John Rowan

DIAGNOSIS

The question of diagnosis is one of the most striking areas in which humanistic practitioners differ from the older orthodoxies.

It seems at first sight - and certainly it must be so if one adopts a medical model - that there is no way out of some responsibility for diagnosis. Surely we must find out what problem a person has before we can put it right? A doctor has to find out the disease before he knows what drug to prescribe; a motor mechanic has to find out what is wrong before fitting a spare part; a plumber has to find out the cause of the trouble before he can put it right. Isn't mental illness like this?

Certainly the vast majority of people working in the field of psychotherapy would argue in this way. And yet, after a hundred years or more of research in this area, we will find the authors of the latest encyclopaedic handbook of research (Garfield & Bergin 1978) saying this:

> Ideally, one would like to be able to say that, given Problem X, the optimal approach is Technique Y. In practice, as the reader will discover, things are rarely so simple or straightforward; on the contrary, since human problems are extraordinarily complex, so are the issues facing the therapist who attempts to deal with these difficulties in therapeutic ways. For the same reason it is unlikely that there will ever be a single optimal approach to the solution of a psychological problem.

In other words, they don't have the answer. It seems that diagnosis is more problematic than we might have thought. For example, we might well feel that at least diagnosis could tell us one important thing - which patients were going to go crazy if they start into psychotherapy. This is sometimes referred to as *"precipitating a psychotic episode"*, sometimes as *"provoking a breakdown"* and sometimes as *"inducing decompensation"*, but it's all the same problem, and a fairly obvious one, at that. Surely diagnosis can at least get us this far? Well, apparently not. In a recent book (Malan 1979) on the science of psycho-dynamics by one of the best-established therapists at one of the best-established clinics, the author has this to say:

> During many years at the Tavistock Clinic, I have accumulated a long list of patients in whom this question arises (relief vs. increased disturbance - JR); and, even being wise after the event, I have found myself quite unable to distinguish between these two possibilites. I am constantly being surprised by patients whom I would not expect to break down, who do break down, and those whom I would expect to break down, who don't. This remains an area where systematic research is badly needed.

But the humanistic practitioner doesn't want to do this systematic research, because of severe doubts, not only about the efficacy, but also about the morality, of this process of diagnosis. Because to diagnose someone is to label them. And labelling does harm to people, even when the labels are correct.

Human beings do have problems, but when it comes to psychotherapy, they are not isolable separate problems which can be treated like a disease or a faulty component or a blocked pipe. They are problems connected with being that person. This is why one label can never be enough to tell us what to do about a person. One of the main characteristics of the humanistic approach is a refusal to label people in any firm or final way.

Possibly the best discussion to be found of this whole area is that to be found in the book by Walkenstein(1975). She tells of giving patients labels - *"Your diagnosis is Excessive Politeness . . . the only cure for you is to practise some excessive rudeness." "You're a marshmallow."* These are all temporary labels - they don't have the certainty or the permanence of science - they just represent a moment of insight, a moment of seeing the obvious in a flash of clarity. They have implications for something to do about changing them.

To someone like Walkenstein, the symptoms represent a shield - they don't represent the personality. The diagnosis then becomes not a life sentence but rather something to be put aside when the person is ready to do so. She looks on the symptoms as a message, a plea for attention, and the diagnosis as a method of giving that attention, in a temporary and non-hurtful way.

Labelling

Much of what we have been saying comes under the heading of what is often called labelling theory. Labelling theory says that social situations tend to be ordered in accordance with social meanings and intentions of various kinds. That is, a whole series of expectations are set up just by the way the set-up is arranged. Whatever then happens within the boundaries of that set-up will be seen in terms of those specific expectations, and no others. That behaviour which does not fit in will be seen as deviant. And this opens up the whole question of diagnosis. How are people labelled, and what are they labelled for?

In the field of *"mental illness"*, just as in the field of criminality (see Rowan 1978) there is a great deal of leeway and a great deal of negotiation involved. If we want to have a good look at how diagnostic decisions are made in practice today, we can make a good start by considering the classic paper by Daniels (1970) on military applications of diagnosis. One of the main points she makes is that the diagnosis of mental illness is dependent not only on the symptoms of the patient, but also on the doctor's awareness of the consequences that a specific diagnostic label may have for the career of the patient. In her actual worda:

> In situations where diagnostic procedures carry clear consequences for disposition of cases, the principle seems to be: Tell me what is feasible or reasonable to do with this person and I will give you a diagnosis which can explain, justify, or in some cases, modify that disposition. These principles are by no means limited to the military setting . . . they also suggest that the construction of psychiatric reality may be almost entirely social.

Social, that is to say, as opposed to medical. This last assertion may seem to be on the strong side, but as we shall now see, it can be supported from several different angles.

It seems to be little known that diagnostic examinations are often very short. Scheff (1966) reports studies of commitment hearings which show that the average diagnosis takes five minutes. This examination is peremptory and ritualistic, and determines sanity or insanity. The key to understanding this is that according to Scheff their actual goal is not to determine **whether** the patient is mentally ill, but only to decide **which** mental illness s/he has. He followed up his original study with further studies in England and Italy (Scheff 1966b) which showed exactly the same state of affairs to exist in these places.

It is not surprising to find, then, that diagnosis is very much open to influence, as Temerlin's (1975) experiment showed. He played a tape of an interview with a *"patient"* (actually an actor who had been given a script indicating a person who was about as normal and average as possible) and a psychiatrist, to various groups. For one group the remark was dropped that this was a very interesting man because he looked neurotic but was actually perfectly normal. For another group the remark was dropped that this was a very interesting man because he looked neurotic but was actually quite psychotic. The first group voted 100 per cent that the person was healthy and normal. In the second group of psychiatrists, 60 per cent voted him psychotic, and 40 per cent neurotic. Control groups who were told nothing about the person **never** said he was psychotic, and only a minority thought him neurotic at all. These are striking results. It seems clear that a one-sentence suggestion from someone who is thought to be important and relevant is regarded more highly than the evidence of one's own ears. The unfortunate patient is likely to be put away even if everything he says is perfectly normal - so long as someone has pronounced him a problem.

Similar doubts arise out of a much more realistic experiment reported on by Rosenhan (1975) which was widely reported at the time. Eight researchers gained admission to mental hospitals by posing as patients; some went to more than one hospital, so that twelve hospitals were sampled in all. They behaved perfectly normally and told the truth about their lives except for three points: they changed their names; those who were in mental health professions changed their jobs to some thing unconnected with medicine; and they gave as their symptoms that they had been hearing voices which were often unclear, but seemed to be saying *"empty"*, *"hollow"* and *"thud"*. They were all diagnosed as schizophrenic, except one in one hospital (the most expensive one) who was diagnosed manic-depressive, and admitted immediately. Once in, they found it very hard to get out again. The length

of their stay varied from seven to fifty-two days, with an average of nineteen days. When they went up to a doctor to ask to be let out, the doctor in most cases kept moving on with his head averted and did not reply; the same thing happened with nurses and attendants.

The accuracy of the diagnostic process is again questioned in a follow-up to the original investigation, where a research and teaching hospital had heard of the study and doubted whether such things could happen in their hospital. All the staff at this hospital were therefore alerted to the possibility of pseudopatients applying for admission. In a period of three months while this was operating, 193 patients were seen. Of these, forty-one were reckoned to be pseudopatients by at least one person; twenty-three were considered suspect by at least one psychiatrist; and nineteen were suspected by one psychiatrist and one other staff member. Actually, however, no pseudopatients attended at all. So what can we say about the nineteen cases where applicants were judged sane? *"One thing is certain: any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."*

So it seems that psychiatric diagnosis is fallible and influencable - but what is interesting is what influences it most in practice. This was put under the microscope by Greenley (1975) in a study of 125 consecutive admissions to a psychiatric unit in New England. He interviewed the psychiatrist and asked how bad the patient was, both absolutely and in relation to other patients; he interviewed the patient, and asked whether he or she wanted to stay in the hospital or return home; and he interviewed one other family member, and asked whether the family wanted the patient to stay in the hospital or return home. He then related the answers to the eventual length of the hospital stay of the patient. It turned out that the strongest influence was the attitudes and wishes of the other family members. How does this work? One quote:

> Sometimes when a family calls and says they don't want to see someone again, I know my (neurotic) diagnosis is wrong and that they are probably schizophrenic. If the family doesn't want them, they are ususlly more sick than I think, so I change and call them schizophrenic.

It could hardly be clearer that a psychiatric label is one of the best ways of getting rid of somebody. Just as the vast majority of *"crimes"* are never *"brought to book"* (Belson 1975), so the vast majority of mental distress is never brought to book, in the sense of labelling someone as neurotic or psychotic.

Who, then, are the people who are most likely to be labelled? They are the most powerless. Just as those criminals are most likely to be caught who go most against the norms of a top-down society, so those other deviants are most likely to be put inside who go most against the norms of such a society. As Brown (1974) reports, most prisoners in state psychiatric hospitals (sorry, most patients in state psychiatric hospitals) are working class, most are women, and third world people make up a disproportionate percentage of the patient population in relation to the general population. As he says:

> The social context of present-day America is of class, sex and race oppression, and those oppressed by these social relations are the prime candidates for the brain police.

This is no less true of Britain or any other country. It appears, then, that psychiatric diagnosis offers an acceptable *"scientific"* story to justify taking a person out of his or her home and putting them in an institution.

It seems from this that labelling theory offers an account of *"mental illness"* which makes social-psychological sense in a class patriarchy. For more evidence and an examination of the counter-case see the article by Scheff (1975) which examines the alternatives rather throughly, and the book by Gove (1975) which deals rather less well with these matters.

But having seen some examples of how the theory works, it seems in order to examine the theory itself - what does it actually say? Labelling theory starts with a simple distinction - that between explicit norms (rules whose breaking can be punished) and residual rules. The residual rules are not stated anywhere, and it may not be legitimate to punish infringements of them, yet they may on occasion be important to specific people. These much more vague and variable infringements tend, in each age, to drift into a catch-all category. Once it was witchcraft (and still is in a number of countries), once it was possession by spirits, sometimes it was possession by the Devil, and so on: today, in our culture, it is *"mental illness"*.

When someone in our family is doing something unacceptable and inconvenient, which cannot be condemned under any existing law, but which makes us nervous or excited, we are liable to see that person as a candidate for the mental hospital. The case histories by Laing & Esterson (1970) give a rather clear picture of this process in action. So labelling theory says that the symptoms of *"mental illness"* can be seen as the violations of residual rules. Scheff states nine formal hypotheses as follows:

1. Residual rule breaking arises from fundamentally diverse sources (that is, organic, psychological, situations of stress, volitional acts of innovation or defiance).

2. Relative to the rate of treated mental illness, the rate of unrecorded residual role breaking is extremely high.

3. Most residual rule breaking is 'denied' and is of transitory significance.

4. Stereotyped imagery of mental disorder is learned in early childhood.

5. The stereotypes of insanity are continually re-affirmed, inadvertently, in ordinary social interaction.

6. Labelled deviants may be rewarded for playing the stereotyped deviant role.

7. Labelled deviants are punished when they attempt to return to conventional roles.

8. In the crisis occuring when a residual rule breaker is publicly labelled, the deviant is highly suggestible and may accept the label.

9. Among residual rule breakers, labelling is the single most important cause of careers of residual deviance.

This is to put more testably and tightly what we have been seeing evidenced all through this paper. It is rather like the old wives' tale about *"if your eyes are crossed when the wind changes, you'll get stuck like it"*. You can cross and uncross your eyes many many times and be none the worse for it, but if you get caught at the wrong moment, that's it - there is no going back.

The implication of this is that if we refused to label people, they would drift into and out of mental states often regarded as *"neurotic"* or *"psychotic"* without ever losing their status as citizen, friend, child, human being or whatever. And this is precisely it. A good example is given by Seymour Krim (1960) when he talks about his own psychotic episode:

> When I was considered out of my mind during my original upward thrust into the sheer ecstasy of 100 per cent uninhibitedness, I was aware of the 'daringness' of my every move; it represented at heart an existential choice rather than a mindless discharge; it could not be tolerated by society, and I was punished for it, but my 'cure' was ultimately a chastisement, **not a medical healing process.**

Krim is now a well-known author, and according to him benefited from the experience - but much of it was horror, because of the way he was treated. He had enough power and influence to fight back - but most patients don't. More examples are given in Berke's (1979) chilling little book. Most patients get labelled and they stay labelled. They *"get stuck like it"*.

Alternative Models

It is clear that we must reject the medical mode. In doing so, we are on common ground with most psychologists, and the overwhelming majority of social psychologists. The current edition of the **Handbook of Social Psychology** has an article by Freeman & Giovannoni (1969) describing the medical model of mental distress as *"entirely irrelevant and handicapping"* and as *"unreliable or meaningless"*. We have seen above how true this is.

Equally objectionable, from quite a different standpoint, is a social-determinist view, which says that mental illness can best be understood as caused by material conditions. The many environmental studies which have been carried out by such people as Faris & Dunham (1939) and Hollingshead & Redlich

(1958) come under this heading: such studies show that people living in the run-down areas of the inner city have a far higher incidence of schizophrenia and other mental disorders than those living in the suburbs; the expectancy of a psychiatric disorder, the types of disorder found and the types of treatment likely to be offered or imposed are all significantly related to the person's position in the class structure. The moral often drawn is that living conditions which are bad enough can drive people crazy. This again is too one-sided, though this time from another direction. It seems at first to be very enlightened and politically challenging - get rid of the slums and improve the lot of the poor - but in fact it is just as mechanical as the medical model, in its own way. The person still gets labelled just the same as before, only now it is the fault of society, or living conditions, or the class system, or whatever. From the point of view of the individual involved, this doesn't make much difference - next year's political manifesto doesn't get this person out of hospital now.

Our view as humanistic practitioners is different from both of these. What we say is that people have problems. Where they attribute these problems to outside forces or other people, we can't help them much - we probably can't do a lot to change the people around them or the world in which they find themselves. (There are important exceptions to this, which we shall look at in the chapter entitled **Listening with the fourth ear.**) But where they attribute their problem to themselves, or to what is going on inside them, we then have an opportunity to work with them on solving those problems.

And from this point of view the standard psychiatric diagnoses are of no use. There is only one distinction which does seem to be useful and to be of practical import to a humanistic practitioner: can the person benefit from a *"session"* (the usual one-hour session or an extended session) or do they need some form of residential care?

The question here is - *"Can this person uncover their problems during the course of a session, and then cover them up again sufficiently to carry on their life (work, relationships, etc.) until the next session?"* If the person can *"go down"* and *"come up"* in the same session, then they are suitable for the usual once-a-week (or twice-a-week or more frequent) session, leading their ordinary life as housewife, clerk, teacher or whatever at the same time. But if the person can *"go down"* but can't *"come up"* again in less than a week, a month or a year or more, then they need some kind of residential facility.

This may be very close to the conventional distinction between neurotic and psychotic states, but it is much more pragmatic. It doesn't rely on diagnosis, it relies on actual practice. It's highly checkable. It means that, as long as you have residential facilities on hand as a back-up, you can take anyone on as a client in psychotherapy, counselling or personal growth. And in the end this may not be such an unusual conclusion. As Malan (1979) says at the end of his book:

> Perhaps the final lesson is certainly that one should undertake psychotherapy with one's eyes open, but that on the whole one should take the risks rather than avoid them.

The humanistic practitioner is always prepared to go to the existential edge with a client - to go with the client to that point where the most difficult choices of life are to be faced and made. It is no part of our work to push the client over the edge, but until that sharp point is reached, no real change can take place. And this process must start from the very first meeting - it is not something to be kept in reserve for another time. This makes the initial interview into a particularly testing arena for the worker who wants to adopt a humanistic approach, and it is to this question that we must now turn.

(This is a draft chapter for a proposed book on humanistic psychotherapy, which so far has not found a publisher.)

REFERENCES

Belson, William (1975) **Juvenile theft: The causal factors,** Harper & Row.

Berke, Joseph H. (1979) **I haven't had to go mad here,** Penguin.

Brown, Phil (1974) **Toward a Marxist psychology,** Harper Colophon.

Daniels, Arlene Kaplan (1970) The social construction of military psychiatric diagnoses, in Hans Peter Dreitzel (ed) **Recent Sociology** No. 2, Collier-Macmillan.

Paris, R.E.L. & Dunham, H.W. (1939) **Mental disorders in urban areas,** University of Chicago Press.

Freeman, H.E. & Giovannoni, J.M. (1969) Social psychology of mental health, in G. Lindzey & E. Aronson (eds) **The handbook of social psychology** (2nd ed) Vol.5, Addison-Wesley.

Garfield, Sol L. & Bergin, Allen E. (eds) (1978) **Handbook of psychotherapy and behaviour change: An empirical analysis** (2nd ed) John Wiley & Sons.

Gove, Walter R. (ed) (1975) **The labelling of deviance,** Sage.

Greenley, James R. (1975) Alternate views of the psychiatrist's role, in Thomas A. Scheff (ed) **Labelling madness,** Prentice-Hall.

Hollingshead, A.B. & Redlich, F.C. (2958) **Social class and mental illness,** John Wiley & Sons.

Krim, Seymour (1960) The Insanity bit, in Seymour Krim (ed) **The beats,** Gold Medal Books.

Laing, Ronald D. & Esterson, Aaron (1970) **Sanity, madness and the family,** Penguin.

Malan, David H. (1979) **Individual psychotherapy and the science of psychodynamics,** Butterworth.

Rosenhan, David L. (1979) On being sane in insane places, in same ref. as Greenley, above.

Rowan, John (1978) **The structured crowd,** Davis-Poynter.

Scheff, Thomas J. (1966a) **Being mentally ill: A sociological theory,** Aldine.

Scheff, Thomas J. (1966b) Hospitalization of the mentally ill in Italy, England and the United States, in **Yearbook of the American Philosophical Society.**

Scheff, Thomas J. (1975) The labelling theory of mental illness, in same ref. as Greenley, above.

Temerlin, Maurice K. (1975) Suggestion effects in psychiatric diagnosis, in same ref. as Greenley, above.

Walkenstein, Eileen (1975) **Shrunk to fit,** Coventure.