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# Symptom-oriented Diagnostic systems guiding Treatment planning: Some critical reflections

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## ABSTRACT

As one of its most important functions, diagnostic systems are meant to guide treatment planning. The author of this article pays attention to the apprehension that a clinician's effort to find the correct diagnostic category may interfere with trust and rapport. From her professional practice as a psychotherapist in psychiatry and private practice she has acquired the opinion that for those clients who would fit into symptom clustered psychiatric diagnostic categories such as classified in DSM-IV, such diagnoses are hardly clinically helpful.

The author proposes that diagnostic assessments be conceptualised in a language, which describes clients' problems or sufferings in depth and also collects information about the apparent obstacles to the client's health at the time of the interview. This may include a psychodynamic hypothesis in terms of early relations, self-image and resources. A psychodynamic understanding of transference and counter-transference is recommended for finding a therapeutically idiosyncratic approach. The author also finds it more worthwhile to assess the client's motivation for treatment and if the case, for hypnosis, than to find the correct diagnostic (symptom) categories.

## ZUSAMMENFASSUNG

Eine der wichtigsten Funktionen, die Diagnosesysteme erfüllen sollen, ist die Steuerung der Therapieplanung. Die Autorin dieses Artikels schenkt der Befürchtung Beachtung, dass das klinische Bestreben, eine zutreffende diagnostische Kategorie zu finden, mit Vertrauen und Rapport im Widerstreit stehen kann. Aus ihrer Berufs-praxis als Psychotherapeutin in der Psychiatrie und aus ihrer Erfahrung in privater Praxis, ist sie zu der An-sicht gelangt, dass für diejenigen Klienten, die in nach Symptomgruppen geordnete psychiatrische Diag-nosekategorien fallen, wie sie in DSM-IV klassifiziert sind, solche Diagnosen klinisch kaum hilfreich ist.

Sie schlägt vor, die vom Klienten eingeholten Daten in eine diagnostische Sprache zu fassen, die die Probleme oder Leidenszustände des Klienten in die Tiefe gehend beschreibt und ebenfalls Informationen sammelt über offensichtliche, zum Zeitpunkt des Interviews bestehende Hindernisse für die Gesundung des Klienten. Dies kann eine psychodynamische Hypothese über frühe Beziehungen, das Selbstbild und Ressourcen beinhalten. Ein psychodynamisches Verständnis für Übertragung und Gegenübertragung wird empfohlen, um zu einem idiosynkratischen therapeutischen Ansatz zu gelangen. (Die Autorin findet es ebenfalls sinnvoller, die Motivation des Klienten zur Behandlung und gegebenenfalls zur Hypnose zu begreifen, als zutreffende diagnostische Kategorien zu finden.)

**KEY WORDS: Diagnosis, treatment planning, psychodynamic**

## SAMMANFATTNING

Diagnostiska system är avsedda att användas som underlag i behandlingsplanering. Artikelförfattaren söker här uppmärksamma hur klinikerns intention att finna rätt diagnostisk kategori kan interferera med tillit och förtroende. Med erfarenheter från psykiatrisk och privat praktik har hon tillägnat sig uppfattningen att de klienter som går att få in i psykiatriska diagnostiska syndromkategorier av DSM-karaktär, knappast är hjälpta av sådan diagnostik.

Författaren föreslår att diagnostiska bedömningar formuleras på ett språk som beskriver problem och lidanden på djupet samt innefattar information om aktuella hinder för psykisk hälsa. Detta kan innefatta en psykodynamisk hypotes om tidiga relationer, självbild och resurser. I syfte att finna ett idiosynkratiskt förhållningssätt rekommenderas en psykodynamisk förståelse av klientens överföring och behandlarens motöverföring. Författaren ser också ett större värde i att bedöma klientens motivation för behandling och eventuellt hypnos, än att finna korrekta diagnostiska (symptom)kategorier.



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## BACKGROUND

In times of economic pressure, the political authorities and economic restraints favour short-term therapies and so-called effective methods.

The benign effects of this trend are that clinicians have to be self-critical and find methods for assessing outcome and quality. There are also less benign effects; due to the current pressure on therapists to work effectively and quickly, there is an exaggerated reliance upon symptom-oriented and generalised techniques. This pressure makes clinicians distressed, and they, just like other distressed people, become tempted to rely on simplifications and generalisations. In clinical seminars and congresses I now encounter more of simplifying and generalising work models, than I did ten or twenty years ago.

According to generalisation models, explorative psychotherapy, cognitive psychotherapy, hypnosis or any other treatment modalities can be recommended to be used or not used depending on the diagnostic category. Consequently, time pressed clinicians are tempted to trust statements like "cogniti-ve psychotherapy is the treatment of choice with eating disorders", or, "hypnosis should be avoided with the psychotic client", without really considering *why*.

The problem I want to highlight is not if there is any empirical significance of diagnostic generalisations, but the omission of critical and analytical thinking inherent in the systems. I regard critical and analytical thinking as a prerequisite for an attitude of always being prepared to perceive and become aware of the exceptions to the taught norms.
Clients within the same DSM categories may need totally different approaches or even therapists.

### An idiosyncratic approach versus categorising

Before discussing my queries on diagnostic systems I will shortly present some ideas on how to be more idiosyncratic as an alternative to symptom-based categorising.

More important than diagnostic classifications for treatment planning, e.g. deciding how to use hypnosis with your client, is what you can make out of the initial interviews. Diagnosis as an instrument for making treatment decisions means to me a deep understanding of the client's problems in terms of

- current *obstacles* to health,
- client's *motivation* to receive help,
- client's behaviour and feelings in the *interview context*,

• client's *attitude* to having *problems* and client's history of *relationships*.

This may include a psychodynamic hypothesis of the patient's problems in terms of
• inner drama of *early relations, self-image and resources*.

From psychiatric diagnostic categories I can only make unreliable guesses about these phenomena. In order to acquire a hypothesis about a specific client I have to become aware of both content and message in the client's communication. Beyond listening to the client's verbal information, I also perceive on a more and less conscious level, the client's non-verbal communication. Becoming aware of content and message, as I perceive them, I can assess:

The client's unique needs of feeling respected, the client's confidence in me and my approach and the eventual development of a working relationship with this specific client.

## A critical discussion on simplistic diagnostic systems

"Diagnosis" is Greek and means *through knowledge*. In the Swedish vocabulary it is also defined to mean *decision* (Norstedts, 1996).

Through our knowledge, as professionals we are obliged to make hypothetical decisions in order to find a professional course of action with healing purposes. Our diagnostic knowledge may be in the form of hypotheses about aetiology, i.e. the reasons to clients' symptoms.

Today, one of the most widespread diagnostic manuals is the DSM-IV. Many clinicians working in psychiatric contexts and some who practise in private settings nowadays are obliged to label their clients according to DSM-IV or other symptom-focussed diagnostic criteria.

I see reasons to be critical to such classifying diagnostic systems, not to their statistical significance per se, but to their utility for understanding the clients' needs in a psychotherapeutic context. The questions answered by DSM are "Which observable phenomena (symptoms) are most common in psychiatric practice and how do they appear in syndromes?" In the process of constructing and reviewing the DSM system, psychiatrists and psychologists representing various schools have found consensus regarding observable symptoms and the most common clustering of these symptoms, thus making a kind of map for the mostly applied diagnostic classifications. Those readers, who are not acquainted with this system, I refer to DSM-IV (1994).
The DSM system is meant to have the advantage of being free from theoretical assumptions regarding aetiology. The manual doesn't offer any hypotheses *why* specific symptoms seem to appear in syndromes or gather into character disorders. Therefore it is meant to have the advantage that any psychotherapist can use it, regardless of their school or belief systems. Psychoanalysts as well as behaviourists can use it.

In practice however, I regard this assumption of theoretical neutrality erroneous, because as soon as you cluster some symptoms together into syndromes, you must actually have some idea about why these symptoms, if they appear together, should belong to the same category. And then as a professional clinician you are supposed to have or trust some supervisor who has some experiential evidence on why and how such a diagnostic label can help you plan the treatment.

The neutral stance of DSM is sometimes claimed to be an advantage in research, although of less practical use for the clinician. But if statistically based categories are of limited use for the clinician - how can research that is based upon these categories contribute more to clinical work? The presumed neutrality of DSM as an advantage in research contexts is not evident. In human research the experimental researchers can't be objective and neutral or eliminate relational factors like the subjects' unconscious fears, motivation, confidence, locus of control, etc. Some researchers have acknowledged these relational influences even in experimental settings. As an example I would like to mention Éva Bányai, Katalin Varga and colleagues, who explored the therapist's state of mind in working with hypnosis. They also studied the neuro-physiological correlates to relational qualities and verified physiological evidence of synchronisms (paper presentation, European Congress of Hypnosis, Budapest 1996).

There are few articles discussing the apprehension that a clinician's effort to find the "correct labels" may interfere with trust and rapport, although I often

meet this opinion in personal discussions with colleagues. In psychiatric settings, a diagnostic category is usually expected by authorities to be documented at the first interview session. This demand might create a considerable communication problem in an interview with the inherent purpose of labelling: *The ambition to find a DSM diagnosis is only inside the clinician's head, but it is rarely an ambition of the client. In practice this may create a conflict between two people with totally or partially different purposes of the interview.*

## Case

I will give you an example to illustrate the problem. I only have my client's version, and after many years of knowing her, I also know she has a deep respect for medical authorities. Her expectations before the interview described below were positive.

This client of mine, a woman of 50, suffered from blushing, sweating and sudden mood swings. Her gynaecologist had assessed these symptoms as due to her menopause but by medical reasons she couldn't ease her symptoms with oestrogen. On one of her sessions with me, this client told me about a recent event: The other day at work she felt so distressed and angry for no obvious reason that she felt an acute need to go consulting the industrial health service. She described her symptoms to the medical doctor. The doctor asked her about all kinds of symptoms and finally he asked: *"Do you have panic anxiety?"* This question may seem natural and sensible, according to his perspective. But the client felt confused and bewildered by this question. The confidence, "rapport" vanished altogether and the communication halted.

The client asked herself: *"What is panic? Why does he ask?"* And like most clients in front of a doctor, she did not ask these questions.

Some clients are so used to this kind of treatment that they resign from intelligent thinking and accept the idea that the doctor as the expert probably has a good reason to ask. This respect for authorities causes a second problem: A compliant attitude makes the client a passive recipient of treatment or it makes her too "patient".

## Case discussion

I will make an attempt to analyse the message of this question *"Do you have panic anxiety?"* as perceived by the client. What she grasped was the unspoken message: *"I obviously should know this term panic anxiety, and it sounds ominous. He obviously believes that I suffer from this severe condition. I must appear to be very ill!"*

The problem is that this communication is not client centred, it is doctor centred. The locus of control is in the doctor's head.

The reason for the doctor's quite authoritarian atti-tude cannot be blamed on a diagnostic system only, although I imagine a possible connection. The doctor may be influenced by his own family background and/or by attitudes in the clinical system where he works: the health and care organisation, how medical professionals are educated, and even the tools cho-sen in the clinical setting, included diagnostic tools. A common attitude in hospital settings is that the lo-cus of control is in the doctor's head. He or she may feel confident with an easy diagnostic system, which demands only an intellectual deduction-through-elimination process and the doctor can bring this intellectual instrument into the interview situation.

But with this attitude, the doctor's diagnostic language may compete with the client's expectations to be confirmed in an idiosyncratic and personal language.

These aspects of diagnostic language are crucial, since it is an acknowledged reality that the client's attitude to her problems is of vital importance for her motivation to take responsibility in the treatment process. This issue has been discussed in depth by Bakal in the treatment of psychosomatic diseases and placebo effects (Bakal, 1999).

In order to stay in touch with the client's perspective and presenting problems, I prefer making a descriptive diagnosis, describing the clients' problems or sufferings in ordinary language.

The client in the case above would have felt confirmed by a formulation like: *"What seems to bother you most is your anger. Right?"* If the doctor had asked her specifically about problematic situations he would have realised, that she could manage anger when being alone. Her concern was more about other people's opinion about her temper. "Other people" did not include her relatives and friends, but only her relations at work. *"And you feel specifically worried about showing your anger at work"* could have been a tentative feedback and definition of the problem.

In order to understand more about the client,

his next reflection could be about the subjectivity of this worry. Were her colleagues worried about her temper? How exactly did she communicate her anger? Did she intimidate work-mates or did she take responsibility for her feelings, expressing anger without putting all the blame on others?

After finding out, he would have reflected back to her something like: *"And it seems like your anger is not creating unfair problems for your colleagues. The problem seems more to be about your fear of not being accepted, your fear of the consequences showing your temperament."* Then he could have shared with her some likely connections: *"Since high blood pressure can become aggravated by repressed anger, an obstacle to your health may be your own worries about being angry."* The next logical questions would be about her subjective reasons for feeling so angry, besides normal menopausal hormonal impact.

If she had felt confident enough, she might also have informed him about a deeply frustrating love affair.

The doctor then could have speculated about her current frustration as a reasonable cause of unresolved anger and a *current obstacle* to her well being at the time of the interview. More obstacles to health would be found in the client's *self image* as influenced by *early relations*. This client's mother had told her from early years on, over and over again, that nobody would ever love her, if she were that angry. So the client's mother had taught her that her anger was totally unacceptable by people she needed for love or, generalised into a work situation, people she needs for self-esteem and appreciation.

A suggested remedy would probably include challenging her attitude to anger and finding out more about her work-mates reactions to her anger, esp. those mates whose opinion she trust. Eventually that would help her accept more of her anger caused by both frustrations and hormonal fluctuations.

Sharing such a hypothesis with the client must of course be concluded by the question: *"Does this make sense to you?"*

Sometimes authority regulations demand a DSM-IV diagnosis to be explicitly formulated. Let's hypothesise that the doctor in this case was obliged to document such a diagnosis. The therapist's behaviour and language while diagnosing in the first interviews are important of yet another reason than collecting information: Showing respect for the client's *resources* settles the roles for future co-operation and communication. Therefore I would suggest the clinician to invite the client into the diagnostic discussion:

*"For insurance purposes (or: due to the other regulations) I have to write a symptom diagnosis. You have described five of 13 symptoms classified as 'panic attack'. Do you agree?* (Showing the list to the client). *However, panic attack is not a diagnostic category, so I must find one. None of the alternatives describe your condition well enough."* (Showing the client the choices) *"300.01 seems close enough, concerning symptoms only, although the concept "panic" may sound somewhat unfair. Another choice could be V62.81 Relational Problems WFS, which will focus the diagnosis upon your concern about your relational problems. We can use both diagnoses, as hypotheses, what do you think? And we can also use the scale for global function, which adds relevant info regarding your relational competence (axis V)."*

Maybe the client would choose not to bother and suggest the clinician to pick whatever seems correct. Maybe the client would object to the regulations and ask the doctor not to document a symptom diagnosis. Whatever the response, such a respectful approach invites to a communication and settles the foundation for a working relationship.

So far I have exemplified an alternate diagnostic communication style with this specific client. Now I will generalise the advocated approach, applicable to any diagnostic interview:

- listen without presuppositions (or put them aside, aware of them),
- mirror the client's concerns in her/his own language,
- summarise your own understanding of the client's problems and
- declare your hypothetical reflections aloud,
- explain why you are considering a specific diagnosis and
- what such a diagnosis would imply for your thinking about the client's needs
- invite the client to reflect upon your conclusions.

## Not labelling diagnoses

are diagnoses, which describe clients' problems or sufferings in a language that reflects their experience and thus makes them feel understood. The clinician may also add some hypotheses of the clients' needs and resources, and what fails them. With this approach the clinician conveys an attempt to understand why the clients are seeking help or asking for help specifically at this moment in their life.

This may ensue a dialogue about the apparent obstacles to the client's health at the time of the interview. Most of my clients also express an overdetermination of their reactions to the current lack of functioning. They ask themselves: "How come I rationally know what to do, know I have the capacity, but still react petrified as if the situation was out of my control?" This query may ensue a discussion on how their earliest relations influenced their self-image. Their self-esteem may have suffered by a devaluation of personal resources.

Therefore, I prefer diagnoses, which describe clients' problems or sufferings, from a perspective that encourages the patient as resourceful and competent in knowing or at least finding what fails her and what she needs for healing. I prefer using ordinary language and I also collect information about the apparent actual and historical obstacles to the client's health at the time of the interview.

This approach includes an intensive investigation of and formulating the client's self-image and resources. Any tool that is within the client's language can be used: words, spontaneous images, guided imagery, hypnosis, dreams, body posture, etc. Various hypnotic-diagnostic exercises are presented in the literature. If, for example, a client presents a psychological conflict as a problem you may explore the conflict by doing "ego state" work, which means letting the parts become more explicit by inviting them to express themselves separately, one at a time (Watkins, 1997). A similar kind of diagnostic work can be done with imaginary situations as described by Joseph E. Shorr. He has described an endless array of diagnostic images and for those clients who respond well the responses can inspire to further therapeutic imagery (Shorr, 1997).

## Diagnosis and emotion

The diagnostic tools required for an idiosyncratic approach in clinical practise include the therapist's subjective emotions. The clinician becomes affected by what clients communicate explicitly and implicitly in the intake interview. There may be feelings of hope or despair, creativity or resignation, energy or fatigue. Every client has his/her unique history of relations to authorities, to dependency and autonomy. They communicate these experiences explicitly and implicitly. Becoming affected as a therapist may appear to subjectify perception, but once made conscious and formulated, it can contribute to a professional understanding of important clues to treatment planning. Psychodynamic efforts have been made to structure how clients convey their history and how to use this kind of affective information in diagnosing and treatment planning (Johnson 1994; McWilliams 1994; Racker 1968; Sullivan 1954).

## A psychodynamic understanding of transference

The term transference means "the process by which a patient displaces on to his analyst feelings, ideas, etc., which derive from previous figures in his life…" (Rycroft, 1972). The acknowledgement of transferential phenomena helps the therapist understand how early relations influence the client's contemporary, sometimes unrealistic, presuppositions of the helping relation. It is quite evident, whether one adheres to a psychodynamic belief system or not, that when people find themselves in the position of needing help they will have certain expectations, hopes and fears, influenced by previous experiences. The issue now is how to make these transferred relational experiences, expectations and needs more explicit in the diagnostic process. Clients communicate them directly by telling their story and indirectly by the here-and-now verbal and non-verbal communication towards the therapist.

An awareness of transference phenomena can help the clinician not to repeat the client's worst expectations of authority figures. A motivated client can be invited to explore under what circumstances he will feel confirmed, disrespected or afraid and what the need for help means in terms of being autonomic, dependent, vulnerable, etc.

I sometimes ask for "the first memory". I have found some evidence that the *first memory image* gives a condensation of the client's self-image, imposed by early experiences and influencing attitudes regarding what to expect from others.

Hypnosis can be used as a tool for finding expected transference reactions complementary to what can be inferred by other means. The client can be asked to imagine looking at mother, saying, "I need you" and then report what feelings are evoked by such an image. The same can be done imagining a father, brother, sister, grandparents, a teacher, etc… This can be done with or without inducing a trance state, but I have the impression that a trance state evokes more spontaneous and unbidden reactions.

## Counter-transference

Counter-transference may be equally important as a diagnostic clue for the choice of treatment approach.

Countertransference is a tool for diagnosing clients' unconscious feelings and transference dynamics.

First I want to explain the term. When Freud introduced the concept "countertransference" he meant the therapist's transference towards the client (Gay, 1988). Later psychoanalytical theory has broadened the concept to mean not only the therapist's past history evoked by a particular client. It has also come to mean all those feelings in the therapist, which are evoked as the client projects or literally transfers denied or unthinkable feelings to the therapist (Racker, 1968). This process, often called projective identification is subtle and difficult to explain in scientific concrete language. There is no consensus on how to explain it. Do therapists react on minimal observable cues and feel what the client feels through empathy? Or is there a direct body - to body communication, through yet unknown means? In ordinary life the phenomenon of emotional communication on a body-to-body level is evident between lovers and between mother and infant. Brazelton & Cramer (1991) document contemporary scientific research and clinical experience of affective mother-infant communication. Needless to say, the ability to discriminate between the Freudian orthodox and the latter kind of countertransference, i.e. to know whether feelings are stemming from the therapist's unconscious past history or from the client's unbearable, unaccepted or not-yet-conceptualised feelings, demands a thorough self-knowledge on behalf of the therapist.

This implies that the therapist gains from making conscious all his emotional reactions to the client. A pattern I have seen in my own clinical work, is that clients who express a severe helplessness may evoke in me a wish to prove to them, that they can be helped. My immediate response is a wish to convince them they are as worthy of a good life as anybody. Such a response is a humane and spontaneous feeling, but as I explore its function I will be more able to use it professionally. This self-exploration made me detect the following components:

I feel that the client is giving me a message and a content like *"I am close to giving up. There is no hope for me."* I feel the client's despair and become a bit desperate myself, feeling that the client is too negative and unfair to herself.

What the client may be trying to convey nonverbally, could be something like: *"I am coming here for help, so a part of me believes in myself, but another part of me which is much stronger denies me the pleasures of a healthy life."*

The client showing me her despair may wish to communicate the question: *"I am victimised, can you deal with that?"* My clinical experience has taught me, that victimised people very often show a pattern of exacerbating helplessness.

The most apt person to help you find out the intended message is the client. You could share your reaction with the client and say something like: *"Since you asked me for an interview I regard that as a sign that you are willing to give me a chance to help. I also hear you telling me there is no hope for you. How would you want me to react on this apparent conflict?"*

Most clients would reflect on this and some would come up with an answer. Those who do are usually strong enough to cooperate constructively in the therapy process, whether you choose to use hypnosis or not. Those who don't may need more time to find their resources, and this may be your main therapeutic goal to begin with.

Thus counter-transference can guide the therapist to choose if and how to use hypnosis. The more anxiety sensed by the therapist, the more time needed to strengthen the therapeutic relation before any hypnosis can be used or through various hypnotic means, like ego strengthening techniques (Watkins, 1997, Frederick & McNeill, 1998).

So, in order to connect to the title *"Symptom-oriented diagnostic systems guiding treatment planning: some critical reflections"* I will use hypnosis as

a specific example of a choice of treatment modality and suggest that regardless of what diagnostic label may fit the client's presented symptomatology, hypnosis can be used if:

• the client feels confident and safe with you ("rapport"),
• the mode of hypnosis is adjusted to the client's motivation and
• the clients feel comfortable with your approach of doing hypnosis.

## Summary and Concluding remarks

My purpose with this article was to contribute to a current discussion going on in hypnosis and psychotherapy societies, regarding the applicability of symptom-oriented diagnostic systems in clinical practice.

I have suggested that the politically and economically reinforced aspiration to make therapies as short and effective as possible may interfere with the clinicians sincere and respectful understanding of the client as a unique person, with a unique history and unique needs. I have also presented the idea that diagnostic simplifications as seen in the DSM symptom categories may encourage a clinical language that competes with a sensitive and idiosyncratic communication style in the first interview. I have suggested that a good therapy can be done with or without the DSM system, preferably without.

I suppose some colleagues find that using the DSM can be combined with a sincere and respectful attitude, and I have suggested an empathetic approach above, in the case where authorities demand a DSM documentation.

I am more worried about institutional values and assumptions as clients experience them, when the therapist has a symptom-oriented focus in the initial interview. An iatrogenic negative transference may be the result. If this problem remains unnoticed by the therapist, it can cause further communication problems and an omission of much more important aspects for treatment planning than finding the DSM category.

I have criticised the generalisation of clients into categories, but accept that generalisations and assumptions are part of all clinical assessments and theories. We use models for understanding and formulating what we are doing and why, in a more economic language than is possible, if we didn't have models and assumptions. In this article I even suggested that a diagnostic system without theoretical assumptions on aetiology is of no clinical value.

As we are planning treatment we must make ourselves aware of all those aspects of the problem that cannot be formulated in a symptom-oriented diagnosis: aetiology, expectations, fears, resources, self-image, etc. I have conveyed a strong attraction to psychodynamic understanding of clients, which to me means perceiving them as unique persons with unique histories, but also to understand transference and countertransference. I have chosen models with assumptions that make sense to me, according to my clinical experience. The reader may have other experiences, deviating from mine.

I acknowledge the reality of the DSM categories and the immense work done to construct a diagnostic model that has been approved by experienced psychiatrists and psychologists. Maybe this immense amount of time and effort invested to find a "neutral" model upon which most schools can agree, is the reason why it has become so very institutionalised?

Since the use of DSM-IV is criticised by some and also accepted and recommended by some, I look forward to responses from colleagues. Is DSM a diagnostic tool in its own right, i.e. does it contribute to treatment planning, or what is its main contribution to the clinician?

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