JUST LISTEN TO THEIR STORIES

Lucy Johnstone and **Jo Watson** propose a radical alternative to the biomedical thinking that they believe is creeping into counselling

The narrative of emotional distress as 'illness' and 'disorder' is everywhere: promoted by anti-stigma campaigns, disseminated in the media, and given added credibility by celebrities such as Stephen Fry and Ruby Wax. Somehow, despite all our knowledge about attachment, trauma and relationships, many counsellors and psychotherapists have ended up accepting the message that people in emotional distress are medically 'ill'.

As therapists working independently and in the NHS, we have seen more and more clients coming to us with the label 'bipolar', 'personality disorder' or 'schizophrenia', and attributing their 'illness' to faulty genes and biochemical imbalances. Many have internalised this as part of their identity, along with the belief these are lifelong conditions that can only be managed with medication. Others have accepted the message, again widespread in the media, that crippling anxiety and low mood come out of nowhere, unrelated to what's happened (or happening) in their lives.

What is most extraordinary is that the current system of psychiatric diagnosis, embodied in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the *International Classification of Diseases*, has been openly discredited by the world's most eminent psychiatrists, including the very people who chaired the committees that wrote these manuals. This is something of which the general public and many professionals are largely unaware. For example, Dr Allen Frances, who chaired the committee that produced the fourth edition of *DSM*, has criticised the fifth and current edition in the strongest terms, saying: 'There is no reason to believe that *DSM-5* is safe or scientifically sound.'[1] In the same article, he writes: '... disappointingly, 30 years of advancing knowledge has had no impact whatever on psychiatric diagnosis or treatment... *DSM-5* hoped to include biological markers that might reflect past research and promote future research. This was a premature and unrealisable ambition: the science simply isn't there now.'

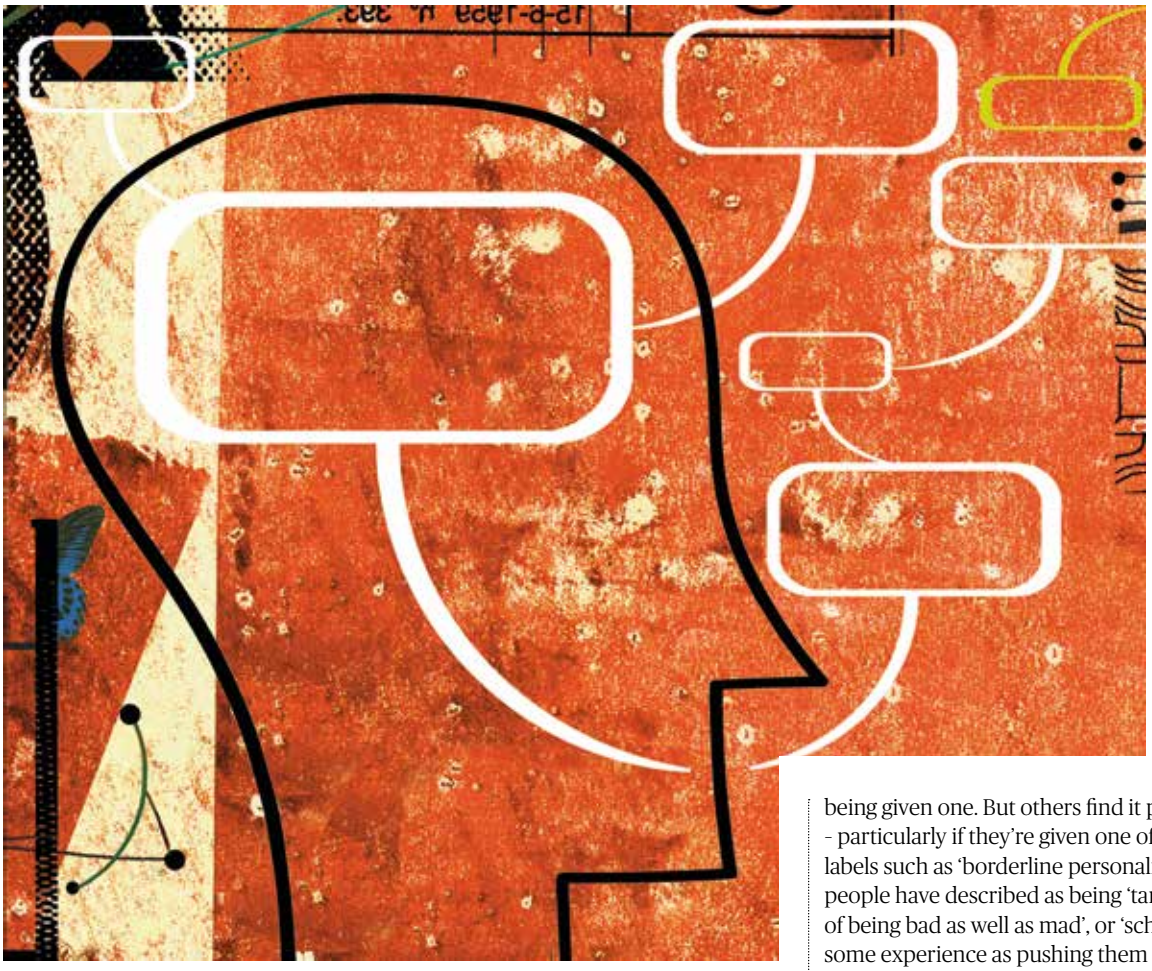
Even the chair of the *DSM-5* committee, Dr David Kupfer, has admitted: 'We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting.'[2] ('Biomarkers' are the biological indicators of genetic or other physiological flaws that are used in general medicine to validate diagnoses.) Not only does the notion of biochemical imbalances as the cause of mental 'illnesses' lack evidence – some psychiatrists are denying that this theory was ever promoted in the first place.[3]

Medical myth

As psychiatrist Joanna Moncrieff has extensively demonstrated,[4] psychiatric medications do not 'correct chemical imbalances'. Rather, they have a range of general effects, primarily sedation, that may or may not bring relief from overwhelming emotions, but that neither 'treat' nor 'cure' – as is suggested by the fact that ever-increasing prescription rates are doing very little to reduce levels of what is called 'mental illness'.

In this context, the encroachment of diagnostically based assumptions into counselling and psychotherapy is particularly concerning. James Davies has documented the processes by which psychiatric diagnoses are literally voted into existence by a small, self-selected group of clinicians.[5] Carl Rogers was opposed to all use of diagnosis.[6] Why, asks person-centred counsellor and author Pete Sanders, have counsellors, in accepting the validity of psychiatric diagnosis, 'abdicated the radical position occupied by client-centred therapy in the 1950s to become tacit supporters of the medical psychiatric system?'[6] Yet the fundamental counselling principles of non-judgmental, positive regard and the belief in human beings' capacity to achieve our best potential, given the right circumstances, seem to have become swamped by diagnostic thinking.

This has been reinforced (in England) by the IAPT programme, which is firmly embedded in a medical understanding of mental distress. In IAPT, psychological



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wellbeing practitioners are required to categorise potential clients' distress under various diagnoses, including 'anxiety disorders' and 'depression', using standardised questionnaires to determine their eligibility for talking therapies. Already the problem has become an illness, often before the client has even met a counsellor face to face, and the diagnosis remains, even if the therapy doesn't help.

Unhelpful dichotomy

However, diagnosis is deeply embedded in our health, medical and welfare systems, and most healthcare practitioners will find themselves having to work with them to some extent. Clients and service users need them to be eligible for support services and benefits. As a society, we seem to be stuck in an unhelpful dichotomy that can be summarised as 'brain or blame':[7] if you have a diagnosis, then your 'condition' must be 'real' and you are considered deserving of help and treatment; without a diagnosis, you just need to pull your socks up.

This helps to explain why some people find a diagnosis helpful, and may experience a sense of hope and relief on being given one. But others find it profoundly damaging – particularly if they're given one of the more stigmatising labels such as 'borderline personality disorder', which people have described as being 'tarred with the brush of being bad as well as mad', or 'schizophrenia', which some experience as pushing them 'deeper into isolation and separation from the rest of humanity'.[7] Research has also shown that a diagnosis can undermine the therapy process in myriad ways: by eroding people's confidence in their own perceptions and their hope that they will feel better again, removing their sense of control and responsibility, focusing on perceived deficits, and, most crucially of all, obscuring the meaning of their experiences and undermining the therapeutic alliance.[8]

The diagnosis may also lead to a profound disconnect between their feelings and the events in their lives, a ▶

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sense of shame, failure and hopelessness, and a belief that only experts can provide answers.[7] Psychiatric diagnosis can thus be a significant and yet largely unrecognised hindrance to our work as therapists.

The increasing involvement of counsellors and psychotherapists in the NHS means that, inevitably, they will have to work alongside the psychiatric diagnostic system. However, there is another way to explore with clients what is going on for them that allows them to make sense of their distress in terms of their relationships and life experiences. The alternative to psychiatric diagnosis is, in essence, to listen to people's stories. As psychiatric system survivor Beth Filson has written:[9] 'Until we are able to use our own words to tell our own stories, the context we find ourselves in – in this case, the psychiatric system – says our stories for us, and usually gets it wrong. In the context of the medical model, the story we learn to say is that we are ill. We begin to see ourselves as ill. We tell stories of illness, and the psychiatric system, and, by extension, society accepts illness as the story of our distress. Being able to tell your own story – not the illness story – sets a new social context: one in which mad people are seen in a new light... In part, healing happens in the re-storying of our lives.'

Collaborative sense-making

There is also an alternative to diagnosis: the practice of psychological formulation, which is now a core skill for clinical and counselling psychologists, and increasingly for other professions as well. This can be defined in various ways, but definitions that fit well with the principles of counselling and psychotherapy are: 'a process of ongoing collaborative sense-making',[10] and 'a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them'.[11]

Briefly, formulation is the process of describing a person's difficulties in the context of their relationships, social circumstances and life events, and the sense that they have made of them. It is, essentially, a personal narrative that a psychologist or therapist co-constructs with a client. The therapist contributes their clinical experience and knowledge – for example, about the impact of trauma. The client brings their personal experience and the meaning they have made of it. These two aspects are then put together, in written or diagrammatic form. Unlike diagnosis, this is not about an expert making a judgment: it is a shared, evolving, collaborative process that also includes the person's strengths and that points to the best route towards recovery.[12]

Lucy Johnstone
About the author

Lucy Johnstone is a UK clinical psychologist, trainer, speaker and writer. She has worked in adult mental health and academic posts for many years, and is the author of several books, including *Users and Abusers of Psychiatry: a critical look at psychiatric practice* (Routledge, 2000) and *A Straight-Talking Introduction to Psychiatric Diagnosis* (PCCS Books, 2014).

Trauma-informed approach

There is also an evidence-based alternative to the dominant biomedical model: the 'trauma-informed approach'. This relatively recent approach is supported by a growing body of evidence demonstrating that a whole range of adversities (such as abuse, neglect, loss, discrimination, poverty and social exclusion) have a powerful negative effect on mental health.[13] The trauma-informed model shows us that what originally evolved as life-saving responses to threat – fight/flight/flee/freeze – can be understood as ways of managing and surviving overwhelming fear, hurt and rejection; they only become problematic if the underlying emotions and memories are not recognised, witnessed and processed.

From this perspective, so-called 'symptoms' – even ones like hearing hostile voices or holding unusual beliefs, which are often labelled 'psychotic' – are better understood as survival strategies. Using this approach to work with the problematic experience, whether it's managing mood swings, or coping with low mood or crippling anxiety, therapists can make links between life events and the meanings people have made of them, without being distracted by the concept of 'mental illness'. Thus, research by the International Hearing Voices Network suggests that hostile voices very often represent overwhelming emotions that could not be processed at the time, and the network offers a whole range of strategies for living with voices once they have been linked to their origins.[14] Similarly, the British Psychological

Jane's story

At our initial assessment Jane told me she was 'bipolar'. ('Jane' is based on a number of clients I have worked with.)

She had been diagnosed three years ago and prescribed medication to 'correct the chemical imbalance' in her brain.

She told me she'd been sexually abused by a neighbour when she was little. She'd come to me for therapy because a TV programme had recently triggered flashbacks. She'd also had other challenges in her life, including a violent relationship in her early 20s.

I was aware that getting too close to the new memories too soon could re-traumatise her, so we worked slowly and gently on strategies around safety and stabilisation, building her resilience. She reached a point in the work where she was able to use dual awareness[1] to bring herself back from a dissociative flashback reasonably quickly.

I hoped the therapy would allow her to

"I was left wondering how different things might have been if she had been supported to make the link between her life events and emotions in the first place"

Society's Division of Clinical Psychology has free downloads describing non-medical approaches to experiences that are more usually labelled 'bipolar' or 'psychosis'.[15,16]

One of the basic principles of person-centred therapy is that people should be able to develop their own, preferred understandings about their struggles and difficulties. For some, this will be a diagnosis. At the same time, we need to be aware that this particular model is rarely freely chosen. The discourse of 'illness' is all-pervasive and usually unquestioned; diagnoses are presented by experts as givens, not contested and disputed categories. A mental health patient who declines to take on such labels may be regarded as 'lacking insight', and may be forced to take medication.

Offer alternatives

As therapists, shouldn't we be informing clients about the pros, cons and controversies relating to psychiatric diagnosis, exploring these issues with them, and offering (not imposing) alternatives? Surely it is for the client to decide whether to explore this different perspective, which may imply a long and painful process of revising unquestioned beliefs and their consequences? The growing weight of scientific evidence (and lack of it) makes it no longer scientifically, professionally or ethically acceptable to offer, or impose, psychiatric diagnoses as undisputed fact.

Listening to people's stories, like any approach, can be practised in pathologising or insensitive ways, as well as helpful ones, but counsellors and psychotherapists need to remember the core person-centred tenets of their profession, and have the confidence to challenge orthodoxies, however pervasive and powerful. ■

Jo Watson
About the author

Jo Watson is a psychotherapist, trainer and activist with a professional history rooted in the rape crisis movement of the 1990s. For the last 20 years, she has worked therapeutically with people who have experienced trauma. Jo founded the Facebook group, 'Drop the Disorder!', in September 2016 as a place where the issues around the biomedical model can be discussed.

Further information

Jo and Lucy are running a series of one-day workshops – 'A disorder for everyone: exploring the culture of psychiatric diagnosis'. They are for counsellors, mental health service users/survivors, carers, all mental health professionals and anyone with an interest. The next event will be in London on 8 June. To book, go to: tinyurl.com/jj86u6n

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make sense of her distress through the exploration and validation of what she had experienced. However, she held on to the strong, core belief that her brain was 'not normal' and that it was, basically, a biological problem. When we started approaching more difficult memories and feelings, she retreated back into what was, for her, the comparatively safe refuge of the 'malfunctioning brain' explanation.

I see it as my role to offer alternative explanations so that clients can make an informed choice about whether or not to take on the diagnostic model. Jane and I discussed these issues, and I pointed her towards leaflets and literature about diagnosis and the causes of mental distress. Ultimately, however, she found her psychiatric diagnosis a more acceptable explanation.

Of course, this was her choice, and she was pleased that the therapy had helped her to gain some control over her flashbacks. But, as often happens in my work, I was left wondering how different things might have been if she had been supported to make the link between her life events and emotions in the first place. I hope we have at least laid the foundations for her to return to therapeutic work in the future, if she feels ready.

Jo Watson

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