

As a person-centred practitioner, *Manu Bazzano* argues that an articulate critique of the stigmatising aspects of diagnosis is as urgent as ever, but also questions his life-long rejection of it. *Illustration by Jason Ford*

# Reclaiming diagnosis

The humanistic tradition of counselling and psychotherapy had, and still has, very good reasons for being suspicious of diagnosis. Diagnosis has been used in harmful ways: in its name, psychiatry supported coercion and did its best to segregate the ‘mad’ from the ‘sane’ – as documented by the pioneering work of Michel Foucault.<sup>1</sup> Through diagnostic labels, classic psychoanalysis in turn affirmed the unquestionable power and authority of the expert, whereas the bio-medical approach has transformed the metaphor of illness into a solid reality.

All of the above trends are alive and well, some operating in a more covert way, others enjoying full state sponsorship. An articulate critique of the stigmatising aspects of diagnosis is therefore as urgent as ever. For me personally, as a person-centred practitioner, this means on the one hand remaining (thoughtfully and critically) loyal to the key metaphors of person-centred therapy – an approach which, in Rachel Freeth’s words, is ‘comprehensive, coherent and holistic... [in relation to] human life and concerns’<sup>2</sup> – and on the other, acquiring a detailed knowledge of psychiatric language and *modus operandi*.

The disadvantages of the bio-medical and psychiatric models are too numerous to be considered in detail here, hence I will only mention three: loss of depth; absence of a developmental perspective; and narrowing of clinical concern.<sup>3</sup> In

other words, reductive diagnostics disregard the sheer complexity of the human psyche, as well as the context in which the person’s life is embedded in terms of age/gender/ethnicity/class etc.

It is nevertheless legitimate to ask: are there any advantages within such models? What happens if a humanistic practitioner decides to examine this closely and without prejudice? Even a superficial study of the *DSM-IV* reveals that diagnostics make available to the practitioner two valuable things in the service of the client: a) it identifies and specifies the area of distress; b) it provides a common language useful for research, interdisciplinary communication and collaboration between professionals.<sup>4</sup>

## Reclaiming diagnosis as perception

Deeper implications emerged from my own experience of working with clients, and these in turn prompted me to question my own life-long rejection of diagnosis. In the process I have found that it is possible to claim a different meaning to it, one that reframes diagnosis within the context of the social sciences rather than the natural sciences. What is true for medicine does not necessarily apply to counselling: in medicine we can’t have a proper treatment without a proper diagnosis, usually explained through symptoms. But an entire tradition of counselling and psychotherapy has grown and developed

outside the bio-medical model, and in order to maintain coherence to its principles, it needs to actively resist the politics of the dominant modality, as Pete Sanders has made clear in these same pages.<sup>5</sup> Furthermore, the issue of power, and more specifically power imbalance in the therapeutic relationship, needs to be constantly on our radar,<sup>6</sup> something that is sharply at variance with the current empty posturing and the rhetoric of ‘empowerment’ and ‘autonomy’ associated with the ‘Big Society’.

In short, when thinking of diagnosis, we need to look for a different matrix altogether. The term ‘diagnosis’ comes from a Greek word meaning ‘distinguish, discern’.<sup>7</sup> Discernment (as in telling hot from cold, making out a shape in the mist, identifying a particular sound etc) is a faculty belonging primarily to perception – and only to a lesser degree to theoretical knowledge and proficiency, least of all policing, a faculty suggesting one’s ability to make out and gain clarity in uncertain matters. A perception that strives to be as accurate as possible, inevitably begins to identify, tell apart, disentangle. When client and therapist are engaged in clarifying and discerning the nature of distress or unease, they rewrite diagnosis as an increasingly clearer perception of the client’s contingent predicament and its context. They work in the service of wisdom rather than in the service of the

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pharmaceutical industry: diagnosis discerns rather than isolates and stigmatises. In doing so, it potentially liberates.

### Co-diagnosis and process diagnosis

A question arises: who does the distinguishing and the discerning? Since the therapist is no magician or technician, the necessary wisdom is acquired by relating to the client, by listening attentively, by being present in the encounter. The client explores, finds out and reflects. The therapist provides the conditions necessary for this unravelling, for disentangling the knots that keep the person from experiencing life more fully and in a more meaningful way. In doing so, the area of distress becomes more and more specific. Both client and therapist find signposts and pointers towards what Schmid calls ‘phenomenological process diagnosis’ and ‘co-diagnosis’.<sup>8</sup> For Rogers<sup>9</sup> each individual is unique and is understood according to phenomenological and existential parameters, attempting to identify his or her unique way of seeing the world, his or her frame of reference. Writing specifically on the person-centred approach in relation to diagnosis, Schmid explains how the individual is understood as ‘an existential process... a joint process of self-development and relationship development’,<sup>8</sup> and how ‘the image of the human being’ is very different from the image in the natural sciences. For Rogers,

‘Therapy is diagnosis and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician.’<sup>9</sup>

### An insight from neuro-phenomenology

In exploring the process of co-diagnosis, I found inspiration in the methodology of a relatively new branch of enquiry, neuro-phenomenology, whose main exponent was the Chilean cognitive scientist Francisco Varela.<sup>10</sup> One of its key methods of investigation consists of combining first person report with third person description.<sup>11</sup> Unlike the allegedly ‘neutral’ and ‘objective’ procedures used in mainstream science, this time the person experiencing and observing a particular phenomenon is fully in the picture, rather than left out. However, the investigation does not stop here; if it did, the enquiry would be merely subjective. Instead, the first person account is described and further clarified by a third person description of the same phenomenon. In the field of counselling, the subjective feeling of the client is further described by the counsellor, clarified further through the therapeutic encounter and the relational to and fro, which takes places between two individuals. The process sparks a dynamic feedback between the subjective account of the client and the descriptive stance of the therapist. A synthesis takes place, which takes the practitioner beyond subjective idealism

but also beyond the objectivism of hard science. I have found this to be interestingly close to some of the inspiring and thought-provoking methods suggested by Spinelli.<sup>12</sup> In both cases we are reminded of the need for a synthesis between subjective experience and objective description.

### An example from client work

I had been working with Alastair for over a year. One day he said, ‘A lot of the time I’ve felt a bit dissociated in the last few days. It has all been quite strange.’ My impression was that he had used the word ‘dissociated’ colloquially, to mean ‘distracted’ or ‘absent minded’. I nevertheless reflected the word back to him, adding that I didn’t quite know what he had meant. He said, ‘I don’t know... I think I was just very anxious; the fear was the same feeling as the days I used to go back to boarding school after a holiday or something and it was always a feeling in my stomach... I couldn’t concentrate, like I wasn’t really there.’

It began to dawn on me that the client had not only started to discern the nature of his distress at the time, but had also expressed it in narrative terms, something that, as research in the field shows, reduces the physiological impact of traumatic memory.<sup>10,11,12</sup> He had also made a clear connection between his present anxiety of moving house and the memory of those days at boarding school. As we explored further, Alastair

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added: ‘I can actually remember those days going back to school... strange how the anxiety of going away from home when I was going back to school comes back, triggered by something in the present... in this case going away from the sort of comfort and security of the flat... it’s almost like... it’s a really violent anxiety... you actually fear for your survival... I suppose that’s what happens with separation anxiety... something really visceral.’

Here the client is beginning to diagnose, ie to discern with increasing accuracy the nature of his distress, not only his mild form of dissociation, but the separation anxiety and the traumatic attachment in relation to which he is now able to make sense through a coherent and articulate narrative. This is very different from those situations in which a client, at the beginning of therapy, comes to the counsellor and says: ‘I suffer from depression, my GP told me so.’

A phenomenological process diagnosis, to use Schmid’s apt phrase,<sup>8</sup> is therefore radically different from a diagnosis dumped upon the unsuspecting client by the doctor or psychiatrist. It is also different from the unchecked labels some clients might decide to give themselves without having explored matters further.

## Conclusion

There is another way of challenging the bio-medical approach to diagnosis other than the customary one-sided emphasis

on the subjectivity of experience. This other mode combines subjectivism and objectivism, art and science, the experiential domain with scientific observation. What is advocated here is a middle path – not of compromise, but one capable of fully embracing polarities and re-claiming diagnosis back from the exclusive property of the medical model and in doing so restoring its original meaning. As advocated by other writers in the field,<sup>2,14</sup> an interdisciplinary dialogue is possible when we set as a priority the welfare of clients and patients. ■

*‘Alastair’ is a fictional name. Details have been changed to protect anonymity.*

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*Manu Bazzano is a person-centred counsellor and psychotherapist in private practice, a tutor at the New School of Psychotherapy and Counselling, London, and an author. Who Loves a Stranger: Towards a Phenomenology of Hospitality, his book on contemporary ethics, is published later this year. Please visit [www.manubazzano.com](http://www.manubazzano.com)*

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