Captain Cook had a Treatment Plan: Diagnosis and Treatment in Psychotherapy

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Abstract

This paper highlights questions regarding the relevance of *diagnosis* and *treatment* methods within psychotherapy. (Psychotherapy is viewed as a separate profession with links to psychoanalysis, psychiatry and clinical psychology). The theses are as follows: Diagnosis and treatment are concepts which prevent therapists from viewing the client as a whole person. Therapists who diagnose client difficulties overlay client presentations with their own favoured perceptions. Treatment plans are usually made according to a defined modality which views the world through a set of theories instead of ideas created by client and therapist together. Diagnostic formulations and treatment plans are also culturally bound instruments which may result in therapeutic colonisation.

Captain Cook set out on a journey which took him into the lives of people he had never met. Along the way he had to manage the process of change by first establishing effective relationships and then enhancing them by being engaged at a personal level. The methods Cook employed to establish relationships with people in the South Pacific led me to ponder psychotherapy as a profession in Aotearoa.

Cook had significant success on many occasions and some relationships were close and rewarding for both parties. Other relationships ended in confusion and there were those that ended in tragedy. The more I thought about the way we present our profession to enquirers, intending clients and trainees, the more I made links in my mind with Cook's missions. His training, experience and cultural formation influenced his approach to people he was meeting for the first time: people who thought differently, described their experiences differently and placed importance on different aspects of their lives. His journey seemed to parallel the journey embarked on by some psychotherapists. People are met with for the first time, a partial knowledge of their history is gleaned, a diagnosis or formulation is made and treatments applied from within a specific knowledge base. Sometimes the formula works, just as Cook found he was welcomed and

honoured by some people in the Pacific. Sometimes clients accept the words and actions of their therapist and view them as definitive. Some people in the Pacific believed in Cook's treatment methods so strongly that the unfortunate repercussions are still with us today.

Likewise some of our psychotherapy clients live with the idea that they suffer from psychological illnesses or traits defined by members of the profession. Just as some people in the South Pacific did not know there were alternatives to Cook's diagnoses and treatment methods, clients may not know there are alternatives to the practice of defining their dilemmas using psychological descriptors.

Contemplations offshore

The following extract from Cook's log uses the language of his era. The summary he makes reminds me of the way diagnoses or formulations are constructed in some settings today.

> *1. the religion of the natives bear some resemblance to the George Islanders-*
>
> *2. they have a god of war, of husbandry &c but there is one suprem god whom the(y) call he made the world and all that therein is-by Copolatio*
>
> *3. they have many priests*
>
> *4. the Old men are much respected -*
>
> *5. they have a King who lives inland we heard of him in Poverty Bay*
>
> *6. They eat their enemies Slane in Battell - this seems to come from custom and not from a savage disposission this they cannot be charged with - they appearto have but few Vices - Left an Inscription*
>
> *Their behaviour was Uniform free from treachery...41*
>
> (quoted in Beaglehole: 1955: 538-9)

In her book *The Trial of the Cannibal Dog* Anne Salmond comments:

> For years, Cook held fast to these conclusions, that Maori were honourable people with 'few Vices' and that cannibalism was simply a matter of custom. In this judgment he was influenced by Enlightenment ideals rather than British popular culture, which linked cannibalism with witchcraft and demonic possession. Many of the crew, however, held opposite views about Maori,

> regarding them as 'savage' and 'treacherous', and these differences of opinion sowed the seeds of future dissension between Cook and his men about how Maori and other 'savages' ought to be treated. (2004:128)

When I read Salmond's book I was impressed with the personal qualities of the courageous Captain Cook and it was salutary to view the process of colonisation through a different lens. The intent was to discover new shores and explore the way people lived; a process not unlike psychotherapy.

The method was diagnostic and treatment-centred and the results were often tragic. Cook approached people with polite curosity but when they indulged in behaviour he could not understand he often meted out 'treatment' based on generalisations and categorisation.

Welcome visitors to life onshore

My relationships with psychotherapists in New Zealand leave me in no doubt that there is real dedication to exercising the utmost care with respect to the lives of the people we touch. Therapists often live through pain, enlightenment and celebration with clients without forming a specific diagnosis or applying a designed treatment. What we name as transference is entered by these practitioners with trust and insight. The uncertain future of the relationship is surrounded by a faith that life has potential and promise. Clients welcome the therapist into their lives trusting they will hear meanings not yet expressed and hoping they will understand without judgment.

Many ships flying different flags

What happens in the practice settings of most of my colleagues seems to be inconsistent with the way we present our profession to those who have not yet become members or to intending clients. If I stand back and view the public face of psychotherapy in most countries, including our own, I see a confused profession.

On the one hand, in practice we are primarily concerned to assist with making the unconscious conscious and in working with the complexities of the relationship between two people in a consulting room. Many of us follow a client's life story without using designed formulations promoted in the literature and in training programmes.

On the other hand, the public image of our profession is different. It is one of a divided self where modalities compete for attention and this supports the idea

that therapists use a variety of ways to diagnose and treat people. Our Association handbook does not mention diagnosis or treatment in relation to psychotherapy but when I am asked to assess a candidate for membership I am asked to forward the name of my main modality. All the modalities I have researched over the years have diagnostic formulae built into them and include treatment methods which are often designed to target specific conditions or aspects of personality functioning. Generic training programmes are few in this country and most training opportunities expect trainees to adhere to specific formulae which are diagnostic and promote preferred methods for treatment.

The word 'formulation' is often used instead of 'diagnosis'. The key question for me is whether the formulation comes from words and ideas formulated by the client or whether the therapist builds a formulation using constructs fashioned by a theorist or a modality.

The chart in my cabin

My definition of psychotherapy is 'a process which encourages creative, well informed and safe contacts between two people in order to explore emotionally significant aspects which enhance or inhibit paths to healing, personal energy, creativity and secure intimate relationships'.

Mapping the chart

In order to practise safe and effective psychotherapy we need to reflect on the way clients present, our personal and professional responses to their presentations and whether we and our clients are safe within the relationship. I have been taught many ways to reflect on the work I do. My formal education covered theology, psychology, social work and counselling.

Initial instruction in these disciplines encouraged me to search for certainty and to respect research findings because they contained facts. During philosophical studies I discovered that certainty is extremely elusive if it exists at all and we make meaning of the world by naming some phenomena as factual. The result is that I have an inner ambivalence toward any process which seeks to define, make certain or propose definitive pathways for people. I now reflect on my work with a conscious (or unconscious) rejection of any temptation to place a template over that which is within a client or that which is within me.

In psychology classes I was accepting of the idea that people's behaviours could be grouped into categories, symptoms could be put into 'sets' and specific

psychological illnesses could be established by combining these 'sets' of symptoms. Undergraduates were expected to trust textbook summaries listing the origins and expressions of depression, psychosis or 'abnormal' behaviour. There was often a footnote in these works pointing out there may be exceptions to the rules but somehow a small number of exceptions did not mean the conclusions might be invalid.

I worked in a psychiatric clinic for six months. Patients were known by their label. The 'obsessive compulsive' was in room three and the 'paranoid schizophrenic' in room five. In the 1970s and 1980s the search was on to find neurological and chemically based treatments for 'conditions' and this often clashed with the work many of us were trying to do using therapy, social work and family based interventions. We were attempting to work with the *person* and I had been trained to be *curious* about association patterns instead of deciding the patterns formed the basis of some kind of illness.

My formal training as a pastoral theologian, a counsellor and then as a social worker engendered a fascination with the way clients constructed their thought patterns, their intricate emotional life and the dreams they had.

I became a member of the Association of Psychotherapists in order to explore the intricacies of the psyche. On the one hand, I heard presentations at conferences highlighting the uncertain world of emotional existence and the powerful world of verbal and non verbal associations. On the other hand I heard presentations illustrating how much therapists wanted to categorise clients' emotional lives, find formulae for managing them and reassurance in what they perceived as predictability in thought patterns. Clients were often categorised as having patterns such as 'drives', 'injunctions', 'disorders', 'energy blocks', 'embedded trauma' 'projective identifications' or 'unhealthy attachments'. The tendency to place a template over the life of a client seemed to me to ignore the ever changing nature of human existence and to place the therapist in the role of an adjudicator. This tendency continues today as therapists make themselves feel safe by using modality -based language to re- name client dilemmas. The client story emerges as one which fits the therapist's view of human development.

The ship's company

There is a place for diagnosis, formulation and treatment. I have never been certain where the boundaries are with regard to interventions appropriate for a psychologist, interventions best carried out by a psychiatrist and processes which belong in the psychotherapy setting but I am certain that many situations demand

competent diagnoses and treatment in order to keep clients safe and functioning well in their social and cultural settings. We refer some of our clients to professionals who are trained in administering treatments or interventions based on sound research. They apply medications or behaviourally focused management for clients who need expertise which lies outside our particular competence. We could not work without these colleagues. There are few definitive boundaries. In our association we have psychiatrists, psychologists, health specialists and medical practitioners who practise what I know as psychotherapy in addition to enhancing and saving people's lives using other appropriate interventions. Diagnosis has a place in psychoanalysis and I am making a distinction between psychoanalysis and psychotherapy. It is my view that in psychoanalysis analysis is *applied* to the client whereas in psychotherapy it is more likely the client will be assisted to draw their own conclusions.

There are situations where analysis and client initiated conclusions coexist and the question is whether clients should be ever be analysed, in the psychoanalytical sense, within a psychotherapeutic alliance. The distinctions between analysis and diagnosis are clear for some practitioners and theorists and not clear for others and I am aware that using the terms interchangeably raises more questions.

Defining the strategy before approaching the shore

The following definitions are offered to facilitate discussion:

Diagnosis or formulation is the process wherein the therapist relies on a summary of symptoms, behaviour or communications which are then 'contained' in a category descriptor and used to find a way forward for the therapist. Where diagnosis encourages the therapist to expand their knowledge and participate in a critique of chosen diagnostic categories the process may be useful in challenging therapeutic assumptions. Where the diagnostic or formulation process defines the client and informs them they have a particular 'condition' or 'fault line' the therapist is ignoring multi- faceted aspects which impinge on client growth and development.

Treatment is the process wherein the therapist chooses to apply a formula for healing which relies on method, a belief that client dilemmas have causes which can be defined and a framework dependent on stages. Treatment ideas assist therapists to contemplate effective ways to communicate with clients. Treatment applied by adhering to defined methodology assumes the client will benefit from being treated in the same way as other clients and may ignore individual or cultural difference.

Is the travel guide book helpful?

The idea that we can diagnose the person we are meeting as a client has its origins in the practice of dividing people into component parts. I am not sure what it is that psychotherapists can claim to diagnose with confidence. Are we confidently diagnosing 'psychological' factors? If this is the case do we know where the psyche is, where it begins and where it ends? Are we diagnosing presenting issues?

If so, how informed are we by the client in order to decide the extent of the dilemmas and how they link with facets we may not be competent to diagnose? Our diagnosis is probably based on having met the person in our consulting room. The relationships they have with other people are reported rather than experienced by us. Their social and cultural setting exists in a different atmosphere from that which we have created in our therapy room. Diagnosis or formulation often freezes people in a moment of time. It relies on stories having a beginning and an end, events existing in defined moments and the idea that client and therapist issues are the same today as they were yesterday. From this limited perspective we then choose a treatment. In most supervision sessions we would agree to "try something out and see how it goes" but the die is cast and the client is unaware we have been conditioned to approach them with a plan in mind in case we need it.

If we acknowledge psychotherapy as a 'process' rather than an 'intervention' we have a dynamic view of what is occurring within and around a client and ourselves as therapists. When clients tell their stories in therapy it is tempting to listen for themes which support therapeutic constructs we have been introduced to in training programmes. For example, we notice clients' association patterns and are tempted to refer to some clients as 'dissociating'. We have a tendency to follow the client story by giving it a form we construct in our own minds. The next step is to reach for an explanation as to why this pattern exists, diagnose it and then choose a treatment approach.

I have learnt from insights into the way our brains function and from the implications of quantum physics that it is impossible to separate one thought from another, one emotion from another and one state of being from another. Parts of each person have been given names and we continue to perceive them as separate entities. Mind, emotions and events are not separate states and do not exist on their own. The same is true of the patterns in a client's story. Patterns which seem to be there are formulations in the mind of the therapist and may not be perceived as such by a client.

Diagnostic procedure names emotions, behaviours and thoughts as if they have a continuous existence. The client whose personal and social history is known to us and seems to exhibit "a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment" may be described to a supervisor

the next day as being 'dissociative'. (DSM-IV: 1994: 477) The client who has had 'one or more manic and or depressive episodes' may be described to a supervisor as 'bi polar'. (DSM-IV: 1994: 350)

It is impossible for clients to have contracted a set of symptoms which, when summarised by the psychotherapist, fix the client in time as 'depressed' or 'disordered' or 'dissociated'. Sets of symptoms are put together by psychiatrists and psychologists using categories defined by selective research processes. Psychotherapeutic formulations which use theory-based categories to define client behaviour are much more subjective and questionable in my view.

I have seen clients struggling with their unique emotions and their overwhelming need to behave in ways that cause them pain but as a psychotherapist I resist giving these definitive descriptions such as 'repressed', 'depressive', 'bi-polar' or 'post-traumatic' episodes. It is more helpful to acknowledge patterns of thoughts, feelings and behaviour and discourage clients from viewing them as fixed within a category which indicates an illness of some kind.

Therapists usually agree that it is important to establish a relationship with the client as a whole person. Information from the scientific world encourages us to acknowledge that each time we intervene in one aspect of a person's existence we are having an effect on another. Intervention in emotional arenas has a profound effect on physical health, intellect, relationships, social and cultural connection. A diagnosis using psychological terminology drawn from a modality or from a psychiatric manual establishes the view that the psyche is separate from the rest of the person. It assumes healing will take place by attending to 'psychological' factors which inhibit growth. The person (or client) is now seen to be divided within themselves and dependent on psychotherapy in order to be healed.

When a physician diagnoses a person's physical ailments they usually point to a body part which can be touched, viewed via an electronic scan and repaired. In our profession we cannot point to the psyche and be sure that it exists. Once we have established a psychologically-based diagnosis we may diminish the person by accepting the notion that each person is the sum of separate parts and give them the message they are the same as every other person who has a similar set of symptoms. The idea that each person is unique has thus been jettisoned in order to make a generalised diagnosis or formulation.

Irvin Yalom writes

> A colleague of mine brings home this point to his psychiatric residents by asking: "If you were in personal psychotherapy or are considering it, what

DSM-IV diagnosis do you think your therapist could justifiably use to describe someone as complicated as you?" (Rosenbaum, personal communication, Nov 2000) (Yalom: 2003: 345)

This land is your land

The practice of assigning categories of psychological illness or disturbance across cultures is overdue for review. The culturally-based advice in the Diagnostic and Statistical Manual of Mental Disorders is being updated and research is being called for to address weaknesses in these publications.

The DSM–IV cautions psychiatrists by stating, "It is important that the clinician take into account the individual's ethnic and cultural context in each of the DSM-IV axes." It continues, " There is seldom a one-to-one equivalent of any culture-bound syndrome with a DSM diagnostic entity." (1994: 844) Unfortunately the next pages highlight comparisons between 'cultural syndromes' and categories in the DSM. A kind of psychiatric colonisation is attempted. The following serves as an illustration:

> ***Falling out or blacking out***: These episodes occur primarily in southern United States and Caribbean groups. They are characterised by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or 'swimming' in the head.
>
> The individual's eyes are usually open but the person *claims the inability to see.* The person usually hears and understands what is occurring around him or her but feels powerless to move. *This may correspond to a diagnosis of Conversion Disorder or Dissociative Disorder. (1994:846)*

It is possible that these symptoms have a cultural explanation which cannot be defined using concepts which originate in another culture. The DSM does what colonisers have often done; it attempts to fit aspects of human behaviour into its own frame of reference. The behaviour is labelled as an episode, and the symptoms are cross-referenced to categories designed by another culture. The behaviours are also viewed as 'disorders'.

Landing with luggage

Early this year I accepted another invitation to work with Maori health professionals to teach them therapeutic theory and process normally taught in a Pakeha setting. I realised I would be taught by my students perhaps as much as I could teach them.

I expected to discover ways of adapting European-based theory and practice to make it relevant in a different cultural setting. I was not surprised to find myself re-examining some of the basic tenets of psychotherapy, especially the traditional notions of diagnosis and treatment. I have addressed some aspects of working cross-culturally in previous publications and that is a separate study. In this paper I am highlighting important issues for psychotherapy in *any* setting. These issues have been underlined by my experiences in teaching within a different culture. What follows is a set of questions which lead me to wonder whether diagnosis and treatment should ever be part of my practice.

Diagnosis revisited

- Integration is built with support, initiatives and nurture embedded in cultural belief systems. Mind, emotion, physical form and spirit can all be spoken of as separate entities but they do not act in isolation from each other. If I address 'mind' I am addressing connections which are woven tightly together. A diagnosis which has its foundation in the separation of mind, body, spirit and emotions assumes disintegration has occurred. How can there be disintegration when there is no separation?

How can I make a diagnosis which addresses emotional forces within one person when those emotions are intricately bound to the emotions of another and to a spirit world woven into the world we call reality?

- Personal pain, described as emotional pain or trauma by European-based theorists, is not confined to the present moment and may exist on a timeline reaching deep into a timeless continuum. Associated events, relationships and formative intrusions may have happened to an historical figure in a cultural setting whose influence affects 'the client' in ways that remain in the shadows of anonymity. How can I form a diagnosis of human pain which sets it within a specific time frame or views it as existing only within the lifetime of one person?

- That which gives rise to personal pain or inhibition may not have a defined beginning. The idea that causes exist as separate entities is questionable within the context of life surrounded by constant ebb and flow. A diagnosis which postulates causes is likely to ignore the complexity of one life being a woven tapestry. To ask when pain began or when dis-ease was first formed is to ignore the interconnections scientists are examining and to reject the idea that there is a powerful collective unconscious.

- Individuals have a 'separate' physical body separated at birth and separate when death occurs. Does this separate physical body 'contain' and keep control of the psyche? The psyche (wairua) is heavily influenced and moulded by forces outside of the physical body which are connected with other bodies on earth and beyond. How can I be certain a diagnosis based on what I have heard from one person will be sufficient to explain individual pain, inhibition or unease? Where is my deep respect for people if I introduce them to a diagnostic explanation which narrows to concepts such as disorder, dissociation, depression, paranoia, repression, drives or injunctions?
- When there seems to be one client in the consulting room there may be others who are 'psychically present' whom we cannot 'see'. These people are not just held in memory or gathered in by association, they are there to be consulted. How can I proceed with a diagnosis of one psyche defining it as an entity within one person? How can I delineate its features using language created by people I have never met?

Treatment revisited

- Treatment implies focus. It selects an aspect to be treated and keeps it in view. My experience leads me to the conclusion that I cannot be selective. Cultural formation is woven and the spaces in between speak of connection rather than selection. Where is the 'individual' who needs 'treatment'? Where is 'the person' to whom the treatment should be applied?
- Treatment is based on a formula. A formula implies a stepped process with a beginning, a mid phase and an ending. Where is the beginning, the mid phase and the ending when it comes to human process? Are all individuals able to respond to the beginning place, the middle phases and the endings which have been built into the formula? The formula is likely to have been tested in selective ways. The assumption is that the psychological profile of research subjects is exactly the same as the psychological profile of any individual client.
- Treatment is targeted. In psychotherapy treatment is usually targeted behaviourally, biologically, psychologically or emotionally. Treatment targets assume people are the sum of separate parts and they often assume a specific starting point somewhere within a separated system. Treatment is often designed to target 'disorder'. Where is the disorder and can there be a decision as to where to target treatment when are no separate entities?

- Treatment is applied. I have developed caution with regard to seeing myself as an agent of treatment especially when it comes to working across cultures. I do not possess any tangible evidence which people can see or touch to prove my expertise in applying therapeutic treatments. Treatment modalities exist in name, in a variety of publications and in the minds of people who view them through different lens. They do not exist as definable methods. I find it difficult to imagine where my authority would come from in order to give myself permission to treat a person with something as intangible as therapeutic method.

The establishment of relationships means being comfortable with uncertainty rather than certainty. It means acknowledging I can never really know a person of any culture (including my own) well enough to apply a method to their person.

- Treatment implies healing. The idea that pain or trauma can be treated and then be healed is an idea that seems to run counter to life that ebbs and flows within a constantly changing universe. What is it that is being healed through psychologically-based treatment? How can one aspect be healed without affecting another? If all aspects of the individual psyche are affected are they all automatically healed? If treatment is applied to an individual does this make them an agent in their own healing and how is this linked to the way healing is dependent on the lives of significant others who have not been invited into the treatment process?

- Treatment is usually applied within a specific context. The idea that treatment should be honed or narrowed to manageable steps is indicative of the belief that specific contexts are important. The separation of one context from another is a process applicable in some cultures but not in others. A whole of life view demands that change to one aspect of a nurturing system does not take place without taking care to include all aspects. Support for people should involve healers, advisers, historians, spiritual guides and links with ancestors to address any matters which may be inhibiting the fullness of life within the nurturing community.

Knowing this, it is difficult to imagine why I would contemplate treating one aspect of a person's life in any cultural setting without making associations with other aspects and without being as inclusive as possible. I may well agree to work with an individual but I will be aware that the idea of targeted treatment within a defined and separated context is a denial of the wholeness my profession espouses.

Notes in the log

My conclusion is that definitive diagnoses constructed around the client rather than with the client are contrary to what we know about human development. I am also suggesting that treatment designed by a theorist rather than client and therapist together, fails to acknowledge clients' unique place in the world and their unique psychic development.

The psychotherapy profession has many practitioners who practise without needing to divide people into categories. The public face of psychotherapy is different. It promotes division and separation and suggests strong links with professions whose role it is to analyse, diagnose, treat and search for definitive solutions to ill health and dis-ease.

Training courses which perpetuate divisiveness through adherence to specific methodologies promote the belief that the psyche can be defined, analysed and changed using the same methods in any setting. I look forward to a time when psychotherapy develops theory and training opportunities which focus on how to manage complex relationships without applying designed formulae and methods. That will usher in a new era for psychotherapy and for clients.

References

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition. Washington, DC: American Psychiatric Association.

Beaglehole, J.C., ed., (1955). *The Journals of Captain James Cook on His Voyages of Discovery, Vol.1: The Voyage of the Endeavour 1768-1771.* Cambridge at the University Press, for the Hakluyt Society.

Salmond, Anne (2003). *The Trial of the Cannibal Dog, Captain Cook in the South Seas.* Penguin Books, London : England.

Yalom, Irvin D. (2002). *The Gift of Therapy.* Harper Collins: New York.