Chapter 2: Family Psychology and Family Psychiatry - Diagnosis

General

A farmer, driving to the nearby town, thinks he discerns a red flush on his field of barley; the event provokes an urgent systematic enquiry. Is it a fact? What caused it? What is the responsible fungus? At the end of the afternoon a small plane trailing a cloud of insecticide delivers the exact remedy. So, diagnosis (*dia-gnosis*, through knowledge) has led to correct therapy.

Yet, in psychiatry, diagnosis is eschewed. The fashionable vogue is to plunge into therapy. It is as if in surgery, at the signal of abdominal pain, we plunged in with no knowledge of the anatomy of the abdominal organs, no understanding of their function and no systematic enquiry to discern the focus of the pain. In psychiatry, the sign of emotional anguish is enough. We plunge in.

But this behaviour is not calculated perversity. It is presumably our defence against the admission of ignorance. The anatomy of the personality has yet to be worked out, the functioning of the psyche is obscure, and the understanding of psychopathology is at a rudimentary stage. Dependant on, and ruled by, the fertile but illogical and uninformed imagination of a number of well-intentioned clinicians over the last 70 years, we hesitate to start afresh – such is the daunting influence of what has become established opinion. Better the wrong landmarks than no landmarks. But lost we are.

To help is a laudable aspiration. But to plunge into the abdomen with no prior examination and no knowledge of anatomy and physiology is not help. It is a hazardous impulse fraught with danger for the patient. In that situation, masterly inactivity and reliance on nature's own defence measures might well be more effective.

To turn to systematic enquiry is the sure road to knowledge. The resources now available make this possible. One fruitful field for garnering knowledge is the pathological. It behoves us therefore to be systematic in the clinical field, to enquire, to understand, to build on understanding and to intervene with knowledge. Diagnosis must come before therapy, not only for the good of a particular family, but also for the future of psychiatry.

Developments in a field depend on a number of factors, but probably none so retards progress in psychiatry today as the confusions of its nosology and, linked with it, the lack of agreement on criteria for defining syndromes together with the imprecision of nomenclature. Ignorance is a matter to be overcome by time and endeavour; the lack of order in known phenomena is something to be righted now. An aetiological classification is a paramount need because accurate delineation of dysfunction leads to logical investigation, and so to the meeting of the central obligation of psychiatry – effective treatment.

The following matters are discussed here. The family psychiatric service accepts referred patients, individual, couple, or family. Thus the *referral* procedures must be

described. From it arises the intriguing question: What dictates the referral of a particular family member at one moment in the life history of this family?

Having accepted an individual or family, it is necessary to explore the presenting *symptomatology*, the complaint, that particular organism's subjective reason for seeking help. Investigation then moves to an assessment of all the indicators, going from a presenting individual's symptomatology to a complete assessment of all the family's indicators. These procedures allow of a diagnosis in terms of organic, psychic, or mixed syndromes.

To make a diagnosis is not to elucidate the psychopathological *process* that set up the indicators. The informant may be clear about his symptomatology and the clinician understand the nature of it, but neither has any notion of the cause of it. Thus exploration now moves to the area of the psychopathology of the disordered family. The understanding of the process leads to effective, deliberate therapy.

Referral

When the organism, the family, dysfunctions, there are repercussions throughout that family. The indicators of dysfunction, symptoms and signs, come to the notice of the family or of others. The awareness of the family, or a part of it, or of an individual varies greatly. In general, paradoxically, the greater the disturbance, the less the insight and the capacity to take action. The link may not be made between the indicator and the emotional state. A physical indicator may be thought to have a physical cause. A behavioural indicator may be thought to be due to some moral deficit. Long drawn-out states of psychopathology may be assumed to be usual. Standards may be low; what are states of ill-health are often widely regarded as being "normal", i.e. usual. The dictates of relatives, or social position, or lack of finance may make it impossible to seek assistance, hence the need for awareness and then for help from outside.

Usually the whole family is affected. Uncommonly, the whole family will appraise itself and seek assistance. More usually, an outside agency will appraise the family and persuade it to seek assistance as a family. Occasionally, a dyad in the family will seek help either on its own initiative or prompted by others. More often it is the individual who seeks help by his own efforts or encouragement from others. The conditions determining the common presentation of an individual will be discussed later.

Frequently one of the indicators becomes so noticeable to the family or others, or so painful, that it becomes "the last straw" and the final reason for taking action. As will be seen later, this presenting symptom is no more significant than other indicators; it may just be the most noticed, the most painful, the most socially acceptable, the one that offers least embarrassment to the family if discussed with others, or the one that allows an overture for help without final commitment.

Referral agencies can be conveniently divided into medical and social, and the latter into statutory and voluntary bodies. Some of the main medical referral agencies are family doctors, family nurses, polyclinics, hospital departments, industrial medical officers, departments for the care of the handicapped, and school clinics. Some of the

main social referral agencies are child-care agencies, workers attached to courts of law, industrial welfare officers, church workers, moral welfare workers, marriage guidance services, housing departments, school welfare officers, the Samaritans, the Salvation Army, and the police.

In some countries medical agencies with associated welfare agencies are ready to offer continuous observation and support of families in what they regard as essentially a medical problem – family psychopathology. Thus whatever the manifestations of dysfunction, they become the main referral channel to the psychiatric service. The continuous medical coverage is given through a family doctor and the continuous welfare coverage either by a home nursing visitor with experience of physical, emotional and social problems, or by an all-purpose social worker with similar experience. These services are supported by specialist medical and social agencies. A vital condition for success is that the workers offering a continuous service should be trained to see the significance of emotional phenomena. The advantage of referral through a medical service is obvious. Family psychiatry teaches the importance of a total somato-psychic approach; much of the symptomatology is physical; continuous support to a family in all its organic and psychic aspects is invaluable.

In the United Kingdom, an appointment is usually sought through the family doctor or personal physician. In an emergency, a family or an individual is accepted at once and the physician responsible for the family is informed. If other agencies, medical or social, become aware of a need for referral, they liaise with the family doctor, who then initiates referral. Experience has shown this to be an indispensable method. It allows of all previous knowledge on the health of the family, physical and emotional, being available. It offers a way whereby, after help from the specialist agency, the family finds itself back with the physician responsible for its continuous care.

The nature of the service given by a department of family psychiatry should in general fall into two categories: (i) A diagnostic appraisal of a family's problem with a clear-cut opinion on its nature and recommendations for management. In the United Kingdom, the referring family practitioner, for instance, is increasingly being encouraged to ofer help from his own resources. Given the skilled assistance of a health visitor or a social worker, a great deal can be achieved at home level. (ii) Undertaking of management beyond the resources of the referring agency.

Intake Procedure

The appointment is fixed, the letter of invitation is sent, couched in a welcoming vein and accompanied by a brochure on the department and a prepaid postcard for reply; the postcard is received back at the department, finally confirming the appointment. That the postcard is prepaid usually guarantees its return and allows appointments not taken up to be given to others. Rapport begins to be established at this early point of contact.

The family arrives by appointment. They already understand the procedure, as it has been explained in the brochure. The building, including the waiting area, is familiar as they have seen it pictured in the brochure. They are met by the receptionist. This is the first direct staff contact – and therefore important. It sets the tone for all that is to follow. Much goes on in a waiting area. In general, especially for early visits, it is a

tense period. It can be relieved by an understanding, helpful, accommodating, receptionist. The décor of the waiting area should be cheerful and a compliment to those who wait. The period of tension can be abbreviated by the interviewer being prompt. Inevitably, from time to time, due to some unexpected demand, a family is forced to wait. When the interviewer meets them, it should be the subject of apology and explanation – as would be expected of a courteous host. Discourtesy, especially unexplained lengthy waiting periods, kill rapport. The receptionist conducts the family, or dyad, or individual to the staff and introduces them. Rapport building continues and the systematic diagnostic procedures have begun.

While the receptionist is usually the first staff contact with a family, it may occasionally be preceded by another staff member – the telephonist – at some routine enquiry before attendance. Departments can fail here. For effective rapport building, the telephonist must be a person of warmth, of infinite patience, and accommodating. New telephonists respond when the importance of their position is explained to them.

Individuals, naturally, concentrate on their own discomfort and tend to seek help themselves; agencies make use of this readiness. Thus a referral service can be based on the individual with intake channels for all age groups – child, adolescent, adult and the aged.

A referral service could also concentrate on *relationships* – e.g.the marital, parent-child, or sibling-sibling. In practice, the last two are usually associated with a children's intake channel; it may be useful to establish a marital problems intake channel to gather in marital problems, a common feature of disturbed families.

Establishing an intake channel for the *family group* is invaluable – with increasing understanding of family psychopathology this will become in time the method of choice; it must never, however, be inferred that only the group as a whole will be accepted by the service.

Intake clinics based on poor *physical circumstances* are already a feature of countries with well-developed welfare systems. In advanced countries problem or hard-core families find their way to such clinics. If the psychopathological nature of their disability is accepted, in future they will be referred to family group intake channels.

Family-community interaction may break down at many points, engendering problems which require special clinics to cope with them, e.g.delinquency clinics, school refusal clinics, university student clinics, industrial clinics, etc.

Intake channels could also be based on clinical categories. Not only may a family show signs of disruption in any dimension, but it may also present with varying types of psychopathology – psychonosis, psychosomatic symptoms, or delinquency. Thus a service could base its intake channels on clinical categories, instead of on signs of pathology in family dimensions – or on both.

Whatever the family or the agency offers should initially be accepted whether it be an individual member, the whole family, or part of it. The department of family psychiatry can then itself work to achieve the desired aim of involving the whole family.

The Presenting Individual Patient

The family is sick as a whole; yet it rarely presents at a psychiatric service as a complete unit. An individual may be referred as the "presenting" patient, the "proposisitus", the "indicating" patient, the "identified" patient, or the "manifest" patient. That an individual who is alone, such as a widow, widower, single person, divorcee, student, etc, comes alone is understandable, but what determines that a fragment of the family is sent for treatment rather than the whole? The understanding of the mechanisms concerned with the referral of one member throws light on the correct arrangement of referral agencies and the organisation of the psychiatric service. It exposes important aspects of the psychodynamics of the family. It underlines the central thesis of family psychiatry – that the family is a social unit specially meaningful for psychiatry.

Some of the mechanisms determining the referral of one member of the family will be briefly reviewed.

1. *Organisation of services*. Should the psychiatric service in an area be based on adults or children or adolescents, then only that particular age group can find its way to the service, while equally, or more, disturbed members of the family cannot be accepted by the service because they are in a different age group. Thus the shape of the service determines who comes from the family.

Referral agencies tend to have special interests and attract family members falling within their speciality. The family doctor, for instance, concerns himself with individuals with physical problems; this explains why two out of three emotionally ill patients in general practice present with psychosomatic problems. Furthermore, a physical complaint allows the patient to try out the doctor and at the same time hide initial embarrassment. A social agency, specialising in social and welfare problems, sends patients with those problems. Should the school be the referral channel for children, it will give special attention to problems of discipline and scholastic failure. Thus the special interests of an agency determine whom they see and refer to a psychiatric service.

2. *The agency and the symptoms*. Sometimes the individual or the family tends to produce symptoms which will demand attention by a referral agency. When a medical practitioner, for instance, concentrates exclusively on physical symptoms, his patients, to gain his attention, must have physical symptomatology. Should such symptoms already be present in a family member, he will consult his doctor because of them and will become the family member ascertained. In such a situation there is pressure to produce a physical symptom – and, if possible, one of special interest to the practitioner or the psychiatric service. For example, much attention was given some years ago by the psychiatric service to amnesia; it was held that it was possible for unconscious acts beyond the patient's control to take place in this state. Many cases of so-called amnesia were reported, but when psychiatric opinion about responsibility in states of amnesia changed, this symptom became less fashionable.

Again, courts of law can be indifferent about psychiatric disorder, but, should someone manifest some sexual anomaly, there may be rapid referral. Their susceptibilities have been provoked.

3. *The state of the family dynamics*. This varies from moment to moment in the life history of the family, as the following clinical example illustrates: At the conclusion of a brilliant survey of the exclusive treatment of an adolescent patient, who was the son of a widow, a therapist observed that, at the end of the adolescent's treatment, the widow had become severely depressed, and was now an inmate of a mental hospital. The therapist had supported the son, the dynamics of the family had changed to the mother's disadvantage, and she had become the propositus.

Thus in families there are "see-saw" movements. The person "down" at a moment in time is likely to become the propositus.

4. *Vulnerability of a family member*. One family member may be so placed as to be specially vulnerable to stresses within the family. More than this, these family members may have constellations of personality characteristics which make them vulnerable to a particular stress. In addition, ordinal position, sex gender, or age may be important for vulnerability.

A child may be the only child, the first, second, next youngest and youngest. Since the speculation of Adler,[1] much attention has been given to the significance of a child's ordinal position in the family. Generally the studies are contradictory. Although the investigations on ordinal position appear contradictory, when groups are studied, the child's ordinal position in a particular family may yet be highly significant, but understandable only in that unique set of circumstances.

The sex of a child may lead to vulnerability. In many families there may be a tendency for parents to reject one gender whilst accepting the other. Again, this may only become apparent when evaluated as part of the psychodynamics of a particular family. Sex gender may also be a factor determining the attitudes of siblings.

The age of a family member may be the cause of vulnerability. The writer has observed that in some problem families a mother may pay a child a great deal of attention for the first two years, because of her own needs for an emotional "lollipop". At the age of two or three, as the child makes demands on the mother, he is rejected and another infant sought; at an early age the child is accepted, later he is rejected. Thus he becomes vulnerable. Similarly, parents talk of difficulties in acceptance of and in relating to their offspring when they are children or adolescents. Old age is anathema to some families.

5. *Anniversary reactions*. Individuals may not fall ill with equal regularity throughout the year. There are peak periods. For example, Fowler[2] reports a higher incidence of suicide amongst the Mormons of Salt Lake City at Christmas; this is probably not unique to Salt Lake City. Not only may there be dates, seasons, months of significance to whole populations, but also to individuals. Furthermore, the individual breakdown may reflect a family's association with a particular moment in time. The significance of the time may not be apparent to an onlooker, as it has meaning only in terms of the life experience of a particular individual or family. It may relate to a great variety of stresses in the past.

6. *Family motivation*. The family may make use of an individual family member; it can punish a member by sending him for psychiatric treatment, express guilt through him, and use him in a crisis as a means for getting assistance.

The psychonotic equilibrium of the family can be broken when the adolescent's behaviour becomes unendurable to himself, the family and/or society. This creates a crisis and then an appeal for help. Suicide or a suicidal gesture by adolescents may also be a cry for help to the family, as these symptoms may be the only symptom-language understandable by their families.

Of the many motivations setting in motion family dynamics, some of the most intriguing are those causing the role of scapegoat give to a family. The member becomes the "butt" for the family. A mother, for example, may imply to her children, "Things go wrong so much because of the feeble father you have".

7. *Communicated symptomatology.* Two or more individuals in a family may share common symptomatology to such an extent that they will be referred together to a psychiatric service. The members may be beset by a common stress, as in the case of two elderly sisters who had lived closely together for many years, and who, on hearing that their house was to be sold, walked quietly into the sea, hand in hand, and attempted to drown together. The members of a coalition may borrow symptomatology from one another by imitation or suggestion. A paranoid person can persuade another of a common enemy and draw him into his delusional system. This manifestation is common in psychonotic patients.

8. *The demand value of the symptom.* From time to time a member of a family will manifest symptoms which are striking, call attention to themselves, or have considerable "nuisance value". Thus another family member, the family, or a community agency will seek his referral. Some examples of striking symptoms are tics, speech disorders, hysterical symptoms and skin conditions. A child with encopresis, enuresis, or awkward behaviour will quickly come to attention, while an equally disturbed, but apathetic, listless, depressed child may be overlooked.

9. *Cultural attitudes.* These too, can play a part. In some cultures, the mother is sent as the family representative to clinics, especially with children. In Nigeria, on the other hand, fathers attend with the children. This can lead to undue importance being given to the members of the family seen at clinics. Culture can also affect the demand for a service. It is noticeable in British clinics that American visitors are more ready to make use of psychiatric facilities than the British.

10. *Referral as a sign of health*. Insight into one's own emotional state is found to be inversely proportional to the degree of the disturbance. Thus highly disturbed family members avoid, "can see no point in", or obstruct, referral to psychiatric services. Less disturbed family members, on the other hand, can "see the point" and come as the family's representatives. Paradoxically, individual psychiatry can lead to a concentration of effort on those members of the family that are least disturbed.

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Investigation

Introduction

The general aim of investigation is to obtain a complete picture of the family's functioning and dysfunctioning, assets and liabilities described in the historical sequence of the Past, the Present and the Future.

The dysfunction of the family is apparent in indicators. One or more of these come to the attention of the family, of an individual member or of the others. When there is sufficient discomfort, relief is sought and either the family, a part of it, or an individual member seeks help. Through the referral machinery already discussed the patient is sent to the family psychiatry service.

On the first appointment, either an individual, a part of the family or the whole family presents. Thus, the investigating procedure can be discussed as it appertains to (A) a family member, or (B) more than one family member, either a part or the whole family.

There are two main steps in the investigation:

1. To elucidate the indicators, the signs and symptoms, and so establish a diagnosis. This will be in terms of (i) psychonosis, (ii) an organic syndrome, (iii) mixed states. Psychonosis is the prime responsibility of the family psychiatry service. Mixed states will call for collaboration with others. Organic syndromes will be referred to other specialities within the medical services.

2. To elucidate the process of the experiential psychopathology that led up to psychonosis.

(i) establishes the nature of the disorder.

(ii) establishes the cause of the disorder. When an individual presents to the psychiatric service, and it is established that his or her disorder is psychonotic, the rest of the family is drawn into investigation as opportunity allows. Thus, it is necessary to move to the family model of investigation.

Built into the formal investigatory procedure is every device for enriching the rapport with the family. The golden road to the elucidation of the intimate, significant and meaningful psychopathology is a sustained deep rapport between the investigators and the family. To follow with precision the procedure suggested could yield, on its own, virtually no useful information. Rapport brings the procedure to life. It is at this point, rapport, that the machine can fail; it requires a warm, tolerant, understanding human relationship to touch and encourage the hurt, embarrassed chords of memory to express themselves. Rapport makes for security, security for communication, and communication for meaningful information.

A. When the Individual Presents

There are five steps:

I Evaluation of the presenting symptom (the complaint).

II Evaluation of the rest of the symptomatology

Individual's account of the symptomatology

Formal evaluation of the symptomatology

History of the development of the symptomatology

History of the development of the person.

III A. An examination for the signs of dysfunction in the individual: psychic, somatic.

B. Special investigations.

IV The diagnosis.

V Evaluation of the process of individual dysfunction through interview procedures.

Step I. The complaint

This is the indicator of personal dysfunction that has reached the awareness of the individual to such a degree of notice, pain or anguish that help became imperative. As it is subjective, it is termed a symptom.

Typical complaints or presenting symptoms are:"I have headaches very badly now";"I am scared, all the time"; "After meals, I have a severe pain in my stomach"; "I just can't sleep at night any more"; "I feel I want to steal things"; "I just feel miserable".

These complaints are likely to be elicited by the psychiatrist by such phrases as "What is it that you find wrong with yourself at the moment?" The patient is encouraged to give a full account of the nature of the complaint, its intensity, time of onset, etc.

The following points should be borne in mind in relation to the presenting symptom:

The Patient must be allowed and encouraged to describe his experience in his own words. It is *his* experience and it must not be distorted by suggestion from others.

The complaint is not the only indicator of dysfunction in the patient. It is the one that causes him to go for help.

The presenting symptom is physical in two-thirds of patients seen in general medical practice. Thus, careful diagnosis to differentiate organic from psychic syndromes is essential.

To some extent, the selection of indicator may be determined by the nature of the agency he consults; e.g. he is unlikely to consult a surgeon except with pain, or a marital problem clinic with anything other than a marital problem.

The presenting complaint may not be the most significant indicator. Its choice is dictated by the above factors.

The presenting indicator has a high chance of being one that is operative at the time of seeking help. More significant earlier indicators may have been forgotten.

In the case of a young child or infant, the parents have to speak for him.

Step II. Evaluation of the rest of the symptomatology

There are four subsidiary steps:

1. *The individual's account of the rest of the symptomatology*. Even the least co-operative or insightful patient, when prompted by such remarks as "What else do you find wrong with yourself?" will be able to add to the presenting symptoms. He may go on, "Well, not only do I have headaches, but I don't eat much nowadays, and my wife complains that I am reluctant to have intercourse with her, and I certainly feel low spirited". Thus, he has already added anorexia, frigidity and depression to his list of symptoms. Further prompting with "And what else bothers you?" "Perhaps there is something else." "In what way do you feel different?" etc., will add to the list.

Points to note are:

No one knows better than the patient where the shoe pinches if he is given time to describe his feelings. Thus, at this point, a subjective account is invaluable. The description must be in his own words, untampered by others. He is not invited to evaluate his own condition, but merely to describe it.

The patient recounts his own condition in his own language. This may often be more descriptive and more accurate than technical language. Certain phrases are highly characteristic of what is felt and of how the man in the street describes his highly significant experience. He may fail to grasp technical terms used by the psychiatrist later, or find them inadequate or limiting in describing his experience. He may use such phrases as: "It's my nerves, doctor"; "I seem to have become highly strung"; "I would give anything for a night's sleep"; "You see, my spirits are so low". Such phrases would be highly indicative of a patient suffering from psychonosis in the United Kingdom. Such phrases have a connotation hallowed by time and the interchange over a long time with those who have suffered similar experiences.

In the case of a young child or infant the account is obtained from the parents.

2. *Formal systematic elucidation of the symptomatology.* The patient has described his dysfunctioning as well as he can in his own language. The psychiatrist now pursues further symptomatology by covering the field of symptomatology himself in a systematic fashion. It is commenced by such a phrase as "I would now like to ask you a number of questions". This usually elicits much more information.

It should be noted that:

The area covered must include every aspect of organic as well as psychic dysfunctioning.

In the organic field every system of the body must be covered.

There are a number of charts of symptomatology available.

In the case of an infant or young child the account is sought from the parents.

3. *History of the development of the symptomatology*. By now, the symptomatology of the complaint, the expansion on symptomatology by the patient and the systematic enquiry by the psychiatrist can be collated into one list. The further question now is "How has this complex of dysfunctions developed through time?"

Useful questions are “How long have you felt like this?”; “When did you first feel like this?”; “Is it true to say that you have *never* felt like this before that time?”; “What started it off?”; “What makes it worse?”; “What makes it better?”; “Has it been like this all the time?”.

It should be noted that:

The disorder may date back a long time, even to childhood. Some factor has caused the patient to complain now or he is a lifelong attendee at psychiatric and medical clinics.

The disorder may be a recent phenomenon.

Its start may be vague, or sharply clear. In the former case there is a probability that it arises out of a long-standing disharmony of environment. In the latter, the precipitating trauma may be concrete and easily ascertained; on the other hand it may be different because the patient may have strong motivation for ignoring the precipitating factor.

The disorder may run a fluctuating course which may make a highly significant pattern. The adult patient may feel relaxed at weekends, but suffer during the weekdays, suggesting trauma t work; a child may be worse during holiday periods at home from boarding school, suggesting trauma in the family.

Persistent questioning may show that the disorder started further back than the date first given.

There may be a gap between the operation of the noxious agent and the onset of symptoms because: (i) the whole person may be so caught up in coping with an incident, e.g. a crash involving the death of a relative, that it is only later that its significance can be evaluated; or (ii) the pathology in a violent quarrel with father may antedate by some days the skin rash which is getting out of hand in the hot weather.

In the case of the infant and young child the account is obtained from the parents.

4. *History of the development of the person.* This is a systematic enquiry into the general life experience of that person and ends with an evaluation of his non-pathological personality as the result of that experience. From this final study the individual’s assets emerge.

Please note that:

The description of the present personality comes next and covers all except the evaluation of the disorder which has been previously described. It can be based on the description of the psyche given earlier in this book.

In the case of a child or infant the account is obtained from the parents.

Step III:A. Formal examination of the individual for signs of psychopathology

Until now the description of the disorder has been dependent on material supplied by the patient, i.e. the patient's indicators are termed *symptoms*. Now the psychiatrist undertakes a systematic examination to discern the *signs* of dysfunction; these are gathered independently of the patient.

It should be noted that:

The examination must embrace the somatic and psychic systems.

The somatic signs can be indicative of (i) pathology in any system; and (ii) pathology in the encephalon – these are often termed "mental" signs.

The signs of psychic dysfunction are often termed "emotional" signs.

Thus, a complete examination will elucideat signs of (i) general somatic pathology; (ii) signs of cerebral pathology; and (iii) signs of psychopathology.

The value of the examination will be enhanced by meticulous care and by long experience. There is an art of examination born of experience, ingenuity, rapport, and inventiveness.

Step III : B. Special investigations

The investigations undertaken in Step III : A are supplemented by special investigations. They are not usually undertaken as a routine, but arise out of the need to supplement the data garnered to date. The appropriate special investigations are suggested by the findings to date.

Points to note are:

Special investigations include examination for somatic and psychic pathology.

Special physical investigations will include radiological, biochemical, electroencephalographic, pathological techniques, etc.

Special psychic investigations will include a large number of psychometric techniques including those to assess ability, interest, aptitudes, character, etc. Most value comes from these investigations if the psychologist receives an adequate brief from the psychiatrist. Not to enumerate the areas of inquiry is as valueless as sending a patient to the radiologist with the request, "Please X-ray this patient".

Play diagnosis will be essential in the case of a child unable to discuss his life situation in an interview. There are two steps here: (i) Play observation. The observer is trained to give an accurate systematic account of the child himself in a play situation. It calls for careful training of the observer. (ii) Play diagnosis. Here techniques are employed to evaluate the child's experience within his own family and society, but especially within his own family.

It is much easier to undertake operation (i) or hastily move on to so-called therapy than to attempt the more difficult, but more useful, stage (ii). There has been a full-time two-year course in these procedures at the Institute of Family Psychiatry for 20 years.

It may be necessary to admit the patient of any age group to in-patient care for observation or special investigation.

Step IV. The diagnosis (the discernment)

The indicators, signs and symptoms, gathered to date are grouped together in a meaningful way to form a syndrome. In addition to the indicators, the fabric and the noxious agent are taken into account in a full diagnosis. It is supplemented by a background picture of the development and present status of the personality to which it applies.

Points to note are:

The diagnosis may indicate an organic syndrome.

(i) This organic syndrome may be based on pathology of the encephalon, i.e. "mental" disorder which includes acute (eg delirium) and chronic (eg dementia) encephalonosis and which, according to the views of this author, also includes cryptogenic encephalonosis (ie what has included conditions hitherto termed schizophrenia and manic-depressive psychosis).

(ii) The organic syndrome may be based upon a body system other than encephalon.

Although the primary pathology is physical, there may be a secondary psychonosis as a reaction to physical handicap, i.e. somato-psychic disorder.

The diagnosis may indicate psychonosis. It is usually accompanied by secondary physical pathology (termed psychosomatic disorder).

The differential diagnosis between the above conditions is made on the evaluation of the nature of the indicators. Psychic or emotional indicators denote a psychonosis but will usually be accompanied also by physical indicators (psychosomatic disorder). So-called "mental" indicators denote pathology of the encephalon. Purely physical indicators typical of dysfunction in a particular body system indicate a primary physical syndrome; if there are accompanying emotional indicators then these may be due to an accompanying psychonosis, or be a psychic reaction to the physical disability.

The diagnosis may indicate a mixed state of a number of primary and secondary syndromes of physical and psychic states, e.g.a psychonosis in a person suffering also from cancer of the bowel, which has sent off satellite carcinoma to the brain, and secondary anxiety precipitated in the patient by the attitude of the family. Here, there are a primary psychic syndrome, a primary organic disorder (the cancer of the bowel), a cerebral disorder (with "mental" symptoms and signs due to the carcinoma of the brain), and a secondary or reactive psychic disorder due to the family attitude. Mixed states call for a high degree of acumen and extensive experience on the part of the clinician.

It is these complex mixed states that separate out the ordinary from the great practitioners. The first duty of a specialist physician is to give an opinion; its value will depend upon his expertise as a diagnostician. In medicine a respected "opinion"

has always been valued more highly than a therapist who, following well-trodden paths, may exert skill only at a technical level.

The diversity of mixed states can be judged from the list of possible conditions below:

(i) Somatic condition only.

Predominantly somatic disorder with associated psychiatric state reactive to the somatic (somato-psychic state).

Primarily somatic condition with coincidental psychonosis.

Primarily psychiatric condition with coincidental somatic state

Predominantly psychiatric condition including associated somatic symptoms, i.e. psychosomatic state.

Psychiatric condition only.

(ii), (iii), (iv), and (v) are mixed states.

It should be noted that (iii), (iv), (v) and (vi) above a person with a psychonotic personality or illness is liable to the following physical conditions:

Psychosomatic symptoms due to the psychic states.

Hysterical symptoms – simulated physical conditions responding to the psychic problem.

More chronic ill-health due to worsening of psychosomatic symptoms or aggravation of existing physical conditions.

More hypochondriasis, i.e. existing physical states are found more difficult to bear.

Psychonosis is not diagnosed by the absence of physical indicators, but by positive indicators of psychopathology.

There is no value in the traditional labels of anxiety states, obsessional states, reactive depression, neurasthenia, etc. They should be discarded. At the Institute of Family Psychiatry they were discarded 20 years ago with great benefit. Such inadequate labels arose because examination was often cursory and the patient was labelled by his presenting symptom, which was assumed to be his only symptom, and thus it was elevated into a disease category. Psychonosis is *never* monosymptomatic, as the whole personality dysfunctions. However, additional symptoms and signs will only emerge after careful history-taking. The indicators change with time, a person anxious today (anxiety neurosis), may seek more help next week by an attentions-seeking symptom (hysterical state) and failing to secure help may soon after become depressed (reactive depression). On each occasion, the patient is labelled by his presenting or most obvious symptom and the other symptoms are ignored. A detailed diagnosis should list all the manifest symptoms and signs of the syndrome at that time – when psychonosis will be seen to be polysymptomatic.

It is useful to describe the time element in the course of the psychonosis, thus – acute, chronic, recurrent, episodic, etc.

It is useful to indicate the degree of the psychonosis. This is impressionistic, but when carried out by an experienced clinician it has value in giving a measure of the general magnitude of the psychopathology, e.g. mild, moderate, or severe degree of psychonosis.

The diagnosis can indicate the general nature of the basic personality of the patient.

It may be useful to mention the psychic noci-vectors if known.

For record purposes the diagnosis can be brief, e.g. “acute, severe psychonosis in middle life in an intelligent woman of previously sound personality, precipitated by desertion by husband”.

A longer diagnostic formulation can give a more detailed account of the indicators of pathology, e.g. to the above could be added “She manifests apathy, anxiety, depression, insomnia, nightmares, irritability, suicidal tendencies, pruritus, amenorrhoea, and colitis”.

The diagnosis may at this point be:

(i) Unclear. In this even, further investigations may be required or “masterly inactivity” to await the development of significant indicators.

(ii) Provisional. It can be a useful evaluation, but tempered by the knowledge that it lacks complete evidence.

(iii) Final.

At this point the psychiatric service may have completed its task. The referring agency may have asked for a diagnostic opinion only. Thus, the individual is referred back to that agency.

At this point the patient will often require an opinion on his condition couched in terms suitable to his understanding and with the maximum explanation consistent with his interests.

Step V. To elucidate the psychopathological process

The aim here is to answer the following questions: What are the psychic noci-vectors and from what disharmonious attitudes did they arise? On what psychic fabric were they acting? What dysfunction did they lead to that produced the indicators that were observed? What caused the person to be referred with his presenting symptom?

Points to note are:

a) To elucidate the indicators is not the same operation as to elucidate the psychopathology.

b) The understanding of the psychopathology should be based on knowledge of experiential psychopathology as outlined earlier.

c) The life history of the patient should be explored in all its aspects both in his present family and in his preceding family.

d) Usually, this exploration immediately reveals how handicapping it is not to have either the present family, preceding family, or both participating in the

investigation. Thus, other family members may be drawn into investigation over time.

e) Most of the work with individuals is undertaken initially in individual interviews. It may be permissible to involve the individual in dyadic or family interviews to improve knowledge of the individual, i.e. at that point in time estimation of the dyad or family itself is either unnecessary or impossible.

f) Not only what is said and done by the individual must be given due weight, but also what is not said and done.

g) Diagnostic interviews to elucidate the nature of psychopathology must not be confused with therapeutic interviews. They are aimed at discovering events and not changing them; a therapeutic technique, to be termed therapy, must demonstrate that (i) there has been a change; and (ii) that this change is beneficial – some changes can do harm.

It is possible, however, for small beneficial change to spring from diagnostic interviews and thus for early therapy and diagnosis to run parallel. However, the two procedures should not be confused. Much of what is termed therapy proves to be diagnosis; if the two are separated it will be clear what little therapy is taking place and extra effort will be made to be more effective

h) There is no value in obtaining more information than is necessary to understand the patient's disorder and to serve as a basis for therapy. Valuable, scarce facilities are wasted in an endless search for irrelevant minutiae of information. Faced with therapeutic decisions, the plea if soften: "We need more information" (as yet we don't know how many of great-grandmother's teeth survived to old age!) - a blatant rationalization to avoid the hazards of decision-making,

Occasionally insufficient psychopathology emerges to explain the symptomatology. This is usually due to insufficient rapport. Extra causes may be the individual has learned to be evasive, due to previous unskilful diagnosis; conditions are not conducive to confidential discussion; the technique is faulty; enough time is not available; the basic psychic noci-vectors are particularly hurtful and embarrassing; or interpretation is being undertaken according to some dogma rather than experiential psychopathology.

i) Understanding the process includes assessments of the psychic noci-vectors, their origin, the clash of attitudes, the choice and nature of the symptoms, the coping devices and the psychic damage.

j) Diagnostic interviews have many of the features of a therapeutic interview, but they can also have some differences. In diagnosis, especially in the first four steps, it is permissible to be more directive, with discrimination. It has been fashionable in some quarters to impress on all the importance of "listening". To listen alone is not enough. The whole field has to be explored and therefore there must be guidance in every direction. He who sits and says nothing will elicit little. He who guides and then sits back to give the floor to the patient learns much. Experience teaches the art of optimum direction – some of which

can be non-verbal. Expectancy, interest, praise and encouragement by the psychiatrist are great motivators of patients. Rapport is the greatest revealer.

k) Individual diagnostic interviews normally last for 50 minutes, with five minutes to read the notes to date and five minutes to add to the record.

l) The number of hours spent on diagnosis will depend on: (i) the urgency of the matter; (ii) the complexity of the disorder; (iii) the facilities available. Thus the time spent may range between one hour a week for three weeks to one hour a week for six months.

m) *Children* call for special procedures. As this book is concerned with principles, detail cannot be given here. However, some comments are deserved

(i) There is no merit in roundabout play techniques if the child is willing to discuss his life situation in an interview.

(ii) Time must be spent to build up rapport.

Questions must be simple.

Indirect techniques are best, e.g. asking for an account of events such as a birthday, first day at school, last Sunday at home, etc.; the account can then be evaluated by the interviewer rather than by the child.

A child may react against the idea of admitting his faults and thus, instead of using a standard “good” or “bad”, one can employ two standards of “good”, e.g. “You have a nice mother. How would you make her even nicer?” or, “How would you make your school even better?”

A child’s experience is naturally limited and he can only offer an opinion in tune with his experience. To ask a child, grossly ill-treated at home and who has never been away from his family, whether he would like to live elsewhere will always elicit the answer “No” as he will naturally cling to the only family he knows. A child who has lived elsewhere may be remarkably frank and accurate in his opinion – thus, “As a matter of fact I much prefer to live with Granny” or even, “Why don’t you send me back to Granny?”

A child may reveal his dissatisfaction concerning the present in his hopes for the future – thus a question such as, “If anything you wanted could happen to you, what would you want?” may be very revealing – “I think I would like to manage on my own without women when I am a man” or “Never go to school”.

Children can also be asked to make lists in order of priority – thus, “If you had to go on a long journey in a car, who would you have to sit next to you. And who next, and who after her?” etc.

A child is not hurt primarily by phantasy, he is hurt by events. Phantasy may reveal the hurts as he may seek solutions or compensation in his phantasy. But he does not want just preoccupation with his phantasy; he wants change in the hurtful life events that they portray.

Elucidation of phantasy is not a direct technique as a recall of real life events by the child. Speculation about bad witches may be highly inaccurate as against a child's explosive "I hate my mother". Fairy castles can't be changed; families can. Child psychiatry has suffered much from a preoccupation with phantasy and its disinterest with facts.

n) Having elucidated the psychopathology, the work of the psychiatric service may have been accomplished. The referral agency may have asked only for (i) an opinion on diagnosis; (ii) an opinion on the nature of the psychopathological process in the individual. Thus, this may be a point at which referral back to the referring agency is possible.

o) The investigation now moves to the rest of the family. They may be added one at a time or may be willing to come immediately as a family group. In the case of a single person, the family that requires involvement may be his or her preceding family.

Occasionally, the rest of the family, preceding or present, due to a variety of circumstances, can only be dealt with through the presenting family member.

B. When the Family Presents

The same procedure applies if two or more members of the family present instead of the whole family.

There are five steps:

I Evaluation of the presenting symptom (the complaint).

II Evaluation of the rest of the symptomatology:

Family's account of the symptomatology,

Formal evaluation of the symptomatology,

History of the development of the symptomatology,

History of the development of the family.

III A. Examination for the signs of family dysfunction: psychic, somatic.
B. Special family investigations.

IV The diagnosis.

V Evaluation of the process of family dysfunction through interview procedures.

Step I. The complaint

This is the indicator of family dysfunction that has reached the awareness of the family (or part of the family) to a degree of notice, pain, or anguish when help becomes imperative; as it is subjective, it is a symptom.

Typical complaints or presenting symptoms are:"We just row all the time";"Our family is breaking up"; Something is continually going wrong"; We are on our own and no one wants to know us"; "People succeed, we don't"; "If I'm not ill, then someone else in the family is"; "Does anyone have as many accidents as we do?"

The complaints are likely to be elicited by the psychiatrist by phrases as “What is it that you find wrong with the family at the moment?”

The following points should be borne in mind in relation to the presenting symptom:

It is not the only indicator of dysfunction in the family. It is the one that caused the family to come for help.

The presenting symptom may be psychic or organic. More usually it will be psychic, as symptoms of physical ill-health are often interpreted by the family in the conventional sense of belonging to an individual.

The selection of a presenting symptom may be influenced by the agency referring the family to the psychiatric service, e.g. work failure ascertained by the industrial medical service.

The presenting complaint may not be the most significant indicator; it is the one which, for a variety of reasons, is paramount at that moment.

The presenting indicator has a high chance of being the one that is operative at the time of seeking help. More significant indicators may have been forgotten.

Families have symptomatology stamped on them by the preceding families. Thus, there may be a history of presenting symptoms over a number of generations, e.g. feeding problems, depression, delinquency, aggression, etc.

The family often has a spokesman who may, or may not, be presenting a consensus opinion.

Step II. Evaluation of the rest of the symptomatolgy

There are four subsidiary steps:

1. *The family’s account of the rest of the symptomatology.* The family may need to be prompted by such remarks as “What else is wrong with the family?” so that further symptomatology can emerge. A family member may go on, “You see, it isn’t only that we all quarrel, but Jimmy (a son) and I are depressed, my husband and I don’t share the same bedroom any more, and our daughter never comes to see us. My husband is under the doctor’s care with his heart”. Thus, to the presenting symptom have been added a number of others – depression in two family members, marital discord, psychosomatic symptoms (frigidity in husband and wife, angina in father), parent-daughter discord. Further prompting is usually necessary with such remarks as, “And there other things wrong?” “In what way would you like to be better than you are at the moment?”

Points to note are:

No one knows better than the family the extent of its own dysfunction. Thus, a subjective account is invaluable. The family describes, the psychiatrist evaluates.

The family should be encouraged to give its account in its own language. Technical jargon which it may have picked up may not exactly describe what it experiences and so limits the account.

Tactful prompting will encourage all the family members, including the children, to add to the family account. Discussion will go on until a consensus is reached; in this fashion the symptoms may be given more detail and thus flavour, extent and conditions of operation emerge.

2. *Formal systematic elucidation or symptomatology.* The family has described its dysfunction as well as it can in its own language. The psychiatrist now pursues further symptomatology by covering the field himself in a systematic fashion. This provides more information.

3. *History of the development of the family disorder.* By now the symptomatology of the complaint, the expansion on the symptomatology by the family, and the systematic enquiry by the psychiatrist can be collated into one list. The further question is how this complex of family dysfunction developed through time.

Useful questions are: “How long has the family been like this?”; “When did you feel the trouble began?”; “Have you ever been a happy family?”; “What brought the change?”; “When is the family happiest?”; “When is the family most miserable?”.

Points to note are:

The history should start from the moment of the first contact between husband and wife, i.e. the first contact between the two preceding families as represented by their respective epitomes.

The dysfunction may date from the onset of contact between husband and wife, or may have emerged at any point subsequently.

There may be nodal points in the life of the family of especial significance, e.g. marriage of the parents, birth of the first child, birth of any of the subsequent children, change of occupation or location, death of relatives, advent of a third party, the last child leaving home, marriage of one of the children, retirement, etc.

The start of dysfunction may be vague or sharply clear. In the former case, it is probable that it arises out of mounting disequilibrium produced by the interaction of the preceding families in their representation in the parents, their epitomes. In the latter, the precipitating trauma may be concrete and easily ascertained, e.g.it may date to the time when the family returned to live close to a preceding family.

The family disorder may run a fluctuating course whose pattern is significant, e.g.the family is harmonious as long as the only child is not at home, or during holiday periods there is harmony as the family is away from a preceding family.

Persistent questioning may reveal that the disorder started further back than the date first given. Not infrequently it dates right back to courtship.

4. *History of the development of the family.* This is a systematic enquiry into the life experience of the family and ends with an evaluation of the non-pathological aspect of the family psyche as it is today, as the result of their life experience. From this latter study the assets of the family emerge, and they are of great value in management.

Points to note are:

The evaluation of the life experience of the family can be covered by a framework that starts at courtship and ends at the present.

The examination in (a) can include, under Dimension of the Individuals, a history of each individual's experience in his preceding family and his personality structure now . It should be noted that the evaluation of the children in the family under Dimension of the Individuals is an account of their experience in the present family .

The description of the present state of the family covers all except the evaluation of dysfunction, already dealt with. It can be based upon the description of the family psyche given earlier in this book .

Step III:A. Formal examination of the family for signs of psychopathology.

Until now the description of the family disorder has been dependent on material supplied by the family, i.e. it has been concerned with *symptoms.* Now, the psychiatrist undertakes a systematic examination of the family to discern the *signs* of dysfunction; they come from an objective examination from outside.

Points to note are:

The examination must embrace the physical as well as the psychic aspects of the family.

Each dimension of the family will be covered in this examination – including signs in the Dimension of the Individuals.

The examination may extend over a long period of time. At first the material coming from the family may be false, as the family is not behaving naturally, or because the observer is not yet attuned to its mode of behaviour. As time goes by and rapport develops, the family behaves naturally. Thus, early assessments are amended as time goes by unti the picture is a settled one.

The value of the examination will be enhanced by meticulous care and by long experience. There is an art of examination born of experience, rapport and ingenuity. Trainees must spend many hours analysing video tapes on set schedules and discussing the analysis with experienced supervisors. After some time the evaluation of material will become automatic and accurate.

Step III:B. Special family investigations.

The investigations undertaken in Step III:A are supplemented by special investigations. They are not undertaken as a routine, but arise out of the need to supplement the data garnered to date.

Points to note are:

Special investigations include the examination of somatic and psychic pathology.

Special physical investigations will include radiological, biochemical, electronencephalographic, pathological techniques, etc.

Special psychic investigations will include a large number of psychometric techniques. Among these is the Family Relations Indicator, which has been found of great value at the Institute of Family Psychiatry.

In the Dimension of the Individuals in the family it may be necessary to employ play techniques in the case of children. See Step III:B earlier for the investigation of the individual.

It may be necessary to admit the whole family into in-patient care for observation. Usually, admission for investigation is for a short period. Indicators for admission include: (i) urgency and the need for quick intensive evaluation; (ii) geographical factors – attendance on a regular basis as an out-patient may be impossible due to distance; and (iii) a difficult elaborate investigation involving a number of special investigations.

Step IV. Family diagnosis (the discernment).

The indicators, signs and symptoms, gathered to date are grouped together in a meaningful way to form a syndrome. In addition to the indicators, the fabric of the family and the various psychic noci-vectors are taken into account in a full diagnosis. This is supplemented by a background picture of the development and present status of the family to which it applies.

Points to note include:

The diagnosis may indicate a disturbance in the physical dimensions of the family. This may involve a part or the whole family. Included in the category of physical disorder it may be found that there is an acute or chronic encephalonosis, e.g. Huntingdon's chorea, or one of the cryptogenic encephalonoses, such as encephaloataxia. There may be a secondary psychonosis as a reaction to a physical handicap.

Most frequently, the diagnosis is that of psychonosis of the family. It is often accompanied by secondary physical pathology, i.e. family psychosomatic disorder.

The diagnosis may indicate a mixed state of primary and secondary physical and psychic states, e.g. a family suffers from hereditary ataxia with secondary psychonosis, resulting from its difficulties of employment, and in addition father's affectional involvement with a voluntary helper has precipitated an acute psychonosis reflected in dysfunction and indicators throughout the family. Thus, there are a primary physical syndrome (hereditary ataxia), a primary psychic syndrome (acute psychonosis), and a secondary psychonosis (reactive to employment problems).

Mixed states call for careful prolonged examination, acumen of a high order, and great experience. Many disturbed families may not respond to prolonged help of great magnitude because wrong assessment of the family makes it impossible to meet the need with accuracy.

Psychonosis of the family is not diagnosed by the absence of physical indicators, but by the presence of psychic indicators.

There is no value in labelling families by any of the traditional clinical label, e.g. anxious families, delinquent families, etc. In this undesirable practice, as in the individual field, families are labelled by the presenting syndrome. Symptoms are fleeting. Furthermore, psychonosis of the family is never monosymptomatic; the family is described in each of its dimensions and often displays a number of symptoms in each of the dimensions.

It is useful to describe the time element in the course of the psychonosis, thus – acute, chronic, recurrent, episodic, etc.

It is useful to indicate the degree of the psychonosis. This is impressionistic, but has value to an experienced clinician in giving a measure of the general magnitude of the psychopathology, e.g. mild, moderate, or severe degree of psychonosis.

The diagnosis can indicate the general nature of the state of the family in its premorbid state.

It may be useful to mention the noxious agents if known at this stage.

For some record purposes the diagnosis can be brief, e.g. “acute, moderate psychonosis in a family showing a mild degree of psychonosis from its inception and precipitated by interaction with the extended family”. A larger diagnostic formulation can give detailed account of indicators of pathology under each of the dimensions, e.g. the following indicators psychopathology were evident:

(i) The individuals (symptomatology can be added in each case):

Marked degree of psychonosis in *father*

Moderate degree of psychonosis in *mother*

Moderate degree of psychonosis in *son*

Severe degree of psychonosis in *daughter*

Internal interaction:

Father-Mother relationship – negative hostile relationship

Father-Children relationship – marked mutual antipathy to daughter and somewhat less to son

Mother-Children relationship – grossly overprotective to both with rejection of daughter, and hostility of children towards mother

General: Father isolated by rest of family members; fragmentation of family imminent.

External interaction: Failure at employment with impending bankruptcy; school failure of daughter; delinquency of son; isolation of family.

Physical: Feeding difficulties in daughter; enuresis in son; gastric ulceration in father; frigidity in mother.

The family diagnosis at this point may be:

(i) Unclear. Thus further investigations are required.

(ii) Provisional.

(iii) Final.

At this point the psychiatric service may have completed its task. The referring agency may have asked for a diagnostic formulation only. Thus, the family is referred back to the agency with the formulation.

At this point the family will usually ask for an opinion on its condition and this should be in terms couched to allow understanding and given with the maximum of explanation consistent with its interests. There is a tendency for clinicians to underestimate the intellectual grasp of the family and its capacity to tolerate and understand what is said to it.

Step V. To elucidate the psychopathological process in the family

The aim here is to ask the question, "What psychic noci-vectors arising from what disharmonious attitudes springing from the past and the present led to the family dysfunction which produced the indicator observed causing the family to attend with its complaint?"

Points to note are:

(a) To elucidate the indicators is not the same operation as to elucidate the family psychopathology.

(b) The understanding of the psychopathology should be based upon knowledge of experiential psychopathology as outlined earlier.

(c) The explanation should extend back from the present family to the preceding families.

The way to the understanding of the dysfunctioning of the present family invariably lies with the understanding of the preceding families of the parents and the interaction of these families through their representatives in the present. The importance of this last sentence cannot be overemphasised. Thus, in a full investigation preceding families may require formal evaluation in the manner described here.

It may be of value to draw the preceding families into the investigation either alone as families, or with the present family. Thus, a family interview may consist of: (i) the present family; (ii) the present family and one preceding family; (iii) the present family and the two preceding families; (iv) collateral related families in addition to (iii).

It may be of value to draw the succeeding families into the investigation, either alone or with the present family. Thus, a family interview may consist of the present family with one or more succeeding families.

A family is the meaningful functioning group at that moment. Thus, it may include lodgers, relatives, servants, etc.

Most work will be undertaken in family group interviews. However, there may be times when it should be supplemented by individual or dyadic interviews. Need for an individual interview may arise if: (i) there is a marked degree of psychopathology in a family member; (ii) an individual can at that moment share the information only with

the interviewer and not with the family. Equally, dyadic interviews may be required, either because of an especially pathological interaction or because the couple cannot share the same information with the rest of the family at that time. Individual or dyadic interviews may have to be undertaken with children and some of the features of an interview with children have been coveed under Step III:B of the individual investigation.

Family diagnosis must not be confused with family therapy. Family diagnosis is concerned with describing and understanding family events and not with changing them. Much of what is termed family therapy proved to be family diagnosis, i.e. no change is effected for the better. If the two procedures are kept separate, therapy will be more effective in that it will be apparent whether or not change is taking place. It is possible for therapy to run parallel with diagnosis, but the distinct nature of the two operations must always be kept in mind. If therapy is the aim, it is a useful practice for the therapist to ask himself, “What change for the better have I produced in the last (number) of interviews – and what proof have I that the interview effected the change rather than extra-interview events?” It can be a salutary exercise.

There is no value in obtaining more information than is necessary to understand the psychopathology of the family. Valuable, scarce, highly expensive facilities are wasted in uncovering irrelevant minutiae of information. Only experience teaches what is relevant. It is easy to meander on seeking endless information; this is a comfortable exercise which only hides the inability to use the information to the advantage of the family – the only justification for the exercise.

Family diagnostic interviews have many of the ingredients of family therapy interviews, thus prolonged discussion of the family interview will be left for the section on family therapy.

There are, however, some differences. It is permissible to be more directive in diagnosis. To listen and leave matters to the direction of the family is not enough. The whole family field, present and preceding, has to be explored and therefore there must be guidance. Sometimes the same area has to be reworked for greater clarification. Experience teaches the art of optimum direction. Rapport with the family is the great revealer.

Family diagnostic interviews normally last for at least two hours. This is necessary as there are more people requiring to talk than in an individual interview. For a dyadic interview at least 1½ hours should be allowed.

There are times when a whole day can be employed with advantage for a family interview. This is required if: (i) a point of crisis has been reached; (ii) urgent work is necessary: (iii) geographical difficulties make it impossible to work in any other way. There should, of course, be rest breaks during interviews lasting 1½-2 hours.

The number of interviews required will depend largely on the complexity of the problem. Thus, diagnostic interviews at weekly intervals lmay extend from three weeks to six months.

Not only what is said or done must be given due insight, but also what is not said or done by the family.

Occasionally the psychopathological process which emerges is not sufficient to explain the symptomatology. This may arise because rapport is inadequate – much the commonest cause – of the technique is inefficient; enough time has not been spent; the interview conditions are unsuitable for confidential discussion; the basic psychic noxious agents are particularly stressful or embarrassing; the family has learnt to evade by previous unskilful attention; or distortion by interpretation is in terms of some dogma rather than in terms of experiential psychopathology.

Having elucidated the psychopathological process, the work of the family psychiatric service may be over. The referring agency may have asked only for: (i) a family diagnosis; (ii) elucidation of the psychopathological process. Thus, at this point the family can be referred back to the agency.

At the completion of family therapy, it is sometimes useful to go through a formal evaluation as here, so that the present state of the family can be compared with its state before therapy.