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CONTROVERSIAL DISCUSSIONS

WILEY

The uses and potential dangers of diagnostic language in psychotherapy and counselling

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Abstract

The following is a discussion between two psychotherapists from different backgrounds (Gestalt and psychodynamic) debating the uses and potential dangers of diagnostic language and thinking within the profession. Starting from different positions, the two authors engage with each other's views in order to explore and expand the notion of diagnosis in more depth. The emphasis is on widening the discussion rather than proving each other wrong. Therefore there is no attempt to wrap things up in a neat conclusion. The reader is left to find his or her own position, which may end up being aligned with both authors at the same time. What on the surface may look like an expression of polar opposite positions becomes a relational exploration of common ground, expressed in different ways for different reasons.

KEYWORDS

diagnosis, dialogue, eating disorder, field conditions, Gestalt Psychotherapy, medical model, personality adaptation, personality disorder, phenomenology, polarisation

The following dialogue between Chris Wise and Steffi Bednarek emerged from an email discussion between Steffi and two other therapists on the Psychotherapists and Counsellors for Social Responsibility Network (PCSR).

A psychotherapist had posted a request to refer a client who had "issues with food," as she put it. Steffi personally knew the referrer and missed the fact that this email was posted to the whole PCSR network. Her reply was brief and, as far as she was concerned, written as a personal message to a friend who knows her very well. In her reply, she used the term "eating disorder" instead of "issues with food." She did not realise that her reply had gone out to all members of the PCSR group. Two group members, who did not know Steffi, took issue with the word "disorder." They initially expressed their views in a passionate and somewhat combative way, defending their deeply held values, which, they felt, were being undermined by the use of the word "disorder." Their main critique was that the word lacked relatedness. However, the combative nature of the way their concerns were worded mirrored this exact lack of dialogue, relatedness and exploration that they were so concerned about.

It is important to note that this exchange happened against the background of Donald Trump's having just been elected as President of the United States. Steffi stressed that, in this climate, there was a heightened need to engage in respectful dialogue with people who hold different views, even if these views offend or scare us. She invited all

parties to engage with each other in an open exploration, trying to suspend judgement and reactivity whilst finding a ground where it is possible to listen to each other with open curiosity whilst also being able to disagree. In this open email exchange, it transpired that the views and values that were held by each party were actually shared by all. What on the surface appeared to be an expression of polar opposite positions ended up as a relational exploration of common ground, expressed in different ways for different reasons.

The discussion covered the oppressive power of words as well as the oppressive nature of shame that can sometimes be used to drive differences underground. Without a robust willingness to stay in relationship and explore differences, prejudices risk remaining unaddressed and can disguise an empty use of language that seems dominant in certain circles. Following this initial PCSR exchange, Chris Wise contacted Steffi and invited her to expand the dialogue.

1 | MONDAY, 9 JANUARY 2017

Hello Steffi,

The first thing I want to say is how much I admired and enjoyed your posting on so-called eating disorders under the PCSR-discussion board. Then I thought it would be great to have a longer discussion where we had the time to send a few exchanges back and forth and just see what happens. There's a quote popped into my head that I can't immediately place: “meander if you want to get to town.” So, let's meander and see where we end up.

I don't like the term “eating disorders” for a variety of reasons. I don't like the word “disorder” attached to any description of what it means to be human. It reifies us. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) series of tomes (produced by the American Psychiatric Association) is now up to edition five, which was published in 2013 and has added dramatically to the number of so-called disorders. There are literally hundreds (I think I appear in three or four!). There are many critics and criticisms, not just from the people you would expect, like Paul Verhaeghe (see his website: paulverhaeghe.com) but from those you would expect to be on board. Indeed, the latest edition was severely criticised by Allen Frances, the psychiatrist who produced the previous edition (DSM-IV) which was itself too much for me. The British Psychological Society (BPS) is sceptical, closer to Verhaeghe than Frances. The Canadian philosopher Ian Hacking reviewed it rather harshly in the *London Review of Books* (2013), again casting doubt on the whole enterprise. He invokes the cliché of the wood and the trees; his criticisms relate to the wood, as do mine. He points out that Frances has been blogging his criticisms of DSM-5 but the focus is more on the trees.

But we need some theory to enable us to talk about the content of our client's presentation, so we have to agree some terms. I talk about transference, the need to hold and contain, Oedipal issues, and so on. I believe in the importance and power of words but I don't like the idea of diagnosis divorced from the human story. I would prefer it if we could move away from a medical model, which we have mainly for historical reasons.

Some thoughts: eating disorders are never about eating, they are a solution to something; or they are ways of being in the world; the gender imbalance is so huge, we need to explore that; if the client won't feed herself, why on earth should she let me feed her?

Regards,

Chris

2 | TUESDAY, 17 JANUARY 2017

Dear Chris,

I welcome your invitation to “meander” on the important and contentious subjects of diagnosis and the use of words that sit within the medical model. I also feel daunted by the enormity and complexity of the subject, as some of these words reflect obvious—as well as hidden—power structures within the field of mental health. How do we do justice to these multifaceted layers?

Firstly, I want to clarify that I am a Gestalt psychotherapist. I view myself as firmly rooted in a humanistic and relational style. Phenomenological exploration of the human experience is one of the most essential tenets of Gestalt

therapy, together with relationality and field theory (Chidiac, 2017; Francessetti, 2017; Spagnuole Lobb, 2017). We are opposed to labelling, fixing and categorising processes, and invested in seeing, feeling, smelling, hearing the person in front of us and how we are impacted by them in a current field context. As a Gestaltist I use my whole person, my senses, my perception, my history and knowledge in the here and now in order to get a sense of how we co-create our relationship. I see any presenting issue as a "creative adjustment" to environmental conditions. In that way, what may be called "disorder" is seen as a creative act of adaptation to a setting in which this pattern of behaviour would have made sense. It sounds like we are in agreement about that?

No-one is the same, nobody is "a borderline," "a schizoid," or "a narcissist," even if they share a pattern of adaptation that has similar traits to other people's adaptations. If used in a reductionist way, I fully share your unease and mistrust of the use of the word "disorder" in relation to our human experience.

And yet, as you know from the PCSR email exchange that followed the original article, I do use the word "disorder" at times. I want to be clear that I am really talking about "patterns," not about people. I realise that it risks reinforcing damaging power structures if used carelessly. So why, you may argue, associate any client with words that come with so much unhelpful baggage?

My personal preference is to use the term "adaptation" rather than "disorder." In relation to eating, the original PCSR member used "issues with food." Whilst we communicate in a rather self-selected group, these different terminologies will make sense and communicate. However, try googling "issues with food." I did and what came up on the first page was confusing. The results included a wide range of interpretations such as: food problems in America and Africa, food and climate change, "eating problems," food sustainability, food safety, just to name a few. Or try to research information about personality "adaptations" in the literature. You won't find much. If I want to communicate information about a "pattern" across modalities, or research what has been written about it, I face a need to express myself in a shared language. If people have to translate "issues with food" into "problems with eating" or "eating disorders" in their minds in order to know what is being referred to, then we are just changing the surface, not how we fundamentally relate to the phenomenon.

I worked as Head of Counselling and Wellbeing for a university and managed a team of psychotherapists from different orientations as well as a mental health team. I was also charged with overseeing a National Health Service project and managing the university's liaison with the medical centre, including their mental health nurse. I worked at the intersection between the medical and the social paradigm. If I used "issues with food" in such a diverse context, it could have meant many different things, like not feeling able to tolerate different food types touching on a plate, not eating certain foods, food intolerances, fear of contamination, refusing to eat, over-eating, being a fussy eater, projecting onto food, and much more. Unless colleagues simply translated" issues with food" into "eating disorder" in their minds, I would have needed to give a lengthy explanation of what I meant. Using terminology that refers to a certain "pattern" and an agreed dimension of severity can be a helpful starting point to find out how colleagues work, what support they may offer and how we may usefully work together across disciplines.

I think about diagnosis as a map rather than the territory. The map has no fixed reality, it merely gives me certain information that may be helpful in having an idea about the demands of the terrain, judging whether I am prepared enough, knowing what areas to look out for and what dangers to avoid. The map is different from the territory and my experience of moving through a landscape—feeling the wind and the sun on my face, getting out of breath, etc., is unique in every moment. No map can predict my actual experience.

However, unless a territory is very familiar, I may need recourse to a map to inform decisions about the general direction, to make the experience safe, to ensure that I don't get lost or take unnecessary risks, or even to know that it is safe to allow myself to be guided by my curiosity. A map gives me a framework that I can check out before I direct my mind to other frameworks, including my direct experience. I find diagnostic criteria useful at times and I also hold them lightly, holding both polarities at the same time, zoning in and out in constant movement. Looking for a pattern does not have to stop me from experiencing the uniqueness of this moment with this person. I do not want to limit my choice of expression to either polarity in a good/bad dichotomy.

Writing this, I start to wonder whether it is not so much the map that is problematic but the way the map is used in certain contexts. Some people use maps in narrow ways that close down options and prescribe direction. Other people just know that there is a map to get back to in case they get lost.

I also want to say that I am acutely aware of the extreme pathologisation of the human experience that has culminated in the DSM-5 and that I completely and wholeheartedly share these concerns without a shadow of a doubt. I am as worried as you are about the dominance of the medical paradigm, and the power and the strong lobby behind it. I agree that we need to be careful how we use diagnosis. I also think that the medical paradigm has helped us to see and understand patterns and has contributed to our knowledge of the human experience. As far as I am concerned, the fact that a strong and dominant lobby have taken the idea of diagnosis too far does not mean that all aspects of diagnosis will be bad and that everything connected to the medical paradigm should therefore be rejected.

There is more to say, but I am interested in your thoughts. I am especially interested in your comment: "I believe in the importance and power of words but I don't like the idea of diagnosis divorced from the human story. I would prefer it if we could move away from a medical model, which we have mainly for historical reasons." Can you say more about that? What would a move away from diagnosis and the medical model look like for you?

Warm wishes,

Steffi

3 | SUNDAY, 22 JANUARY 2017

Dear Steffi,

In your PCSR postings, I liked the way you created the potential for living alongside another language which wasn't yours but could possibly add something of value.

When it comes to . . . and I'm not sure of my own language here when I want to describe the ways people try to deal with the problems of living, of being-in-the-world, of finding—if I may borrow a word from your language—an adaptation. To some degree this is us all. We deal with our anxiety (and everyone is anxious) in many creative ways, though some are less helpful than others. The so-called alcoholic has a problem not so much with drinking as with sobriety. If alcohol is his solution (his cure, his adaptation), could he find a better one?

If not eating is a way of coping with what the young woman encounters in the world, what is it that she finds—I was about to write "distasteful"—so challenging that the possibility of dying may be insufficient to change her way of living, because that way of living is what gives meaning to her life? My experience in this area, which is not extensive, makes me aware of a number of issues: we are talking almost exclusively about young women; they are wary of anything that I may have to offer (if they won't feed themselves why would they let me feed them?); the consequences may be potentially fatal; there are clearly cultural issues about being female and having a female body and that has always been true.

I'll finish for now with language. I previously said I didn't like the so-called medical model with an emphasis on diagnosis. But I was grateful to the doctor who diagnosed my chest infection and gave me appropriate medication last week. So, if there is a diagnosis of anorexia and you talk about her adaptation and I talk about her way of living with the vicissitudes of her life and others of differing theoretical persuasions bring their own language to bear and finally, or foremost, we attend to the language of our young women, what may come out of that?

Warm wishes,

Chris

4 | WEDNESDAY, 8 FEBRUARY 2017

Dear Chris,

I very much like, and resonate with, your exquisite attunement to the field conditions that our lives emerge out of and chime with. The ecology of our lives and their interconnectedness with the lives of others and the political,

social and spiritual aspects are too often forgotten when we enter the linear language of the medical model. The medical paradigm focuses almost exclusively on the symptoms the client brings and rarely asks whether these symptoms could be healthy adaptations to a dysfunctional context or a sick world. Its focus is to rid the client of the symptom rather than to deepen the relationship to the symptom in order to understand the deeper message it carries. If I include the possibility in my thinking, that the context may be "disordered" and that the symptoms of individuals may simply be an attempt to adapt or to highlight this, then would that not also be diagnostic thinking, but in a different direction? My interventions as a therapist would certainly be very different. In terms of a symptomology to do with food, Hillman and Ventura (1993) talked about our culture, our cities and our buildings being anorexic, devoid of nourishing soulfulness. They reminded us how difficult it is to distinguish between individual pathology and the pathology of the world and how our clients' symptoms are often a refusal to conform to the sickness of the world. Whilst this is certainly not the view of the medical model, I also want to stress that using a term from the medical model to describe individual symptomology does not mean that I am limited to operating within this model.

For me, diagnosis is an ongoing, fluid process of curious enquiry. I listen to the language of the client and notice the impact of their words and actions on me. This process falls on the background of my professional experience, my reading, my training, my view of the world. I check my background for what it is that needs to emerge as a response or intervention that may be useful for the client. With most clients, this interplay evolves in the moment, but, for me, diagnostic thinking is always a part of judging whether or not an intervention is helpful for a specific client. What do they need—in this moment or over time? What patterns emerge and need gentle, or at times rigorous, challenging? What parts are not supported enough?

There are some clients with whom my diagnostic thinking is more in the foreground than with others. I notice, for instance, that my practice has changed with acquiring more knowledge about personality adaptations/disorders. Even though I recognise the risk of slipping into the medical model when thinking in categories, I have found it enormously useful to recognise certain common adaptive patterns and learn from existing literature what may be needed from me on a consistent basis. I am grateful for other people's writing and research into the most common personality adaptations. It has helped me to learn and recognise when it may not be useful for me to follow the client, for instance. Before I engaged with these maps in more depth, my work with certain clients was sometimes ineffective and I got caught up in their patterns too easily. This was not helpful.

I guess I come back to the image of the map. The cartographer has to ignore the individual tree in order to extract categories. The person who walks in the territory can be informed by the map, but have a deep and meaningful encounter with one tree. I am grateful to the cartographers, whilst also being concerned that we seem to move more and more into a paradigm that tries to fix things, to reduce people to symptoms and to medicalise the human experience.

I would love to hear more about your concerns about diagnosis.

Warm wishes,

Steffi

5 | WEDNESDAY, 22 FEBRUARY 2017

Dear Steffi,

I think you have spelt some of them out. I would say: don't medicalise the human experience.

One of the problems we have was handed down to us by the scientific revolution that divided the world into matter and mind and left no language to those of us who wanted to talk about mind. So we use analogies. We don't know what the mind is or how it arises. Actually, I'm not sure we really know what the body is except in a rather mundane sense. We don't know how we acquire a mind but how do we get a body? Susie Orbach is doing some fascinating work on this. She has said, à la Winnicott, there is no such thing as a body. Her book *Bodies* (2009) and

her regular seminars explore these issues. She has, of course, written extensively on eating issues. I am not citing her in support of what I am saying here, just saying that she is worth reading.

Anorexia seems to be a physical solution to a psychological and philosophical dilemma. It then creates its own physical problem which may become life-threatening and the focus then becomes about the young woman's refusal to eat. It is seen as her problem and the solution is easy—eat. But that diagnosis ignores the cultural pressures that women have always been subjected to. It ignores how a young woman finds meaning in her life. How does she respond to the dictates of a culture that demands her body conforms to the image of the perfect female form that is always sexualised, evaluated, and criticised?

Puberty is the key event in adolescence (although I recently had a pre-pubescent 10-year-old girl tell me that "food is the enemy"). How that is dealt with is a huge issue not just for the individual but for parents and the wider culture. It is a time of enormous change, adjustment and confusion when other demands are also being made: in education, in relationships, and in choices about how to live. A 14-year-old female client (worryingly thin) said if she could stop worrying about what others thought about her, she could work out how to live. That led to some illuminating conversations about how she might do that.

Given that this issue is almost exclusively female (I have had just one anorexic male client), I think we need a discussion on gender, but maybe we save that for next time.

Warm wishes,

Chris

6 | FRIDAY, 3 MARCH 2017

Hi Chris,

Yes, to all of the above. However, what you say sounds like diagnostic thinking or reflections to me. We are discussing whether or not diagnostic thinking and language are appropriate within our field of practice, are we not? I would actually argue that we run a risk of doing harm if we intervene without any form of diagnostic thinking. We may not use the medical map, but it may also be helpful to know how and where we differ from it and where there may be connecting points.

Warm wishes,

Steffi

7 | THURSDAY, 30 MARCH 2017

Hello Steffi,

To diagnose something usually means to detect a fault or flaw (I am aware of other uses of the word, and its origins, but this is the first meaning given in the dictionaries I have). My doctor may do it, but so might the mechanic looking at my car. With a car, it is relatively easy—with our bodies, much less so. Either way, I don't think I am doing that. But we obviously need ways of describing what we think is going on, and from both sides of the therapeutic relationship. Describing mental events is difficult but we have to try to do that, so we have terms like depression. Of course I accept that, but I want to keep it within the human story and the life story of the individual. I also want us to be realistic and say depression can be a natural response to the world. If you watch the news and don't feel depressed about the state of the world, then there is something wrong with you. It's what you do next that is important.

We all need concepts to help us think. A framework of ideas that describe what it is to be human. Is this what you mean by diagnostic thinking? If mine differ from yours it makes for an interesting conversation, but doesn't seem to matter much in how we work (and in my experience, our clients don't care about our theories, they just want to have a conversation). The ferocious arguments in our world about whose concepts are better have lessened, but the demand for evidence-based practice persists and what constitutes evidence is interpreted narrowly because we can't break

free of the medical model (the pressure on therapists to conform to that model can be enormous and the politicisation of that is disgraceful. Colleagues like Paul Williams report on and fight against this). Measurement is the mantra but how does one measure relationship? Why would one want to? The danger of diagnosis is that it closes down discussion about other possibilities. That's fine when it's my car—there's an electrical fault, it's fixed and I can drive again. But in our world, I want to open up possibilities.

What all this touches on is the discussion about how we classify what we do. Freud said that it wasn't medicine, but the medical model persists.

I'm not sure where this gets us, Steffi. I think our differences are fascinating but we agree on the important stuff. That's my diagnosis of where we are! (What should we talk about next? Gender?).

Warm wishes,

Chris

8 | MONDAY, 10 APRIL 2017

Hi Chris,

I think where we clearly and whole-heartedly agree is that a person's unique experience should not be reduced to fit a rigid and linear model. We also agree that a lot of client issues are healthy adaptations to a sick world and that it often is the environment that may need changing rather than the individual.

Where we seem to disagree is what diagnosis is and what it is for. I don't agree that to diagnose means "to detect a fault," as you say. As explained earlier, I see it as a way to constantly assess what we are working with. This allows us to make an informed judgement about whether we are adequately equipped, trained and experienced to work with a certain client presentation.

The therapeutic relationship supports a large proportion of clients, but not all. Some people have had to make adaptations that are too complex and rigid. They may not be able to take in the fact that there is an independent other out there, but be locked in their projection of their inner world for a large proportion of time. For me, diagnosis is an important part of recognising who these clients are and what is needed from me in order to help them and—most importantly—not to harm them. Diagnostic thinking gives me information about what kind of therapeutic relationship is needed. I believe that this requires learning from the experience of others and being open to all knowledge that is out there. We may risk short-changing our clients if we move from the medical model completely to the other polarity. Is it not useful to be able to operate in the whole spectrum and to choose what may be most appropriate in a given circumstance, rather than position ourselves on one side or the other? So as a provocative statement, let me say this: I think overreliance on the medical model has reduced our society to a dangerous state of affairs, but I think it can be equally dangerous and harmful to move to the other polarity and to completely reject the insight that a diagnostic map can provide.

When working with PTSD, psychosis or borderline presentations, it is possible for psychotherapy to contribute to a significant deterioration of wellbeing to a point where clients may need hospitalisation. I believe that without inclusion of diagnostic thinking we run the risk of being, at best, ineffective and, at worst, causing harm to clients. A knife can cause harm or be helpful, depending on how we use it. I find myself thinking about diagnosis and outcome measures in the same way.

I am grateful for your initiation of this debate. It has given me a lot of food for thought and I thank you for that. I agree with your "diagnosis" that we agree on the important stuff.

Warm wishes,

Steffi

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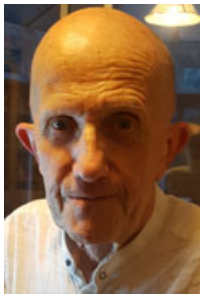

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