Beyond the medical model

Rachel Freeth

On my mind for a number of years has been the so-called medical model. Increasingly I have focused on examining what this umbrella term might mean, and the difficulties and conflicts it presents for therapists who work in medical model contexts while practising from a radically different value base.

As a psychiatrist who is expected to operate according to the medical model (having been trained to do so), but one who at heart embraces the attitudes and values of the person-centred approach, I am acutely aware of these tensions within me.

Inherent within the medical model, the helper is cast in the role of a particular kind of expert (I say 'particular kind' because there is nothing wrong with experts and expertise *per se*).

As a psychiatrist, this expertise regularly takes the form of having to think about psychodiagnosis. This is one subject that creates in me particular discomfort and tension. I am required to evaluate people's problems using the language of symptoms, to embrace the constructs of a classification system and, in short, generally work within the traditional frameworks of psychopathology.

Leaving aside important concerns about the validity and reliability of psychodiagnosis, I notice how the expectation on me to 'make a diagnosis', using a particular form of expert knowledge, conflicts with my preference to know how people make sense of their experience of distress for themselves, in their own terms. It is for this reason that, up until now, I have resisted the convention many psychiatrists use of stating a diagnosis as a header on letters to GPs, usually in bold type.

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Of course, there are many instances where the organisational system (the NHS) does require me to provide a diagnosis and I have to work with this. There are also occasions when not to state a diagnosis would seriously disadvantage patients – for example, when it comes to negotiations with the welfare and benefits systems. A diagnosis is also often the gateway to particular services or forms of help within the mental health service itself.

I am also mindful that not every patient can easily – or even wants to – think for themselves. I am sometimes struck by the discomfort patients show when I invite them to tell me what they think about their experiences – whether they have any ideas or assumptions about what has led to their distress and, importantly, what kind of response or form of help they are hoping from me.

Usually by the time they come to see a psychiatrist most people are expecting a diagnosis. Indeed, a request for a diagnosis may be the reason for their referral by a GP. I have noticed a great variety of responses to my reluctance to readily apply a diagnostic label (some labels more than others). Some people are disappointed and frustrated. Others are greatly relieved and value being seen as unique people with their own, unique set of life experiences, rather than collections of categorised psychiatric symptoms.

Returning to the issue of expertise, then, while many mental health colleagues and patients would recognise expertise in my role as a diagnostician, this is not what I value. Rather, I value being able to explore and discern the meanings diagnosis may hold for patients. For example, how does a diagnosis influence the way people see themselves? What role is it likely to play as they receive help from different parts of the health and welfare systems, and how does it influence their sense of personal agency as they pass through these systems?

The ability to inhabit an individual's personal world of meanings is a form of expertise to which I attach great importance. However, I don't think much importance is attached to this within psychiatry.

Thinking about the potential meanings of psychodiagnosis is not routine, in my experience of my profession. Perhaps it is only in the therapy room that different forms of knowledge and the concept of diagnosis can be explored and negotiated, along with a more honest and open sharing of expertise. Of course, this would depend on how much therapists embrace the medical model. ■

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