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Article 6

Knowledge vs. Wisdom in *DSM* Diagnosis: A Person-Centered Perspective

Paper based on a program presented at the 2012 Association for the Development of the Person-Centered Approach, Savannah, Georgia, July 14.

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Opening Remarks

Thank you for the invitation to speak with you. I first would like to acknowledge a few people that I have not yet had the privilege to speak of in my career but they have greatly influenced me. I want to mention a few words regarding; Victor Frankl, Carl Rogers, and Native Healers.

Frankl

Forty years ago, I was assigned to assist Frankl for about six months, just before writing my doctoral dissertation on *Resentment of Authority: A Phenomenological Approach*. I was very lucky because he resented authoritarian behavior and oppression and understood phenomenology. His influence on my writing still prevails to this day. However, what I most remember about him was his dry sense of humor. From his past experiences, he had little logical reason to be that humorous. He taught me that humor and wisdom are intricately connected. He said that "Humor expands our potential for wisdom. Being too serious shrinks the boundaries of what is possible." My only regret is that I did not quote those words in my dissertation, but then I was acting far too seriously at the time.

Rogers

Another major influence was Carl Rogers who, 30 years ago, came to St. Lawrence University for a week in the early 80's to study our person-centered counselor and teacher education programs. He was extremely generous when, later on, he asked me and others to be contributing authors and write about both programs in one of his books

Freedom to Learn for the Eighties (Rogers,1983). Of course, I can remember this being a "big deal," with thoughts of how it would affect my career and other self-centered thinking. Yet, Rogers demonstrated first-hand the importance of empowerment and person-centered thinking. I found him to be an unassuming and humble person. Actually, his humility was very surprising but it eventually taught me to stay focused on others. He seemed to stay in the moment and showed little interest in emphasizing his expertise.

Native Healers

For the past 35 years, I have worked closely with Native Healers from the Akwesasne Mohawk Reservation, and what has most impressed me about them is the honor and respect they give to authentic people. They taught me the difference between being honored and being rewarded which has helped define my understanding of humanism. In my culture at the University, we are rewarded for following the rules. In Native culture a person is not rewarded but is honored and respected for showing personal balance, and authenticity. They show a unique ability to balance the harmony found in the human spirit (Bastine & Winfield, 2011).

What I Have Learned from Them?

The most important teachings that I have learned from these unforgettable individuals is they all carry a specific message namely, "Less is more" Their messages are focused on obtaining the simplicity found in wisdom rather than in the complexity found in accumulating knowledge or expertise. In some ways, this has made their humor, humility and honor essential guidelines in my self-evaluation. Regardless of the knowledge I have gathered over the years, it is these and other simple messages that have helped define my identity. Whether it is Frankl's search for meaning in suffering, or Roger's holistic view of humans growing and changing, or Native Healers cultural understanding of balance, these messages go beyond knowledge and have helped many of us find wisdom in how to evaluate ourselves. These simple messages have also helped in how to evaluate others and are at the foundation of my presentation, today.

The Nature of a Medical Model Diagnosis

I start this section of the presentation with a question, "Where is the wisdom in a *DSM* Diagnosis?" The wisdom of such people as Frankl, Rogers, and Native Healers seems lost in the present medical model methods for diagnosis and treatment in mental health where knowledge is more important than wisdom, and where the message sent seems lifeless and sometimes indifferent—where little meaning is found in Frankl's view of suffering, where Roger's holistic growth and change is ignored, and where a solely medical view of being human may actually throw human beings out of balance according to the wisdom of Native Healers.

Furthermore, I believe a medical model of diagnosis has other problems. First, it disregards the wisdom found in the therapeutic alliance between client and practitioner. Secondly, it exclusively relies on statistically acquired symptoms in conjunction with specific rules and timelines fabricated by experts as its basis for diagnosis. I find this to

be a serious error that lacks professional wisdom. To deny the alliance between client and practitioner seems short sighted and sends a mixed message, namely "I know more about you, than you know about yourself." I believe that such a position may possess statistical knowledge based on a fabricated set of rules and guidelines, but delivers little wisdom and can send the wrong message to a person in need of help.

It may be fair to say that professional knowledge based on a medical model of diagnosis expresses certain knowledge to insurance companies, managed care agencies and other professionals in the health care system, but is this knowledge imparting a specific message or wisdom to the clients receiving the diagnosis? Frankl, Rogers, and Native Healers would probably ask a more specific question such as, "Where is the wisdom in a *DSM* diagnosis for the client?" Frankl might ask, "How does the diagnosis help the client find meaning in his or her suffering?" Rogers would probably want to know, "How does the diagnosis accurately reflect an evaluation of the whole person?" Native Healers could ask, "How does such an evaluation create balance and harmony in a person's life?"

Here is a quote from Carl Rogers that sets the tone for what I am about to discuss with you, "In a very meaningful and accurate sense, 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" (Rogers, 1951, p. 223).

Let me try an analogy to make Roger's point. There is a difference between writing a book and the "book writing business" as much as there is a difference in making a mental health diagnosis for the client and the "mental health diagnosis business." Regardless of its original intentions, the *DSM* has become the diagnostic instrument for the "mental health diagnosis business" with categories and labels used as the language for insurance reimbursement, pharmaceutical treatment, and collaboration between experts. However, it is my belief that it has *lost perspective therapeutically* when making a mental health diagnosis that helps clients grow and change. When the "business" of mental health diagnosis becomes more important than making an accurate mental health diagnosis for the client, questions need to be considered regarding this practice in mental health. Just as the book writing business is different than writing a book, making an accurate mental health diagnosis for the client is different than diagnosing for the mental health business.

I have struggled with this perspective for 30 years both in teaching graduate classes in mental health and in actual practice as a mental health clinical supervisor who oversees diagnosis for insurance reimbursement and pharmaceutical treatment. Separating the art of mental health diagnosis and complying with the mental health diagnosis business can be, at times, a pseudo-schizophrenic experience. Ethically, I find it troubling that *DSM* diagnoses submitted to insurance companies by most medical model practitioners, fail to capture the client/practitioner's actual experience. For example, I understand that in medicine being diagnosed with a brain tumor does not require the patient to advise the surgeon when making a medical diagnosis or when performing medical treatment. However in mental health, a diagnosis excluding input from the client seems counter-productive and should not imitate the same process as found in medicine, especially when most of the treatment based on the diagnosis is carried out by the mental health client—not by the mental health practitioner.

As a further challenge to the mental health diagnosis business, one could say that the nature of the client's suffering becomes clear to the client only in the course of therapy, that "diagnosis" cannot be made prior to the client's own formulation of his or her suffering, which takes place during the relationship between client and therapist (Purton, 2004)—only in this process can be found the wisdom in making a mental health diagnosis at least for the client. However, in the "mental health diagnosis business" there is a mandate to make the diagnosis before you get started, at the beginning of therapy, or shortly thereafter; again imitating the field of medicine more than mental health.

This leads to my view on the importance in establishing a therapeutic alliance before making any diagnosis. It seems that effective diagnosis is in collaboration with the client's perspective on diagnosis, combined with the therapist making responses to this perspective based on professional training and experience. This is where a mental health diagnosis becomes valid and where the wisdom of making a diagnosis becomes more collaborative and person-centered rather than expert-centered. In some respects, a Person-Centered diagnosis is a mediated agreement based on two crucial points of view between the client and the practitioner, and this agreement is discovered in the common ground that emerges after creating a therapeutic alliance. I cannot tell you how many times a diagnosis based on this mediated agreement changed an original medical model diagnosis for my clients, regardless of how many assessments were performed before the actual therapy experience. Yet, it does raise the question as to which diagnosis is more valid: a medical model diagnosis based on expertise, or a person-centered diagnosis based on the therapeutic alliance between client and practitioner? This may be answered based on what perspective is most valued, namely a diagnosis for the client or a diagnosis for the mental health business. In my professional practice, I have upheld the belief that, "*a mental health diagnosis appears more effective when based on the mediated agreement between the client and practitioner."*

The Medical Model Threat

So, why is an expert-centered, medical model diagnosis such a big problem for me? They have been going on for years and they happen routinely with little apparent threat to the nature of mental health diagnosis or treatment. Yet, this apparently benign reality may reveal a subtle yet insidious problem for the future identity of many mental health clients. In my opinion, one of the biggest threats to mental health clients in the 21st Century is an addiction to authoritarian power. This is most evident in diagnosis from a medical model, perspective. As long as, we allow experts to be solely responsible for diagnosing our problems in mental health, our "addiction to the power of experts" will continue to cripple our personal identities. Using only the experience and knowledge of experts to make a diagnosis without considering someone who lives their suffering 24/7, sends the message that, "I know more about your experience than you do." At best, again in my opinion, an expert can add up mental health symptoms based on statistical probability and give a diagnostic label without actually knowing the client, but it baffles me how an expert can describe, understand, or live through the nuances of any client's experience without asking them. In a sense, a medical model of diagnosis flattens human complexity for the sake of diagnosis and shows indifference to the humanistic, holistic, and nuanced perspective of the client.

In the 21st Century and in our current Information Age, mental health diagnosis continues to lag behind other professional areas. Here are some examples. In an Information Age, there is an emerging paradigm shift from a traditionally rule based format to a more problem solving format where individuals have increasing input into decision making processes that affect their lives. In the legal field, mediation and conciliation practices are now being used in the place of judges to resolve many disputes that do not pertain to serious or violent crimes (Ladd, 2005). In business and industry, input from workers and lower level managers are making the decisions of CEO's more collaborative and inclusive (Hansen, 2009). In the education system, we see a shift away from rigid and strictly rule based structures to efforts at shared decision making, peer mediation, and alternative teaching approaches to accommodate different learning styles (Kruger, 2009).

Such examples should be recognized as warning signals to the field of mental health. In the 21st Century, our age is changing from a rule-based society to a more problem-solving based society. Such a shift has strong implications for more person-centered practitioners. For some mental health practitioners in practice areas such as social work, nursing, clinical mental health counseling, and humanistic psychotherapy, there is an underlying responsibility to form a therapeutic alliance with clients while listening to their problems (Spiers & Wood, 2010). It may be the importance of the therapeutic alliance that helps define mental health diagnosis in the 21st Century, where solving problems is more important than following rules, especially when the rules may render an inaccurate diagnosis.

I personally see questions being raised in mental health between a medical model, rule-based form of diagnosis, and a more holistic, problem-solving based form of diagnosis in the present controversy over the new *DSM-5*. While questioning the rules of the *DSM-5*, professionals also may want to question whether diagnosing a client should be solely based on rules (Ladd, 2009). The rules connected to the *DSM-5*, in my opinion, lean more towards who gets financially reimbursed, what model of being human wins the day, or what companies or professionals most benefit from the rules. All of these issues overlook the welfare of the client. Although my position may seem extreme, the current concerns with the *DSM-5* may also hint at a broader yet significant underlying battle between the traditional role of experts practicing "old school," 20th Century authoritarian power vs. 21st Century Information Age problem solving. The therapeutic alliance between client and practitioner is just one example of what might become important for a mental health diagnosis in a more problem solving era.

Yet, a serious consideration must be made regarding our Information Age. As much as we are becoming more problem solving, we are also becoming more technological. For me, human beings are natural problem solvers, so the Information Age offers much hope for more person-centered thinking. Yet, our use of technology may have negative implications for a person-centered approach.

I want to make a brief note as to why I feel this way and why the *DSM* has been adopted and is being used by so many professionals who are *not* psychiatrists, and who do not specifically adhere to a medical model in the field of mental health. We are surrounded by technology and the two most important characteristics of technology are in my opinion, order and efficiency. For example, as a college professor in the pursuit of scholarship, I have gone from hours in the library either seeking out information or

sending for articles that took weeks to arrive. Now, it takes me seconds on my iPhone to receive comparable information. So in my search for knowledge, technology is beneficial for its order and efficiency.

However, human beings are different than iPhones. Though we embrace technology, what makes us human is not technology but the wisdom found in practicing our humanity. Let me paraphrase being humanistic from the wisdom of Carl Rogers:

> Being humanistic emphasizes the human capacity for choice and growth. The overriding assumption is that humans have free will and are not simply fated to behave in specific ways or as machines blindly reacting to their environments. So, what counseling and therapy should focus on is the human subjective experience of the client—how clients experience things, why they experience things, and so on.

This, or something similar to this, is what Rogers told me 30 years ago in his backyard in La Jolla, CA in a discussion regarding phenomenology. He thought that psychology should be more of a human science and not based solely on the order and efficiency found in natural science or technology. He believed that human perspective is based on our ability to experience the world, not make it orderly or efficient, regardless of how valuable that appears. I agree with Rogers that human experiences are not always orderly or efficient. If we are too orderly or too efficient as humans, we flatten our perspective, and miss all those nuances before us. Again, as I said earlier, a *DSM* assessment flattens the nuances of being human for the sake of an orderly and efficient diagnosis. For those of us who were not trained and do not believe in a strict medical model form of diagnosis or treatment, such order and efficiency plagues us with contradictions in our training and beliefs.

Person-Centered Diagnosis and the Medical Model Threat

Part of the problem is that a *DSM* diagnosis (APA, 2000) is based on a medical model perspective not on more person-centered perspective. A medical model thrives on order and efficiency yet this should not be at the expense of human characteristics such as: trust, honor, social justice, respect, culture, empathy, authenticity, positive regard, and doing the right thing—regardless of whether it is orderly or efficient. AnnMarie Churchill and I have tried to address this issue of order and efficiency in the book *Person-Centered Diagnosis and Treatment in Mental Health* (Ladd & Churchill, 2012), but with a balanced approach that recognizes more than the statistical probability found in the *DSM*. The therapeutic alliance found in person-centered thinking lessens the role of order and efficiency while strengthening the role of empowerment and valuing the whole person.

Another problem with the *DSM* diagnosis is its lack of sophistication regarding how it speaks about people. In my opinion, it indirectly de-personalizes them. As an example of depersonalization, I wrote a statement in one of the Association for the Development of the Person-Centered Approach (ADPCA) blogs that the lack of a person-centered perspective found in the *DSM* may be partially attributed to the semantics found in it (Ladd, 2012). For example, the *DSM-IV* has such labels as Bi-Polar Disorder or Obsessive/Compulsive Disorder. Semantically, a person may incorrectly say, "I am bi-polar or I am obsessive/compulsive." Even from a strictly medical model, such semantics do not make sense. In medicine one does not say, "I am Cancer or I am stroke."

However, with mental disorders one can personalize them as though they were connected to one's identity.

As I look back over the past 30 years of practice, *DSM* diagnoses have misguidedly defined many clients in this manner. Part of my work with these clients has been in changing their focus away from their *DSM* labels to what they are experiencing as human beings. This leads me to conclude that the lack of sophistication in *DSM* labels, may lead to increasing the severity of disorders rather than reducing them. This means that it may be important in diagnosis to significantly separate a person's mental disorder label from their identity. The *DSM,* though orderly and efficient, is not sophisticated enough in understanding human dynamics to achieve this function. In practice, using a system that statistically categorizes mental disorders has explicit advantages for insurance companies, pharmaceutical companies, and for those practicing a medical model of diagnosis, yet such a focus may be detrimental to clients. The question this raises is, "Do we have a responsibility as mental health professionals to act in a manner where diagnosis is beneficial for all involved?"

A similar danger in medical model diagnosis falls in the category of a diagnosis being primarily based on symptoms. Again, this may cause confusion for the client in the form of over–identification with the diagnosis where a client may believe "they are their symptoms," or "they are the diagnosis," leading to a negative effect on client recovery. I like what Albert Ellis said about client symptoms. A person cannot actually *be* a pattern of thoughts, feelings and behaviors, yet some clients may confuse their diagnosis with their identity (Ellis & Dryden 2007). A *DSM-IV* or *DSM-5* diagnosis is a description of a client's symptoms and not an identity or judgment of self-worth (Rueth, Demmitt, & Burger 1998).

Related to this is what Rogers believed was the sign of a healthy person. Again, many years ago in La Jolla, I asked him what was his definition of a healthy person. He said that, "Unhealthy people were highly predictable but not very dependable and healthy people were highly unpredictable but very dependable" To accept a *DSM* label as one's identity may reinforce a person's predictability. How many self-fulfilling prophecies have been created when a suffering person receives a *DSM* label? The *DSM* is based on statistical probability not facts. Its main purpose is to categorize the dysfunctional predictability in human beings. However, does it not also marginalize the importance of our unpredictability or our dependability? I think it does.

I am concerned about the current view of diagnosis and treatment in mental health and the possibility of over-emphasizing symptoms at the expense of human perspective. I believe there is a danger facing mental health practitioners in losing their perspective and the perspective held by clients in becoming too focused on the symptoms found in the *DSM*. I would like to make the assertion that in order to obtain a more accurate diagnosis mental health professionals need a *balance between medical model symptoms, and person-centered perspective.*

Actually, on a personal note, I do not completely believe in such a balance. I believe that human perspective is far more important than symptoms in the diagnosis of a client—regardless of its lack of statistical probability demanded by the "mental health diagnosis business." However, we live in a political world where order and efficiency through the use of authoritarian power consciously or unconsciously is aimed at dominating our mental health perspective through the authority given to a *DSM*

diagnosis. So, I am reluctantly willing to compromise for a balance between symptoms and perspective in mental health diagnosis so that I can directly confront our addiction to the authoritarian power of experts, who are now diligently working on our new look at mental health reality namely, the *DSM-5*. Unfortunately, our diagnosis of other human beings becomes as much political as it is therapeutic. Authoritarian power in the mental health profession is backed up by statistical research which has politically proclaimed the medical model as *the* model, and historically has dictated mental health reality to the mental health field, with no exceptions. As I have told my co-author AnnMarie Churchill, any acknowledgement of a person-centered model of diagnosis should be viewed as a political success—regardless of the criticisms it may provoke. I think we have reached a point in mental health diagnosis where person-centered thinking can be criticized but not dismissed.

Person-Centered Treatment and the Medical Model Threat

This leads me to person-centered treatment as opposed to medical model treatment or any other therapeutic treatment. I had the opportunity to ask Rogers about different treatments as opposed to client-centered treatment during my brief association with him. It seemed to me that Rogers believed that other treatments based on behavioral or cognitive theory were valid if they emerged from the relationship formed between client and practitioner. The interesting point made by Rogers hopefully is understood in the book, *Person-Centered Diagnosis and Treatment in Mental Health* (Ladd & Churchill, 2012). We discuss many different treatments in the book not as experts, but as common sense treatments based on where the therapeutic alliance has taken us.

In this manner, I understand Rogers more as an artist than as an expert where other techniques become important if they help express a client's growth and change; where any specific expertise should not be used unless it is relevant to empowering a client's personal discovery and personal identity. I believe this is why Rogers talked against Client-Centered or Person-Centered Therapy being considered a school of therapy. He understood the difference between creating a therapeutic climate that advocated for human potential than in creating a competing school of therapy (Rogers, 1980). [Note: I find myself more client-centered or possibly relationship-centered than embracing any other expertise, but I believe this can be attributed to my belief in the therapeutic alliance where outside expertise becomes relevant only at specific times and for specific purposes during the therapy process.] Maurice Merleau-Ponty, the famous phenomenologist, might say a therapist is working from a "disciplined naivete" and is open to the moment, using their professional discipline only when necessary (Merleau-Ponty,1970). Usually, if the client and I try certain psychological techniques such as, CBT or Mindfulness Training, it is because we have discovered its usefulness, together.

Here is another point that I would like to make on treatment. In some respects, a medical model treats mental illness in the same manner as they treat terminal illness with little emphasis on growth and change. The model does this by emphasizing symptoms reduction and symptoms maintenance. Is this not the same view of treatment that is practiced, for the terminally ill? This brings up the questions, "Is it possible in a medical model of treatment for clients to become standardized while client experience becomes

marginalized?" In other words, with the emphasis on matching client treatment to relieving client symptoms, "Can there be a de-emphasis regarding client experience?"

The book, *Person-Centered Diagnosis and Treatment in Mental Health* (Ladd & Churchill, 2012), is our response to the dangers found in the medical model, which is based on statistical probability. In the spirit of Rogers, I am willing to make the statement that, "Even when clients are discussing certain symptoms that can be found in the *DSM*, they are still talking *about themselves as a whole person.* Regardless of individual symptoms, a holistic understanding by the client can evolve into a more person-centered perspective as mental health treatment progresses."

Closing Remarks

As a footnote, Rogers also told me something that I remember clearly. Being a young man in my early thirties and he being at the other end of the spectrum, I asked him, "Does life get easier when you grow older?" He said to me, "No, actually life gets harder the older you become but if you have gained wisdom it seems easier."

Now, being older, I realize that Roger's statement about gaining wisdom was correct not only for me, but hopefully for anyone I have diagnosed and treated with a mental disorder. I also hope that any wisdom coming from this presentation makes your life seem easier.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm