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FAMILY DIAGNOSIS and CLINICAL PROCESS

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FAMILY DIAGNOSIS AND CLINICAL PROCESS[1]

Our approach to the concept of family diagnosis evolves from the nature of the clinical encounter. To diagnose means to distinguish by knowing. In this special context, the clinician acquires a "knowing" through his involvement in a series of exploratory family interviews. It is through this participatory experience of face to face confrontation that the therapist empathically "feels into" and "sees into" a troubled family. The method involves continuous observation and interpretation of relevant events. The encounter stimulates in the therapist a progression of clinical hunches, deriving from and enriched by his knowledge of psychodynamic and psychosocial processes and by his past personal and professional experience. These hunches are continually put to the test of the prevailing interpersonal realities. Across time, the therapist develops fragments of theory concerning family diagnosis which must be tested, amended, and verified in an ongoing process of consensual validation. This, in effect, is our "manner of inquiry"[2] into the problem of family diagnosis, a stage by stage development of diagnostic insight derived from the experience of therapeutic involvement. What is learned is a function of how we learn it.

Thus, family diagnosis and family therapy are parallel, interdependent activities. Insofar as the family is an ever-changing phenomenon, the diagnosis changes as the family changes. Diagnosis serves as a guide to action.

It provides a strategy for therapeutic intervention.

Within the limits of present-day knowledge, does the task of family diagnosis make sense? Is it realistic? Is it feasible? Whatever one thinks and however one does it, whether well or badly, it is a fact of everyday clinical practice. The issue is not shall we but rather *how* shall we diagnose. Clinicians inevitably draw judgment on the families they treat. They describe, compare, and contrast them; they draw meaningful distinctions among them. In a tentative way, therapists hypothesize certain correlations between family transactions and the adaptation of individual members. They cannot help but do so. The functions of observing, conceptualizing, and interpreting such correlations are inherent in the therapeutic encounter. The issue is, therefore, family diagnosis toward what ends, by what means, with what criteria, by whom, and with what measure of reliability.

In taking this posture on the problem of family diagnosis, we are fully cognizant of the existing climate of opinion. The disenchantment with the medical model of psychiatric illness is widespread. The bias against labeling people and families is sharp. In many quarters, psychiatric classification is viewed as passe, useless in therapy, or even harmful. Nonetheless, the challenge is there to be met. The answer to bad diagnosis or the abuse of diagnosis is better diagnosis—not to toss out this responsibility altogether.

The turbulence of contemporary behavior theory, the disillusionment with traditional standards of diagnosis, these are precisely the products of new knowledge. What is called for now is a fresh start, a new, more effective paradigm for the responsibility of clinically oriented family diagnosis. Such a model needs to take into account the ecological perspective, the changing theory of behavior, of therapeutic process, of mental illness and its causation. Within this framework we must underscore the contagious and communicable nature of pathogenic emotion in family group process. We are impelled, also, to adopt a broader interpretation of psychiatric disorder as a family phenomenon, a cluster of multiple disturbances among the members of the family group, interdependent, interacting, and emerging in series across time. Individual diagnosis, whether child or adult, achieves a fuller meaning within the matrix of the family as a behavior system.

To sum up the argument thus far, family diagnosis begins with a clinical hunch, an intuitive, informal fragment of theory; it then moves gradually toward a more formal, explicit, systematic diagnostic judgment, a shift by progressive stages from a subjective toward a more objective formulation. The use of multiple observers facilitates this process.

The Family Group

In the family-group procedure, we are evaluating a group different from

other groups, a culturally patterned biosocial unit embracing two or more generations, both sexes, a constellation of persons sharing emotion, identity, a way of life, and a related quality of struggle and growth. We are judging persons within the family, the family within the community. We are assessing a path of movement, what the family is, was, and where it is going. The family is a living entity, an open system of behavior, characterized by a life cycle uniquely its own. It grows up; it grows outward. It undergoes periods of slow change and rapid change. It experiences a sequence of crises. To maintain its functions, it must weather each crisis in turn. The family moves forward, or else it loses its vital force (gets "sick") and "dies". Following each upset, it must mobilize its homeodynamic powers to restore equilibrium and yet preserve its potential for movement and growth.

We evaluate what goes on inside and outside the family, inside and between the minds of individual members. We examine the structure and functions of the family, how the family fulfills its multiple responsibilities or fails to do so, and how this molds the experience, development, and emotional health of its members.

The family is a unit of living, yet its parts are divided and differentiated. It has male and female, old and young, big and small, strong and weak, smart and stupid, appealing and unappealing members. Within its larger representations of unity, there are shifting alignments and splits. A conflict of

identity, values, and strivings brings a rift, a split in the family group which mobilizes one faction against another. These factions do battle with one another for a position of dominance in determining what the family does for, with, and against its members; what they do, in turn, for, with, and against the family. Such splits within the group may be horizontal, vertical or diagonal. They may be male against female, mother and son against father and daughter, mother and children against father, the younger against the older generation. Fragmentation and alienation of family relationships may proceed to the extreme where finally it becomes each member for himself. Such trends divide the family, throw its functions off balance, favoring some, disabling and warping others.

It is the character of a living system that it has a boundary, and across this boundary there is an incessant exchange from outside in and from inside out. How we define the family, its boundary, whom we include and whom we exclude, depends on what we are trying to do. We expand or contract the "rubber fence" (L. Wynne) of family in accordance with our special interests and purposes. If we adopt too narrow a focus, we get more precise data but are in danger of omitting important processes. If we use too broad a focus, we clutter our understanding with an overabundance of unmanageable data. Of necessity, our focus is selective; it concentrates on those components of family experience that are relevant and specific for the emotional destiny of the members. Within this framework, diagnosis has a special meaning related

to the clinical goal, a program of intervention that seeks to exert a favorable influence on the critical balance of forces as between those that predispose to breakdown and those that enhance health.

The Functions of a Family Therapist

As indicated, diagnosis and therapy depend on the clinician's use of self as family therapist. Therapeutic family interviewing is a personal art; yet each artist is called on to optimize existing knowledge of the dynamics of family and individual behavior. The role of the family therapist is that of a participant observer. He engages a family group in a face- to-face interview, searching for the forces, both open and hidden, that affect the wellbeing of the family and its members. The encounter is a free-wheeling, open-ended adventure, limited only by the potentials of the fit between family and therapist. With a particular family, one clinician may make it; another may fail. A special kind of human chemistry is involved. It is the idiosyncratic quality of the match of family and therapist that determines the potentials both of therapy and of diagnostic understanding.

With the involvement of the therapist, the family group is instantly "re-peopled." The therapist becomes part of what he is observing. He is drawn into the whirlpool of the family struggle. He moves in but must also know when and how to move out. He must be continuously aware of the risk of

being sucked into the family system and thus lose his capacity for autonomous, flexible, and appropriate intervention. Stage by stage, the therapist evolves the priorities and sequences of his actions. The selection and timing of his interventions are of the essence. Through his active participation, the therapist shakes up the existing alignments and splits of the family.

In face-to-face confrontation, the therapist makes instant observations of appearance, mood, and behavior of the members and their integration into family roles. He pays attention to their demeanor, manner of entry, and seating arrangements. Who joins with whom? Who is against whom? Who speaks? Who is silent? Who is open, who closed? Who looks cheerful, who seems sad? Who moves quickly into the fray? Who slides into retreat?

The mood is all important. What part of the group is alive and spirited; what part is depressed and dying? Which of the members are hopeful, expectant, or on the other hand, resigned and despairing? What are the expressions of hurt, fright, and anger? Of confusion, mistrust, and hostility? Do the members reach out to one another and to the therapist? Are they receptive? Do they turn coercive? Do they sink into apathy and cease to ask for anything?

A first concern of the therapist is to establish rapport, a feeling of trust

and empathy (a touching quality of contact and communication), and to rekindle the hope of something better. The therapist reaches out to meet the family members on their own ground, to join them emotionally where they live. He feels his way toward the idiosyncratic mood and language of the family, how they talk, what they talk about, what they do not talk about. The therapist, through his openness and candor, catalyzes the interchange of conflict-loaded material. When the members engage in a silent pact to evade such confrontation, the therapist seeks ways to penetrate their complicitous denials. He draws judgments as to how far these family secrets are valid, or false, how far they are on the side of health, or on the side of sickness. To whatever extent they are judged to be pathogenic pseudo-secrets, the therapist supports the family in exposing and sharing the hidden content. In a white family with three daughters and one son, it was necessary to crack open the pseudo-secret: One daughter lives with a black man, and the only son is homosexual. Every member knows yet pretends not to know, a conspiracy of silence.

The therapist zeroes in on the most destructive levels of conflict, on those relationships that generate the most intense anxiety. To stir movement, he engages in a tactic characterized by “tickling” the defenses. He catches the family by surprise, pointedly confronting them with contradictions between their self-justifying rationalizations and the truer emotions. He exposes the discrepancies between verbal utterances and what is felt below the level of

words in facial expression, gesture, and bodily posture. He challenges empty verbalisms, clichés, and pat formulae for the problems of living. Maximizing the stream of empathic emotional interchange, he invites increasingly candid disclosures. Stage by stage, he reaches out for a deeper, more meaningful emotional interchange.

He assays the main patterns of conflict and coping, the patterns of complementarity, the interplay of family defense and individual defense. He traces the sources of anxiety that freeze the reaching out of members, the asking for closeness one with the other and with the therapist.

He cuts through the vicious cycle of blame and punishment, which is nothing less than an unconscious collusion to prevent change. When one part of the family armors itself to assault and scapegoat another, the therapist intervenes to neutralize and soften the assault. By counteracting scapegoating as a pathogenic defense, he retransposes the conflict to its place of origin within the group. By identifying a cluster of interrelated roles—persecutor, victim, and peacemaker or healer—he is enabled to support and strengthen the forces of healing within the family.

The emotions and images evoked in the therapist by the crisscross currents of feeling moving among the family members and toward himself serve, in effect, as a diagnostic yardstick for what is being experienced below

the surface. Sequence by sequence, and in a selective way, the therapist puts his clinical hunches and insights to the test. The face-to- face interview provides a continuous opportunity for consensual validation of hypotheses. What one member conceals, another reveals. What one expresses in a twisted, prejudicial way is counterbalanced by another. The social structuring of the interview promotes a sustained process of working through of partly shared, partly clashing, images and emotions. The therapist acts as a balance wheel, checking experience against the prevailing interpersonal realities.

The core of the exploratory process involves colliding images, the family's image of itself, the conflicting images of the warring factions, the community's image, and the therapist's own image of the family. Throughout the entire process, the therapist is engaged in a subtly shifting encounter, joining or jousting with one or another family factions. What is involved is a kaleidoscope of forces epitomizing a shifting balance of continuity within change, change within continuity. The quest for relevant insights moves from the family as a whole, to the warring subgroups, to the cluster of interlocking disturbances, and finally, to the pathogenic effect on the labeled patient. In so doing, the therapist assays the relative severity of disturbance and the family's capacity for change and growth. Step by step, he optimizes the opportunity for teasing out the essential character of the family.

This is our picture of an exploratory family interview; the how of the

encounter determines the what; the information we gather depends on how we get it.

A Clinical Illustration[3]

This family consists of the two parents in their thirties and five children. The mother is Italian Catholic; the father is half-Jewish. This is a working-class family. The first issue is survival. The mother is depressed and shabby looking. She has made repeated attempts at suicide. Her face is marred with acne; she has a facial tic. The father is a good-looking man; neat and trim, fearful and yet overbearing.

This couple has been separated for a month, but is again joined. The father has terminated an affair with another woman, whom the mother contemptuously calls “the pig.”

During the interview, the mother seats herself next to the therapist. The father leans away; he “plays it cool”. The presenting mood is one of explosive rage between husband and wife, barely controlled. The eldest son, twelve years, has a masked, frightened look; the eldest daughter, ten years, seems depressed. The younger children are restless and noisy.

The therapist comments on the mood and facial expression of the older children. He asks the son how he feels about having his two parents together

again. The boy likes it, but feels helpless as to how to keep them together. The father is distracted by the noise making of the younger children. He tosses them a menacing look, as if he would kill them. The therapist gives explicit recognition to the father's mean look. The father admits he hits them if they do not behave. They must keep their place.

The therapist points out that the father has been unable to keep the mother in her place. He now confronts the father and mother with their spatial separation in the interviewing room. The wife agrees she does not want to be close to her husband; she feels safer that way. At this point, the therapist removes himself from his chair between husband and wife and challenges the parents to talk with one another. They choose to argue about the children. The mother wants the children present at the interview; the father wants them out. The children are frightened and stay out of the parental war. The mother uses the children as allies against the father. He, in turn, scapegoats them. The therapist now excuses the children.

Once the mother and father are alone with the therapist, the mother speaks up in a pained, martyred manner. The husband always treats her as a "kook," the sick one. He is severely critical of her. She feels deprived and fed up. She screams that he cares more about that other woman than he does about her. The husband denies this. The wife angrily asserts that she has tried to be a good wife and mother but never got any approval. The therapist asks

the husband what he wants from his wife. His answer: She must take care of the children, the home, and feed and sleep with him. He accuses her of being sloppy, disorganized, and neglecting the children. He blames this on his wife's family. Her mother was a drinker and lived a promiscuous life, like a whore. "It made me sick," says the wife. She sobs agitatedly about her mother's abuse of her and her husband's infidelity.

She tells of a telephone call from her father alleging that her husband had made a sexual advance to her sister. He denies this and rebuts with a countercharge that the wife's father had made a sexual advance to her. This she affirms; she bows her head, crying now in a softer way. She discusses her suicide attempts but agrees with the therapist that despite her anguish, she very much wants to live.

This leads to an exploration of their sexual life. At first, the wife brags; no matter what, she can keep her husband happy in bed. She then contradicts herself; she does not even feel loved in bed. In fact, she is nowhere satisfied. She reverts to screaming at her husband that as a man he never makes it; he's gutless. Alone with him, she would not dare expose him because he would beat her. In the meantime, he screws around with "this other woman." In a flash of fury, "Yes, you can feel powerful on the outside, but at home with me, you're nothing!

The only time she is happy is when her belly is filled with a baby. At her husband's insistence, she had her tubes tied. She reacted with a sense of loss and depression. Her husband wanted her to have an operation because he felt her vagina was too big. She, in turn, felt his penis was too small.

Diagnostic Comment

This is a family with recurrent crises. The marriage relationship is immature and unstable. Each partner is still tied to family of origin. Each parentifies the other. The prime need is for security and service. The pattern is one of mutual dependency in which neither partner satisfies the other. Of the two partners, the husband is stronger and more adequate. The wife suffers a cyclic mood disturbance. She is infantile, demanding, insatiable, rebellious, and vindictive. When depressed and agitated, she insults and emasculates her husband, and sabotages her domestic functions. Incest guilt makes her feel low, dirty, and unworthy. The husband responds by turning dictatorial and violent. Having failed in his original role of savior for his wife, he overreacts with an exaggerated assertion of male supremacy that barely cloaks his underlying panic regarding a total loss of power. The mother allies with the children against the father, who turns tyrant and scapegoats the children. In crisis, all family functions collapse.

A Conceptual Framework for Family Diagnosis

The work of building a theory of the psychosocial dynamics of the family and a corresponding concept of family diagnosis is barely begun. At this moment, we are betwixt and between; we are in a kind of no man's land, striving to discover an appropriate conceptual framework. At best, we have evolved a set of partial hypotheses, relatively unintegrated, a far cry still from a unified theory. The biopsychoanalytic model of family and individual personality is inadequate and biased, as is the medical model of mental illness. The science of psychodynamics and psychopathology shows progress but has its own built-in limitations. Signs of diminishing returns begin to appear in the framework of individual psychology. Now come two further developments, the psychosocial model and the systems theory model. Both are in the formative stages.

The psychosocial model, therapeutically oriented, places a main emphasis on the internal dynamics of the family while leaving room for conceptualization of events at the interface of family and community. Recognizing that the external environment cannot be viewed as a constant, the psychosocial approach must nonetheless specialize on the inner life of the family. It seeks the psychotherapeutic contribution to a theory of the family.

Systems theory is an ecologically oriented model; as such, it holds a rich potential for illuminating the issues of conceptualization. Yet, in the opinion of its founder, von Bertalanffy, it is neither exhaustive nor final. At present,

the effort to implement systems theory reveals certain limitations and risks. The abstract quality of systems theory opens a large gap between the theory model and a concrete case. Discrepancies emerge between the model and reality. There is often a lack of fit between theory and empirical events. Systems theory lacks a methodology. As von Bertalanffy puts it: “New horizons have been opened up but the relations to empirical facts remain tenuous.”

Systems theory aspires to universality. But, the more a theory approximates a mathematical model, the less easy it is to apply to a human situation. To quote Einstein: “Insofar as the laws of mathematics refer to reality, they are not certain; insofar as they are certain, they do not refer to reality.” Therapeutic experience suggests that an upper-range theory must be reduced to a lower order of generalization before we can make practical use of it in analysis of a clinical problem. A middle- range theory provides a closer connection with the time- and space-bound vicissitudes of the human struggle with conflict.

Criteria for Family Diagnosis

Family diagnosis here signifies a means of identifying the psychosocial configuration of the family entity, a basis of classification and differential diagnosis of family types according to potentials of health and growth, and

finally, a method of correlating the dynamics of family and individual behavior.

For twenty-five years we have worked and reworked the criteria for family diagnosis in order to make them more simple, practical, and authentic, and at the same time render a live image of the character of the family. For the examination of family, we propose the following criteria.

The Most Destructive Foci of Conflict

The most destructive foci of conflict are the contagion of anxiety; the alignments and splits within the group and related coping patterns; and the interplay of family and individual coping.

The first step in diagnosis is to mark out the most destructive levels of conflict, the contagious flow of anxiety, and the family relationships within which conflict and anxiety are trapped. The coping patterns are reflected in the organization of alignments and splits and in the interaction of these competing factions. One part of the family clashes with another about what the family is and ought to be, how the family serves or fails to serve the needs of its members, and what the members do, ought to do, or fail to do with the family. Family conflict revolves around issues of security, need satisfaction, love expectation, struggle for control or support of a needed self-image.

Family coping has as its purpose the protection of the integrity, continuity, and growth of the family. *The levels of coping* may be identified as follows:

1. A shared search for specific and suitable solutions to conflict, leading to a changed configuration of family relationships.

2. A strengthening of family unity, integrity, and functional competence through an enhancement of the bonds of love and loyalty, and with this a consolidation of sound family values.

3. "Re-peopling" of the family, that is, removing a person from or adding a person to the functioning family unit.

4. Mobilization of external support for family integrity through social service, psychotherapy, religious guidance, and so on.

5. A spiritual rebirth, an enhancement of family closeness and health, after recovery from a family crisis such as the death of a family member.

6. Reintegration of family role relationships through: (a) tightening of the family organization, rigidification of authority, sharper division of labor, constriction and compartmentalization of roles; (b) a loosening of the family organization, dilution of the family bond, distancing, alienation, role segregation, thinning of the boundary between family and community, and displacement of family functions from inside to outside; and (c) reorganization of the complementarity of the family

roles by a reversal of sex-linked parental roles and/or reversal of parent- child roles.

7. Reduction of conflict and danger through avoidance, denial, and isolation.

8. Reduction of conflict and danger through compromise, compensation, and escape, that is, sexual escapades, delinquency, alcohol, drugs, and the like.

9. Realignment of family relationships through splitting of the group, scapegoating, and compensatory healing.

The Typical Family Role Relationships and Patterns of Complementarity

As the second step, we identify the typical family role relationships and complementary patterns. In the reciprocal adaptations of husband-wife, father-mother, parent-child, parent- grandparent, we examine the question of complementarity in terms of five items: (1) self-esteem; (2) need satisfaction; (3) a shared search for solutions to conflict; (4) buttressing of needed defenses against anxiety; and (5) support of growth and creative development.

At what specific levels is complementarity preserved; at what other levels is it sacrificed? We draw a further judgment: In the emotional involvement of triangular relationships, such as mother-father-child, do the

needs and anxieties of a family pair impose an emotional sacrifice on the third member, or do the needs and anxieties of one member of the threesome invade and impair the emotional complementarity of the other two?

We classify role complementarity in three broad categories: (1) lacking; (2) partial; and (3) complete. A lack of complementarity exists when there is a critical reduction at all levels. Complementarity is partial when it exists on some levels and is absent on others. For example, a satisfactory quality of complementarity may prevail in terms of need satisfaction and support of defenses against anxiety, but it may be lacking at other levels—in the support of self-esteem, in the quest for solutions to conflict, in nourishment of growth and development. Partial complementarity may contribute to the control of anxiety by offsetting possible breakdown in one of the partners, while limiting growth of the relationship and of each partner as an individual. We characterize this as a form of negative complementarity. Complementarity is high or relatively complete where there is reciprocal emotional satisfaction on all five items.

The diagnosis of the marital partnership is a part of family diagnosis. To be considered are the capacity for love, mutual adaptation, adaptation to external change, and adaptation for growth.

We are concerned with evaluating the role complementarity of the

marital partnership, the levels of conflict, benign and destructive, and the patterns of coping. Worthy of emphasis here are two special features: (1) the use of the marital partnership to compensate anxiety and support one or both partners against the threat of breakdown; the use of external relationships to mitigate marital failure and provide compensatory gratification, and (2) the quality of integration of each partner into the marital role and the fit of marital and parental roles.

The performance of the parental pair can be similarly judged by:

1. The complementarity of parental roles, the mutuality of adaptation, adaptation to external change and adaptation for growth.
2. The levels of conflict, benign or destructive.
3. The integration of each partner into the parental role.
4. The effects of parental behavior on the child and the effects of the child's behavior on the parents.

Fulfillment, Harmonization, and Balancing of Family Functions

We may assess the family's capacity to fulfill, harmonize and balance its multiple functions according to the following items: (1) survival and security; (2) affection; (3) the balance between dependency and autonomous development; (4) social and sexual training; and (5) growth and creative

development.

What priorities are assigned to these functions? How are they integrated and balanced? Which are selectively safeguarded? Which others are neglected or distorted? Which are sacrificed so as to protect which others?

Identity, Stability, Value Striving, and Growth

We come now to the question of family identity. Family identity is what the family stands for. It pertains to a dominant identity, a representation of shared goals, values, and strivings. Family identity is never fixed; it represents a fluid, continuously evolving image of the family as a living, growing entity. It is crystallized out of an ongoing clash of multiple competing and cooperating partial identity representations. It is molded by the manner in which each subgroup, whether a family pair, triad, or an individual member, strives to reconcile personal identity and values with shifting representations of family identity across time. This highlights the value struggle within the family and between the family and community. Family identity answers the question: Who are we as a family at a given time and place and in a defined life situation?

Family identity and stability must be considered together. Stability epitomizes the family's capacity to protect the continuity and integrity of the

family's identity under the pressure of changing life conditions. It assures the intactness of family adaptation in the face of new experience. This is the conservative phase of stability. The other aspect must provide for the capacity to adapt flexibly to new experience, to learn and achieve further development. It represents the potentials of change and growth. Effective adaptation or homeo-dynamic equilibrium requires a favorable balance between the protection of sameness and continuity and the need to accommodate to change. It requires the preservation of the old coupled with receptivity to the new, a mixture of conservatism and readiness to live dangerously.

Evaluation of the Family's Capacity for Change and Growth: Discrepancy between Actual Performance of Family and a Theoretical Model of a Healthy Family

In determining the performance of a family one can assess:

1. Fulfillment of strivings and values.
2. The stability, maturity, and realism of the family.
3. The presence or absence of regressive and disintegrative trends.
4. The quality and degree of successful adaptation.

Our concern here is to evaluate how far the family gets stuck at different points in the growth curve, how far the family falls short of what it might be in the family's view of itself, in the community's view of family, and finally, in

terms of a professional standard of a healthy family unit. We try then to conceptualize the relations of family performance to the alignments and splits within the group and the effect on the emotional development and health of individual members. In this way we strive for a clearer picture of the balance of forces within the family, those that predispose to breakdown and illness and those that protect health and growth.

Guide for Family Diagnosis

For the gathering and organization of comparable data on a range of family types, we offer a guide for family diagnosis, which should be implemented in a flexible and appropriate manner for each family.

1. Identifying data

a. Age and sex of family members and of other persons, in or outside the home, who are significant participants

b. Living arrangements

c. Number of years married

d. Occupations and incomes

e. Education

f. Religious, ethnic, and cultural factors

g. Special features: previous marriages, separations, pregnancies, illnesses, deaths, and so on

2. The problem: presenting complaints

a. Disturbance of "labeled" member; disturbances of other members

b. Family conflicts; stress factors; crisis in relationships; impairment of family functions

c. Family attitudes toward problem and toward intervention

d. Previous intervention

3. Conflict and coping

a. Conflicts: explicit, implicit, benign, destructive

b. Mechanisms of control and coping

c. Interplay of family and individual defense and coping

4. Internal organization

a. Typical family role relationships (husband-wife, parent-child, and so on)

b. Alignments and splits

c. Complementarity: lacking, partial, complete, or "negative

complementarity”

d. Adaptation of individual members

5. Family functions: integration, harmonization, balance

6. External adaptation

a. Kin network

b. School, work

c. Social network

d. Religious, ethnic, cultural factors

7. Historical development of family group

8. Identity and stability: standards, values, and strivings

9. Family’s capacity for change and growth: discrepancy between actual performance of family and a theoretical model of a healthy family

Case Illustration of the Guide for Family Diagnosis[4]

Identifying Data

A white, Jewish, conservative family consisting of Mr. O, forty-two; Mrs.

O, forty-one; Helen, eighteen; Judy, sixteen. Mr. O works as a printing salesman, earning $17,000 yearly. Judy is in junior high school. Helen quit college after one semester and is now working as a secretary. Mrs. O held a job as stenographer for four years; she quit when trouble with Helen began.

Referral

Family referred by psychiatrist; Helen was the "labeled" patient.

Problem

When Helen was sixteen, the family received an anonymous letter saying she was dating a black boy. She became pregnant, and the parents helped to arrange an abortion. This fall Helen became pregnant again, this time by a white boy she met in a bar. She wanted to get married. He did not. When she contacted the black boy, he proposed marriage and she accepted. Later, she restored contact with her parents, left her husband, and with the parents' help had a second abortion and divorced her husband.

Family as a Group

This family is laden with contradictions. Helen enters, looking every inch the streetwalker. Her own description of herself, "I'm no plain Jane," is the understatement of the year. She is pretty, blond, overweight, heavily

made up, wearing false eyelashes, a bright orange dress, and dangling jewelry. In contrast, her father sits next to her looking like Herbert Marshall, gentle, controlled, conservative. He is the kindly philosopher trying to light the road of life of the family with a Norman Vincent Peale approach.

Judy and her mother resemble each other; they are not so attractive nor so flamboyant as Helen. There is something just slightly blowsy in their dress and grooming. The mother is overweight, has tinted red hair, and is wearing a red suit and black blouse. Judy just misses the poor taste of her mother, mainly through dint of her youthful figure and teenage garb.

The father, in his characteristically controlled manner, relates the above harrowing experiences; he finishes by stating that things are better now, that he has faith in Helen's courage and strength of character, that he knows she is going to come through "true- blue." He concedes there has always been difficulty between Helen and her mother, but they are both wonderful people. He knows they will work things out between them, and everyone is going to be happy. During all this, the mother is crying, Helen looks depressed, and Judy sits nervously twisting her hair and cracking her knuckles, the picture of guilt.

During one session, while the father was saying how well things were going, the mother was literally choking in the corner. She could not get her

breath, blaming it on asthma, though she had never had asthma before.

Helen's appearance sharply contradicts her manner. If one were to hear her without seeing her one would visualize a shy, withdrawn, frail, colorless girl. She speaks barely above a whisper with a slight speech impediment. It took a long time before she was able to say anything besides "I guess so." Once she found her voice, however, her statements were terse, and pregnant with hostility and bitterness. "Why try to express myself, Mother always has the last word." "She wins every battle. If I talk back to her, I take away her role as mother. She'd feel unwanted."

She summed up her relationship with the black boy in one sentence. "I could never be myself at home. With Joe I was myself." She gave Joe the same kind of treatment he gave her. She was bossy, domineering, and always had the last word.

Though the family describes the mother as being loud and domineering at home, unable to tolerate anyone's opinion but her own, in the interviews she is submissive, silent, appears frightened, constantly cries and timidly defends herself against Helen's accusations. She emerges as a fragile monster who through the years has dominated the family with a combination of sergeant commands and unnerving tears.

The two sisters themselves are an interesting study in contrasts. Helen,

the beauty, the sexpot, has always had difficulty dating. Her greatest fear is that she will be an old maid. Judy, the plainer one, is the belle of the ball. She has a steady boyfriend and is barraged with phone calls. Despite Judy's popularity, she is jealous of Helen's beauty. Helen is jealous of Judy's outgoing personality and her relationship with her parents. Judy is aware she is favored by both parents and that she constantly overshadows Helen because of her natural vivacity. She feels responsible for Helen's unhappiness. Despite her guilt over hogging the spotlight, however, she also enjoys it and is most reluctant to share it. When Helen began expressing herself in the interviews, Judy suddenly became uncomfortable, accusing Helen of sounding like a "queen" and "high-flown." Though Judy constantly talks back to her mother she finds it intolerable when Helen does. She feels she has to protect her mother from Helen's intense hostility.

Recently Judy was distressed, as Helen had become despondent over having no dates and threatened to commit suicide. Judy felt it was due to her popularity.

Family Mood

The underlying mood of this family is one of apprehension and guilt. They are suffering from shell shock from the many bombs Helen has exploded during the past two years. They live in constant fear of another explosion.

They are currently engaged in trying to patch up the blanket of pretense and denial under which they have lived and go on as though nothing had happened. Sex, death, hostility, jealousy are taboo subjects in this family. There has always been an aura of mystery surrounding sex in the home. The parents never close their bedroom door, and the girls wonder when they have intercourse. When Helen, as a child, asked her mother about babies, Mrs. O was embarrassed to talk about it as grandmother was there. She said she would tell her later. Helen never asked again.

Helen feels she must cover up her depressed moods on a weekend to keep the family from becoming upset. She pretends to be in good spirits; the parents pretend to believe her, though they never go out for fear of leaving her alone. They deny suicide has ever entered their minds regarding Helen or anyone else. Yet Judy remembers her mother threatening to drive the car off the bridge and kill both herself and Judy when she received the anonymous letter about Helen. The mother has no recollection of this incident.

This denial has a demolishing effect on Helen. Her experiences over the past two years are being ignored and wiped out by the family. She herself feels wiped out. “Mother pretends I was never married to Joe. I’ll never forget it as long as I live. So I don’t know how to relate to people from here on. I don’t know what she expects of me.”

Internal Organization

Marital Relationship

The parents have formed a united front in covering up any dissatisfaction they may feel in the marriage. They have insisted that they have "average sexual relationships" and "seldom quarrel." The father is extremely protective of the mother, frequently jumping to her defense. However, his description of her as a "good woman, well-meaning, hard-working, and conscientious" is a damning one. His hostility has emerged little by little as the interviews progressed until he recently blurted out "Yes I always obeyed her. Who'd want to tangle with her? She is a very tough customer." Through the years, whenever he showed the slightest resistance to her plans, she burst into tears, and he was forced to back down. He takes his revenge by "turning her off." He does not mind her loud voice as he simply does not hear it. Mrs. O denied she had any awareness of his "shutting her out." Yet Judy recalled her mother as having said only yesterday, "He never hears a thing I say. It's like talking to a wall." Mr. O also retaliates by teasing, saying to the girls, "watch your mother bite at this one." She always bites and ends up agitated and crying.

Their only open conflict has been over the disciplining of the girls. Mr. O has felt the girls should have stricter rules and regulations. However, he wanted the mother to enforce them. He has been squeamish in dealing with

the girls. He admits he does not understand women and he likes to "avoid scenes."

The parents met at a dance in an old ladies' home when Mrs. O was sixteen and Mr. O eighteen. Then followed what appeared to be a conservative courtship. They dated for two years. Mr. O broke off the relationship when his father lost the store and he had to help support the family. Two years later he resumed the courtship. They dated for another two years before marrying.

Parent-Child Relationship

Both parents have always had a communication problem with Helen. She was a quiet child, and they never knew what she was thinking or feeling. Mrs. O has been able to cope with Judy because she fights back openly, and they can clear the air. Helen never opposes her mother openly. When Mrs. O criticizes her for eating too much ice cream, she just quietly has another dish.

Despite the father's distance from the girls there is a measure of warmth, affection, and humor expressed between them in the interviews. He seems to be more free and easy with Judy than with Helen. Helen finally turned to him in desperation about a year ago. She confided her hatred of her mother in what seemed to be a plea for his interference with the mother's intrusiveness. He made one feeble effort. He sided with Helen against the mother's waiting at the door every morning to give her the critical once over.

Both girls feel he should have actively intervened to give them more protection from the mother's family. Helen's fear of being an old maid seems to be related to her fear of being unable to break her symbiotic tie with the mother. Her fantasy is that she will be going to work, coming home to her parents every night, just as she is now, when she is fifty. Actually, she is more concerned with her own rejection of boys than she is with their rejection of her. She doubts her ability to love anyone for very long. She quickly grew tired of Jerry, her first steady boyfriend at fifteen, and lost interest in Joe after she married him. She felt her mother did not approve of Jerry, though the mother denies this. Helen feels helplessly dominated and overwhelmed by her mother who constantly nags and criticizes her. The father summed up their relationship succinctly when he stated "they devastate each other."

Families of Origin

This family is a carbon copy of the mother's original family even to the number, sex, and spacing of the children—two girls three years apart. Mrs. O's older sister was the bane of her family as Helen is the bane of this one. Though the older sister was never involved in delinquent behavior such as Helen's, Mrs. O describes her as "a slouch, irresponsible, and fat." It is this irresponsible quality she identifies with Helen. When it came time for work, her sister always disappeared just as Helen does. Mrs. O would always do her sister's work to keep her mother from being agitated. "My older sister ate my

mother up inside"—precisely what Mrs. O feels Helen is doing to her. Mrs. O considered it her responsibility to save her mother from her older sister, the role in which Judy is cast in the present family. Mrs. O's relationship with her mother was the same as Judy's is with her. They were able to fight openly and clear the air.

Mrs. O continues in an extremely close and dependent relationship with her original family, whom Judy, Helen, and Mr. O dislike intensely and describe as being "terribly loud and overbearing." They have secretly resented the weekly visits they have been subjected to over the years but until now have not expressed this resentment for fear of "devastating Mrs. O." Mrs. O would not dare interrupt them for fear of "devastating mother." She is deathly afraid of her mother's "hysterics."

Helen in particular has felt overwhelmed and depressed by the enforced visits. According to her, the grandparents speak of nothing but scholastic achievement and rave about her eighteen-year-old male cousin who is going to Yale. When Helen and this cousin were leaving for college last year, their grandparents gave them a sending off party. But only the cousin's name was on the cake. No one in Helen's family took issue with the grandmother, although they were all aware of the glaring omission.

The maternal grandmother is much closer to the older sister's children

(two boys and a girl) than to Helen and Judy. Mrs. O pretends this does not bother her; it does. Her sister's family lived with the grandparents for five years after the sister's husband died.

None of the relatives was informed of Helen's relationship with Joe or the two abortions. The parents were forced into revealing her marriage only after she disappeared. The maternal grandparents were enraged that they were not informed earlier, feeling they could have prevented the whole thing.

The father is the middle child in a family of three boys. His father was a salesman who owned a clothing store at one time, which he lost during the depression. Mr. O quit school to work to support the family. Very little of significance can be gleaned about his family relationships because of his positive thinking approach to life. He insists he had a happy childhood and a good relationship with both parents and siblings. At present he has a warm, affectionate but not overly involved relationship with his parents. The family sees them about once a month. Helen and Judy are fond of them.

External Organization

Social Functioning, Values, and Strivings

The values of this family are conventional, constricted, and tightly bound up with the older generation. The father has inherited the salesman's

approach to life from his own father. The mother is still trying to fulfill the standards and expectations of her parents through the performance of her children. Helen wanted to get a secretarial job after high school, but allowed her mother to maneuver her into college. She stayed one semester, hated the experience and failed every subject. She is currently performing well at a secretarial job.

Family Diagnosis

This family illustrates in graphic terms the transmission of pathology from one generation to another. The family is isolated, feeds on itself, and reinforces a regressive, destructive, symbiotic pattern. Mrs. O duplicates in her own family the mother-daughter-sister triangle she experienced in her original family. Mrs. O unconsciously identified Helen with her older sister, molding her through her anticipatory attitudes into her sister's image. Helen's statement, "I could never be myself at home," indicates the influence of the sister's ghost. She proved to her mother just how much of a "slouch" she could be since this was what was expected of her. This is indicated in Helen's retort regarding Joe. "Since you disapproved of Jerry I thought I'd bring you someone who was really good enough for me." Her pregnancies were a desperate attempt to establish her identity as a person and free herself from the symbiotic tie with her mother. One cannot underestimate their shock value either. They served as a temporary means of smashing her parents'

denial. From the feeling in the interviews, Helen's unspoken bitter communication seems to be "Stop pretending; sex exists; it's here in my belly. Hostility exists; I hate you. Jealousy exists; you prefer my sister. Death exists; I feel suicidal. I exist; I'm not your sister."

The part the father has played in Helen's acting out is not clear except by virtue of his absence as a person who might have intervened to dilute the relationship between Helen and her mother. Being afraid and bewildered by these strange creatures, women, he withdrew from the fray, giving Helen little support.

Although Judy seems to be functioning well socially and scholastically, she shows signs of nervousness and anxiety. Her job as mediator between Helen and her mother is proving too big a burden for her.

Conclusions

In this essay we have outlined a perspective on the relations of the concept of family diagnosis to clinical process. In our view, family diagnosis and family therapy are twin processes, each dependent on the other. We have described here our version of a clinician's encounter with a troubled family. The functions of observing, conceptualizing, and interpreting relevant emotional events are inherent in the nature of this encounter. The testing of clinical hunches, step by step, against the existing interpersonal realities leads

to hypotheses concerning the relations of family transaction and individual adaptation. We have presented here a conceptual framework for family diagnosis, a guide that enables us to compare and contrast family types, and have illustrated these themes with clinical examples.

Bibliography

Ackerman, N. W. *The Psychodynamics of Family Life*. New York: Basic Books, 1958.

----. "Family Psychotherapy: Theory and Practice." *American Journal of Psychotherapy*, 20, no. 3 (1966).

----. *Treating the Troubled Family*. New York: Basic Books, 1966.

----. "The Role of the Family in the Emergence of Child Disorders." In E. Miller, ed., *Foundations of Child Psychiatry*. New York: Pergamon Press, 1968.

----, and Behrens, M. L. "A Study of Family Diagnosis." *American Journal of Orthopsychiatry*, 26, no. 1 (January 1956).

----, Papp, P., and Prosky, P. "Childhood Disorders and Interlocking Pathology in Family Relationships." In *International Yearbook for Child Psychiatry*. Vol. 1. The Child in His Family. New York: Wiley, 1970.

----, and Sobel, R. "Family Diagnosis: An Approach to the Pre-School Child," *American Journal of Orthopsychiatry*, 20, no. 4 (October 1950).

Coles, R. "Profile of Erik H. Erikson. *The New Yorker*, November 14, 1970.

Stein, I. L. Systems Theory and Casework. Unpublished monograph.

Notes

1 I received this chapter from Nathan Ackerman a few weeks before his untimely death. Its vivid style and content help us realize the magnitude of our loss.—G.C.

Grateful acknowledgment is offered to Dr. Walter Sencer and Judith Lieb for thoughtful criticism of this chapter.

2 What is called truth constantly changes. Since no fact is immune to new information, what remains much longer is a viewpoint of "manner of inquiry."

3 For other examples see *Treating the Troubled Family*.

4 This summary of family diagnosis was written by Peggy Papp, staff member of The Family Institute.