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THE SIGNIFICANCE OF DIAGNOSIS IN THE PSYCHOTHERAPEUTIC TREATMENT OF MENTAL DISORDERS

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Summary

Within the Polish psychotherapist community, there are differences of perspective regarding, among other things, the definition of psychotherapy, its training, and the role of diagnosis in the psychotherapeutic process. These differences have been particularly pronounced during the development of the Act on the Profession of the Psychotherapist. This article seeks to demonstrate the relevance of diagnosis in the psychotherapeutic process and to outline its forms. In the field of psychotherapy, diagnosis refers to three areas and three types of assessment: medical diagnosis (identification), psychological diagnosis, and therapeutic diagnosis. The aforementioned forms of diagnosis are not mutually exclusive and can therefore be used complementarily and employed narratively throughout the process of psychotherapy. The author also presents selected definitions of psychotherapy proposed by Polish psychotherapists Jerzy Aleksandrowicz, Czesław Czabała, and Bogdan de Barbaro. Furthermore, she engages in a debate on the role of diagnosis in psychotherapy with the perspectives of prominent U.S. psychotherapists such as Irvin Yalom, Harlene Anderson, Michael White, and David Epston. In doing so, the author draws upon her many years of clinical and therapeutic practice, whilst also acknowledging the differing opinions of other experienced practitioners.

Introduction

The way psychotherapy is thought about, the way it is defined, shapes how it is treated in practice, and consequently shapes the approach towards the training of psychotherapists as well as those who seek their help. At present (September 2025), there is no consensus within the Polish psychotherapeutic community regarding the definition of psychotherapy or the foundational education required for individuals wishing to become certified as therapists. For the purpose of this particular article, I cite definitions proposed by selected Polish psychotherapists: Jerzy Aleksandrowicz, Czesław Czabała, and Bogdan de Barbaro. With regard to the role of diagnosis in psychotherapy, I engage in debate with internation-

ally renowned experts such as Irvin Yalom, Harlene Anderson, Michael White, and David Epston. Divergences in views regarding diagnosis in the psychotherapeutic process might stem, among other factors, from differences in the understanding of psychotherapy itself. Based on observations of current discussions, one can assume that the attitudes of psychotherapists who are reluctant to make diagnoses are related to their preferences for adopting a broader definition of psychotherapy, one that extends beyond the field of treatment. This hypothesis, however, would require confirmation through research.

Psychotherapy

In order to provide better insight into what psychotherapy actually is, taking into account our cultural context, it is essential to refer to Polish authority figures within this field. This is particularly important as defining psychotherapy is intrinsically connected to the perception of diagnosis in psychotherapy. At present, discussions are taking place in Poland that sometimes resemble debates on psychotherapy that were already being conducted in the 1990s. These concern the definition of psychotherapy and the question of what educational background should qualify an individual to apply for psychotherapist certification.

In his article titled "*Psychoterapia czy psychoterapie*" ("Psychotherapy or psychotherapies"), Jerzy Aleksandrowicz writes: "Undoubtedly, the task of defining the essence of psychotherapy is immensely difficult, if only because of its location within a field where the phenomena of health and illness, helping and treating, and human relationships and interactions intersect. Therefore, it seems that formulating such a definition requires, above all, distinguishing between psychosocial interventions aimed at treatment and those whose purpose is to provide support. The term 'psychotherapy' is appropriate only for the former, whereas the term 'psychosocial support' appears more suitable for the latter" [1, p. 22].

When defining psychotherapy, in the introduction to his book *Czynniki leczące w psychoterapii* (Healing factors in psychotherapy), Czesław Czabała writes: "I hope that the Readers of this book will share my conviction that psychotherapy is a method of treating mental disorders, the practice of which requires extensive knowledge grounded in scientific findings and skills that can be acquired through education. Psychotherapy is only an art in the sense that each psychotherapist adjusts their gained knowledge and skills to their own competencies for using them and to the needs stemming from each patient's individual problems" [2, p. 16].

Meanwhile, in a spoken statement, Bogdan de Barbaro offers a broader definition of psychotherapy: "Psychotherapy is a kind of method that helps people cope better with suffering, symptoms, conflicts, and problems. What is also important is that it provides an opportunity to better understand oneself" [3].

The amendment to the Polish Mental Health Protection Act [4], which entered into force in January 2024, introduces a definition of psychotherapy into Polish law for the first time. "The new regulations state that psychotherapy consists of deliberate and planned psychological interventions aimed at alleviating or eliminating the symptoms of a mental disorder and improving psychological and social functioning, supporting the efforts of an individual or a family towards health and development, and directed at persons with mental disorders" [5].

"The regulations also specify who may practise psychotherapy. They do not limit eligibility to persons with specialised education in a relevant field (e.g. those holding a Master's degree in psychology). Anyone who holds a Master's degree—whether in mathematics or Polish studies—may apply for the status of a psychotherapist, provided that they obtain the required certificate by completing the postgraduate training specified in the Act and passing the certification examination" [5].

At the same time, the Executive Board of the Polish Psychological Association appointed a Psychotherapy Committee, which prepared its own proposals regarding the legal regulations concerning the profession of the psychologist and psychotherapeutic services (Resolution of the Executive Board of the Polish Psychological Association No. 6/14.10.2024) [6]. Independently of the work and findings of the Working Group on the Act on the Profession of the Psychotherapist, as well as the proposals of the Psychotherapy Committee of the Executive Board of the Polish Psychological Association, the Coalition for Psychotherapy was formed. Under its auspices, the SWPS University of Social Sciences and Humanities, the Jagiellonian University, the University of Warsaw, and the Institute of Psychology of the Polish Academy of Sciences entered into an agreement aimed at incorporating the voice of the academic community into the development of public health policy in the field of mental health [7]. As of September 2025, the Working Group's draft is being proceeded by the Parliamentary Team on the legal regulation of the profession of the psychotherapist, with dissenting views expressed by representatives of the psychotherapeutic community, including the Executive Board of the Polish Psychological Association [8].

Diagnosis in the field of psychotherapy

The word diagnosis originates from the Greek language and was later adopted into Latin. In medicine, terms such as "to establish a diagnosis", "to diagnose", and "to make a diagnosis" are used [9].

Being a method of treatment, psychotherapy implies the necessity of diagnosis. Psychiatric diagnosis has long been an issue of contention, especially visible since the development of anti-psychiatry and social constructionism. Dyga and Opoczyńska write: "Diagnosis is a word that acts. The one who makes it (the clinician) affects the one about whom it is made (the patient), identifying in them what is being given (the diagnosis). A diagnosis, understood as an identification, does in fact interfere with the patient's process of self-discovery: they are now enriched with a word (and at the same time perhaps poorer) that they previously did not know (or, even if they knew, they did not use to describe themselves). And so they ask themselves: who am I? As I am seen, so I am described (spoken of)? As I am described (spoken of), so I am seen? Am I the one who is not seen (not spoken of or written about)? Am I who they make me into? A diagnosis – though it is typically said that it is made to identify somebody as somebody, or as something they have (or suffer with) – in fact poses questions *to the person to whom it has been given*: what connects me with the diagnosis that has been attributed to me? Do I have anything in common with it? If I fail to recognise myself in it, is it truly mine? Reflections on diagnosis cannot therefore omit reflections on the significance for the identity of those being diagnosed" [10, pp. 74–75].

And although the aforementioned authors discuss psychiatric diagnosis in their articles in relation to the patient without specifically focusing on the issue of psychotherapy, I do believe that their viewpoints can also be considered in this context. They observe both benefits and risks associated with diagnosis, as written in the article's introduction: "(...) we consider reification and self-fulfilling prophecies to be the most significant of the dangers for the identity of the patient. Reifying the illness itself tends to result in the ill person being treated as if they were an object, disregarding the meanings of their symptoms, as well as the patient's very own individuality and uniqueness, which are expressions of their self-identity. A self-fulfilling prophecy primarily points to the real effects of the psychiatrist's expectations and interpretations on the patient's mental state and their identity" [11, p.87]. The term *diagnosis* is generally equated with medical identification, that is, a nosological diagnosis. I do believe, however, that in psychotherapy diagnosis can be, and oftentimes should be, examined in three aspects: medical (psychiatric and/or somatic), psychological, and therapeutic.

Nosological diagnosis is made based on the diagnostic criteria of the ICD (International Classification of Diseases) and with supplementary reference to the DSM (Diagnostic and Statistical Manual of Mental Disorders, a mental disorder classification created by the American Psychiatric Association). Both classifications are periodically updated based on new clinical findings – but they are not immune to social and cultural influences. Poland currently applies the ICD-10 Classification, as a five-year transitional period is expected prior to the implementation of the ICD-11 Classification. That said, in their practice clinicians refer to the criteria contained in the ICD-11 Classification, as well as descriptions provided by the DSM-5.

Psychological diagnosis is formulated based on psychological assessments, and concerns primarily cognitive, emotional, and motivational processes. Diagnostic assessments ought to be conducted using methods and psychological techniques meeting EBA (evidence-based assessment) criteria. The aim is to ensure that any practical actions remain based on scientific frameworks, which primarily requires the use of structured methods and procedures that have been empirically verified. Psychological assessments are conducted and interpreted solely by a psychologist.

Psychotherapeutic diagnosis currently lacks standardised tools and criteria, which has been pointed out by Błażej Kmieciak, a representative of the Polish Commissioner for Human Rights, during discussions in a parliamentary committee regarding the Act on the Profession of the Psychotherapist [12]. Nevertheless, psychotherapeutic diagnosis continues to be practiced and has its own traditions, though its process depends on the therapeutic modality. Because the description of psychotherapeutic diagnoses in different modalities extends beyond the scope of this article, I shall mention only that the cognitive-behavioural approach uses diagnostic protocols, and psychotherapists also rely on recommended methods of initial assessment such as the semi-structured Kernberg interview; practitioners of the psychoanalytical modality use psychotherapeutic diagnostic frameworks developed by Nancy McWilliams, whereas in the systemic approach, family diagnosis takes into account its structure, communication, relational complexity, as well as intergenerational transmissions [13-16].

Psychotherapeutic diagnosis can also be considered as an initial assessment or an ongoing assessment. An initial assessment consists of an array of procedures aimed at developing a conceptualization of the illness as well as at identifying the dominant processes responsible for its development, which allows the therapist to select the appropriate treatment methods and conditions. It includes factors such as identifying the patient's needs, motivations, and expectations, as well as routine matters like the patient's life history, their history of problems or disorders, and the narrative used by the patient and/or their family when providing information. Conversely, an ongoing assessment is a series of consultations focused on gathering data and developing a conceptualization of the illness. In every form of diagnostic practice, it is advisable that the therapist be prepared to modify their initial assumptions in light of new information or clinical changes.

One of the components of therapeutic diagnosis is the patient's formulation of their expectations regarding psychotherapy. Due to the lack of clearly defined criteria and tools for preparing a psychotherapeutic diagnosis, which depends on the approach used by the psychotherapist, I will narrow the concept of psychotherapeutic diagnosis to the verification of the patient's expectations for the purposes of this article.

The significance of medical, psychological, and therapeutic diagnosis in psychotherapy

Medical/nosological diagnosis of mental disorders is imperative in areas such as treatment within the National Health Fund (NFZ), insurance benefits, as well as education and decisions regarding teaching methods (one-to-one teaching, special education, reduced academic requirements, etc.). Some diagnoses additionally require a psychological diagnosis concerning emotional, cognitive, and intellectual processes. A medical diagnosis can be considered in a narrative manner throughout the process of psychotherapy, including the psychotherapy of children, adolescents, and families. There are controversies in the psychotherapist community regarding the legitimacy of introducing medical diagnosis narratively into the process of psychotherapy. Discussions concern whether to address the topic of existing medical diagnosis during psychotherapy or to even share suspicions of such a diagnosis, and to advise the patient (in the case of minors – their parents) to receive a psychiatric consultation. It is vital to bear in mind that a significant portion of patients seek therapy due to psychosomatic ailments, therefore making it difficult to ignore their symptoms through the course of psychotherapy.

Psychological diagnosis constitutes one of the areas of a psychologist's work. In the academic textbook titled *Diagnoza psychologiczna. Diagnozowanie jako kompetencja profesjonalna* (Psychological diagnosis. Diagnosing as a professional competence), author Katarzyna Stemplewska-Żakowicz distinguishes three meanings of the term *diagnosis.* The first refers to a "layered process encompassing the formulation of diagnostic questions, the selection of appropriate tools, data collection, the assessment and integration of said data, and ultimately formulating answers to the diagnostic questions, which often becomes the starting point for posing new questions or hypotheses that are tested in subsequent series of assessments" [17, p. 15].

The second meaning refers to the effects of the diagnostic process. As Stemplewska-Żakowicz points out, in addition to the term *diagnosis*, the Polish language also recognises the term *identification*, which is more frequently associated with the medical model of nosological diagnosis. That being said, the author of the textbook writes: "one of the effects of psychological diagnosis may be, first and foremost, gaining an understanding of the given phenomenon, an explanation of its factors, mechanisms, and dynamics, the prediction of possible future developments, as well as the planning of a psychological intervention, and later its monitoring and assessment of effectiveness" [17, p.15]. The author notes that when diagnostic activities are carried out by clinical psychologists, it constitutes identification of the disorder, determination of its prognosis, and therapy planning. Conversely, psychologists specialised in different areas, such as career counselling, create a competency profile based on the results of these assessments.

Stemplewska-Żakowicz also identifies the third meaning of psychological diagnosis as "scientific knowledge and the professional practice based on it. (...) Understood as such, psychological assessment is a scientific discipline and – like medicine – an art of practicing in accordance with its own rules" [17, p.16].

Referring to the aforementioned textbook, Stemplewska-Żakowicz also provides a definition of diagnostic competence: "it is the ability to use appropriate methods (e.g. interviews, tests, observations) in order to define (due to the nature of the service provided) principal characteristics of the assessed individual, group, organisation, or situation [17, p.21]. In turn, "competence is defined as consisting of three elements: knowledge, skills, and values" [17, p.10].

Diagnosis ought to be based on empirical evidence (evidence-based practice, EBP), hence based on scientific grounds, which involves making use of structuralised methods and procedures that have been empirically verified. "This approach was born in the early 1990s in the medical field as evidence-based medicine (EBM), from where it spread first into psychotherapy as empirically supported therapies (EST), before encompassing the entirety of psychological practice as evidence-based practice in psychology (EBPP)" [17, p. 44].

As can be seen in the above description of psychological diagnosis, it requires competencies that are specifically accessible to psychologists, who make independent and autonomous assessments of the condition of the individual being examined. A psychological diagnosis can also be the basis for medical identification or have a significant influence on making a nosological diagnosis, as well as constitute a meaningful part of therapeutic diagnosis and the process of psychotherapy.

Psychological diagnosis carries particular significance in therapeutic work with children, adolescents, and families. This is because, due to developmental factors affecting a child or teenager's cognitive and emotional condition, acquiring information necessary for initiating and continuing (both individual and family) psychotherapy frequently proves difficult. In family therapy – among other reasons due to the child's experience of a conflict of loyalty – psychological diagnosis is oftentimes the only means of determining the child's thoughts and feelings. This raises the question of why some psychotherapists downplay and/or dismiss the legitimacy and value of psychological diagnosis in the psychotherapeutic process.

Psychotherapeutic diagnosis, similarly to psychotherapy itself, is a process. It typically begins with the patient formulating their expectations regarding psychotherapy. Next, the

therapist, on the basis of the therapeutic process, poses hypotheses that gradually undergo verification throughout the stages of the process. The therapist also examines the patient's expectations with regard to whether those can be accomplished throughout the course of psychotherapy. It does happen that the therapeutic diagnosis changes during the process of psychotherapy, either due to progression, clinical manifestation, or new topics brought up by the patient. Occasionally, a thorough therapeutic diagnosis makes it possible to acquire information leading to the need for a psychiatric consultation in order to establish or revise the medical diagnosis.

As mentioned before, at the present moment no explicit guidelines, methods, or tools used for making a therapeutic diagnosis have been developed, which causes a hindrance for its establishment in the Act. Therefore, I will focus on one area that is common for various modalities – the patients' expectations, especially in the treatment of mental disorders in children and adolescents. In the case of children and adolescents, it is frequently their caregivers who set the expectations, usually as a response to concerns about changes in the cognitive, emotional, and/or social functioning of their child. Children and younger teenagers (up to 12-13 years of age) often face difficulties when formulating expectations, either because they do not share their parents' concerns, or due to developmental factors are not able to name them, or still due to other reasons, such as loyalty conflicts, do not wish to discuss them. In these cases, psychological assessments and psychological diagnosis remain paramount. When it comes to family therapy, there may be at least as many expectations regarding therapy as there are family members participating in the sessions. Regardless of the type – whether it is individual or family therapy – therapeutic diagnosis often undergoes revisions, transformations, and changes, and is thus a process.

Discussion and debate

Some contemporary therapists such as Irvin Yalom, Harlene Anderson, and the founders of narrative therapy Michael White and David Epston, question the legitimacy of referring to medical diagnosis in the process of psychotherapy. Irvin Yalom notes that psychotherapy is a process that unfolds gradually, during which the therapist strives to fully get to know the patient. According to Yalom, diagnosis "narrows the field of view, reduces the ability to treat the other person as an individual. Once we make a diagnosis, we have a tendency to selectively omit those aspects of the patient that do not fit that particular diagnosis, and to excessively attach importance to subtle characteristics that seem to confirm the initial diagnosis. Moreover, diagnosis can function as a self-fulfilling prophecy" [18].

I have my reservations regarding Yalom's view and I notice certain inconsistencies in it. My doubts concern the lack of sources and research findings that would support Yalom's categorical statement that diagnosis "narrows the field of view, reduces the ability to treat the other person as an individual". With regard to the lack of research findings, one might assume that the author formulated this claim on the basis of his own observations. If one allows for references to therapeutic experience and a discussion between subjective observations, then my views are completely contrary. My clinical and therapeutic experience spans many years, including 35 years of work in the Clinic of Child and Adolescent Psychiatry,

which I believe gives me sufficient ground to argue that diagnosing a disorder enables the therapist to view the person from a broader perspective— as an individual who, at a given moment in life, is struggling with symptoms that form part of their personal experience and cannot be disregarded in the process of psychotherapy.

I find it equally difficult to agree with the further part of Yalom's claim that "once we make a diagnosis, we have a tendency to selectively omit those aspects of the patient that do not fit that particular diagnosis, and to excessively attach importance to subtle characteristics that seem to confirm the initial diagnosis". Similarly to the previous part, it remains unknown on what sources or findings the author bases these claims. Perhaps he relies on his own experience; however, in my therapeutic practice, nosological diagnosis does not define boundaries, nor does it contribute to a selective omission of certain aspects of the patient's life. Quite the opposite – it allows the individuality of the person to be recognised despite symptoms that, even within the same diagnosis, may be understood, interpreted, and emotionally experienced differently by each individual.

Finally, Yalom asserts that "diagnosis can function as a self-fulfilling prophecy". While such a possibility cannot be excluded a priori, in my own clinical and therapeutic experience, a nosological diagnosis, as opposed to being a "self-fulfilling prophecy", often allows the patient to free themselves from feeling guilty or responsible for the way they are currently functioning and the things they are experiencing. Not infrequently, as is evident not only from my own observations, a conversation with a patient suffering from, say, depression about the symptoms of their disorder, allowed them to release feelings of guilt for lacking strength and energy, working at a slower pace, failing to fulfill their obligations, or for not taking pleasure in others' nor their own achievements. The possibility of being free from guilt brings relief from suffering in patients with depression. I have also repeatedly heard patients with other diagnoses express feeling a sense of relief – for instance, patients diagnosed with autism spectrum disorder report feeling relieved after receiving their diagnosis from the assessment team, as it helped them finally understand why they perceive their surroundings differently or experience situations in a different way than others.

Based on my professional experience, it is difficult to disregard nosological diagnosis in family therapy of adolescents, in particular those diagnosed with autism spectrum disorder or schizophrenia. I notice an inconsistency in Yalom's statement that "once we make a diagnosis, we have a tendency to selectively omit those aspects of the patient that do not fit that particular diagnosis", as the author uses a term *patient*, which is closely tied to diagnosis, whilst simultaneously negating the legitimacy of diagnosis in psychotherapy. Diagnosis pertains to a patient, whereas an individual who is not undergoing any sort of assessment or treatment, nor has been given a diagnosis, is hard to describe as a patient.

Yalom, who applies the existential approach in his therapeutic work, uses the term *patient* in his publications, yet does not define or redefine its meaning. The term itself is understood in a similar manner in various languages. For instance, the Great Dictionary of Polish defines a patient as a "sick individual receiving medical care" [19].

The origin of the word is also quite compelling. As one source notes, "the term *patient* was borrowed directly from German (*Patient)*, but its roots are older and go back to Latin. The fundamental meaning of the Latin word *patiens* was 'enduring, resilient, bearing something'. Hence came further meanings, formed as logical extensions of its basic meaning:

'tough, unyielding, also patient (resilient), but also suffering something – and later suffering from something. The 19th century Polish language had an elegant synonym for the word patience – *pacjencja* (also used as an exclamation: *Pacjencja!*, meaning 'Patience!'). The term itself functioned until the 16th century as an honorary title for a person seeking medical treatment from a certified physician (as opposed to those who were "inferior" and were treated by folk healers). Only later did it acquire more of a general meaning of a 'person suffering something or from something and in need of help'. Until the end of the 19th century, not only doctors but also lawyers and legal advisors had patients" [20].

Returning to the issue of psychotherapy, in the constructivist-narrative paradigm, which began developing in the mid-1980s, therapists such as Harlene Anderson and the founders of narrative therapy, Michael White and David Epston, understood psychotherapy as a process of "co-constructing meanings" [21, p. 127]. Barbara Józefik writes: "Harlene Anderson questions the use of theoretical and practical knowledge for understanding an individual, as she argues that only through dialogue can one uncover what was previously invisible and what constitutes the condition for the emergence of new meanings" [21, p. 127]. On the other hand, White and Epston oppose the notion of therapy as "the treatment of illnesses, disorders, and defects through the use of medical procedures" [21, p. 128]. In accordance with these assumptions, therapists place their focus on the ways the patient/client describes, interprets, and constructs their life situation. As Józefik observes, the aforementioned therapists, when working with individuals diagnosed with psychiatric conditions (anorexia, schizophrenia, or depression), "diagnosis does not constitute the fundamental lens through which they perceive those seeking therapy" [21, p. 128].

It would be indeed hard to disagree with the view that diagnosis "does not constitute the fundamental lens", but does dismissing it not mean overlooking a certain area of the patient's experiences and/or suffering – the very reasons why the patient seeks psychotherapy? A literal interpretation of Harlene Anderson's recommendation to "question the use of theoretical and practical knowledge for the understanding of an individual" may raise particular doubts. What should a psychotherapist refer to then, if not theoretical and practical knowledge? Their intuition, imagination, or perhaps their projections? Although intuition, imagination, and at times even projection have their place in psychotherapeutic work, they are treated as hypotheses and are therefore subject to verification and supervision. This raises the question of whether the literal interpretation of Anderson's suggestion to "question the use of theoretical and practical knowledge for the understanding of an individual" aligns with the substantive and ethical standards of treatment that psychotherapy is expected to meet.

As Józefik notes: "The concept of narratives as a method of understanding reality constitutes an inseparable element of being a subjective being in the world. We have no other way of describing the time we have experienced than in the form of a story. This structuring of experiences in the form of a story organises them and gives them meaning. The narratives that a person uses to describe their own life and the lives of others influence which aspects of their experience are noticed and subsequently expressed." [22, p. 2]. Therapeutic approaches based on the ideas of social constructionism are frequently defined as narrative approaches, in the broad understanding of the word [23]. This indicates that, as Józefik points out, "they tend to concentrate on the role of language and culture in the creation

and interpretation of events, in making sense of human experiences, as well as on clients' stories, their interpretations, and meaning-making practices. In therapeutic approaches based on these frameworks, the key questions concern how individual family members arrive at particular understandings of the world, family relations, perceptions of themselves and of other family members; what role is played by significant people, important life events, and key decisions in sustaining these narratives. Other major issues include whether the content of family narratives is jointly constructed and whether those narratives are prone to modifications, changes, new information, and new experiences" [22, p.5].

It would certainly be interesting to analyse and discuss the understanding of the term *patient* and the definitions of psychotherapy, both from a broader perspective – across different modalities – and from a narrower one, within models based on the ideas of social constructionism, particularly within the systemic therapy approach, such as the reflecting team (Anderson), systems based on reflexive conversation (Anderson, Goolishian), post-Milan family therapy (Cecchin, Boscolo), solution-focused practice (de Shazer), as well as narrative therapy (White, Epston). This particular issue, however, goes beyond the scope of this article.

A different matter is *not-knowing* as a method of conducting a conversation, which is based on curiosity, asking questions, and formulating hypotheses throughout the conversation with the patient. The not-knowing proposed by Wojciech Drath and Bogdan de Barbaro in their book *Psychoterapia. Między wiedzeniem a niewiedzeniem* (Psychotheraphy. Between knowing and not knowing) is understood as the therapist's lack of knowledge about the patient's thoughts and feelings [24].

The opposite of not-knowing, understood in this way, would be directiveness, as proposed by Aleksandrowicz: "Therapeutic relationships are different, however, from relationships established for the purpose of providing help; the tasks, principles, and competencies of those who help also differ from those who treat. With regard to providing help, the primary task that drives the formation of such a relationship stems from the needs and wishes of the client. The client themselves is the only one who should determine the type and scope of help, and the helper ought to 'follow them' – otherwise it will not be help, but rather 'forcing happiness'. Therapeutic relationships, on the other hand, are established based on the practitioners' knowledge of the illness and of what might help to alleviate it. The ideas and expectations of the patient must thus be subordinated to that knowledge and to the decisions that follow from it regarding the way the task is to be carried out. Certain circumstances may minimise (as in the case of surgery) or significantly increase (as in the case of psychotherapy) the need for the patient's active participation. That being said, it is always the practitioner who must determine the optimal direction, scope, and rules of this cooperation. Therefore, it is not a fully equal partnership" [1, pp. 23-24]. According to Aleksandrowicz, it is less a matter of the therapist knowing what the patient thinks and feels than of understanding what is beneficial and advisable for them. I believe that between the areas of not-knowing and certainty, there is an equally important area of the therapist's competencies regarding therapeutic methods that are able to alleviate the patient's suffering, help remove their symptoms, and consequently improve their quality of life.

By contrast, White and Epston reject the interpretation of therapy as the "treatment of illnesses, disorders, and defects, through the use of medical procedures", thus prompting

the question: what is psychotherapy to the aforementioned authors? If not treatment, then on what grounds are these "psychosocial interactions" (to quote Aleksandrowicz) applied to individuals with specific nosological diagnoses such as anorexia, schizophrenia, or depression? Furthermore – what research findings, what theoretical foundations, and what ethical values do authors of this approach refer to?

In my practice and understanding of psychotherapy, I draw upon theories stemming from years of research conducted by Professor Norcross, who highlights the significance of personalised therapy – meaning therapy tailored to the patient as an individual, their responsiveness, expectations, and disorder. During a lecture delivered at the invitation of the Executive Board of the Polish Psychological Association, Professor Norcross explained that in psychotherapy, evidence-based practice is based on the integration of three components: making use of the best available evidence, combining it with knowledge and clinical expertise, and then taking into account the patient's unique characteristics, such as their cultural background or preferences [25].

As my practice shows, there are patients – for instance, those suffering from eating disorders – who almost explicitly expect the therapist to "guide" them rather than "follow them". That is because, as they often put it metaphorically, "I have no idea where to go". In contrast, therapeutic work with children and adolescents differs enormously, as they lack the developmental abilities, and oftentimes motivation, to define expectations, goals, and the direction of the therapeutic process.

Referring once again to narratives and highlighting the meanings of certain words, psychotherapy is often described as something that is "conducted", that somebody conducts psychotherapy. In that sense, the practitioner also assumes the role of a guide. The term *guide* (a term of my own) refers to the factors influencing the effectiveness of therapy, which, according to Norcross, depend on multiple factors. Among the most important are the stages of patient change: precontemplation, contemplation, preparation of action, and maintenance. Each of these stages requires adjustments in the psychotherapeutic work, as certain approaches are more effective at particular stages. The author also argues that in the process of psychotherapy, it is vital to adapt the treatment to the patient's coping style. Researchers distinguish two types: externalisers and internalisers. For therapy to be effective, it is essential for the practitioner to attune their method of work to the patient's coping style [25].

Conclusions

Words, being the primary tool of a psychotherapist's work, are present in every psychotherapeutic approach, and thus construct a widely understood narrative – a dialogue between the therapist and the patient or a polyphony of voices in family work. The effectiveness of psychotherapy is largely dependent on the psychotherapist's knowledge, clinical and therapeutic experience, as well as their attentiveness to detail and ability to make use of various methods. At the same time, unspoken words and contents can also constitute valuable material for formulating therapeutic hypotheses.

Narrative therapy, which is rooted in the principles of social constructionism, has introduced a new perspective broadening the perception of the patient and offering a wide array of possibilities in terms of communication and understanding the person seeking psychotherapy. Nevertheless, an important question remains: can a therapist, when working with patients outside the framework of diagnosis, dismiss – as Irvin Yalom, Harlene Anderson, Michael White, and David Epston seem to suggest – a nosological diagnosis that may sometimes be the sole reason for seeking therapy? Opponents of the inclusion of diagnosis point to risks such as the possibility of labeling the person participating in therapy. Yet this raises another issue and question: who participates in this very labeling, if not psychotherapists themselves, who try to avoid diagnoses, attaching a negative connotation to them? In psychotherapy, one does not work "with a diagnosis" but with an individual who, due to various afflictions or disorders, may be suffering, unable to function naturally, or causing concern to their loved ones—particularly in the case of children and adolescents. And it is especially adolescents who tend to self-diagnose medically (sometimes correctly, other times not) and then proceed to announce their diagnosis during their first therapy session. These are the very cases where it is advisable that the psychotherapist help the young person "free" themselves from their "diagnosis".

At a time when ongoing efforts are being made to formulate a definition of psychotherapy, one might raise the question: if psychotherapy is understood as a form of treatment, should it not be preceded by a medical and/or psychological diagnosis, in the same manner that other illnesses and disorders are treated within the healthcare system? If, on the other hand, psychotherapy is not meant to be understood and practised as a form of treatment, a further question arises: on what substantive and ethical grounds could it be applied to individuals with medical diagnoses or those meeting the criteria for a nosological diagnosis? I believe that if the psychotherapist maintains attentiveness and intentionality in order to avoid treating diagnosis as reification or a self-fulfilling prophecy, a psychiatric or psychological diagnosis may become one of the topics explored during the process of psychotherapy. A skillful and inclusive exploration of diagnosis in the process of psychotherapy offers, in my view, far more benefits compared to its exclusion from the treatment process.

Individuals with psychiatric diagnoses are not the only ones seeking psychotherapy, as so do those with somatic diagnoses (including oncological ones), as well as individuals with disabilities. One might ask then, by analogy, whether a therapist would allow themselves to overlook their illnesses or disabilities when conducting psychotherapy. The aim is not to focus specifically on diagnosis, but to determine what the illness or disability means to the patient, how they experience it, and whether they wish to discuss it as one of the themes explored in the psychotherapeutic process. If deliberately overlooking (or not seeing) a somatic illness or disability may appear difficult to do in psychotherapy, the question arises: for what reasons would a therapist fail to acknowledge a psychiatric diagnosis?

As previously stated, criticism of psychiatric diagnosis can be traced back to the 1960s—a period marked by the rapid development of the anti-psychiatry movement—and is also closely linked to the development of social constructionism. Michael Foucault, associated with postmodernism, made a significant contribution to the sceptical attitude towards psychiatric diagnosis by drawing attention to the interconnections between knowledge and power. It would be hard to disagree with Foucault's views regarding power, understood as

a relation present in every sphere of life [26]. It is equally important, however, to remain attentive to these interconnections, as well as to the social and cultural factors that influence the functioning of individuals, families, and societies and shape perspectives aligned with broadly defined "political correctness".

Nevertheless, over 40 years have passed since the publication of Foucault's works, and throughout these years many changes have occurred across various areas of life, including psychiatry and diagnostic criteria, which have become increasingly flexible and are regularly updated in line with research and the development of evidence-based medicine (EBM). Several changes have been evident in the classifications of illnesses and disorders – for instance, the ICD-11 has moved away from rigid categorical distinctions in favour of broader categories and assessments of symptom severity.

The issues I have raised, along with their significance and importance, stem from my concern regarding the application of psychotherapy in the treatment of mental disorders in children, adolescents, and adults, as well as in family therapy.

References

1. Aleksandrowicz JW. Psychoterapia czy psychoterapie. Psychoterapia. 2004; 2(129): 22–23.
2. Czabała JC. Czynniki leczące w psychoterapii. Warszawa: Wydawnictwo Naukowe PWN; 2013.
3. de Barbaro B. Czym jest psychoterapia [Video]. Euphire, 2018 [cited 21 Feb 2025]. Available from: https:// www.facebook.com/EUPHIRE/videos/576366392714269
4. Ważne zmiany dla psychoterapeutów. Weszły w życie przepisy regulujące zawód. Jest definicja psychoterapii [Internet]. RynekZdrowia.pl; 2024 [cited 24 Apr 2025]. Available from: https:// www. rynekzdrowia.pl/Psychiatria/Wazne-zmiany-dla-psychoterapeutow-Weszly-w-zycie-przepisyregulujace-zawod-Jest-definicja-psychoterapii,253659,16.html
5. Nocuń K. Definicja psychoterapii: Celowe i planowe działania psychologiczne [Internet]. Prawo. pl; 2024 [cited 16 Mar 2025]. Available from: https://www.prawo.pl/zdrowie/definicja-psychoterapii-od1-stycznia-2024-r-w-ustawie,524659.html
6. Wykowski J. Stanowisko PTP: Psychoterapia nie jest odrębnym zawodem i zawsze powinna być poprzedzona diagnozą [Internet]. RynekZdrowia.pl; 2024 [cited 11 Mar 2025]. Available from: https://www.rynekzdrowia.pl/Psychiatria/Stanowisko-PTP-psychoterapia-nie-jest-odrebnymzawodem-i-zawsze-powinna-byc-poprzedzona-diagnoza,265107,16.html
7. Koalicja dla Psychoterapii [Internet]. Instytut Psychologii PAN; 2024 [cited 25 Mar 2025]. Available from: https://psych.pan.pl/aktualnosci/koalicja-dla-psychoterapii
8. Stanowisko Polskiego Towarzystwa Psychologicznego w sprawie projektu ustawy o zawodzie psychoterapeuty [Internet]. psych.org.pl; 2025 [cyt. 10 Jul 2025]. Available from: https://psych.org.pl/ fileadmin/user-files/aktualnosci/STANOWISKO_PTP_USTAWA_O_ZAWODZIE_PSYCHOTERAPEUTY.pdf
9. Müldner-Nieckowski P. Diagnoza a rozpoznanie [Internet]. Repliki, czyli odpowiedzi. Lekarski Poradnik Językowy [cited 26 Mar 2025]. Available from: https://lpj.pl/index.php?op=31&id=3
10. Dyga K, Opoczyńka M. Znaczenie diagnozy dla tożsamości pacjenta. Cz.1: Od zapoznania do rozpoznania. Psychoterapia. 2015; 3(174): 73–86.

11. Dyga K, Opoczyńska M. Znaczenie diagnozy dla tożsamości pacjenta. Cz. 2: Uzgadnianie czy uznanie. Psychoterapia. 2015; 3(174): 87–97.
12. Kmieciak B. Wywiad z Konsultantem Krajowym w dziedzinie Psychoterapii mnie dzisiaj zatrzymał. Kilka refleksji w ważnym dla mnie temacie ustawy [Internet]. Błażej Kmieciak; 2025 [cited 25 Aug 2025]. Available from: https://www.facebook.com/permalink.php?story_fbid=-pfbid04MULjTNNgVkJqSwLCYa8DC1xAuJNtV6g7uR2TN9Rjq8AQvek5FqFLo5kWHEeQ71C l&id=100063635632562
13. Kuyken W, Padesky ChA, Dudley R. Konceptualizacja w terapii poznawczo-behawioralnej. Wrocław: Urban & Partner; 2024.
14. McWilliams N. Diagnoza psychoanalityczna. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2025.
15. Siewierska A, Śliwczyńska J, Namysłowska I. Czy możliwa jest diagnoza systemowa. Psychiatr Pol. 2008; 1(tom XLII): 17–24.
16. de Barbaro B, Józefik B, Drożdżowicz L. Terapia rodzin w zaburzeniach osobowości: Wątpliwości i możliwości. Psychoterapia. 2008; 1(144): 5–16.
17. Stemplewska-Żakowicz K. Diagnoza psychologiczna: Diagnozowanie jako kompetencja profesjonalna. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2013.
18. Yalom ID. Dar terapii. List otwarty do nowego pokolenia terapeutów i ich pacjentów [Ebook]. Warszawa: Czarna Owca; 2024.
19. Pacjent [Internet]. Wielki Słownik Języka Polskiego [cited 26 Mar 2025]. Available from: https:// wsjp.pl/ haslo/podglad/2330/pacjent
20. Cierpliwy jak pacjent [Internet]. Narodowe Centrum Kultury [cited 26 Mar 2025]. Available from: https:// nck.pl/projekty-kulturalne/projekty/ojczysty-dodaj-do-ulubionych/ciekawostki-jezykowe/ Cierpliwy_jak_PACJENT,cltt,c
21. Józefik B. Kultura, ciało (nie)jedzenie, terapia: Perspektywa narracyjno-konstrukcjonistyczna w zaburzeniach odżywiania. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2014.
22. Józefik B. Terapia jako proces współtworzenia nowych znaczeń i opowieści. Idee i praktyki narracyjne. [Internet]. Repozytorium Uniwersytetu Jagiellońskiego [cited 25 Mar 2025]. Available from: https://ruj.uj.edu.pl/entities/publication/eab1cefb-9320-455f-ac28-f92c2d1dfa24
23. Tokarska U. Narracja autobiograficzna w terapii i promocji zdrowia. In: Trzebiński J, ed. Narracja jako sposób rozumienia świata. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2002, 221–261.
24. Drath W, de Barbaro B. Psychoterapia. Między wiedzeniem a niewiedzeniem. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2022.
25. Norcross JC. Evidence-based therapy relationships and treatment adaptations [Unpublished lecture]. Polskie Towarzystwo Psychologiczne. Masterclass Lectures: Psychologia. Nauka. Praktyka oparta na dowodach; 03 Sep 2025.
26. Grzymski J. Wszechobecność władzy i postawa krytyczna. Inspiracje myślą Michela Foucaulta. Athenaeum. Polskie Studia Politologiczne. 2017; 54: 85–98.

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