Naming the Pain and Guiding the Care: the Central Tasks of Diagnosis

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Foreword

The field of psychiatric diagnosis, like many others within the mental health disciplines, has known peaks and valleys in terms of conceptual and theoretical foundations, quality of accumulated knowledge, and practical applicability. Its trajectory over centuries has earned praise and recognition for positive accomplishments, as well as criticisms and objections to ambiguities and contradictions. This is not only because the very etymology of diagnosis covers a wide variety of areas, but also because its purpose, structure, and use have been the subject of increasingly complex research and scientific advances, themselves open to debate and controversy (1, 2).

Traditionally, the scope and impact of diagnosis focused on the systematic delineation of clinical symptoms and syndromes, and on some implications of causality. Furthermore, the historical role of diagnosis implied generic indications and guidelines for treatment, as well as the estimation of prognosis or outcomes whenever possible (3).

The 21st century, almost one decade old already, savors the progress brought about by consistent clinical and heuristic work. Contemporary psychiatric diagnosis is the foundation of large and deep epidemiological surveys (and epidemiology is, indeed, the basic science of clinical practice), the basis for the elucidation of risk and protective factors, the reflection of the dynamic roles of families and communities in mental health and mental illness and, most importantly, the repository of initiatives in policy-making and delivery of services. Last, but by no means least, diagnosis in the mental health field now recognizes culture and cultural variables as essential components in the assessment of real clinical entities occurring in really suffering human beings (4-6). Thus, present-day psychiatric diagnosis encompasses a multitude of areas, and forces the mental health practitioners to view their work from a broad, comprehensive, and consistent perspective.

In the United States, and indeed across the world, the highest expression of the “state of the art” in psychiatric diagnosis is the current Fourth Edition-Text Revised of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV TR) (7). The creature of expert groups’ consensus with innumerable printings over the years, translated into all languages on Earth, in short, another symbol of the multicephalous hegemony that this country exerts -- not always wisely, we must say --, DSM-IV-TR is now on the spot. The initial steps toward the development of DSM-V are taking place: the APA has already appointed the Task Force as well as different Work Groups, international conferences have taken place (coordinated by APA, with the participation of the World Health Organization, National Institute of Mental Health, and World Psychiatric Association), new field research and contributions of representatives of the public health and academic communities are being planned. The new Manual is expected to see the light around the year 2011 (8, 9). Needless to say, the stakes are high, expectations are intense, and people involved in the work towards the DSM-V are looking forward to very exciting four or five years.

Everybody agrees that for a diagnosis to be effective and useful, it has to be thorough and comprehensive. Historically, the field of psychiatry has been a productive, at times chaotically so, setting of efforts to break down the barriers of an old-fashioned Cartesian dualism (10, 11). At this stage, suffice it to say that the old debate between categorical and dimensional approaches will regain center stage (12). The contributions from basic neurosciences will be an important ingredient of forthcoming diagnostic conceptualizations (13), as will the obvious needs and demands of public mental health (14).

This latter development will take place because issues such as poverty, inequality, social injustice, stigmatization, diversity, prejudice, and repression reside (whether we like it or not) at the core of what we call mental illness. And practically all of the above concepts are part and parcel of culture, understood as a set of meanings, behavioral norms, and values or reference points utilized by members of a particular society as they construct their unique view of the world, and ascertain their identity (15). The concept of culture enriches the notion of a multidimensional definition of health, beyond the now old-fashioned biopsychosocial umbrella (16, 17). Why? Because culture goes beyond material or nonmaterial elements (language, traditions, values, social relationships, financial philosophy, or the ascertainment of technology). It implies context, meaning, and integration, not only for the internal consistency of a diagnosis but also for the external presentation of its multiple variations. And culture is a vital and decisive notion because it also entails religious beliefs, spiritual needs, moral thoughts and structures (18, 19).
It is in this crucial area that *Naming the Pain and Guiding the Care* by Donald D. Denton, not only builds on his first volume, *Religious Diagnoses in a Secular Society*, but advances the field both conceptually and pragmatically, a rare and notable accomplishment indeed. In the manner of an initial reflection about the book, one has to say that the spiritual and religious experiences of a human being, touch the most sensitive cord of the science vs. humanism dichotomy. And thereof a number of questions emerge. Shall such experiences be considered an element – or product-- of the cognitive apparatus and functions of the individual? Or are they mostly phenomena of the highest order, resulting from the thirst for transcendency and search for meaning in everyone’s life? Shall spiritual and religious aspects of the individuals suffering be evidence-based or, more than that, value-based so that the true humanistic entity of psychiatry and mental health be vindicated? How do the spiritual and religious aspects of human life apply to the so-called “special populations” reflected in ethnic diversity, age differences, gender interactions, and the

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like? And finally, to what extent do spiritual and religious matters play a role in what we call clinical symptomatology, a varied body of manifestations, both physical and psychological, that must be systematized not only in the name of “diagnostic accuracy,” but also because our job is to deal with the “whole” human being asking for help? Twenty-two chapters (each one of them well designed, well written, exciting texts) give shape to the book. With the premise that “spiritual pain is the most personal of human suffering,” the structure of diagnosis as a cultural product is described from three “world views”: the ontological, the teleological, and the integrative. The first “tends to see disease as being built into the nature of reality, in categories such as the ‘wrath of God’.” The second attempts to accomplish the most difficult task of “accurately identifying the etiology of the disease” in the author’s view, something that is at the core of DSM. It advocates the use of instruments of evaluation and treatment, technology and psychometrics in a way that may be as yet unreachable as it is ambitious. The integrative world view, as the name implies, “attempts to take into account the importance of issues related to being and quality of life (ontology), as well as health factors that are objectively verifiable and responsive to a course of care that can be replicated across cultures (teleology).” In the author’s assessment, the evidence-based clinical practice is an example of efforts at integration. Needless to say, effectiveness of management is emphasized, and ending the polemics between science and humanism, while practicing a truly person-centered treatment, are duly recognized needs. Ultimately, the provision of “humane care” becomes the main goal of a good diagnosis.

Not surprisingly, the book proposes a “clinical interview with spiritual implications,” and provides itemized points of exploration. Those bulleted lines in several pages of Part One, particularly chapters 3 and 4, are welcomed gems of clinical pragmatism, usefulness, and wisdom. One of the most original contributions of this volume is the proposal of “systems of faith” that approach the diagnosis examining “the inherent tensions between various clinical and non-clinical models.” Parts II, III, and IV present all these perspectives quite cogently. The first, ethical guilt or the feeling of blame is a component that, from a clinical point of view, cuts across different entities. The second perspective addresses idolatry or the feeling of betrayal. It has to do with “naming the Gods in diagnosis,” an effort to set the stage for “the soul of pastoral counseling.” The description of “secular gods of cultural religion,” the gods of ambiguity shaping up clinical features (primarily of personality disorders), the fusion of a particular world religion with a culture or nation, are scary pathogenic routes. Thus, “helping individuals name such terror for what it is, becomes a part of the healing task.” Nothing could be more truthful.

Dread or the feeling of defilement, puts both the patient and the diagnostician/therapist straight into the “care versus cure” dilemma. The language of defilement evokes self awareness at its most tragic scope. Defilement may symbolize stain and stigma, a sense of abandonment, but also entails the promise of cleansing.

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“transforming the soul” into the unique personal experience of happiness or inner serenity that comes as liberation, yet not without a “saving sacrifice.”

Denton moves from metaphor to clinical discussions with ease and elegance. His three axes of a “theological model” (that, some would rightly assert, goes beyond theology), are rounded up by illustrative case vignettes. They enrich the theoretical concepts, present real-life situations, and respond to the needs of clinical practitioners as much as anything else in the book. Part Five addresses “special cases” such as children,
substance abuse, stress disorders, and bereavement. Each subsection keeps a straight eye on faith needs, spiritual concerns, experiential debacles, and existential hopes.

The therapeutic value of a spiritually-oriented diagnostic work is undeniable (25, 26). Caregivers get frustrated at the limitations of neurology and physiology, but also at their own inability to achieve the total erasure of suffering. In such context, the instillation of hope is certainly one of the most extraordinary contributions to the effectiveness of any kind of psychotherapy (27), its spiritual and profoundly human origins and repercussions being difficult to ignore. Thus, the achievement of , reconciliation, and restoration is both, a precious goal of a good diagnostic work, and an essential and rather critical ingredient of psychotherapy or counseling. The assessment and management of a “crisis of religious belief, triggered by a life crisis or chaos in life created by an overly pious practice of a religion’s central tenets,” could lead to lofty goals such as the search for meaning, provision of creative values, foster self-esteem, or stimulate growth of inner freedom and autonomy.

The book ends with a suggestion and a challenge. The first is the conceptualization and inclusion, in any forthcoming diagnostic manual, of either an Axis VI, or an original spiritual/theological multiaxial diagnosis with Axis I as guilt, Axis II as idolatry, and Axis III as dread. The challenge comes through a question: Will there be any intentional integration of the spiritual or religious diagnoses within the official lexicon of diagnosis? I have to agree with the notion that nosology of the DSM-IV-TR “hardly does justice to the anguish of all concerned.” In agreement with APA’s pronouncements about the recognition of cultural variables, and specifically religious and spiritual aspects of human suffering into the diagnostic task, the author hopes for an end of the “clinical bifurcation” noted in the last two or three decades regarding the religious dimensions of human distress and human equanimity, deplores the lack of bibliographic support (that Naming the Pain and Guiding the Care undoubtedly provides), and supports going beyond an essentializing, disease-centered approach driven almost exclusively by biomedical technologies.

Nevertheless, the book also urges the pastoral counselors and professionals involved in spiritual and religious care, to abandon their own isolation, fight extremisms, and go beyond diagnosis in an authentic search for integration and integrity. Providing “diagnostic criteria” for individuals with “unhealthy or faulty awareness of providence, grace, and/or dependence” becomes a crucial task. The need for primary research is rightly proclaimed, and the summary chapter of this volume offers a book, Caldwell (31) elucidates faith as obedience, guilt as transgression, ostracism, disgrace and death. One wonders about the pathogenic power of such formidable entities – faith, as a potentially rigid, supra-rational dictum, guilt as the perhaps unplanned result of the dominance of inexhaustible “immoral impulses.” It is therefore clear that diagnosis, its role and implications, go far beyond clinical considerations, if we accept the moral dimensions of behavior.

One final point. Let’s reiterate another unequivocal reality: globalization is a fact, a concept, and a practice (32, 33). Therefore, together with its recognition, keeping a vigilant, critical eye on the term’s genuine meaning of balance and equity must be everybody’s task. Religious and spiritual needs respond to the communal, globalizing needs of humankind. Yes, fundamentalism should be rejected, but this rejection should not be used as an excuse for violation of the rights of many other groups or communities throughout the world. I read this book – beyond its nuclear purpose-- as a proclamation of real integrative humanism, trying to put an end to artificial divisions and separations, emphasizing values that are inherent to our human condition, rejecting intolerance, protecting privacy, and caring for the public good (34). La Rochefoucauld, the 17th century French thinker, praised the coexistence of human beings in a social conglomerate because it restricts “immoderate appetites,” and fosters the learning of reciprocity, a social ideal that overcomes selfishness and irresponsibility. This balanced recognition in social life, is as important as an objective diagnosis is for our patients. Naming the pain and guiding the care are examples of how psychiatry and mental health transcend medicine, and the bureaucratic scope of the professions. One of our fundamental missions in this noble effort is to see the human through spiritual lenses, and to see the spiritual through human lenses. Selah!

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