

Clinical Psychology Practice Without Using Psychiatric Labels: An alternative approach using Personal Construct Psychology

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Despite attempts to contextualise distress some psychologists appear to use psychiatric labels uncritically. Personal Construct Psychology is suggested as a framework from which to practice without using psychiatric labels.

As a clinical psychologist I have often found myself feeling puzzled and disappointed when reading books or articles by fellow psychologists who seem to incorporate psychiatric diagnostic classifications and theories of 'mental illness' into their formulations as if they were fact. A recent example of this can be found in literature describing Dialectical Behaviour Therapy (DBT), which suggests it is a 'treatment' for 'clients with borderline personality disorder' (Swales & Heard, 2009). The language used here suggests that 'borderline personality disorder' (BPD) is an actual entity, rather than the construct that it really is.

In my view, the construct of 'BPD' is the profession of Psychiatry's way of describing a particular person's extreme distress which manifests itself in the form of agreed upon patterns of behaviour which constitute this particular 'psychiatric disorder'. 'BPD' is theorised to have 'a biological susceptibility' but this has never been proven. However, as Rowe (2006) suggests, categorising problems in this way can certainly place a barrier between the person so labelled and their clinician i.e. the clinician is the 'expert' in 'treating' their 'BPD'. Rowe (2006) also suggests that psychiatric diagnoses act as a 'security blanket' for some clinician's, 'saving them from having to confront the messiness of life and its great uncertainties', whilst also thinking of people as if they are 'puppets' rather than 'agents', and thus 'the outcome of the actions of genes, biochemistry ...'. I agree with Rowe's (2006) view.

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What I find particularly disappointing from personal observation is the readiness with which some child psychologists seem to accept that behaviour described as 'ADHD' is a disorder of biological origin. There is yet to be any clear evidence for this theory (Brown, 2005), and such a label could have numerous long term implications on a child. Radcliffe, Sinclair, & Newnes (2004) suggested that 'locating the problem within the young person may exacerbate their difficulties - labelling a young person as having a psychiatric disorder may give them a sense of self as being 'different' from others and negatively impact upon their confidence and self-worth'.

I have worked with a number of people with (sometimes numerous) psychiatric labels, and I cannot think of one occasion where I have personally found such labels helpful when attempting to understand the person in front of me. The person's psychiatric label simply tells me that they have had their difficulties categorised in a particular way.

Some of the possible consequences of using psychiatric classification systems can be highlighted when considering research from social psychology. For example, Perceptual Set theory highlights how people are prone to 'a perceptual bias or predisposition or readiness to perceive particular features of a stimulus' (Allport, 1955). Relating these phenomena more widely to everyday experience, Brown (2005) highlighted how attribution theorists have broadly found that 'people typically have a strong bias to explaining other people's behaviour in terms of assumed internal factors'. A study by Thomas, Katsabouris, & Bouras (1997) seems to show such psychological factors at work. Their study looked at medical staff's attitudes towards people wanting to reduce their psychiatric medication who had been categorised as suffering from 'chronic schizophrenia'. They found that any changes in behaviour would be interpreted as a 'relapse of illness' without consideration for any other explanations. What is also interesting about this study is that it found that staff attitudes remained the same, or became more entrenched, even when a reduction in medication did not lead to 'relapse' of their 'illness'.

A look at how some assessment tools are worded and categorised show how easy it can be to fall into the trap of 'perceiving' another person's difficulties as psychiatric 'illnesses' and 'personality disorders' (i.e. see the Structured Clinical Interview for DSM-IV Axis I Disorders, 1997). This is before exploring the person's difficulties and how they perceive them has even begun.

I'd expect that most clinical psychologists would be aware of this problem. There's plenty of social psychology research demonstrating that we all have a tendency to see what we expect to see and discount evidence that contradicts our expectations in a number of contexts (see Gilovich, 1993 or Sutherland, 1992). Should awareness of such knowledge not provide a healthy scepticism about psychiatric classification and the concept of 'mental illness'?

None of this should be particularly groundbreaking knowledge for clinical psychologists, especially given the availability and accessibility of works by Bentall (2004) for example. Hence my dismay when I hear, observe, or read

about clinical psychologists who seem prepared to accept psychiatric classification and theories of 'mental illnesses' as if they are actual proven entities. This might then lead to 'psychological interventions' being targeted at 'symptoms of the illness', which seems to me to have similar logic to a medical model approach. This seems at odds with the 'scientist-practitioner' approach that I thought was a crucial element of practicing as a clinical psychologist.

Perhaps I'm being too churlish here, after all during my own clinical training I don't recall much, if any, teaching discussing for example how research suggesting theorised 'mental illnesses' such as 'schizophrenia' have strong 'genetic components' are so flawed as to be meaningless (Joseph, 2003). I also don't recall much teaching critiquing psychiatric diagnostic categories, despite there being persuasive arguments suggesting their lack of credibility (Boyle, 1999). Likewise, I had to discover by private study that psychiatric theories of how drug treatments 'work' is not supported by objective empirical research (Rowe, 2006; Moncrieff, 2008).

The dominance of cognitive-behavioural therapy (CBT) and its compatibility with psychiatric classification and quick fix 'cost-effective treatment' probably part explains why some psychologists might fall into the habit of labelling their fellow humans with psychiatric labels. I guess it would also be much easier to step outside of a medical model framework if there weren't a number of books detailing how to practice 'CBT' for numerous 'disorders' using a 'medical model language' (i.e. see Butler, Fennell, & Hackman, 2008).

Of course, many people have reported finding CBT useful but it is influenced by the philosophy of the person practicing it, as are all approaches (Frankl, 2004). For example, I'd guess (and have observed) that community psychiatric nurses practicing CBT are likely to bring a firm 'perceptual set' of psychiatric classification and medical model approach to therapy, but is this helpful? For some people it might be, especially in the short term. I have worked with people who speak of their relief at 'finally knowing what's wrong with them' (according to a medical model perspective of course), but this could also result in the long term consequence of living by a narrative that places limitations on their lives, for fear of 're-triggering their illness' due to a medical model influenced focus on 'managing symptoms'.

In the culture of 'evidence based approaches' how can you practice as a psychologist in the NHS without being influenced by psychiatric labels while utilising the undoubted helpfulness of some effective evidence based therapies and other approaches within a unified framework? I'd like to suggest taking a look at Personal Construct Psychology.

Personal Construct Psychology

I do not have enough space to outline George Kelly's Personal Construct Psychology (PCP; Kelly, 1955) in great depth but will attempt to describe the essence of the theory and how I use it as a framework for my own clinical

practice. I have found this to be a helpful way of practicing while eschewing psychiatric classification and labelling.

PCP is a theory concerned with how human beings make sense of the world (Bannister & Fransella, 1989). Kelly (1955) hypothesised that there is such a thing as a 'real world', which is interconnected and in constant motion. As humans, we do not have access to this 'real world'; that is we cannot see reality directly due to the limitations of our senses. Neuroscience research appears to support this view. Frith (2007) reports that what each of us sees is our brain's constructed picture of reality, and not reality itself.

In a nutshell, as humans we are constantly trying to make sense of the world, but due to the limits of our senses, we can only ever arrive at 'a best guess' as influenced by our personal construction of reality and never 'the truth'. This hypothesis of human understanding led Kelly to define the philosophy underpinning PCP as being that of 'constructive alternativism', which he summarised by stating:

We take the stand that there are always some alternative constructions available to choose in dealing with our world. No-one needs to paint themselves into a corner; no-one needs to be completely hemmed in by circumstances; no-one needs to be the victim of their biography. (Kelly, 1955)

There is some overlap here with cognitive-behavioural theories, as there is with Kelly's (1955) idea that all people are essentially 'their own scientist'.

Kelly (1955) suggested that all people are making their own idiosyncratic theories about the 'real world' in order to anticipate and predict their future. From this point of view, our behaviour in the world *becomes* our experiment, which can either validate or invalidate our theories. Predictions that are accurate make our world appear to be safer and more secure; predictions that are inaccurate make our world appear shaky and less certain. In the latter case this can be so threatening and unacceptable that we can deny what seems evident to keep our ideas about ourselves intact.

For example, a person may think of himself as 'a good judge of character', and this construct or belief about himself might be central to how he regards himself in terms of his self-identity and self-worth. Therefore, any evidence to the contrary might be so threatening that instead of accepting that his best friend has just been found guilty of major fraud, he might deny the validity of the jury who have convicted his friend and believe a conspiracy has taken place. This might be preferable and less threatening than having his idea of himself as 'a good judge of character' proven inaccurate etc. This example could also be similarly explained by cognitive behavioural theories, including theories of cognitive dissonance (Festinger, 1957). However, in my view there are crucial differences that make it much easier to eschew psychiatric labels using PCP rather than other approaches.

Kelly (1955) rejected the concept of 'mental illness'. He believed that mental distress could be understood in the context of a person's life experiences and

how they have made sense of their experiences in their unique idiosyncratic way. For example, I have worked with people labelled 'paranoid schizophrenic', and have on occasion been asked if I could 'challenge' paranoid beliefs using CBT as part of ongoing 'treatment' to help such people 'develop greater insight'. Using PCP theory as a rationale, I felt this would be too threatening and would likely lead nowhere. PCP theorists such as Bannister (1986) found that using such a challenging approach with paranoid clients was more likely to lead to the person becoming more entrenched in their beliefs, due to the threat to their sense of self if their ideas might be 'proven' inaccurate.

Consistent with PCP theory I have often found when working with people that paranoid beliefs seem understandable given traumatic life experiences and how such experiences have been interpreted. Therefore, the paranoid beliefs could be viewed as rational conclusions to draw given such histories, which I may well have drawn myself had I experienced similar circumstances. Such paranoid beliefs appeared to be protective, with a common theme being that 'if everyone is a threat then at least I know where I am with people, and can prevent threat or rejection'. The belief that others are thinking of you can also be preferable to thinking you're no more important than anyone else in the grand scheme of things.

Using a PCP approach, I have found I could acknowledge and understand why a person has come to the beliefs that they have without directly 'challenging' their paranoid thoughts. This can help the person to avoid feeling the type of threat to self that might lead to distrust or denial, and harm the therapeutic relationship. The philosophy of constructive alternativism can be discussed by collaboratively exploring whether the person's beliefs still reflect reality as accurately as they may once have done. Thus beliefs become propositions to be tested and if the beliefs prove inaccurate, then this might lead to the person reconstruing some of their ideas. The subtle but significant difference here lies, I believe, in the creation of a therapeutic relationship of two equal human beings on a journey to understand the origins of one person's distress (albeit with one being paid for the encounter), and to see if there's scope for change without the person feeling under attack and having to dig in to save their sense of self. Examples of the effectiveness of this way of working with people labelled as 'schizophrenic' or 'bipolar' can be found in Bannister (1986) and Rowe (2006) respectively.

Summary

This short piece was written to highlight the shortcomings of psychiatric theories and the seemingly uncritical acceptance of psychiatric classification of 'mental illness' by some clinical psychologists. Until the psychiatric profession can demonstrate beyond reasonable doubt that such 'mental illnesses' exist, then as scientist-practitioners I believe we owe it to the people we work with to be sceptical of labels, and to offer an alternative approach as and when necessary. Otherwise we risk being nothing much more than 'Assistant Psychiatrists' in

my view. Using the ideas of Personal Construct Psychology is one suggestion for an alternative framework from which to practice without using psychiatric labels.

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