Psychiatrists make Diagnoses, but not in Circumstances of Their Own Choosing: Agency and Structure in the *DSM*¹

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ABSTRACT

Psychiatric classification is a profoundly important activity that directs subsequent treatment decisions, assumptions about etiology, and prognostic considerations. While the ideal classification scheme would be clear, concise, comprehensively inclusive of, and hospitable to, the entities under consideration, in practice, all classification systems reflect trade-offs and embody flawed structures. Accordingly, it is essential to be fully cognizant of the shortcomings, biases, and tacit assumptions of extant systems so that classifications can be improved and so that misrepresentations will not be blindly repeated or reproduced. Modern psychiatric classification and diagnosis are almost exclusively defined within the context of the nomenclature and diagnostic categories of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This article adapts Giddens's (1984) theory of "structuration" to explain how at least some of the consequences of relying on the *DSM* for classification result in unexamined conditions of its use and unintentionally reproduced its underlying assumptions. This article uses the *DSM* to explicate agency in structuration theory and structuration theory to illuminate the structure and use of the *DSM*. The discussion suggests that Mouzelis's (1995) four-fold duality-dualism typology, by empowering the agent not only virtually but in actuality, is a necessary and salutary modification of structuration theory. Finally, it will be suggested that several prominent issues and concerns in psychiatric nosology resonate profoundly with those that have concerned, and continue to interest, library classificationists.
INTRODUCTION

Classifying (understood most broadly as arranging or grouping phenomena on the basis of some system or principle) is fundamental to, and underlies, all human thought (see, for example, Svenonius, 1983) and is thus an indispensable tool for understanding contemporary knowledge structures as well as their era-specific historical place and development. Classification is both the scientific origin and an arena of ongoing evolution, evaluation, and contention for the development of systematic knowledge. All classifications of knowledge, including library classifications and psychiatric nosologies, have been objects of contention because they ineluctably harbor tacit presuppositions of all kinds—e.g., scientific, sociocultural, practical, and ideological, to name but a few.

The ideal classification scheme would be clear, concise, and comprehensively inclusive of, or hospitable to, the entities and to the approaches to classifying the entities under consideration. Obviously, realizing such a classification is impossible. Thus, all attempts to classify reflect, to some degree, trade-offs, compromises, biases of omission and/or commission, possibilities, impossibilities, successes, and failures. Because an ideal classification is impossible, it becomes essential to be fully cognizant of the shortcomings, biases, and tacit assumptions of extant systems so that classifications can be improved and so that problems will not be repeated blindly or reproduced. This discussion is an attempt to contribute to that project.

This article elaborates on a theoretical framework for analyzing the operation of the official diagnostic classification system within the mental health professions. However, it is perhaps unremarkable that many of the most prominent issues and concerns of psychiatric nosologists resonate with those that have concerned, and continue to interest, library classificationists. The birth of psychiatry (as well as of library and information science [LIS]) was characterized by the introduction of classifications with a three-fold purpose (Pichot, 1986)—i.e., social, scientific, and pragmatic: “The early psychiatric nosology tried simultaneously to attain these three goals. Basic to this position was the conviction that, if the classification was ‘natural,’ i.e., scientific, it was at the same time the most pragmatic” (p. 63).

Compare the above assertion to Bliss’s resolutely held conviction that the library classification that best mirrors the scientific and educational consensus would also be the most useful to library patrons (see, for example, Bliss, 1929). Clearly, the status and validity of the warrants, if any, that underwrite classification schemes are a source of ongoing controversy.

Critical, recurring, and LIS-relevant issues in the history of psychiatric classification include the following (see, for example, Freedman, Silverman, Brotman, & Hutson, 1986). First, what is classified in a
psychiatric nosology—disease, disorder, syndrome, individual patients, or patient/client groups? This problem of identifying the unit or object of classification has its parallel in librarianship with the problem of distinguishing, descriptively, among the work, book, or manifestation.

Second, for whom is the classification scheme created? Is it for the researcher, mental health practitioner, or the courts? In other words, there are ongoing concerns with the audience for, and purpose of, the psychiatric classification. In LIS, classifications have traditionally been constructed for use by librarians but recently, with the advent especially of online public access catalogs, it has become increasingly clear that classification schemes need to be useful to the patron or end-user as well.

Third, there are concerns about the social inputs and consequences of classifications in terms of which fashions, societal trends, or pressures influence (or bias) the categories of a classification and of how types of knowledge (and people) get represented (and obliterated). Because of the relatively compelling economic and political implications of psychiatric classification (and, conversely, of the seeming absence of such ramifications with classifications of library materials), such sociocultural and ethical concerns have received far less attention in library science than in psychiatry.

Fourth, two related, common, and recurring themes in the history of psychiatric nosology arise directly from its ineluctable subjectivity: lumping versus splitting and the categorical/hierarchical versus dimensional (or, in library and information science terms, faceted) approach to classification construction (Mack, Forman, Brown, & Frances, 1994). The number and granularity of categories, and whether they can be considered discrete isolatable entities, are ongoing and potentially insoluble problems for both psychiatry and library science. These issues concern the epistemic status of our classifications and the distinctions they make and have equal applicability both to the classification of diseases/disorders in patients and to that of subjects/topics in LIS materials.

Finally, perhaps most symptomatically, both disciplines have been deeply concerned with the consistently inconsistent manner in which their classifications have been applied. In psychiatry this concern goes under the name of inter-rater unreliability, while in LIS it has been referred to as inter-indexer inconsistency. The intractability of this vexatious problem in both professions suggests their foundational relevance to each other.

Thus, it can now be readily appreciated that the study of psychiatric classification has much to offer library classification in terms of the relevance of, and overlap among, common and recurring themes. This article will therefore exploit the sociological-sensitive research about the former to frame and illuminate the latter.

This article will focus on the Diagnostic and Statistical Manual of Mental Disorders (hereafter the DSM-III, DSM-III-R, and DSM-IV will be collectively
referred to either as the *DSMs* or as the collective singular, the manual, unless otherwise indicated). The *DSMs* comprise the official nomenclature and classification system of the American Psychiatric Association and as such delineate the boundaries within which psychiatry claims epistemic and professional authority (Kirk & Kutchins, 1992; McCarthey & Gerring, 1994). However, the *DSMs* reflect a compromise of interests. While their primary goal is the pragmatic one of clinical utility, their underlying structures reflect not only (or even primarily) researchers and clinicians, but also the interests of lawyers, statisticians, epidemiologists, insurers, and disability claims personnel, among others. Accordingly, many decisions were made on the extra-clinical and non-empirical basis of expert consensus (Blashfield, 1984; Kirk & Kutchins, 1992) in the absence of empirical data. The *DSMs* are documents of mixed origins and conflicting purposes, based partly on scientific interests but also reflecting other clearly political and social (including professional) concerns.

While the *DSMs* have been the object of intense scrutiny, especially scientific, philosophical, and linguistic (see, for example, the contributions in Sadler, Wiggins, & Schwartz, 1994), they have not as yet been read from a "structurational" perspective. The purpose of this article is to analyze the *DSMs* by employing Giddens's theory of "structuration."

This discussion will begin with an outline of the major tenets of structuration theory, highlighting those principles especially applicable to classification in general and to diagnostic identification in particular. This will be followed by a close structured reading of two situated activities related to the development and use of the *DSMs*. To illustrate the analysis of strategic conduct, I will reread, from a "structurational" perspective, McCarthey's (1991) review of the use made of *DSM-III* by one child psychiatrist in her hospital-based clinical practice. This will be compared to the article with McCarthey and Gerring (1994) in which the child psychiatrist of the 1991 article, as a co-author, rhetorically analyzes the sociopolitically motivated revision process leading to *DSM-IV*.

This comparative analysis will illustrate an important weakness of Giddens's duality of structural theoretical framework and the utility, at least in terms of the analysis of strategic conduct, of maintaining the duality-dualism distinction. Briefly, Giddens's structuration theory simply does not exhaust the types of relationships that actors have toward rules, resources, and social objects, such as classifications. In fact, opting, as Giddens does, for subject/object duality conflates agency and structure so that the possibility for actors to distance themselves from social resources to view, and orient toward, them strategically is severely curtailed, contradicting his useful distinction between institutional and strategic conduct analysis. In effect, this limitation in Giddens's duality-of-structure notion limits the ability to distinguish the effects of classifications on classifiers and classificationists from those of the latter on the former.
STRUCTURATION THEORY

Giddens's structuration theory is especially useful in attempting to understand the social context and consequences of classification. Structuration theory is concerned with the conditions governing the continuity or transmutation of structures and therefore the (re)production of social systems (Giddens, 1979, 1984, 1993, 1995).

Basic concepts of structuration theory especially relevant to this discussion can be adumbrated as follows:

1. The duality of structure refers to the fact that social structures are simultaneously produced and modified by human agents and are used as resources; structures are dual in the sense that they are both the medium and outcome of the interactions and institutions they recursively organize.

2. Structure is a virtual order of rules and resources that exists only when instantiated in interaction and simultaneously both constrains and enables knowledgeable and skilled human agency. Conversely, systems are reproduced relations between actors, organized as regular/routine social practices; systems are the observable patterns of social interaction and can be said to exhibit, rather than have, structures or structural properties.

3. Modalities of structuration are rules that guide action (normative and interpretative) and facilities that empower action (authoritative/political and allocative/economic resources). Modalities (i.e., interpretative schemes, norms, and resources) are understood to be drawn upon by actors in the production of meaningful interaction: communication, sanctions, and power while, simultaneously, they are the reproductive media of the structural components of interaction systems: structures of signification, legitimation, and domination. The analytic significance of the modalities is that they provide the coupling elements whereby the analysis of interaction is linked to the (re)production of the structural components of social systems.

Critics of Giddens's explication of structure (see, for example, Archer, 1982; Layder, 1987, 1990) accuse him of obscuring the ontological status of structures. Because Giddens claims that structures exist only when instantiated in human activity, they reason that structures must be recreated anew each time. In other words, structures are created by human agency but must pre-exist any given actor's appropriation of them as resources in activity. However, supporters of Giddens have suggested that such criticisms exaggerate this difficulty by focusing almost exclusively on structures as necessarily instantiated in action, neglecting their continuity as "memory traces" (Giddens, 1984, p. 17).

However, there is a more serious problem with Giddens's concept of duality of structure. It conflates agency with structure and, in doing so,
simply does not address all the important relationships between agents and the rules and resources that comprise social objects (Mouzelis, 1995). As we will see when examining a psychiatrist’s use of the manual, by maintaining the duality-dualism distinction, agency can be better theorized both sociologically and critically. It is essential for agents to be able to distance themselves from rules so that we can account for their strategic use (and possible transformation).

THE Diagnostic and Statistical Manual of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders is the official classification system of mental disorders published by the American Psychiatric Association. The third edition of the DSM (DSM-III) was published in 1980, was revised (DSM-III-R) in 1987, and the fourth edition (DSM-IV) was published in 1994. It can be considered a charter document in that it “establishes an organizing framework that specifies what is significant and draws people’s attention to certain rules and relationships. . . . defines as authoritative certain ways of seeing and deflects attention away from other ways . . . stabilizes a particular reality and sets the terms for future discussions” (McCarthey, 1991, p. 359).

Since 1980, the DSMs profoundly influenced the way in which the mental health field defines itself, the way in which it conducts its clinical and research work, the way it educates and socializes new professionals entering the field, and they have shaped legal and financial arrangements, including which treatments are eligible for insurance reimbursement (McCarthey & Gerring, 1994). Moreover, through the manual, a relatively small group of closely knit psychiatrists, known as the neo-Kraepelinians (Blashfield, 1984; Kirk & Kutchins, 1992), has attempted to accomplish three other things.

The primary goal of the neo-Kraepelinians is to assert the primacy and dominance of the biomedical model in the mental health field. There are at least two competing and contradictory models that have dominated psychiatry. The first, the biomedical-empirical model, comprises two primary assumptions. First, there are real discrete entities to which disease labels such as “dysthymia,” “schizophrenia,” or “attention deficit disorder” ought legitimately to be applied. These disorders are seen as generic and applicable across cultures, and there is the related assumption of underlying behavioral, psychological, or biological dysfunction: the disturbance is not to be located in the relationship between the individual and society. Second, the model employs the assumption of specific etiology, which in medicine states that diseases are caused by a single biological factor. That assumption has been modified in psychiatry to include patterns of multiple, discrete, and interacting etiological factors: biological, psychological, genetic, environmental, and/or social. Because these etiological factors are not well understood, the DSMs have adopted a fully or purely
descriptive approach: they attempt to describe comprehensively the manifestations of disease—i.e., they are intended to be atheoretical as regards the etiology of mental disorder.

The second model is hermeneutic-intuitive and fundamentally evaluative. The mentally ill patient is seen as an individual whose symptoms have meaning particular to him or her. In this model, the focus is less on distinguishing, describing, and classifying symptoms as manifestations of some unknown (and heretofore unknowable) underlying disease process, than on the meanings that those symptoms have for the individual. Mental health professionals, working within the hermeneutic model (many with psychodynamic and psychoanalytic orientations), understand the patient as an individual with a "story to tell" that must be understood and explained, while those working within the biomedical model see the individual as a member of a group with impairments to be explained. A psychiatrist's choice of perspective, which is often taken without awareness but which has profound ramifications for how the patient is conceptualized, is a result of personality, education, interests, and situational and professional pressures, a point that has important implications for this argument.

By imposing the biomedical model on mental health classification, this small group of psychiatric researchers (who are, most importantly, not clinicians) has attempted to accomplish two other more exclusively professional goals: (1) to achieve superiority over neighboring non-medical disciplines within the mental health field; and (2) to strengthen their affiliation and to achieve parity with other medical specialties (Kirk & Kutchins, 1992; McCarthey, 1991; McCarthey & Gerring, 1994).

The publication of DSM-III has often been referred to as a landmark event and a major scientific achievement (Kirk & Kutchins, 1992). According to Blashfield (1984), four major changes were made between DSM-I, DSM-II, and DSM-III and beyond: "(1) the use of diagnostic criteria; (2) a multiaxial approach to patient evaluation; (3) expanded descriptive information; and (4) a reorganization of the diagnostic categories" (p. 112). However, these diagnostic systems were, and are, controversial. Criticism has come from a wide variety of perspectives, some focusing on specific diagnostic entities and categories and others on broader conceptual issues, such as diagnostic boundary problems and the implications of a categorical classification for the measurement of comorbidity (Clark, Watson, & Reynolds, 1995). Without undertaking the impossible task of reviewing all critiques of the DSMs, three recurrent and important ones will be highlighted below.

One of the major criticisms of these diagnostic manuals is the focus on the individual, its individualistic metaphysics: "minds reside in brains, which in turn reside in individual persons. Minds, and subsequently mental disorders, do not reside in the social world" (Sadler & Hulgus, 1994,
The underlying assumption is unrealistic in that all psychiatric disorders (in fact, all human experience) are deeply embedded in social, community, or family networks (see, for example, the essays in Sadler, Wiggins, & Schwartz, 1994). This underlying structural principle undermines the usefulness of the DSM's multiaxial structure (especially with regard to axes IV and V) at least as it is currently constructed.

The second major area of criticism has been most strongly voiced by psychoanalysts and other dynamically oriented psychodiagnosticians. It focuses on the historical emptiness in the DSM (McHugh & Slavney, 1983), claiming that they largely ignore the life story of the person: "The etiological, clinical, and practical significance of these [historical events such as job loss, catastrophic loss of loved ones, marital discord, and other stressful life events] and other life events in the patient's past are pushed into the nosological background" (Sadler & Hulgus, 1994, p. 262).

This fundamental disregard for the temporal and contextual dimensions of lived experience tends to reify or naturalize diagnostic categories. Instead of seeing DSM nosological entities as potentially useful abstractions, clinicians are encouraged to see their patients in terms of—and as being coextensive with—concrete diseases. Giddens (1984) talks about reification in a manner particularly apposite to classifications:

The concept [reification] should not be understood simply to refer to properties of social systems which are "objectively given" so far as specific, situated actors are concerned. Rather, it should be seen as referring to forms of discourse which treat such properties as "objectively given" in the same way as are natural phenomena. That is to say, reified discourse refers to the "facticity" with which social phenomena confront individual actors in such a way as to ignore how they are produced and reproduced through human agency. Reification thus should not be interpreted to mean "thing-like" in such a connotation; it concerns, rather, the consequences of thinking in this kind of fashion . . . . The "reified mode" should be considered a form or style of discourse, in which the properties of social systems are regarded as having the same fixity as that presumed in laws of nature. (p. 180)

As a result, a vast literature exemplifying the vital relevance of recent and remote historical life events to psychiatric problems, as well as an equally vast literature on human development and its pertinence to such problems, are excluded from consideration in the DSMs.

The third, and perhaps most celebrated, problem area in the DSMs has to do with their alleged atheoretical stance toward etiology. However, while no overt declaration is made in the manuals, they describe or structure diagnostic reality so that some etiological theories are more applicable or relevant than others (Faust & Miner, 1986). The diagnostic approach selects operationalized individualistic signs and symptoms as the relevant clinical data, whereas other kinds of contextual and temporally
sensitizing data are ignored as classificatorily irrelevant. As Sadler and Hulgus (1994) observe:

This descriptive, syndrome-bound approach to diagnosis fits the needs of a biological psychiatry much better than other etiological models as, for instance, a family interactional model . . . or a developmental, life story approach. . . . Because DSM-III-R [as well as DSM-III and DSM-IV] fit biological psychiatry's theory base better than other psychosocially oriented therapies, the DSM-III-R diagnosis tends to make biological conceptualizations of the patient primary and the psychosocial secondary. In summary, DSM-III-R may not state a theory, but the metaphysical structure of its classification prefers the theoretical bases of descriptive/biological psychiatry. (p. 263)

**Structuration Theory, Classification, and the DSMs' Modalities of Structuration**

As has been already stressed, all human action and interaction is inextricably and simultaneously composed of structures of meaning, morality, and power. In terms of the modalities of structuration, social practice links the realm of human agency with that of social structure. Interpretative schemes are standardized shared stocks of knowledge that humans draw upon to interpret behavior and events, thereby achieving meaningful interaction. They are the cognitive means by which each actor makes sense of what others say and do. Resources are the means through which intentions are realized, goals are accomplished, and power is exercised. Norms are the rules governing sanctioned or appropriate conduct, and they define the legitimacy of interaction within a locale's moral order. As Orlikowski and Robey (1991) state: "Those three modalities determine how the institutional properties of social systems mediate . . . human action and how human action constitutes social structure" (p. 148).

**Interpretative Schemes**

From the point of view of strategic conduct, human interaction involves the communication of meaning which is achieved via interpretative schemes—i.e., stocks of mutual knowledge that agents draw upon in the production and reproduction of interaction. "These form the core of the mutual knowledge whereby an accountable universe of meaning is sustained through and in processes of interaction" (Giddens, 1979, p. 83). Interpretative schemes do more than merely enable the communication of shared meaning; they also serve as media for the imposition of structural constraints and affordances.

From the viewpoint of institutional analysis, interpretative schemes comprise structures of signification that represent the social rules that enable, inform, and constrain the communication process itself. Thus, in any interaction, mutual knowledge does not merely provide background for the communication process but is constitutive of it, in part organizing it and in part being constituted by the process itself.
As such, a diagnostic nosology like the DSM is an interpretative scheme that mediates between signification structure and social interaction in the form of meaningful communication among researchers, clinicians, patients, and such other organizational actors as insurers and government agencies. The signification structure in those cases comprises the shared rules, concepts, and theories that are drawn upon to make sense and organize communication about etiology, diagnosis (including reliability and validity issues and concerns), treatment plans, efficacy, and of course reimbursability.

Facilities (Resources)

From the point of view of strategic action, power enters into human interaction by providing the facilities and capabilities to accomplish outcomes. For example, the DSMs provide clinicians and researchers with categories that determine the applicability of various types of treatments. Power is understood here in both its broader meaning as transformative capacity—that is, the ability to transform or to affect the social and material world—and in the narrower sense of "power over"—that is, power as the domination of some individuals over others. Its use in organizations is mediated by the resources that agents appropriate within interaction.

All social systems and institutions are characterized by an irreducible asymmetry of resources (involving relations of both autonomy and dependence), the existing structure of domination is reinforced through the use of those resources, and it is when the existing asymmetry of resources is explicitly challenged or resisted, via what Giddens calls the dialectic of control, that the existing structure of domination may be creatively transformed.

This is especially the case with psychiatric diagnoses. For many, if not most, of the reasons mentioned above, both those diagnosing or applying the classification and those diagnosed may use a diagnosis (or assignment) for purposes of their own, purposes for which the nosology was not intended. Kirk and Kutchins (1992) explain in some detail the use of the manual to misdiagnose (both to under- and over-diagnose patients for purposes of stigma avoidance or to ensure reimbursability, respectively). Several authors (see, for example, Starr 1992; Hacking 1992) have called attention to the fact that, while classifications of the natural world are one-way relationships in that only people categorize natural objects, "[p]eople, however, have their own ideas about group membership—not only ideas but strong sentiments. When institutions classify, therefore, they often confront the self-conceptions of the subjects" (Starr, 1992, p. 158). Nowhere do those concerns, essentially with power, apply more problematically than in psychiatric classification.

Norms

From the viewpoint of strategic action, norms are organizational rules
or more or less binding conventions legitimating appropriate conduct. Such moral codes for legitimate conduct are created out of the continuous use of sanctions by agents in interaction. Norms play an active role in the shaping of institutional notions of "correct" behavior, that is, in what is to be regarded as vice or virtue, as important or trivial, and as obligatory or merely contingent. In this way, the practice of psychiatric diagnosis ineluctably involves the communication of a definite set of values (see Fulford, 1994, concerning the repolarization of illness and disease in terms of a value-based perspective on classification). The practice of diagnosis and of consequent classification can then be seen as involving the communication of notions of what should be, and it is primarily on the basis of those notions that sense is made of (or meaning constructed and imposed on) what psychiatrically exists.

From the viewpoint of institutional analysis, norms articulate, conventionally reproduce, or creatively (usually incrementally) transform established structures of legitimation. The legitimation structure institutionalizes the reciprocal rights and obligations of social actors and mediates, through norms and moral codes, the sanctioning of particular actions and interactions. Systems of psychiatric classification provide and legitimize the categories to which people can be assigned. For example, a DSM diagnosis is necessary for reimbursement from insurance companies or other third parties for treatment costs. The classification system embodies norms (such as reliability, validity, and conceptual operationalism) that legitimate diagnoses made from within its descriptive biomedical framework.

However, the modalities, either from the perspective of strategic conduct or from that of institutional analysis, are only isolatable for analytic convenience; in the flow of conduct and institutional life these are inextricably intertwined in each action and interaction. From an institutional perspective, modes of signification, domination (and subordination), and legitimation are intersecting dimensions of the wholeness of institutional social practice. From the point of view of strategic conduct, any interaction simultaneously exemplifies "three fundamental elements: its constitution as meaningful, its constitution as a moral order, and its constitution as the operation of relations of power" (Giddens, 1993, p. 110).

We can now explore, in detail, the use of the DSMs from a structurational perspective. A diagnostic classification system, as does all classification, exists in and as language (Hodge & Kress, 1993). Once inscribed in language, and after legitimizing sociocultural resources are mobilized and aligned (i.e., after much necessary, but often invisible, social and political work is transacted), a classification scheme becomes capable of coordinating and controlling action across long durations of time and large tracts of space. Moreover, as language, a classification scheme can be seen, structurally, as a set of generative rules and resources
which are drawn upon (and, often, in the process, reproduced) in its application, in this case classifying.

However, to understand the actual operation of such systems, it is helpful to go beyond descriptive and conceptual accounts and examine the conditions and consequences of its use in actual situated practices. In practice, different people will perceive a particular system in a variety of ways, and their appropriation of systemic resources will both reflect and reproduce their various interests. Moreover, the use of a classification system will inevitably reflect its unacknowledged conditions and generate unintended consequences because, according to structuration theory, actors, while inherently knowledgeable, may be unaware of the conditions of at least some of their actions and certainly of all the consequences that feed forward from previous—and feed back to subsequent—action.

To illustrate the application of structuration theory to the study of diagnostic classification, I will analyze one child psychiatrist’s experience with the DSMs in her clinical practice, suggesting both that we pay too high an analytic price by eliding the subject-object distinction and that to re-energize agency in structuration theory, we must allow for dualism, as well as for duality subject-object relations. Actors must be permitted to stand back and distance themselves from rules, resources, and interactive situations for the vitally important, and commonly observed, purposes of strategy or monitoring (Mouzelis, 1995).

**Strategic Conduct and the DSMs**

McCarthey (1991) and McCarthey and Gerring (1994) have provided a detailed picture of the use of the manual by the child psychiatrist Gerring, who coauthored the 1994 article. In particular, this comparative analysis, while certainly not parallel, illustrates how Gerring’s conception of (and, by implication, use of) the manual obviously changed over several years. The material presented in this section relies heavily on McCarthey’s (1991) and McCarthey and Gerring’s (1994) papers, which should be read in the original for a detailed and more complete accounting of their research. On the one hand, McCarthey (1991) will afford the analysis, from a structurational perspective, of the strategic conduct of one child psychiatrist to better understand and illustrate the ways in which structures (that are virtually present in the classification system) are appropriated and drawn upon to constitute social action as meaningful, legitimate, and enabling (and simultaneously constraining), while also being unintentionally reproduced through their appropriation and use. On the other hand, McCarthey and Gerring (1994) present the same psychiatrist interacting with the manual strategically and critically (however, not clinically). In terms of Mouzelis’s duality/dualism typology, the former article illustrates paradigmatic duality and syntagmatic dualism, while the latter illustrates paradigmatic dualism and syntagmatic duality.12
McCarthey (1991) used a multi-methodological approach to study the epistemological and textual consequences of *DSM-III* for the diagnostic work of Gerring, who was a child psychiatrist on the staff of a university hospital-based rehabilitation team that ministered to children who had suffered brain injury. McCarthey's detailed analysis follows Gerring through one case as she conducts interviews and draws her diagnostic conclusions. As might be expected, a biological psychiatric model, rather than a hermeneutic perspective, is more likely to be adopted (and reinforced) by psychiatrists working in this setting. Moreover, Gerring admitted to McCarthey that her own training emphasized the biomedical approach to studying psychiatric disorders as a result of studying pediatrics for years before undertaking her psychiatric training.

McCarthey presents her analysis in terms of how the manual structured and determined the gathering of data, the presentation of data, and finally, and most importantly, the analysis of the data that were gathered and presented in the psychiatrist's clinical diagnostic evaluations of one brain-damaged and comatose patient. McCarthey breaks those down into two general areas for analysis.

The first area concerns "*DSM-III* selectivity" (McCarthey, 1991, p. 365). The diagnostic classification determined the type and amount of data that were gathered about patients. Thus, while the categories of the manual were enabling in that they facilitated the collection of detailed information about some aspects of the patient's condition, they more problematically constrained Gerring from seeing other important data about the patient. In terms of the aforementioned structural principles that tacitly underlie the manual, the data required to make a *DSM* diagnosis do not include contextual and, for the most part, historical data about people (Sadler & Hulgus, 1994).

The manual assumes that mental disorders are real discrete entities that can be identified in patients by their clinical symptoms. Not only did the psychiatrist neither speculate as to the underlying meaning of the symptoms nor attempt to specify their etiological significance (unknowable in terms of the *DSM*), she used a highly structured interview schedule based on, and derived from, the *DSM* itself. In fact, not surprisingly, the schedule is designed to lead specifically and rigidly to a *DSM* diagnosis. We can see, then, that the conditions of its use reproduce the structural properties of the *DSM*. For example, as reported by McCarthey (1991): "If . . . [she] found no symptoms for a particular disorder, she moved on quickly. However, when her questioning revealed the presence of some [DSM-validated] diagnostic criteria for a disorder, she questioned . . . further" (p. 366). While Gerring reports feeling frustrated by what the manual and the interview schedule leave out, it is not surprising that the time constraints she feels—"[t]ime is the problem" (McCarthey, 1991, p. 368)—are the logical result of using a *DSM*-based interview schedule.
that merely reproduces the manual’s lack of concern with temporal issues. Speeding through the interview looking for “legal” diagnostic criteria ensures that these, and only these, will be found.

Moreover, in terms of how the data are presented, the psychiatrist evinces her commitment to the biomedical model that tacitly underlies the DSM. As McCarthey (1991) points out, the headings that are used closely follow the hidden logics of the manual (Fulford, 1994) and the manual-based interview schedule. Three pages of the five page report that she completes on the patient are devoted to the data elicited from using the manual-based interview schedule. Two pages are left for basic facts about the patient, information sources, history of the present illness, observation of the patient, and family information, as well as other types of contextually and historically sensitive information. In more Giddensian terminology, she shows relatively little discursive penetration into the conditions of the perspective that organizes her clinical reality. And in terms of dualism-duality typology, on the paradigmatic level, she relates to the DSM dualistically in a taken-for-granted performative way. The instantiation of the rules and resources of the DSM are the medium and outcome of its use. On the syntagmatic plane, she relates in terms of dualism as something external to her over which she has little or no effect or control.

Most importantly, those aspects of the clinical evaluation suggest an acceptance of the belief that DSM, as a classification of mental disorders, is atheoretical; it presupposes both pure perception uninfluenced by thought, raw facts free of interpretation, and an atheoretical observational language. Unfortunately, “there is no perceptual experience that does not involve cognitive processing directed by assumptions, no fact that is not constituted by theory-guided interpretation of sensory stimuli, and no observational language that can describe experience without involving some theoretical background, whether explicit or implicit” (Goodman, 1994, p. 295; for a highly influential treatment of the theory laden-ness of observation, see Kuhn, 1970). The problem with an implicit commitment to atheoretical description (in addition to its falsity) is that, by accepting only those theories (paradoxically, atheorism is of course also a theory) or particular worldviews based on descriptive realism, a clinician will only consider an unnecessarily restricted range of options when contemplating alternative, and perhaps equally valid, conceptions of clinical reality. To the extent that such factors operate tacitly or covertly without being subject to examination, clinicians will unintentionally further and reproduce the presuppositions that subserve the sectional interests of such hegemonic groups as the neo-Kraepelinians.

The second, and more important, way in which Gerring relies on the DSM is not only to analyze the information that she gathered, but also to authorize her specific diagnoses, referred to by McCarthey as “DSM-III-backed analysis.” In her analysis, Gerring refers to diagnostic criteria and
DSM categories in a taken-for-granted manner without explanation. The audiences for which this evaluation is intended require DSM-based diagnostic analyses. Only in this legitimized and legitimating nomenclature can Gerring authoritatively communicate with the other rehabilitation unit medical personnel, other mental health researchers, and insurers and legal personnel. Thus, her conclusions are validated by the same document that generated the type and form of her data. The same document, the DSM, determined not only the data and information that were collected but also their communication, interpretation, and authority.

Giddens (1984) would rightly call such a system a reproduction circuit: "By circuits of reproduction, I mean fairly clearly defined “tracks” of processes which feed back to their source, whether or not such feedback is reflexively monitored by agents in specific social positions” (p. 192). According to Giddens, these circuits of reproduction are implicated in the “stretching” of institutions across time and space. In the case of a psychiatrist who gathers data on the basis of the same system of diagnostic categories in terms of which she analyzes them, we have a relatively closed impermeable circuit in which the structures instantiated in the DSM are both the medium and outcome of her practice.

Subsequent to her work with McCarthey, the psychiatrist Gerring co-authored a paper on the revision process leading to DSM-IV (McCarthey & Gerring, 1994), a paper that evinces a radically different view of the DSM from the orientation of McCarthey (1991). While not a clinically-oriented study like the latter paper, the former offers a rhetorical analysis of the DSMs, along the more critical lines of Kirk and Kutchins (1992). Specifically, in the 1994 paper, the authors analyze the revision of DSM-III-R by observing work groups, by textually analyzing documents, and by interviewing principals in the revision process. The paper concludes with a detailed analysis of work group deliberations about the conception and inclusion of a new diagnostic category, BED (Binge Eating Disorder).

After critically discussing the theoretical and sociopolitical background of the DSMs, McCarthey and Gerring (1994) move to a detailed rhetorical analysis of the "selling of DSM-IV." Without repeating their argument, they bisect the persuasion strategy used to "sell" DSM-IV into strategic use of two rhetorical repertoires. First, the contingent repertoire is used when task force leaders attempt to distance themselves from DSM-IV’s predecessors. Invoking the rhetoric of contingency allows them to account for mistakes made in past revisions in terms of the personalities and biases of the individuals involved.

However, since there is direct and virtually unbroken continuity between DSM-IV and its predecessors (in fact, the former can only be discussed and understood in terms of the latter), too severe criticism of the past would inevitably undermine their current efforts. Consequently, DSM-IV task leaders can securely position themselves as being "in a direct line
with DSM-III and DSM-III-R, by using the empiricist repertoire to describe the development of all three manuals” (McCarthey & Gerring, 1994, p. 166). In what they call the progress of the science repertoire, the false steps of past revisions can be “presented as vital stepping stones in the increasing adoption of the empirical method by the mental health field, as the best and only thing that could have been done under the circumstances” (p. 167). This rhetorical move allows the framers of DSM-IV to represent their work as another logical and essential step towards “a time when mental disorders will be understood well enough to be classified according to their pathogenesis, that is, their causal mechanisms [i.e., etiology], rather than just according to their symptomatology, as at present” (p. 167).

Finally, on the basis of observations of the deliberations of the BED work group, as well as of discussions with the participants, the authors draw four conclusions. First, the work group followed a strategy designed to present psychiatry as a mature biomedical discipline. Second, work group deliberations were shaped by scientific and clinical data, conceived as professionalizing concerns. Third, just as the texts themselves are influenced and shaped by unacknowledged personal and sociopolitical agendas, so were the work group discussions of BED. For example, “work group conversations were shaped by members’ differing assumptions about the maturity of the field and the role DSM should play in either stimulating new research or slowing change and stabilizing current knowledge in psychiatry” (p. 171). Finally, they found evidence in the work group deliberations both of the contingent repertoire to describe their predecessors’ erroneous work and of the empiricist progress of science repertoire to account for their more scientific work on BED.

Comparing this rhetorical analysis with the description of the conventional reproductive rule-following of Gerring in McCarthey (1991) suggests that a transformation in her orientation to the manual has occurred. In terms of the four-fold typology, we see, on the paradigmatic level, a movement from duality to dualism—i.e., from a natural-performative to a strategic-theoretical orientation to the rules and resources that structure the manual. On the syntagmatic level, there is movement in the opposite direction from dualism to duality—from a situation in which the actor is inseparable from, and whose actions constitute, the system to one in which the system is perceived as external to the agent. In other words, by distancing herself from the manual, rather than merely enacting the presuppositions of it, the psychiatrist is able to critically analyze and perhaps transform her interactions with it.

Thus, by examining the perception and use of the manual by a psychiatrist over time, the utility (necessity) of maintaining the duality/dualism distinction to truly empower the knowledgeable and capable agent has, it is hoped, been demonstrated. As Mouzelis (1995) correctly states,
if one opts exclusively for a subject/object duality approach, the only way of conceiving the relationships between subject and structure is to see the latter as medium/outcome—which means conflating agency and structure, and eliminating the possibility of actors distancing themselves from rules and resources in order to view them strategically. (p. 123)

While Giddens claims that his construal of reflexivity encompasses both that of the agent (as social theorist) in the flow of action and that of "the institutionalization of an investigative and calculative attitude towards generalised conditions of social reproduction" (Giddens, 1993, p. 6), a theory of knowledgeable and capable agency must allow the actor the necessary distance to strategically "stand back" from institutionalized rules to be able to attack or defend them or their variously perceived contradictions and incompatibilities. Consequently, agent-structure dualism, while problematic if not rigorously conceptualized, cannot be eliminated from structuration theory without paying too high a price, that is without sacrificing the agent to the constraints and affordances of structure.

**DISCUSSION**

Structuration theory has several theoretical (as well as meta-theoretical) implications for classification research in general and for construction of diagnostic classifications in particular. As mentioned earlier, structuration theory allows not only for theorizing processes leading to change and continuity within theoretical systems but also facilitates theory-guided specification of generative mechanisms, processes underlying system dynamics that account for their surface manifestations. Such a distinction exists in psychiatric classification as the ongoing interlevel debate between etiological explanation and symptom description.

Second, not only does structuration theory focus our attention on situated practices as constitutive frames for understanding structures, but it also maintains that classification is an inherently social practice and, as such, cannot be understood without reference to the larger forces in which it, as a social practice, is embedded. The manual must be understood not only as the official nomenclature and classification of the American Psychiatric Association but also as a field of competing and intersecting forces, including psychiatrists, psychoanalysts, clinical psychologists, clinical social workers, psychiatric nurses, and insurers, each striving to control its ultimate form and content.

Equally applicable to library classifications, Kwasnik (1993), echoing the introduction to *DSM-III*, states that the *DSM*, as a conceptual structure intended to coordinate and articulate interaction (Schmidt & Bannon, 1992), is meant to facilitate and further the intradisciplinary necessary functions of providing a common language, an accurate diagnostic tool, and a standardized vocabulary. However, she asserts unequivocally that:

The mandate for [the *DSMs were*] . . . politically and economically
motivated: government agencies, insurance companies, benefits programs, and others wanted to be able to differentiate and “tag” patients with mental disorders unambiguously for the purpose of reimbursement, legal action, confinements and so on. (Kwasnik, 1993, p. 64)

Consequently, to nontrivially understand the development, amplifications, and uses of a discipline’s powerful conceptual structures—its official classifications-nomenclatures—it is imperative to account for both intradisciplinary and professional as well as societal, cultural, and historically situated forces and contingencies. As Bowker and Star (1991) said of the International Classification of Diseases (ICD), an even more widely used and thus consequential conceptual scheme, “the list cannot be made homogeneous, neutral and appeal to all parties” (p. 77) because different categories of developers and users have (often incommensurable) different needs and impose conflicting demands on its design.

De Grolier (1982), employing the seminal observation of cultural anthropologists Durkheim and Mauss (1903/1963) that conceptual classification systems depend upon and reflect social conditions, bibliometrically investigated classification structures from medieval times to the present as cultural artifacts, and suggests that library classifications both are correlated with conceptual structures prevailing at their respective times and are thus inextricably historically situated. Additionally, Britain (1975) and Batty (1969) looked at the cultural context and embeddedness of classification and subject indexing, especially differences between British and American classificatory practices.

Britain (1975) states that there continue to be strongly held, contentious opposing points of view about, and dissident reactions to, classification as a tool and as the basis for subject analysis precisely because there are neither transcultural nor panhistorical acceptance of any consistent set of underlying principles. He quotes A. C. Foskett approvingly that “practically any classification scheme one would care to examine, far from being objective as it should be according to the emphasis of classification theorists is likely ‘to reflect both the prejudices of its time and those of its author’ [i.e., the classificationist]” (p. 34).

He rightly concludes that librarianship, being a historically situated professional subculture, has “its own ideas, its norms, and its tools... [which] will always tend to reflect the larger culture of which it is a part—its ideas, its laws and mores and even its aberrations” (Britain, 1975, p. 35).

Batty (1969) asserts that, in addition to such extrinsic (or external) factors as the sociopolitical system (e.g., democratic versus oligarchic class structure) of a culture, the intrinsic meaning of indexing and classification systems vary and must be understood if such differences are to be appreciated rather than judged or blindly repeated. He concludes that:

To the Western European, classification is an almost inevitable method of expression: it seems so natural to order subjects or ideas into
groups, each with a group name that therefore allows the further collection of groups-as-units into higher classes still. To the Americans, classification has meant only one thing: shelf—"marking and parking". . . . It is not that there is any inability to understand how complex numbers are put together, or even how facet theory can be used to make a classification scheme: it is rather an inability to understand why they should be. [emphasis in original] (Batty, 1969, p.6)

Clearly, Batty is alluding to deeply held beliefs about the what, why, and how of library classification, and not merely to the more superficial (and probably more cross-culturally stable) technical abilities of classifiers to master any given scheme.

In sum, what Grob (1991) said of psychiatric nosology can be said of all attempts to classify and order, including LIS classificatory activities:

Classification systems are neither inherently self-evident nor given. On the contrary, they emerge from the crucible of human experience: change and variability, not immutability, are characteristic. Indeed, the ways in which data are organized at various times [and in various places] reflect specific historical circumstances. (p.421)

Nosologies and classificatory schemes are rarely, if ever, etched permanently in stone. They ineluctably grow out of specific historical contexts and reflect the various Zeitgeist of the times and places in which they were, and are, developed.

Reviewing three comprehensive, and currently used, library classifications, the Dewey Decimal Classification, Library of Congress Classification, and Bliss Classification, second edition, Langridge (1995) makes the apposite and salutary observation that:

The number, scope, and order of main classes represents a conscious or unconsciously held view of the world. . . . Yet all three systems, samples of a liberal humanist attitude, look alike when compared with Marxist schemes devised for Russia or China or with mediaeval schemes. [It seems likely that] . . . changes over long periods of time make different classifications appropriate to different epochs. The knowledge of the ancient world, the middle ages, and modern times are best accommodated by different schemes. (pp. 12-13)

Programmatically, structuration theory affords the study of library classification what it offers the study of the development and use of the conceptual structures and schemes of any other discipline: discursive penetration into the sociocultural conditions of the multiple perspectives that organize the context within which historically situated practitioners act.

CONCLUSION

In closing, the inability of Giddens's structuration theory, at least the version of it presented above, to theorize intentional transformative action has an unfortunate and particularly paralyzing relevance to the
ongoing revision of a living, yet institutionalized, text such as the manual. In general, change is problematic and only some sorts of it are always everywhere realistically possible. Unless we maintain the distinction between duality and dualism, allowing for agent-structure distanciation, implications of Giddens's structuration theory are that only an arbitrarily limited range of options will be possible for particular agents, that of possible changes only some will be known and desired, and that only an unrealistically limited range of those may be realized as the unintended consequences of agents' otherwise (but contentless and sterile) knowledgeably directed action. While Giddens emphasizes the importance of a critical reading and application of theory (see, for example, Giddens, 1984), he pays much more attention to the unintended consequences of social reproduction than to intentional creative transformation, which emphasis itself seems an ineluctable (unintended) consequence of his misguided and unsuccessful attempt to transcend agent-structure dualism.

According to New (1994), we intentionally change social structures by identifying them, the activities in which they are used, and their role in the reproduction of the social system to determine their liability or susceptibility to change. Moreover we, as knowledgeable agents, need to understand how these social structures simultaneously enable and constrain various position-practices, and how, by offering channels for agents' purposes, those generative rule-resource sets themselves consciously motivate. Consequently, New (1994) rightly concludes:

[Effective “reflexive appropriation” requires agents to recognise their own structural capacity and to use it to the full, or act to increase it. . . increasing our understanding of all the “unacknowledged conditions of action,” which would include unconscious sources of motivation, is likely to reduce the proportion of unintended consequences. . . . The better these are theorised, the more likely that the chosen policy will fulfill its [intended] purposes. (p. 203)]

In the final analysis, knowledgeable transformative action presupposes intentionality. Otherwise, we will be left in the ironic and unenviable position that "society is transformed by knowledgeable agents," that this represents an "achievement," and that nevertheless these knowledgeable agents know not what they do, since they both change and reproduce society by mistake, unintentionally, as a side effect of everyday social life" (New, 1994, p. 200). Unless we successfully theorize intentional processes of social change, for example, by acknowledging the situated reality of agent-structure dualism (or subject-object distance), agents, such as the psychiatrists of this paper's title, are unhappily and unnecessarily reduced to Garfinkel's "judgmental dopes," despite Giddens's protestations of knowledgeability, producing invalid diagnoses for seemingly valid organizational and professional reasons.
NOTES

1 This, of course, is a rather broad transposition of Marx's celebrated aphorism, "Human beings make their own history, but not in circumstances of their own choosing" (cited in Cohen 1987, p. 273). However, Giddens takes Marx's point very seriously; in fact, one could cogently argue that a large part of the Giddensian project is directed at explicating the full import of that aphorism. Additionally, throughout the paper the acronym DSM will be used to refer to various editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

2 According to structurational analysis it is essential to distinguish between the study of structure-agency interdependencies at both the social and systemic levels. Consequently, there are two principal ways to study social system properties, each of which is separated out by a methodological epoche:

- To examine the constitution of social systems as strategic conduct is to study the mode in which actors draw upon structural elements—rules and resources—in their social relations. "Structure" here appears as actors' mobilisation of discursive and practical consciousness in social encounters. Institutional analysis, on the other hand, places the epoche upon strategic conduct, treating rules and resources as chronically reproduced features of social systems (Giddens, 1979, p. 80).

However, the introduction of the duality/dualism typology enables a more nuanced interpretation than the binary (and, perforce, reductionistically false) methodological bracketing advocated by Giddens.

3 For full treatments of structuration theory, it is essential to read Giddens's evolving and variously nuanced accounts, which can be found in Giddens (1979, 1984, 1993) among others.

4 According to Cohen (1989), "structure 'exists' in manifest form only when it is instantiated in social practices. It otherwise persists between instances of social reproduction only as 'memory traces' sustained by knowledgeable social agents" (p. 46). Mouzelis (1995, p. 138) correctly observes that:

"a proper study of the linkages between a micro and a macro approach should not take the form

\[
\begin{array}{c}
\text{Institutional Structures (macro level)} \\
\downarrow \\
\text{Participants (micro level)}
\end{array}
\]

but the more complex configuration

\[
\begin{array}{c}
\text{Macro Institutional Actors} \\
\downarrow \\
\text{Micro Institutional Actors} \\
\downarrow \\
\text{Macro Actors} \\
\downarrow \\
\text{Micro Actors}
\end{array}
\]

Simply put, Mouzelis's more complex configuration posits that the consequentiality of an actor's actions for others can be large (macro) or small (micro), whether the actor is a single individual or a collective.

5 One of Giddens's important contributions to social science research is the realization that such analysis always involves a double hermeneutic:
The intersection of two frames of meaning as a logically necessary part of social science, the meaningful social world as constituted by lay actors and the metalanguages invented by social scientists; there is a constant "slippage" from one to the other involved in the practice of the social sciences (Giddens, 1984, p. 374).

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The so-called neo-Kraepelinians comprised a relatively small group of research oriented psychiatrist-nosologists, who, in the 1960s and 1970s, promulgated tenets of diagnostic classification first advanced by nineteenth century German nosologist, Emil Kraepelin. Their credo can be summarized as follows: psychiatry is a branch of medicine and should seek to establish scientific knowledge; psychiatry treats people who are sick, and who can be reliably distinguished from those who are well; psychiatry should conceive of mental illnesses biologically, as discrete isolatable entities; and classification and diagnosis are important and legitimate areas of research within the biomedical science of psychiatry. For detailed treatments of the neo-Kraepelinians see, for example, Blashfield (1984) and Klerman (1978).

According to Abbott (1988), the successful advancement of a profession's knowledge base is central to its jurisdictional strength. He states that:

the academic knowledge system of a profession generally accomplishes three tasks—legitimation, research, and instruction—and in each it shapes the vulnerability of professional jurisdiction to outside interference. Legitimacy provides a central foundation for jurisdiction, and its absence provides a central line for attack. . . . The academic knowledge system also provides new treatments, diagnoses, and inferences for working professionals; if it fails in this function, professional jurisdictions gradually weaken. (pp. 65-67)

Giddens (1979, 1984, 1993) distinguishes two types of resources: allocative, arising from command over objects and material phenomena, and authoritative, arising from capabilities to organize and coordinate the activities of social actors. These clearly have implications for use of the DSM. For example, allocative resources pertain to the eligibility of DSM diagnoses for third party reimbursement, while allocative resources refer to the power of the DSM to construct mentally ill identities.

Sewell (1992) makes the useful point that if structures are virtual, then they cannot include both rules and resources, and if they include both, they cannot be virtual. Resources, as media of power, and particularly allocative resources, must exist materially, and thus cannot be considered virtual. Thus, Sewell (1992) suggests that structure should refer only to rules or schemas, not to resources, which are better seen as effects of structures, as "media animated and shaped by structures, that is, by cultural schemas" (p. 11).

According to Giddens (1984), the dialectic of control is characterized by "the two-way character of the distributive aspect of power (power as control); how the less powerful manage resources in such a way as to exert control over the more powerful in established power relationships" (p. 374).


On the syntagmatic level [actual relationships], subject-object dualism refers to situations where a subject's participation in a game does not seriously affect its outcome, whereas duality refers to situations where the opposite is true.
On the paradigmatic level [virtual linkages], actors can, for strategic/monitoring reasons, distance themselves from rules (paradigmatic dualism); or they can use rules in a taken-for-granted manner (paradigmatic duality). (p. 156)

Thus, on the one hand, in terms of practice, dualism (separation) connotes little consequentiality, while duality describes situations wherein the consequences of an actor's practice for others are large and compelling. On the other hand, in terms of the structural properties of social practices, duality (closeness) refers to a performative relationship of actor to object, while dualism describes situations in which actors distance themselves from formal structures for strategic purposes. Only by considering the consequences of the full range of relationships that actors have with rules and resources at both strategic conduct and institutional analytic levels can we fully account for the irreducible logics of the dispositional, interactive-situational, and positional dimensions of social action.

An admittedly arbitrary overview of social scientific realism posits that knowledge is a social product and lacks any sort of secure foundations; that there is a knowable external world; that while the social world is a construction, it is profoundly constrained by a specific history that provides agents with the materials for continued reproduction and, less frequently, transformation; and that valid social science aims to explain rather than predict. As to whether Giddens is a realist, there seems to be little doubt, but what kind of realist he is has been the subject of some debate. Some complain that he emphasizes structure over agency, others that he privileges agency over structure, and finally some accuse him of merely conflating agency and structure, explaining neither. In addition to Mouzelis's (1995) critique, as presented in this paper, for differing but suggestive viewpoints, see, for example, Archer (1982), Layder (1987, 1990), Pawson (1989), the collected essays in Bryant & Jary (1991) and Held & Thompson (1989), and finally the special issues of *Theory, Culture, and Society* (1982), 2(2) and *Journal for the Theory of Social Behavior* (1983), 13.

**References**


