The Person Behind the Psychodiagnosis

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Abstract

Psychodiagnosis procedures have become more routinized in the practice of psychotherapy. This article looks at the person who performs a psychodiagnosis and identifies areas which have the potential to contaminate the psychodiagnostician's objectivity. The areas identified are psychodiagnostician's values, theoretical orientation, ability to judge, cultural influences, unconscious lures, and ethical considerations.

This article focuses on the person performing a psychodiagnosis and contends that even the best of psychodiagnostic procedures will never be fully objective because of the pervasive influence of the psychodiagnostician's personality upon these procedures.

Psychodiagnosticians are human beings applying a process that requires professional maturity and discipline when making motivational and behavioral judgments about another person (Seligman, 1986). As human beings, psychodiagnosticians can never be in complete control of those personality factors that can have a negative influence on the integrity and accuracy of the psychodiagnostic process. While the psychodiagnostic process has become more used in recent years (Seligman, 1986), its increased use has also produced critiques dealing with the possible inaccuracy of the process because of the influence of the psychodiagnostician's personality (Eysenck, 1986; Garfield, 1986; Robbins & Helzer, 1986; Boy, 1989; Cain, 1989; Moursund, 1990).

Issues Affecting Psychodiagnosis

Basic Values

The psychodiagnostician's values will have an effect on the psychodiagnostic process. These values will often influence how one responds (Kottler & Brown, 1985). Sometimes these values

are clearly known while at other times they are not. The psychodiagnostician may consciously know that he or she values honesty, hard work, and the rights of others. When a client also possesses these values, the psychodiagnostician may feel close to the client and the tone and texture of the psychodiagnosis may have a quality of empathy. The same psychodiagnostician may feel distant from another client who has no respect for honesty, hard work, and the rights of others and the tone and texture of the psychodiagnosis may contain little empathy. The possibility is high that a psychodiagnosis performed on a serene nursing home resident will be empathically different from one performed on an adolescent who was sexually abused as a child.

We may consciously know our values, and have some idea of those that may be hidden in our unconscious, but we often have great difficulty controlling the influence of those values and not allowing them to intrude on the objectivity of a psychodiagnosis. To keep values out of psychodiagnostic judgments is nearly impossible. The basis for many of our judgments is our system of values. Our values are too deeply ingrained into our personalities not to influence our judgments. They can intrude on the objectivity of a psychodiagnosis.

Theoretical Orientation

The psychodiagnostician's theory of personality will influence the tone, texture, and conclusions reached in a psychodiagnosis (Woody, Hansen, & Rossberg, 1989). A rational- emotive theory of personality (Ellis, 1962) has very different things to say about the causes and cures of human behavior than does the psychoanalytic viewpoint (Goldman & Milman, 1978). A psychodiagnosis performed by a rational-emotive clinician will, therefore, be very different from one performed by a clinician who is committed to the psychoanalytic viewpoint.

Anastasi (1982) points this out when she says that clinicians may often look for client data that support their own hypotheses:

> By the type of questions they ask and the way they formulate them or by subtle expressions of agreement or disagreement, they may influence what the client reports. Such biased data-gathering techniques probably account for the remarkably uniform etiologies found among the clients of some psychoanalysts (p. 489).

Arkes (1981) indicates that a clinician's theory of personality will often have a decided influence upon a psychodiagnosis. It may prove to be a more powerful influence than the data gathered. It can prompt the clinician not to add new data that could change his or her assessment of the client.

A psychodiagnosis is filtered through a theory of personality and, thus, is a reflection of that theory. It is difficult to avoid this influence. A psychodiagnosis is performed by a clinician whose training included an exposure to different theories of personality. While studying these theories, we become drawn to one or more which describe the causes and cures of human behavior in ways that make sense to us. As a psychodiagnosis is performed, the clinician is perceiving the data, or what the client is reporting, from the perspective of a particular theory of personality. When clinical judgments are made, they cannot avoid this influence; they become biased toward the theory of personality which best meets their needs and interests.

Objectivity and the Ability to Judge

We assume that a psychodiagnostician is objective and possesses the ability to judge a client's behavior as it is revealed through assessment instruments and face-to-face interviews. This may be a weak assumption if we examine the degree to which objectivity and judgment vary among clinicians (Seligman, 1986). Objectivity and the ability to judge are qualities not always present

among clinicians because of variances in their life experiences, values, intelligence, and educational backgrounds.

Corey (1986) and Brammer and Shostrom (1982) indicate that a psychodiagnosis may be problematic because of the difficulty involved in being truly objective when judging behavior. Kottler and Brown (1985) point out the problem when they state:

> Suppose a client presents symptoms of irrationality, listlessness, low energy, failed performances at work, lack of sex drive, and loss of appetite; these symptoms may be diagnosed in a number of ways ranging from anorexia nervosa to depression to an acute stress reaction. Errors are possible not only in the conclusion drawn about a case but also in the ways chosen for working with a client (p. 274).

Anastasi (1982) indicates why a clinician's judgment may be in error:

> A distinguished characteristic of clinical assessments is their reliance on judgment in at least some aspects of the process, the observer often relies upon assumed similarity to oneself (p. 488).

The ability to exercise objectivity and judgment implies that the psychodiagnostician is free from personality factors which have the capacity to impair the accuracy of the psychodiagnosis. Also implied is the transferability of that objectivity and judgment from one clinician to another. For example, it is assumed that the objectivity and judgment used in a psychodiagnosis made on client Jones should be the same whether it was performed by a rational-emotive clinician or by a psychoanalytic clinician. It is assumed that the clinicians would be in diagnostic agreement because both applied sound principles of objectivity and judgment. It is doubtful, however, that such theoretically different clinicians

would agree on common standards of objectivity and judgment; and if they could agree on these standards, their diagnoses would still be very different because of the different theories of personality they would apply.

In pointing out the lack of agreement that can occur when applying assumed standards of objectivity and judgment, George and Cristiani (1986) state that the most common examples are the:

> ...multitudes of professional opinions expressed in evaluating individuals who are on trial for various crimes, and the studies of individuals who are readmitted to hospitals for various mental conditions and are seen by different psychiatrists or psychologists. The diagnostic reliability among professionals in these cases seems to be lacking (p. 223).

Cultural Influences

Levine and Padilla (1980) state that a particular psychological disorder may not be identifiable when the psychodiagnostician is from a different culture than that of the client. They point out that a psychological disorder in the diagnostician's culture may not be considered as a disorder in the client's culture but the client becomes unjustly labeled.

Anastasi (1982) and Kottler and Brown (1985) indicate that the clinician's socio-economic background will influence what he or she hears and sees during the psychodiagnostic process. A middle class clinician has the potential to impose the values of that class when evaluating a client from a lower class. There is a tendency to judge behaviors according to the standards of the clinician's socio-economic class and this tendency will influence the objectivity of the psychodiagnostic process and the reports that flow from it.

Sue (1981) indicates that some clinicians include ethnic prejudices in their evaluations of clients. Sue gives the example of mental health professionals who judge that Asian Americans are the most emotionally repressed of all clients without an awareness

that in Asian American families the restraint of feelings is a much desired behavior as well as the reluctance to discuss personal issues and problems with persons outside the family.

Psychodiagnosticians are not immune from becoming socialized. They assimilate cultural attitudes and include them in their judgments about human behavior. Social influences exist and they affect us both personally and professionally (Torrey, 1974). They can influence the tone and texture of psychodiagnosis. It would be interesting to compare the tone and texture of a psychodiagnosis performed on Viet Nam veterans in 1970 with those performed more recently. It would be interesting to see if society's changing attitude toward the Viet Nam War is expressed by the psychodiagnoses performed at these different times.

Unconscious Lures

The psychogiagnostic process is directly derived from the medical model. While a medical practitioner performs a diagnosis on a concrete physical entity, the human body, the mental health clinician performs a psychodiagnosis on an abstract entity, the human psyche. There is also the assumption that the diagnostic instruments (personality tests and inventories) have an equivalent degree of validity and reliability as the technology used in a medical diagnosis.

Patterson and Eisenberg (1983), Ivey and Goncalves (1988) and Sherrard (1989) indicate that mental health's emergence as a profession has been hampered because of attempts to equate its processes and procedures with those of medicine. Some continue to emulate medicine because of the high degree of respect medicine has attained. The human psyche, however, cannot be diagnosed and treated with the same precision as the organic body. Further, medicine is not burdened with a range of clinical viewpoints. Medicine agrees, for example, on the causes and cures of appendicitis, while in the mental health profession there are

conflicting viewpoints, for example, regarding the causes and cures of depression.

There are additional unconscious lures that have been identified. They are the lure of pathology (Brammer & Shostrom, 1982), the lure of case histories (Corey, 1986), and the lure of being looked upon as an expert (Belkin, 1987). One who is unconsciously lured by pathology tends to be more interested in what is wrong with a client than what is right. Such persons enter the psychodiagnostic process intrigued by the desire to discover what may be wrong with a client and their psychodiagnostic outcomes usually reflect this interest. One who is lured by case histories tends to regard the family as the cause of most psychosocial disorders and focuses the psychodiagnostic process on reinforcing the premise of the family's influence. The lure of being considered an expert is sometimes the most difficult to avoid since ego needs can be overpowering. The problem of being an overconfident expert is cited by Arkes (1981) who points out that as clinicians are given more information about clients, they become more confident without being more accurate. Arkes (1981) also points out that the most confident judges tend to be the least accurate and that persons who consider themselves to be experts usually do not change errors made in a psychodiagnosis.

Ethical Considerations

As was pointed out, psychodiagnosis has become more routine for an increasing number of clients and patients in recent years (Seligman, 1983). A review of the literature, however, reveals the absence of new information, procedures, or breakthroughs to account for the increased application of psychodiagnosis (Ginter, 1989). Other reasons, however, are identified. Patterson (1985) indicates that behaviorists continue to stimulate interest in psychodiagnosis because of their traditional interest in stimulus and response patterns. Seligman (1983) links the interest to the accountability movement. Corey (1986) and Kottler and Brown

(1985) state that the recent interest may be due to the insurance requirement that reimbursement cannot occur unless the client's problem is classified through a known psychodiagnostic process. Some practitioners are fulfilling the insurance company requirement of a psychodiagnosis in order to be eligible for financial reimbursement rather than because of a belief in the accuracy of the process.

Conclusion

Since the personality of the psychodiagnostician will always have an influence on the psychodiagnostic process, we must exercise caution regarding what a psychodiagnosis tells us. Anastasi (1982) captures the essence of the problem when she says:

> Undoubtedly the objectivity and skill with which data are gathered and interpreted--and the resulting accuracy of predictions--vary widely with the abilities, personality, professional training, and experience of individual clinicians (p. 492).
>
> We regularly perceive the world in three dimensions without being able to specify the cues we employ in the process. Similarly, after exposure to a test protocol, a set of test scores, a case history, or a face-to-face interaction with a client, the clinician may assert that the patient is creative, or a likely suicide, or a poor psychotherapy risk, even though the clinician cannot verbalize the facts he or she used in reaching such a conclusion. Being unaware of the cues that mediated the inference, the clinician may also be unaware of the probabilistic nature of the inference and may feel more confidence in it than is justified (p. 490).

Those involved in the preservice and inservice education of mental health professionals must place emphasis on the degree to which idiosyncratic personality influences can undermine the

integrity of the psychodiagnostic process. We must never allow the psychodiagnostic process to become so hallowed that we stop raising questions about its presumed accuracy. We must especially recognize the degree to which a psychodiagnosis can be a reflection of the clinician's personality needs. As Fischer (1989) has said, "When one individual assesses another, that person inevitably uses his or her own life as access to the other person" (p. 167). The ancient admonition to "know thyself" remains critically important when one considers the degree to which a clinician's personality can influence the tone, texture, scope, and accuracy of a psychodiagnosis. Until we learn how to recognize, control and diminish the influence of the psychodiagnostician's personality, we must question the degree of objectivity contained in psychodiagnostic procedures and outcomes.

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