Editorial: Role of Assessment and Diagnosis in Counseling

It is a pleasure to serve a second term as column editor for the Assessment and Diagnosis Column (henceforth "the Column") of the Journal of Counseling & Development. As noted in my initial editorial 3 years ago (Hohenshil, 1993a), this section of the Journal has enjoyed varying degrees of popularity over the last 30 plus years, largely reflecting the emphasis placed on testing in the counseling profession at any particular time. A number of outstanding leaders in the profession (David Tiedeman, Warren Findley, Gerald Hanna, Andrew Schauer, Charles Healy, Donald Zytowski, and Edward Watkins) have provided leadership for the Testing Column over the years. Although much of the emphasis in the early years of the Column was focused on test reviews, Watkins made a deliberate effort to move the content from a focus on test reviews to the broader concept of "assessment." Under his leadership, articles were published dealing with theoretical issues and topics in general assessment, as well as traditional test reviews. This change reflected a general trend away from selection-oriented prediction models in which test scores were used to "predict" various attributes (achievement, career choice, etc.) to more qualitative assessment techniques designed for exploration, self-knowledge, self-assessment, and diagnosis (Goldman, 1994; Hohenshil, 1993a; Zytowski, 1994).

During the last 3 years, the content of the Column was broadened even further by focusing attention on the use of assessment data in the diagnostic process and on various contemporary assessment issues. This led to a deemphasis on the publication of test reviews, because there are now numerous other good outlets for that type of material. Articles were published that dealt with the assessment and diagnosis of depression, dementia, personality disorders, attachment problems, multicultural assessment, racial identity, vocational assessment, and new developments with the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM-IV], American Psychiatric Association, 1994). The response of readers to the increasing emphasis of the Column on broad issues and the more qualitative features of assessment and diagnosis has been quite positive, and so it is my intention to continue this focus for the next 3 years. Upcoming articles will deal with such topics as assessment and diagnosis of a variety of child and adult behaviors (anxiety, sleep, sex, attention deficit, conduct, etc.), use of the Internet for assessment and diagnosis, uses and misuses of the DSM-IV system, and the attempt by psychologists to limit the assessment services provided by counselors, to mention a few.

SHOULD COUNSELORS DIAGNOSE?

Although the overall response to increasing the emphasis on diagnosis in the Column has been gratifying, there are many counselors who believe that our profession should follow the developmental model exclusively and, thus, not diagnose and treat pathology. They believe that the primary factor that distinguishes counseling from psychology and psychiatry is that counselors have traditionally provided services for those with normal developmental problems, and other disciplines should deal with clients with more severe mental disorders. They further believe that diagnosis contradicts some of the other accepted counseling models, especially the client-centered, humanistic, and family systems approaches (Denton, 1990; Gladding, 1992).

Although I recognize these traditional beliefs about the developmental nature of the counseling profession, the fact of the matter is that thousands of counselors in this country are currently employed in the private sector or by public mental health agencies, and they routinely diagnose and treat clients with both developmental problems and more serious mental disorders. These counselors are expected by their employers, licensing agencies, and insurance companies to know how to formally diagnose mental disorders as part of their practice. Furthermore, school counselors are becoming increasingly aware of the need to move beyond the developmental model because more students with severe learning, behavioral, and emotional difficulties are remaining in the public schools rather than dropping out or being placed in residential settings. In addition, knowledge of diagnostic criteria assists school counselors in knowing when to refer to other mental health professionals and helps them interact more effectively with those professionals in community mental health settings to which students and their families may be referred (Hohenshil, 1994).

Frankly, one could make the case that all counselors diagnose, either formally or informally. When developmentally oriented or client-centered counselors determine that the client's behavior is not pathological and thus appropriate for their counseling approach, this is a form of diagnosis in which the only two diagnostic categories are "normal developmental problem which we can help with" and...
more serious problem which we should refer to a psychologist or psychiatrist.” Career counselors also diagnose. For example, a client may have little knowledge of career information, the career decision-making process, and his or her own interests, aptitudes, values, and aspirations. On the basis of this information (the symptoms), the counselor may make the judgment (diagnosis) that the client is “vocationally immature” and implement a plan of career counseling (treatment) that is designed to help the client learn more about the world of work, his or her own interests, values, aptitudes, the career decision-making process, and so on, and thus become a more effective career decision maker.

**IS DIAGNOSIS MORE THAN A LABEL?**

Given that diagnostic skills are important for counselors, the question is often raised about the usefulness of diagnostic information. Some counselors believe that the purpose of diagnosis is merely to attach a label to a client to get paid for their professional services by health insurance companies. They believe that diagnosis is something that is done primarily for economic purposes and is not an integral part of the counseling process (Mead, 1994). Experienced counselors know, however, that a diagnosis serves the purpose of developing information that may lead to more effective methods of helping their clients. The relationship between diagnosis and treatment represents one of the major advantages of using a diagnostic system for counseling research is now at a level where we know which intervention techniques are most effective with various types of client problems (Seligman, 1990). If counselors do not diagnose effectively, regardless of the employment setting, how can the best treatment techniques be determined? Also, the diagnosis helps counselors to determine the effectiveness of intervention techniques used with a particular client. When a formal diagnosis is made, certain symptoms must exist; they must have existed for a designated period of time; and they must be severe enough to interfere significantly with the client’s life. As treatment progresses, the diagnosis serves as the benchmark against which counseling effectiveness can be measured. In other words, have the symptoms that led to the diagnosis been reduced or eliminated, and has the client’s level of functioning returned to a higher level (Hohenshil, 1993b)?

Another criticism of diagnosis is that the labeling process inherent with the major diagnostic systems has the potential for abuse. It is possible that an inappropriate label could follow a person throughout life, affecting family, social, educational, and occupational status. However, diagnostic decisions should be viewed as an evolving process, not a static event. Avoiding inappropriate labeling requires periodic reappraisal of the client’s mental status and the accurate updating of mental health records (Hohenshil, 1993b; Shea, 1991). Even under the best circumstances, however, using diagnostic labels remains a troubling issue for some counselors. It is their contention that labels cause the dehumanization of clients, which may lead them to devalue clients, discredit their concerns, and disengage from authentic interaction (Benson, Long, & Sporakowski, 1992). However, this position is a result of a common misconception that a classification of mental disorders classifies people, when what are actually being classified are disorders that people have. Thus, the authors of the DSM-IV (American Psychiatric Association, 1994) have developed some innovative ways to deal with the labeling issue. They recommend referring to clients as people with particular types of mental disorders, such as “a person with schizophrenia” or “a person with mental retardation,” rather than using terms like the “mentally retarded” or the “schizophrenics” when referring to their clients. Here the effort is first to recognize the client as a person, then second to recognize the client as a person who might have a disability. In this way, we are first identifying clients as valued human beings, and secondarily classifying mental disorders they may have. Using labeling in this way emphasizes that the mental disorder is only one characteristic of the individual, not a descriptor of the whole person (American Psychiatric Association, 1994).

**ROLE OF ASSESSMENT AND DIAGNOSIS IN THE COUNSELING PROCESS**

Testing, assessment, and diagnosis are integral components of the counseling process that are frequently misunderstood. In an effort to clarify the meaning of terminology that is frequently used in the Column, I devote the following section to defining the terms testing, assessment, and diagnosis and discussing their use in the counseling process. Although many counselors tend to use these terms almost interchangeably, there are significant differences among them. Assessment is the process of collecting information for use in the diagnostic process. Assessment data can be obtained through a variety of formal and informal techniques, including standardized tests, diagnostic interviews, projective personality measures, questionnaires, mental status examinations, checklists, behavioral observation, and reports by significant others (medical, educational, social, legal, etc.). Formal, standardized testing is only one of several ways to assess the client. Diagnosis, on the other hand, is the meaning or interpretation that is derived from assessment information when it is interpreted through the use of a diagnostic classification system (Hohenshil, 1993a). Diagnosis is not a process that occurs at a fixed point in time during the counseling process, nor is it a static concept. Testing, assessment, and diagnosis are intertwined throughout the six stages of the counseling process. The following is a brief description of how this occurs in actual practice.

**Stage 1: Referral**

Clients, regardless of the counseling setting, either self-refer or are referred by others. How a client comes to counseling is important, because it has implications for the
individual's motivation to change and the type of information that is available to the counselor in this first stage of the counseling process. The collection of important assessment data begins at this stage, and experienced counselors also begin to "hypothesize" about possible diagnoses or whether there is a diagnosable problem at all. Referral information is normally obtained through informal techniques such as self-reports by the client, through reports from significant others (parents, teachers, spouses, and friends), and through behavioral observation. Information might also be provided from various types of educational, medical, social, and legal records.

**Stage 2: Symptom Identification**
Identification of the client's symptoms is a critical part of the counseling process, for most currently used diagnostic systems are highly dependent on the identification of client symptoms. Some information about the type, duration, and severity of symptoms can be obtained from data generated through the referral process noted above. In addition, symptom information can be obtained through diagnostic interviews, problem checklists, mental status examinations, behavioral observation, medical evaluation, and psychological testing. It should be noted that in the major diagnostic system (DSM-IV), psychological testing is not actually required for the diagnosis of the majority of mental disorders, with the exception of mental retardation, learning disabilities, and some types of communication disorders. This is not to say that psychological testing cannot produce useful diagnostic information for other mental disorders listed in the DSM-IV, such as depression or anxiety, but it is not actually required. The DSM-IV is much more dependent on diagnostic interviewing, mental status examinations, behavioral observations, and reports by significant others than on formal psychological testing.

**Stage 3: Diagnosis**
Diagnosis is the process of comparing the symptoms exhibited by the client with the diagnostic criteria of some type of classification system. For example, counselors in private practice and mental health agencies use the DSM-IV classification system. School counselors might be involved with several classification systems, the most common being that for special education programming in the schools. And, as noted previously, many school counselors also find it necessary to become familiar with the DSM-IV system to help them determine when it is appropriate to refer students to other mental health professionals. Family counselors might favor yet another type of classification system for diagnosis that emphasizes family dysfunction, rather than the individually oriented DSM-IV system (Sporakowski, 1995).

**Stage 4: Treatment Planning**
Treatment planning requires accurate diagnoses because the intervention techniques selected to reduce the symptoms should correspond to the particular developmental problem or mental disorder. Although research on differential treatment techniques is relatively new, we are at a point where it is possible to determine the intervention techniques that are most effective with specific problem behaviors. The treatment plan normally includes a description of the behavior or disorder, both short- and long-term treatment objectives, interventions to be used, and the prognosis.

**Stage 5: Treatment**
The treatment techniques should follow the course outlined in the treatment plan. The counseling techniques, frequency of counseling, and the type or orientation of the counselor are important factors. After conclusion of successful treatment, the diagnosis may be changed because the symptoms may be in remission. Or, other disorders may become evident as counseling progresses, and additional diagnoses may need to be made. In any event, there is a fluid nature to the assessment, diagnostic, and treatment processes in which each cannot be considered independent of the others. Assessment data are especially important to assist in the determination of when termination is in order.

**Stage 6: Follow-Up**
Follow-up is important to determine if the symptoms remain in remission and if additional counseling is necessary. Assessment data here might include client self-reports, behavioral observation, and reports by significant others (Hohenshil, in press).

**DISCUSSION**
As noted earlier, counselors are extensively involved in assessment and diagnosis as part of the overall counseling process, regardless of their employment setting. Whether the counselor uses a highly formalized diagnostic system such as the DSM-IV or a more informal system, all counselors make decisions about clients that help guide selection of counseling interventions. Over the next 3 years, this Column will provide considerable assistance with this important component of the counseling process by publishing both solicited and unsolicited articles dealing with a variety of assessment and diagnostic issues. If readers are interested in sharing ideas and research through the development of a manuscript for possible publication in the Journal, please send by electronic mail (via Internet to thohen@vt.edu) a one-page proposal outlining the topic. It is interesting to note that, in preparation for editing this section of the Journal, a notice was sent to all major counseling listservs on the Internet soliciting manuscripts dealing with the topics mentioned at the beginning of this editorial. Although the power and potential of the Internet have always impressed me, I was surprised at the response. Within 24 hours, proposals were received from coast to coast, and as far away as South America and Europe. Several of these proposals were excellent, and the authors are now preparing their manuscripts. Potential uses of the Internet
for assessment and diagnosis may well be one of the most significant developments in counseling in the foreseeable future. This outstanding response indicates a high degree of interest in the areas of assessment and diagnosis and suggests that the next 3 years should be productive ones for this Column.

REFERENCES


Thomas H. Hohenshil, Column Editor