B, Criterion C, and so on). Like other diagrammatic classifying systems, lists arrange items according to hierarchical organizing principles in such a way that each listed item occupies a permanent, discrete position and items acquire stable relationships between and among other items in the system of classification (Goody, 1977). Diagrammatic modes of classifying, such as the diagnostic criteria sets, which itemize, arrange, and contain information and package knowledge in discrete chunks, reduce communicative acts to static objects (Goody, 1977; Ong, 1958). Thus literate practices play an important role in the textual standardization of the diagnostic manuals.

The complete alpha criteria for the classification Posttraumatic Stress Disorder run A through H, and the numeric criteria total 24 (see Appendix 13 for the complete diagnostic criteria for this disorder). In its entirety, criterion D reads as follows:

> D. Negative alterations in cognitions and mood that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced by 3 or more of the following: **Note**: In children, as evidenced by 2 or more of the following:
>
> 1. Inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs).
> 2. Persistent and exaggerated negative expectations about one's self, others, or the world (e.g., "I am bad," "No one can be trusted," "I've lost my soul forever," "My whole nervous system is permanently ruined," "The world is completely dangerous").
> 3. Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)
> 4. Pervasive negative emotional state -- for example: fear, horror, anger, guilt, or shame
> 5. Markedly diminished interest or participation in significant activities.
> 6. Feeling of detachment or estrangement from others.
> 7. Persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing) (APA, 2012g)

The D descriptor sets out the types of behaviours that fall under this rubric and establishes how many of the D criteria must be met in order to assign a diagnosis, in this case 2 of the 7, and the numeric entries annotate the signs and symptoms. The D descriptor includes the diagnostic qualifier "as evidenced by 3 or more of the following," which operates as a metapragmatic instruction to the user to choose three criteria from a list of seven consecutively numbered criteria arranged vertically in space. While the phrase "as evidenced by 3 or more of the following" indicates equivalent weight among the choices, the alphabetic and numeric values and vertical arrangement indicate an implicit hierarchy within the constituent items that make up the cluster of symptoms on Criterion D: the organizing principles of lists dictate that items with the highest weight appear at the top of the column, while those with the lowest weight appear at the bottom (Goody, 1977, p. 103).

On the *DSM-5* draft diagnostic criteria, Criterion D2 includes what appear to be five occurrences of patient reported speech. Quotation marks anchor the utterances to an unattributed speaker/speakers and provide a formal marker of a change of speech subject, indicating that the utterances enclosed in quotation marks originated elsewhere—from a prior context/s—even when, as in this case, the speech reports lack attribution. Thus reported speech blends information about the utterances with information about the world not necessarily conveyed by those utterances and the blending creates potential ambiguities. While the speech reports retain the quotation marks of direct reported speech, the absence of attribution of speaker and context make ambiguous the notion that these reports represent verbatim speech from a prior speech event.

Two speech reports make use of the first-person singular pronoun *I* ("I am bad"; "I've lost my soul forever") and two make use of the first-person possessive *My* ("I've lost my soul forever" ; "My whole nervous system is permanently ruined"). The first-person pronoun *I* and the first-person possessive *My* indicate an individual with a social identity inhabiting the social world. Yet their placement on Criterion D2 and the absence of attribution destabilizes and decontextualizes their deictic centres (the situational coordinates of person, place, and time) and the prior context of utterance is unrecoverable. Therefore, because the pronouns and possessives are no longer attached to an actual empirical case—the social interactions out of which the utterances

emerge, if, in fact, the utterances emerge from empirical cases—the pronominal speaker category *I* results in an abstract essentialization: who is the speaker/s, who is the addressee/s, when, where, and in what context/s did the speech reports occur? In this regard, the quotation marks that enclose the utterance serve to alter the tone, pointing to the boundaries of the utterance and to the change of speaking subject.

While quotation marks appear to keep intact the wholeness of an utterance (in the sense of a bounded speech event), when reported speech is recontextualized on the draft diagnostic criteria the interactional, reported context falls away—an unreadable or unrecoverable surround and background—while reported speech remains seemingly intact. In this regard, the quotation marks, a common way to entextualize a stretch of discourse and indicate its boundaries, facilitate the detachment/extraction of the speech reports from their rich indexical surround (for example, psychotherapeutic discourse from a clinical setting) and change spoken discourse into an idealized speech situation with highly stylized and standardized features (*DSM-5* diagnostic criteria). The recontextualization of spoken discourse in a published printed text produces a more concise, more systematic, more complete product than the spoken mode. A stretch of spoken discourse recontextualized as *DSM-5* diagnostic criteria—a truncated, vertical list of observable signs and symptoms—provides a framework that further decontextualizes the speech reports, which becomes data for the psychiatric researcher. The transmission of reported speech onto the diagnostic criteria lifts oral discourse from one context through the technology of writing and recontextualizes spoken discourse as scientific data: seemingly autonomous and meaningful, detached from historical processes, and transported across spatiotemporal boundaries (virtual, textual, generic, generational, and so on).

In this regard, the quotation marks provide a discursive resource that assists the cultural portability and textual trajectory of the speech reports from the reporting context to the reported context. And, in this sense, reported speech makes for “better culture”: a discourse feature of the *DSMs* made portable and repeatable through the textual standardization of discourse features—the “common language”; through the diagrammatic organizing principles of the diagnostic criteria; and through the discursive features of these examples of reported speech—the quotation marks, the first-person

pronoun, the first person possessive, and orthographic practices, for example, capitalization and punctuation.

While, traditionally, the presence of quotation marks and use of the first-person pronoun *I* and the first-person possessive *My* index verbatim reported speech, on the diagnostic criteria, the lack of speaker attribution, the detachment from local context, and the lack of differentiation of speaker/s between and among the string of five speech reports, point to a creative text-building strategy: the speech reports are composite sketches representative of patient talk that construct the "voice" of a stereotypical patient; that is, they are the linguistic construction of social persona.

The presence of a stereotypical patient "voice" on the draft diagnostic criteria, detached from local context, provides an opportunity for readers to identify with and inhabit the "narratized" subject position—the "voice" or persona—and thus reported speech facilitates the cultural portability of the "common language." However, the sameness or difference of personhood, that is, the discrete voice of the speaker who produces the utterance is recognizable only in the context of production. Once the utterance becomes detached and recontextualized, the likeness or unlikeness of the voice, as differentiable from others, vanishes (Agha, 2005). In the course of institutional recontextualization, the discrete voice of the speaker blends with the other discourse features and helps to construct other (new, different) social meaning. Readers borrow the characteristics of speech associated with the standardized features of the diagnostic criteria and fashion their own identities through these recognizable "voices" or personae. The speech reports become a kind of disembodied, transmissible sound-bite—decontextualized and detached from an individual speaking subject yet paradoxically representative of the psychiatric patient.

Direct and indirect reported speech represent one of the hallmarks of narrative and literary genres (Bakhtin, 1981; Vološinov, 1986). Tannen's term *constructed dialogue* makes this sort of connection between literary dialogue in a novelistic or theatrical framework and the "voice" of a character or persona (see also Agha, 2005). Psychotherapeutic discourse borrows this resource from the narrative mode (Ferrara, 1994) and from the case history narrative in medicine (Atkinson, 1992) and psychiatry (Berkenkotter, 2008). For Freud, the case history narrative served both analytic and

rhetorical purposes; in the clinical setting he encouraged free association and verbal interaction, and when writing case histories he blended conventions from science genres (psychoanalytic theory; nosological details) and literary genres (linear narrative; realist authors' construction of characters personalities; dialogue between analysand and analyst; reported speech) as a way to gain insight into his patients' symptoms and suffering, particularly their repressed traumas (Berkenkotter, 2008; Berkenkotter & Hanganu-Bresch, 2005). In doing so, Freud "creates a sense of verisimilitude for his readers" through the inclusion of reported speech, while at the same time patients' speech reports provide the "scaffolding" for Freud's psychoanalytic theory and "data" for the psychiatric investigator (Berkenkotter & Hanganu-Bresch, 2005, p. 272, p. 279). In the genre of the psychiatric nomenclature, the presence of quotation marks make the reported speech more authoritative than if they belonged to an individual speaking subject in novelistic discourse or a case history narrative, for example.

Rhetorically, reported speech acts on the senses to lend *presence* to the voice of an individual speaking subject, bringing sense elements to the foreground and establishing *communion* between speaker and hearer (Perelman & Olbrechts-Tyteca, 1969, pp. 115-120). The term *presence* bears some similarity with the classical figure of thought known as *energeia*: "bringing-before-the-eyes." This figure allows rhetors to actualize sense perceptions so as to persuade audience members toward judgment or action (*Rhetoric*, Book III, 1411a-1411b). In this case, "bringing-before-the-eyes" the voice and persona of the patient induces audience members to come to judgment and accept reported speech as psychiatric data. The diagnostic criteria gain epistemic authority in the classification system through this rhetorical effect and reported speech enters the corpus of psychiatric knowledge or scientific "data." Thus reported speech serves metacommunicative functions in both the case history narrative and in the *DSM*s, helping members of a professional discourse community to interpret and assign meaning to utterances.

Of course, as the name of the genre indicates, the case history narrative focuses on the details of an individual patient's experiences. Freud (1953), for example, narrates the particulars of his patient "Dora" in *Fragment of An Analysis of a Case of Hysteria*, whereas the organizing principles of the diagnostic criteria do not derive from a particular case. Yet both psychiatric genres draw on the rhetoricity of reported speech, "bringing-

before-the-eyes" of their respective audiences the voice of *a* patient (a particular case) and *the* patient (the universal law) as evidence of mental disorder. Use of the particular in the form of speech creates a sense of *identification* between speaker and hearer/writer and reader: we persuade only in so far as we are able to convince people to *identify* their beliefs with our beliefs—to become *consubstantial* with them—thus inducing the auditor to participate in the rhetorical process (Burke, 1969, pp. 20-21). Thus, I am identified *with* this group, and therefore *not with* that group. Yet, while identified with a group, an individual remains separate and distinct and the shared (group) characteristics do not cancel out an individual's uniqueness or substance (Burke, 1969, p. 20). In the diagnostic manual, the organizing logic of the diagnostic criteria depends upon the dual and seemingly paradoxical structure of identification—both substance and consubstantial—and on interpellation—the ideological constitution of the individual as a subject through address. Thus when the deictic markers *I* and *My*, traditional linguistic resources that locate an individual speaking subject in a particular situation (spatially and temporally), become recontextualized as the diagnostic criteria of a psychiatric nomenclature (ahistorical, atemporal) they recontextualize putative patient speech as psychiatric data and psychiatric knowledge.

Distinct differences exist between transcriptions of patient speech in, for example, case history narratives and psychiatrists' case notes (albeit rhetorical and recontextualized) and the string of five speech reports on the diagnostic criteria. With these difference in mind, how does the transmission of reported speech onto Criterion D2, that is, detaching the speech reports from the reporting context (whatever that might be) to the reported context (*DSM-5* draft diagnostic criteria) re-accentuate the discourse, to frame this in Bakhtinian terms? Put another way, on criterion D2 what do the recontextualized utterances *index*? Indexical forms, such as the first-person pronoun *I* (Silverstein, 1976), depend on interactional context for meaning, and affirm and/or create social meaning beyond the strictly denotational meaning, providing a semiotic link between the linguistic form and the social meaning (Ochs, 1992; Silverstein, 1976, 2003). If as Vološinov (1986) says, "reported speech is speech within speech, utterance within utterance, and at the same time also *speech about speech*, *utterance about utterance*" (p. 115; emphasis in original), what are these particular utterances *about*; that

is, in the course of blending an utterance within an utterance on Criterion D2, what social meanings do the speech reports affirm and/or create?

As a starting point toward answering these questions, I wrote to Katherine Phillips, a *DSM-5* revision Task Force member and Chair of the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group. Phillips referred me to work group member Matthew Friedman to whom I posed a question about the context of production of reported speech. After introducing myself, I include Criterion D2 and write:

> My interest is in what appear to be five occurrences of patient speech (in quotation marks). Would you say these above examples, where speech is enclosed in quotation marks, are actual instances of patient speech from, for example, psychiatrists' case notes or are these examples meant to be representative of patient speech and as such are a kind of composite sketch of the types of things patients might say or are they something else entirely? (P. A. Kelly, personal communication, April 27, 2012)

To date, Friedman has not responded to my email. However, on dsm5.org under "Rationale" the Work Group members cite four references in support of their draft revisions to the diagnostic criteria for this classification. Two of those references come from Work Group members Matthew Friedman and Roberto Lewis-Fernández and their respective colleagues. Both authors, separately, cite the scholarship of Edna Foa—an acknowledged expert on Posttraumatic Stress Disorder. Foa's research provides details about the prior context, recontextualization, and text trajectory of three of the speech reports on the diagnostic criteria: "I am bad," "No one can be trusted," and "The world is completely dangerous."

Foa and her colleague Barbara Rothbaum (1998) develop a theory about posttraumatic psychopathology and identify what they call a "fear structure" with underlying major beliefs about the world that make people who hold these beliefs more likely to develop PTSD. They say:

> We propose that trauma memories may also be distinguished from other fear structures by a large number of diverse response elements. First, the perception that *the world is completely dangerous* engenders a particularly large number of the typical physiological (e.g., HR) and

> behavioral (e.g., escape) response elements in a fear structure. (p. 81; emphasis added)

Foa & Rothbaum's theoretical construct includes the idea that persons predisposed to develop PTSD have a belief system about the world, which the authors represent as *the world is completely dangerous*. Thus the authors generate the phrase as part of a theory about posttraumatic psychopathology that differentiates its cognitive schemas from those of other fear structures, and link a theoretical perspective to social identity through language features.

In addition to negative cognitions about the world, the authors identify a complex of "dysfunctional beliefs" (p. 192) about the self and others that typify the fear structure associated with trauma survivors:

1. "I must be a bad person, or this wouldn't have happened to me."
2. "I can't trust anybody."
3. "The world is dangerous."
4. "I am vulnerable."
5. "I am helpless."
6. "I have to be in control at all times."
7. "No one is trustworthy."

The authors present the dysfunctional beliefs in a numbered, vertical list and each belief takes the form of direct reported speech with quotation marks. Five of the seven utterances use the first-person pronoun *I* and the authors use standard orthography to represent patient speech. That is, like reported speech on the diagnostic criteria the authors write these utterances as complete sentences: grammatically correct; no hesitancies or disfluencies; correct capitalization and punctuation. Four of these seven utterances approximate three of the *DSM-5* speech reports:

> "I must be a bad person, or this wouldn't have happened to me." **/** "I am bad." "I can't trust anybody." and "No one is trustworthy." **/** "No one can be trusted." "The world is dangerous." **/** "The world is completely dangerous."

The following year, Foa, Ehlers, Clark, Tolin, & Orsillo (1999) design the Posttraumatic Cognitions Inventory (PTCI): an assessment/measurement tool consisting of 33 trauma-related thoughts and beliefs all of which take the form of reported speech without quotation marks. The PTCI instructions ask participants to rate each item using a 7 point

scale from 1 *(totally disagree)* to 7 *(totally agree)*. Item number 7 on the PTCI reads "People can't be trusted" and item number 17 reads "The world is a dangerous place." None of the 33 items approximate the *DSM-5* speech report "I am bad," although many of the items represent negative cognitions about the self, for example, item 12, "I am inadequate." Below, I include a brief portion of the PTCI to show items 7 and 17 in the context of the surrounding utterances (see Appendix 14 for the complete PTCI):

> 5. I can't deal with even the slightest upset.
> 6. I used to be happy but now I am always miserable.
> **7. People can't be trusted.**
> 8. I have to be on guard all the time.
> 9. I feel dead inside.

And,

> 15. My reactions since the event mean that I am going crazy.
> 16. I will never be able to feel normal emotions again.
> **17. The world is a dangerous place.**
> 18. Somebody else would have stopped the event from happening.
> 19. I have permanently changed for the worse.
> (Foa et al., 1999, p. 313; emphasis added)

Foa et al. (1999) describe the PTCI item pool as derived from a combination of : (1) detailed clinical interviews with trauma survivors; (2) current theories of posttraumatic psychopathology; (3) rewordings of some items during development (p. 305). Thus a whole complex of co-authoring practices and institutional recontextualizations contribute to the production of the PTCI items.

In addition to the research of Foa and her colleagues, two members of the Work Group published articles in the same issue of the journal *Depression and Anxiety* with recommendations for the *DSM-5* draft diagnostic criteria for PTSD (the Work Group cites these articles on dsm5.org). Hinton & Lewis-Fernández (2011) reviewed the PTSD literature to search for cultural- race- or ethnicity-related factors that might limit the universal applicability of the *DSM-IV* criteria. The second author is a member of the *DSM-5* Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative

Disorders Work Group, and, as the authors note, the article was commissioned by the Work Group (p. 785). The authors suggest criteria modifications to improve the cross-cultural validity of the *DSM-5* diagnostic criteria:

> The wording for the examples illustrating the proposed criterion D2 in *DSM-5* should be broadened to include other damaging effects of traumatic exposure, including physical, cognitive, and spiritual consequences. The following text is suggested for evaluation: ''Exaggerated negative expectations about one's self, others, or the world (e.g., 'I am bad,' 'no one can be trusted,' *'I've lost my soul forever,' 'my whole nervous system is permanently ruined,'* 'the world is completely dangerous')." If this construct is not added to the diagnostic criteria, it should be emphasized in the PTSD text and in the chapter on cultural features in *DSM-5*. (p. 795; emphasis original).

The authors conclude that the addition of two speech reports "I've lost my soul forever" and "my whole nervous system is permanently ruined" to Criterion D2 improves the cross-cultural validity of the *DSM-IV* Criterion C7, and that including diagnostic criteria that represents the "spiritual consequences" of trauma means that the *DSM-5* iteration of the classification achieves "universal applicability" of the PTSD construct (p. 783).

The second article in the same issue of *Depression and Anxiety* comes from Friedman et al. (2011) who review the relevant literature (this is the same Friedman I wrote to). The authors incorporate the Hinton & Lewis-Fernández (2011) modification for Criterion D2 into their recommendations to the Task Force. The authors write:

> Here are the proposed criteria for the new D Criterion in *DSM-5*:
>
> (D) Negative alterations in cognitions and mood that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced by three or more of the following: (Note: In children, as evidenced by two or more of the following):
>
> (1) Inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs) (*DSM-IV* C3).
>
> (2) Persistent and exaggerated negative expectations about one's self, others, or the world (e.g. ''I am bad,'' ''no one can be trusted,'' ''I've lost my soul forever,'' ''my whole nervous system is permanently ruined,'' ''the world is completely dangerous'') (*DSM-IV* C7).

> (3) Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)(new symptom).
>
> (4) Pervasive negative emotional state–for example: fear, horror, anger, guilt, or shame (new symptom).
>
> (5) Markedly diminished interest or participation in significant activities (DSM-IV C4).
>
> (6) Feeling of detachment or estrangement from others (DSM-IV C5).
>
> (7) Persistent inability to experience positive emotions (e.g. unable to have loving feelings, psychic numbing) (*DSM-IV* C6). (Friedman et al., 2011, p. 759)

As these excerpts show, an amalgamation of prior texts, contexts, and recontextualizations contribute to reported speech on Criterion D2. While on first view, the five speech reports appear to bring evidence of the "real world" patient and patients' voices to the classification and to the nomenclature, as I have shown these speech reports do not represent accurate transcriptions of verbatim patient speech, but rather complex practices of co-authoring and recontextualization. Therefore, while seemingly verbatim speech, these reports may be closer to what Bell (1991) calls "pseudo-direct speech"(p. 60), that is, a collage of what was said at different times—a practice used in news discourse to construct the voice or persona of a speaker. This is the sort of creative co-authoring that Tannen and Ferrara's respective terms *constructed dialogue* and *joint production* index and that I queried Friedman about when I asked if the reports represented a composite sketch of the types of things patients might say. Foa & Rothbaum (1998), Foa et al. (1999), Hinton & Lewis-Fernández (2011), and Friedman et al. (2011) demonstrate these sorts of creative text-building strategies and institutional recontextualizations that contribute to the co-authoring of reported speech on the diagnostic criteria.

Whereas Bakhtin's notion of heteroglossia posits an individual speaker as stylistically and socially multi-vocal, Goffman's (1981) decomposition of the speaker into three constituent roles points to how published printed texts sometimes distribute a single voice across multiple speakers. The term *speaker* commonly refers to one individual who performs three undifferentiated functions: the person who takes responsibility for and decides what to say (*principal*), the person who plans the actual

words of the text (*author*), and the person who writes down or speaks the text (*animator*) (Goffman, 1981). Thus, with reported speech, the current speaker embeds the language of an entirely different speaker in their own (Goffman, 1981, p. 149). In reporting the voice of another the reporter takes a particular stance toward that talk, and a shift from saying something ourselves to reporting the speech of another indicates a change in footing, that is, how people orient to their own and others' conversational roles to manage the production and reception of utterances (Goffman, 1981, p. 128). For both Bakhtin and Goffman, however, "voice" is not so much a personal attribute as the socially agreed upon attributes of a recognizable type or persona (Keane, 1999, p. 272). Therefore, the speech reports are inseparable from the social world that produced them. The voicing effect of reported speech evokes a particular type of speaker or a positioned subjectivity (Agha, 2005); however, the subject is non-biographical; that is, the voice is not of an individual speaking subject but a social stereotype produced from and linked to social, professional and institutional practices.

The analysis of these complex, shifting, and sometimes overlapping participant roles (principal, author, and animator) offers a way to make transparent some of the prior texts and multiple, overlapping contexts—the embedded social, professional, and institutional practices—that contribute to the recontextualization of reported speech in the classification. The differentiation of these commonly collapsed participant roles provides a way to analyze reported speech designed for (what will be) a highly edited and stylized, published printed text produced in accord with institutional and professional aims and commitments.

The attribution of voice and the construction of patient identity come about as the result of the *DSM-5* work group members who *author* the classification and *voice* the patients using the discursive resource of reported speech to do so: psychiatrists embed what passes for patient speech on Criterion D2 of the classification with important social consequences. In doing so, putative patient speech becomes a constitutive discourse feature of the classification and of the psychiatric nomenclature. From this perspective, identifying the prior texts helps identify the *principals* who co-author the speech reports: the trauma researchers (for example, Foa, Rothbaum, Friedman, Lewis-Fernández, and so on) and the *DSM-5* work group members who take responsibility for and *decide what to say* on the *DSM-5* draft diagnostic criteria for posttraumatic stress disorder.

The complexity of participant roles and participants' shifting alignment to the production and reception of reported speech together with the concepts prior text and text trajectory show that, while the *DSM-5* authors appear to merely transcribe patients' prior speech by placing the utterances on the diagnostic criteria, they actually design the speech reports to represent the posttraumatic patient voice through the borrowing of discourse features (quotation marks, first-person pronouns, and first-person possessives, standard orthographic use of capitalization and punctuation). Analysis of prior texts shows how *DSM-5* authors design the diagnostic criteria using discursive resources and creative authorial practices usually associated with literary genres and with Freud's appropriation of literary devices for the case history narrative. Further, analysis shows how authorial artfullness (*techne*) constitutes an integral aspect of the writing, revising, and editing process, and, in this sense, points to the "necessarily *suasive* nature of even the most unemotional scientific nomenclatures" (Burke, 1966, p. 45, emphasis original). On this view, the diagnostic criteria are not merely the neutral representation of something objectifiable in the real-world; that is, not simply the result of empirical observation and scientific data-collection but part of the history of discourse that gives rise to *DSM-5*. Through social actions—inventions and interventions in the social world—the *DSM-5* authors reword and recontextualize the utterances to make them available to and intelligible as psychiatric data in the form of diagnostic criteria. Thus, identifying some of the prior texts and contexts demonstrates the rhetoricity of the speech reports as opposed to their seemingly factual, objective, and evidentiary status as data-driven diagnostic criteria—the hallmark of the diagnostic manuals since *DSM-III*.

In this case, the putative speech reports represent the types of voices that populate a social world of individuals diagnosed with Posttraumatic Stress Disorder according to the diagnostic criteria developed for a psychiatric classification system. The borrowing of language resources from direct reported speech such as quotation marks, first-person pronouns, and first-person possessives, as well as standard orthographic practices such as capitalization and punctuation recontextualizes the putative quotations on Criterion D2 as "the accurate representation of the particular," to borrow from Tannen. Yet the speech reports are actually something more akin to constructed dialogue or pseudo-direct speech meant to represent a composite sketch of the posttraumatic patient. Thus the *DSM-5* iteration of the classification recontextualizes

pseudo-direct speech without accounting for prior context—actual patient speech in the context of its production (heteroglossic, polyphonic, multi-vocal). The degree to which the "voice" of the speech reports persuades audiences of their authenticity as patient speech depends on, in part, a view of the speech reports as representative of a discrete illness category. The institutional recontextualization of discourse provides "narratized" subject positions constitutive of psychiatric knowledge.

While the speech reports remain detectable as self-enclosed units of discourse, at the same time, they become part of the syntactic, compositional, and stylistic design of the reporting author/reporting context (Vološinov,1986, p. 116). When the reported context meets the reporting context, as Bakhtin (1981) puts it, "certain features of language knit together with specific points of view, specific approaches, forms of thinking, nuances and accents characteristic of the given genre" (p. 289). The new context into which the detached utterance is transported is responsible for the dialogizing background (p. 340). In this case, the given genre is a psychiatric classification system, and the point of view is that of the *DSM-5* work group members who co-authored the draft diagnostic criteria for PTSD.

Conclusion

In soliciting public feedback on the *DSM-5* draft diagnostic criteria in a culturally shareable form on dsm5.org, that is, draft diagnostic criteria detached from local context, the APA positions site visitors as exemplary speakers, writers, and revisers of the "common language"—a professional style developed to facilitate communication about mental disorders and enhance diagnostic replicability.

I suggested that the textual standardization of the professional style contributes to the public visibility and the social transmission of the "common language." Thus textual standardization, particularly the diagnostic criteria, facilitates the cultural portability of the professional style through the use of the diagnostic criteria themselves and through the use of reported speech on Criterion D2 of the draft diagnostic criteria for Posttraumatic Stress Disorder. I suggested that the diagrammatic attributes of the diagnostic criteria help determine how readers pay attention to, interpret, and evaluate

the text. Furthermore, the hierarchical structure compels users to draw inferences between the five speech reports that occupy fixed positions and assists the blending of the reported context with the reporting context. As a consequence, I showed how spoken discourse becomes recontextualized as data—the product of scientific inquiry and the organization of scientific knowledge. Thus the institutional recontextualization of reported speech as data on the diagnostic criteria assists speaker uptake and contributes to the expanded community of speakers of the *DSM-5* "common language."

The analysis of reported speech on Criterion D2 showed how the diagnostic criteria recontextualize the characteristics and qualities of the items under consideration, in this case, the "voice" and persona of putative patient reported speech. I suggested that the stylistic design and the placement of reported speech on the diagnostic criteria severs utterance from speaker and assists the cultural portability of the utterances from the reported context (whatever that might be) to the reporting context (diagnostic criteria on dsm5.org). The *DSMs* appropriate this discourse convention from antecedent genres (Jamieson, 1975), the case history narrative in medicine and psychiatry and literary genres such as the novel, and, as a result, reported speech becomes a standardized discourse feature of American psychiatry's professional style.

Finally, I suggested that, with the publication of the *DSM-5* draft diagnostic criteria for Posttraumatic Stress Disorder, this discursive resource becomes a constitutive feature of the classification. Furthermore, what first appeared to be examples of putative patient speech are highly-edited and co-authored recontextualizations. Therefore, the five occurrences of reported speech on draft Criterion D2 represent the product of scientific inquiry and the organization of psychiatric knowledge.

Chapter 5.

The Discursive Construction of Psychiatric Knowledge in the *DSMs*

Twenty-first century American psychiatry is bound up with questions of cultural values, cultural orthodoxies, and medical ethics often on the distinction between what constitutes normal human suffering and discomfort and what constitutes medical pathology: What grounds or rules of evidence differentiate grief from Major Depressive Disorder; repetitive thoughts from Obsessive Compulsive Disorder; shyness from Social Phobia Disorder; shock from Posttraumatic Stress Disorder? When do we intervene to relieve pain and suffering, whom do we authorize to intervene, and by what methods of intervention: psychopharmaceutical supplementation from a biomedical psychiatrist, talk therapy on the psychoanalyst's couch, cognitive behavioural therapy (CBT) from a counselling psychologist, Magnetic Resonance Imaging (MRI) of the brain from a neuroscientist, or a combination of diagnostic practices and treatment protocols? The discourse of the *DSMs* helps to shape the psychiatric knowledge on which these practices and treatments are based.

Rhetorical approaches to science and medicine often work to interrogate assumptions that underlie disciplinary values, for example, values that work to elevate psychiatry to the status of science through prescriptive language practices under cover of descriptive language practices. Leach and Dysart-Gale (2011) suggest that rhetoric and medicine are "mutually beneficial" practices (p. 4). In the introduction to their edited volume on rhetorical questions in health and medicine, they note that medicine and rhetoric share a historical relationship. Specifically, they point out, matters of decorum and etiquette have long joined rhetoric and medicine: "decorums and etiquette manuals have a concrete historical relation to medical practice, and physicians have also written credibly on rhetorical matters as they have considered medical decorum" (p. 5). Questions informed by a rhetorical perspective offer theoretical and methodological

purchase in the realm of medicine, particularly on matters of language etiquette or decorum as they pertain to the textual standardization of a medical discourse community.

In the preceding chapters, I have argued that the purported objectivity of scientific prose and the absence of emotional appeal in the *DSM*s are rhetorical strategies and as such do not represent a neutral stance on the part of the writers. What I found was that the *DSMs* help create psychiatric knowledge, in part, through the prescriptive and proscriptive discursive and pragmatic practices and the written depictions of those practices in published printed texts. I illustrated how the *DSMs*, as products of empirical science, do not simply contribute data to our knowledge system, often they are treated as the locations for and containers of psychiatric knowledge. Bowker and Star (2000) identify classification as "one of the central kinds of work of modernity, including science and medicine" (p. 13). Their analysis of the *ICD* focuses on the classification system and not on standards or standardization per se. However, the authors note the close relationship between standards and classification (p. 13). The notion of *standards* involves several elements including, for example, a "set of agreed-upon rules for the production of (textual or material) objects" (p. 13), and often the success of maintaining standards depends upon "a community of gatekeepers" (p. 14) who favour and promote the standards from asymmetrical positions of power and prestige. In the second and third chapters, I included in the discussion of prescriptive language practices terms similar to Bowker and Star's term "community of gatekeepers" to characterize those who intervene in language practices in order to ensure adherence to correct standards of use: "linguistic gatekeeper" (Cameron, 1995, p. 57) and "language guardian" (Milroy & Milroy, 1991, p. 14) are two such terms. Therefore, one of the elements involved in the textual standardization of a professional style (the production of a material object) is the successful maintenance of standards of practice through linguistic gatekeeping practices.

The existence of a stable set of standards, like that of a standard language and a standardized professional style, is an ideal that embodies goals of practice and production and as such is never entirely achievable (Bowker & Star, 2000, p. 15). The preceding chapters showed how medical classification systems represent the imposition of an idealized speech situation with highly stylized and standardized features in a

published printed text. I argued that the purported neutral stance of scientific classification systems, for example, the "descriptive approach" of the *DSMs*, helps make invisible or at least backgrounds the manuals' "necessarily *suasive* nature," to borrow a phrase from Burke (1966, p. 45). For example, I showed how the discursive interactions of the Task Force and Work Group members who theorized, designed, wrote, edited, and revised *DSM-III* receded into the background because the authors presented their prescriptive and proscriptive language interventions as the "descriptive approach" to psychiatric nosology, that is, as simply the neutral linguistic depiction of observable phenomena. In calling their approach "descriptive," the authors foreground psychiatry's "common language" as the product of objective, scientific practices and methods.

If we take Burke and Bowker and Star's claims to be the case—that scientific classification systems perform persuasive work of central importance—then, psychiatric nosology occupies a prominent place in twenty-first century biomedicine. This seems to be the case with *DSM-5.* On 10 February 2010, the American Psychiatric Association (APA) published the draft diagnostic criteria for *DSM-5* on their website dsm5.org (APA, 2012, n. p.). On that same day, *The New York Times* (NYT) covered the release of the *DSM-5* draft diagnostic criteria in Section A of the newspaper as follows: a front page article by science writer Benedict Carey, "Revising Book on Disorders of the Mind," suggesting that newly proposed classifications such as "'binge eating disorder' and 'hypersexuality' might become part of the everyday language" of Americans (p. A1); an OP-Ed article, "Disorder Out of Chaos," from Roy Richard Grinker, professor of anthropology at George Washington University and the father of a daughter with Asperger Syndrome, who focused on the controversial proposal to replace this classification with Autism Spectrum Disorder (p. A23); and the feature, "Quotation of the Day," from Michael First who along with the *DSM-5* Task Force Chair and Vice Chair designed and wrote the research agenda for *DSM-5* (Kupfer, Frist, & Regier, 2002). First's quote of the day says, "Anything you put in that book, any little change you make, has huge implications not only for psychiatry but for pharmaceutical marketing, research, for the legal system, for who's considered to be normal or not, for who's considered disabled" (p. A27). The front page story ranked as *Times'* readers most frequently emailed article of the day, and at the end of a seven day period that included *Times'* coverage of such cultural cornerstones as the Super Bowl win by the New Orleans

Saints, the opening ceremonies of the Vancouver 2010 Winter Olympic Games, and the shooting deaths of three faculty members by a disgruntled neuroscientist on the University of Alabama's Huntsville campus, the *DSM-5* story remained the fourth most frequently emailed article after seven days, and the seventeenth most frequently emailed article after thirty days.

This snapshot of one newspaper's coverage of the release of the *DSM-5* draft diagnostic criteria (on a single day, in a single section) and readers' uptake and repeatability of that article over the span of one month, provides some evidence for a central claim of this project: the development of a "common language" and a professional style for American psychiatry, which I identified as the textual standardization of the profession, facilitates the cultural shareability and portability of the "common language" across a range of rhetorical situations.

In the preceding chapters, what I found was that one of the upshots of the textual standardization of the APA's professional style is that the classification system carries out much of its rhetorical work invisibly. I showed how the standardized discourse of the *DSM*s directs itself toward specialized audiences, pursues professional and institutional aims, and achieves authoritative status as psychiatric knowledge, in part, due to the highly stylized, carefully drafted and edited features of the diagnostic manuals. I showed how the APA "descriptive approach" to the discursive construction of psychiatric knowledge—an approach that holds that scientific language simply refers to natural and given categories in the "real world" that exist prior to and separate from discourse—participates in "pragmatic bleaching": the removal of all discursive interactions and the sociohistorical conditions that helps constitute the text (Haviland, 1996, p. 64). This means that discursive interactions "are only available to be read out *behind* the pragmatic bleaching and normalization (Haviland, 1996, p. 64; emphasis original).

This study demonstrated that, due to its nature as explicit commentary on the text, psychiatrists' metadiscourse about language style and standards provides a method of reading some of the discursive interactions *behind* the textual standardization of American psychiatry in the *DSMs*. I analyzed metadiscourse as a way to foreground some of the social processes that create seemingly natural relationships among texts, contexts, and authors, and that contribute to the textual standardization of a professional

discourse community's communicative practices. As I have argued throughout the foregoing chapters, often these relationships appear natural and given because participants view language as referential discourse. A view of the classification system as referential discourse—as the division and arrangement of natural kinds—fails to account for the text's history of discourse: the psychiatrists (rhetors) who write, revise, edit, deign, and publish the various editions of the classification system in order to accomplish the communicative aims and goals of the professional discourse community.

In many ways, the research question I posed at the outset of this study is an example of a "prior question" in rhetoric of health and medicine (Segal, 2009). According to Segal, sometimes projects in rhetoric of health and medicine "aim to be useful" (p. 228). The "usefulness" of these projects "often lies in their ability simply to pose questions that are prior to the questions typically posed by other health researchers" (p. 228). Segal uses cosmetic surgery as her example: instead of asking typical medical questions about how to make cosmetic surgery safer or whether health insurance should cover these surgeries, a rhetorician might ask how we come to see ourselves as "improvable by cosmetic surgery in the first place" (p. 228). My "prior question" focuses on psychiatric discourse, particularly the *DSMs*, and asks about the discursive construction of psychiatric knowledge in the *DSMs*. Much of the research on the *DSMs* positions the manuals as hegemonic discourse. From this position, researchers often focus their critique on the diagnostic manual as a mediating structure, and research findings proceed from and support the positioning of the manual as a "discursive formation" (Foucault, 1972, p. 37). I argued that positioning the manual as a transcendent construct (Foucault's discursive formation) removes the *DSMs* (plural) from their rich indexical surround, "bleaches" the complex overlapping contexts of production, and decontextualizes the discursive interactions of the Task Force and Work Group members who theorize, design, write, edit, and revise the *DSMs*. I suggested that starting from this position presents ideological and methodological limitations that preclude prior questions—questions that do not a priori take the *DSMs* to be hegemonic discourse but instead ask how the *DSMs* help create psychiatric knowledge in the first place.

In this project my "prior questions" focused on psychiatry's discursive practices and on how those practices became constitutive of psychiatric knowledge in the *DSMs*.

This project positioned the *DSMs* in the micro-situational contexts that give rise to them and used psychiatrists' own talk and texts as evidence. Specifically, this study identified some of the ways in which psychiatrists' metadiscursive and metapragmatic practices prove integral to the development of a professional style for the APA and to the textual standardization of the profession. Furthermore, the study showed how the *DSMs* help to discursively construct psychiatric knowledge—research well-suited to a project in rhetoric of health and medicine. By asking about the ways in which the *DSMs* help constitute psychiatric knowledge, and by analyzing psychiatrists' metadiscourse, primarily in the *DSMs*, as a method of providing some evidence toward answering in what ways and to what ends a professional association's diagnostic manuals discursively construct psychiatric knowledge, I found that the development of a professional style for American psychiatry and the textual standardization of that style in the APA's diagnostic manuals was central to the discursive construction of the APA as a professional medical society, to the discursive production of psychiatric knowledge, to the standardization and codification of that knowledge in the *DSMs*. In this project, each of the three chapters of analysis focused on different processes and stages in the textual standardization of American psychiatry, and each chapter took psychiatrists' metadiscourse about the development of a professional style as the object of study.

In Chapter One, the analysis of metadiscourse showed that psychiatrists' prescriptive and proscriptive practices in *DSM-I* and *DSM-II* helped the profession develop a set of approved terms for the diagnostic manuals, for example, *disorder* and *diagnostic*. I analyzed psychiatrists' visualist and diagrammatic practices in the first three editions of the manual and argued that three types of diagrammatic structures—bracketed tables, diagnostic decision trees, and lists of diagnostic criteria—helped readers bring prior knowledge from the earlier manuals to bear on the new *DSM-III* knowledge structure. I argued that the development of standardized terms of art and metapragmatic practices helped shape the APA's professional identity as a medical society and positioned psychiatrists as medical specialists with scientific methods of practice.

In Chapter two, I analyzed psychiatrists' prescriptive and proscriptive metadiscourse about the *DSM-III* "descriptive approach" to standardizing the "common language" of American psychiatry. I identified the development of a professional style for

the APA and the textual standardization of the "common language" to foreground how, through a program of textual standardization, Spitzer's paradigmatic revision of the diagnostic manual produced a professional style for the APA, which I likened to a "house" style, in a published printed text. The analysis revealed that delimiting discursive and pragmatic practices in the *DSMs*, particularly in *DSM-III*, became the means of delineating and delimiting psychiatric knowledge structures in the classification system. I argued that when language structures became the object of scientific inquiry, which analysis of metadiscourse showed sometimes happened, the textual standardization of the *DSMs* and the development of a professional style for American psychiatry contributed to knowledge-making because psychiatric nosologists located the evidence for epistemic claims in discourse structures.

In Chapter Three, I used the classification Posttraumatic Stress Disorder as a case study to show how standardization of a particular set of diagnostic criteria, specifically reported speech on Criterion D2 for this classification, contributed to the public visibility and cultural portability of the profession's standardized language. I argued that the institutional standardization and recontextualization of discourse assists the transmission of reported speech across generic boundaries and beyond professional borders to diverse populations. The analysis of prior texts demonstrated that what first appeared to be examples of verbatim patient speech were highly-edited, co-authored, idealized constructions produced by psychiatrists in institutional settings to help meet their communicative goals. I concluded that the standardization of reported speech according to the interests and commitments of a medical discourse community helped to constitute the "voice" and persona of the psychiatric patient. As a consequence, spoken discourse (what began as putative patient speech) became recontextualized as data—the product of scientific inquiry and the organization of psychiatric knowledge.

This final section frames some of the limitations of the current research and points to possible areas for future inquiry. In this study, the method of approach—paying attention to specific stretches of discourse at a fine-level of detail—helped answer the research question: In what ways do the *DSMs* help constitute psychiatric knowledge? As a way to provide some evidence toward answering this question, I chose to focus on the production format of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*. I did so for a number of reasons. While

conventional ways of talking about discourse roles often collapses several footings, Goffman's (1981) production format presented a way to think about speech events different from that of (1) the Saussurean model of the speech circuit that establishes the Speaker-Hearer dyad as the privileged unit of interaction (two talking heads, speaker and hearer, facing one another), and (2) the traditional Western notion of the singly-authored text. This approach proved particularly useful for the analysis of a text whose multiple authors adopt a professional style that, for the most part, backgrounds their participant roles. As well, I found that this approach helped foreground the diagnostic manuals' history of discourse (Silverstein & Urban, 1996, p. 1)

Many discourse analysts use an ethnographic approach to data collection and analysis. The data for this study, however, derive from published printed texts, primarily the *DSMs*. As such, the research methods and data have some limitations. I did not, for example, conduct oral history interviews with any of the Task Force and Work Group members who wrote, edited, and revised the *DSMs*. This study did not follow the *DSMs* into clinical settings, for example, to analyze how the *DSMs'* standardized professional style helps shape and is shaped by the discursive practices of healthcare professionals and mental healthcare consumers. Nor did I conduct research at the APA archives to analyze, for example, the records (written or spoken) of Task Force and Work Group meetings during the development and revision processes for the manuals. Therefore, while the methods for this study are empirical they are not field methods. Given these limitations, however, and as I pointed out in the preceding chapters and in the above discussion of "prior questions," the data and methods for this study helped to answer the research question.

Understanding the limitations of this current research can help shape future projects, and I have made some initial steps in that direction. Early in the research for this study (2009-2010), I twice contacted the APA archivist requesting access to *DSM-III* Task Force records (using the APA library's online form). To date, I have not received a reply from the archivist. In March 2010, I wrote Robert Lifton one of the *DSM-III* Reactive Disorders Work Group members asking if he could provide any information about his involvement in drafting the descriptive text and diagnostic criteria for Posttraumatic Stress Disorder. As a member of Vietnam Veterans Against the War (VVAW), Lifton established the Vietnam Veterans Working Group (VVWG) to draft a proposal for Spitzer

advocating the inclusion of the new classification in the third edition. However, Lifton did not reply to my query (the other members of the VVWG are deceased). Then, in the Spring of 2012, while researching Chapter Three, I wrote to Katherine Phillips, Chairperson of the *DSM-5* Work Group that oversees the revisions for Posttraumatic Stress Disorder, with a question about reported speech on Criterion D2. A representative of the public relations department for Phillip's institution referred me to Work Group member Matthew Friedman. As I documented in that chapter, neither Phillips nor Friedman answered my query. Recently, historian of psychiatry Andrea Tone suggested I contact Robert Spitzer to conduct an oral history interview (personal communication, 13 September, 2012). Following Tone's suggestion, I wrote *The New York Times* science journalist Benedict Carey (who had recently interviewed Spitzer for the newspaper) asking if he would share Robert Spitzer's contact information (personal communication, 30 September, 2012); more recently still I wrote to Spitzer at Columbia University to ask if he would consent to a personal interview or respond to written questions about the development of the "descriptive approach" and the "common language" of *DSM-III* (personal communication, 5 October, 2012).

Despite these less than fruitful outcomes, I do think field work and the study of spoken discourse can provide generative methods and sites for future projects, specifically research on *DSM-5* classifications and on the *DSM-5* revision process. However, as this study of the prescriptive and proscriptive discursive practices of the APA showed, American psychiatry closely guards and circumscribes their discursive sites, and this makes medical humanities research in this area particularly challenging. In the introduction to their edited collection on rhetoric of healthcare, Heifferon and Brown (2008) write, "rhetoric is known for its willingness as a discipline to take on the hard questions and analyze the intangible, even within such situated discursive sites as those in medicine" (p. 7). By way of conclusion, I have a story that demonstrates the degree to which the APA patrols its discursive borders, thereby complicating the process of posing questions, receiving answers to questions, and engaging in dialogue. At the 2012 Rhetoric Society of America (RSA) conference in Philadelphia, PA, I told neuropsychiatrist David Bresch about the seeming unwillingness of the APA archivist and the *DSM-5* Work Group members to communicate with a medical humanities researcher. Bresch, a sleep specialist at the Neuroscience Institute, Saint Francis

Medical Center, Trenton, NJ had a similar experience to mine. He, too, had written to *DSM-5* Work Group members (the Psychotic Disorders Work Group) with questions about the development of the Schizophrenia disorders. His questions, like mine, went unacknowledged and unanswered. He assessed the situation in this way: "they're a cabal and they've circled the wagons" (personal communication, 28 May 2012). Despite Bresch's mixed metaphor, his point seems clear: the psychiatrists revising *DSM-5* operate like a secret society—a secret society that closes ranks to protect against perceived threats and attacks. Sometimes those attacks target the APA's "common language." Recall APA President Alan Schatzberg's (2010) warning to the membership about "critics attacking" the profession from outside: "attacks have been by English and history professors" who "come to believe they are experts in psychiatry" (p. 1163). The reason this happens, says Schatzberg, "is our use of common language. Other medical specialties have disorders based on Latin and Greek terms that are complimented by lay terminology. . . .When you look at psychiatry, you see disorders that are distinctly unmedical in sound" (p. 1163). Although Schatzberg locates attacks on the profession in the humanities, Bresch's experience seems to demonstrate that sometimes the APA perceives experts within psychiatry as critics attacking the profession too.

Since Bresch knew of my research interest in language standardization in the *DSMs*, he introduced into the conversation his own linguistic "complaint" about the *DSMs*: the frequency and vagueness of the term "bizarre" in the descriptive text for the Schizophrenia disorders. At Bresch's suggestion, I searched *DSM-IV* (1994) and found that the manual uses derivatives of the term *bizarre* a total of 42 times—29 times in the descriptive text and diagnostic criteria for Schizophrenia and Other Psychotic Disorders (pp. 273-315) and twice in the descriptive text and diagnostic criteria for Schizotypal Personality Disorder (pp. 273-315). In one paragraph of the descriptive text for Schizophrenia, derivatives of the term *bizarre* occur 7 times (p. 275). This story demonstrates that at least some of Bresch's questions, like mine, concern the *DSMs*' discursive practices and the ways in which those practices come to constitute psychiatric knowledge. As Western psychiatry aligns more and more with the values of biomedicine, a rhetorical approach that foregrounds prior questions, hard questions, and ethical questions (of the sort I began with) concerning the discursive construction of mental illness prove to be of central importance for those on the inside and those on the outside

of psychiatry. Some of the questions from outsiders, for example, medical humanities researchers like myself, will continue to focus on the discursive construction of psychiatric knowledge in the *DSMs*, and on the discursive uptake of psychiatric knowledge beyond the pages of the *DSMs* and beyond the borders of the APA.

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Appendices

Appendix 1.

DSM-I: Gross Stress Reaction

TRANSIENT SITUATIONAL PERSONALITY DISORDERS

This general classification should be restricted to reactions which are more or less transient in character and which appear to be an acute symptom response to a situation without apparent underlying personality disturbance.

The symptoms are the immediate means used by the individual in his struggle to adjust to an overwhelming situation. In the presence of good adaptive capacity, recession of symptoms generally occurs when the situational stress diminishes. Persistent failure to resolve will indicate a more severe underlying disturbance and will be classified elsewhere.

000-x81 Gross stress reaction

Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established.

This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less “normal” persons who have experienced intolerable stress.

The particular stress involved will be specified as (1) combat or (2) civilian catastrophe.

(APA, 1952, p. 40)

Appendix 2.

DSM-II: Adjustment Reaction of Adult Life

VIII. TRANSIENT SITUATIONAL DISTURBANCES

(307) 307* Transient situational disturbances[1]

This major category is reserved for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress. A diagnosis in this category should specify the cause and manifestations of the disturbance so far as possible. If the patient has good adaptive capacity his symptoms usually recede as the stress diminishes. If, however, the symptoms persist after the stress is removed, the diagnosis of another mental disorder is indicated. Disorders in this category are classified according to the patient's developmental stage as follows:

307.0* Adjustment reaction of infancy*

Example: A grief reaction associated with separation from patient's mother, manifested by crying spells, loss of appetite and severe social withdrawal.

307.1* Adjustment reaction of childhood*

Example: Jealousy associated with birth of patient's younger brother and manifested by nocturnal enuresis, attention-getting behavior, and fear of being abandoned.

307.2* Adjustment reaction of adolescence*

Example: Irritability and depression associated with school failure and manifested by temper outbursts, brooding and discouragement.

307.3* Adjustment reaction of adult life*

Example: Resentment with depressive tone associated with an unwanted pregnancy and manifested by hostile complaints and suicidal gestures.

Example: Fear associated with military combat and manifested by trembling, running and hiding.

Example: A Ganser syndrome associated with death sentence and manifested by incorrect but approximate answers to questions.

307.4* Adjustment reaction of late life*

Example: Feelings of rejection associated with forced retirement and manifested by social withdrawal.

[1] The terms included under *DSM-II* Category 307*, "Transient situational disturbances," differ from those in Category 307 of the ICD. *DSM-II* Category 307*, "Transient situational disturbances," contains adjustment reactions of infancy (307.0*), childhood (307.1*), adolescence (307.2*), adult life (307.3*), and late life (307.4*). ICD Category 307, "Transient situational disturbances," includes only the adjustment reactions of adolescence, adult life and late life. ICD 308, "Behavioral disorders of children," contains the reactions of infancy and childhood. These differences must be taken into account in preparing statistical tabulations to conform to ICD categories.

Appendix 3.

DSM-III: Post-traumatic Stress Disorder

308.30 Post-traumatic Stress Disorder, Acute

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture) and others produce it only occasionally (e.g., car accidents). Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor may be noted on Axis IV (p. 26).

The traumatic event can be reexperienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is reexperienced. In rare instances there are dissociativelike states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed significant activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal sleep disturbance may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are often avoided. Symptoms characteristic of Post-traumatic Stress Disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or uniformed guards for death-camp survivors, hot, humid weather for veterans of the South Pacific).

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder. Increased

irritability may be associated with sporadic and unpredictable explosions of aggressive behavior, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behavior can occur, such as sudden trips, unexplained absences, or changes in life-style or residence. Survivors of death camps sometimes have symptoms of an Organic Mental Disorder, such as failing memory, difficulty in concentrating, emotional lability, autonomic lability, headache, and vertigo.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after a latency period of months or years following the trauma.

When the symptoms begin within six months of the trauma and have not lasted more than six months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than six months after the trauma or last six months or more, the chronic or delayed subtype is diagnosed.

Impairment and complications. Impairment may either be mild or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may result in occupational or recreational impairment. “Psychic numbing” may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Substance Use Disorders may develop.

Predisposing factors. Preexisting psychopathology apparently predisposes to the development of the disorder.

Prevalence. No information.

Sex ratio and familial pattern. No information.

Differential diagnosis. If an Anxiety, Depressive, or Organic Mental Disorder develops following the trauma, these diagnoses should also be made.

In Adjustment Disorder, the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.

Diagnostic criteria for Post-traumatic Stress Disorder

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the

following:

(1) recurrent and intrusive recollections of the event

(2) recurrent dreams of the event

(3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities

(2) feeling of detachment or estrangement from others

(3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:

(1) hyperalertness or exaggerated startle response

(2) sleep disturbance

(3) guilt about surviving when others have not, or about behavior required for survival

(4) memory impairment or trouble concentrating

(5) avoidance of activities that arouse recollection of the traumatic event

6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

SUBTYPES

Post-traumatic Stress Disorder, Acute

A. Onset of symptoms within six months of the trauma.

B. Duration of symptoms less than six months.

Post-traumatic Stress Disorder, Chronic or Delayed

Either of the following, or both:

duration of symptoms six months or more (chronic)

onset of symptoms at least six months after the trauma (delayed)

Appendix 4.

DSM-III: Appendix C: Annotated Comparative Listing of *DSM-II* and *DSM-III*

Appendix C

DSM-II ***DSM-III***

IV Neuroses

In *DSM-II* disorders in which the "chief characteristic" was anxiety, whether "felt and expressed directly" or "controlled unconsciously and automatically by conversion, displacement and various other psychological mechanisms" were grouped together as Neuroses. In contrast, in *DSM-III* the disorders in which anxiety is experienced directly are grouped together in the class of Anxiety Disorders. The other *DSM-II* neuroses are distributed among other classes, each defined by shared symptoms or other descriptive characteristics. So that one can identify the categories that in *DSM-II* were grouped together in the class of Neuroses, the *DSM-II* terms are included separately in parentheses after the corresponding *DSM-III* categories. (See *DSM-III* classification.)

300.14* Hysterical neurosis, dissociative type* . . . . . . ⎧ **300.12 Psychogenic amnesia**
⎪ **300.13 Psychogenic fugue**
⎪ **300.14 Multiple personality**
⎩ **307.46 Sleepwalking disorder* (in the childhood section)**

In *DSM-III*, the four disorders included in the *DSM-II* description are defined as separate disorders because of differing clinical pictures, predisposing factors, and course. The first three disorders are included within the Dissociative Disorders. Sleepwalking Disorder is listed in the section Disorders Usually First Evident in Infancy, Childhood or Adolescence and is defined as a disturbance of a particular stage of sleep.

Phobic disorders

300.20 Phobic neurosis . . . . . . { **300.21 Agoraphobia with panic attacks**; **300.22 Agoraphobia without panic attacks**; **300.23 Social phobia**; **300.29 Simple phobia**; **309.21 Separation anxiety disorder* (in the childhood section)**

DSM-III subdivides phobias into separate categories because of differing clinical pictures, ages at onset, and differential treatment responses. Even though Separation Anxiety Disorder is a form of Phobia, because it characteristically begins in infancy or childhood, and rarely persists into adulthood, it is classified in the section Disorders Usually First Evident in Infancy, Childhood or Adolescence.

300.30 Obsessive compulsive neurosis . . . . . 300.30 Obsessive compulsive disorder

300.40 Depressive neurosis . . . . . . { **Major depression**; **296.22 single episode, without melancholia**; **296.32 recurrent, without melancholia**; **300.40 Dysthymic disorder**; **309.00 Adjustment disorder with depressed mood**

This *DSM-II* category was defined merely as "an excessive reaction of depression due to an internal conflict or to an identifiable event. . . ." For this reason, it was applied to a heterogeneous group of conditions. The three major conditions to which it was applied have each been defined descriptively without reference to etiology. When an "identifiable event" is judged to have contributed to the development of the illness, this factor can be noted on Axis IV.

300.50 Neurasthenic neurosis

This *DSM-II* category was rarely used.

300.60 Depersonalization neurosis . . . . . 300.60 Depersonalization disorder

This *DSM-III* category is included within the class of Dissociative Disorders, even though this is controversial, because the feeling of one's own reality, a component of identity, is lost.

300.70 Hypochrondriacal neurosis . . . . . 300.70 Hypochondriasis
300.50 Neurasthenic neurosis
This *DSM-II* category was rarely used.
300.60 Depersonalization neurosis . . . . . 300.60 Depersonalization disorder

This *DSM-III* category is included within the class of Dissociative Disorders, even though this is controversial, because the feeling of one's own reality, a component of identity, is lost.

300.70 Hypochrondriacal neurosis . . . . . .300.70 Hypochondriasis

Hypochondriasis is included within the class of Somatoform Disorders because of the presentation of symptoms suggestive of physical disorder.

300.81 Somatization disorder

This disorder has been described in the literature as either "Hysteria" or "Briquet's Syndrome" and validity data have been gathered in a series of studies.

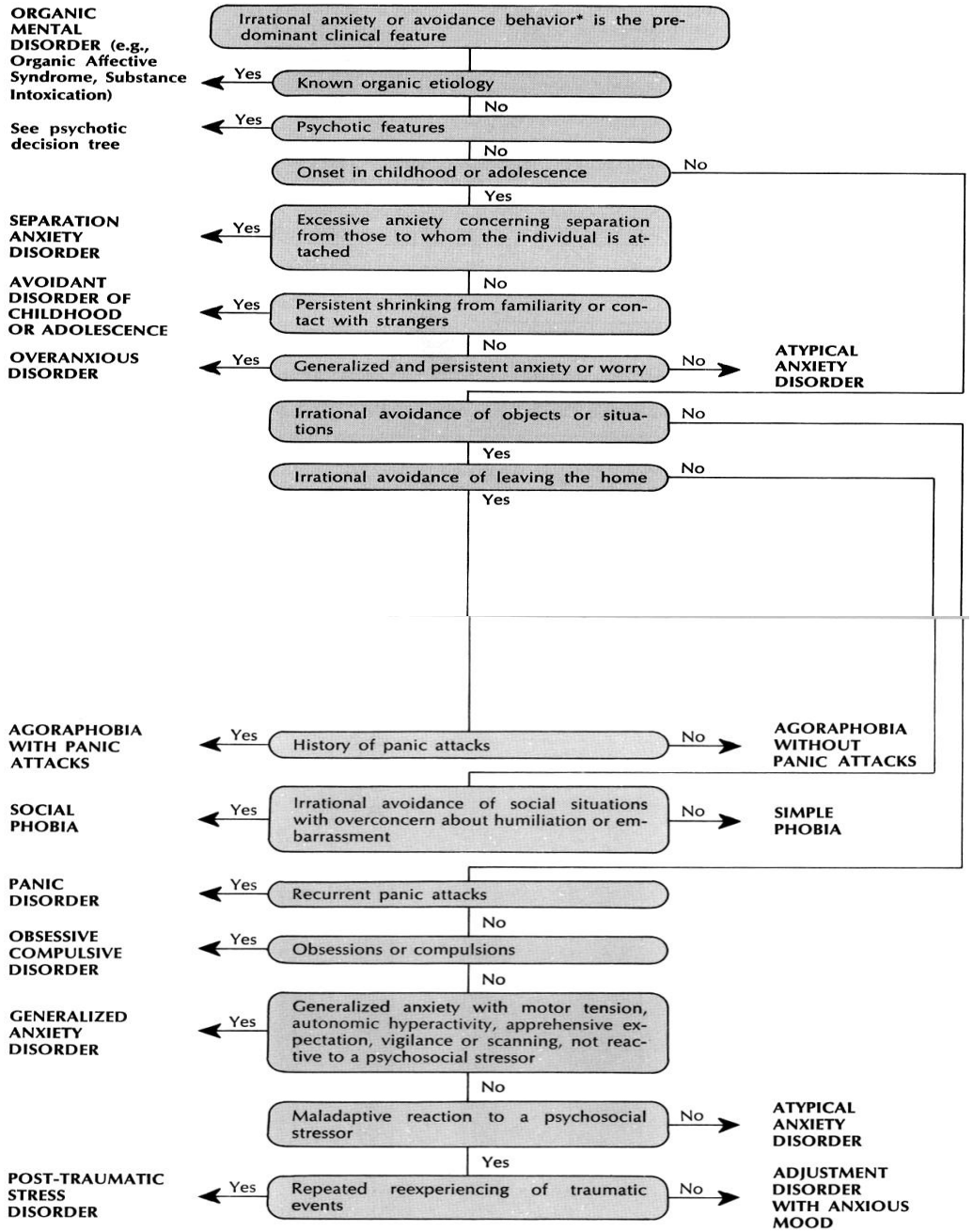
Post-traumatic stress disorder
308.30 acute
309.81 chronic or delayed

This category used to be referred to as Traumatic Neurosis. It's subdivision into acute and chronic forms is justified by longitudinal studies showing differential outcomes for the two forms.

Appendix 5.

DSM-III: Appendix A: Decision Trees for Differential Diagnosis

DIFFERENTIAL DIAGNSOSIS OF IRRATIONAL ANXIETY AND AVOIDANCE BEHAVIOR



Appendix 6.

Comparison of *DSM-I* and *DSM-II* Terms of Art: From Reactions to Neuroses

***DSM-I* Code Numbers and Titles**		***DSM-II* Code Numbers and Titles**
40 Psychoneurotic Reactions	. . . . .	300 Neuroses
40.0 Anxiety reaction	. . . . .	300.00 Anxiety neurosis
40.1 Dissociative reaction	. . . . .	300.14* Hysterical neurosis, dissociative type*
40.2 Conversion reaction	. . . . .	300.13* Hysterical neurosis, conversion type*
40.3 Phobic reaction	. . . . .	300.20 Phobic neurosis
40.4 Obsessive compulsive reaction	. . . . .	300.30 Obsessive compulsive neurosis
40.5 Depressive reaction	. . . . .	300.40 Depressive neurosis
40.6 Psychoneurotic reaction, other	. . . . .	300.50 Neurasthenic neurosis 300.60 Depersonalization neurosis 300.70 Hypochrondriacal neurosis 300.80 Other neurosis [300.90 Unspecified neurosis]

Appendix 7.

Comparison of *DSM-I* and *DSM-II*: From Gross Stress Reaction to Adjustment Reaction of Adult Life

DSM-I Code Numbers and Titles		*DSM-II* Code Numbers and Titles
TRANSIENT SITUATIONAL PERSONALITY DISORDERS	307*	Transient situational disturbances
54.0 Gross stress reaction.	307.30*	Adjustment reaction of adult life*
54.1 Adult situational reaction.	307.30*	Adjustment reaction of adult life*
54.2 Adjustment reaction of infancy	307.00*	Adjustment reaction of infancy*
54.3 Adjustment reaction of childhood.	307.10*	Adjustment reaction of childhood*
54.4 Adjustment reaction of adolescence.	307.20*	Adjustment reaction of adolescence*
54.5 Adjustment reaction of late life	307.40*	Adjustment reaction of late life*
54.6 Other transient situational personality disturbance.		No corresponding diagnosis (Assign another diagnosis in 307 category based upon patient's age)

*Asterisk indicates classification is not part of *International Classification of Diseases*

Appendix 8.

From Reactions to Neuroses to Disorders: Genealogy of *DSM-I*, *DSM-II*, and *DSM-III* Terms of Art

***DSM-I* Code Numbers and Titles**	***DSM-II* Code Numbers and Titles**	***DSM-III* Code Numbers and Titles**
40 Psychoneurotic Reactions	300 Neuroses	Anxiety states (or Anxiety neuroses)
40.0 Anxiety reaction	300.00 Anxiety neurosis	300.01 Panic disorder 300.02 Generalized anxiety disorder
40.1 Dissociative reaction	300.13 Hysterical neurosis conversion type	300.11 Conversion disorder 307.80 Psychogenic pain disorder
40.2 Conversion reaction	300.14 Hysterical neurosis, dissociative type	300.12 Psychogenic amnesia 300.13 Psychogenic fugue 300.14 Multiple personality 307.46 Sleepwalking disorder
40.3 Phobic reaction	300.20 Phobic neurosis	Phobic disorders (or Phobic neuroses) 300.21 Agoraphobia with panic attacks 300.22 Agoraphobia without panic attacks 300.23 Social phobia 300.29 Simple phobia 309.21 Separation anxiety disorder
40.4 Obsessive compulsive reaction	300.30 Obsessive compulsive neurosis	300.30 Obsessive compulsive disorder
40.5 Depressive reaction	300.40 Depressive neurosis	Major depression 296.22 single episode, without melancholia 296.32 recurrent, without melancholia 300.40 Dysthymic disorder

DSM-I Code Numbers and Titles	*DSM-II* Code Numbers and Titles	*DSM-III* Code Numbers and Titles
		309.00 Adjustment disorder with depressed mood
40.6 Psychoneurotic reaction, other	300.60 Depersonalization neurosis	300.50 Neurasthenic neurosis 300.60 Depersonalization disorder
	300.70 Hypochrondriacal neurosis	300.70 Hypochondriasis
	300.80 Other neurosis	300.00 Atypical anxiety disorder
	300.90 Unspecified neurosis	
		300.81 Somatization disorder
		Post-traumatic stress disorder 308.30 acute 309.81 chronic or delayed

Appendix 9.

DSM-IV: Diagnostic Criteria for Posttraumatic Stress Disorder

- **Diagnostic criteria for 309.81Posttrauamtic Stress Disorder**

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

(2) the person's response involved intense fear, helplessness, or horror. **Note**: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note**: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note**: In children, there may be frightening dreams without recognizable content

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note**: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increasing arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hyper-vigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

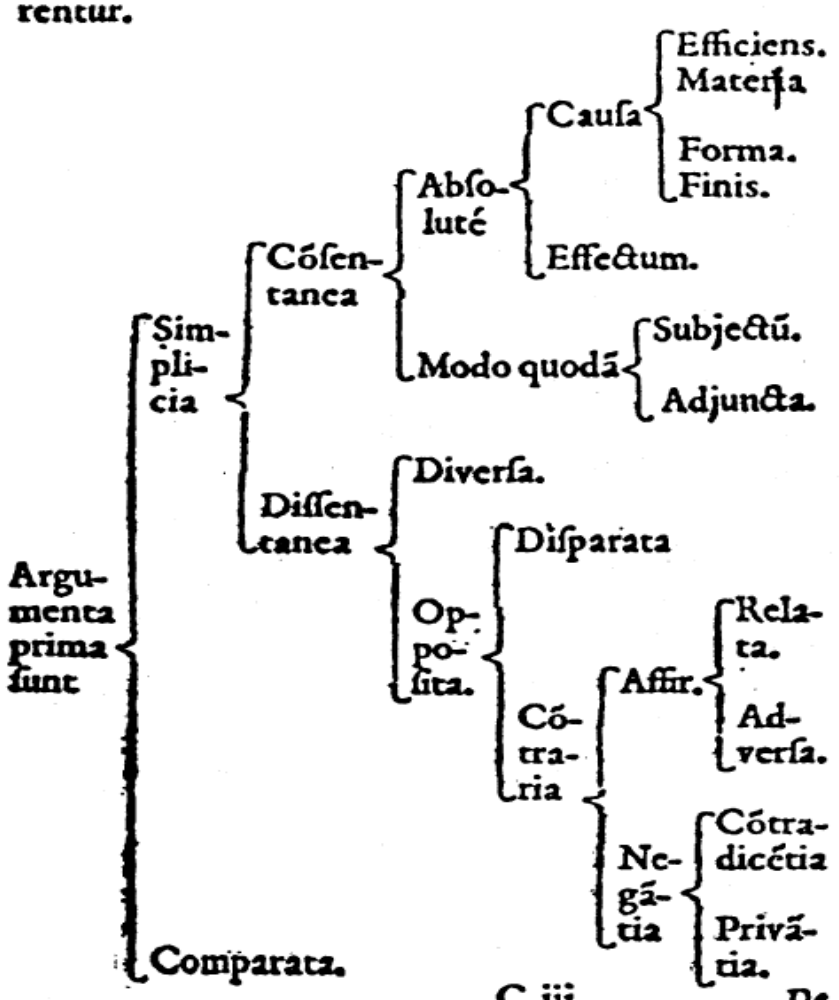
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix 10.

Peter Ramus' *Dialecticae Libri Duo*

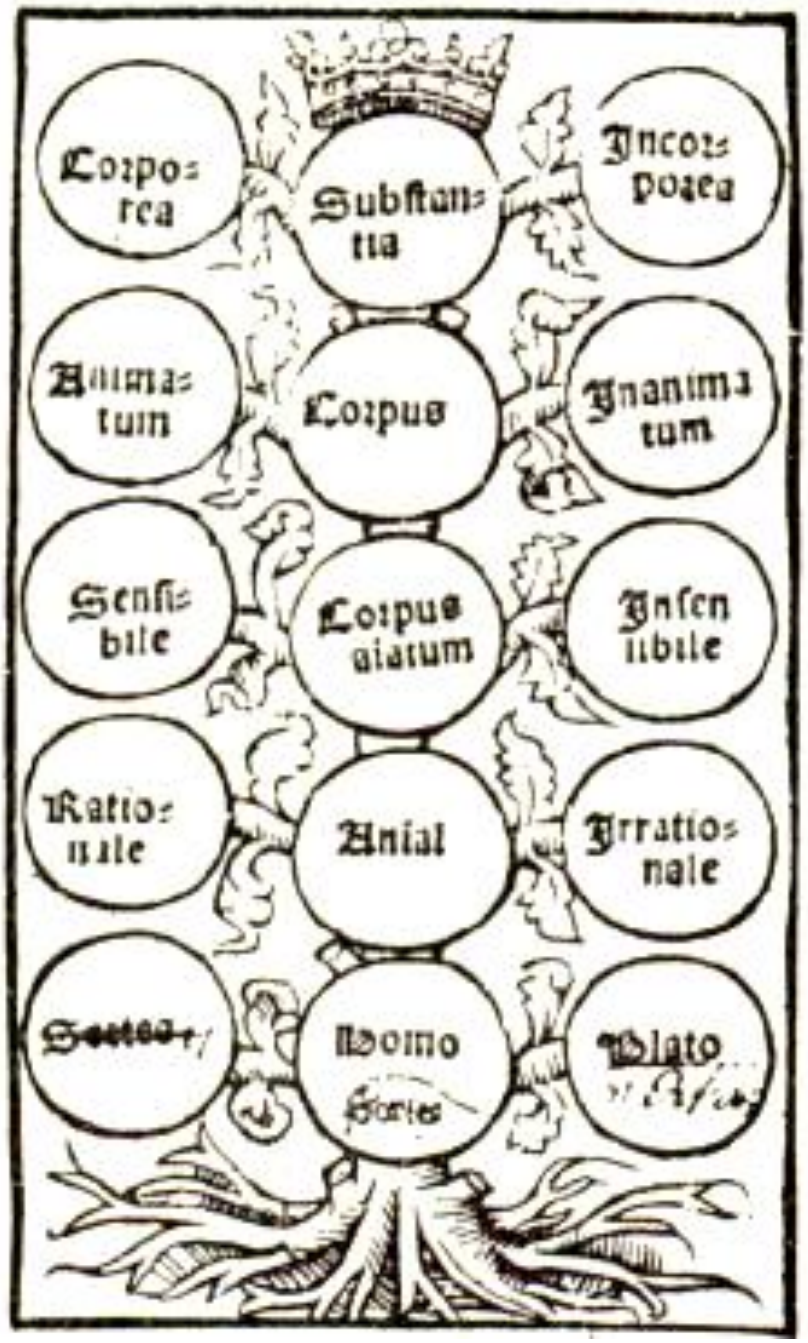
CAP. XVIII.
De Paribus.

HActenus de argumentis ſimplicibus ſtrictim diſſeruimus: quæ idcirco ſic appellantur, quód abſoluté abſque ulla omnino comparatione conſiderentur.



Appendix 11.

The Porphyrian Tree (Tartaret)



Appendix 12.

Thomas Johnstone's Bracketed Table for Emil Kraepelin's Classification Of Mental Diseases

CLASSIFICATION OF MENTAL DISEASES

			LECTURE
INTRODUCTION			I.
VARIETIES OF INSANITY.	MELANCHOLIA		I.
	MANIACAL-DEPRESSIVE CONDITIONS	DEPRESSED CONDITIONS	II.
		MANIACAL EXCITEMENT	VII.
		MIXED CONDITIONS	VIII.
	DEMENTIA PRÆCOX (OF ADOLESCENCE)	DEMENTIA PRÆCOX	III.
		PARANOIDAL FORMS	XVI.
		FINAL STAGES	XXI.
	GENERAL PARALYSIS (OF THE INSANE)	STATES OF DEPRESSION	V.
		STATES OF GRANDEUR	X.
		FINAL STAGES	XX.
	KATATONIA	KATATONIC STUPOR	IV.
		KATATONIC EXCITEMENT	IX.
	PARANOIA (MONOMANIA, PROGRESSIVE SYSTEMATIZED INSANITY)		XV.
	AFTER ACUTE DISEASES (DELIRIUM OF COLLAPSE)		XII.
	AFTER HEAD INJURIES (TRAUMATIC)		XXV.
	EPILEPTIC		VI.
	HYSTERICAL		XXVI.
	PUERPERAL		XIV.
	ALCOHOLIC	ALCOHOLIC MENTAL DISTURBANCES	XI.
		CHRONIC ALCOHOLISM (COMBINED FORMS)	XVIII.
	MORPHINISM, COCAINISM		XIX.
VARIETIES OF IMBECILITY.	ACQUIRED OR DEMENTIA	FROM COARSE BRAIN LESIONS	XXII.
		OLD AGE (SENILE)	XXIII.
		EPILEPTIC	XXIV.
	CONGENITAL OR ORDINARY	EPILEPTIC	XXIV.
		CONGENITAL	XXVIII.
		CRETINISM	XXX.
VARIETIES OF DELIRIUM			XIII.
VARIETIES OF DELUSIONS			XVII.
IRREPRESSIBLE IDEAS AND IRRESISTIBLE FEARS			XXVII.
MORBID PERSONALITIES			XXIX.
CRETINISM—CONCLUDING REMARKS			XXX.

T. JOHNSTONE.

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Appendix 13.

DSM-5: Draft Diagnostic Criteria for Posttraumatic Stress Disorder

G 05 Posttraumatic Stress Disorder

A. The person was exposed to one or more of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:

1. Experiencing the event(s) him/herself
2. Witnessing, in person, the event(s) as they occurred to others
3. Learning that the event(s) occurred to a close relative or close friend; in such cases, the actual or threatened death must have been violent or accidental
4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Intrusion symptoms that are associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by 1 or more of the following:

1. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content. ***
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to reminders of the traumatic event(s)

C. Persistent avoidance of stimuli associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by efforts to avoid 1 or more of the following:

1. Avoids internal reminders (thoughts, feelings, or physical sensations) that arouse recollections of the traumatic event(s)
2. Avoids external reminders (people, places, conversations, activities, objects, situations) that arouse recollections of the traumatic event(s).

D. Negative alterations in cognitions and mood that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced

by 3 or more of the following: **Note**: In children, as evidenced by 2 or more of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent and exaggerated negative expectations about one's self, others, or the world (e.g., "I am bad," "no one can be trusted," "I've lost my soul forever," "my whole nervous system is permanently ruined," "the world is completely dangerous").
3. Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)
4. Pervasive negative emotional state -- for example: fear, horror, anger, guilt, or shame
5. Markedly diminished interest or participation in significant activities.
6. Feeling of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing)

E. Alterations in arousal and reactivity that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s)), as evidenced by 3 or more of the following: **Note**: In children, as evidenced by 2 or more of the following:

1. Irritable or aggressive behavior
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance -- for example, difficulty falling or staying asleep, or restless sleep.

F. Duration of the disturbance (symptoms in Criteria B, C, D and E) is more than one month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., medication or alcohol) or a general medical condition (e.g., traumatic brain injury, coma).

Specify if:

With Delayed Onset: if diagnostic threshold is not exceeded until 6 months or more after the event(s) (although onset of some symptoms may occur sooner than this).

Appendix 14.

Posttraumatic Cognitions Inventory (PTCI)

ID: INITIALS: DATE:

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

1. Totally disagree
2. Disagree very much
3. Disagree slightly
4. Neutral
5. Agree slightly
6. Agree very much
7. Totally agree

1. The event happened because of the way I acted.
2. I can't trust that I will do the right thing.
3. I am a weak person.
4. I will not be able to control my anger and will do something terrible.
5. I can't deal with even the slightest upset.
6. I used to be a happy person but now I am always miserable.
7. People can't be trusted.
8. I have to be on guard all die time.
9. I feel dead inside.
10. You can never know who will harm you.
11. I have to be especially careful because you never know what can happen next.
12. I am inadequate.
13. If I think about die event, I will not be able to handle it.
14. The event happened to me because of die sort of person I am.
15. My reactions since the event mean that I am going crazy.
16. I will never be able to feel normal emotions again.
17. The world is a dangerous place.
18. Somebody else would have stopped the event from happening.
19. I have permanently changed for the worse.
20. I feel like an object, not like a person.
21. Somebody else would not have gotten into this situation.
22. I can't rely on other people.
23. I feel isolated and set apart from others.
24. I have no future.
25. I can’t stop bad things from happening to me.

26. People are not what they seem.
27. My life has been destroyed by the trauma.
28. There is something wrong with me as a person.
29. My reactions since the event show that I am a lousy coper.
30. There is something about me that made the event happen.
31. I feel like I don't know myself anymore.
32. I can't rely on myself.
33. Nothing good can happen to me anymore.