

5-1-2018

What does a diagnosis of Asperger's syndrome mean to a school-aged Japanese client? A case study illustrating the use of positioning theory

Hatsuho Ayashiro

Komazawa Women's University (Japan), hatsuho.ayashiro@gmail.com

Follow this and additional works at: <https://scholarworks.lib.csusb.edu/wie>



Part of the [Counseling Commons](#), and the [Counseling Psychology Commons](#)

Recommended Citation

Ayashiro, Hatsuho (2018) "What does a diagnosis of Asperger's syndrome mean to a school-aged Japanese client? A case study illustrating the use of positioning theory," *Wisdom in Education*: Vol. 8 : Iss. 1 , Article 2.

Available at: <https://scholarworks.lib.csusb.edu/wie/vol8/iss1/2>

This Article is brought to you for free and open access by CSUSB ScholarWorks. It has been accepted for inclusion in *Wisdom in Education* by an authorized editor of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.

What does a diagnosis of Asperger's syndrome mean to a school-aged Japanese client? A case study illustrating the use of positioning theory

Abstract

Many researchers and practitioners refer to diagnoses of mental disorders in their work. While possibly suggesting helpful perspectives, this practice has also been criticized. A previous study suggests that such references produce a deficit discourse that enfeebles clients. However, some Japanese who are diagnosed with developmental disorders state that their diagnoses help them to assert themselves. What, then, does the diagnosis mean to the client? To examine this question, I studied from a discursive perspective the case of a Japanese client diagnosed with Asperger's syndrome, using Rom Harré's positioning theory. In analyzing the data, four positions (deficit, competent, abnormal, and normal) were found. The diagnosis influenced the client and those around him to engage in a deficit discourse, featuring identification of the person with the diagnosis (totalizing language) and normalizing judgments. These results suggest that Asperger's syndrome could function as a double-edged sword that both gives the client the right to assert himself and forces him to accept that he has a deficit or is abnormal. This can be called an Asperger's-syndrome position. I recommend non-normative practices proposed previously, to neither deny nor normalize the diagnosis.

Keywords

diagnosis of Asperger's syndrome, deficit discourse, discourse analysis, positioning theory, totalizing language, normalizing judgment

Author Statement

Dr. Hatsuho Ayashiro is a lecturer in the College of Human Studies at Komazawa Women's University and a certified clinical psychologist in Japan. He was a visiting scholar at California State University, San Bernardino from June 2014 to February 2015.

Cover Page Footnote

I would like to thank Enago (www.enago.jp) and Editage (www.editage.jp) for the English language review. This work was supported by Grant-in-Aid for Leading Initiative for Excellent Young Researchers (LEADER) Grant Number J170000117.

INTRODUCTION

Diagnoses of mental disorders are used for gaining insight into individuals by many researchers and practitioners such as counselors, therapists, psychologists, and teachers, as well as by psychiatrists. Diagnosis provides perspectives for helping people. For example, when counselors have some knowledge of schizophrenia, they may be able to think of effective ways to help people with this diagnosis, instead of seeing them as experiencing something strange. In some cases, such people would feel ashamed of their condition, "I'm crazy because I think differently from others." Diagnosis can make them understand that their suffering is not unique. Knowing this can decrease negative feelings. When a teacher finds that a student has ADHD, attention-deficit hyperactivity disorder, for instance, they can search the internet or a library for ways to manage the student's behavior instead of blaming them. In summary, diagnosis can provide people with evidence-based practices, reassurance, and useful information (Craddock & Mynors-Wallis, 2014). Moreover, researchers can more easily develop effective practices and intervention programs for people with a defined mental disorder. If they had no definitions or guidelines for depression, for instance, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD), this condition would become difficult to study. In the absence of such agreed-upon definitions, it would be also

impossible for practitioners to communicate with each other about their clients. Even if they all used the same term, such as social anxiety disorder, they would all have different understandings of it. Thus, diagnosis gives mental health professionals the definitions needed to discuss mental disorders with precision (Hyman, 2010; Rössler, 2013).

However, the use of diagnoses of mental disorders has been criticized as well, even when such diagnoses seem to benefit practitioners and researchers. For example, some people mention that the concept of depression could be a device for labeling societal problems as individual problems (Elliot & Chambers, 2004). Support for this view comes from facts such as the economic recession having continued in Japan for about 20 years, and Japan also having a high rate of suicide. A large-scale study at Kyoto University (2006) revealed that, statistically, suicide is best predicted by unemployment, yet suicide is often linked to an individual factor such as depression. It has also been claimed that a recent increase in the prevalence of mental disorders is profit-driven, due only to some pharmaceutical and biotechnology companies trying to increase their sales of medications (Conrad, 2005). In fact, some Japanese psychiatrists have suggested a close relationship between the appearance of SSRIs on the market and the increase in numbers of patients diagnosed with major depressive or bipolar disorder (Ihara, 2011; Tomitaka, 2009). Others claim that the evaluation of mental symptoms has been altered for business reasons to

follow American standards such as the DSM (Watters, 2010), despite the fact that the diagnosis of a mental disorder reflects socio-cultural values that influence people's experience of mental disorders (Kitanaka, 2014). For example, "depressive" states in Sri Lankan culture can be seen not as a sign of a mental disorder but rather as an indicator of being a good Buddhist (Obeyesekere, 1985). This implies that the diagnosis of a mental disorder reflects the diagnosing person's inner state of mind, which is, in turn, constructed by wider contexts such as society, culture, and economics. As discussed above, it is true that we can benefit from diagnoses of mental disorders. They can aid us in understanding and helping our clients. At the same time, however, we should be careful when referring to such diagnoses to refrain from assuming that the diagnosis defines the client.

The above discussion focuses mainly on the interests of practitioners and researchers. What does the diagnosis of a mental disorder bring to the client? This question is of deep concern in my work because I am a clinical psychologist in Japan and have worked in the educational field, where formal diagnosis is not always a precondition for treatment as it is in the medical field. Diagnosis must necessarily vary across cultures and societies, as well as according to type of mental disorder. Thus, I will describe a specifically Japanese example of a developmental disorder.

Developmental disorders are well-known in Japan, where Amazon offers almost 3000 books on the topic.

Japan also has many television shows that feature individuals with developmental disorders, websites devoted to developmental disorders, and a famous fashion model who has "come out," admitting that he has a developmental disorder. These disorders have become of such concern or popularity that many people are willing to wait for long periods to be examined by a doctor (for ten months in one case) due to a shortage of hospitals and clinics (Ministry of Internal Affairs and Communications, 2017). Some claim that these disorders have become popular, partly because the Japanese government enacted support for persons diagnosed as having a developmental disorder in 2005 (Litalico Hattatsu Navi, 2016). The new law covers those diagnosed with autism, Asperger's syndrome, attention-deficit hyperactivity disorder, learning disabilities, and so on, and it aims to ensure that persons so diagnosed are respected and allowed to live their daily and social lives as individuals with fundamental human rights. The Ministry of Internal Affairs and Communications (2017) concludes that understanding and support for those with developmental disorders has improved since the law came into force.

Interestingly, many people diagnosed with developmental disorders seem to think of their diagnoses as something positive. For example, one woman who was diagnosed with autism spectrum disorder told the following story on a website: "Right after I was diagnosed, I was relieved and thought, 'That's just what I expected.'"

This woman felt that, “For me, (the term) developmental disorder is ‘simply a user’s guide to myself,’ which makes my life a little bit easier.” (Matsumoto, n.d.). Another man wrote on Twitter: “I am a developmental disorder person. I would be in trouble without the term “developmental disorder.” For us, it is a symbol for expressing our ‘difficulty’” (Ishibashi, 2016). This tweet was in response to the following tweet by a journalist: “I hate the term ‘developmental disorder.’ What is normal and what is abnormal? It is a convenient term for guys who want to judge everything in black and white” (Ito, 2016). In brief, for the second person quoted, the diagnosis was a useful tool for expressing himself clearly, rather than a negative label as the journalist had implied. Although I have no data on how many people diagnosed with developmental disorders agree with this point of view, the journalist’s tweet was criticized by many who had been so diagnosed. It seems certain that some people in Japan think of their diagnoses as being useful in their daily lives.

Deficit Discourse and Totalizing Language

It has been said, however, that a diagnosis of a mental disorder can influence people negatively. Gergen (1994) suggests that such a diagnosis can lead clients to see themselves as people who cannot solve their problems on their own, as if it were a diagnosis of cancer. As a result, they come to depend on professionals such as psychiatrists and psychologists. In brief, a diagnosis of a

mental disorder could deprive clients of their power to solve their own problems. This is known as self-eneffement. According to Gergen, it arises from the deficit discourses behind the diagnosis.

A discourse is a particular set of views or texts that are saturated with socio-cultural meanings, stories, images, metaphors, and so on. A discourse is used as an interpretive frame for seeing events and listening to words (Burr, 1995). Deficit discourse is a phenomenon of psychiatry and psychology, and it leads to the view that those who are diagnosed with a mental disorder lack something and in effect, that they themselves are the problem. Here is an example. One of my clients was diagnosed as having an intellectual disability and was in a special education class. After he got into a fight with students attending regular classes, he claimed that he did not break a window even though he broke a locker. Although he asserted that the other students broke the window, a vice-principal said to him, “Your head was messed up, right?” This utterance clearly reflected a deficit discourse behind the diagnosis. The client’s explanation was enough to be understood, but it was seen as unworthy of consideration because the client suffered from an “intellectual disability.” In the end, he became the cause of the problem.

This case shows an example of totalizing language, i.e., words or phrases that totalize a person (Cheney, 1989; Winslade & Williams, 2012). When a person is described by totalizing language, such as that of having a

developmental disorder or an intellectual disability, the person is then seen only as such a person and, consequently, his or her unique qualities are ignored, even though he or she has many different stories. This occurs because the deficit discourse behind totalizing language is reductionist (Winslade & Williams, 2012). If a person broke a window, there could be many reasons why he or she did so. If the person were totalized with a mental disorder, however, the problem would be reduced to a deficit of his or her mind. In brief, deficit discourse totalizes a person as the problem, instead of encouraging people to bear in mind that only the problem is the problem (White, 2007).

The Increase in Deficit Discourse in the Schools

Deficit discourse can be useless in educational fields. This is because a medical model based on diagnosing and treating does not help children learn (Winslade & Williams, 2012). A student may well have other, more positive stories of himself such as, “I am a good singer.” His teachers or friends may have other favorite stories such as, “His sense of humor is amazing.” When deficit discourse dominates in schools, however, it becomes much harder for people to recognize the existence of alternative stories that tend to contradict the problem stories. A school provides a chance for students to learn how to live with others inclusively rather than exclusively. This is what people in democratic societies need to learn.

It is impossible, however, for students to learn this in a school where deficit discourse dominates.

Winslade and Williams (2012) point out that deficit discourse has become increasingly common in schools. While this point was made in the context of schools in New Zealand and the U.S.A., Japan is in a similar situation. The Japanese Ministry of Education, Culture, Sports, Science, and Technology (2012) surveyed 600 elementary and junior high schools in Japan, recording the numbers of children who seemed to have developmental disorders. The report showed the ratio of students who needed special education and possibly had a developmental disorder, not the ratio of students who actually had a developmental disorder. The survey, however, used questionnaires that assessed students for learning disabilities, attention-deficit hyperactivity disorder, and autism spectrum disorder, to examine the domains of learning, behavior, and social relationships. In addition, the survey was based on the observations of the teachers, rather than those of doctors. This meant that the teachers were forced to see their students from the perspective of deficit discourse. Because this survey has been influential and has impacted current education policies in Japan (e.g., Ministry of Education, Culture, Sports, Science, and Technology, 2016), deficit discourse is likely to become more common in the future.

What Does a Diagnosis of Asperger's Syndrome Mean to a Japanese Client?

As Gergen (1994) suggested, a diagnosis of a mental disorder can deprive people of their sense of agency, because of deficit discourse. Therapists who reproduce dominant discourses, including deficit discourses, risk suppressing their clients rather than helping them (Ayashiro, 2016; Hare-Mustin, 1994). Thus, mental health professionals and educators should be sensitive to using deficit discourse in their interactions with clients and students. As Winslade and Williams (2012) discussed, this is especially important when dealing with school-aged clients. However, judging by the experiences of individuals with developmental disabilities in Japan, some see their diagnosis as useful in their daily lives. Therefore, it is also important not to discourage a client's choice to use their diagnosis as "...a symbol for expressing our 'difficulty'" (Ishibashi, 2016), even though we specialists may see the diagnosis as problematic.

How, then, should we think about the diagnosis of a mental disorder, especially a developmental disorder, in Japan? The question is not what is right or wrong, but how counselors can best practice without ignoring either the dominant discourse or our clients' personal experiences (Winslade, 2005). To consider both, it is useful to study what a diagnosis of a mental disorder means to a person, in practice rather than in theory. Considering Winslade and Williams (2012) and the

current situation in the educational field, it is first necessary to examine what a diagnosis of a mental disorder means to school-aged people. Especially in Japan, it is important to focus on the diagnosis of a developmental disorder. However, one finds few relevant case studies to draw upon. Therefore, in this study, I examine the case of a Japanese student from my practice who was diagnosed as having Asperger's syndrome¹, one particular developmental disorder.

METHODS

Discourse Analysis and Positioning Theory

This study uses discourse analysis. This is an approach to analyzing data based on social constructionism, and it has no particular method or standardized procedure

¹ According to DSM-IV (American Psychiatric Association, 2000), Asperger's disorder is characterized by "qualitative impairment in social interaction... (for example, such as) failure to develop peer relationships appropriate to developmental level" and "restricted, repetitive, and stereotyped patterns of behavior, interests, and activities... (for example, such as) apparently inflexible adherence to specific, nonfunctional routines or rituals" (p. 84). [I used the term Asperger's "syndrome," not "disorder," because the client's psychiatrist had used it in communicating the diagnosis.]

(Burr, 1995; McLeod, 2001). To analyze the data from the perspective of discourse analysis, I used the framework of positioning theory (Harré & Moghaddam, 2003; Harré & van Langenhove, 1999). Positioning theory enables us to examine both social discourse and personal experiences (Winslade, 2005).

Position refers to a set of rights and duties that are given to people in a discourse. That I am a counselor means that I have a right to ask a client for private information such as, “Would you tell me what happened to you?” A client usually does not have the right to ask such things of me. In addition, what I say acts as a kind of command given to the client rather than a mere request. This idea originates from Austin (1962), who proposed the concept of a speech act. This means that a particular position determines what the person so positioned can, cannot, should, and should not do (Burr, 1995). We can understand such positions or acts, because they have developed in the context of counseling. However, if the context is that of a lovers’ conversation in a romantic movie, for example, the positions and acts would be different if a person said, “Would you tell me what happened to you?” Such context is also known as a story line. Thus, position, acts, and story line are connected in what is called the positioning triangle (Harré & Moghaddam, 2003).

The positioning triangle derives from the social discourse of counseling. Even though I may be very careful, asking something has the power to command

clients to some degree. This is because the position of counselor, the story line of counseling, and the acts of what a counselor says, are warranted not by myself but by our society or culture. If a society had no culture of counseling, people in the society would not talk using such a moral order.

While we cannot go outside of social discourse, it can be changed by our personal experiences. When I ask a client about something of which I know nothing, the client might position himself as a teacher who has knowledge about it, instead of as a client. This new story line might be called education at the time, rather than counseling. Although the social discourse of counseling would still be there, it might not dominate our interaction as much as it had before. If the counselor then asked the client, “Would you tell me what happened to you?” it might be interpreted as showing curiosity rather than commanding. Even if a social discourse is shared among people, individuals do not always have the same experiences. Thus, using the perspective of positioning theory is suitable for this study’s purpose.

Data Collection

The data are comprised of documents written by the counselor (the author) after each counseling session. The sessions were conducted in a public educational counseling center in Japan. The reason for choosing this case is that the client was a student in junior high school

(and later, high school) and was diagnosed as having Asperger's syndrome in the middle of the counseling period. This circumstance has enabled me to examine what the diagnosis meant to the client. In this study, therefore, the analysis focuses on the sessions where the client spoke in relation to the diagnosis.

The Client

The client was a 12-year-old Japanese boy at the first session. We had 97 sessions altogether, spanning nearly 4.5 years. At the first session, the boy's mother had brought him to a counseling center where I worked. She had found raising her son quite hard ever since he was born. For his part, the son complained about his parents, because they would not listen to him. He also sometimes spoke in our sessions of having difficulty with relationships with his friends.

Ever since the boy was bullied by his football team, he had suffered from anxiety. He therefore saw a consultation liaison psychiatrist between our 22nd and 23rd session. The psychiatrist diagnosed him as having Asperger's syndrome and communicated the diagnosis not to him but only to his parents. His parents concluded that this syndrome was the main cause of their difficulties with their son. About six months after the diagnosis, they told him that he had Asperger's syndrome. The boy did not immediately (i.e., at the next session) tell the counselor about his diagnosis.

Two months after entering high school, the boy dropped out because of a miserable school experience due to poor relationships with his friends. At almost the same time (the 36th session), the client first referred to Asperger's syndrome. After that session, we sometimes talked about Asperger's syndrome during counseling. For this study, I analyzed all sessions after the 35th.

The Counselor

I, the counselor, was a 26-year-old Japanese man at the first session. Although I had qualified in Japan as a clinical psychologist, I was then a beginner and had just started working at the counseling center, also in Japan. While I had learned basic counseling skills, simple methods of cognitive behavioral therapy, and non-directive play therapy, I had not majored in any particular therapy. Moreover, I was not conversant with discourse analysis or discursive therapies (Lock & Strong, 2012) until I was 29 years old, almost one year before the end of the period of counseling this client. Thus, the counseling reported here was not based to any degree on discursive approaches.

Ethical Approval

At the end of counseling, I told the client and his mother that I was interested in what had occurred during our sessions and asked for permission to use the data in a publication. They then gave written consent for it to be

so used. I also received approval for this use from the head of the public educational counseling center. I have changed some of the names in the data to preserve the anonymity of the client.

Analytic Procedure

I analyzed the data as follows. First, I read the session transcripts multiple times to examine the words and expressions in detail. Next, I extracted several sessions in which the phrase Asperger's syndrome appeared, and identified the story lines that contextualized the term. Finally, I examined how a diagnosis of Asperger's syndrome and the related deficit discourse are expressed, mainly by focusing on the client's positions and acts in these story lines. In this study, I did not examine the counselor's utterances, despite these being very important. This was because the written data had rarely included them. I analyzed the data in Japanese and translated the extracts into English after analysis. The present paper, including the extracts, has been checked by

native English speakers and copyedited by a native English speaker.

RESULTS

Analyzing the data, I found that the client took one of four positions (deficit, competent, abnormal, or normal) when talking about Asperger's syndrome. In this section, I examine these positions in relation to several excerpts drawn from the counseling process.

The Deficit Position and Self-Enfeeblement

When he first referred to Asperger's syndrome in counseling, at the 36th session, the client was positioned as in deficit. The diagnosing psychiatrist had told him that he had "no common sense", because he had left something behind at home that he was supposed to bring to the appointment. The counselor asked him if he felt bad to be told that. He answered as follows.

Excerpt 1 (36th session)

| | | |
|---|--------|--|
| 1 | Cl: | No. Well, I thought it was right. My parents were also told by him (the psychiatrist), |
| 2 | | “People who have Asperger’s (syndrome) should be taught common sense because |
| 3 | | they lack it.” So, my parents said to me: “Why don’t you take lessons about |
| 4 | | Asperger’s and common sense from Mr. Ayashiro (the counselor)?” |
| 5 | Co:Cl: | No common sense? |
| 6 | | They said, “You tried to apply to too high-level high schools where you couldn’t be |
| 7 | | admitted. You also said that you would become a football player. We thought that |
| 8 | | made no sense.” |

Co, counselor; Cl, client; ((...)), ellipsis; (), author’s edit for clarification.

The story line here was that the boy was being positioned as having Asperger’s syndrome by his psychiatrist (lines 2–3) and his parents (lines 3–4). This was approximately deficit discourse, because those who had Asperger’s syndrome, including him, were suggested to be lacking something (line 3). In this story line, even the boy’s past hopes of enrolling in a high school and becoming a football player were seen as signs of his problem (lines 6–8). Moreover, his parents recommended that the boy be taught common sense by his counselor (lines 3–4). This was a kind of self-enfeeblement (Gergen, 1994), because the boy was seen as one who could not resolve his “problems” without professionals. Therefore, his position in the story line was one in which he had a deficit.

It is also important that the client seemed to accept the deficit position uncritically. He admitted that what the psychiatrist had said was right (line 1). Moreover, he had

indeed left something behind at home that he was supposed to bring to the psychiatrist, but it is possible to see this event as a simple lapse of memory. In the story line, however, his forgetting was a sign that he had Asperger’s syndrome. From this discursive perspective, the boy’s acceptance of the deficit position could be seen as indicative of the force of deficit discourse. As Winslade and Williams (2012) have pointed out, children and young people are vulnerable to positioning by deficit discourse from adults and tend to internalize such positions eventually. The force of the discourse becomes stronger when such positioning comes from professionals. Thus, it is no wonder that the boy agreed with the deficit position. The position was derived not from him, but from the adults around him, especially his psychiatrist.

Asserting Himself Through the Deficit Position and the Competent Position

The client sometimes used the diagnosis of Asperger’s syndrome for his own ends, even though it positioned

him as having a deficit. At the 39th session, the boy complained about his parents. According to him, they had not allowed him to join a football team, although they had promised to. He then told the story described in excerpt 2.

Excerpt 2 (39th session)

| | | |
|---|-----|--|
| 1 | Cl: | I remember good things. Well, it’s kind of a flashback. Thanks to football, I could talk |
| 2 | | with friends. Life would be too boring if I couldn’t play football. I have Asperger’s, |
| 3 | | and so I must play football. I’ll never go to school if they (his parents) don’t let me |
| 4 | | play football. Tell them that, please. |

The story line here is how important football was for him, considering the boy’s reference to a “flashback” (line 1) and “Asperger’s” (line 2). These words were related to deficit discourse. At the end, he asked the counselor to tell his parents to let him play football (line 4). Gergen (1994) also admitted that deficit discourse makes people sympathetic to those who have been diagnosed as having mental disorders, because they are seen to be suffering from an illness. Deficit positioning, therefore, could be

seen here as a speech act aimed at justifying the client’s hope of playing football.

During the 40th session, the client showed similar speech acts. He narrated a story in which he complained about his parents. It was influenced by a significant conflict with his parents that had occurred between the 39th and 40th sessions. In excerpt 3, he described how much he disliked them.

Excerpt 3 (40th session)

| | | |
|----|-----|---|
| 1 | Cl: | My parents, both my mother and father, only get on my nerves. I have no good |
| 2 | | feelings about them. They said they read many books on Asperger's, but they know |
| 3 | | nothing about how to relate to people with Asperger's. I hate my parents, that's all. |
| 4 | | Us just talking here now can't change them. You have telephoned me before. You can |
| 5 | | do that, so why can't you counsel them? |
| 6 | Co: | I can't do that because I'm your counselor. What I can do here is listen to your |
| 7 | | complaint, do something to make you feel at ease, or consult with you on how you |
| 8 | | live. |
| 9 | Cl: | There's no way out. My parents don't understand Asperger's. |
| 10 | | ((...)) |
| 11 | Cl: | I'm going to get some sickness other than Asperger's. There is no place in the world |
| 12 | | to escape stress. They (his parents) should change. It's unfair for me to change. |

The client blamed his parents for not knowing "...how to relate to..." (line 3) or not understanding (line 9) people with Asperger's syndrome (including himself), as well as for getting on his nerves (line 1). He also said that he would get "...some sickness other than Asperger's" due to the stress from his parents (line 11). The story line was that the problem was his parents, who did not comprehend Asperger's syndrome, and that it was not him who had the problem. This led to the conclusion that

his parents should change rather than him (line 12). Thus, positioning the boy as having Asperger's syndrome made him justify himself to his parents and the counselor.

Interestingly, the diagnosis of Asperger's syndrome sometimes even provided the client with a competent position. At the 46th session, he asked the counselor to describe the characteristics of Asperger's syndrome. He explained his reasons as shown in excerpt 4.

Excerpt 4 (46th session)

| | | |
|---|-----|---|
| 1 | Cl: | Asperger's people have great powers of concentration. I wanted to know my strong |
| 2 | | points and weak points. A famous doctor Mori said that Ichiro was an Asperger, and |
| 3 | | so he had special talents. I hope to attain powers of concentration like his. |
| 4 | | ((...)) |
| 5 | Co: | What do you want to accomplish by knowing the characteristics of Asperger's? |
| 6 | Cl: | I want to do athletics. It's an individual event. Well, I want to take part in a |
| 7 | | tournament. My muscles are still a problem, but I'm young. I'll develop them before |
| 8 | | it's too late. |

The client positioned himself as having Asperger's syndrome, but in a way that was positive, not negative. This was because he had heard that those with Asperger's syndrome, such as Ichiro, a famous baseball player, also have special talents. Although the client admitted to having weak points (line 2), he emphasized that he also had strong points, by making claims like: "Asperger's people have great powers of concentration." (line 1) The boy felt that if he could use his strong points, he might become an athlete in the future (lines 6–8). The story line here was, therefore, that he had potential because he had Asperger's syndrome. This was still along the lines of deficit discourse, but his position could be described as one of competence rather than deficit. In brief, the boy could be competent because he had Asperger's syndrome.

While a diagnosis of Asperger's syndrome constructed the boy as having a deficit, it could also provide him with

the means to justify himself and even the possibility of having potential. In a sense, the boy received the right to assert himself positively, which might have been impossible without his having been diagnosed as having Asperger's syndrome.

Asperger's Syndrome as Totalizing Language

In the previous excerpt, the client seemed to have confidence arising from his having Asperger's syndrome. In the 46th session, however, his story line changed. After the interaction in excerpt 4, we read part of a book that provided an introduction to Asperger's syndrome, in accord with the client's wish to learn the characteristics of Asperger's syndrome. Excerpt 5 shows the interaction after this reading.

Excerpt 5 (46th session)

| | | |
|---|-----|--|
| 1 | Co: | Are there characteristics (written in the book) that apply to you? |
| 2 | Cl: | Weak at friendships, inflexible, poor at jump rope and the bar when I was in |
| 3 | | elementary school, though I was good at PE. I always act quite ahead of schedule. I |
| 4 | | didn't see my habit of saying something bad to others, as I sometimes did when I was |
| 5 | | in junior high school. I also flashbaced to elementary school days. |

The boy's position was now one of deficit and having many negative features along with a deficit discourse. When the counselor asked the client whether there were some features written in the book that applied to him (line 1), he told a story about his past experiences, mainly from his school days (lines 2–5). In other words, his past experiences were described as providing evidence that he had Asperger's syndrome. Therefore, the diagnosis of Asperger's syndrome here led to totalizing language that

summarized the boy in one phrase or word (Winslade & Williams, 2012). The client might have had many experiences in his past contradicting the features of Asperger's syndrome. His past experiences here, however, were reduced to those of Asperger's syndrome.

Such totalizing could lead to others seeing him in a negative light rather than seeing him positively as a competent individual. Therefore, this would lead the client to hide his diagnosis from others.

Excerpt 6 (46th session)

| | | |
|----|-----|---|
| 1 | Cl: | I see myself as having Asperger's (syndrome), but I want to keep it secret from my |
| 2 | | friends. If I become a famous athlete, it would draw media attention and then people |
| 3 | | would say of me, "(client's name) has Asperger's." I would deny it. I don't want to be |
| 4 | | seen like that. Of course, some people would then see me as grossly autistic. I don't |
| 5 | | want to be seen as disabled. Should I say so? |
| 6 | Co: | It depends on you, to quote a counseling formula, but I suppose you could tell it to |
| 7 | | some people but not to other people, right? |
| 8 | Cl: | When people belittle me for it, I'll reject them. I'll have relationships with people who |
| 9 | | don't judge me like that. However, I would want to deny it if I'm asked if I have |
| 10 | | Asperger's. |

As the client had described in excerpt 4, he seemed to believe that he could become a competent athlete (line 2). The main story line here, however, was that he would not describe himself to others as having Asperger's syndrome. He suspected that some people would think of him as being disabled, such as is the case with autism (lines 4–5). While he would have relationships with people who did not judge him for the fact that he had Asperger's syndrome, he would deny the fact itself if he was asked whether he had Asperger's syndrome (lines 9–10). These narratives reflect the fact that he identified himself as

Excerpt 7 (57th session)

| | | |
|---|-----|---|
| 1 | Cl: | The team had a number of hooligans. I was a stranger. Some were good players from |
| 2 | | city or prefecture leagues, and I couldn't get used to the team because they'd already |
| 3 | | developed their own camaraderie. And I couldn't get used to things because I didn't |
| 4 | | know I had Asperger's. So, I got bullied and I left the team. |
| 5 | Co: | You got bullied? |
| 6 | Cl: | I got tackled hard and left out of plays. Many tackled me behind the coach's back.... I |
| 7 | | couldn't get used to it partly because I had Asperger's. |

According to the boy, the reason he could not get used to the team (lines 3–4), and even the reason he was bullied by teammates (line 4), was that he had Asperger's syndrome. It was important for him to connect Asperger's syndrome with the problem of his competence at getting used to things (lines 3–4). This reflected the fact that he thought of it as inside him. It was also important for him to say "...because I didn't know I had Asperger's." (line 4). This implied that he could have avoided the

having Asperger's syndrome and that he was now focused on other's judgments of him rather than on his potential competence.

Excerpt 7 clearly shows the problem of diagnosis with Asperger's syndrome as involving totalizing language. In the 57th session, the boy said that he could overcome the flashback from his school days using a training method taught by an instructor, whom he respected. When the counselor asked the client about the flashback, he told a story about a football team to which he had belonged in junior high school.

bullying if he had known. Therefore, he was wrong, not his teammates. This was because Asperger's syndrome was inside him, and he could prevent the bullying if he could recognize and control the deficit inside him.

If he had no competence in getting used to people (line 3 and lines 6–7), he would have had no relationships with his other friends and the counselor. Even if he was not good at building up relationships with others, this never justified the bullying. In fact, the boy said "The

team had a number of hooligans” (line 1). These might be alternative story lines. However, the boy summarized his story of suffering as caused by a deficit stemming from his having Asperger's syndrome (lines 4 and 7). In summary, the totalizing language of Asperger's syndrome led to the conclusion that he was wrong.

Analyzing the data, I found that the client finally tried to be “normal,” by which he meant behaving like people who did not have Asperger's syndrome. During the 68th session, the client told the counselor that he was going to see his friends from his former high school after the session. When the counselor asked the client about his new school, he answered as follows:

Normalizing Judgment and Abnormal and Normal Positions

Excerpt 8 (68th session)

| | | |
|---|-----|---|
| 1 | Co: | Do you have friends at school too? |
| 2 | Cl: | Yes, and I'm on speaking terms with them. I talk more often than you would expect. |
| 3 | | When we get together before starting a part-time job, I usually talk with them. I've |
| 4 | | gotten better at doing that. Since I've known I had Asperger's, I know that I have to |
| 5 | | talk with others to know what they think. |
| 6 | Co: | You grew up. |
| 7 | Cl: | I satisfactorily grew up. |

In excerpt 8, the client could have reciprocal conversations with others more frequently than before. He seemed to have confidence about this, for example, when he stated: “I talk more often than you would expect.” (line 2), and “I satisfactorily grew up.” (line 7). According to him, the secret of his getting “...better at doing that” (line 4) was that he had realized that he had Asperger's syndrome and had thus made an effort to be conscious of what others thought (lines 4–5).

The boy's experiences of talking with others well (lines 3–4) could be seen as an exception to the story lines of deficit discourse. In addition, his promising to see his friends later in the day and having had a good conversation with the counselor so far showed the existence of realities distinct from that of the deficit position. However, he (and the counselor as well) were unable to grasp this. Instead, they constructed the story that the boy with Asperger's syndrome grew up. This meant that Asperger's syndrome totalized his story lines

as those of deficit discourse. He could say that he had grown up because he had adopted having a deficit in talking with others due to his Asperger's syndrome.

The reality that the boy had Asperger's syndrome positioned him quite negatively, as seen in the following excerpt. During the 72nd session, we played a table

football game after talking about his hopes of going to university and his daily life, such as his part-time job and his athletics training. The client suddenly stopped playing the game and started crying as he was talking, as described in excerpt 9.

Excerpt 9 (72nd session)

| | | |
|---|-----|---|
| 1 | Cl: | I suddenly remember my parents or something. Well, it's like a flashback. I've |
| 2 | | communicated with some people so far, but they aren't my generation. People don't |
| 3 | | play table football (game) at my age. I should be getting counseling instead of this. I |
| 4 | | suspect I'm seriously crazy. My parents said to me (that I have) Asperger's. So, I tried |
| 5 | | to be normal but I couldn't, as I expected. I don't know how to be normal. Now we |
| 6 | | are playing table football. I wonder if it's strange. I wonder if you see me as crazy for |
| 7 | | playing it. |
| 8 | | ((...)) |
| 9 | | You know, I think I'm crazy. I also think I shouldn't have been born. |

Here, the boy provided a story line in which he was crazy. In this story line, playing a table football game demonstrated that he was crazy (lines 2–3 and lines 6–7), and that he needed counseling (line 3). In addition, the boy seemed to think communication was meaningless because he had not communicated with people from his own generation (line 2). In brief, he "...tried to be normal..." but could not (line 5). For him, the counselor also thought he was crazy (lines 6–7). As a result, he concluded, "...I'm crazy...I shouldn't have been born." (line 9).

These narratives partly include normalizing judgment (Foucault, 1975; White, 2007), while they also reflect self-enfeeblement (Gergen, 1994) and totalization (Winslade & Williams, 2012). A normalizing judgment is a tool for controlling people used in modern societies, which makes people judge themselves when they deviate from any "normal" standards such as "correct behaviors," "average students," "having common sense," and so on. His utterance "People don't play table football at my age" (lines 2–3) showed that the boy judged himself against a "normal" social standard. According to Foucault (1975),

if people deviate from standards, they are subjected to punishment and standard discipline to correct the deviation. The client stating, "...I tried to be normal but I couldn't, as I expected." (lines 4–5) could imply that his deviations had not been corrected. Also, his phrase, "I should be getting counseling..." (line 3), could be seen as a kind of discipline. In addition, if people cannot attain "normal" standards, they can see it as their own failure (White, 2007, 2011). In fact, the client concluded in his story that he was crazy and that he should not have been born (line 9).

With respect to the normalizing judgment, the client told his story, not just because he had Asperger's syndrome, but because he could not be normal. Therefore, his position in this story line was the "abnormal" position. Although it was clear that the story line was that of deficit discourse, his positioning of "crazy" could reflect not just a deficit discourse, but also other discourses relating to "normal" standards.

As the counseling progressed, the client told me that he could be normal. During the 90th session, he told of his experiences of being diagnosed with Asperger's syndrome.

Excerpt 10 (90th session)

| | | |
|---|-----|--|
| 1 | Co: | How did you feel when you were told you had Asperger's? |
| 2 | Cl: | It really shocked me. It's like, I thought I was normal, but in fact I wasn't. Well, now |
| 3 | | I'm alright because I know I can become normal by learning conversation or |
| 4 | | something. It's good that I was able to talk with co-workers normally while working |
| 5 | | part-time as a mover and then I knew, "Oh, I can talk normally better than I |
| 6 | | expected." |

While he was shocked by the diagnosis of Asperger's syndrome at first, he now realized that he could talk with others normally. His position could be called normal (lines 2–3). It seemed that he could overcome what was "abnormal" about him, and thus this might be seen as an alternative story line. However, he said that he became normal by "...learning conversation or something" (lines 3–4). In other words, the boy felt he could not become

normal without learning social skills such as conversation. In fact, the story line developed along with a "normal" standard in talking with others. This might mean that he was originally abnormal. Also, the boy had not denied that he had Asperger's syndrome and had been "abnormal." He could become normal and his story line was now entirely different from the one presented in

excerpt 9. However, the client had judged himself from a “normal” standard in the same way as in excerpt 9.

DISCUSSION AND CONCLUSIONS

Asperger’s-Syndrome Position as a Double-Edged Sword

What could the diagnosis mean to the client? The client shifted among four different positions in relation to his diagnosis of Asperger’s syndrome. He had sometimes used the deficit position for justifying himself to his parents. It would have been harder to do this without the diagnosis, because his parents had underestimated him and thus he probably had few ways to assert himself to them. In fact, the man cited in the Introduction [Twitter post] also asserted that it would become harder to express his difficulties without the phrase “developmental disorder” attached to him. In addition, diagnosis even gave the client a positive possibility. He also positioned himself as competent, referring to Asperger’s syndrome. The woman cited in the Introduction also said that the diagnosis of autism spectrum disorder was useful because it gave her “a ‘user’s guide’” for understanding herself. This could imply that the diagnosis enabled them to achieve a positive outlook and a less difficult life. It could be that the diagnosis of Asperger’s syndrome gave my client the right to justify and assert himself better than before.

Nevertheless, the diagnosis clearly influenced my client negatively. According to him, his psychiatrist blamed him and his teammates bullied him because he had a deficit. This clearly showed self-enfeeblement (Gergen, 1994). In addition, he positioned himself as abnormal, as judging himself from the perspective of normal standards in society. This reflects a normalizing judgment (Foucault, 1975). While he positioned himself as normal at the end of the counseling period, I suggested that he still had the possibility of being positioned as having a deficit or as abnormal, because he had not questioned the diagnosis. Thus, the diagnosis imposed on him a duty to be normal and implicitly accept that he had a deficit or was abnormal even if he could meet normal standards.

These results suggest that the client believed he had a right to assert himself to others and had a duty to recognize that he had a deficit or was abnormal. Remembering that a position is a cluster of rights and duties (Harré & Moghaddam, 2003), this position can be called an Asperger’s-syndrome position. This position includes the four positions revealed in this study: deficit, competent, abnormal, and normal. In brief, the position includes various story lines, which could construct the boy both positively and negatively. Therefore, the diagnosis of Asperger’s syndrome could function as a double-edged sword. An Asperger’s-syndrome position or diagnosis could give the client the means of asserting himself against others and, at the same time, force him to

accept that others see him as having a deficit or as being abnormal.

Implications for Helping People

How can the counselor best help the client who has a “double-edged sword” diagnosis? I will discuss this issue in light of the findings of this study.

The client in this study was first positioned as having a deficit because he forgot to bring something to his psychiatrist. Even though he might have forgotten it by chance, the episode was seen as a sign that he had Asperger's syndrome. The boy sometimes positioned himself as competent. He expected to show talent in the future, because he had Asperger's syndrome, such as Ichiro might have had. He told the counselor his experience of being bullied by his football team. He noted that it happened because it involved a deficit, rather than because the teammates or the coach were wrong. He also stated that playing the table football game reflected his having Asperger's syndrome. According to him, he was playing it, not simply because it was fun, but because he was abnormal. In addition, even if he could be normal, it could also show that he had a deficit or was abnormal. For him, being normal meant being conscious of having Asperger's syndrome. Any facts showing that he might have related to others “normally” without being aware of the diagnosis disappeared at that point.

These stories might suggest that the diagnosis led the boy to interpret his past, present, and future experiences through the lens of his diagnosis. His story of being bullied, his present interaction with the counselor (such as enjoying games), and his future dream of being an athlete all developed alongside the diagnosis. Here, the boy could not see the facts that 1) he might not be wrong, 2) might just enjoy playing games, and 3) might have some talents unrelated to Asperger's. In brief, alternative stories that could counter the boy's dominant story were suppressed. As a result, it became almost impossible to deny the validity of having Asperger's syndrome. In other words, the diagnosis became the truth.

We cannot, and probably should not, deny these diagnoses. As seen in the Introduction, diagnoses of mental disorders can give those diagnosed effective practices, useful information, and tools for expressing themselves. They could gain the right to assert or justify themselves, as the study also showed. We have no right to assert that their dominant stories are not true. Nevertheless, we have no duty to reinforce or reproduce any dominant discourses behind their stories. Non-normative practices are preferred because they do not normalize the dominant discourse (White, 2011). When we talk with our clients, therefore, we need to engage in non-normative practices instead of denying dominant discourses. This will lead us to speak with our clients using alternative discourses and to find some favorite truths other than the diagnosis.

How can we engage in non-normative practices? It could be useful to discover the positions required to give our clients the right to assert and justify themselves, or to speak their wishes without needing the diagnosis. However, this could be easier said than done. To engage in non-normative practices, we need to examine our sessions in detail from discursive perspectives, becoming researchers as well as practitioners. In other words, we need to be reflective practitioners (Schön, 1983) to avoid normalizing dominant discourses, such as deficit discourse.

Study Limitations and Future Research

The findings of this study may be useful in working with some clients. In particular, it may help us to understand Japanese people in Japan who have been diagnosed as having Asperger's syndrome. Seeing the diagnosis of a mental disorder as a double-edged sword makes us conscious of both the risks and merits associated with diagnosis and challenges us to discover methods that do not involve either affirming or denying the diagnosis.

This study has several limitations. It examines only a few parts of the whole counseling process and focuses on the sessions in which the client talked about Asperger's syndrome. I could find alternative positions in the rest of the counseling process. I also did not study the role of the counselor due to data limitations. It is important to focus

on the counselor's side of the interaction, however, partly because counselors can suppress their clients if they accept dominant discourses (Ayashiro, 2016). I also studied the counseling process with only one client who was diagnosed as having Asperger's syndrome. The diagnosis of Asperger's syndrome is no longer used and now the concept is included in autism spectrum disorder. Those diagnosed as having autism spectrum disorder may not see their diagnosis the way my client saw Asperger's syndrome. In fact, the client saw "autism" as an even more negative term than Asperger's syndrome (see excerpt 6). Furthermore, this study was based on Japanese culture. Culture clearly affects positioning (Moghaddam, 1999). Even if a client is Japanese, she or he may show positions different from those of this study if the client lives in a country other than Japan. Thus, it is impossible to generalize the findings of this study. They may be entirely different in other cases.

Future studies that include the counselor's utterances, as well as including the whole counseling process, will be necessary. The methods of this study should also be applied to different cultures and with individuals who are diagnosed as having various mental disorders, especially autism spectrum disorders. These studies could demonstrate the different positions not only of clients but also of counselors as well as various culture-specific discourses. They could, therefore, also reveal various forms of non-normative practice that will enable us to avoid normalizing deficit discourses.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington DC: Author.
- Austin, J. L. (1962). *How to do things with words*. Oxford, UK: Clarendon Press.
- Ayashiro, H. (2016). Reproducing dominant discourses for therapy: Discourse analysis of a Japanese client's therapy. *Journal of Systemic Therapies*, 35(1), 37-51. doi: 10.1521/jsyt.2016.35.1.39
- Cheney, J. (1989). Postmodern environmental ethics: Ethics of bioregional narrative. *Environmental Ethics*, 11, 117-134. doi: 10.5840/enviroethics198911231
- Conrad, P. (2005). The shifting engine of medicalization. *Journal of Health and Social Behavior*, 46, 3-14. doi: 10.1177/002214650504600102
- Craddock, N., & Mynors-Wallis, L. (2014). Psychiatric diagnosis: Impersonal, imperfect, and important. *The British Journal of Psychiatry*, 204, 93-95. doi: 10.1192/bjp.bp.113.133090
- Elliot, C., & Chambers, T. (Eds.). (2004). *Prozac as a way of life*. Chapel Hill, NC: University of North Carolina Press.
- Foucault, M. (1975). *Surveiller et punir: naissance de la prison* [Discipline and punish: The birth of the prison]. Paris, FR: Gallimard.
- Gergen, K. J. (1994). *Realities and relationships: Soundings in social construction*. Cambridge, MA: Harvard University Press.
- Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process*, 33, 19-35. doi: 10.1111/j.1545-5300.1994.00019.x
- Harré, R., & Moghaddam, F. (2003). Introduction: The self and others in traditional psychology and in positioning theory. In R. Harré & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 1-12). Westport, CT: Praeger.
- Harré, R., & van Langenhove, L. (Eds.). (1999). *Positioning theory: Moral contexts of intentional action*. Boston, MA: Blackwell.
- Hyman, S. E. (2010). The diagnosis of mental disorders: The problem of reification. *Annual Review of Clinical Psychology*, 6, 155-179. doi: 10.1146/annurev.clinpsy.3.022806.091532
- Ihara, Y. (2011). Sokyoku-sei-shougai to shikkan-kenden [Disease mongering and bipolar disorder in Japan]. *Psychiatria et Neurologia Japonica*, 113, 1218-1225.
- Ishibashi, H. (2016, January 9). Hattatsu-shogai toujisha desu. Watashitachi kara sureba Hattatsu-shogai toiu kotoba wa watashitachi no "komari-kan" wo hyougen suru kotoba desu node naito komari masu. Ato "ai-no-arushien" wa fuyou desu.

Watasitati ga hosii noha “tekisetsu-na-shien” desu kara. “Ai-wa-arukedo-fu-tekisetsu-na-shien” hodo fuyou na mono wa nai. [I am a developmental disorder person. I would be in trouble without the term development disorder. For us it is a symbol for expressing our “difficulty.” In addition, “support with love” is useless because what we need is “appropriate support.” Nothing is more useless than “inappropriate support with love.”] [Twitter post]. Retrieved from <https://twitter.com/ihi1484/status/685670700254769153>

Ito, S. (2016, January 7). Hattatsu-shougai? toiu word ha daikirai da. Naniga seijoude naniga ijou nanoka? Nandemo shirokuro tsuketagaru renchuu niha kakkouno yougo. Kodomo no seichou ya manabino katei ha hontouni hitori hitori chigau. Kagirareta jikan no nakade ketsuron wo dasou tosuru kyouiku ha jiritsu wo matsukoto no yutori wo wasurete seika dakewo motomeru. Hontouni hitsuyou nanoha ai-no-arushien ni chigainai. [I don't like the term developmental disorder so much. What is normal and what is abnormal? It is a convenient term for guys who want to judge everything in black and white. In reality, processes of child growth and learning vary with the individual. However, education wants to assess them in a limited time, and so it demands only achievements, and makes no exceptions. All they

need is support with love.] [Twitter post].

Retrieved from

<https://twitter.com/itoshunya/status/685112336403709952>

Kitanaka, J. (2014). *Utsu no iryou jinrui gaku* [Medical anthropology of depression]. Tokyo, Japan: Nihon Hyouron-sha.

Kyoto University Economic and Social Research Institute. (2006). *Jisatsu no keizai-shakai teki youin ni kansuru tyousa-kenkyu-houkokoku-sho* [Report on a study of socio-economic factors in suicide]. Retrieved from

<http://www.esri.go.jp/jp/prj/hou/hou018/hou018.html>

Litalico Hattatsu Navi. (2016). *Hattatsu-shougai-sha shien-bou' kaisei, osaete okitai nanatsu no pointo matome* [A summary of seven points to bear in mind concerning a revised “Act in support of persons diagnosed as having developmental disorders”]. Retrieved January 29, 2017, from <https://h-navi.jp/column/article/837>

Retrieved January 29, 2017, from <https://h-navi.jp/column/article/837>

Lock, A., & Strong, T. (2012). Discursive therapies: Why language, and how we use it in therapeutic dialogues, matters. In A. Lock, & T. Strong (Eds.), *Discursive perspectives in therapeutic practice* (pp. 1-22). Oxford, UK: Oxford University Press.

Matsumoto, M. (n.d.). *Daigaku-sei no watasbi ga hattatsu-shougai to shindan sareru mae to sarete kara* [Before and after I, a college student, was

- diagnosed as having a developmental disorder]. Retrieved from <http://storys.jp/story/23515>
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.
- Ministry of Education, Culture, Sports, Science, and Technology [Japan]. (2012). *Tsujon no gakkyu ni zaiseki suru hattatsu-shougai no kanousei no aru tokubetsu na kyounikuteki shien wo hitsuyou to suru jidouseito ni kansuru tyousa kekka ni tsuite* [Results of a survey of students in regular classes requiring special education and possibly having developmental disorders]. Retrieved from http://www.mext.go.jp/a_menu/shotou/tokubetu/material/1328729.htm
- Ministry of Education, Culture, Sports, Science, and Technology [Japan]. (2016). *Youchi-en, shou-gakkou, chuu-gakkou, koutou-gakkou oyobi tokubetsushien-gakkou no gakushuushienyouryou-tou no kaizen oyobi hitsuyouna housaku-tou nit suite (toushin)* [Concerning the improvement of the Ministry's curriculum guidelines, etc., for kindergarten, elementary school, junior high school, high school, and special education school, and the necessary measures, etc. (Report)]. Retrieved from http://www.mext.go.jp/b_menu/shingi/chukyo/chukyo0/toushin/1380731.htm
- Ministry of Internal Affairs and Communications [Japan]. (2017). *Hattatsu-shougai-sha shien ni kansuru gyouseihyouka kanshi <kekka ni motozuku kankoku>* [Evaluation and monitoring of support for persons with developmental disorders <Official advice based on the results>]. Retrieved from http://www.soumu.go.jp/menu_news/s-news/110614.html#kekkaoukoku
- Moghaddam, F. M. (1999). Reflexive positioning: Culture and private discourse. In R. Harré & L. van Langenhove (Eds.), *Positioning theory: Moral contexts of intentional action* (pp. 74-86). Boston, MA: Blackwell.
- Obeyesekere, G. (1985). Depression, Buddhism, and the work of culture in Sri Lanka. In A. Kleinman. & B. J. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 134-152). London, UK: University of California Press.
- Rössler, W. (2013). What is normal? The impact of psychiatric classification on mental health practice and research. *Front Public Health*, 68, 1-4. doi: 10.3389/fpubh.2013.00068
- Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.
- Tomitaka, S. (2009). *Naze utsu-byou no hito ga fueta noka* [Why has the number of people with depression increased?]. Tokyo, Japan: Gento-sha Renaissance.
- Watters, E. (2010). *Crazy like us: The globalization of the western mind*. London, UK: Robinson.

- White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.
- White, M. (2011). Bringing the world into therapy and subverting the operations of modern power. In D. Denborough (Ed.), *Narrative Practice: Continuing the Conversations* (pp. 3-26). New York, NY: W.W. Norton.
- Winslade, J. (2005). Utilising discursive positioning in counselling. *British Journal of Guidance and Counselling*, 33, 351-364. doi: 10.1080/03069880500179541
- Winslade J., & Williams, M. (2012). *Safe and peaceful schools: Addressing conflict and eliminating violence*. Thousand Oaks, CA: Corwin.