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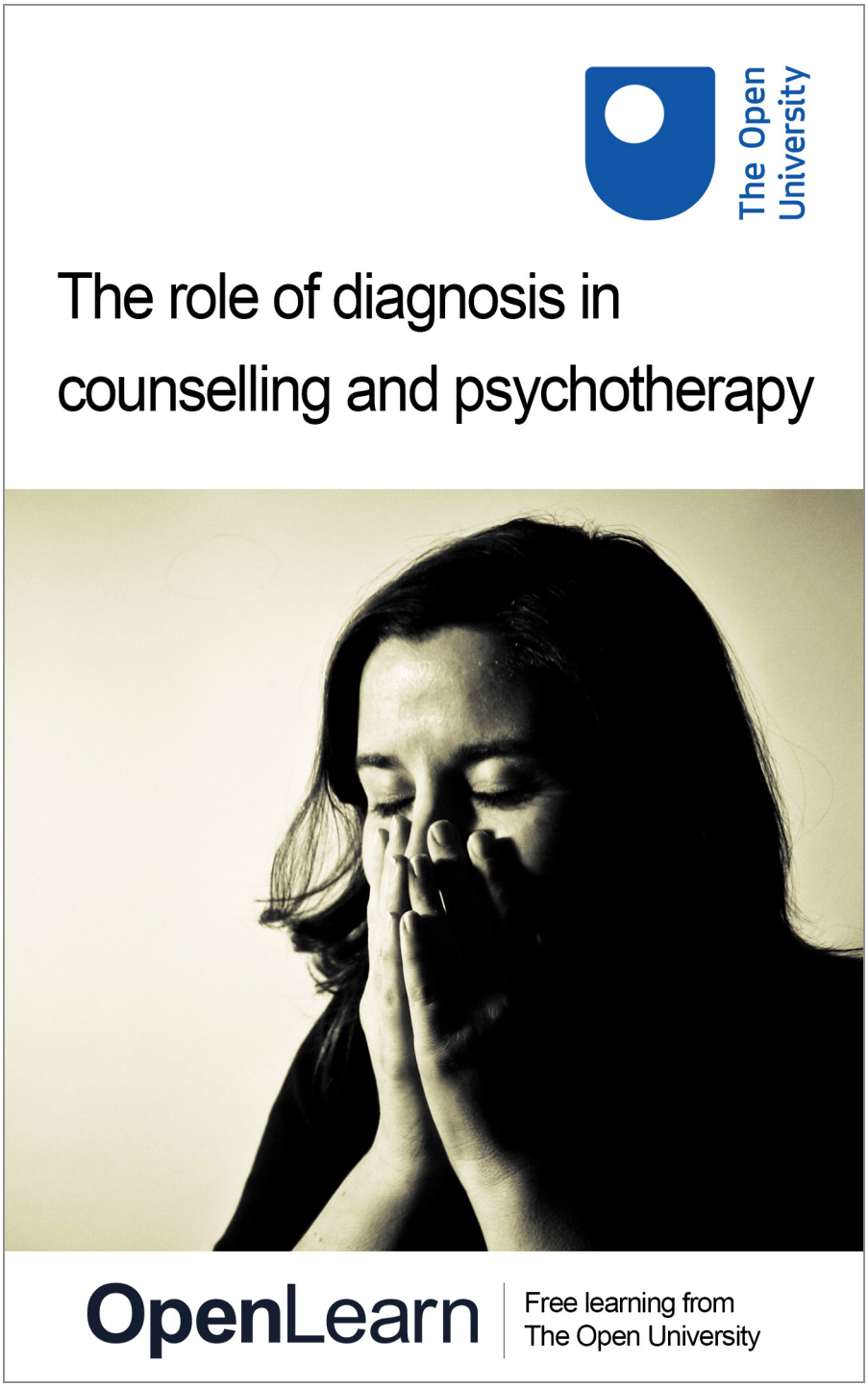
The role of diagnosis in counselling and psychotherapy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The role of diagnosis in counselling and psychotherapy
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Contents

Learning Outcomes

After studying this course, you will be able to:

- describe how views of mental health problems have changed over time
- explain current classification systems of psychopathology
- explore the costs and benefits of psychiatric diagnosis to different interest groups, particularly counselors and psychotherapists and their clients
- consider the potentials and pitfalls of diagnosis versus formulation in relation to fear and sadness.

Introduction

This course explores how what is now termed ‘mental illness’ has been understood over time, focusing especially on justifications for, and criticism of, psychiatric diagnosis. It introduces the historical emergence of a categorical approach to mental abnormality and how that approach culminated in systems of diagnosis now advocated by the American Psychiatric Association (the APA Diagnostic and Statistical Manual of Mental Disorders – DSM IV, 1994) and the World Health Organisation (the WHO International Classification of Diseases – ICD10, 1992).

Problems with these systems will be illuminated using ‘common mental health problems’: the varieties of fear and sadness often diagnosed by General Practitioners in primary care services. The course will mostly take a ‘critical’ view on diagnosis, focusing on the problems that come along with labels such as ‘depression’ and ‘anxiety’.

This course is an adapted extract from The Open University course D240 Counselling: exploring fear and sadness.

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1 The complexities around diagnosing mental illness

You will be encouraged throughout this course to relate the material back to individual clients to consider what they may gain, and lose, from embracing diagnoses, and to think about how clients and therapists might work with such dilemmas. Towards the end of the course you will be asked to consider 'formulation' as an alternative to diagnosis. Formulation is where, rather than giving a diagnostic label, a counsellor, psychotherapist or other mental health professional gives a description of the experiences that the client is struggling with, along with a theory about the way it has developed over time and how it is currently being maintained. This is then revisited and reconsidered throughout the therapy.

Before we start with a historical consideration of diagnostic systems, let's consider one person's experience with a label of 'mental illness', to begin to understand the complexities which might be involved.

Case Study 1: Mario and depression

When Mario was in his early twenties at university, he became worried because most years around Easter he seemed to go into what he called a 'slump'. During this so-called slump he stopped going out with his friends and being involved in the theatre group that he usually enjoyed so much. He worried that people didn't really like him and imagined the kinds of things they might say when he was out of earshot. Sometimes these worries kept him awake at night. When he was back at home, Mario sought the advice of a family friend whom he knew suffered from 'depression'. The friend said that Mario couldn't possibly be depressed, because when someone is depressed they can't even get out of bed in the morning, and Mario was attending lectures and doing fine in his studies.

The following Easter, when Mario again hit a slump, he felt even worse about it, knowing that he wasn't properly depressed, so there was no good reason for his struggles. He criticised himself for not being able to do simple things, like choosing what to wear, or complaining to his landlord about the state of the house. Everyone else seemed to manage such things, so what was wrong with him?

Ten years later Mario was working as a researcher for a television company. The pattern of going into slumps had continued, but more frequently. Half the year he felt fine and would throw himself into activities and be the life and soul of the party. The other half he felt like he was moving through treacle. Everything he did was a huge effort and he hated himself for finding it so difficult. Eventually he mentioned this to his GP who immediately diagnosed Mario with 'depression', gave him a prescription for Prozac and put him on a waiting list for brief counselling. Partly, Mario was relieved to finally know what was wrong with him, but he was also scared by the label. Did that mean he was always going to be like this? Would he ever get better?

Activity 1 Losses and gains of a label

Think about Mario's situation and that of other people you have known who have received a 'mental illness' label such as 'anxiety' or 'depression'. Spend 15 minutes writing a list of the things a person in today's society might gain from such a diagnosis, and also what you think they might lose. It might be helpful to also think what is lost and gained from not having such a label. Then watch the video below, 'Experiences with diagnosis and stigma'.

Gains

Provide your answer...

Losses

Provide your answer...

Questions

While you are watching, think about the following questions:

- Are there any further losses and gains to receiving a diagnostic label that you can add to your existing lists?
- Do the people speaking have the same, or different, perspectives on diagnosis? Who do you agree or disagree with, and why?
- Does having a diagnosis help people to be less stigmatised or does it increase stigma, or both?
- What alternatives might there be to diagnosis?

Video content is not available in this format.
Experiences with diagnosis and stigma

Discussion

We shall come back to Mario's example later in the course and see how a counsellor might work with him to explore the losses and gains of taking up the label of 'depression'.

2 Current western diagnostic systems and their history

Let's now consider how these diagnostic labels came to be such an accepted part of our understanding. Diagnosis first emerged during the nineteenth century as part of the new medical specialism of psychiatry. At first, this focused narrowly on madness: 'mania', 'dementia praecox' (later to be dubbed 'schizophrenia') and 'melancholia' (now 'depression'), as it was referred to when diagnosing wealthier patients, or 'mopishness' when diagnosing pauper lunatics.

The formalisation and elaboration of the sorts of diagnosis used today (as described below) is largely associated with the work of the German psychopathologist Emil Kraepelin. Kraepelin (1883) established three main axioms which became popularly understood (sometimes termed 'medical naturalism': Hoff, 1995):

1. Mental disorders are genetically determined diseases of the nervous system.
2. Mental disorders are separate, naturally occurring, categories.
3. Mental disorders are fixed and deteriorating conditions.

Kraepelin depicted abnormal states in the way a botanist would classify plants. But this was not just about classification, because assumptions about genetic causation came with the descriptions. These assumptions brought with them, and justified, the need for medical control over patients. They also reflected and fed the eugenic ethos of the Victorian period. Eugenics refers to the betterment of human society or a particular racial group by increasing the birth rate of some groups and lowering it in others. It was assumed, simplistically, that physical and mental strengths and weaknesses were all, and always, inherited.

This social movement of eugenics was common across the political spectrum in Victorian times and arose largely because of the fear the middle classes had of the birth rate among the very poor. Because madness, idiocy, epilepsy, prostitution and criminality were more prevalent in this poorer group, eugenicists encouraged their control in a number of ways (including gender segregation in institutions: Pilgrim, 2008). The chronically poor were considered by eugenicists to be a product of a 'tainted' gene pool and were thus deemed to be responsible for 'degeneracy', and all the deviant behaviour that followed in its wake, if allowed to breed uncontrollably.

This eugenic–genetic emphasis on accounting for mental illness came into crisis, however, during the First World War, when many soldiers were hospitalised suffering from 'shell shock'. The shell shock problem had two major implications for the development of psychiatric knowledge. First, 'neurotic' problems enlarged the jurisdiction of psychiatric interest, which had previously focused on 'psychosis' (experiences such as mania or delusions where people were seen as having 'lost touch with reality' in some way). Second, the core eugenic–genetic assumption of the late Victorian era was challenged. Those breaking down in the trenches of France and Belgium were 'England's finest blood': officers and gentlemen, and working-class volunteers (Stone, 1985). In this context, the eugenic assumption of asylum psychiatry was tantamount to treason.

Figure 1 Casualties during the First World War, many of whom were found to be suffering from shell shock

Today, assumptions about the genetic origins of mental illness still maintain a strong position in psychiatry. However, the enlarged classification system in the early twentieth century, to include the neuroses, personality disorders and substance misuse, meant that the primary role of biology was more ambiguous or even unlikely. Psychiatrists influenced by psychoanalysis developed a theory of neurosis that emphasised interpersonal and intra-psychic conflicts to account for mental abnormality. Also, behaviourist psychology began to provide its own environmentalist explanations for neurotic experience and conduct. Observations following those around shell shock continued to challenge simplistic genetic arguments. For example, the Wall Street Crash in 1929 showed that sudden shifts in social conditions could have rapid implications for the mental health of the population (Dohrenwend, 1998). What we now call 'common mental health problems' increased in frequency during this downturn in the economy. To take another example, when the concentration camps which housed the survivors of the Holocaust were opened at the end of the Second World War, this provided environmentalist insights into the profoundly disabling impact of 'institutional neurosis'. Barely alive, skeletal figures paced up and down over and over, arms folded, and refused to move from their insanitary huts to newly fumigated and cleaned ones. The same behaviour could also be seen in psychiatric patients contained in the legacy of the Victorian asylums during the mid-twentieth century (Barton, 1958).

The above examples of changing views about environmentalist explanations for mental health problems have not diminished the enthusiasm for genetic explanations in psychiatry, but they have created healthy disputes within, and about, the profession. Consequently, even those who still retain a categorical approach to mental disorder are asked to suspend any assumptions about causation or 'aetiology'. The current system – the *Diagnostic and Statistical Manual of Mental Disorders* (or DSM) – used by the American Psychiatric Association does not presume any knowledge of aetiology. Instead, it focuses on agreed symptom checklists as necessary and sufficient criteria for a particular label such as 'depression' or 'anxiety' (see the box for an example of the kinds of checklist used in the DSM). This more cautious approach to assumptions about the

cause of mental health problems arose because within the APA biological and psychoanalytical psychiatrists had such opposing and irresolvable views about aetiology.

Figure 2 Examples of the DSM and ICD. DSM-I dates from 1952; DSM-III came into use in 1980, and was revised in 1987; the fourth edition came into use in 1994 and DSM-IV Text Revision in 2000. ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States from 1994.

The WHO uses the International (statistical) Classification of Diseases and related health problems (ICD) system, which includes similar checklists to the DSM. Both the APA and the WHO endeavour to maintain consistency between their systems, but there are still some differences if you compare the two. In the UK practitioners in the National Health Service (NHS) tend to use the ICD (which covers all diseases, but has one chapter dedicated to 'mental and behavioural disorders'), whilst counsellors, therapists and people in general are often more familiar with the DSM.

Box 1 Diagnosis of depression

To give an example of the kinds of checklist used in diagnosis, the DSM-IV criteria for 'major depressive episode' are as follows (APA, 1994, p. 356). A 'major depressive disorder' (p. 369) is diagnosed if a person has had two or more such episodes:

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g. a change of more than 5 per cent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The DSM is readily available online and in libraries, so you might find it useful, at this point, to look up the other 'mood' and 'anxiety' disorders listed to see what the common diagnoses are for 'fear'- and 'sadness'-related problems.

Pause for reflection

Given this checklist, do you think that Mario's GP was correct to diagnose him with depression?

Modern systems of classification based upon these kinds of behavioural criteria were consolidated in the late twentieth century. For example, Fish (1967) provided a basic psychiatric classification that still resonates in highly elaborated forms in more recent versions of the DSM and the ICD:

1. Abnormal variations in mental life:
   - abnormal intellectual endowments ('learning disability')
   - abnormal personalities ('personality disorders')
   - abnormal personality developments (for example, the emergence of pathological jealousy)
   - abnormal reactions to experience (for example, 'post-traumatic stress disorder', neurotic distress, paranoid reactions).
2. Mental illnesses:
   - the functional psychoses (such as schizophrenia and bipolar disorder)
   - organic states (such as toxic reactions, drug-induced psychosis and some forms of senile dementia).

3 Problems with diagnostic classifications

3.1 Validity and reliability

Fish's classification seems simple enough. However, an indication of the fragile and arbitrary character of diagnosis can be seen if we look at the ways in which the boundaries between 'variations in mental life' and 'mental illnesses' become readily permeable, as do the divisions within these headings. If 'abnormal variations' become chronic, then they are reclassified as 'personality disorders' or 'paranoid schizophrenia'. Also, many doctors consider neuroses to be minor 'mental illnesses'. Thus there is only a precarious agreement on divisions of labelling by those adopting a diagnostic approach.

There are other fundamental problems about diagnosis today regarding validity and reliability (see box for definitions).

Box 2 Validity and reliability

Validity refers to whether there is objective evidence to support a diagnosis. *Conceptual validity* is whether a diagnostic category is conceptually separate from others (see Case Study 2, below). *Predictive validity* is whether diagnosis can predict the outcome of an illness. *Reliability* relates to whether it is a stable diagnosis (would different people reach the same diagnosis, and would the patient be diagnosed the same at different points in time?).

Case Study 2: Different diagnoses

Julie has been hospitalised because she experiences frightening hallucinations following her cannabis smoking (which she has been doing daily for several years). One psychiatrist argues that she has 'drug-induced psychosis', whilst another says that she has developed 'schizophrenia'. Another suggests the diagnosis of 'substance misuse'. When in hospital without access to her preferred drug, Julie becomes depressively withdrawn and is deemed to be suffering from 'major depression' and is treated with 'anti-depressants'. Between hospital admissions, she gets involved in petty crime and moves from one difficult sexual relationship to another, which at times spills over into domestic violence, with police involvement. This culminates in another psychiatrist recording a diagnosis of 'dual diagnosis', which implicates a 'personality disorder'. A few years down the line all of these diagnoses appear cumulatively in Julie's case notes.

Conceptual validity problems are also seen within specific diagnoses. For example, schizophrenia is a disjunctive concept (Bannister, 1968): two patients with the diagnosis may have no symptoms in common. Whilst reliability can be improved by psychiatrists being trained carefully in the use of common symptom checklists (such as those in the DSM), reliability is not the same as validity and it is possible to consistently use a label which is still not valid. Predictive validity is particularly imperfect in psychiatry, because

human behaviour (of any sort) is difficult to predict accurately. These problems with the validity and reliability of psychiatric diagnoses have led some to argue that mental disorder is very difficult to measure and that the dividing line between the normal and abnormal is fuzzy (Wakefield, 1992).

3.2 Normality and abnormality

The division between normality and abnormality is highlighted when we consider 'common mental health problems'. For example, we are all frightened of something and most of us worry about lots of things. These worries are not the same for everyone and differ over time. For example, the worries of the adolescent may not be the same as those they experience later in life when they become the parent of an adolescent. Also, most of us become sad when someone we know dies or we lose control in our lives. Moreover, when we lose control and become sad this also worries us. Misery becomes a ball of wax, which picks up distressing signals from our outer lived context and spirals of distress, insecurity and self-doubt from our inner life. Fear and sadness coexist and reinforce one another. Making distinctions between them in practice becomes difficult.

Misery thus comes in all sorts of shapes and sizes, depending on the person and their context. In the light of these regular shifts in our emotional life, what sense does it make to turn sadness and fear into medical diagnoses? What if people are oblivious to problems that *ought* to worry them? Hence the comic variation on Kipling's verse found in graffiti: 'If you alone can keep your head when all around are losing theirs, then you clearly do not understand the situation!' After all, fear is a normal physiological response to threat. Similarly, sadness is a normal response to loss.

Thus life should frighten us sometimes, just as it should depress us. Why are anxiety and depression medical conditions to be diagnosed and split off from ordinary life? Why should recurrent ordinary human suffering, which simply comes with living and dying, turn as all into patients? For example, the *capacity* to be sad reflects a form of mature human development; a point emphasised by the psychoanalyst, Donald Winnicott:

> The capacity to become depressed, to have a reactive depression, to mourn loss, is something that is not inborn *nor* is it an *illness*; it comes as an achievement of healthy emotional growth … *the fact* is that *life itself* is *difficult* … probably the greatest suffering in the human world is the suffering of normal or healthy or mature persons … this is not generally recognised.
>
> (1988, p. 149, emphasis added)

Winnicott's final lament is interesting, because he does not explain what he means precisely ('generally recognised' by whom?), but we could surmise that he is complaining of an increasing assumption in the late twentieth century (and still with us) that misery is pathological and should be treated. For him, in a sense, we are all ill (thus making it normal not abnormal) and the question is an existential one: how should we make sense of, deal with or endure misery in our lives?

'Neurosis' can be thought of as blocked creativity when it dominates the person's consciousness, takes on a life of its own of self-absorbed, socially disabling 'psychopathology' and diverts them from addressing the existential challenges noted above. 'Mild to moderate depression', 'phobic anxiety' or 'agoraphobia' can be treated as illnesses by doctors and psychologists or they can be addressed as provocations about the patient's life and invitations to him or her to be more productive. If these symptoms of

'illness' were suddenly removed, where would the person be in their life? What tough aspects of their life might they need to face up to? What opportunities could be taken or what choices might need to be made?

Pause for reflection

Think about your own life experience in the light of these questions. Consider a time in your life when you experienced fear or sadness. In your view was Winnicott saying something important or do you disagree with his conclusions? If you agree or disagree (or a bit of both), consider why.

4 The survival of diagnosis

What you have read so far suggests that we should be more sceptical about diagnosis and try to understand distress both as part of the human condition and as a vehicle for avoiding an honest acknowledgement of our challenges and responsibilities in life. Despite this invitation to cast doubt on the simple view of anxiety and depression as being medical (rather than existential) conditions, the diagnostic view still prevails in many quarters. That view places all of the complexities and biographical idiosyncrasies of particular symptom presentations into pre-formed categories preferred by professionals (remember, this approach started with those like Kraepelin, who believed in the objective existence of natural categories of mental illness). In the light of those agreeing and disagreeing with a categorical view, we can now see the following sort of dynamic debate about diagnosis:

- Some defenders simply argue for a greater refinement of systems like the DSM and the ICD and their consistent use in medicine. This has been the history of the APA, which every few years revises the past edition of the DSM and adds more categories and occasionally drops others (an example here would be homosexuality, which disappeared in 1973).
- Some critics argue for the complete rejection of psychiatric diagnostic categories in favour of individual formulations about presenting psychological difficulties (for example, Bruch and Bond, 1998).
- Some defenders point out that the DSM has moved beyond simple categorisation (the logic of a disorder being present or absent) and now includes a dimensional view (mild, moderate and severe categories of various ‘disorders’). This tension between a categorical view (for example, a patient suffers from phobic anxiety) and a dimensional view (for example, we are all, to some degree, phobic about something) fuels ongoing debate (Kendell and Zealley, 1993).
- Some critics argue for the rejection of some types of people with difficulties from psychiatric jurisdiction. For example, some argue that only mental illness (psychotic and neurotic patterns of conduct) should fall within their jurisdiction. Those with acute transient distress, serious personality problems and substance misuse are not deemed to be worthy of formal psychiatric diagnosis. Others disagree and champion the treatment of these groups and even specialise in their diagnosis.
- Some accept the principle of diagnosis but emphasise cross-cultural sensitivity when assessing patients.

5 Focus on ‘depression’ and ‘anxiety’

The word ‘depression’ has now entered the vernacular. Even lay people can be heard making a confident distinction between ‘clinical depression’ and everyday misery. What gives this taken-for-granted modern discourse extra significance about ‘depression’ is that it is the ‘common cold of psychopathology, at once familiar and mysterious’ (Seligman, 1975). Indeed, it is so common that we are told by the WHO that depression is a pandemic impacting on modern populations (Murray and Lopez, 1995). We can, however, ask, ‘a pandemic of what?’ There are a number of fundamental problems with this, the commonest of all psychiatric diagnoses (Dowrick, 2004; Pilgrim and Bentall, 1999):

- Depression is not easily distinguishable from normality (see above).
- Depression is not easily distinguishable from other diagnoses, especially anxiety states when life feels out of control, but also forms of psychosis when people are in a black tunnel contemplating suicide, and are desperate for ways out (Shorter and Tyrer, 2003).
- Experts emphasise different core features. Some claim that it is primarily a disturbance of mood (Becker, 1977) others of cognition (thought) (Beck, Rush, Shaw and Emery, 1979). They also vary in the criteria required for diagnosis and some do not even define the condition but take it to be self-evident.
- Some cultures have no word for ‘depression’ (Wierzbicka, 1999). Western medicine often presumes that physical presentations in minority ethnic patients are masked depression: for example, some people from south Asia express distress mainly by pointing to their chest and describing ‘a falling heart’. Western psychiatry is arrogant to assume that this is a ‘somatic’ expression of what is ‘really’ depression (Fenton and Sadiq, 1991). This presumes that one cultural experience of distress is more valid than another.

Given the confusion and doubts about the term, when the diagnosis of depression is researched in randomised controlled trials of drugs or psychotherapies we can ask what exactly is being treated and assessed? Depression is a poor category and it is also poor *because* it is a category. This takes us back to the flawed logic of Kraepelin about natural categories. Depression is not a ‘thing’ but one way of conceptualising human distress which is now understood by many people to be a medical ‘fact’. However, what it signals is a persistent and universal tendency in human beings across time and place to experience profound unhappiness.

Figure 3 A sad dog

Moreover, the latter is not limited to human beings. For example, we can all spot a miserable dog (Pilgrim, Kinderman and Tai, 2008). Misery has been universally and trans-historically linked to loss: of people, control, status, dignity and so on (Brown, Harris and Hepworth, 1995). It reflects what Buddhists have always known of the clinging ego having problems in accepting change and the inevitability of suffering in the life span. Misery potentially, then, has a variable meaning for people but it is also easy to recognise the characteristic environmental conditions that increase the probability of any of us becoming depressed or anxious.

With regard to the anxiety aspects of misery, we find the same mix of global and historical continuities, as well as the lack of uniqueness of the human species (all mammals can be frightened, as we know). Moreover, fear brings with it certain predictable physiological consequences across time and place and across mammalian species (raised heart rate and blood pressure, sweating, muscle tension, etc). Thus depression or anxiety have some common behavioural and experiential features from person to person and even from species to species, *but* the meaning of their appearance in this person at this time in their life is what is at issue. If we want to find meaning in distress (rather than treat it as an unfortunate but meaningless affliction to be removed), then formulation, rather than a diagnosis, is required. Also, formulation assumes that there are not two categories of humanity (those ill and those not) but that our experience of emotions is on a fluid continuum. The way this might work is suggested in Figure 4.

Figure 4 The continuum of fear and sadness

Pause for reflection

What do you make of this continuum I offer using words from my own culture? Do you agree that misery can jumble feeling states above and below the permeable line or do you think they are always experienced distinctly? What might move people up or down the continuum? Write down your reflections on these questions in the light of your own experience of life.

6 Losses and gains of diagnosis

Having considered some of the general problems with diagnostic categories such as ‘depression’, let’s return to the example of Mario presented at the beginning of the chapter and explore how a counsellor who is aware of such issues might work with him.

Case Study 3: Mario and Emma explore the losses and gains of diagnosis

The following is a transcript of some of the first session between Mario and his counsellor, Emma.

Emma: So what brings you here today, Mario?

Mario: Well, Dr Harris referred me to you because he says I have depression … [pause]

Emma: What are your feelings about that?

Mario: [laughs] Mixed, I have to say, mixed.

Emma: Can you say a bit more?

Mario: Well, I’ve felt like this most of my life: falling into a slump every now and then. I always thought it couldn’t be depression, because I managed to get out of bed every day. You know, I never seriously thought about killing myself or anything.

Emma: So you thought it couldn’t be depression?

Mario: That’s right. But now he says it is. I don’t know. It is a relief because it kind of makes sense of all those times when I’ve felt that way. And my family have been a lot more sympathetic since I told them, they used to just think I was a grumpy so-and-so.

Emma: People are more sympathetic now?

Mario: Yes, like it’s not my fault. And at work I know I could put in for sick leave. I could never do that before. I worried that I’d be fired if I took any time off. Now it’d be discrimination if they did that. And I’ve been reading about other people’s experiences online. It feels good to know that other people have been through what I’ve been through.

Emma: But you still sound quite hesitant. Are there some losses associated with ‘depression’ for you, as well as these gains?

Mario: Absolutely. I mean for a start now I feel like I’m different, you know, and I was trying so hard to be normal. I’m worried that other people will think I’m a freak if I let them know: some kind of psycho. I don’t want my family walking on eggshells around me.

Emma: So you’re worried about how others will view you?

Mario: And how I view myself, I guess. I read all those stories online and I think ‘Is this me?’ I mean some of it fits, but some of it sounds nothing like me. Plus now I’m worried I’ll be stuck like this forever. Before, I always thought that I’d find a way out of it, but if I have this thing that’s an illness, maybe it isn’t in my control to do something about it.

Emma: That sounds frightening, to be out of control.

Mario: [sigh] It is. It really is.

Activity 5 Losses and gains for the counsellor

Look back at the previous lists you made about the losses and gains of a diagnostic label. Take a few minutes to add anything to it, having read the exchange between Mario and Emma.

Now take 15 minutes to create a similar list of the potential gains and losses of embracing a label like 'depression' for the counsellor. What might Emma gain if she sees Mario as a man with depression? What might she lose?

Gains
Losses

Discussion

You might consider that counsellors could be drawn to such labels because they give them a sense of understanding and control from early on with a client. If they've worked with a 'depressed' person before, they may feel more comfortable and able to predict what will be helpful. They might feel they can look to research evidence to find out what works best with depression. They might even feel a sense of connection with the client if it is something they have been diagnosed with themselves.

On the losses side, therapists like Yalom (2001) argue that there is a danger that counsellors will treat someone as a diagnosis rather than as a human being. They may look for features that fit with their understanding of depression and ignore what is unique for that person. Also, the stigma around mental illness may prevent them from connecting with someone with an unfamiliar, or frightening, diagnosis, or one that it has been suggested by research may be difficult to work.

You might want to look back to this example and consider how counsellors from different approaches might work with Mario's ambivalence.

Perhaps it is particularly important to reflect on the common everyday perception, explicit in Mario's account here, that having a diagnosable 'mental disorder' means that a person is not 'to blame' for their difficult feelings and associated behaviours, whilst not being diagnosable is assumed to mean that they are somehow responsible for them. A particular (but problematic) gain of a diagnosis for many people is the sense that it is, therefore, not 'their fault'. We might question whether it is ever useful to regard someone as 'to blame' for feeling anxious or sad, but also consider the implications of believing that someone with a diagnosis has no control over or responsibility for their emotions and/or reaction to the situation.

Some have distinguished between primary and secondary gains of embracing a diagnostic label, and patient role, for the client. 'Primary gains' are the ways in which a preoccupation with one's symptoms (say being fearful of leaving one's house) may avoid addressing background difficulties from the remembered past, lived present or feared future. 'Secondary gains' would include, for example, agoraphobia being a way of manipulating an errant spouse into being more attentive at home.

Thus, although anxiety and depression *are* forms of distress, they are not *merely* distress, as they also generate psychological benefits: they have an 'upside', even if that is not necessarily consciously recognised by the client. It is worth noting here that our understanding (and the client's) of aspects of primary and secondary gains from symptoms are the basis of *formulation* rather than diagnosis. This distinction will be returned to below.

7 Working without diagnosis

If we abandon the medical categories of ‘depression’ and ‘anxiety’, how then do we understand and work with human misery? The first point is about words: different cultures vary in their description of transient inner states. The second point is that as we grow up we learn in our particular culture how to express the feelings we do and in what context. Our capacity to reflect on these feeling rules are important in understanding why the broad description of ‘neurosis’ typically involves ‘insight’. The depressed or agoraphobic patient is fully aware of their distress (indeed, they may be obsessed by that awareness), whereas someone diagnosed with ‘psychosis’ is generally seen as not having such insight.

Thus we cannot really understand the distinction between productive and unproductive expressions of distressed feelings unless we understand what is expected of people in different societies in different times. For example, the challenge of agoraphobia emerged largely in a period when women were expected to appear more and more in public spaces and were at risk of being outside the protection and control of men (de Swaan, 1990). In industrialised societies the challenges of most work roles require confidence and motivation; these are undermined or displaced by fear and sadness and so incapacitate the worker. Thus, when discussing emotions we need to be constantly aware of their meaning in different times and places. Different words are used and different rules apply over time and from place to place. A fundamental problem with a categorical view of mental illness is that it offers concepts that are imposed independent of time and space.

At the same time (as I argued earlier), it might be quite legitimate to claim that there are certain predictable aspects of fear and sadness that really do apply in all contexts (and to all mammals, not just humans). A different way of putting this is that ‘depression’ and ‘anxiety disorders’ are medical constructs: they are words. However, people are really distressed in particular ways. The meaning of these real experiences is then open to reflection within the person and negotiation with others.

One meaning that can be attributed is that ‘depression’ or ‘anxiety’ are medical conditions to be treated by drug or talking ‘treatments’. Alternatively, the person and their friends and family might ‘work out’ what the distress means without professional help. If a distressed person seeks help from counsellors or psychotherapists, then they are more likely to enter a negotiation of meaning in which the professional develops a view (a formulation) of what the presentation of distress means for the client.

8 The politics of diagnosis and formulation

Both diagnosis and types of formulation are forms of sense making about distress in our midst. Because a diagnostic view has been linked to the history of medicine, one explanation for its domination in our culture is simply about medical dominance: it is the highest status profession responsible for understanding distress. Accordingly, we find this sort of conclusion: 'Ownership of the DSM trademark has guaranteed psychiatry's reign over psychopathology because psychiatry controls how mental disorders will be named, determined, described, and diagnosed' (Blashfield and Burgess, 2007, p. 104).

Whilst medical dominance explains the retention of a diagnosis to an extent, it is not the full story. I have argued elsewhere that the survival of psychiatric diagnosis is only partially about medical dominance (Pilgrim, 2007). Many psychiatrists themselves are ambivalent about diagnosis. Also, some non-medical counsellors and psychotherapists retain a faith in the validity, or at least utility, of diagnosis and they may be required to submit diagnostic codes for payment in insurance-based health systems (such as Australia and the USA), or if they work within the NHS. Patients and their relatives at times find diagnosis helpful, though this depends on the label in question. 'Depression' might be a badge of honour for celebrities and politicians but 'schizophrenia' is rarely the basis of a positive career move. For relatives, a psychiatric diagnosis may reduce confusion and even alleviate a sense of personal guilt, if what Szasz (1961) called 'problems of living' are deemed to be specifiable illnesses like any other.

Pause for reflection

Think of examples of discussions of mental illness in the mass media. Which diagnoses are evident? Which are more associated with sympathy and which are feared or disliked by journalists and the public? Your answers might give you a sense of the variable status of diagnosis in our society today.

Thus, a social negotiation to maintain diagnosis implicates more than the medical professional alone, when a person with difficulties in their life world becomes a patient with a medical label. As de Swaan (1991) puts it, 'troubles become problems' when professionals begin to talk of 'presenting problems' or 'symptoms'. In this way, for example, misery is reframed as 'common mental health problems', 'anxiety states' or 'mild to moderate clinical depression'; recurrent nuisance or incorrigible offensive conduct is reframed as 'personality disorders'; and madness is reframed as 'schizophrenia' or 'bipolar disorder'. This reframing can suit a number of interest groups beyond the psychiatric profession.

There is disagreement in the literature regarding the conceptual distinction between diagnosis and formulation. At one extreme, diagnosis and formulation are viewed dichotomously. For example, Johnstone (2006) maintains that a formulation focuses on the personal meaning of psychological distress, whereas personal meaning is irrelevant to diagnosis. Accordingly, if diagnosis is correct, then formulation is redundant and vice versa. Carr and McNulty (2006) also point out that the diagnostic categories of the DSM IV (APA, 1994) are atheoretical, whereas formulation is fundamentally concerned with theory.

Other authors, however, see diagnosis and formulation as part of the same process. Scott and Sembi (2006), for example, claim that there is no inherent reason why diagnosis and formulation need to be mutually exclusive. Since the current classification (or nosology) of mental disorders is descriptive rather than aetiological, the purpose of formulation could be to fill the gap between diagnosis and treatment (Eells, 2002), echoing the logic of Carr and McNulty noted above.

9 Mixed messages from psychotherapies

If we look at the range of therapies on offer in the marketplace, ambivalence of non-medical therapists towards diagnosis remains. Pentony (1981) notes that broad affiliations exist within three separate rationales for personal change:

1. There are those that explicitly focus on faith in the interpersonal therapeutic alliance. This position is strongest in humanistic counselling.
2. There are those that have a rationale about resocialisation: habits and inner events are dismantled and new learning takes place. This approach is evident in psychoanalytical therapy and in cognitive–behavioural therapies.
3. There are those that emphasise contextual factors in maintaining and changing mental health problems. The latter has been largely derived from general systems theory and more recently constructivism in philosophy and social science. It has been associated far more with family than with individual therapy, although existential therapy shares its more critical stance.

This long but still partial list of forms of therapy reminds us that the therapeutic understanding of mental health problems is not a monolith. Each therapy brings with it separate and sometimes quite discrepant versions of formulation. These subsume different assertions about relevant antecedents of problems (which may or may not retain the notion of ‘aetiology’) and different explanations. Given this picture, what potentially opposes psychiatric diagnosis is not formulation but formulations. Vigilance is required by advocates of each therapeutic approach to construct and reproduce a particular and distinctive rationale because tribal membership, hierarchical status and salaries rely upon it.

Thus, a formulation is both a rationale for counsellors and psychotherapists within a school (about antecedent and maintaining factors relevant to particular problems and their resolution) and a rhetorical device to claim particular expertise about mental abnormality. Therefore, the ideological battle that ensues within the mental health professions is not merely between those who are biologically minded with their diagnoses and those who are psychotherapeutically minded with their formulations.

10 Conclusions

Because the scientific literature generally, and randomised controlled trials specifically, are organised around diagnostic categories, they have to be taken into consideration when counsellors and psychotherapists communicate with third parties. This suggests that the privileging of diagnostic-related groups by health policy analysts, drug company-sponsored medical researchers, government health departments and 'third sector' authorities, such as the WHO or APA, maintains the importance and legitimacy of diagnostic categories (despite the range of difficulties with diagnosis we examined earlier). Thus there are *pragmatic reasons* for considering the role of diagnosis in communication between different groups, despite the many criticisms made of it (Brown, 2005).

This pragmatic obligation to maintain a common language or conceptual framework locks counsellors and psychotherapists strongly into a discourse of diagnosis. This is even the case when mental health professionals in their daily local practice may be mindful of the limitations of a simplistic label for the client before them, with his or her biographical peculiarities. Thus the professional may use diagnosis, as crude shorthand, but then might do their best to understand unique constellations of symptoms in their life context.

Further reading

It is worth familiarising yourself with the diagnostic categories generally used in discussions of counselling and psychotherapy clients. The ‘mood disorders’ and ‘anxiety disorders’, particularly, relate to sadness and fear:

> American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: APA.

This is a very readable introduction to the history of how ‘madness’ and ‘mental illness’ have been understood and treated over time:

> Bentall, R. (2003). *Madness Explained*. London: Penguin.

This engaging book focuses on psychiatric diagnosis and the DSM, presenting a critical perspective on the definitions of ‘mental disorders’ put forward:

> Kutchins, H. and Kirk, S. A. (1997). *Making Us Crazy.* London: Constable.

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