

Reinterpreting Psychiatric Diagnoses¹

Peter B. Raabe

University College of the Fraser Valley

In discussing the psychiatric diagnoses, the author explores not the “formal” diagnoses of the so-called mental illnesses, but the “informal” judgments made by psychotherapists in regard to their method or the process of their therapy. These diagnoses include transference, repression, resistance, denial, negativism, projection, and suppression. While these are not precisely the symptoms of psychopathology, they are an integral part of the language which psychotherapists use to describe and label what they see as problems in their patients. These so-called problems, which are interpreted by the therapist as existing within the patient, can be reinterpreted and largely avoided in philosophical counseling. The author argues that, when a person is observed or diagnosed by a psychotherapist as exhibiting one of these supposedly problematic traits the therapist is in fact misinterpreting what is going on.

Many of my clients come to philosophical counselling as a last resort. This means they have often already been diagnosed, and in many cases “treated” by psychotherapists, psychoanalysts, psychiatrists, clinical psychologists, and/or other sorts of therapists and counsellors.²

Of course I also see clients who have been to less conventional healers who offer everything from aromatherapy to past-life regression. In North America there is now even a movement within the field of psychotherapy to incorporate religious metaphysical beliefs into diagnosis. Not long ago one of my clients told me she was diagnosed by her psychotherapist as being “demon possessed.” I consider North American psychotherapy to be our Don Quixote: psychotherapists are known to diagnose dragons where there are only windmills. There are many reasons why this is so. One of the main reasons is money: the money that is made by medical researchers working in the field of so-called mental illnesses, the money that is made by pharmaceutical companies who want to sell their drugs to fight these so-called mental illnesses, and the money that is made by a psychotherapist when the diagnosis of a patient’s distress and confusion is made to sound like a medical illness. These economic issues are all very complex, and each one could easily be the topic of its own essay. But I would like to focus your attention on a very small area of psychotherapy: the problems in the relationships between therapists and their patients that can lead to patients being unfairly diagnosed and labeled.

In the many personal discussions I’ve had with psychotherapists, most of them have claimed that they don’t subscribe to the practice of diagnosing

their patients according to the criteria set out in *The Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)*. But this raises the question, “Why are these manuals printed and sold by the thousands every year?” Doesn’t this mean someone is buying them? I would think it’s safe to assume that psychotherapists are buying them. And I doubt that they’re buying them just for entertainment purposes. And while psychotherapists have assured me they don’t label their patients, their former patients who come to see me tell me a very different story. Most of my clients are willing and able to tell me in detail what their former therapists have diagnosed and labeled them with. The formal diagnoses they have been given by these therapists, such as depression, anxiety, and schizophrenia, are straight out of the “official” North American diagnostic manual, the *DSM*.

The terminology I want to discuss is not the “formal” diagnoses of the so-called mental illnesses, but rather the informal judgements made by psychotherapists in regard to their method or the process of their therapy. I will therefore call them “informal” diagnoses. These diagnoses include transference, repression, resistance, denial, negativism, projection, and suppression. Again, these are not the names of any “formal” mental illnesses found in the North American or international diagnostic manuals, because they’re not precisely the symptoms of any psychopathology. And yet they are an integral part of the language which psychotherapists use to describe and label what they see as problems in their patients.

The point I’m going to make is that these so-called problems—which are interpreted by the therapist as existing within his patient—can be reinterpreted and largely avoided in philosophical counselling.³

I believe that when a person is observed or diagnosed by a psychotherapist as exhibiting one of these supposedly problematic traits the therapist has in fact misinterpreted what is going on. Take, for example, when a psychotherapist sees in his patient the symptom of “transference.” In reality the characteristic of “transference” is in fact not something located in the patient. Instead it’s a dynamic, sometimes positive and sometimes negative, within the therapeutic relationship between the patient and the therapist. Most therapists would agree with me on this. But they would not agree when I say that the problems that arise in psychotherapy, which the therapist will label either negative or positive transference, are most often the fault of the therapist. I believe that transference is not something the patient is exhibiting or suffering from. I believe transference is nothing more sinister

than a natural response by the patient to the therapist's behaviour. And I believe that a patient's response to the therapist, which the therapist calls "transference," is usually a response by the patient that is understandable and totally justified by the patient's own experience of the way the therapist is relating to her. But I'm getting ahead of myself. I'll come back to a more detailed discussion of how a philosophical counsellor might interpret this so-called "transference" thing in a moment.

First, consider how diagnosing and labeling is connected with the displacement of responsibility, for the dynamics within a therapeutic relationship, away from the therapist.

I've been a teacher for a number of years, and I believe that it's the teacher's job and responsibility to help the student understand what is being taught. When the student doesn't understand the teacher, the onus is always on the teacher to try again. But what is it that often happens when a student doesn't understand? The teacher blames the student for not paying attention, for not thinking hard enough, and even for not being smart enough. But I believe that when a student doesn't understand what is being taught it always means the teacher is not teaching well enough, because it is the teacher's job to help the student understand according to that student's learning ability. Locating the responsibility in the student who doesn't understand what the teacher is saying is the same as locating the responsibility in the patient who doesn't understand what the therapist is saying. Lack of understanding in either the classroom or the therapist's office are very similar in that they're both the result of a problem in the *interaction* between two individuals: the teacher and student or the therapist and patient. One is trained, one is not; and more importantly, one is an authority figure, the other is not. So when the therapist claims that when his patient doesn't understand him this is due to the patient's so-called "denial" or "resistance," the therapist is in fact displacing responsibility away from himself and holding the patient responsible for the shortcomings of his own practice within that therapeutic relationship.

Second, the therapist's external perspective of the therapeutic relationship can be significantly different from the internal perspective experienced by the patient, and this difference can lead the therapist to unfairly label the patient.

A patient will sometimes disagree with her therapist; at other times the patient will express a lack of understanding about what the therapist is claiming about her so-called mental illness. For example the patient may

disagree with the therapist who says she is being difficult, or the patient may not understand why the therapist is claiming that her thinking is irrational. This lack of understanding is then “informally” diagnosed by the therapist as “resistance” or “denial.” But this diagnosis of either resistance or denial is an external evaluation by a therapist from *outside* that two-person relationship. It is a perspective of the patient’s so-called illness by an authority figure who intentionally steps back and excludes himself from that dyadic relationship, thereby denying his own influence on what is taking place. The psychotherapist locates the problem within the patient, as part of her symptomatology, rather than acknowledging that a problem might exist within the therapeutic relationship. But it’s really no surprise that a therapist might do this, because for a therapist to take an internal perspective, to look at the therapeutic relationship itself, is a dangerous undertaking since it has the potential of illuminating the shortcomings of both the character of his therapeutic method and the character of the therapist himself. So by taking only the external perspective, the therapist is able to avoid criticism of himself and his professional work, and to attribute to the patient yet another symptom of mental illness that the therapist can then label and offer to treat.

These two aspects of psychotherapy—the therapist’s desire to avoid responsibility for the defects in his practice, and the therapist’s refusal to shift perspective from external to internal—are crucial to an understanding of the “informal” psychotherapeutic diagnostic labels.

Let’s look at each one of the seven “informal” diagnoses one at a time to see, first of all, how they are defined and explained by psychotherapy, and then how a philosophical counsellor might deal with them.

Transference

The unconscious assignment to others of feelings and attitudes that were originally associated with important figures such as parents, siblings, etc. in one’s early life. The transference relationship follows the pattern of its childhood prototype. In the patient-physician relationship, the transference may be negative and hostile or positive and affectionate.⁴

In other words whether the patient feels hostile or affectionate toward the psychotherapist, the therapist is trained to assume that the patient’s feel-

ings are created by something outside the therapeutic relationship and not by the therapist himself. Freud explains that a very strong unconscious idea that needs expression can enter into the preconscious and “exert an influence there only by establishing touch with a harmless idea already belonging to the preconscious, to which it transfers its intensity, and by which it allows itself to be screened.”⁵

Now imagine this: the patient feels the therapist’s professional manner as uncaring and aloof, or condescending and paternalistic. The patient therefore develops a dislike for the therapist’s attitude. If the therapist notices the patient’s dislike for him, the therapist then diagnoses the patient’s negative feelings as “transference.” The therapist avoids responsibility for the patient’s negative feelings by simply diagnosing those feelings as the patient’s unconscious or residual childhood animosity towards her parents. If the patient says something like, “You don’t seem to care about me as a person,” the therapist thinks, “Aha, this patient unconsciously believes that her parents don’t care about her.” Therefore, no matter how uncaring the therapist is, the patient can’t win because the therapist never considers himself part of the patient’s problems. This is a convenient way for a therapist to avoid responsibility for his own inability to feel an empathetic response to the patient. To put it another way, the diagnosis of “transference” can be seen as a therapist’s avoidance of his own incompetence.

In philosophical counselling there is no informal diagnosis of “transference.” The philosophical counsellor understands that a client may become annoyed or even angry if he has failed to understand what she is trying to say. But this is not understood as some sort of eruption of emotion from the unconscious actually meant for the client’s parents. I’ve had many clients who have told me that their psychotherapist simply refused to acknowledge when he was wrong, such as when he misunderstood what they were saying about their feelings. When they pointed this out to their therapist he would then simply label their frustrations with him as “transference.” As one client put it, “I wasn’t frustrated with my parents. I was frustrated with my therapist’s condescending attitude. But he didn’t want to accept that.”

Repression

A defense mechanism, operating unconsciously, that banishes unacceptable ideas, fantasies, affects, or impulses from consciousness or that keeps out of consciousness what has never been conscious. Although

not subject to voluntary recall, the repressed material may emerge in disguised form.

Freud believed that “the theory of repression is the pillar upon which the edifice of psychoanalysis rests.”⁶ He gives a concise definition of repression in neurotic patients in his essay “The Psychology of the Dream-Processes.” He explains that among the wish-impulses originating in an infant’s life

indestructible and incapable of inhibition, there are some the fulfillments of which have come to be in contradiction with the purposive ideas of our secondary thinking. The fulfillment of these wishes would no longer produce an affect of pleasure, but one of pain; *and it is just this conversion of affect that constitutes the essence of what we call “repression.”*⁷ (Italics in original)

This informal diagnosis of repression first of all raises the question, “Why would a patient who is turning to a psychotherapist for help raise her defenses against the very help she is asking for?” The diagnosis of repression is nothing more than the therapist’s accusation against his patient for hiding what he believes to be the Truth as he sees it. One of my clients told me that after our many philosophical counselling sessions she finally came to the realization that her mother was a psychopath because of the way her mother had treated her as a child and young adult. This client explained that, if she had told her former psychotherapist this, the therapist would no doubt have said she had been repressing this realization in her unconscious. So I asked her why she thought she had not been repressing it? She responded by saying, “It was only through our philosophical discussions, by examining the evidence of the way my mother related to me, that I eventually came to this conclusion. My belief that my mother was a psychopath didn’t just jump out of my unconscious; it was a gradual realization, based on the information that came out of the many discussions we’ve had, and the research I did in trying to figure her out.”

An observant and experienced philosophical counsellor will note that while some painful thoughts may be repressed because they are not consciously tolerable, this repression is not an unconscious avoidance of those thoughts. What is labeled as the symptom of an unconscious defense mechanism may simply be that person’s acceptance that he is unable to make sense of a painful issue, and that it is therefore best removed from everyday

thinking. With a philosophical counsellor's help such so-called repressed thoughts can be recalled from memory, brought to active attention, and worked through with great success. This conscious act of self defense by which an individual chooses to temporarily remove a painful event from immediate thought is a far cry from the theoretical unconscious "defense mechanism" of psychotherapy which is said to somehow automatically banish unacceptable thoughts from consciousness.

Incidentally, research has shown that the claim made by psychoanalysts—that dreams and free association give access to the unconscious—is simply not true. There is no evidence that there are any so-called repressed memories in an unconscious which continue to act on a person's conscious thinking and behaviour. In fact there is no convincing evidence that an unconscious part of the mind even exists. But this is a discussion topic for another day.

Resistance

One's conscious or unconscious psychological defense against bringing repressed, unconscious thoughts into conscious awareness.

Freud believed that whatever disturbed the progress of the work in psychoanalysis is a resistance.⁸ For him resistance "opposes and blocks the analytic work by causing failures of memory."⁹ It seems to me that the therapist who informally diagnoses his patient as being resistant is saying something like this, "Because my patient doesn't want to discuss what I want to discuss, this patient therefore has a problem." This diagnosis is based on a belief in the primacy of the therapist's point of view, and the inerrancy of his expertise and authority. In other words, whenever a patient feels that a particular area of discussion isn't helpful to her, the therapist feels free to informally diagnose this as resistance. Again, this diagnosis relies on the existence of an inaccessible unconscious which is said to determine the behaviour of the therapist's patient. It is the claim that when the patient resists the therapist's observations about her behaviour or thinking, this is the patient's unconscious resisting on its own accord.

One of my clients told me how her therapist diagnosed and accused her of resistance when she refused to accept the therapist's claim that her suicidal tendencies originate from the fact that she was abused as a child. This client told me she had carefully explored this possibility in numerous

intimate discussions with family members, and there was absolutely no basis to the therapist's theory that she had any sort of concealed memories of sexual abuse in her unconscious. But she was unable to convince her therapist of this, and the therapist continued to see her as exhibiting resistance. This client told me, "What can you do when your therapist says you're showing resistance? You either agree to your therapist's fabricated theory about your childhood, or he adds the diagnosis of resistance to your symptoms." I've always found my philosophical counselling clients to be very open and truthful in what they offer for discussion. I would suggest that any therapist who believes his patient to be exhibiting unconscious resistance is looking for a problem in his patient which is in fact a problem in his professional relationship with that person.

Denial

A defense mechanism where certain information is not accessed by the conscious mind. Denial is related to repression, a similar defense mechanism, but denial is more pronounced or intense. Denial involves some impairment of reality. Pathological denial is irrational denial in the face of conclusive evidence.

Freud saw denial as a hysterical symptom, a "striving against ideas which can awaken painful feelings, a striving which can be put side by side only with the flight-reflex in painful stimuli."¹⁰ But imagine the patient who is diagnosed with "demon possession" by her psychotherapist. She disagrees with her psychotherapist who then diagnoses her as exhibiting denial. Or the patient who is told by her therapist that it is her own fault she was raped by her boyfriend. When the patient refuses to accept this blame, the therapist diagnoses her as being in denial. The key to recognizing the problem with the informal diagnosis of denial is to notice that when a therapist claims his patient is in denial he is in fact taking her denial personally. What I mean is that the therapist sees his patient's disagreement with his theories as a denial of his competence, his professionalism, and ultimately his authority.

Notice that so-called pathological denial is defined as irrational in the face of conclusive evidence. But what does "irrational" mean? And what is "conclusive evidence"? The psychotherapeutic diagnosis of denial is not an empirical statement about a person's physical or biological state; it is merely the therapist's subjective evaluations of his patient's disagreement with

him. When a therapist considers his patient to be irrational in the face of conclusive evidence he is making two subjective judgement calls: first, that because his patient's perspective differs from his own, therefore his patient's perspective is the irrational one; and second, that what the therapist believes to be true should be accepted as conclusive evidence by anyone he would call rational. In other words, the therapist has set himself up to be the judge of his own judgements. How credible is this?

In philosophical counselling the client is never diagnosed as being in denial. Philosophical counsellors understand that they are not infallible; they don't consider themselves the direct link to "the Truth" about their clients or the contents of their so-called unconscious. When there is a disagreement, the philosophical counsellor is always willing to consider the fact that he might be wrong and the client may be right.

Negativism

Negativism is the opposition or resistance, either covert or overt, to outside suggestions or advice. May be seen in schizophrenia.

Freud actually defines negativism differently from its modern usage. He equates it with irony, that is, the use of irony—which he describes as a negative statement that is opposite from its intended meaning—as a form of humour and avoidance of a painful issue raised by the therapist.¹¹ But for the purposes of this paper, I will discuss the modern understanding of negativism. The issue of advice-giving is an important one in philosophical counselling. There is a significant difference between a therapist who gives advice and a philosophical counsellor's practice. Advice is something like saying, "This is what you should do." There's a certainty to advice because it is the claim that *this* is the correct thing to do. And there's an expectation, especially among therapists, that when they give advice it won't be questioned or disputed by their patients. The patient who questions or disputes such advice is considered to be exhibiting negativism. What a philosophical counsellor will do instead of giving advice is to offer the client a variety of perspectives and possibilities for both thought and behaviour. What sets a good philosopher apart from an advice-giver is that the philosopher has a fertile imagination, a very sharp mind's eye with terrific peripheral vision. This allows him to offer his client a great variety of alternative points of view from which the client can then choose a course of action that is in

line with her own values and beliefs. Rather than telling the patient, “This is what you should do,” the philosophical counsellor might ask the client, “What do you think about this approach...?” Expressing a possible course of thought or action in the form of a question leaves the discussion open-ended and allows the client to consider other alternatives without being accused of exhibiting negativism.

A very different problem with the definition of negativism is the claim that it may be seen in schizophrenia. My own research into the diagnostic criteria employed in psychotherapy has led me to conclude that the psychotherapeutic community’s definition of schizophrenia is not only inconsistent but blatantly confused and contradictory. Therefore its claim that negativism may be seen in schizophrenia is totally meaningless. But a thorough discussion of schizophrenia is also a topic for another day.

Projection

Projection is a defense mechanism, operating unconsciously, in which what is emotionally unacceptable in the self is unconsciously rejected and attributed or projected to others.

Freud describes projection as a mechanism in which an unknown hostility in the unconscious, “of which we are ignorant and of which we do not wish to know, is projected from our inner perception into the outer world, and is thereby detached from our own person and attributed to the other.”¹² This definition is somewhat misleading. Keep in mind that this informal diagnosis is what the therapist claims to be seeing in his patient; it is a diagnosis that is true by definition only. In other words, the therapist defines his patient as projecting when for example the patient accuses the therapist of making inappropriate sexual advances toward her. He might say something like, “You’re projecting your sexual desires for me on to me, as though I were having sexual desires for you.” I actually had a client who told me she had been in precisely this situation with her therapist. She provided me with convincing evidence of his unethical behaviour toward her, but he avoided all responsibility simply by accusing her of projection. As you will no doubt have noticed, the problem with projection is that the patient is always at a disadvantage, because it is the therapist who is in the position of authority and who has the power to “clinically” judge the situation. This allows him to protect his own self-interest no matter what the

outcome of his sexual advances may be, because he knows he can openly exhibit his unethical intentions toward his patient and later simply accuse her of projection. It will then be the patient's words against the professional opinion of her therapist.

Statistical research has revealed that psychotherapists take advantage of their clients in many different ways. As a philosophical counsellor I recognize that the term "projection" is nothing but a clumsy subterfuge to put the patient on the defensive. I don't doubt that my clients sometimes become defensive when they're required to examine their own beliefs and values, but this is a long way from the so-called unconscious defense mechanism in patients which psychotherapists call "projection."

Suppression

Suppression is the conscious effort to control and conceal unacceptable impulses, thoughts, feelings, or acts.

I was raised in a strict fundamentalist Christian home. One of my most vivid childhood memories is that of having thoughts about religion and asking questions about God that were deemed unacceptable by church elders. But what does it mean to have unacceptable impulses, thoughts, feelings, or acts in a therapeutic or counselling relationship? Freud talks about the suppression of ideas in the unconscious meant to stifle ideas which could cause painful unwanted emotions to erupt.¹³ His explanation of the process of suppression is vague and admittedly incomplete, but he is convinced of its functional existence.

I have a client who has been diagnosed with schizophrenia. In discussions with him it has become clear to me, and to him as well, that his psychotherapist has made him very aware of what she considers to be his unacceptable impulses, thoughts, feelings, and acts. For example, she has clearly let him know that it's unacceptable for him to tell her that some of the many medications she requires him to take are not actually helping him; it is unacceptable for him to tell her that he doesn't have some of the symptoms of schizophrenia which the textbook says all schizophrenics have, such as auditory hallucinations and paranoia; it is unacceptable for him to ask his therapist questions about what he might do to satisfy his desire for female companionship; it is unacceptable for him to let his apartment become messy if he wants to be considered normal; and it is even unacceptable for

him to expect to fully recover some day. This man was clearly trained by his therapist to suppress any number of impulses, thoughts, feelings, and acts she considers to be unacceptable for a schizophrenic in her professional care. Suppression is indeed something a patient may practice in the company of a therapist. But the symptom of suppression originated not in the patient but in the therapist, and in the sort of suppressive therapeutic relationship the therapist has fostered.

Philosophical counselling avoids the judgmental diagnostic gaze on which much of psychotherapy is based. A philosophical counsellor is careful not to treat his client in such a way that she feels some of her impulses, thoughts, feelings, or acts are unacceptable within the counselling relationship. And because philosophical counsellors don't diagnose their clients, there is no symptomatic "norm" of behaviour for any particular mental illness to which the client is expected to conform. This absence of expectation is very liberating for the client in philosophical counselling. It allows the client to have a great variety of impulses, thoughts, feelings, and acts without having to consider herself abnormal.

The examples I've presented from actual stories my clients have told me are all instances of psychotherapists refusing to accept the fact that they are not always right. And this comes from the therapists' desire to defend and maintain their position as the expert and authority; the one who knows the patient, and the patient's mental illness, better than the patient knows herself. The diagnoses of transference, repression, resistance, denial, negativism, projection, and suppression were actually a transference of responsibility from the therapist to the patient; a repression of the truth of the therapeutic relationship; they are a resistance by the therapist to acknowledge his own imperfections as a human being; a denial that sometimes the patient knows herself better than the therapist knows her; a negativism brought into therapy by the therapist's claim to authority; a projection by the therapist of his own weaknesses onto the person he claims to be helping; and a suppression—a conscious effort by the therapist—to control and conceal the fact that his patient is aware not only of his limitations but even of his blatant incompetence. In the final analysis, they were attempts by the therapist to blame the victim.

Furthermore, these "informal" diagnoses of transference, repression, resistance, denial, negativism, projection, and suppression raise the question, "How accurate and meaningful are the many other diagnoses made by psychotherapists?" Making a diagnosis in psychotherapy is not an exact,

empirical science like it is in medicine. It does not employ blood tests, x-rays, or urine samples. It is always a subjective evaluation, a hermeneutic or “reading into” the patient by the therapist, a judgement call based on what the therapist believes to be “normal” and how far he believes his patient has deviated from his conception of the norm. Given what I have done here with these “informal” diagnoses in psychotherapy, it makes me wonder: what might it be possible for a philosophical counsellor to do with the formal diagnoses of those so-called mental illnesses that are not medically verifiable, and whose consequences are far more catastrophic to a person’s life, such as clinical depression, anxiety, and schizophrenia?

References

Abess, J.F. (2005). Glossary: Terms in the field of psychiatry and neurology. Retrieved December 28, 2005 from John F. Abess’ website: <http://www.abess.com/glossary.html>.

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th Ed.). Washington, D.C.: American Psychiatric Association.

Freud, S. (1995). The basic writings of Sigmund Freud. (A.A. Brill, Trans. & Ed.). New York: Modern Library.

Notes

¹ This paper, originally titled “Windmills to Dragons: A Philosopher’s Perspective on Psychiatric Diagnoses,” was presented as part of the 1st Iberoamerican (Spanish-speakers) Conference on Philosophical Counselling, Sevilla, Spain, 2004.

² For the sake of brevity I will use the word “psychotherapy” to mean all forms of main-stream psychologically-based therapy.

³ I will be referring to the therapist or the counsellor as “he” and the patient or client as “she.”

⁴ Numbered definitions are adapted from *Glossary: Terms in the Field of Psychiatry and Neurology* by John F. Abess online at <http://www.abess.com/glossary.html>

⁵ Freud, Sigmund. *The Basic Writings of Sigmund Freud*. New York: Modern Library, 1995 ed. p. 475.

⁶ Freud. p. 907.

⁷ Ibid., p. 505.

⁸ Freud. p. 442.

⁹ Ibid., p. 907.

¹⁰ Ibid., p. 71.

¹¹ Ibid., p. 724–725.

¹² Ibid., p. 823–824.

¹³ Ibid., p. 489.