Chapter draft for F. Kaslow (Ed.) *Relational Diagnosis*, Wiley, 1996.

Is Diagnosis a Disaster?: A Constructionist Trialogue

- Kenneth J. Gergen, PhD
- Lynn Hoffman, MSW
- Harlene Anderson, PhD

For some time the three of us have been deeply engaged in exploring the implications of a social constructionist view of knowledge for therapeutic practice. From a constructionist standpoint, our languages for describing and explaining the world (and ourselves) are not derived from or demanded by whatever is the case. Rather, our languages of description and explanation are produced, sustained, and/or abandoned within processes of human interaction. Further, our languages are constituent features of cultural pattern. They are embedded within relationships in such a way that to change the language would be to alter the relationship. To abandon the concepts of romance, love, marriage and commitment, for example, would be to alter the forms of cultural life; to obliterate the languages of consciousness, choice, or deliberation would render meaningless our present patterns of praise and blame, along with our courts of law. By the same token, as we generate new languages in our professions, and disseminate them within the culture, so do we insinuate ourselves into daily relations - for good or ill. It is against this backdrop that the three of us wish to consider the issue of diagnosis in general, and relational diagnosis in particular. We opt for the trialogic conversation as a means of vivifying in practice (as well as in content) the constructionist emphasis on meaning through relationship.

KJG: I find myself increasingly alarmed by the expansion and intensification of diagnosis in this century. At the turn of the century our system for classifying mental disorders was quite rudimentary in terminology and not broadly accepted. However as the century has unfolded, the terminology has expanded exponentially, and public consciousness of mental deficit terminology has grown acute. In the 1929 publication of Israel Wechsler's The Neuroses, a group of approximately a dozen psychological disorders were identified. With the 1938 publication of the Manual of Psychiatry and Mental Hygiene (Rosanoff, 1938), some 40 psychogenic disturbances were recognized. (It is interesting to note that many of the terms included therin, such as paresthetic hysteria, and autonomic hysteria have since dropped from common usage, and some of them - such as moral deficiency, vagabondage, misanthropy, and masturbation - now seem quaint or obviously prejudicial. In 1952, with the American Psychiatric Association's publication of the first Diagnostic and Statistical Manual of Mental Disorders (APA, 1952) some 50-60 different psychogenic disturbances were identified. By 1987 - only twenty years later - the manual had gone through three revisions. With the publication of DSM IIIR (APA, 1987) the number of recognized illnesses more than tripled (hovering between 180-200 depending on choice of definitional boundaries). DSM IV expands the list even further (APA, 1994).
At the present time, one may be classified as mentally ill by virtue of cocaine

intoxication, caffeine intoxication, the use of hallucinogens, voyeurism, transvestism, sexual aversion, the inhibition of orgasm, gambling, academic problems, antisocial behavior, bereavement, and noncompliance with medical treatment. Numerous additions to the standardized nomenclature continuously appear in professional writings to the public. Consider, for example, seasonal affective disorder, stress, burnout, erotomania, the harlequin complex, and so on. What, we might ask, are the upper limits for classifying people in terms of deficits?

As these terminologies are disseminated to the public - through classrooms, popular magazines, television and film dramas, and the like - they become available for understanding ourselves and others. They are, after all, the "terms of the experts," and if one wishes to do the right thing, they become languages of choice for understanding or labeling people (including the self) in daily life. Terms such as depression, paranoia, attention deficit disorder, sociopathic, and schizophrenia have become essential entries in the vocabulary of the educated person. And, when the terms are applied in daily life they have substantial effects - in narrowing the explanation to the level of the individual, stigmatizing, and obscuring the contribution of other factors (including the demands of economic life, media images, and traditions of individual evaluation) to the actions in question. Further, when these terms are used to construct the self, they suggest that one should seek professional treatment. In this sense, the development and dissemination of the terminology by the profession acts to create a population of people who will seek professional help. And, as more professionals are required - as they have been in increasing numbers over the century - so is there pressure to increase the vocabulary. Elsewhere (Gergen, 1994) I have called this a "cycle of progressive infirmity."

LH: Ken's thinking has been most helpful in my particular struggles to find a way out of the naming bind, which is the belief that in order to be helpful about a complaint, you have to describe it and name it. The describing and naming makes it real. Medical practitioners have been so successful in creating a taxonomy of physical distress that psychological professionals have sought to follow suit.

There is an implicit contradiction between the non-essentialist stance of social construction theory and the present volume on relational diagnosis. If social construction theory challenges psychobiological naming systems, it also challenges the descriptive truth of a relational syllabary. None of these self-confirming systems of naming provide a comfortable resting place for the social constructionist. At the same time, what is to become of the profession of family therapy if it doesn't join in the practice of naming? The threatened extinction of our way of life is at stake.

Trying to think why I was drawn to social constructionism, I reflected that I had been through several "diagnostic worldviews" in my lifetime, each more convincing than the last, and was beginning to see this as evidence of a very relativistic and joking cosmic God. As far as psychology was concerned, I had come of age in total innocence. The community of left-wing artists I grew up in had their own brand of qualifying phrases: reactionary, fascist, business man, Republican, Philistine. Only when I got to college did I find out about neuroses and psychoses and "mental illness." My earlier worldview took a hit, in addition to which I found that many of the new terms could describe myself. My discovery of the family therapy movement,

which took the onus off the person and put it on the "system," was therefore a great relief.

I felt pleased with myself as the family systems movement gathered speed. Then I was challenged again. I discovered an article by a scholar from Ontario, Gerald Erickson (1988) who attacked systemic thinking from a postmodern point of view. As I scrambled to read about these new ideas, I realized that all of the models in the family therapy field had great failings. They were all modernist and mistaken. There were no systems out there, no patterns that connect, no levels, no structures waiting to be observed. For me this kind of thinking put an end to diagnostics of any kind. This is a bit tongue in cheek, but I assure you that each epistemological earthquake leaves enormous damage in its wake. Every time you build a world of ideas or join one, it is like a screening device that limits you from seeing other worlds. Out of sight are those you left behind or those you uneasily suspect may lie ahead. There is also a gathering coherence that seems to go with the territory. As time passes, this coherence may become increasingly well defined and more fully knit. That is why it is only necessary to damage one piece of a world to bring down many related structures.

Nevertheless, these worlds have enormous resiliency. In my lifetime, in the field I am in, I have been shaken by earthquakes several times. I have tended to move on to a new community, but many of the inhabitants of the old ones have rebuilt and gone on as before. It takes an earthquake that strikes at a deep structure level, like finances, to mark historic change. The health care upheaval, for better or worse, has given one of the cities in my field a mandate to be the capital. Gathered under the medicalized roof of DSM IV, we find an attempt to enumerate and describe all existing problems of behavior: life problems, death problems, mind problems, disease problems, poverty problems, class problems, violence problems, sex problems, work problems, love problems. We see the proliferation of pathological titles Ken has talked about, and there seems no upper limit on what can be absorbed into the system of naming.

At the same time, I think this may be the good fortune of family therapists. Conditions that are "merely" relational have been exempted from inclusion in DSM IV, except for a brief nod to a relationship-oriented axis that may not even be reimbursed. So perhaps we have been rescued from the "rage to order." Harlene Anderson (1994) and Ken Hardy (1994) were recently asked to answer the charge that family therapy would be marginalized unless it became more identified with the "major disciplines" in mental health (Shields, Wynne and Gawinski, 1994). So much the better, they said. Only by remaining the one health industry that does not give people labels or diagnose conditions, can it represent an important stream of evolution in the field. That is my position too.

HA: The passionate plea for the inclusion of relational diagnoses in the DSMIV locates family therapy within psychiatric discourse, with its medical heritage, its aspiration to mimic natural sciences, and its modernist, positivist disposition. This is understandable. As Ken suggests, diagnostic systems give a sense of legitimacy, confidence and predictability both to the professional and to the client. In both psychotherapy and the broader culture, a diagnosis implies that the object of inquiry and the method of inquiry are gbased on stable assumptions like those in the

biomedical realm. It operates as a professional code which ahas the function of gathering, analyzing and ordering waiting-to-be-discovered data. As similarities and patterns are found, problems are then fitted into a deficit-based system of categories. In a larger sense, this framework is bassed on the assumption that language is representational and can accuragtely depict "reality." Whin I think of diagnosis, I think of cybernetician, Heinz von Foerster's remark, "Believing is seeing."
Implicit in the DSM IV is the assumption that psychotherapy is a relationship between an expert who has knowledge and a non-expert who needs help. The public, the profession and the state have given authority ot the therapist to collect information about the client and place it on a pre determined therapist map from which the diagnosis is then derived and the treatment plan decided. This process reduces uncertainty by telling the therapist what the therapist ought to do and suggesting how the client ought to change in order to get well.
From a postmodern pserspective, a relational or "between persons" diagnosis is no different from an individual or "within-the -person" diagnosis. The inclusion of family therapy criteria for "behavioral health" would simply place a new layer of labels upon an old one. For political, economic, and legitimation reasons, this would be a great step forward for family therapy, but in terms of its heritage as an alternative explanatory view, it constitutes a great step back. Simply to assume that the issue is a question of an individual versus a relational classification is to oversimplify a set of complex, ever changing human dynamics.
If one approaches these questions from a postmodern, social constructionist perspective, these are no longer relevant questions. Social constructionism frees one to think in terms of individuals-in relationship rather than an individual-relationship dichotomy. It also locates psychological knowledge in a sociohistorical context and treats it as a form of discursive activity (Danziger, 1990, Luria, 1971; Gergen, 1973, 1985). Discursive activity refers to Wittgenstein's (1962) challenge to see language as representational - an expression of the nature of things - and his alternative idea that we generate descriptions and explanations in the means of coordinating ourselves with each other. It is the language that constructs what we take to be the person and the relationship. Diagnoses, for instance, are socially constructed meanings put forth by the dominant professional culture. A diagnosis is an agreement in language to make sense of some behavior or event in a certain way. But a social constructionist perspective warns us that this kind of agreement may mislead us into holding the diagnosis to be true. Is it the diagnostic reality we should be treating in therapy? Social constructionism invites alternative questions: What is the intent of a diagnosis? What questions are believed to be answered by diagnosis? What information is thought to be gained? What does one want a diagnosis to communicate and to whom? If there are many ways to think about, to describe what may be thought of as the same thing (i.e., behaviors, feeling), how can we respect and work within all realities? Should we consider the possibility of multiple diagnoses? How can we bring the client into the process? How can, and is it possible, for a diagnosis to be meaningful for all involved? How can it be collaborative, tailored to the individual, useful? What other words can we use? If we reject diagnostic terms, should we try to persuade the helping system to change its nosology? How do we develop a way in which multiverses can co-exist?

If one views life as dynamic, unstable, and unpredictable then inquiry about it must be ever active. If one views knowledge as socially created and knowledge and knowers as interdependent, then it makes sense to include the client in the diagnostic process. This moves diagnosis from the realm of a private discourse to a shared inquiry in which diagnosis becomes a mutual discovery process.

In a serendipitous way clients have become involved in creating their own diagnoses and ideas about treatment. Our culture-bound human nature compels us to want to know what is wrong, to have a name for a problem. With the help of the media, diagnostic language and preferred treatments have leaked into the public domain. We all have clients who come in with self-diagnoses such as "co-dependent" and "adult child of an alcoholic" and clients who request Prozac for depression or a twelve step group for addiction. I question, however, whether these self-diagnoses do not often yield unworkable problems for both the client and the professional. Diagnoses, official and unofficial, often concretize identities that limit people; they create black boxes with few, obscure exits; and they form obstacles to more viable and liberating self definitions (Anderson, 1992).

I recently talked with a couple who had appeared on a television talk show focused on gender issues in couples. The show's guest expert had diagnosed the husband as "irresponsible" (an individual description), the wife as an "adult survivor of childhood incest" (an individual description) and the couple as "co-dependent" (a relational description). When I saw them they were embroiled in a battle to make him responsible, to promote her "survivorhood" and to make them independent of each other. They were prisoners of diagnosis-created unworkable problems. Or, as Ken Gergen suggests, every move they made was dysfunctionalized. This is the tyranny of diagnosis.

Thinking of therapy and diagnosis from a postmodern social constructionist perspective redefines the therapist-client relationship and challenges professional knowledge. It moves therapy from a relationship between a knower and on who is ignorant to a collaborative partnership in which the deciding of, the exploring of, and the "solving" of problems is a process of shared inquiry in which the diagnosis is not fixed and the problem may shift and dissolve over time. It invites the client's voice and their expertise on their lived experiences. Bringing in the client's voice - the words and terms that have significance for the client - gives productive life to everyday language. The yield is a more jointly created and thus more cooperative language, that generates more possibilities than professional vocabularies - based on pre-knowledge that produces lifeless, sterile look-a-likes - and suppresses the uniqueness of the individual client's narrative (Anderson, 1992). A constructionist stance favors a more mutual, personalized knowledge. This view of therapy and diagnosis entails uncertainty, and I realize that some might question this ethic of uncertainty, but I question the ethic of certainty.

This is why I do not favor adding a "relational diagnosis" to the one already in use. Kaslow (1993) envisages the "formulation of a language and a typology that can be utilized, with a high degree of consensus about definitions and criteria sets, based on solid reasearch findings, by family therapists emanating from many disciplines and theoretical persuasions" wich would eventuate in a "validated nosology of relational disorders." There are many reasons, both theoretical and practical, for doubting this

possibility; and there are many reasons for arguing against such an end. Like Ken and Lynn, I suggest that rather than talk about a relational diagnositic system, we need to consider new and more promising directions for family therapy and psychology.
Of course this leaves us shaken. Many questions are left hanging. What do therapists do with their professional knowledge and past experience? How do we then communicate with professional colleagues, clients and insurance companies? The ethical questions that face us in this new era of managed health care are far broader and more daunting, for instance, than simply whether submissions for insurance reimbursement are factually correct.

KJG: As I have been deliberating on your comments, Lynn and Harlene, I have been trying to take the role of an essentialist, diagnostician, and asking myself what questions I would raise. One of these is a question I have often faced myself, and it concerns the existence of what we would generally take to be "the real world." In more homely fashion, one asks "isn't there something these terms refer to, and aren't these kinds of behaviors deeply problematic both for the individuals (or families) as well as the society? We must have some way to talk about these patterns within our profession, some way to share our knowledge of effective treatment. So don't we require just these forms of terminology?" And, such an interrogator might add, we need such terms even if we agree with the constructionist argument that these may not be the only or the most accurate ways of describing such actions.
I would view this as a reasonable question, granting that we spend most of our time in cultural traditions where the "real world" counts. However, granting in this sense that there is "something these terms refer to," the question becomes, as you suggest Harlene, whether and for what we require the professional labels? At the outset, the argument simply doesn't hold that the diagnostic terms describe observable behaviors. None of our terms, either from DSM IV, or from the newly developing vocabulary of relational diagnosis, actually refer to the specific movements of people's bodies through time and space, the sounds they emit, the liquids or smells they exude - or anything else we could assess with a set of mechanical instruments. Rather, they refer to hypothetical processes, mechanisms, or purposes lying behind or served by a set of behaviors. If I say an individual is "depressed," based on a set of items from a depression inventory, it is not the checkmarks on the paper to which I am referring but what these checkmarks suggest about a state of mind. Yet, I have no access to a state of mind; this I presume a priori (or you might say, because of the particular myths about the mind which I inherit from cultural history.) In the same way, I don't as a therapist observe dysfunctional behavior. I observe behavior which I label as dysfunctional given a set of values which I hold about what is functional. To be sure, these are academic arguments simply designed to deflate the presumption that professional labels have unambiguous referents (see also Sarbin and Mancuso, 1980; Wiener, 1991). However, shortly I will propose that because of this problem, the therapeutic community stands in great danger.
Now, if our labels are but scantily tied to observables, the question of "why label" takes on new dimensions. We can not say that we need the labels to communicate professionally about the cases we confront, because there is no grounds to believe that what you mean (in terms of specific behavior) by "oppositional defiant disorder,"

or "partner relational problem" is the same thing that anyone else means; and should we agree, there is no means of substantiating this conclusion outside our local agreement. Thus, the diagnostic terms help us to think that we are all working on the same phenomena, but this is to create a false sense of security. Do the professional diagnoses then help the client? Surely this is the most significant question we should be asking. There is reason for debate here, for some clients may indeed prefer the security of a professional term to replace what they feel are their own floundering attempts to comprehend. The availability of the diagnosis suggests that such cases are possibly common, well known, well understood, and quite effectively treatable. And, while to give a diagnosis under such conditions would be an act of bad faith on the therapist's part, there might be ameliorative placebo effects.

At this point I am drawn to the wisdom of Harlene's comments concerning the ever-shifting character of daily activity, the communal construction of meaning, and the ways in which languages function in daily life. For, it might be asked, in the long run is it not a greater contribution to the lives of our clients (and indeed our own), if we have multiple ways of understanding our activities, if we can see how different groups might describe what we do, if we understand how these various descriptions add or subtract from life's quality? Most of us are fully aware that we ourselves are too complex to slot into categories, that relationships are subject to infinite interpretation, that the same actions and the same descriptions may mean different things at different times and with different consequences. Would we not wish our clients to take advantage of these forms of cultural wisdom? In whose service do we "freeze the frame?"

Earlier I mentioned the possibility of danger. Both Lynn and Harlene endorse a field of family therapy that is unique in its avoidance of a professional nosology, a field that in my opinion would thus be at the cultural forefront. In the long run there is reason to believe that the other helping professions will follow suite. For there is much grass roots antipathy developing for the kinds of diagnoses to which patients have been exposed over the years, organizations of ex-mental patients who feel they have been ill served by the practices of the mental health professions (Chamberlin, 1990), and feminist groups who feel women to be victims of the existing nosologies (see, for example, Caplan, 1987; 1991). And there are professionals from around the globe who (like us) feel that diagnostics are more injurious than helpful. The day will soon come (and indeed I will lend my efforts to the outcome) in which those who require assistance for their problems will bring formal litigation against those who diagnose. When diagnostic categories become part of one's permanent records, and such records become available for various evaluative purposes, the mental health profession will have no legitimate grounds on which to defend the practice of diagnosis.

LH: I agree with your warnings, Ken and Harlene, about the harmfulness of diagnostic labeling, or what I call "psychiatric hate speech". To find out what is actually experienced as hateful, I have been experimenting with consultations in workshops. I will talk with a therapist about a family situation (I have abandoned the term "case") while the family is sitting there overhearing us. I will then ask the family to comment on our conversation. Next I will ask the audience, in small groups, to

arrive at some ideas to reflect back to the family. The groups take turns telling me their ideas, which I write down on a flipchart, but only after these are filtered through family members' reactions. This has been a very interesting procedure, in that we create a family-sensitive set of descriptions rather than the usual professional ones imposed from outside. I remember one incident involving a stormy couple who couldn't stay together and couldn't stay apart. One audience group had commented that the couple seemed to have an addiction to crisis. Another group, referring to a local spot which was known as the Bungee Capital of North America, likened their relationship to a pair of married bungee jumpers. The couple objected to the first idea, but warmly accepted the second. Operations like this replace the usual expert model for diagnosis with a less pejorative one.

In doing homework for this piece, I found myself examining some of the more relational schemes for diagnosis. One that actually made it into the DSM IV (1994), at least into the Appendix, is family psychiatrist Lyman Wynne's "Global Assessment of Family Functioning Scale" (GARF) which parallels the "Global Assessment of Functioning Scale" (GAF) for individuals, reported under Axis V. GARF reflects the early thinking about family therapy that was based on the idea that the family is a "system", that is, a unit composed of subparts acting interdependently upon each other. This analogy was apparently contributed by Talcott Parsons (1951), whose normative model for family functioning was a powerful image in the field until recently, when the late psychologist Harold Goolishian (1988) challenged it.

Another effort to create a relational framework for diagnosis has been offered by Karl Tomm (1991), a psychiatrist from Canada. Tomm believes that a family in which there is a patient is one in which the communication is dominated by harmful patterns. These patterns are not produced by the family system per se, but are a result of vicious cycles in which efforts to stop the pattern only reinforce it. Tomm calls these sequences Pathological Interpersonal Patterns (PIPs), and sees therapy as a matter of replacing them with Healing Interpersonal Pattern (HIPs). As a constructionist, I find both Wynne's and Tomm's formulations an improvement on DSM IV's categories in that they are not so unkind to the individual, but I still feel uncomfortable with their assumption of an ontologically transparent pathology.

Fortunately, the recent jump to a narrative analogy has put diagnosis on a new track. This track jettisons the notion of an objective assessment of pathology, preferring to think of these formulations as stories, or forms of discourse. In one swift shift of metaphor, we are catapulted into a postmodern universe where "reality" is placed in quotes. White and Epston (1990), among others, shoved the canoe from the bank by opposing the "problem-saturated" story and joining forces with the family to find a new, more hopeful one. A kindred soul to White is Chris Kinman of British Columbia. In working with First Nations youth, Kinman has been very concerned to help create alternatives to the usual stereotyped pictures of problematic teens. While trying to come up with a narrative based set of diagnostic tools, he has been experimenting with the term "discourse," using it to frame the situation of a young client by locating it under headings like, "Discourses of Youth and Peers" or "Discourses of Youth and School" (Kinman and Sanders, 1994). These descriptions are arrived at by conversations with the individual in question and with other people in the family or community.

I mention these efforts because even though many of us deplore the psychiatric profession's extraordinary attempt to cover all bases in a grab for territory, the appearance of DSM IV has acted as a most important gadfly. The field of family therapy seems to have been preparing itself for this fight in view of the increasingly swift acceptance of a social constructionist and narrative point of view.

I would like to make one last point in saying that this constructionist view is congruent with the movement toward user friendliness in family therapy (Reimers and Treacher, 1995). A recent news report on malpractice suits against medical practitioners found that the number of suits correlated with a poor "bedside manner": those who take time with their patients, listen attentively to them, and show kindness, are sued far less often than their brusquer counterparts. In an era of managed care, the client's story is going to be listened to more carefully, and there will be a move toward including the user in the conversation, especially the conversation around diagnosis.

At the same time, even when I disagree with a position, I like to join with what is already in place. In this respect, I find that the structuring of diagnosis around axes of varying hues offers a useful starting point. It is easy to imagine this format transforming into a Roshomon-like array of differing perspectives. Customers could have a special axis to themselves or a separate place to comment on each axis. Since the process of definition is the primary framing act of any kind of therapy or consultation, it deserves as much time as is needed. Attention to this aspect seems to me crucial, not only in exposing the bedrock nature of therapy as a political as opposed to a medical event, but in allowing all parties to have their day in court.

HA: I am particularly captured by Ken and Lynn's interest in the client's voice--the ways in which some clients either jointly through organized associations or singularly through the courts are securing an arena for the consumers' sentiments and grievances. Ken speaks of the days of litigation to come. I think they have already begun. Media reports of patients suing therapists (and winning) are no longer an anomaly. We read reports of patients who sued therapists for creating false memory syndromes and multiple personalities. Recently parents sued their sixteen year old daughter's therapist for not thoroughly investigating her accusations of sexual abuse. Such actions threaten the false sense of security that diagnosis gives the professional and highlight the complexity of human behavior and interactions. Likewise, such actions shout the importance of guaranteeing the consumer's voice, be it client, insurance company, managed health care agent or therapist.

Like Lynn, I am drawn to the hope that a narrative perspective can provide a possible relief from the deficiency and illness language in the mental health field. Narrative understanding takes into account the beliefs and intentions and the narrative histories and contexts that underpin, shape and give significance to those actions. As such, narrative understanding offers the possibility of understanding, and equally important, not understanding the actions of others. I would like to echo Goolishian's comment in his plenary paper for the Houston Galveston Institute's conference, The Dis-diseasing of Mental Health, held in October, 1991. He said, "We must rely on the capacity that people have for the narrative construction of their life and we must redefine therapy as a skill in participating in that process...It will take more than

relational language...We must develop a language of description that moves us out of the linguistic black hole in which we are now captured." Inspired by Wittgenstein's words in Culture and Value:

Nobody can truthfully say of himself that he is filth.
Because if I do say it, though it can be true in some
sense, this is not a truth by which I myself can be penetrated;
otherwise I should have to go mad or change myself.

Goolishian continued, "Our languages of description are not only normative but they have, over the years, ended up forcing socially constructed self narratives on our clients of uselessness and filth." Is it possible that as a result they often select the option "to go mad?"

KJG: One hope that the three of us shared in this effort, was that the trialogue as a form of writing would itself demonstrate some of the advantages of a constructionist orientation to relational diagnosis. What happens if we depart from monologue (which parallels the singular voice of diagnostic labeling practices) and approach a multi-vocal conversation (favored by the constructionist)? In some degree I think we have made good on this hope, inasmuch as each of us has brought a unique voice to the table, drawing from different experiences, relationships, and literatures. Our case is richer by virtue of our joint-participation. At the same time, because there is so much general agreement among us, the trialogic form hasn't blossomed in fullest degree. We have not yet cashed in on its catalytic potential.

To explore this possibility, I want to focus on a point of disagreement. How can we treat conflict within this conversational space in a way that is different from a monological orientation (where the interlocutor typically shields internal conflicts in favor of achieving full coherence)? The fact is that I do not in the case of diagnostics favor Lynn's preference for joining "what is already in place." As she points out, "the process of definition is the primary framing act of any kind of therapy or consultation," and, by virtue of our various critiques, proposes to multiply the range of definitions, even to include those of the clients themselves. Perhaps I feel more critical toward diagnosis, but I ask, if it is injurious to our "clients," why join what is in place? Why should we accept the process of definition as a primary feature of therapy or consultation?

Now I realize that it is perhaps easier for me to take this strong position, because I am not a therapist and do not depend on maintaining the therapeutic traditions for my livelihood. I need not be so concerned with what is already in place because I have fewer worries about what it does to my relationships within the tradition (and my family) should I deviate sharply from it. And too, we have already seen Lynn's concern that the profession maintain itself in a realistic world of competition with the more diagnostically prone mental health professionals. Thus, as a constructionist I must understand the intelligibility of Lynn's preferences in terms of the relational matrix in which she lives. And vice versa. But where does such recognition take us? And, to play out the parallels with professional-client relations, what might follow if both the professional and the client realized the parochial nature of various diagnostic

labels, respecting each other but realizing that such understandings represent only one tradition among many?

There is no single answer to these queries. The more general question of how to go on in a world of multiple and conflicting realities is as profound as it is complex. However, let me suggest that at least one possibility in the present instance is to locate an alternative intelligibility with which we can both live comfortably. I am thinking here primarily in terms of clinical practices. It seems to me that we might share in the belief that the process of labeling may sometimes have value, that it is sometimes injurious, but that it is not essential to the process of therapy. That is, therapeutic efficacy does not depend chiefly on slotting clients into a set of predetermined and publicly acknowledged categories. If we could agree on this assumption, then we might ask whether it would be possible to establish some form of "no fault" insurance coverage for therapy. Such policies have been a major boon to divorce courts, where establishing the original source of marital problems has proved impossible. We enter much the same thicket in attempting to diagnose "the problem" in cases of most human suffering. If insurance companies no longer required diagnoses for third party therapy billings, then diagnosis could become optional - available when useful but not essential for treatment. If every insured party in a given insurance plan had the right to a limited number of consultations, then the fact that the individual (or family) felt their suffering was severe enough to demand professional attention might be sufficient. Might we explore the possibilities together of instituting such policies across the mental health professions?

Reflexively speaking, it seems to me that our present trialogue has now managed to press our joint thinking on these topics forward - so that the three of us are changed during the course of our conversation. I am not in precisely the same place I was when I entered the conversation. If this is so, is there not a lesson here for the traditional tendency in the profession toward monologue? Diagnostic labeling has a way of "stopping the conversation." The professional announces "you are X" or "Y" and there is no obvious means of the diagnosis being transformed by the subsequent conversation with the client. Monologue insulates itself from change; diagnostics radically truncate the possibilities for therapeutic transformation.

HA: Ken suggests that our trialogue has not created the catalytic potential that hoped to achieve. For me, it has created more thoughts than my written words reveal. I have more of a dialogue in my head about diagnosis, and I frequently bring the issues of diagnosis into my conversations with colleagues and students. As in therapy, is the catalytic potential ever visible? Can our words on paper further the dialogue about diagnosis for others? I hope so.

I will tell a story about a case that vividly illustrates the complexities of human problems and how diagnosis and diagnosis driven treatment can oversimplify and exacerbate them: "I asked my daughter, why do you have this exotic white woman’s disease?" These words were spoken by the exasperated father of Joan, a sixteen year old Afro American girl who, in her efforts to control her weight, was starving herself to death. She met the essential criteria for Anorexia Nervosa. Joan was hospitalized a year ago at a private psychiatric hospital where her treatment included individual, family and adolescent group therapy. She was discharged after 30 days when her

psychiatric hospitalization insurance benefits were exhausted and admitted to a private hospital medical unit where her problem was diagnosed as a medical disorder. She was discharged after one week when the insurance company challenged the medical diagnosis, having determined it was a preesxisting psychiatric diagnosis, and therefore denying coverage.

The hospital physician urged the family to commit their daughter to a county charity psychiatric hospital where she could receive psychiatric care for 30 days at no charge. The family refused. The physician said that Joan was "the most difficult" and "the most devious anorectic" that he had treated. He feared she would "slip through the cracks" if she did not receive continuous inpatient psychiatric treatment. His fear was corroborated by her and the family's behaviors. In talking about the family he said frustratedly," We're not on the same page of the book. No, we're not even in the same book." He believed that the father's responses did not match the daughter's life-threatening illness, and his belief was validated each time the father, who was a minister, talked about spirituality and expressed his faith in his daughter's "finding her way" and "trusting the process." The physician was also frustrated with and puzzled by the family's insincerity and by a family in which the father was more absorbed with the daughter's eating disorder than the mother. He said the father's calmness, as he described the father carrying his limp daughter into the hospital emergency room, was "bizarre."

Two weeks after the medical hospital discharge Joan drank a bottle of syrub to induce vomiting, and began vomiting uncontrollably. Her parents took her to the county charity hospital where she was admitted because the staff thought Joan was suicidal. Joan insisted that she was not trying to kill herself. In the county hospital she had individual therapy and was discharged after two weeks with the condition that her family agree to engage in intensive family therapy. She was referred to a private psychiatric clinic whose intake screened her out because the insurance benefits were exhausted. The private clinic, in turn, referred Joan to a nonprofit counseling center. The referral was made to a specific therapist-in-training who the intake person at the private clinic knew had personal experience with an eating disorder. Joan's parents took her to see the counseling center therapist where it was agreed that the therapist would continue to see Joan and that the parents would meet with the therapist whenever the therapist, Joan, or the parents felt it necessary.

The family continued to consult their family physician who felt Joan's problem was out of his realm of expertise. He referred Joan -- simultaneously with the referral to the nonprofit counseling center -- to a private practice therapist who specialized in eating disorders. The family took Joan to the specialist who added the diagnosis Major Depression, Single Episode and initiated individual therapy for Joan and family therapy for her and her parents. He too said that the family was "the most bizarre family I have ever seen." He felt that Joan had "too much power over her parents" and was "victim" of, and in turn was "acting out her parent's estrangement and conflict." When he found out that the parents had authorized a home-bound school program for Joan he warned the counseling center therapist that "Joan must go to school...don't you know that anorectics manipulate and isolate." He saw the school decision as evidence that Joan had too much power over her parents and now the counseling center therapist and her supervisor.

The private therapist continued to see Joan and the family and the counseling center therapist continued to see Joan, sometimes twice a week, and to occasionally meet with members of her family in different combinations. Who came to the sessions depended on what as being talked about and who wanted to come. The counseling center therapist thought the parents were cooperative. They always kept their appointments and often requested additional appointments. Dad usually brought Joan to the sessions because mother worked and went to college.

Joan talked with the counseling center therapist frequently about the people who were "bugging" her by trying to be helpful. Referring to a previous therapist, Joan said, "He thought he knew all about me just because I'm an anorectic." She talked about how he confronted her and accused her of being secretive, isolating, and dishonest. She wished people would let her be herself.

The therapist asked curiously, "How do I treat you?" Joan said, "I like working with you because you don't treat me like I'm an anorectic. You let me by myself." Joan talked about how she wanted to be a teenager with teenage problems, how she was worried about the way she expressed her anger, and how ill at ease she was with what her peers were doing. She expressed anxiety about social awkwardness, boys, the dark, being lonely, expectations at home that she should take care of her younger brothers, taking up slack for chores her sister did not do, and wanting a job to earn some money. She said she felt like an "ugly duckling" and that people always commented on how pretty her sister was. She said, "I want to be an individual where others cannot copy me." Joan expressed concern about her parent's relationship, worrying that they were "so distant" and that "mom buries herself in her work" and described how her mother's "stacks of paper had taken over the house." She expressed her worry about how her parents get "so stirred up" when they talk with the eating disorder therapist.

The therapist's curiosity about the father's question, "Why do you have this exotic white woman's disease?" led her to learn that the family lived in an all white neighborhood and that Joan had all white friends. (Joan did not see the racial issue as a problem the way her father and brother did). She learned that the father was a prominent black minister and that the mother was a devout Catholic. The daughter went to church with the mother and the son went to church with the father. The father, persuaded by his religious beliefs, felt that the daughter's illness was "the work of the devil." "All things happen for a purpose...God is testing her strength," he said, and he backed up his belief with Biblical quotes. He was firm in his belief that "This is something she is working out..I trust her that she will work through this..trust her to make decisions about what is best for her..to find her own way."

The mother seemed genuinely concerned, "I want Joan to feel that I am here for her." (Of course, Joan thought the mother was "intrusive.") The mother hoped that the therapist could "help Joan with her emotions" and could "help Joan talk with the family about what is really bothering her." Joan's sister, like her mother, thought it would be helpful "if she would just talk to us about it."

Joan's older brother pinpointed the stressful relationship between Joan and her younger sister as the culprit. He felt strongly that if they were in a school where the majority of students were black that Joan, and her sister as well, would not have problems or the split between them because "In an all black school you have to stick

together to protect yourself." He had several other thoughts about Joan's problem -- all relating to cultural issues. He agreed with the dad that, "Black girls don't have anorexia."

In reflecting on her work with Joan and her family, the counseling center therapist said, "At first I took the diagnosis that the family and I had inherited seriously. I believed it. Influenced by my preconceptions of anorectics as rigid, controlling, isolating, perfectionists, I did not question the psychiatrist's and the eating disorder specialist's opinions and recommendations. I tried hard to help Joan and her family. I tried to talk with Joan and her family about the diagnosis and convince them of the experts' opinions on the individual and family dynamics associated with anorexia nervosa. The harder I tried, the worse Joan became, and the more upset and worried I became."

Like the others before her, the more the therapist tried to treat the diagnosis the more fmaily members acted in ways that verified her preconceptions about anorectics and their families and hence confirmed the diagnoisis. Frustration mounted until, as the therapist put it, "As I got to know Joan and her family, I gradually realized that I was getting to know another Joan, another mother, and another father. My interest in what they were concerned about led to conversations in which Joan and her family found causes and answers that were meaningful to them. To my surprise I too was beginning to trust that Joan would find her answers and her own way. I realized that I was seeing and hearing the person not an anorectic and a dysfunctional family."

Through the therapist's inquisitivenss about each person's ideas, she learned far more about the family and its members than simply pursuing what the diagnosis permits. The dysfunctional nonsense of their actions and beliefs now made sense. As the therapy with Joan and her family illustrates, there are as many definitions of "a problem," including what casued it and its imagined solutions, as there are people in conversation about the problem. And these ideas can change over time.

As I think about Joan and her family I keep returning to the notions of monologue and dialogue that Ken mentioned. Embedded in my earlier comments is a bias toward the process, or the essence, of therapy as a dialogue. Diagnosis is part of this dialogue. Preconceptions can lead a therapist to an inner monologue and can lead to dueling monologues between client and therapist - and among professionals. The therapist's ability to question and not hold onto her preconceptions allowed her to be open and curious about others. Joan and her family and the therapist joined in dialogue - a conversational process involving a shared inquiry that led to shifts in the "proble m" amd mew possibilities for all of them. This leads me to Lynn's comment on joining.

I am not sure if by joining Lynn means agreeing with or using as a starting point for conversation. Nevertheless, I do not believe that diagnosis or problem defining necessarily need to be part of the therapy, although clients do usually want to talk about their problem. That is why they come. How problems and solutions emerge and dissolve through dialogue, however, is beyond the scope of this trialogue. (See Anderson and Goolishian, 1988; and Anderson, 1995.) I agree that thinking of diagnosis in terms of either-or oversimplifies and clouds. Several questions have been intimated in this discussion on diagnosis and I think are worth highlighting. If there is a diagnostic process, toward what aim and who determines that aim? What

meaning does the diagnosis have for each person involved? Most importantly, what meaning does it have for the client? Is it a useful meaning? Is it respectful? Does it allow for the opening of doors - the creation of potentials - or does it close doors and restrict possibilities? Does it perpetuate the problem? Does it create new problems? These are the questions we should confront prior to developing yet a new range of diagnositics.

Lynn mentioned managed health care. I think that managed health are will further marginalize the client's voice. Managed health care is already dictating and policing diagnoses. It is not unusual for a managed health care company to refuse to authorize services except for the diagnosis assigned by their case manager. Therapy is not only a political and a medical event but also an economic event. But this leads us to another topic.

LH: It does seem that the conversation is now taking us into new spaces. The question I have is whether the shift would have happened if I had not "joined the opposition" or if Ken had not chosen to "disagree"? If we had used a debate format from the outset, with each person taking a different side, could we have reached this point earlier? Catherine Bateson said at a recent conference that to have the kind of improvisational conversation she finds useful, people first have to establish that they have a common code. So perhaps it is a matter of stages. What do the two of you think?

In response to Harlene's last comments, it seems to me that therapists struggling to find a niche in managed care apparently see no other way out but to stay within the diagnostic framework. Although I have opted out of this framework. I felt that I should put myself back in to represent their "side." But I think Harlene is right to say that this shift toward the medical metaphor not only distances us from our customers but makes us less effective. Then, since no one admits to the metaphor, we throw in mystification as well. I am glad, Harlene, that you included such a vivid story to illustrate the dilemma.

I also greatly liked Ken's idea of "no fault" psychotherapy. With this suggestion, he has put himself in the category of "causal agnostic." I got this term from a recent Nobel prize winner, the economist Ronald Coase (Passell, 1991), who pioneered the idea that you didn't have to establish cause in cases of conflict over, say, responsibility for pollution. If you left it to the parties themselves to figure out, they would probably come up with a more workable solution on their own. The idea of exchanging air rights is an example. Coases' kind of thinking, like Ken's, starts to give everybody breathing room.

What is especially interesting here is that what Ken is advocating is already coming to pass. The cutting edge of family therapy is moving away from a concern with problems and their causes. The brief solution oriented approaches that have gained such popularity and the narrative approach of Michael White are future-oriented, except for ways in which the past predicts what White (1989) calls "unique outcomes." An even more extreme version of that position, of course, is the "not knowing" stance of the late Harry Goolishian and Harlene. The therapist who takes that stance does not concern herself with causes except to the degree that they form part of different people's stories. She assumes that the complaint would not have

come to her attention if it had been embedded in ways of talking that were helpful. The focus is therefore as much on changing the style of the conversation as on what the conversation is about.

Another idea that I think might shake things up is to divest ourselves of the corpus of thought known as modern psychology or the study of the "psyche." The idea of the psyche is useful because "it" is presented as a representation of an entity sitting inside the person like a tiny foetus. This makes it easy to think of "it" as susceptible to failure, breakdown or distortions in growing. However, during psychology's period of supremacy in this modernist century it has failed to present any classification of disorders equal to that which medical research and practice has come up with. The most cursory look at DSM IV shows it to be built on cobwebs. This is because "invisible illnesses," as I call them, are not analogous to disorders expressed in the body and are not, therefore, susceptible to category and measurement. It is an exercise in absurdity to claim that they are.

It is interesting to think of getting rid of the whole extended family: "psychology", "psychiatry," "psychotherapy" and the like. Ken has already done a brilliant job in contesting many of these concepts, together with their assumptions about the reality of the "self." For instance, he has suggested that psychology, in its explanation for emotional distress, is wedded to a dubious belief in the stages a so-called "psyche" must go through to be properly mature. Psychiatry, when it is not being as medical as possible, continues to subscribe to this idea of an intrapsychic unit, even though it is no more persuasive than Descartes' little homunculus. As for psychotherapy, the word and what it has represented are undergoing rapid change. Since the middle of this century, I have been watching the course of what I call the social therapies (based on ideas about relational difficulties) as opposed to the psychological therapies (based on assumptions of intrapsychic dysfunction). It may well be that counseling, assuming that it is not stamped out by managed care, will eventually end up in the social camp, leaving psychiatry and psychology to the material world of memory, chemical imbalance, and genes.

Calling counseling a "social therapy" at least enlarges its scope. This widening process started with the anti-psychiatry movement of the mid-twentieth century, for which we may thank rebel philosophers like Thomas Szasz (1974) and R.D. Laing (1971). Family therapy, the bastard mutant that came into being around the same time, has been another source of change. There have been successive widenings since that original impulse, representing an effort to include progressively more of the social context. One could say that family therapy was only stage one; stage two highlighted the professional context; throwing gender into the ring moved us to the level of the society; and now the concern with multicultural issues is pushing us to include inter-societal issues world wide.

There is still a conservative element in the family field which has kept a version of developmental theory on which to base its ideas about dysfunction and cure. By this I mean the life stage template on which various versions of what I call "family repression theory" have been played out. This theory includes all explanations for emotional distress supposedly caused by repressed or unresolved memories. Family therapy orientations that locate reasons for problems in losses that have not been grieved, anger that has been suppressed, or untold family secrets, fall into that

category. This psychodynamic template is also enshrined in widespread folk beliefs about the relationship between expressing emotions and mental health. But the free radicals in family therapy have always been those who rejected the emotional repression theories for a more interpersonal focus on communication and exchange. In any case, the three of us represent the position of a growing number of relational therapists and researchers who are willing to challenge the use of labels for mental disorder and the expansionist push to medicalize the whole enterprise. Our hit list includes all and any diagnostic systems - biological, psychological, or relational - that have been proposed. If we could but cease our psychologizing, perhaps the discipline of therapeutic conversation could be released from the grip of Newtonian science and placed under the aegis of language arts, where we believe it belongs.

References

- American Psychiatric Association (1952) Diagnostic and statistical manual for mental disorders, First ed. Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association (1987) Diagnostic and statistical manual for mental disorders, Third ed. revised. Washington: D.C.: American Psychiatric Association.
- American Psychiatric Association (1994) Diagnostic and statistical manual for mental disorders, Fourth ed. Washington, D.C.: American Psychiatric Association.
- Anderson, H. (1992) C therapy and the F word. American Family Therapy Association Newsletter. 50, 19-22.
- Anderson, H. (1994) Rethinking family therapy: A delicate balance. Journal of Marital and Family Therapy, 20, 145-150.
- Anderson, H. (1995) Collaborative language systems: Toward a postmodern therapy. In R. Mikesell, Lusterman, D.D., and McDaniel, S. (Eds.) Intergrating family therapy: Handbook of family psychology and systems therapy. Washington, DC: American Psychological Association.
- Anderson, H. and Goolishian, H. (1988) Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. Family Process, 27, 371-393.
- Anderson, H. and Goolishian, H.A. (1992) The client is the expert: A not-knowing approach to therapy. In S. McNamee and K. Gergen (Eds.) Therapy as Social Construction. London: Sage.
- Caplan, P.J. (1987) The myth of women's masochism. New York: Signet.
- Caplan, P.J. (1991) What's happening these days with the DSM? Feminism and Psychology, 1, 317-319.
- Chamberlin, J. (1990) The ex-patients' movement: Where we've been and where we're going. Journal of Mind and Behavior. 11, 323 336.
- Danziger, K (1990) Constructing the subject: Historical origins of psychological research. New York: Cambridge University Press.
- Erickson, G. (1988) Against the grain: Decentering family therapy. American Journal of Marital and Family Therapy, 14, 225-236.

- Gergen, K.J. (1973) Social psychology as history. Journal of Personality and Social Psychology, 26, 309-320.
- Gergen, K.J. (1985) The social constructionist movement in modern psychology. American Psychologist, 40, 266-275.
- Gergen, K.J. (1994) Realities and relationships, soundings in social construction. Cambridge: Harvard University Press.
- Hardy, K. (1994) Marginalization or development? A response to Shields, Wynne, and Gawinski. Journal of Marital and Family Therapy, 20, 139-144
- Kaslow, F.W. (1993) Relational diagnosis: An idea whose time has come? Family Process, 32, 255-259.
- Kinman, C. and Sanders, C (1994) Unraveling addiction mythologies. Sardis, BC: Valley Education and Therapy Services.
- Laing, R.D. ans Esterson, A. (1971) Sanity, madness and the family. New York: Basic Books.
- Parsons, T. (1951) The social system. Glencoe, Il: Free Press.
- Passell, P. (1991) For a common-sense economist, a Nobel - And an impact on the law. Profile of economist Ronald Coase, "The Week in Review", New York Times, Oct. 20, pg.2
- Reimers, S. and Treacher, A (1995) Introducing user friendly family therapy. London: Routledge.
- Rosanoff, A.J. (1938) Manual of psychiatry and mental hygiene. New York: Wiley.
- Sarbin, T., and Mancuso, J. (1980) Schizophrenia: Medical diagnosis or verdict? Elmsford, N.Y: Pergamon.
- Shields, C., Wynne, L. and Gawinski, B (1994) The marginalization of family therapy: A historical and continuing problem. Journal of Marital annd Family Therapy, 20, 117-139.
- Szasz, T. (1974) The myth of mental illness. New York: Harper and Rowe.
- Tomm, K. (1991) Beginning of a 'HIPs' and 'PIPs' approach to psychiatric asssessment. The Calgary Participator, 1, 21-24.
- Weschler, I. (1929) The neuroses. Philadephia: Saunders.
- White, M. (1989) The externalizing of the problem and the re-authoring of lives and relationships. In Selected Papers. Adelaide: Dulwich Centre Publications.
- White, M. and Epston, D. (1990) Narrative means to therapeutic ends. New York: Norton.
- Wiener. M. (1991) Schizophrenia: a defective, deficient, disrupted, disorganized concept. In W.Flack, D. Miller, and M. Wiener (Eds.) What is schizophrenia? New York: Springer-Verlag.
- Wittgenstein, L. (1953) Philosophical investigations. Oxford: Blackwell.
- Wittgenstein, L. (1980) Culture and value. Oxford: Blackwell.

She was treated with a diagnosis of acute respiratory infections without improvement. Shortness of breath increased, body temperature increased to 39.00Đ¡, although chest pains on the left decreased. Objectively: the condition is satisfactory.Â 3. Differential diagnosis is carried out with nonspecific pleurisy. In favor of tuberculous etiology is evidenced by A wide variety of technologies and tools are involved in the diagnostic process (see Figure 5-1), but the primary focus of the chapter is on health information technology (health IT) tools. Health IT covers a broad range of technologies used in health care, including electronic health records (EHRs), clinical decision support, patient engagement tools, computerized provider order entry, laboratory and medical imaging information systems, health information exchanges, and medical devices. A diagnosis that may be present, but further evaluation is needed before ruling in or ruling out the diagnosis. For example, during a first session with a client I may see and hear about some anxiety and depression symptoms that have occurred foll...Â Answered 3 years ago Â· Author has 366 answers and 484.2K answer views. A diagnosis that may be present, but further evaluation is needed before ruling in or ruling out the diagnosis. For example, during a first session with a client I may see and hear about some anxiety and depression symptoms that have occurred following a significant change in the client's life. I may diagnose Adjustment Disorder with mixed depression and anxiety, r/o Depressive disorder, r/o Anxiety disorder. Diagnosing GAD and PD requires a broad differential and caution to identify confounding variables and comorbid conditions. Screening and monitoring tools can be used to help make the diagnosis and monitor response to therapy. The GAD-7 and the Severity Measure for Panic Disorder are free diagnostic tools.Â Generalized anxiety disorder (GAD) and panic disorder (PD) are among the most common mental disorders in the United States, and they can negatively impact a patient's quality of life and disrupt important activities of daily living. Evidence suggests that the rates of missed diagnoses and misdiagnosis of GAD and PD are high, with symptoms often ascribed to physical causes.