Practitioner Perspective

Response to Eugene McHugh's 'A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy' – The Rogerian Perspective.

By Pat Comerford

Introduction

Mullen (2016) previously promoted the use of the DSM-5 (APA, 2013). I responded by raising concerns about breach of boundaries professionally, legally and ethically by counsellors using this manual (Comerford, 2016). McHugh (2018) is a recent apologist for DSM-5 use and attempts to show how its use can be considered "person-centred" (p. 24). His use of 'person-centred' is generic, but bears no relationship to Rogers "Person-Centred Approach" (Sanders, 2012a, p. 13).

For my part in the conversation on DSM-5 use I will answer McHugh's question: "What is the resistance of our profession to using the DSM-5 ...as a useful resource?" (2018, p. 21). I will show how his framing of 'Mental Health' and the use of the DSM-5 conflicts with one counselling approach in our profession, the theory and practise of "Classical Client-Centred Therapy", a.k.a. 'Person-Centred Therapy' (Merry, 2012, p. 21).

Professionally, I most closely associate with: "existentially informed person-centred therapy" (Cooper, 2012, p. 131). The 'Humanistic Orientation' (Comerford, 2018) of Client Centred Therapy - CCT henceforth - is the perennially wise antecedent to the "Integrative" (Hegarty, 2014, p. 38) and "Pluralistic" (Finnerty, Kearns & O' Regan, 2018, p. 17) approaches. It is the springboard for and shapes my response to McHugh's promotion of the DSM-5.

Emotional and Mental Health

Phenomenologically, users of the DSM-5 represent a: "...dualistic philosophy of separation between the knower and the known..." on the "subjective-objective axis" (Shlein, 2003a, p. 155). McHugh reflects this dualism: "...a differentiation between Emotional Health and Mental Health where the former is a'dis-ease' and the latter is a physical 'disease' within the client." (2018, p. 23). His understanding concurs with that of Dailey, et.al.: "...that mental health disorders are medical conditions" or 'physical diseases' (2014. p. 14, cited in McHugh, 2018, p. 23).

Borrowing from Maslow: "In essence, I am deliberately rejecting our present **easy distinction** between sickness and health..." (2014, p. 17, bold type added). CCT has a dynamic view unlike the psychiatric/medical construction 'mental disorder'. We understand that clients are living at the "difficult

edge" (Warner, 2000, p. 144) engaging in "difficult processes" (Warner, 2017, p. 95). In other words difficulty is: "…when they arrive at the edge of their experience or the limit of their capacity" (Pearce and Sommerbeck, 2014, p.vi).

DSM-5

According to the American Psychiatric Association:"The primary purpose of the DSM-5 is to assist **trained clinicians** in the diagnosis of their patients' mental disorders…" (APA, 2013, p. 19, bold type added). This manual is for 'trained clinicians' and has no reference to counsellors and counselling.

The DSM-5 is a medical taxonomy of "symptom-led diagnostic categories" (Sanders, 2012b, p. 18). The manual is grounded in a "medical model" (Mullen, 2016, p. 21) and its use is quintessentially mechanistic (Mullen, Op.cit., p. 20). The 'trained clinician' atomises the person's behaviour so as to arrive at a diagnostic label, this is not regarded as a holistic approach for therapists trained in CCT. The beliefs and practices of CCT are grounded in humanistic values which are directed: "… on the holistic lived experience of the person (individual) and its implications for practice, pushing back on more mechanistic, reductionistic, and dehumanising approaches." (Hoffman, Cleare-Hoffman & Jackson, 2015, p. 42).

While McHugh promotes the DSM-5 my copy of the manual more often gathers dust.

DSM-5 Promotion

McHugh promotes this manual as an efficacious 'assessment tool': "I do wish … to look at using the DSM as an assessment tool for **ourselves** and as a communication tool with other **professionals** such as: medical practitioners, insurance companies, Employee Assistance Providers (EAP), psychiatric services, researchers." (2018, p. 23, bold type added).

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His campaigning for the manual is centred in its value as 'an assessment tool for ourselves', and as a 'communication tool' for medics, and the 'professionals' and agencies linked to the medical profession. He explains the 'usefulness' of DSM-5: "To be abundantly clear, I am not proposing that the DSM criteria are discussed with clients, it is about being more proficient in the use of an internationally recognized tool when in discussion with other **professionals and agencies**." (2018, p. 23, bold type added).

His comments buttress an 'expert and client' type relationship; they are "expert-centred" (Wilkins 2017, p. 144). Counsellors who usually do not work in this way then need to evaluate the manual and its 'usefulness' in their practise.

DSM-5 Evaluated.

McHugh writes a non-critical "brief history of the DSM" and its "current version" (2018, p. 21-23). Lynch, however, presents us with a comprehensive critique on "…the validity of the DSM…" (2018, p. 5) and concludes:

> Rather than embrace the DSM, I encourage the counselling profession to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right, rather than repackaged as "mental disorders" within a system whose "bible" is utterly lacking validity. (2018, p. 9).

What Lynch's critique shows is how historically the construction of the DSM-5 was shaped by an epistemology that is "doxic", in turn creating a classification that is arbitrary (Sanders, 2017, p. 16, and p. 28).

In spite of the DSM-5 lacking 'validity' McHugh (2018) writes that: "It is my belief that it is essential that the therapist is trained to consider themselves competent in the use of the manual." (p. 23). He cites Brammer, Shostrum & Abrego (1989, p. 148), who recommend that therapists: "simultaneously understand diagnostically and therapeutically" (2018, p. 24). Does 'competent in the use' mean that all counsellors also need to be 'trained clinicians' before using the DSM-5 as the APA intended?

His belief discords with the humanistic values, the theoretical and professional positioning of therapists in the CCT community. It can be regarded as a defining 'discount'. To 'discount' is when: "… people minimise the significance of parts of themselves, others and the environment" (Feltham & Dryden, 2004, p. 66).

Discounting and CCT

It is important to give one fundamental understanding of what CCT is before addressing McHugh's discounting the fact that: "Client-centred therapy is a theory of dynamic change, in directions chosen by the client, not prescribed by the therapist." (Shlien, 2003b, p. 71).

He attempts to address "Issues for Counsellors" using the DSM-5 – namely "assessment" (2018, p. 23-25) and "labelling" (2018, p. 23). But, he simultaneously discounts these two 'issues' which are significant in CCT.

On questioning clients for DSM-5 assessment, he writes: "One can see that these might not be considered as person centred questions and

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Rogers and Wallen (1946)

more from the medical model. They form, **however,** an important part of our hypothesis and **decision making for the client**." (2018, p. 23, bold type added). He presents his discount with his use of the word 'however', justifying asking 'medical model' questions by counsellors and psychotherapists.

He has the additional discount 'decision making for the client' which is divergent to the ethos of CCT and not part of the CCT lexicon. His advocacy is consistent with the view expressed by Mullen (2016) on the use of this diagnostic tool in that: "It…is our best source of help in sorting pathology in order to unlock, manage, and understand what we are encountering." (p. 21). Her use of the word 'what' is an unfortunate objectification of the client.

On assessment questions McHugh states that: "I accept that while all the aforementioned can be argued as not being person-centred, **professionally it is something** that one **does for** the benefit of the client." (2018, p. 24, bold type added). 'Professionally it is something' is a discount in the sense that it is a rationale for DSM-5 questioning. Reinforcing this discount and justification he advocates 'does for'. This assessment approach is contrary to the beliefs of CCT.

To emphasise his advocacy for using the DSM-5, he explains that: "…it does not direct how it is brought to the client, **but** the therapist does use it to understand the client's experience." (2018, p. 24, bold type added). The discounting is achieved with his use of the word 'but' and further, his concluding sentence has two further discounts: "On balance, I believe that with **careful use**, the DSM-5 is a worthwhile **tool** in Counselling and Psychotherapy." (2018, p. 25, bold type added). The 'careful use' of the DSM-5 is at variance with the "non-directivity" of CCT (Levitt, 2005).

To regard CCT as a "relational therapy" (Mearns & Cooper, 2005, p. 1) is essential. And advocating a 'tool' to label persons discounts and flouts the values of the collaborative relationship watermarked in CCT.

Labelling Discounts, the Contradictions

McHugh, in the second paragraph of his article, asserts: "I am fully behind the idea of not labelling our clients and in meeting them wherever they are" (2018, p. 21). He immediately discounts what he has just written with the first word of his next sentence: "**However**, I am curious as to how we might use the assessment tools to inform ourselves about our clients' lives and in turn support interventions to aid their emotional support" (2018, p. 21, bold type added). From the CCT orientation, his two statements contradict each other.

In counselling returned servicemen, Rogers and Wallen (1946) disavowed the use of labels: "The counsellor must be ready to understand the motives that this client has for his behaviour, without trying to fit him into some preconceived pattern."(p. 10, bold type added). Labelling clients using the DSM-5 is a contradiction in CCT. It contravenes the humanistic theory and philosophy of Rogers (1959), since CCT is about 'a way of being' with clients (Rogers, 1980).

Rogerian Theory

Client-Centred therapists do not use the DSM-5 in order 'to understand the client's experience'. We rely totally on the "**necessary** and **sufficient** conditions" of congruence, empathy, and unconditional positive regard (Rogers, 1957, p. 95, bold type added). These "attitudinal ingredients" (Rogers, 1967, p. 90) enable the client-centred therapist to understand the client's phenomenological experience, their "Internal Frame of Reference" (Raskin, 1996, p. 3). In other words, to understand their "perception" or interpretations of "objects, others and self" (Spinelli, 2005, p. 59-102).

Client-Centred therapists are committed to the core Rogerian belief in the "actualising tendency" (1951, p. 487-491) of every client, as they journey in 'becoming a person' (Rogers, 1961). This belief is articulated as follows: "The person increasingly discovers that his own organism is trustworthy, that it is a suitable instrument for discovering the most satisfying behaviour in each immediate situation." (Rogers, 2015, p. 18).

For CCT therapists:

> Therapy is not a matter of doing something to the individual, or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development, of removing obstacles so that he can move forward. (Rogers, 1942, p. 29).

Schmid (2018) remarking on Rogerian theory noted that: "Rogers focuses on the salutogenetic dimension of facilitating the actualising tendency of the person for growth…not on the psychopathological category of curing from diseases" (p. 134).

This "revolutionary innovation" (Raskin, 2002, p. 105) creates the possibility for CCT therapists to make contact with clients, and, in turn, supporting them to make contact with themselves as they address their 'lost connections' (Hari, 2018, p. 179-261). It supports CCT counsellors to appreciate clients' own directional choices. It safeguards against the disempowerment of clients by 'decision making for' them. It enables 'forward' movement by understanding clients' 'internal frame of reference'.

Clients' Internal Frame of Reference (IFR)

I concur with McHugh that counsellors may have impressions about clients from their first moment of contact that may lend to making some guesses about them. I disagree with him on how we address these impressions. Formulating "theoretical maps" and then using the DSM-5 to prove or disprove "our hypothesis" because of the client's "gait, dress, appearance, culture, shape, facial expressions, mannerisms and tone of voice" is not Client-Centred (2018, p. 23).

> In CCT it is:
> ... in the therapist's attention to the client's attitudes and feelings was the idea that the client's frame of reference, which came to be referred to as the IFR (internal frame of reference), was the therapist's basic consideration, rather than his own appraisal of what was going on. (Raskin, Op.Cit., p. 3).

He appears to put more value on the assessment (his own appraisal) of the client, rather than their IFR. This is "psychodiagnosis", which: "...looks at the client, primarily, from an **external frame of reference**" (Boy, 2002, p. 388, bold type added). In other words the focus of assessment is on his hypotheses, and not the clients'.

To counterbalance these 'discounts' an understanding of CCT's perspective and praxis in the area of mental health is necessary.

CCT and Mental Health

Sommerbeck (2003) was a Client-Centred therapist in a psychiatric hospital, and in her relationships with clients given a DSM-5 label stated that: "...the client-centred therapist consistently receives and follows the client's expressive process with acceptant empathic understanding. Doing this, the therapist's attitude is non directive, since empathic understanding is post-dictive, not pre-dictive." (2005, p. 170-171).

CCT is unreserved in expressing their disquiet with colloquial terms like 'mental illness' (Joseph, 2017). Sanders opines: "Person-centred therapy suggests an organismic growth metaphor for human distress, and person-centred theorists and practitioners should declare this in juxtaposition to the dominant illness metaphor at every appropriate opportunity." (2017, p. 13).

Using the DSM-5 leads to what Cooper has called an "it-ifying versus humanising" attitude when: "...others may be construed in such object-ifying terms as 'a neurotic' or 'a borderline personality'" (2017, p. 59).

Warner noted that Client-Centred therapists: "...have hesitated to conceptualise clients as having 'characterological' disorders such as narcissistic personality, borderline personality or dissociative identity disorder" (2000, p. 144). She explains that: "Diagnoses of people experiencing these difficult forms of processing tend to be misleading since such diagnoses attempt to characterise the whole person" (2000, p. 145).

CCT Praxis/Applications

Prouty created 'Pre-Therapy', a person-centred/experiential approach focused on: "...the development of the psychological functions necessary for psychotherapy" (1994, p. xxix). He developed 'Contact Reflections' (Sanders, 2007). These 'Contact Reflections' are: "...empathic responses that are very concrete and close to the clients' actual words and facial and body gestures" (Warner, 2017, p. 100). They: "...offer the therapist an appropriately concrete way of following the client's overt 'being in the world' with unconditional acceptance" (Sommerbeck, 2005, p. 175).

'Pre-Therapy' enables the Client-Centred therapist to make contact with those clients who: "...are experienced as being 'out of contact' ('autistic')..." (Sommerbeck, 2005, p. 175). Prouty (2008) recorded how 'Pre-Therapy' can be used with persons with 'Special Needs' (Portner, 2008), and those with 'Somatic Hallucinating' (Van Werde, 2008).

Other examples of 'processes' at the 'difficult edge' that Pearce and Sommerbeck (2014) review in CCT are: childhood sexual abuse, psychoses, catatonic depression, trauma, terminal illness, brain damage, adolescent process, and clients with learning disabilities or autism. They declare the intention driving their publication: "We hope...to demonstrate that such edges can be moved considerably by therapeutic practice which is person-centred and incorporates the invaluable example and well-established wisdom of Pre-Therapy." (Pearce and Sommerbeck, 2005, p. vi).

It is worth referencing Morten (1999) who focuses on employing 'Person-Centred' approaches to dementia care.

Warning: Ersatz CCT

Self-proclaimed Client-Centred counsellors using the DSM-5 could be perceived as performing "Medical-mimicry" which: "…is the attempt to use a pseudo-scientific justification for the application of a range of approaches according to what the therapist diagnoses as the client's need." (Sanders, 2012c, p. 244).

Sanders wrote: "So it is a 'diagnostic – selection of method – application of method' model and sometimes advocates of such an approach will cite themselves as 'person-centred' as an underpinning to the model." (2012c, p. 245).

He recorded that:

> Dryden (1984) refers to this approach disparagingly as 'hat-trick eclecticism', where, in one variation, practitioners wear different 'hats', e.g., '…a Gestalt hat with one client, a psychoanalytic hat with another, and so on' (p. 351) again depending upon the practitioner's analysis/ assessment/diagnosis of the client's needs. (2012c, p. 245).

Schmid avers:

> To try to justify traditional diagnoses and 'intervention techniques' in person-centred therapy, arguing that modern applied sciences and mainstream health politics require us to do so, and thus **to manualise person-centred therapy** by describing categories of therapeutic techniques, **is simply a contradiction**. (2017, p. 84, bold type added).

Classical CCT

McHugh on the use of the DSM-5 wrote: "This will help the client in their self-discovery, which can be argued is a person-centred effort" (2018, p. 24). Classically trained Client-Centred therapists would resist this rationale as a justification for using this manual because employing "…a general category (**is**) anathemous to client-centred therapy…" (Saunders 2003, p. 80, bold type added).

On 'diagnosing', Sommerbeck pointed out that: "…the client-centred therapist sees the **uniqueness** of the client, whereas the psychiatrist sees their **averageness** in relation to a certain diagnostic group." (2017, p. 119, bold type added).

Raymond-McKay (2018) brought to our attention the historical consequence of standardising and averaging, which is: "The individual became anonymous and irrelevant" (p. 4). With DSM-5 use, this means the loss of 'individuality'. Today, more than ever, CCT is an important and indispensable counterweight in the mental health service so as to honour the relevance and uniqueness of each individual.

Sanders commented on the 'Person-Centred' theory and practice of Warner (2000): "This positions her work in the person-centred tradition of critiquing the medical model of mental illness, eschewing symptom-led categories, and letting understanding of distress to be phenomenological, defined and led by the client's experiences." (2012b, p. 18).

Future Conversations

CCT therapists using the DSM-5, is like putting a 'square peg in a round hole'. We consider that its use is not classic Client-Centred; ergo, it is not humanistic. Person-centred "Empathy" (Shlien, 2003a, p. 159-161) or "Understanding" (Shlien, 1984, p. 170-173) is our motivation, not 'diagnosing'. For the CCT School of counselling this is central to our 'resistance' to using the DSM-5 'tool'.

I accept for McHugh and 'Integrative' counsellors, with a medical and mechanistic orientation, that they use the DSM-5 to inform and shape their relationships with clients. In CCT practice, however, we do not use this 'tool' to profile our person-centred relationships.

We need more conversations with each other about our different 'humanistic', 'integrative', 'pluralistic' and 'medical' understandings of 'mental health', 'mental disorder', 'assessment' or 'psychodiagnosis', and 'psychiatric labelling'. We need not rush to embrace the DSM-5 as the standard 'assessment tool'.

CCT is truly humanistic in relating to all clients, led by their needs. I believe unreservedly that Client-Centred/Person-Centred/ Humanistic psychotherapists, in Ireland, need to voice our ethical concerns about possible mandatory use of the DSM-5 in our practice.

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