

# Chapter 1 Introduction

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Welcome to *Understanding Counselling and Psychotherapy*. We hope you enjoy reading this book and come to understand more about counselling and psychotherapy in the process. We've brought together several of the leading counsellors, psychotherapists and academics in their fields to tell you about different ways of understanding counselling and psychotherapy with people who are struggling with experiences relating to fear and sadness.

As you go through the book please don't just treat it as something to read and digest. The more that you engage with the material, the more you will learn and the more useful you will find it in your own life: whether you are a counsellor or therapist yourself, someone considering those professions or just someone who is interested in knowing more about different ways of understanding, and working with, fear and sadness. For this reason we have included lots of 'case illustrations' to bring the material to life for you with real-world examples. You might want to supplement these by reflecting on your own experiences or chatting with other people in your life about theirs. We have also included 'pauses for reflection' where we ask you to consider something before moving on, and 'activities' where you can try out a particular technique or type of research, for example. Please do have a go at these exercises and feel free to scribble all over this book (unless it is a library book!) with your thoughts and comments on the exercises, questions and other content. Or make such notes in a personal journal if you would rather.

## 1.1 Why 'understanding'?

It is important to explain what we mean by 'understanding' in the title of our book because we don't want to give the impression that reading it will give you one definitive understanding of counselling and psychotherapy. Rather, there are many different types of counselling and psychotherapy, based on different ways of understanding human distress. These may be complementary or they may conflict with each other. Also, the ways in which these theories translate into practice when different counsellors and psychotherapists work with clients may look very different. We will explore some of the key themes and tensions in both theory and practice throughout this book. Today, many

counsellors and psychotherapists operate within the context of ‘mental health’ organisations. Therefore we thought that it was important that this book included some basic material about how the problems that people come to counsellors with are understood in terms of ‘mental health problems’, and how they can be treated medically as well as psychotherapeutically. Increasing numbers of people take antidepressants or anxiety medication as well as seeking help from counsellors. We have also included material about the different contexts and settings in which counsellors work, and how their practice is researched, as these are the key ways in which governments decide which approaches to give funding to within the health service.

Counsellors and psychotherapists also operate within the wider society. For that reason, throughout this book, we will reflect on the ways in which difficult emotions are generally understood (often in the context of ‘mental illness’). In particular, we will make sure that you are aware of the history of counselling and psychotherapy from its roots in early psychoanalysis (which became known as ‘the talking cure’) to how it is practised today by the various different approaches, and the ways in which sociocultural issues impact on how difficult emotions are experienced, and expressed in the therapy room.

## 1.2 Why focus on fear and sadness?

By far the most common emotional difficulties for people to report, and seek counselling for, are those related to sadness and fear. These are often classed under ‘depression’ and ‘anxiety’ if they are diagnosed, but we are using the terms ‘fear’ and ‘sadness’ throughout this book to encompass various different ways of understanding these emotions. In Britain anxiety and depression have been found to affect at least one in six people each year (Office for National Statistics, 2001). Many authors have written on their own experiences of these problems (Lewis, 2006; Lott, 1997; Solomon, 2001; Wolpert, 2006) and celebrities such as Stephen Fry and Trisha Goddard have spoken about them on widely accessed television and radio programmes. However, fear and sadness are certainly not new things, and these aspects of human suffering have taxed thinkers for centuries, from philosophers and scientists, to artists and writers. Over the last 100 years, a medical approach has dominated which sees them as ‘mental health problems’ and the related ‘helping professions’ of counselling and psychotherapy have developed to work with people who are troubled by difficult emotional experiences.

It would be an extremely rare person who went through their whole life without experiencing fear or sadness: for example, the majority of people have some kind of phobia (fear of heights, spiders and snakes being particularly common), and almost everyone at some point will be bereaved and experience the sadness of losing someone they were close to. For most of us there will be times when fear or sadness will become extremely hard to deal with and it will become difficult to carry on with our lives in the ways we had before. That is when ‘diagnostic’ words such as ‘anxiety’ and ‘depression’ often get used. Chapter 2 of this book will say much more about the pros and cons of these kinds of categories, and we will see in subsequent chapters how some therapeutic approaches see fear and sadness as universal experiences (for example, many humanistic, existential and mindfulness approaches), whilst others distinguish between everyday struggles, and ‘anxiety’ and ‘depression’ as ‘mental illnesses’ (for example, many psychoanalytic and cognitive–behavioural approaches).

For now it is just important to start to think about the commonality of the kinds of experiences we are talking about in this book. It can be easy to think that ‘emotional problems’ or ‘mental health difficulties’ are things that happen to the people who come to counsellors and therapists for help (the ‘clients’ or ‘patients’), and not to the counsellors and therapists themselves. However, many of the key theorists you will meet in this book (such as Sigmund Freud, Carl Rogers, Aaron Beck, Irvin Yalom and Steven Hayes) experienced anxieties and depressions themselves through their lives, and there are biographies and autobiographies detailing how their experiences informed their own therapies. Many counselling and psychotherapy students report being drawn to these professions because of what they have been through themselves, or because they have been involved with friends and family who have suffered greatly with such difficulties. They are keen to help others in these situations. Whilst it is, of course, problematic to counsel other people with the aim of helping yourself with your own problems (and we will consider such issues around ‘boundaries’ and ‘self-disclosure’ in Chapters 11 and 12), many therapists and counsellors find that counselling training and working with clients are hugely beneficial in their understanding of themselves.

Also, writers such as Johnstone (2000) and Richards (2010) warn that it can be dangerous for counsellors and psychotherapists to view their work in an ‘us and them’ kind of way, where ‘us’ (the professionals) have no problems and can help clients get better, and ‘they’ (the clients)

have lots of problems and can't help themselves. It can lead to therapists being discomfited if clients do improve (because that breaks down the 'us and them') and finding it difficult if they don't (because then they feel that they haven't been a good helper). Clients who pick up on this are placed in a very difficult situation, at a point where they are particularly vulnerable. Remembering that counsellors have problems just like their clients do, and that clients have their own strengths to bring to the situation which therapists, themselves, might learn from, are both good ways to avoid getting stuck in that trap.

This kind of thinking can also help to break down the stigma around 'mental illness' (Pilgrim, 2005) which is still very present in the use of words such as 'nuts', 'mad' and 'crazy', and the unfounded stereotypes that anyone with such problems is dangerous to others, is unintelligible, incompetent and unable to function. Such prejudice may deter people from seeking help from counsellors and psychotherapists for fear of being labelled in these ways. Perhaps the most common worry expressed by people coming to counsellors for the first time is that they will discover that they are not 'normal'. We will come back to such issues in Chapter 2.

To help illustrate these points, here are two of the authors of this book talking about their own experiences of fear and sadness.

### Case illustration: Experiences of the authors of this book

*Meg:* I've definitely had times of quite extreme sadness and fear throughout my life. One of the most intense times was back when I was studying in college. My partner at the time was really struggling with the death of his father and, in trying to support him, I became quite shut off from the rest of my world (most of whom were more interested in drinking beer and socialising than talking about loss and pain!). Friends were hurt by the way I withdrew to look after my partner and were angry with me. That resulted in me withdrawing more and, for a while, the world became a dark and scary place. I found it hard to get up in the mornings and leave behind the safety of my bed. I often couldn't leave the house, and simple exchanges (with a shopkeeper or a plumber, for example) completely terrified me for fear of what they might think of me.

I've found counselling and psychotherapy helpful at such times, but have also found my own ways of dealing with fear and sadness, for example meditation (which I write about in Chapter 8), keeping a

journal and finding ways to face the things that frighten me in a gradual way (see Chapter 7). Personally, I don't find diagnosis words like 'depression' and 'anxiety' helpful (see Chapter 2), because I don't see my experiences as that different from the kinds of existential struggles that all people go through at some point (see Chapter 6). I've also found it useful to think about how my culture, gender and sexuality relate to my experiences of fear and sadness (which I write about in Chapter 10), and to share my experiences with people who've been through similar situations instead of keeping them to myself because of the stigma that surrounds them.

*Fred:* The experience of moderate levels of anxiety and sadness has been a lifelong one for me. However, it was only in 1973, at the age of 30, that things got really bad. I was overcome with chronic anxiety, which took the form of incessant intrusive thoughts concerning harm coming to myself and others. The condition was perhaps most accurately characterised as obsessive–compulsive disorder (OCD). OCD consists of repetitive unwanted thoughts that usually frighten or disgust. The compulsive behaviour is an attempt to neutralise the obsession. So, for example, a fear around security might lead to endless rituals of checking doors and windows. For me, depression and anxiety were locked into interaction with the OCD, indicating how difficult it is to draw tight boundaries (see Chapter 2).

I was prescribed medicine (see Chapter 3) but I cannot attribute my recovery to this. I feel that I just got better with time. It seems to me that OCD is a particularly difficult case for counsellors to consider. The temptation to give reassurance and to use rational methods of discourse to solve the problem is very strong but this risks consolidation of it. To risk a cliché, I think that I learned a lot from the experience, such as just how bad psychological pain can be. I think that I became more empathetic as a result of it. Finally, it was suggested that I produce an autobiographical account of my experience, which first appeared in 1990. A second edition appeared in 2002 (Toates and Coschug-Toates, 2002).

### Pause for reflection

Imagine that each of these people came to you, as a counsellor or as a supportive friend, during the times they describe when they were really struggling. How would you work with them? What kinds of things do you think would be useful? What would be unhelpful?

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### Activity 1.1 Your fear and sadness

Remember a time when you felt strong fear or sadness (or both together). Spend 15 minutes writing a couple of paragraphs (similar to those above) about your experience: one about what it was like, and one about what you found helpful and unhelpful.

### Discussion

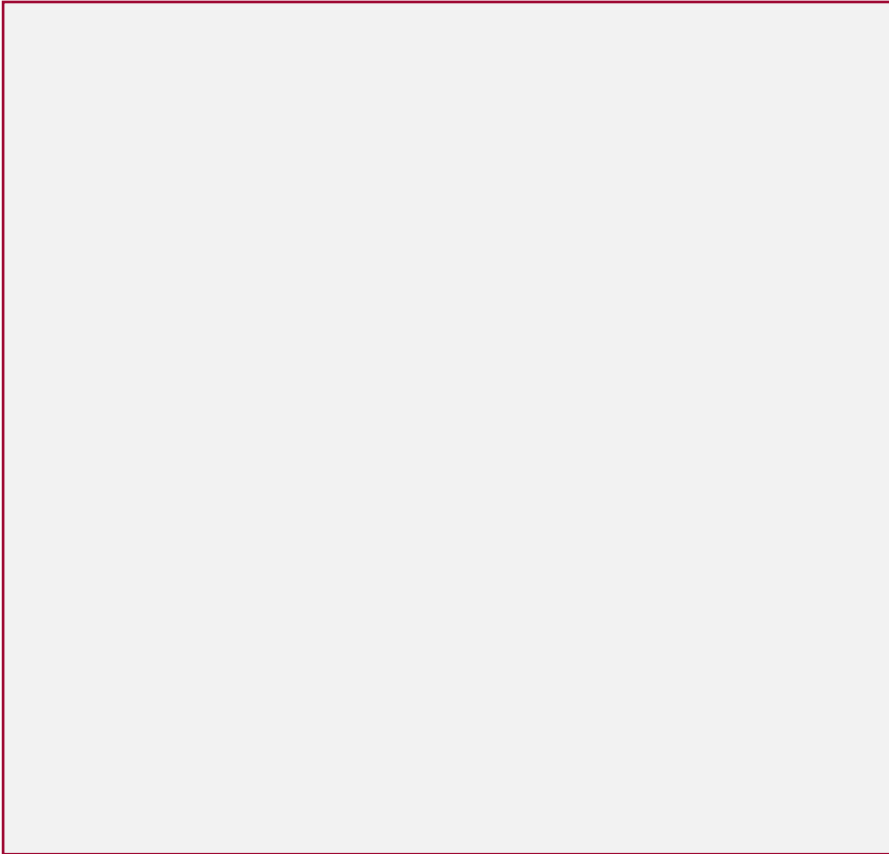
It will be useful to return to this experience throughout the book to consider how you would have felt, at that time, about the different approaches discussed. Return to the following questions:

- Would a diagnosis like 'depression' or 'anxiety' have felt useful or not?
- How would you have felt about the possibility of medical treatment?
- Which, if any, of the psychotherapeutic approaches in this book would have felt most useful, or fitted best with your own understanding of what you were going through?
- In what setting would you have liked to have been counselled (face to face, on the phone, online, alone or with others)?
- Would it have been important to you to have a form of therapy which had been researched?

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## 1.3 Counselling and psychotherapy

Counselling and psychotherapy could be seen as the boom industry of the new millennium, with huge numbers of people seeing a counsellor or therapist at some point in their life, and many more joining group therapy for issues such as alcoholism and bereavement, phoning counselling helplines such as Samaritans or ChildLine or purchasing counselling-related 'self-help' books which frequently sell copies into the millions and become part of the language (see, for example, Jeffers, 1997; Rowe, 2003). It is estimated that there are over 350 courses teaching counselling theory and practice in the UK alone (British Association for Counselling and Psychotherapy (BACP), 2009). There is specialist training in counselling for bereavement, eating problems, infertility, sexual difficulties and a plethora of other issues.



Examples of counselling and therapy from popular TV programmes and films: *Frasier* (top left); *The Sopranos* (top right); and *Prime* (bottom)

### Pause for reflection

Think about the ways in which counselling and psychotherapy are represented in the media, such as the counsellors and therapists who appear in Hollywood movies or popular TV programmes. What are the common ideas about counselling and psychotherapy in mainstream culture? What might a client who has never had counselling before be expecting when they walk into the room?

Counselling and psychotherapy are increasingly depicted in films and television shows, with people talking about their experiences of therapy on chat shows and in magazines and newspapers. So, perhaps people generally have a better idea about what counselling involves than they did 20 years ago. However, it is still common for people not to realise how many different kinds of therapy there are, and to assume, for example, that they will be expected to lie on a couch and talk about

their dreams or their childhood. Many of the popular perceptions are about psychoanalysis, since this therapy has been around the longest (see Chapter 4). Karasu (1986) estimated that there are actually over 400 distinct models of counselling and psychotherapy, and this is only likely to have increased. We will see that the six main approaches that we are covering in this book, whilst sharing some things in common, all have quite different understandings of fear and sadness, and also would feel quite different to a client who experiences them. You might consider how important it is, in the first session, for the counsellor to inform the client about how they work, as well as for the client to inform the counsellor about their difficulties.

There is also a lot of confusion in popular understandings between the different kinds of mental health professionals. See the box for a brief overview (and the further reading at the end of the chapter for more details).

### Mental health professionals

*Psychiatrists* are people who have trained to be a medical doctor and then specialised in psychiatry. They may use many of the same therapies and techniques as counsellors and psychotherapists, but they can also prescribe drugs, and often work with more severe psychological problems (for instance in an inpatient setting) and/or see people more briefly.

*Clinical and counselling psychologists* are the main kind of psychologists who see clients in a therapeutic role. They are trained to doctoral postgraduate level. They use many of the therapies and techniques used by counsellors and psychotherapists. Clinical psychologists will often use cognitive–behavioural therapy (CBT) and work briefly with clients. Counselling psychologists, on the other hand, are often informed by humanistic and existential ideas (note, though, that these distinctions are broad and general and you will find clinical psychologists informed by humanistic ideas and counselling psychologists working using cognitive–behavioural techniques). Both often work more briefly, and work within mental health organisations rather than privately (although this is probably more true of clinical psychologists than counselling psychologists). Counselling and clinical psychologists are also often involved in researching their practice (see Chapter 13).

*Counsellors and psychotherapists* are pretty similar in terms of their jobs. The BACP (2009) states that ‘it is not possible to make a



generally accepted distinction between counselling and psychotherapy. There are well-founded traditions which use the terms interchangeably and others which distinguish between them. If there are differences, then they relate more to the individual psychotherapist's or counsellor's training and interests and to the setting in which they work, rather than to any intrinsic difference in the two activities.' Others disagree, however, and suggest that they can be distinguished by how long and deep they work (with psychotherapists tending to work longer term with more difficult and intransigent problems than counsellors). Psychotherapists are generally trained to postgraduate level and counsellors to diploma or undergraduate level. The United Kingdom Council for Psychotherapy (UKCP, 2009a) says that this means that 'a psychotherapist can work with a wider range of clients or patients [than a counsellor] and can offer more in-depth work where appropriate'.

There are others who may use 'counselling skills' in mental health settings, or call themselves 'therapists' (such as mental health nurses, or the briefly trained Improving Access to Psychological Therapies (IAPT) practitioners), but these people will generally only be working in a limited context with clients.

Most counselling and psychotherapy involves the following elements (see BACP, 2009; UKCP, 2009a):

- the counsellor or psychotherapist meeting the client face to face and one to one (although see Chapters 9 and 11 for some alternatives to this and note that many therapists will see people in relationships as well as single clients)
- a private and confidential setting (see Chapter 11)
- the client being in some kind of distress
- the counsellor listening to the client and striving to understand where they are coming from
- the aim being that the client makes some kind of change or finds ways to cope with the situation or see it more clearly.

Beyond this, the kind of relationship that develops, the practical techniques used and the ways of understanding the client's distress all depend very much on the approach that the counsellor or psychotherapist is drawing on.



A counselling session

## 1.4 The history of counselling and psychotherapy

Figure 1.1 summarises some of the key points in the history of counselling and psychotherapy, though do note that this excludes many aspects of the history that is relevant to different traditions. Going back to a time before counselling, Pennebaker (1990) points out that most cultures at most times have had some ritualised way of expressing troubling emotional experiences, such as prayers, the writing of diaries or forms of group discussion or outpourings of emotion. Up until the eighteenth century in Europe emotional problems were dealt with in a religious context with activities like communal confession and repentance. Michel Foucault and others have pointed out that a major shift occurred with the industrial revolution: capitalism began to dominate and science to replace religion. A key change at this time in western societies was from more communal culture to an individualistic one, with an emphasis on internalised rules. As people moved about more, rather than remaining in the same village all their lives, it made sense for them to consider themselves as having a self-identity which

moved from place to place with them (rather than a static role in their community). The sense of having autonomous goals for oneself, rather than shared goals with others, came along with that, and with the decrease in belief in an afterlife, which meant that people were more focused on being rewarded within this life.

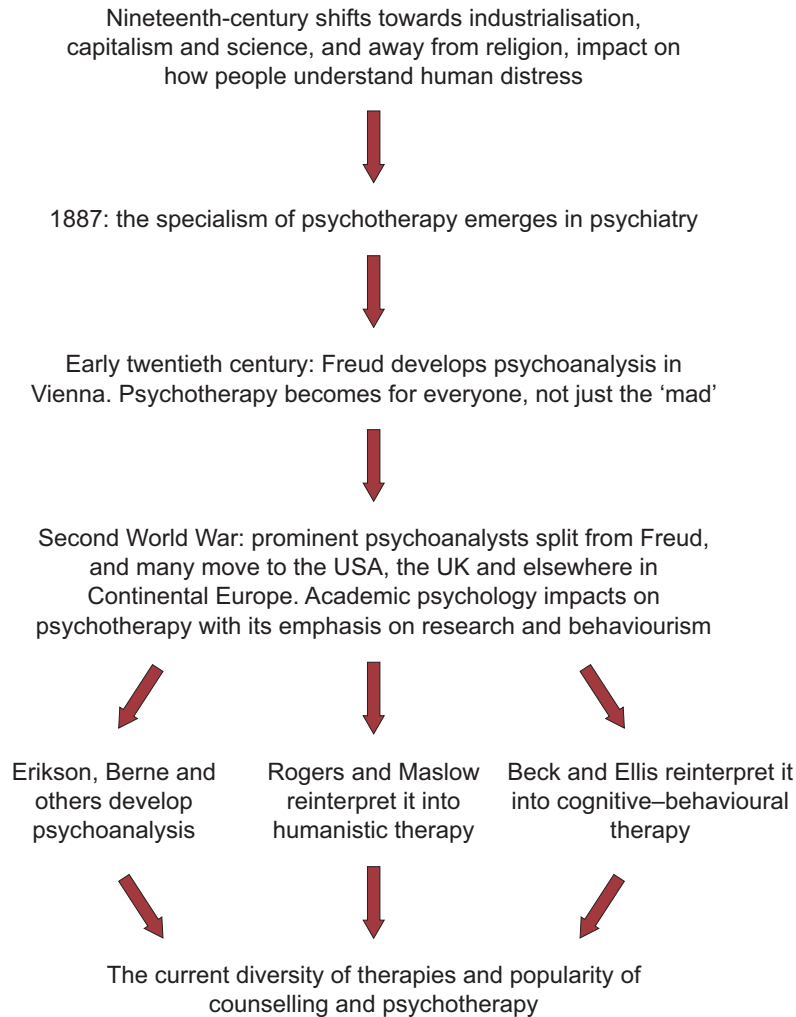


Figure 1.1 The history of counselling and psychotherapy

It was in this context that the idea of counselling and psychotherapy addressing the inner life of the person began to make sense. Also, human distress came under ‘medical’ rather than ‘moral’ control at this time, as science began to replace religion. The problems that people had in their lives became medicalised, and people began to categorise emotional problems as they did physical ones (see Chapter 2), and to

consider them as ‘illnesses’ which could be medically treated (see Chapter 3). McLeod (2003b) reports that hypnosis played a significant role in the emergence of counselling and psychotherapy because it represented the transformation of mesmerism (which was very popular at the time, and which resembled more traditional religious healing rituals) into scientific medicine. As we will see in Chapter 4, Sigmund Freud can be credited with popularising (if not inventing) the ‘talking cure’, which forms the basis of most therapeutic approaches today. He was arguably the first to assimilate his ideas, and those around at the time, into a coherent theoretical model, and he made therapy relevant to all people, not just those in the asylum.

Figure 1.1 tracks the history of the counselling and psychotherapy professions, particularly how this led to three of the main forms of therapy (psychodynamic therapy, which developed from psychoanalysis, humanistic psychotherapy and cognitive–behavioural therapy). The other three approaches covered in this book (existential, mindfulness and systemic) have slightly different histories given that they have backgrounds in different areas of philosophical thought (for example existential, Buddhist and social constructionist). In Chapter 10 we will return to the question of the specific cultural context in which counselling and psychotherapy has developed, and the limitations of this when applied beyond this context.

In the UK, the extent of anxiety, depression and other ‘mental health problems’, and the impact on incapacity benefits, has been highlighted in the high-profile study by Layard (2006b), *The Depression Report*: see Figure 1.2. This report led to a Department of Health commitment to significantly increase the availability of mental health therapies. This was also influenced by the National Institute for Clinical Excellence guidelines (NICE, 2009), which concluded that psychological therapies are as effective as drug treatment in the short term and superior in the long term. Of course, fluctuating economic climates can impact on both the need for counselling and psychotherapy, and the funding that is given to it. Also, it is important to remember that different therapeutic approaches enjoy different levels of acceptance and success at different times.

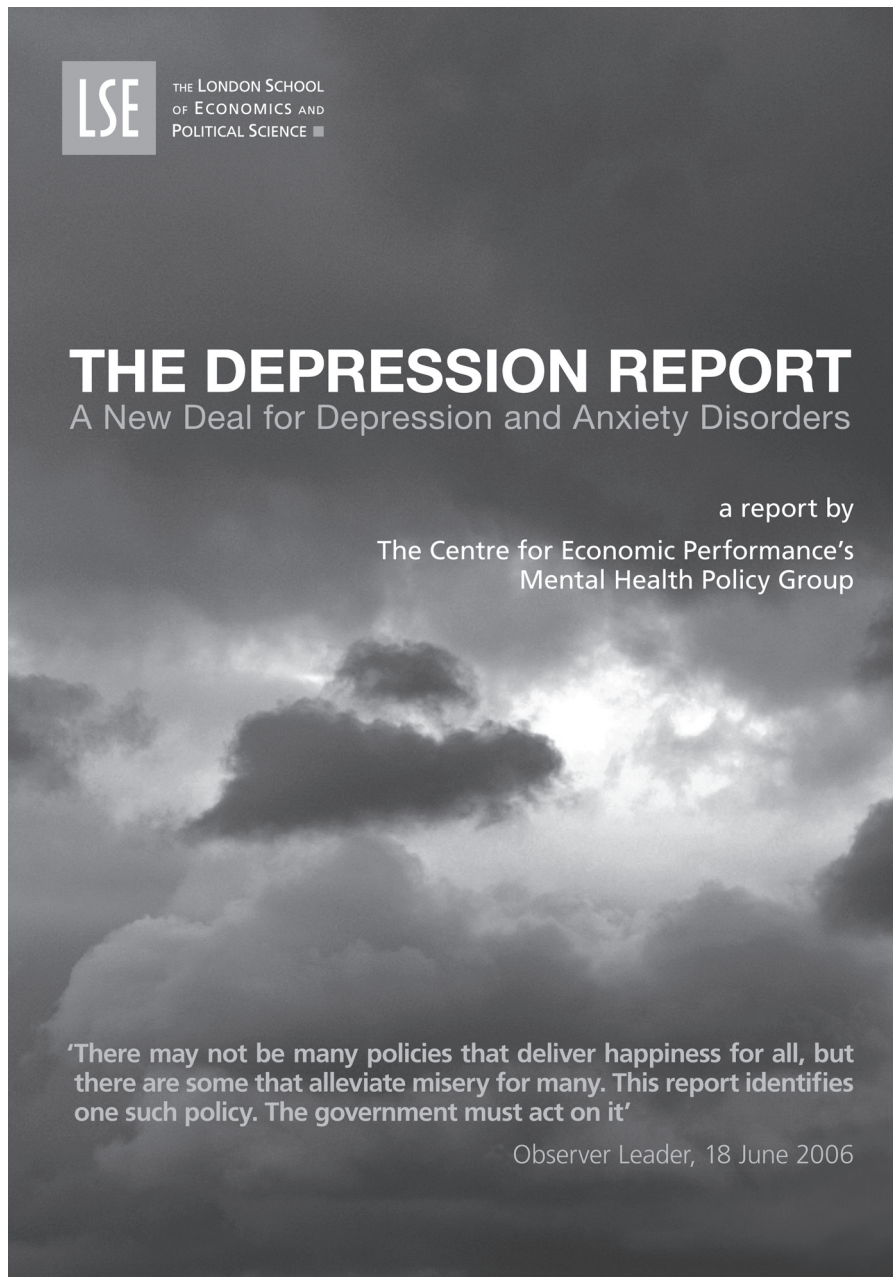


Figure 1.2 The cover of *The Depression Report*

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## Activity 1.2 Self-help

All of us have our own ways of dealing with fear and sadness. Before learning any more about the different approaches of counselling and psychotherapy, spend 10 minutes listing the strategies that you use under the following headings:

Strategies I use when I am afraid/anxious

Strategies I use when I am sad/depressed

Now go through underlining those which you find most helpful. Are there any that you find difficult to actually do in practice but would like to do? Add those to the list.

## Discussion

Whilst going through the rest of this book you might want to keep adding to these lists and rethinking which are the most helpful ways of dealing with fear and sadness for you.

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## 1.5 Moving forward

We will now run through what is covered in the rest of the book. Whilst there are four separate parts to help you through the material, it is important to remember that these are really quite artificial splits. For example, Part 2 focuses on different therapeutic approaches, but we also deal with one important approach (psychoanalytic) in Part 1, and one (systemic) in Part 3. Whilst Part 4 draws together a lot of strands from the rest of the book, it could be argued that it contains the starting points of counselling and psychotherapy (the contexts these take place in, the relationship and the results of research evidence). Don't feel that you have to read each chapter in order. It might well be useful to follow links between chapters, and each one can be read alone.

The first part of this book will continue setting the scene, with consideration of the history of our current understandings. Chapter 2 explores the current emphasis on diagnosis in more depth, examining the concepts of anxiety and depression and how they came to be classified as 'mental health problems'. Along with this medical diagnosis recent decades have seen increasing medical treatments of emotional difficulties, such that many people approaching their local doctor with emotional problems will be invited to consider drug treatments as well as, or sometimes instead of, counselling or psychotherapy. Chapter 3 of



this book outlines the biological mechanisms involved in fear and sadness, which relate to the idea that they can be medically treated. However, it also questions whether it is possible to separate out biological, psychological and social factors and instead argues for a ‘biopsychosocial’ understanding of fear and sadness. Chapter 4 returns to psychoanalysis, the origin of the ‘talking cure’, and gives more detail about the early forms of psychoanalysis, and how it has developed over time. Psychoanalysis is one of the key approaches we cover in this book. We include it in Part 1 because its history has been so influential, but please remember that it is still one of the main therapeutic approaches today and so should be thought of as bridging Parts 1 and 2.

Part 2 of the book introduces four further approaches to counselling and psychotherapy. The first, covered in Chapter 5, are humanistic therapies, particularly the person-centred approach of Carl Rogers, which is often the first therapy that counsellors learn, with its emphasis on empathic listening. The next approach, covered in Chapter 6, is the existential approach. In this chapter we will see how a psychotherapy works which is rooted in the work of philosophers who have particularly engaged with the issues of human existence. Chapter 7 deals with the cognitive–behavioural approaches, which, as we have seen, are currently most used within mental health services, and most researched in terms of outcomes. Finally, in this part, Chapter 8 explores Buddhist ‘mindfulness’ ideas and how they have recently been taken up, by cognitive–behavioural therapists particularly. We hope that through all these chapters you will begin to draw out the similarities and differences between the approaches covered.

The third part of the book highlights the importance of looking beyond the individual in relation to fear and sadness. All the approaches covered in Part 2, along with the psychodynamic approaches, consider people in their wider context (their relationships, families and communities) to some extent. However, in individual therapies there is some danger that in working with one person in the room (as much counselling does), the problems they experience may be located mostly in them and their ways of seeing, and dealing with, the world. Whilst this is often important, many authors and therapists have pointed out that problems might frequently be more usefully located in the dynamics between people and/or in the wider society that people occupy. Chapter 9 covers systemic therapy, which focuses on people in relationship and generally works with families and other systems in

which people live and work rather than on individuals. Chapter 10 considers the impact of sociocultural issues on counselling and therapy, and why it is important to take into account the culture, gender and sexuality of the client, as well as other aspects of their background and the sociocultural context that they now occupy.

Towards the end of the book, in Part 4, the focus will turn to the way in which counselling and psychotherapy are practised and researched. Chapter 11 looks at the context and setting of counselling, comparing face-to-face counselling to the increasingly popular phone and internet varieties. Through this chapter we will explore what counselling actually looks like and how the process works between counsellor and client, including the way contracts, boundaries and ethical issues are negotiated. Chapter 12 concentrates on the counselling relationship: the building of a therapeutic alliance and the ways in which the relationship is conceptualised and used within different forms of therapy. In Chapters 13 and 14 research evidence on the outcomes and process of therapy will be introduced and discussed, encouraging you to consider how counselling might usefully be evaluated. Can we find out whether counselling ‘really works’ for people with problems relating to fear and sadness? In what ways can, and should, counsellors and therapists research the process of their work?

### Pause for reflection

Which chapters of this book are you looking forward to most? Which do you have reservations about? It might be helpful, before carrying on, to think about why certain chapters appeal more than others. Do you have ideas about certain topics and approaches already which it might be worth being aware of when you read these chapters?

## 1.6 Conclusions

We hope that this introduction has helped to set the scene for you, and has whetted your appetite to read on and find out more about the different approaches to counselling and psychotherapy and the ways in which these understand, and work with, fear and sadness. In the final chapter of the book we will return to draw out some of the major themes and tensions that have emerged.



## Further reading

Johnstone, L. (2005). *Users and abusers of psychiatry*. London: Routledge.

Pilgrim, D. (2005). *Key concepts in mental health*. London: Sage.

A good overview of the history of mental health systems and the ways in which they work today can be found in the above books.

You might also find it useful to read some of the autobiographical accounts of fear and sadness mentioned in this chapter (for example, Lewis, 2006; Lott, 1997; Solomon, 2001; Wolpert, 2006).

# Chapter 2 The diagnosis of mental health problems

David Pilgrim

## Aims

This chapter will:

- 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 counsellors and psychotherapists and their clients
- consider the potentials and pitfalls of diagnosis vs formulation in relation to fear and sadness.

## 2.1 Introduction

In this chapter I shall explore how what is now termed ‘mental illness’ has been understood over time, focusing in particular on justifications for, and criticisms of, psychiatric diagnosis. I shall introduce 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 (APA, 1994) and the World Health Organization (WHO, 1992). Problems with these systems will be illuminated using ‘common mental health problems’: the varieties of fear and sadness often diagnosed by general practitioners (GPs) in primary care services. In particular, I shall concentrate on the example of ‘depression’, since it is often regarded as the ‘common cold of psychopathology’ (mental illness).

I shall mostly take a ‘critical’ view on diagnosis, focusing on the problems that come along with labels such as ‘depression’ and ‘anxiety’. Such categories are often accepted without question; therefore, it is important that counsellors and psychotherapists are also aware of difficulties with them. In particular, many have argued that categorising mental illnesses in this way obscures the biographical and social complexity of human distress.

You will be encouraged throughout this chapter 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 chapter 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 illustration: 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?

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### Activity 2.1 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 what you think they might lose. It might be helpful to also think about what is lost and gained from not having such a label.

Gains	Losses
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### Discussion

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

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## 2.2 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', and 'dementia praecox', which was later known as 'schizophrenia') and 'melancholia' (now known as 'depression'), as it was referred to when diagnosing wealthier patients (pauper lunatics were instead diagnosed with 'mopishness').

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):

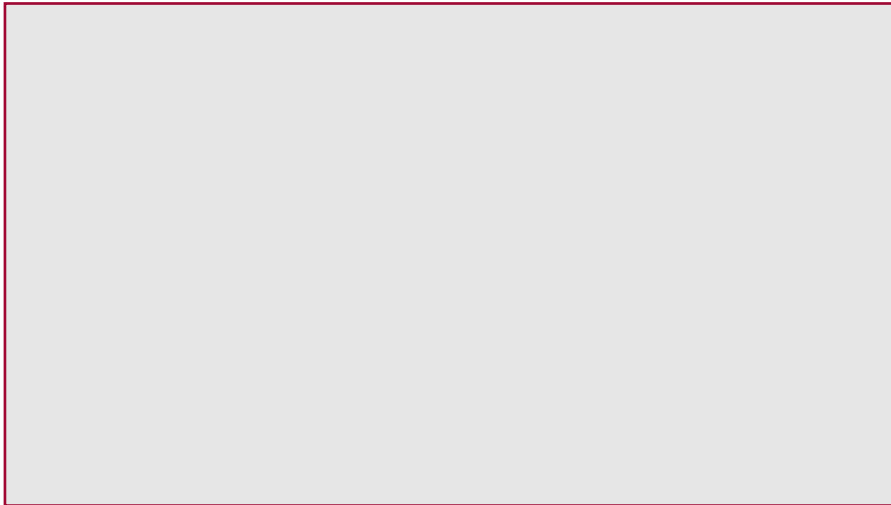
- 1 Mental disorders are genetically determined diseases of the nervous system.
- 2 Mental disorders are separate, naturally occurring, categories.
- 3 Mental disorders are fixed and deteriorating conditions.

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 high birth rate amongst 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

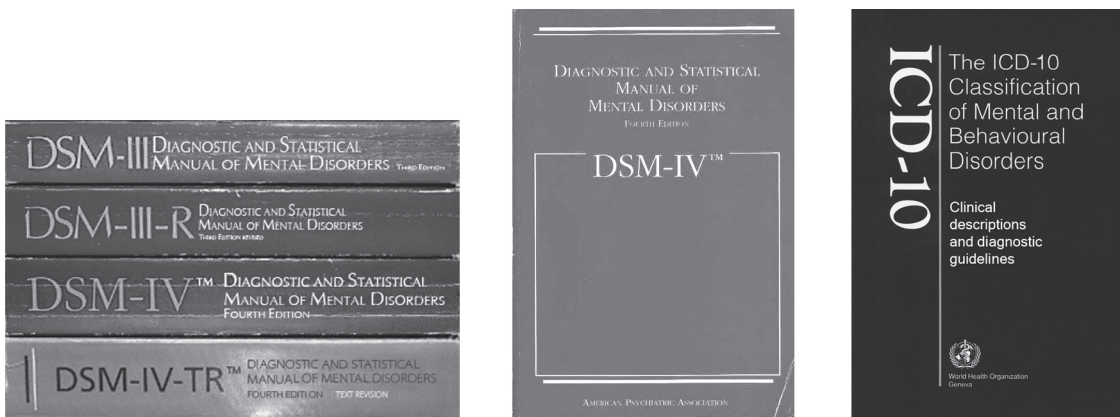
psychiatric interest, which had previously focused on ‘psychosis’ (experiences such as mania or delusions where people were seen as having ‘lost touch with reality’ in some way). Second, the core eugenic–genetic assumption of the late Victorian era was challenged. Those breaking down in the trenches 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.



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 (see Chapter 3). Psychiatrists influenced by psychoanalysis developed a theory of neurosis that emphasised interpersonal and intra-psychic conflicts to account for mental abnormality (see Chapter 4). Also, behaviourist psychology began to provide its own environmentalist explanations for neurotic experience and conduct (see Chapter 7). 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).



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 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.

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.

### 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 2-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 2 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 which 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’ (PTSD), 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).

## 2.3 Problems with diagnostic classifications

### 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).

### 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 illustration 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 illustration: 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 'antidepressants'. 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).

### 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 instance, 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 recognized.

(1988, p. 149, emphasis added)

Winnicott's final lament is interesting, because he does not explain what he means precisely ('generally recognized' 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 (see Chapter 6): 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.

## 2.4 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: see Chapter 10).

- 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 (see Chapter 10).

## 2.5 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):

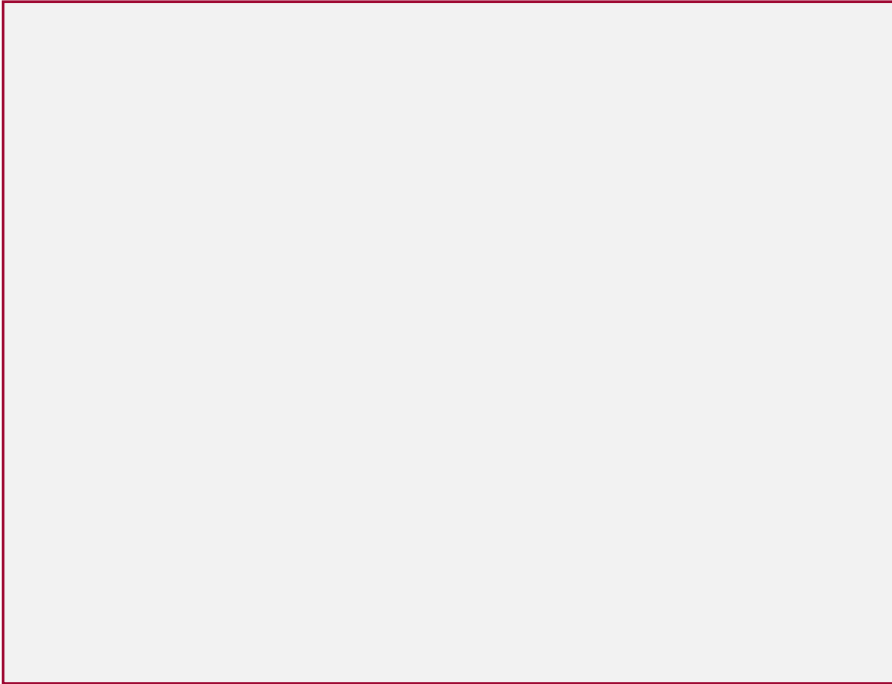
- Depression is not easily distinguishable from normality (see above).
- Depression is not easily distinguishable from other diagnoses, especially anxiety states when life feels out of control, but also forms of psychosis when people are in a black tunnel contemplating suicide, and are desperate for 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 (see Chapter 10).

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 (see Chapter 13)? 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.

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 (see Chapter 8). 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.: see



### A sad dog

Chapter 3). 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 2.1.

Serenely calm ... Confident ... Unsure ... Worried ... Scared ... Panicky ... Terrified



Happy ... Content ... Fed up ... Sad ... 'Blue' ... Hopeless ... Despairing and suicidal

Figure 2.1 The continuum of fear and sadness

### Pause for reflection

What do you make of this continuum I offer in Figure 2.1 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.

## 2.6 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 illustration: 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.

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## Activity 2.2 Losses and gains for the counsellor

Look back at the previous lists you made about the losses and gains of a diagnostic label (Activity 2.1). 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 (see Chapter 13) 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 with.

Later in the book you might want to look back to this example and consider how counsellors from different approaches might work with Mario's ambivalence.

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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.

## 2.7 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 have and in what context. Our capacity to reflect on these feeling rules is 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 independently 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.

## 2.8 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 (1990) 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.

## 2.9 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 (see Chapter 12). This position is strongest in humanistic counselling (see Chapter 5).

- 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 (see Chapters 4 and 7).
- 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 (see Chapter 9), although existential therapy (see Chapter 6) 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.

## 2.10 Conclusions

Because the scientific literature generally, and randomised controlled trials specifically (see Chapter 13), 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 other key 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 the client's life context.

## Further reading

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

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.

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

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

Kutchins, H. and Kirk, S. A. (1997). *Making us crazy*. London: Constable.

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