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DIAGNOSIS: WHAT'S IN A WORD?

ABSTRACT: This article reviews the long-standing issue regarding the role and function of diagnosis within the counselling process. The controversy has traded upon the spectrum of functions assigned to diagnosis ranging from diagnosis as (1) a dynamic causal model of disease to (2) a descriptive summary statement of correlated symptomatology. It is argued that the irreconcilable positions taken by client-centered versus diagnostic counsellors have been largely sustained by the failure to resolve definitional ambiguities.

> "When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean — neither more nor less."
> Lewis Carroll, *Through the Looking Glass*

One of the most persistent theoretical (if not ideological) issues within the counselling professions has been the "problem of diagnosis" or, more literally, the nature and function of diagnosis within the counselling process. Those who recognize that diagnosis *is* a problem for the counselling enterprise generally trace the problem's origin to the acceptance of a questionable analogy. Essentially, it is asserted that psychological diagnosis has become problematic because it has attempted to imitate the functions of physical diagnosis as understood

by medical practitioners. Arbuckle (1961), for example, has remarked that, "diagnosis provides a particularly good example of the unhappy results of assuming that the problems of the mind and heart are the same as the problems of the physical body (p. 222)."

This analysis of the problem, as a false analogy, generally presupposes the functional utility of physical diagnosis. The therapeutic value of medical diagnosis is taken for granted. Carl Rogers (1951), for example, once called physical diagnosis "the *sine qua non* of treatment (p. 219)" in coping with organic disease. But to some extent these typically invidious comparisons between psychological and physical diagnosis have been overdrawn. Physical diagnosis is usually portrayed as the "capsule solution" for organic ills, at once including the etiology, symptoms, treatment, and prognosis for a given condition. The accuracy or generality of this characterization, however, may be legitimately questioned. While there are doubtless occasions on which physical diagnosis does provide a nearly complete pathogenic explanation, there are also a significant number of instances in which it falls far short of this diagnostic ideal. Consider, for a moment, the relatively common diagnosis, "gastritis, acute, right upper-quadrant." As it stands, this "diagnosis" informs us of nothing more than the spatial location of a particularly severe stomach ache which may portend anything from common indigestion to a gastric neoplasm.

The easy phrase, "just a matter of definition," is perhaps invoked too often to depreciate or dismiss various perplexing questions for which semantic ambiguity may have only tangential relevance. The problem of diagnosis, however, would seem to restore some pertinence to this rhetorical cliché. As Tyler (1961) suggests, "to add to the confusion different meanings have become attached to the term 'diagnosis' so that persons who argue over it are not always using it in the same way (p. 59)." In practice, the functions of diagnosis extend from dynamic explanation to static description — these two functions representing the end points on a kind of epistemological continuum. The first purpose probably represents diagnosis in its strongest sense, that is, as a causality decision, whereas the latter refers to the more modest diagnostic function of providing a salient data summary. In this latter capacity, diagnosis does not differ greatly from the related concept, syndrome. And, indeed, the syndromic character of many psychiatric diagnoses is well known, being "based upon observations of symptoms that appear correlated, rather than on an understanding of causal factors (Tyler, 1961, p. 60)." As suggested above, many physical diagnostic statements are also essentially "syndromic" in character, that is, merely descriptive summaries of symptoms with only very tentative causal implications. If there are any differences at all, then the difference between psychological and physical diagnosis is largely one of degree rather than kind.

Elsewhere, Weitz (1954) has argued the view that any diagnostic label is simply a statement of probability:

> The principle of nonidentity has important implications for diagnosis. If we accept the principle that no two objects, or events, or conditions are exactly the same, and if we accept the principle

> that the diagnostic label is only a considerably removed abstraction of the behavior it symbolizes, we must look upon the terms we use in diagnosis in a new light (p. 71).

The diagnostic enterprise is, therefore, an act of probabilistic categorization intended to mediate and facilitate analysis and communication, "to provide symbols for objects, events, conditions, etc., which can be manipulated meaningfully in the counselling process (Weitz, 1954, p. 73)."

While much of the representative counselling literature contains cautions regarding the use and abuse of diagnosis, historically the practice of diagnosis has been most notably opposed by Carl Rogers and other client-centered counselling theorists. Somewhat parenthetically to his major objections to diagnosis, Rogers (1951) noted two essentially contingent problems associated with diagnostic classification, namely, (1) the lack of inter-judge or -examiner reliability, and (2) the tendency for certain diagnoses to imply a rigid and unfavorable prognosis, e.g., psychopathic personality. While serious deficiencies, these problems may be tentatively regarded as contingent in the sense that they may be solvable through technical improvement or practical re-education.

Rogers' real objections to diagnosis are clearly of a theoretical or philosophical character and are not, in principle, subject to empirical refinement or clinical improvement short of the abandonment of diagnosis altogether by counsellors. In structuring the counselling relationship, Rogers (1951) contends that "the very process of psychological diagnosis places the locus of evaluation so definitely in the expert that it may increase any dependent tendencies of the client (p. 223)." One might reply that perhaps there are beneficial placebo effects to be derived from such "expert" diagnostic determinations. But this is but a hasty suggestion and one must, with Rogers, decry any such pontifical use of diagnosis. But to some extent, the force of this objection does require the assumption of a certain amount of counsellor obtuseness in dealing with client expectancies.

In a larger perspective, Rogers also envisions certain long-range, Szaszian social implications of psychological diagnosis — implications that he acknowledges may be regarded as "far-fetched" by some. Psychological diagnosis, insofar as it implies treatment choice and outcome, presumably helps to shape certain molar aspects of the client's subsequent behaviour and personality. In this sense, diagnosis necessarily deals with the individual in a manipulative, dispositional way. For Rogers, this is tantamount to "social control of the many by the few (p. 224)." While not necessarily far-fetched, this distrust of diagnosis does inflate the problem to somewhat grand proportions by placing it in a broad, socio-political context. From another perspective, however, diagnosis in perhaps its most dispositional form, that is, for purposes of legal, institutional commitment as society demands, can be viewed as just the opposite of what Rogers condemns, namely, social control of the *few* by the *many*.

What client-centered counsellors, however, regard as the most telling objection to the act of diagnosis is that it virtually precludes the

"therapeutic experience." "In order for behavior to change, a change in perception must be experienced. Intellectual knowledge cannot substitute for this. It is this proposition which has perhaps cast the *most* doubt upon the usefulness of diagnosis (Rogers, 1951, p. 222)." Summarizing the same objection, Arbuckle (1961) states that the client-centered counsellor is "skeptical about the capacity of a counsellor to relate closely and intimately with another person, and at the same time be functioning as a diagnostician of that individual's problems and difficulties (p. 226)." Thus diagnosis, as a cognitive enterprise, necessarily impairs the counsellor's (and the client's) capacity to empathically and affectively participate in the therapeutic relationship. It is this client-centered interpretation of the nature of the therapeutic process that prompts Rogers (1951) to conclude (somewhat cryptically) that "in a very meaningful and accurate sense, therapy *is* diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than the intellect of the clinician (p. 223)."

Despite the objections of Rogers and others, there remain a number of counselling theorists who consider diagnosis (or something very like it) nearly unavoidable. Tyler (1961), for example, concludes that the "attempt on the part of the counsellor to see the whole picture, whether we call it diagnosis or not, and whether it results in prognosis or not, is an important activity of the counsellor (p. 63)." Similarly, McGowan and Schmidt (1962) argue that "a certain amount of diagnosis takes place within all counselling interviews, but there is a great difference in the need for and emphasis given to diagnosis from client to client (p. 339)." These apologists for diagnostic counselling typically construe diagnosis in its weaker, more probabilistic, descriptive sense or what Tyler has called a "working image." They rightly de-emphasize any omniscient connotations the "diagnosis" may have acquired, but affirm the necessity for some intellective interpretation of the data of counselling. The necessity of diagnosis, in even its weakest sense, is perhaps most evident in the initial, selection decisions confronted by every counsellor, namely, Does this individual *need* counselling?, Should this individual be referred to another treatment specialist or facility?, etc. These either-or, forced-choice decisions obviously demand something like a diagnostic commitment on the part of the counsellor — in spite of the awesome responsibility that it entails.

Beyond these diagnostic selection or placement decisions, there are those who consider counselling a continuous diagnostic activity. As one writer (Weiner, 1959) puts it, the task of the counsellor "may be conceived of as a never-ending series of diagnostic evaluations during the course of therapy (p. 110)." This meaning of "diagnosis" in the counselling process would appear to be so inclusive that it renders "diagnosis" the near equivalent of "cognition."

The position of counsellors regarding the place of diagnosis within the counselling process ranges then from unconditional rejection as an inappropriate, even counter-therapeutic model of disease, to complete acceptance as a necessary, even continuous, therapeutic activity.

And while this issue may represent a fundamental conflict between counselling theories and orientations, there is reason to believe that the lack of common definitional ground is more than partially responsible for the problem's survival.

RESUME: Cet article revoit le problème longtemps débattu du rôle et de la place du diagnostic à l'intérieur du processus de counseling. La controverse découle et est maintenue par la variété des fonctions attribuées au diagnostic, variété qui s'étend du diagnostic compris comme (1) modèle explicatif d'une dynamique maladive à (2) celui provenant d'une description sommaire des symptômes qui sont en corrélation. L'auteur présente des arguments selon lesquels les positions irréconciliables de la consultation centrée-sur-le-client versus la consultation basée sur un diagnostic ont été en grande partie entretenues par l'incapacité de résoudre les ambiguïtés au niveau des définitions mêmes.

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La Société Canadienne d'Orientation et de Consultation a décidé cette année d'attribuer un prix à la meilleure thèse et au meilleur mémoire présentés depuis les deux dernières années. Il y a aussi un prix pour le meilleur article de recherche publié durant la même période de temps. Bien que ces prix ne comprennent pas une récompense monétaire, un bref hommage sera rendu aux récipiendaires à l'occasion du Congrès national de la SCOC à Vancouver, en juin 1975.

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Les auteurs d'articles de recherche devront soumettre neuf (9) tirés-à-part ou photocopies de leurs articles. Les auteurs de mémoires ou de thèses devront soumettre neuf (9) copies d'un résumé de 2,500 mots effectué selon les normes de publication indiquées dans le *APA Publication Manual.* Ce résumé devrait être tel qu'il pourrait être publié. Tout résumé devrait être dactylographié à double interlignes, soit en français ou en anglais.

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La page titre devrait inclure les informations suivantes (a) le nom du candidat; (b) son adresse; (c) son numéro de téléphone; (d) le titre complet du mémoire ou de la thèse; (e) le nom de l'institution où le grade est obtenu; (f) l'adresse de l'institution; (g) les noms et adresses du président et des membres du jury; (h) la date de la soutenance orale; (i) la date d'attribution du grade par l'université.

8. *A qui doit-on faire parvenir les résumés ou les articles?*

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9. *Quelle sera la procédure d'évaluation des candidatures?*

(a) Le Comité des Prix sera composé du président de la SCOC, du président élu et des co-présidents du Comité de la Recherche;

(b) Chacun des articles ou résumés sera lu par au moins trois membres de la SCOC choisis par le Comité des Prix;

(c) Les finalistes de chacune des trois catégories de prix seront constitués par le petit groupe de candidats dont les travaux auront reçus la cote "excellent". Le Comité des Prix demandera alors à trois membres de la SCOC de former trois petits comités de membres qui ne faisaient pas partie des comités de thèse des finalistes. Un comité verra à la sélection du meilleur mémoire, un second choisira la meilleure thèse et un troisième comité choisira le meilleur article de recherche parmi ceux soumis par les finalistes.