Clive Perraton Mountford
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IS THE DSM PUSHING THE RIVER?

When international criticism of the DSM-5 becomes a Maclean's cover story, *something* is happening: "everyone…stands on the brink of some mental-disorder, or sits on some spectrum."[1]

Well, one might respond, *that's probably true.*

Yes. And.

The long and profitable arm of "big pharma," increasing medicalisation of "normal" distress, plus a toxic mix of questionable science and vested interests are being invoked. In addition, something thought provoking and potentially practice changing for counsellors is going on.

1. Choices

If you don't like your nose, you have options:

- "Live with it," uneasily accepting that here's something you don't really like but never—as it were—going nose-to-nose with the issue.
- Hire a cosmetic surgeon.
- Work to understand, to "get a handle on," what it is about your nose that seems so wrong and why it needs to change, and seek to work it through; to "process," wherever that leads you.[2]

In consequence of that last option, you may return to the second, or you may acquire a deeper more comfortable acceptance of your nose as it is.

Now suppose you don't like the way your mood shifts—highs and lows—without clear environmental reasons. Again, there are choices:

- Live with it as best you can.
- Ask a physician to prescribe drugs which will flatten out those highs and lows.
- Seek a therapy which pathologises such oscillation and will work to change you.
- Work to know and, in so far as possible, understand your own affective tides and what they mean to you. You can seek to accept—not in the sense of beaten resignation, but in the sense of a compassionate embracing—that this is part of you, just like your nose. And you can hire a therapist to accompany you.

This time, there are *two* middle options, but only because there are *two* "change it" routes. When faced with physical or mental characteristics which are not as we would like, there are usually three basic possible options:

- Live with it.
- Change it.
- Seek to compassionately accept and understand who and what we are and work to process whatever that leads to.

2. A Short Answer

These options raise issues within issues. Most involve a distinction between ways of practicing counselling that speaks directly to the DSM-5 controversy.

Wherever a counsellor has trained, and whatever their subsequent professional development, they will offer a particular blend of "change-it" and "accept-and-process" therapy. Some counsellors lean towards "change-it," others—perhaps a minority—offer mostly "accept-and-process." The DSM-5 ups the ante on behalf of change-it therapy by increasing the reach of "mental illness" and designating "wrong" or "pathological" characteristics which, until now, were just part of the tapestry of human difference.

That is because deeming something an "illness," or even just "not normal," creates a supposition that it *should* be changed. A big nose—at least for now—is just a big nose. Choosing to come to terms with rhinological splendour would seem reasonable to most people. But when mood swings are labelled "bi-polar disorder," the decisions to seek and offer the accept-and-process option become harder.

This does not mean that the DSM-5 is necessarily misguided nor that it is doing us a big favour. However, the change-it approach is not necessarily benign; it can involve activities which are unrealistic, harmful to the client, or even banned in some jurisdictions.[3] Responsible change-it work involves repeated decisions which can be summed up as: *When do I, and do I not, facilitate a client's choice to impose change upon themselves?*

For example, a client who is afraid to fall asleep in the dark, who pretty much has a handle on why, but still struggles to do it, determines to leave the lights off, night after night, and see if their fear passes away. *Is there a problem with that?* It didn't trouble me much.

However, a client who probably experienced things as a child which she couldn't remember, and who thought we should be "making her remember" was gently but repeatedly discouraged.

So far, so good? These are pretty mainstream choices. But what about the client labelled "bi-polar"?

I supported his decision to refrain from pharmaceuticals. Our goal was that he learn to ride his personal roller coaster, benefiting from the highs and surviving the lows. That is not so mainstream. And when I look around at others who work similarly, no particular

counselling orientation or tradition dominates the landscape: We have come from different places.

This yields a first, and possibly interim, "conclusion":

- *Conclusion one:* For practicing counsellors—and for other caring professionals—there is good reason to ask where we stand in respect of the change-it/accept-and-process balance and why. The DSM-5 is, at minimum, adding to that. If I was a potential client, it would be something I would want to know about available therapists.

3. Glass Slipper Therapy

So where am I in respect of this balance?

When I sat reading that Maclean's article, I didn't know the answer to that question; not in a fully aware—here is my answer—kind of way. Using examples and referring to theory, I will summarize the journey I then took, showing what I mean by "good reason to ask where we stand," and digging deeper into the change-it/accept-and-process distinction.

He is an aspiring professional on the training ladder who hates his job. He comes to counselling to change that. We explore and find that who he is and what the job involves are a terrible fit. He insists: 'This is going to be a really good career.' Our task is to make him fit.

She is to be married. She doesn't love the guy, but for all kinds of reasons she believes he will make a splendid husband. The job description is to change her so she will be happy with him.

These clients are seeking 'Glass Slipper Therapy,'[4] as in Cinderella's step-sisters: *My foot has to fit, and if that means butchery, so be it*.

I am a terrible choice of therapist for someone in this kind of predicament, and—more generally—a terrible choice for anyone who insists on following through with a reasoned course of action despite what they are feeling and what their organism is telling them. Although I may feel deeply for their predicament, I am usually even more deeply convinced that this is a terrible mistake.

Why? The answer has at least something to do with who I am.

I don't like topiary; I do like Japanese gardens. Both are a product of ingenuity and artifice, but the former imposes an alien pattern and the latter—in my perception—work with and express something inherent in trees and plants, rocks and water. I'm not saying topiary is wrong and Japanese gardens are right. I'm saying topiary upsets me, and Japanese gardens are places I like to be, and that there is a depth and intensity involved which—at this stage of the journey—remains unexplained but undeniable.

I may sometimes reassure clients by explaining that counsellors can be crazier than the folks they work with, but I certainly cannot tell a client who hardly knows me that pushing ahead with change-it therapy is a terrible mistake, and that this is because I prefer Japanese gardens.

4. A Longer Answer

I noted earlier that no orientation or tradition dominates this landscape, but perhaps my person-centered origins *are* relevant: Person-centered counsellors *do* have an aversion to "pushing the river."[5] Unfortunately, "I can't help you because I'm some kind of person-centered counsellor," is not even theoretically sound.

Although received person-centered practice[6] places an emphasis on *actualization* and an *internal locus of evaluation* which is arguably *incompatible* with much change-it activity, it *also* requires empathically standing alongside the client in *their* world, partaking sufficiently of *their* reality to know how it is for *them*. That creates a presumption *in favour* of change-it activities attractive to the client.

There may be added tension in the balance between change-it and accept-and-process uniquely attributable to person-centered leanings, but both are consistent with that tradition.[7] However, received person-centered counselling and experiential focusing both grew from the same initial research and theory, and I am deeply involved in focusing, so you could ask: Is focusing the key to my particular aversion to change-it activities?

No one can simultaneously pursue change-it activities and utilize focusing:

- Psychotropic drugs affect experiencing—they are intended to—and that interferes with focusing. A client who routinely uses focusing was recently prescribed a low dose of amitriptyline as an antidote to a skin problem. He was assured the dose was too low to have any psychotropic effect. Even so, seeking his "felt sense"[8] became like trying to land a plane in dense fog without instruments.
- More subtly perhaps, using focusing while pursuing an agenda or specified outcome will not work. Focusing exists to facilitate an unfolding of what is not yet known or realized, and that necessitates a complete preparedness to welcome *whatever* does unfold.[9]

In other words, focusing is quintessentially accept-and-process. *Does that also mean a focusing-oriented therapist must eschew change-it?* Not necessarily.

Focusing with someone using psychotropic drugs is, in my experience, a waste of time and money, but, that aside, one can certainly offer other things alongside focusing in a counselling session, and there is no principled reason why some should not be change-it activities. Sure, "don't push the river" sits particularly comfortably alongside focusing, and focusing is incompatible with simultaneous change-it activities, but "being focusing-oriented" no more rules out change-it than does "being person-centered."

But perhaps all is not yet lost. There are different ways of relating to focusing, and they can be thought of in terms of a continuum with these endpoints:

- Focusing is done to better understand and gain a fuller sense of some particular aspect of experiencing. Once achieved, the focuser returns to a more everyday way of being.
- Focusing is the greater part of that everyday way of being. The focuser lives, or seeks to live, with a gentle, ongoing awareness of the body and the places within it

where "felt sense" resides. Overall experience becomes an ongoing conversation between felt sensing and more cerebral processes.

For me, moving along this continuum feels a good thing to be doing. It feels "right." There is more space. Experiencing joins up better. Bad things which happened in the past are not undone, but they are less crippling. And change-it solutions start to look brutal and ineffective, like glass slipper solutions.

This is only my experience, but focusing colleagues, and clients and counsellors-in-training whom I have helped onto the continuum, and particularly those who have moved some way along it, agree: This is a better way to be and to live.

Job done?

5. Another Way to Slice the Pie

Referring to focusing *can* explain an accept-and-process preference and help a client understand how I work. But it is not the whole story.

I am not uninterested in change. In fact, focusing pretty much guarantees change. However, I do discriminate between changes that grow from within and those imposed from outside. Focusing is part of my personal and professional practice because it facilitates the "right kind" of change—an unfolding from within. (The Japanese garden story is similar.) This *predates* my interest in focusing or counselling. Therefore, although focusing may help me justify myself to clients and colleagues, it is only a step towards a fuller account.

This makes good sense. Focusing is not the only path leading to accept-and-process. Meditative and spiritual practices can lead somewhere similar. Person-centered practice weighted towards reliance on inner potential heads this way. So will training and working as a counsellor in other traditions which emphasize bodily experiencing, authenticity, and the acceptance of experiencing.

In short, the change-it/accept-and-process distinction cuts across the orientations and counselling traditions which usually divide the counselling pie. Switching metaphors, it can be seen to reveal branch lines within the practice of counselling that different orientations feed into.

6. The DSM Revisited

To end, I will stress two further conclusions:

- *Conclusion Two*: The DSM aside, the change-it/accept-and-process distinction is a powerful and important distinction in its own right.

For example, the distinction explains why a focusing-oriented person-centered therapist such as myself, finds his clinical practice likened to analytic body psychotherapy by one client and Buddhist psychotherapy by another.

Ironically, perhaps, distinctions are what the DSM-5 is all about. But accept-and-process *therapy,* and associated practices, are untidy, messy, and personally challenging for

everyone involved. They cannot easily be manualised or answer questions like, "How long will this take?" They are out of step with the DSM and much contemporary culture, yet they "work," yielding change that is deep, permanent, and according to clients, students, and colleagues,[10] life-changing in the best way. The DSM-5's perceived authority and new taxonomy will marginalize them more completely than any previous iteration.

- *Conclusion Three*: Accept-and-process approaches to counselling are vitally threatened by the DSM-5. Counsellors, and not just passionately focusing-oriented ones, should approach it with caution and scepticism.

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[1] "Is she a brat, or is she sick?" *Maclean's,* March 25, 2013. (http://www2.macleans.ca/2013/03/19/is-she-a-brat-or-is-she-sick/)

[2] These are focusing words. For example: Gendlin, E.T. (2007) *Focusing.* Reprint. Bantam Books. Gendlin, E.T. (1996) *Focusing-Oriented Psychotherapy: A Manual of the Experiential Method.* New York: The Guilford Press.

[3] For example, "Statement of ethical practice (1)" sent to British Association for Counselling and Psychotherapy members in a letter from Amanda Hawkins, Chair of BACP, dated 18 September 2012 and headed "Statement of ethical practice" informs members: "BACP opposes any psychological treatment such as 'reparative' or 'conversion' therapy…based on the premise that the client/patient should change his/her sexuality. "

[4] Elsewhere, I have written of "glass slipper syndrome", but "therapy" is more accurate. See, for example, section 4 of Mountford, C.P. "Unpacking the congruence box". *Self & Society,* 38 (4), Summer 2011, pp 5-17. Available at www.counsellingpeople.com/cliverd/a.

[5] As in the title of Stevens, B. (1970) *Don't push the river (it flows by itself).* Real People Press.

[6] "Received person-centered practice" originates with Rogers, Carl R. (1957) "The Necessary and Sufficient Conditions of Therapeutic Personality Change". *Journal of Consulting Psychology* 21, no. 2: 95–103. It is well represented by the evolving editions of Mearns, D. and Thorne, B. *Person-Centered Counselling In Action.* London: Sage Publications Ltd. An excellent synopsis is provided by the opening pages of Purton, C. (2004) *Person-Centred Therapy: The Focusing-Oriented Approach.* New York: Palgrave Macmillan.

[7] This "tension" is redolent of the balance which must evolve between *empathy* and *congruence*. See, for example, Mountford (2011) in footnote 5. For a recent discussion of the interrelationship between all three "core" or "counsellor" conditions, and Rogers's view of it, see the section on "The Three Conditions in Combination" and particularly pp 125-126 in Mearns, D. and Thorne, B. with McLeod, J. (2013) *Person-Centred Counselling In Action.* 4th edition. London: Sage Publications Ltd.

[8] See, for example, Gendlin (2007) in footnote 2.

[9] See, for example, Gendlin (2007) and (1996) in footnote 2.

[10] There is a wealth of literature to support these assertions—see also www.focusing.org—but I am more persuaded by direct experience: this is what I have been told over the time I have been using, developing, and teaching accept-and-process therapy.