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DIAGNOSIS IN LOGOTHERAPY: OVERVIEW AND SUGGESTIONS FOR APPROPRIATE USE

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(ABSTRACT) *Some may perceive diagnosis in logotherapy (and all psychotherapy) as a necessary evil. A shorthand of symptom clusters is needed so that mental health professionals can communicate in concise and coherent ways. However, principles of diagnosis and logotherapy often appear to be incompatible: diagnosis is inherently reductionistic and does not recognize resources as well as the deficit areas. This paper outlines the benefits and criticisms of diagnosis, offers a logotherapeutic model of diagnosis, and presents suggestions for the logotherapist in carefully using diagnosis with clients.*

Attempts to classify medical and psychological conditions have been ongoing for thousands of years since the time of Hippocrates and Aristotle.[3,5,20,21] Today, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the predominant classification tool of mental health professionals.[5] The DSM has expanded tremendously since it was first published in 1952, with revisions in 1968, 1980, 1987, 1994, and 2000. The most recent edition is the DSM-IV-TR (Text Revision).[1] The first two editions of the DSM were largely theoretical, not based on research, containing nebulous and unreliable diagnostic criteria.[3,5,16,20] The DSM-III (1980), -III-R (1987), and particularly –IV's (1994) largely atheoretical and empirical focus led to widespread use by mental health professionals from diverse training backgrounds.[3,5,16,20] These latter recent editions of the DSM, including the current DSM-IV-TR, use a multiaxial classification system that allows for more systematic evaluation of the client on an individual level.[5,20] In the DSM-IV-TR, Axis I allows for notation of clinical disorders and other conditions that are a focus of clinical attention (excluding personality disorders and mental retardation).[1] DSM-IV-TR Axis I clinical disorders include anxiety disorders, depressive disorders, substance-related disorders, and adjustment disorders, to name a few. Examples of other conditions that may be a focus of clinical attention include occupational, academic, and

spiritual/religious problems, among others. Other axes afford opportunities to document personality disorders and mental retardation (Axis II), general medical conditions related to a mental health diagnosis (Axis III), psychosocial and environmental problems associated with a diagnosis (Axis IV), and Global Assessment of Functioning (Axis V), a rating of the client's well-being as appraised by a clinician.[1]

The Value of Diagnosis

Diagnosis is an essential means of communication in the field of mental health.[3,5,20] It helps organize information and observations and facilitates research and treatment.[3,5,20] Ideally, a diagnostic system should organize data in such a way as to suggest possible etiologies and courses of treatment.[3,5,20] There are benefits of knowing one's diagnosis (relief, disability benefits, academic accommodations), and once a person understands the diagnosis, then a proactive plan for dealing with the problem may be undertaken (logotherapy may be of particular use in this latter context).

Although some symptoms/diagnoses have limited cross-cultural application, and accurate cross-cultural diagnosis depends heavily on clinicians who may lack the necessary training,[12] there is literature that points to some symptoms and diagnoses having cross-cultural utility. Greater attention is being paid also to cultural issues in recent editions of the DSM, including the importance of cultural identity, culture-specific syndromes, and the meaning of symptoms in relation to the norms of the person's culture.[3,5,12,16]

Criticisms of Diagnosis

There are a variety of concerns that relate to the diagnosis of mental health problems. Often diagnosis can be difficult due to the accuracy of client self-reports, limited availability of clinical information (the diagnostic picture may change based on new information), or making diagnostic distinctions. For example, comorbidity (the coexistence of multiple disorders) is not well understood and its prevalence continues to be problematic.[5,20,21] Along these lines, does a person with multiple diagnoses actually have more than one mental health condition, or does the person have one mental health problem being addressed with more than one diagnosis? [5,21] Comorbidity may be due to a variety of factors (e.g., some diagnoses share common symptoms or may share a common causal factor); however, it may also be a conceptual problem of a diagnostic system where multiple diagnoses are assigned to a single diagnosis.[5] Such a conceptual problem may result in over-diagnosis or misdiagnosis that may cause problems for the client (e.g., someone receives treatment they don't need for a diagnosis they don't have, or does not receive the correct treatment for a condition that they do have). For further information regarding sources of diagnostic error, the interested reader is referred to Kirk and Kutchins.[14]

Diagnosis may also result in stigma for some people.[3,5] Over-identification with a label may result in a loss of individual information and could threaten a person's sense of individual control and responsibility. In some cases, clients may "hide" behind the label in an attempt to avoid responsibility. For example, one of the authors (SES), while working in a treatment facility geared toward therapeutic intervention of adolescent male sex offenders with mental retardation/developmental disabilities, noted that some of these youths attempted to justify their continued sexual offenses, given their various diagnoses related to sexual offending behavior (as if to say: "I am a sex offender and this is what I do"). Issues of choice and responsibility were a critical focus of treatment efforts.

The DSM-IV-TR is a categorical diagnostic tool (a disorder is present or a disorder is not present), as opposed to a dimensional one (symptoms existing on a continuum).[20,21] This distinction, in and of itself, is controversial. Categorical systems for diagnosis are prominent for a variety of reasons. They are largely derived from the medical field and have a lengthy history extending back to Hippocrates, human beings have a tendency to categorize, and many mental health decisions are categorical (e.g., yes or no diagnostic/treatment decisions).[5,21] Criticisms have been leveled against categorical systems. For instance, although seemingly leading to clear-cut diagnoses, categories do not effectively address the early appearance of a disorder, some clients may be disabled by a pattern of symptoms that does not meet formal criteria for a categorical diagnosis, and it is not uncommon to find that the boundaries between various categorical diagnoses are not clear cut.[5,20,21] A dimensional approach is of interest given the focus on symptom extremes. By way of example, whereas a categorical approach would view a personality disorder as a distinctly different entity from "normal" functioning, a dimensional approach to understanding a personality disorder would consider it as maladaptive extremes of traits that all human beings possess to varying degrees. The debate over categorical versus dimensional classification continues and has resulted in empirical scrutiny (see, for example, Widiger and Coker for a review).[21]

Diagnosis can be criticized from a specific logotherapeutic perspective as well. First, diagnosis is inherently reductionistic, thus it does not honor the whole human being.[22] Because the act of making a diagnosis is a reductionistic process, logotherapists must use caution to insure that they do not mistake the diagnosis for the living complex human being sitting before them. Second, Frankl cautioned against misdiagnosis as it may lead to iatrogenic, or clinician-caused problems.[9] Finally, diagnosis, in general, does not typically document the positive qualities or resources the client possesses. Although attempts to diagnostically identify strengths are being developed (see, for example, Lopez and Snyder, Peterson and Seligman, and Seligman),[15,17,19] these methods do not fully embrace the noetic dimension (uniqueness of the client, spiritual resources that are yet to be discovered, etc.).

Improving Diagnostic Accuracy

Recent editions of the DSM have enhanced the detail in descriptions of categories and clinical symptoms, and thus have improved psychometric properties.[3,5,16] As a case in point, such improvements benefit the inter-rater reliability of diagnostic categories. Studying and expanding the psychometric properties of the DSM is an ongoing enterprise. Despite advancements over the years, there continues to be a number of pitfalls to the diagnostic process. Clinicians need to be judicious in all phases of diagnosis in order to enhance their accuracy.

Clinicians may work to improve diagnostic accuracy in a number of ways. Clinicians need to be appropriately trained, familiar with cross-cultural and ethical issues, and cognizant of developmental and environmental variables that influence behavior.[5,12] Use of structured questionnaires is one means of helping to facilitate diagnostic reliability and validity.[5,13] Clinicians may also improve diagnostic accuracy by avoiding premature decision making, examining alternative hypotheses, looking for disconfirming data, considering base-rate information, gathering systematic data from multiple sources, and exploring their own biases and tendencies so they do not distort the diagnostic process.[3,5,13] Clinicians should use diagnostic and assessment tools that are reliable, valid, and that have clinical relevance and utility.[3,5,13]

Diagnosis and Logotherapy

A DSM-IV-TR diagnosis, while descriptive, does not honor the full range and detail a logotherapist needs to understand when treating a client. Other diagnostic classifications, such as the *International Classification of Diseases* (ICD), offer more description for the somatic range of conditions, but do not assess the noetic dimension. Newer schemes of classification, such as signature strengths,[17] touch the noetic dimension by discussing positive resources of the individual, but do not fully account for the resources of the noetic dimension. Viktor Frankl's diagnostic scheme, summarized by DuBois,[4] focuses on the etiology of conditions. Considering Frankl's contributions in this area as a foundation, there may be a need to address all dimensions (Somatic through Noetic) simultaneously. In addition, it is important for the model to incorporate assessment of client strengths, in order to better provide therapeutic direction for logotherapists.

A Bio-Psycho-Social-Spiritual Diagnostic Scheme

Logotherapy calls for holistic diagnosis. This may be termed a bio-psycho-social-spiritual diagnostic process. The diagnostic process includes four categories: assessment tools used, symptoms, resources, and treatment planning. Each of these categories is applied to the dimensions of the individual: Somatic or biological, Psyche or psychological and social functioning, and Noetic or existential/spiritual functioning. A matrix of these domains may be formed with the dimension being assessed on the vertical axis and the categories of assessment on the horizontal axis (see table).

Bio-Psycho-Social-Spiritual Diagnosis Matrix				
	Assessment tools	Symptoms (problems)	Resources	Treatment Plan
Somatic- biological				
Psyche – psychological				
Psyche – social				
Noetic – spiritual				

At the Somatic or biological dimension, the diagnostic assessment begins with an interview using client report. A thorough medical exam may be required to rule out physical causes of impairment, or to treat physical symptoms that may coincide with non-physically based symptoms. Symptoms may include medical disease symptoms, as well as poor diet, insufficient exercise, etc. Resources in the biological dimension include good health and energy. The Somatic level may or may not be a focus of treatment. It is important to note that even if the Somatic dimension is not the primary cause – treatment at this level may be warranted (e.g., encouraging exercise for someone who is depressed).

Assessment of Psyche typically includes a clinical interview, including a review of such areas as family and social history, as well as academic and occupational functioning. Standardized assessment tools administered and interpreted by clinicians trained in their psychometric properties, appropriate uses, and limitations (e.g., an objective personality inventory) are often necessary to aid in the clarification of the diagnostic picture. The symptoms assessed include the full range of psychological symptoms such as depression, anxiety, and anger. Resources may include a positive history of emotional balance, high intelligence, and a history of "making it through difficult times." The psychological dimension is usually a focus of treatment. A critical subset of the psychological assessment is social functioning. Symptoms of difficulty with social functioning may include loneliness and feeling alienated from others. Resources include the social support system the client already has (actual and perceived), as well as the skills in developing relationships and the ability to be empathic. Often the social dimension is a focus of treatment.

The interview is also a cornerstone in the assessment of the Noetic dimension; however, tools administered and interpreted by trained individuals, measures with established psychometric properties such as the Purpose in Life test and the Life Purpose Questionnaire,[2,11] may be of added assistance. Noetic symptoms may include existential vacuum, despondency (pain, guilt, death) and despair (depression, aggression, and addiction). Frankl and Graber provide explanations of these symptoms.[6,7,8,10] Noetic resources include previous coping, values the client holds, and potential meanings the client may discover (e.g., an artistic interest the client held long

ago, but has “forgotten” in his or her current life). Often the Noetic dimension is a focus of treatment. Even if the symptoms presented are not primarily in the Noetic dimension, it is possible to use resources of the Noetic dimension to treat other symptoms. For example, chronic back pain may be first treated with medication and or surgery, but if these do not relieve the pain, then Noetic interventions to live fully with the pain may be appropriate. One of the authors (MRW) has developed a worksheet and example for using this diagnostic scheme. Those interested in these materials are encouraged to contact him.

Providing Diagnostic Feedback to Clients

Given the impact that a diagnosis can have on a person, clinicians should take great care in formulating and communicating diagnoses.[5,20] Logotherapy’s given emphases on choice, responsibility, and hope can play important roles in providing diagnostic feedback to clients. Here the approach is one of empowerment, and on what clients can do in order to address their difficulties. As discussed in another article in this issue of the Forum,[18] a logotherapeutic approach to feedback stresses the importance of people addressing their difficulties without internalizing their diagnoses, while at the same time taking responsibility, striving to make adaptive choices, and working with mental health professionals as indicated. A logotherapeutic approach to providing diagnostic feedback may help to inoculate clients against threats to their meaning potentials and galvanize them toward a more positive outlook.[18] Specifically, the following is recommended regarding communicating diagnoses to clients:

1. Always use care with diagnosis (i.e., avoid casual use of diagnosis, or use of diagnostic terms without full and careful explanation of the diagnosis).
2. Explain the ramifications of a diagnosis provided to insurance companies (it may be passed on to future insurance carriers, etc.).
3. If a client asks about a diagnosis, a logotherapist should provide a personalized assessment of the client’s problems and include an assessment of the client’s strengths (the resources that will help the client overcome his or her difficulties).
4. When discussing diagnosis with a client, a logotherapist should be sure there is a clear treatment goal at the heart of the discussion. In discussing the diagnosis, it is important to assist clients in understanding the nature of symptomatology, but most important is the challenge of the logotherapist to explain that the treatment is based on the person as a unique individual with unique resources.
5. If a client has been diagnosed previously – this may be a point of therapeutic discussion – it is important to learn what

they were told about the diagnosis and how they feel about having that diagnosis. It is key for clients to be aware that their logotherapists see them as much more than the set of symptoms described in the diagnosis.

Summarizing Comments

Diagnosis is a necessary communication tool in any psychotherapy. However, diagnosis as shorthand simplifies a complex human being with problems and strengths to a "code." There is a substantial literature on the value and criticisms of diagnosis. A model of diagnosis to account for the myriad levels of human existence was briefly presented and described. Finally, suggestions for discussing diagnosis with clients were presented. Logotherapists should work to balance the need for diagnosis with the problems associated with its use.

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