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Article 7

Shattering the Dichotomy: Integrating Diagnosis and Wellness

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Abstract

Through a voluntary, confidential, intentional relationship, counselors are able to work with clients from a wellness perspective, or a premise that individuals can change in positive ways despite the presenting issue. From this wellness perspective, diagnosis is often viewed as a counter-productive, mutually exclusive archetype. However, this article presents a model for uniting a wellness lens and diagnostic perspective into a complimentary paradigm. Implications for counselor education programs and supervision practices are included.

Counseling is a voluntary, confidential, intentional joining of two or more individuals, in a professional relationship, working towards gaining an understanding of both self and others in order to effectively resolve conflicts in daily life (Pistole, 2001; Spruill & Fong, 1990). Historically, the counseling profession has shied away from the medical model, an emphasis on diagnosis, and a lens that the people are in some way ill (Altekruse, Harris, & Brandt, 2001; Pistole, 2001; Spruill & Fong, 1990). Rather, counselors adhere to a wellness perspective, or a premise that individuals can change and grow in positive ways despite the situation or presenting issue (Crose, Nicholas, Gobble, & Frank, 1992; Makinson & Myers, 2003; Myers, Willse, & Villalba, 2011). From a wellness lens, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, American Psychiatric Association [APA], 2000) is generally viewed as a mutually exclusive, insoluble dichotomy to be used with clients. As a profession, counselors often use the lens of holistic wellness, rather than a diagnostic illness perspective, to conceptualize diverse cases and enact multifaceted helping tasks.

Counselor' roles are diverse and numerous to help in the journey to success for the clients entrusted to their care (Adams, 2010; Crethar, Rivera, & Nash, 2008; Henriksen & Trusty, 2005; Hutchinson & Lema, 2009; Murphy & Kaffenberger, 2007; Myers & Sweeney, 2008). Within their typical roles, counselors are vital members of a

health network team who attend to diverse clients to empower change, foster growth, provide education, and develop wellness (American Counseling Association [ACA], 2010; Crose et al., 1992; Myers et al., 2011). In a counseling relationship, counselors join with clients from a holistic wellness path to help bolster the clients' personal strengths, promote insights into life choices, and enhance mental, spiritual, and emotional health (ACA, 2010; Hutchinson & Lema, 2009; Makinson & Myers, 2003; Myers & Sweeny, 2008; Myers et al., 2011). The profession of counseling then requires exceptional skill, knowledge, awareness, passion, and commitment to help those who seek their care.

From a wellness lens, counselors conceptualize clients from a strength-based, holistic-oriented perspective. When clients come to counseling, the counselor conceptualizes the individual synergistically as a whole, rather than individual parts (Eriksen & Kress, 2006; Hansen, 2010; Myers & Sweeney, 2008; Savolaine & Granello, 2002). Through this conceptualization, the counselor may draw attention to strengths of the individual that may help in walking the journey to more complete wellness (Crose et al., 1992; Eppler, Olsen, Hidano, 2009; Kostanski & Hassed, 2008; Nanda, 2009; Savolaine & Granello, 2002). From this wellness perspective then, clients are not viewed as "sick" and in need of a diagnosis, but rather as using other strengths to compensate for an area in need of bolstering to promote a more integrated self. This orientation is a foundational component that separates counselors from other helping professionals, such as psychiatrists, psychologists, or social workers.

The *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth revision (*DSM-IV-TR*; APA, 2000), soon to be fifth edition, is the cornerstone work of helping professionals such as the aforementioned (Erisksen & Kress, 2006; Flanagan, Davidson, & Strauss, 2007; Hansen, 2010; Hays, Prosek, & McLeod, 2010). Historically, the *DSM-IV-TR* is used as a best effort to approximate a scientifically based nomenclature of problematic mental states (Flanagan et al., 2007; Widiger & Clark, 2000). Based on a multiaxial assessment classification system of mental disorders, the *DSM-IV-TR* is used as a primary language of communication among helping professionals regarding clients' presenting issues (APA, 2000; Eriksen & Kress, 2006; Widiger & Clark, 2000). In addition, the *DSM-IV-TR* is often used to more accurately help clinicians understand their clients' experiences from a common nomenclature to further assist in treatment planning (APA, 2000; Flanagan et al., 2007).

Although the *DSM-IV-TR* is more commonly associated with the field of psychology, the counseling profession also feels pressure from outside entities to adhere to a diagnosis model. While counseling is grounded in a wellness model, current Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) accreditation mandates (CACREP, 2009, II.G.7) that counselors-in-training participate in curriculum that includes instruction in the use of the *DSM-IV-TR* in diagnosing clients. Counselor educators are charged with the responsibility of effectively training and preparing future counselors (Adams, 2010; Luke & Bernard, 2006; Richardson, 2003). As such, counselor educators must ensure that emergent counselors develop the knowledge, skills, and awareness necessary to appropriately diagnose.

While the *DSM-IV-TR* is commonly used in the helping profession and pressure rises to apply diagnoses to clients, counselors working from a wellness perspective often find integrating the *DSM* model into their counseling personhood to be difficult. Within the counseling identity, the wellness model and the diagnostic model may appear to be in

conflict (Davis, Chang, & McGlothlin, 2005). However, upon further exploration, the wellness model and diagnostic model do not have to be mutually exclusive entities. Rather, diagnosis becomes an act of translation from the wellness model to other helping practitioners, third party-payers, and various stakeholders (Anastasi, 1992; Eriksen & Kress, 2006; Hansen, 2010; Juhnke, 1995; Nelson, 2002). To understand this working relationship, a description of the wellness model, the interrelationship of the *DSM-IV-TR* to human development and wellness, as well as potential pedagogical and supervision experiences for counselor educators is be explored.

Defining Wellness

The wellness model may be one of the most prominent features that distinguishes counselors from other helping professionals. As a counseling paradigm, the wellness stance implies that one constituent of a person cannot be treated without knowing the balance of all the individual's components (Myers & Sweeney, 2008; Savolaine & Granello, 2002; Westgate, 1996). These components vary by model of wellness, but generally include aspects of mental, physical, emotional, spiritual, social, creative, coping, environmental, and life-tasks modules (Crose et al., 1992; Myers & Sweeney, 2008; Myers et al., 2011; Savolaine & Granello, 2002; Witmer & Sweeney, 1992). As aspects of wellness are minimized in life, other aspects of wellness are also compromised to compensate and maintain balance, similar to a yin-yang relationship (Kostanski & Hassed, 2008; Nanda, 2009; Savolaine & Granello, 2002).

From this interconnected, fluid relationship, individuals are viewed as whole, with oriented tendencies toward growth, self-improvement, and aspects of physical, emotional, and psychological wellness (Carmody, 2009; Crose et al., 1992; Myers & Sweeney, 2008; Myers et al., 2011; Nanda; 2009; Rothaupt & Morgan, 2007). Through the lens of wellness, individuals can change their behaviors, thoughts, actions, and feeling through educated, mindful choices (Hutchinson & Pretelt, 2010; Kostanski & Hassed, 2008; Lee, Semple, Rosa, & Miller, 2008; Nanda, 2009). In addition, individuals are not viewed as sick, disordered, or damaged; rather all people have the capabilities to grow and learn from previous experiences or situations (Gardiner & Kosmitski, 2008; Semple, Reid, & Miller, 2005; Nanda, 2009). Therefore, individuals are seen as capable of continual change, healing, and growth rather than stagnant sickness or disordered behaviors.

With a definition of wellness grounded in fluid development and constant growth as a foundation for the counseling profession, the integration of a diagnostic manual may seem contradictory or counter-intuitive. However, this dichotomous thinking need not be the case for the counseling profession. Integrating diagnosis into the counseling identity provides a foundation for translating a process from a wellness-counseling orientation to a third-party-payer diagnostic language (Anastasi, 1992; Eriksen & Kress, 2006; Hansen, 2010; Juhnke, 1995, Nelson, 2002). A diagnosis, in this case, does not counteract the wellness orientation inherent in a counseling identity, but serves as a bridge to continue in the growing and healing process. For instance, an individual may be diagnosed as depressed through the lens of the *DSM-IV-TR*, but struggling to recognize individualized strengths and areas of reliance through the wellness perspective. By focusing case conceptualization grounded in wellness, a diagnosis simply becomes an externalized

nomenclature for the current experiences of the client (Eriksen & Kress, 2006; Hays et al., 2010; Reisetter, Korcuska, Yexley, Bonds, Nikels, & McHenry, 2004).

Integrating the *DSM*

Although often viewed as negative from a wellness-perspective, the diagnosing process may well benefit the counseling experience and serve as a tool of empowerment (Eriksen & Kress, 2006; Hansen, 2010). From multiple theoretical perspectives, externalizing the presenting issue for further examination and understanding is critical (Eppler et al., 2009; White, 2007; White & Epston, 1990; Winslade & Monk, 2007). For instance, in both Gestalt and narrative counseling, the problem is placed outside of the individual, as an external entity, to view and process from a distanced perspective. From this externalized perspective, the presenting issue becomes less inherently "ugly," more manageable, and enables the client to separate self from the problem (Passons, 1975; White, 2007; Winslade & Monk, 2007; Woldt & Toman, 2005). Therefore, the diagnosis that is required by other stakeholders, such as third-party-payers, clinical setting bylaws, or other helping professionals serving on a case-team, may be used as an externalized entity from which the client may gain back his or her power (Passons, 1975; White, 2007; Woldt & Toman, 2005). For example, a client's diagnosis may be turned into an externalized power that steals the individual's sense of happiness, wholeness, or purpose. In this exercise, the client can then have an external source to fight against in his or her battle for healing, growth, and wellness. By using the diagnosis as an externalized entity from which to reclaim personal power and choice, clients are empowered to work from a wellness model, where change and growth are central to the counseling process (Carmody, 2009; Nanda, 2009; White, 2007; Winslade & Monk, 2007).

From this integrated model, the counselor may also provide support in the battle against the diagnosis. For instance, warmth, empathy, and insight can be provided to help the client see that the diagnosis is not all-encompassing, but rather a brigand attempting to steal total wellness and balance in life (Hutchinson & Lema, 2009; Kostanski & Hassed, 2008; White & Epston, 1990; Woldt & Toman, 2005). From a human growth and development perspective, as the client changes, so too will the diagnosis, or at least the power the entity has in his or her life. Supporting the clients through this growth and change process provides a foundation from which critical incidences may ignite the change process (Etherington, 2009; Furr & Carrol, 2003; Hutchinson & Pretelt, 2009). Through these uses of diagnosis, counselor educators have an essential role in supporting the CACREP standard of integrating diagnosis into the counseling curriculum (2009; II.G.7).

By integrating the *DSM-IV-TR* into the counselor education curriculum, counselors-in-training begin to learn the foreign language of diagnosis and develop skills to translate their conceptualization into another model's language. Clients' presenting issues, from a wellness model, are viewed as fluid, flexible, and changing (Gardiner & Kosmitzki, 2008; Nanda, 2009; Semple et al., 2005). Therefore, as counselors-in-training begin to learn the integral process of diagnosis, the wellness model should be kept at the forefront of their educational mindset. For instance, rather than viewing a diagnosis as static, unchanging, or permanent, a counselor-in-training can be educated in such a way that the diagnosis is for that time-period only, and that the symptoms experienced by the

client are capable of change, growth, and betterment. In this way, counselors are then able to meet the client where he or she is at that time period, and walk through a journey to more holistic wellness, where a diagnosis may be set at the beginning and alter or ebb throughout the client's progress. From a wellness perspective, the diagnosis is not torpid; rather, the diagnosis can be viewed as ever changing, just as the client is ever growing.

In addition to meeting clients where they are in their personal journey, integrating the diagnostic lens into a wellness perspective also helps counselors meet other allied helping professionals where they are in their professional journey. For instance, while other helping professions require a diagnosis, a counselor may translate his or her wellness lens to a diagnostic perspective in efforts to help both professionals fluidly collaborate on client cases. A fluency lens of the *DSM* allows for individuals to grow, rather than be stagnant, while also helping bridge a language gap between counselors and other professional stakeholders. Therefore, counselors are able to use translation skills, of wellness to diagnosis and back to wellness, in efforts to meet other helping professional where they are, further aligning the counseling profession to its philosophical foundations.

Pedagogical Experiences

Given an integrated perspective of the diagnostic and wellness-oriented models, counselor educators may need to develop new curriculum and pedagogical experiences. This integrated curriculum is especially crucial in assessment and diagnostic courses but is also critical in practicum and internship experiences. While the redefined integration of models may be most important for community mental health counselors, this theoretical amalgamation is also critical for other helping professionals, such as school counselors, marriage/couple/family counselors, psychologists, psychiatrists, and medical doctors. Through understanding the differences and similarities between conceptualizations and vernaculars, the consultation process may be further developed among helping professionals (Altekruse et al., 2001; Epstein & VanVoorhis, 2010; Eriksen & Kress, 2006; Hansen, 2010; Melnick & Fall, 2008; Holcomb-McCoy & Bryan, 2010). Through this mutual understanding, school counselors, clinical mental health counselors, couple/family counselors, and student affairs counselors may all gain a more holistic picture of diagnosis to better influence future working relationships. By experiencing an integration of specific exercises into coursework and field experiences, counselors-in-training may further develop their understanding and meaning-making of a diagnosis as it relates to their own wellness-oriented personhood.

Through classroom activities and internship experiences, emergent counselors begin to integrate a diagnosis component into their wellness model identity. For instance, in an assessment course, counselors-in-training can be asked to diagnose from a wellness perspective. In this experience, counselors-in-training would be asked to select a movie or book character, either fictional or nonfictional, and write a treatment plan based within the wellness model, complete with diagnostic criterion. The wellness model perspective would highlight strengths as well as components of self that struggle to maintain healthy wholeness. Diagnosing from a wellness perspective provides a foundational opportunity for students to practice translating their wellness conceptualization into the diagnostic

language expected by other stakeholders (Anastasi, 1992; Eriksen & Kress, 2006; Hansen, 2010; Juhnke, 1995; Nelson, 2002).

An additional class exercises may take place in cultural courses. During this coursework, students may discuss cultural considerations in the diagnosis process from a wellness perspective. For instance, students may experience a cultural activity such as BARNGA (Thiagaraian & Thiagaraian, 2006), Pedersen's Triad-Training (Pedersen, 1994, 2000), or case study reports and then discuss how they feel diagnosis may have an impact on their client's perspective of self, others, and the helping relationship. Counselors-in-training may then explore how cultural factors influence a diagnosis, perspective of wellness, and an integration of the two. Just as culture influences a diagnosis, so too does it affect a clinician's view of the individual's holistic wellness. By open discussion and experiential activities, new perspectives and integrations of theory may be brought to the counselor-in-training's awareness and developmental process.

Another potential pedagogical experience could stem from an internship experience in which students are working with clients. From this experience, students could choose one of their cases to track throughout the internship experience. In a portfolio, they include the beginning intake information, initial treatment plan, diagnosis, and write-up from a wellness perspective. Intentionally following the case throughout the internship experience provides students the opportunity to see change, growth, and development within the individual, to being able to shed the original diagnosis. Through such experience, emergent counselors gain further insight into the fluidity of human nature rather than a static conceptualization of a stagnant diagnosis (Carmody, 2009; Gardiner & Kosmitzki, 2008; Hays et al., 2010).

Other pedagogical experiences may include assigning students to speak with a psychologist, medical doctor, psychiatrist, or social worker. Speaking with another health professional about the *DSM-IV-TR* may help clarify other opinions and conceptualizations of clients. In addition, counselors-in-training may then ask questions to gain perspective regarding other uses and benefits of a diagnosis for clients. Through collaboration and consultation, emergent counselors may practice their other clinical skills as well as apply the integrations of diagnoses into their wellness counseling identity. In these experiences, counselor educators are also able to help counselors-in-training foster healthy collaborative relationships, reframe clinical jargon, and apply health perspectives of diagnosis into their clinical conceptualizations of clients.

Supervision Experiences

As supervisors, counselor educators create a learning alliance to develop skills of a counselor-in training (Adams, 2010; Edwards & Chen, 1999; Luke & Bernard, 2006; Murphy & Kaffenburger, 2007). In the supervision experience, the counselor educator must provide experiences, questions, and insights to further an emergent counselor's awareness of self and others (Luke & Bernard, 2006; Taylor, 2009; Thomas & Gibbons, 2009). Experiential activities, group supervision, and individual supervision can provide a hot bed for change, growth, personal insight, and group meaning-making (Connors & Caple, 2005; Kivlighan & Kivlighan, 2010; Melnick & Fall, 2008; Perusse, Goodnough, & Lee, 2009). In this process, counselors-in-training also learn to professionally

collaborate with others, identify self through professional orientation, and advocate for issues in which they feel most passionate.

Through individual discussion in supervision, the counselor educator can provide a positive, open, learning alliance to explore cultural considerations within diagnosis (Adams, 2010; Luke & Bernard, 2006; Murphy & Kaffenberger, 2007). Through interactive learning activities, counselors work together to understand self, self-in-relation, and the influence of diagnosis on self and others (Arredondo et al., 1996; Berger, 2004; McWilliam, 2008; Richardson, 2003). Moreover, in group supervision, counselors can collaborate with other mental health professionals concerning the influence diagnosis may have on specific client cases (Adams, 2010; Luke & Bernard, 2006; Murphy & Kaffenberger, 2007; Perusse et al., 2009). Through these interactions and activities, counselor educators and supervisors empower students to gain personal insight into their own reactions to diagnosis, learn to collaborate with other helping professionals, and assess how diagnosis may be influenced by a variety of factors.

Summary

Current CACREP standards (2009, II.G.7) require that counseling curriculum integrate *DSM-IV-TR* diagnostic skills and knowledge. Being grounded in a wellness philosophy, this required integration may seem counter-productive (Davis et al., 2005). However, after exploring the literature that grounds the wellness counseling philosophy, the two models are not mutually exclusive paradigms. Instead, a translation must occur between wellness models and the *DSM-IV-TR* diagnostic model so that all stakeholders may understand the fluid and dynamic process happening within the counseling process (Anastasi, 1992; Eriksen & Kress, 2006; Hansen, 2010; Juhnke, 1995; Nelson, 2002). This working relationship may be used in counselor training experiences so that students are more readily able to perform translation when entering the field.

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