EXPERIENTIAL PSYCHOPATHOLOGY

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Dr John Howells – Experiential Psychopathologist

John Howells founded Family Psychiatry. He believed the experience of adverse emotional events in and out of the family caused psychopathology. Experience is all – hence experiential psychopathology. Assessment of these events comes before treatment; thus the emphasis on family diagnosis. Therapy follows – individual, dyadic, and family group therapies.

Howells came to see that an individual and family live in a field of emotional forces; those vectors can be assessed and manipulated to the advantage of individual and family – vector therapy.

As important as direct assessment and treatment is prevention. He developed views on health promotion towards creating a salutiferous community/

Topics include family psychology, family psychiatry, experiential psychopathology, family diagnosis, family group therapy, vector therapy, a salutiferous community, and a list of publications by John Howells.

The Institute of Family Psychiatry

Dr John Howells, MD, FRCPsych, DPM, AKC, DFAPA, was Director of the Institute of Family Psychiatry from 1950 to 1985. The Institute was associated with the University of Cambridge and was part of the post-graduate medical programme of that university.

After training at the National Hospital, Queen's Square, London, in neurology and at the Maudsley Hospital in psychiatry, Howells became disillusioned with the psychopathology in practice at that time. He worked for a period in the Psychoanalytical Unit at the Maudsley Hospital. He became increasingly dissatisfied with psychoanalysis because its practice gave no assistance to his patients. Thus he left the Maudsley Hospital in the hope of being able to practice a different psychopathology elsewhere. This was at the inception of the National Health Service when innovation was encouraged and this unit was set up in a general hospital. It was understood that most of his time would be devoted to research and his contract allowed him to undertake clinical work for one day a week and research for the remainder of the week.

The Institute was filled up over the years to have a staff of six whole time consultant psychiatrists. These were supported by a large number of professions in associated clinical fields such as psychology, social work, occupational therapy, speech therapy, radiology. The staff co-operated with all the other clinical departments of a general hospital. Referrals came from the General Practitioner and the waiting list remained

at two weeks for the whole length of the 35 years. Referrals could include individuals, such as children, adolescents and adults, dyads – such as marital couples, and family groups. Research had shown that the individual was brought up by the family rather than by any one individual within it. Therefore diagnosis and treatment was based on this realisation, hence family diagnosis and family psychotherapy. Psychoanalysis was replaced by **experiential psychopathology**. The individual's psychological experiences resulted from real experiences with his or her emotional environment. The understanding of real events and experiences replaced the utilisation of symbolism and the speculations of psychoanalysis.

Based on experiential psychopathology two aspects of family psychology and family psychiatry could now be developed – family diagnosis and family psychotherapy. Research also showed that the individual lived in a web of interacting forces – vectors. These vectors could be understood and evaluated and, more than that, could be manipulated to the advantage of the individual and the family, hence **vector therapy**.

More and more, over the years, it became apparent that the key to an improved emotional life of society lay in being able to guarantee a satisfactory childhood to every child. To arrange a new media for every child of the population called for a complete re-organisation of the facilities associated with child upbringing. Only thus could be created a health promoting society, a salutiferous society.

Thus Howells's contribution was to develop experiential psychopathology, family psychiatry, vector therapy and the concept of a salutiferous society.

Chapter 1: Experiential Psychopathology

Definition

Experience is all that an organism (individual, family or society) has been subject to or undergone in life. In the organism that we meet today is found the end result of the whole of its experience until now, beneficial and harmful. Here the view is held that all psychopathology arises from harmful experience – hence experiential psychopathology.

Experiential psychopathology regards psychopathology as having arisen from harmful experience – all the harmful events the organism has been subject to or undergone in life.

Experiences are seen in actual, real terms, as they occurred to the organism and not as assumed to occur by someone else at the time or later. Translation into any other than real terms is not required. The only truth is the event as it occurred. Events must not be fancied, manufactured, or distorted. Symbolic meanings cannot replace facts. It follows that no weight is given to schools of thought which rely on the translation and interpretation of events in the light of accumulated and stereotyping dogma. Truth cannot be limited in this way. To reveal, clarify, describe, is permissible, but to translate into other terms is distorting. Harvey (1) repeated the saying of his teacher, Fabricius, "Let all reasoning be silent when experience gainsays its conclusions".

The events to which an organism can be subject are legion. Every possible event can be met by any organism. However, so infinite are the possibilities that it would be extraordinary if any two organisms were to meet the same two sets of events. Thus an organism has to be understood against the background of its own unique experience. That is its life experience. Most organisms meet predictable common events; some meet the unusual; some meet both.

The possible combination of events is infinite. Thus variation is great. To expect that all combinations of circumstances can be covered by a few well described situations, even if fanciful and intriguing, serves merely to limit the truth and produce dogma. Experiential psychopathology allows a new beginning in the understanding of the disorders of psyche; it implies starting from a *tabular as* and relying on careful observation, deduction, and experimental verification.

Experience must not be confused with the process of learning. Learning is concerned with specific data, is deliberately acquired, formal, guided, regulated, and only a part of experience. Experience is concerned with general data, is unsought, often informal, often unregulated, not always discerned, and includes learning. Each is important. But experience would be limited if regarded only as learning.

The family moves through its experience and sends of epitomes of itself, individuals, to found new families, and both individual and family are significant organisms within another and larger organism, society. Thus we must take account of the experiential psychopathology of each, individual, family and society. Each is equally significant as a phenomenon, but in clinical practice there are operational advantages in taking the family as the functional unit.

The Basic Psychopathological Process

The psychopathological process is understood in terms of the experiential process – all the adverse events the organism has undergone in its life experience. A "process" is defined as "a continuous series of events".

The organism is either an individual, a family or society. The organism is especially vulnerable to adverse events in its early history and early damage will influence subsequent reactions to events.

The fundamental need of the organism (individual, family or society) is to function harmoniously; harmony results from conformity with the biological rules or "cosmic plan". This harmonious functioning can be disrupted by a number of agents, noxious or harmful agents, physical and psychic, acting on the fabric of the organism – either psyche or soma, or both. For its defence the organism employs a number of coping devices against the noci-vectors.

If the coping devices are only partly adequate or fail there is a resulting dysfunction, morbid process, which may or may not be appreciated by the organism. The morbid process reveals itself by indicators; if only the organism is aware of these, they are termed symptoms, but if they are apparent to others as well, they are terms signs.

The psychopathological process is an amalgam of the psychic noci-vector, the coping mechanism of the psyche, its damaged fabric and the indicators of this damage.

A purely psychically based medicine is as valueless as is a purely organically based medicine. A holistic approach is alone acceptable. Therefore the fabric of the organism must be conceived as a whole – soma and psyche, and the impact of disruptive agents considered as they apply to both. Thus we have to practice a medicine of the whole psychic and somatic entity – psychosomatiatria – and in the case of an individual, pananthropic medicine (healing of the whole man). However, the effects of physical noxious agents are so adequately covered in medical texts as not to need discussion here. The emphasis will be on the effect of psychic, rather than physical, disruptive agents. Thus, we consider the effects of psychic noci-vectors (*psychic* – from psychic source; *noci* – harmful; *vector* – a force with direction) on the somato-psychic organisms – Individual, Family and Society.

Psychic Noci-Vectors

General

A "vector" is a force with direction. "Noci" indicates its harmful, adverse, damaging, noxious nature. "Psychic" displays that it arises from a psychic or emotive source. The adverse effect of a psychic noci-vector on an organism is felt throughout that organism, both in its somatic and psychic parts; a psychic noxious event can as readily produce migraine as it can anxiety.

Here is an example of a powerful psychic noci-vector operating on an individual organism: After intercourse a husband says to his wife, "I did not have an orgasm because I am saving it for someone else". One might expect a marked physical and psychic hurt reaction from the wife; she could be expected to be sick, angry, tearful, miserable. A reverse vector, and a beneficial one, might be as follows: A husband sitting on a settee says to his wife, "I think I shall always sit on this settee rather than on a chair, then I can always have you close to me". The wife might be expected to glow, physically and emotionally with pleasure.

Psychic noci-vectors can be actual or threatened. The psyche has the endowed property of anticipation and can maintain itself in a state of anxiety while anticipating stress. The psyche of the individual or the group also has the property of imagination and can thus set up internal stresses that can be damaging.

The essential nature of communication is as follows: Organism A conveys a meaning to Organism B and this alters the relationship between them. The meaning conveyed may have

varying degrees of acceptance by B, depending on its degree of beneficiality; it may also convey varying degrees of harmfulness. In psychopathology we are concerned with harmful communication. What has been described is the simplest interaction. Normally B reciprocates and a continuous process of communication is initiated which continues for varying periods.

In the above we have considered only two psychic organisms, A and B. Interactions may be more complex. A and B may be groups of people, e.g. families interacting with families. Again, A and B may be psychic organisms within a number of organisms and a complex psychic pattern of communication occurs among all the protagonists – a transaction. In this transaction the fortunes of A, or any other psychic organism, can fluctuate from moment to moment; at one instant a number of psychic sources collectively convey pleasant meanings, at another they band together to convey hurtful meanings. The meanings may even be contradictory.

Communication, then, is a complex pattern of transactions. Benevolent communication leads to harmonious functioning in the recipient. Malevolent communication leads to malfunctioning in the recipient. This applies to any organism – individual, family, society, or group within society.

The psychic part of the organism during its experience acquires attitudes, as explained previously. *An attitude*, with its related beliefs, myths, interests and values, *is to assume an opinion* in relation to an object of thought, i.e. to endow an object with qualities. These qualities can often be graded in opposites, e.g. love at one extreme and hate at the other. It is also possible to make a scale of degree, e.g. much love, some love, neutral, some hate, much hate. These attitudes or opinions dictate the meanings conveyed to other psychic objects. At the receiving end they may be acceptable. On the other hand they may be so unacceptable as to do considerable damage; in this event they constitute psychic noci-vectors. An attitude cannot be separated from its context, e.g. in one setting an individual may feel strong hate towards one person, but convey love to another person in the same setting. The term "vector" takes account of the attitude as a force and its directive quality.

In estimating the effect of a psychic noci-vector a number of factors have to be taken into account. These will be briefly described. They are concerned with source, meaning, conveyance, dynamic qualities, vulnerabi8lity, latent period and restitution factors. The chapter will conclude with some illustrations of psychic noci-vectors.

Source

Psychic noci-vectors must come from a psychic source – individual or group psyche. An individual may be beset by forces from others within the family as individuals, or groups of individuals, and from individuals and groups within society. A family can be beset by individuals within the family, or individuals or groups of people outside the family. Society can be beset by individuals or families or groups of people within society.

As the family is the basic unit in society, it is of special importance. It is the unit within which the founders of new basic units, families, are forged. Psychic noci-vectors from the preceding families can do great damage to the functioning of the present family. Again, psychic noci-vectors in the present family can do great damage to the epitome of itself which it sends forth into the future to found new families. Within the family are the closest interactions, those that last longest, the most significant and intense, and those likely to be reinforced again and again through time. A family can produce the most benevolent of vectors and at the same time the most malevolent.

All psychic organisms possess the capacity of *imagination*. New thoughts can be generated out of the raw material of the psyche. These thoughts need not be expressed, but they can be altered according to immediate experience. There is a capacity to anticipate attack, even to exaggerate or diminish the force of probably attack, and to visualise its results. Thus people as individuals, or as groups, are prone to worry. Such thoughts can become psychic noci-vectors themselves. Thus there is attack from within – intra-psychic trauma. A possible setback is assumed to happen although it may never happen. It may be exaggerated. The event may show that it could not have happened, or was not as disastrous as expected. People "worry before it happens" or "jump their fences before they come to them". People or groups made insecure by previous experience are especially prone to anticipate stress. Thus, this state of anticipatory anxiety is to some extent manufactured. Others are in an expectant state, a state of tension, because of the anticipation of real stress.

Meaning

The effect of a communication is dependent on the meaning conveyed. The recipient interprets from the message the attitude of the other party on the point at issue. The attitude may be for or against him and vary greatly in its quality. The meaning may be open or overt, e.g. fear of being dropped or a threat of aggression; or hidden and covert, e.g. a husband becomes greatly anxious when his wife is giving birth because of the loss of his mother during his sister's birth. The recipient may even be unaware of the source of anxiety. It may be simple or subtle and in the latter event take on the character of a hint, innuendo, implication, insinuation or intimation. Again, some vectors of low threshold value may not reach the awareness of the recipient – subliminal trauma. The message cannot be separated from its context, e.g. in one situation an exclamation conveys joy and in another alarm. The same word or act may be interpreted as friendly by one person, while another person in the same setting sees it as hostile; the interpretation depends upon the meaning to that person or group and this is dependent on a host of factors such as previous experience, vulnerability, age, etc.

Meanings can be conveyed to others by the *absence* of action, e.g. not to send a birthday card to one's child may be as significant as to have done something hurtful. Again, parents may not tell their children that sex is taboo, but the absence of discussion conveys the same meaning. Dylan Thomas relates in "Under Milk Wood" how the prostitute passes the women gabbling at the village pump and how she senses their hostility "by the noise of the hush". These negative noci-vectors may escape the on-looker. What is inappropriately not said is as vital as what is said.

Some *physical* vectors, though immense in power, may have little effect on individuals or groups. Physical or material lack have no effect unless they injure the psychic worth of the person, e.g. economic status may be important because the grandparents demand it and without it the image of self suffers, or because it leads to psychic stress, e.g. poverty may mean continual personal degradation, disturbing neighbours, etc. Physical hazards may even be advantageous to the psyche; external hazards such as earthquakes, floods, forced migration, persecution, war, may have the result of bringing people together so that the quality of communication actually improves.

Psychic noci-vectors may be *contradictory*, i.e. the same psychic source may emit simultaneously two or more messages with conflicting meanings. Or the conflicting, or different, messages may come from a number of sources. The organism, as will be seen later, can cope with such contradictions up to its own capacity.

Conveyance

Psychic noci-vectors are communicated, as with any vector, through the *five senses*. The commonest avenue is through speech. Verbal symbols have meaning which is conveyed to others in this economical fashion. But non-verbal communication can be equally compelling. Sometimes a composite message is conveyed by an amalgam of the five senses, or by combined verbal and non-verbal behaviour. Very subtle messages can be conveyed in this fashion. Within a family, economy of expression takes place over time and much can be conveyed by grunts, mannerisms, affectation of speech, gesture, etc.; these meanings may not be apparent to those outside the family circle until they become attuned to them. Fortunately, most people and families talk about the same things in the same way.

Dynamic Qualities

A noci-vector can have varying degrees of *strength* or intensity. Effect depends on a number of factors, but given a certain degree of vulnerability or sensitivity in the recipient, the greater the strength of the vector, the greater the effect. The use of strength is sometimes calculated by the sender so as to produce a wanted degree of effect. Often the vector is not under control and no calculation made of the probable effect, indeed there may be surprise at the effect created.

Communications may occur once or be *repeated* a number of times. The latter probably brings a considerable accumulation of effect. Once a vulnerability has been established, repetition of the same psychic noci-vector brings increasing damage; repetition even after the gap of years can still bring a response.

The *number* of psychic noci-vectors must be taken into account. There is probably a limit to the number of sources to which an organism can pay simultaneous attention; knowledge about this is least exact with respect to families and social groups. It seems that an individual can only pay attention to five or six other people at one time. Groups over about seven in number begin to fragment – this happens also to large families. Thus, an individual can be traumatised by up to seven noxious agents but beyond that number he has difficulty in conceptualising individuals as individuals. Another related limiting factor is that of span of attention; it is difficult to pay attention for long periods of time without reaching a point of exhaustion.

The programme of attack and reaction may pass through a *sequence*. It may escalate to the point of exhaustion on either side, or until another factor intervenes. A husband reacts to being ignored by aggression; the wife reacts to aggression by withdrawal; wife is upset and ignores husband; he becomes hostile; wife withdraws; husband's hostility increases and wife withdraws further; as the situation escalates, a point is reached when wife looks like a rejected, deprived child; a new factor now appears – the husband identifies himself with this deprived child, the child he was long ago; his hostility turns to tenderness and the vicious circle is broken.

The psychic noci-vector may operate over a short or long period of *time*. Time is an element that has tended to be underestimated. In the past much attention has been given in psychopathology to the nuclear incident – one devastating incident at one moment in time. Significance has to be given not only to the acute stress, but also to a long-drawn-out sustained stress. To the former there is considerable, but not complex, capacity to adjust; all the adjustment mechanisms are urgently brought into action. But for the latter the capacity to adjust is much less, for the threshold of coping may not be reached, and the adjustment may not take place. Time, therefore, is a significant factor and the experience may be stamped into the psychic organism, making eradication difficult.

To pinpoint the *moment* in time when a psychic noci-vector was operating may be of great value in diagnosis for it may supply a clue as to the nature of the psychic noci-vector, e.g. abdominal pain at breakfast on each school morning, and never at weekends or in the holiday period, implies a relationship between school and the abdominal pain. The more obvious the indicator, usually the easier it is to make the association.

Vulnerability

Vulnerability is general or specific. Some situations would cause trauma to most people – e.g. a new, unfamiliar situation. It can also be specific due to a number of reasons. There may be a constitutional weakness, e.g. of intelligence, that might make understanding difficult. Again, the sender of the message may have special significance to the recipient and this would make the latter vulnerable. Or, the recipient may have developed over time a susceptibility to that type of stress; in the case of a family member this may be dependent on experience in his preceding family, which not only subjected him to that experience but did not allow the appropriate coping mechanism to develop. Time may have reinforced a vulnerability. For example, a child's lack of social confidence springs from the family's inability to encourage him in his first social situations; the family then encourages him to avoid social situations; it reinforces his anxiety over the years; thus lack of social confidence is maintained and he is now vulnerable to the stress of social exposure.

Age of the recipient is a factor that influences the effect of a psychic noci-vector because it influences the capacity to give meaning.

A young child has a brief memory span; it is not clear how much can be retained in the first few months. This may be a biological protection to see the child through the trauma of birth. Later, as the cerebral centres develop, the capacity for memory increases. Thus after about the age of two the sensitivity to psychic noci-vectors increases. There is evidence that early memories can have far-reaching effect on behaviour, e.g. aversions to types of food laid down in the early years last a lifetime. Early experiences that dictate early reactions may influence later behaviour because, at an early age, they are the raw material of behaviour for that person. However, the young are also protected, especially in the early months. A child's intelligence grows only with the years and a child does not develop the capacity for abstract thinking until about eight to ten years; thus the more subtle attacks on him may not have meaning. The child has the quality of "innocence" too, i.e. he can react in an open unbiased way, if allowed to do so, as he has yet no inbuilt prejudices. It is a calamitous mistake to assume that the child's mind behaves and reacts like the adult's mind. This is an important area, capable of elucidation by careful experiment; it is no longer necessary to rely on speculation in this field, which has benefited greatly from the work of developmental psychologists.

In the senium, again, the results of age may need to be taken into account; the memory span decreases, intelligence wanes and abstract thinking becomes more difficult. Recent events, in particular, are quickly forgotten. But the sway of inbuilt prejudices is great.

Latent Period

A psychic noci-vector may appear to have had no effect because there is a *latent* period between the action and its result. This may be due to a number of reasons: (i) There is a state of shock – it can be seen in bereavement, for instance. (ii) The event may call for immediate action and thus attention is given to this and there is not time to work out the meaning of the event. Later, when the emergency is over, the meaning of the event becomes apparent and its effect shows itself. (iii) When the effect is somatic, it may take the organ concerned time to show evident signs of damage, e.g. a woman quarrels with the neighbour, but the swelling in

her neck, due to the reaction of her thyroid gland, is only apparent many days later. Thus, the connection between the stress and its effect may be lost. To be able to tie the indicators of stress to an event is of great value diagnostically.

Restitution Factors

Psychic noci-vectors may be counteracted by chance *restitution factors*. For instance, a foreman becomes antagonistic to a man at his work. The man reacts by anxiety, yet he cannot take the obvious step of finding alternative employment. His anxiety increases. He becomes ill. He loses his job because of his absences. He now has to take another job and does so with marked improvement in himself. Thus chance operates to counteract noci-vectors. Examples of restitution factors include – marriage to a compatible partner, death of hurtful parents, loss of harmful husband, a new teacher, change of neighbours, a pleasant playmate, etc. One of the aims of vector therapy is to systematise the deployment of restitution factors, which are then not left to chance.

Illustrations

Some psychic noci-vectors may be *shared* by a number of people – there are hazards common to all – e.g. failure to have children; undertaking a pioneer role with consequent colleague and social antagonism; children leaving home with consequent adjustments; death of a spouse or child or relative; denial of intercourse because of physical defects; separation due to war service; relating own experiences as a child to the nurturing of one's own children; illegitimate births; loneliness of old age; hospitalisation of spouse or child; problems of accepting new developmental roles; cultural clashes, etc. All these are common hazards, and ability to cope does not appear to be due so much to the strength of the stress as to having developed a right attitude in the past – usually in the preceding family. A sign of good psychic health is the capacity to adjust to life's inevitable hazards.

A few of an infinite number of examples of psychic harmful interactions would be:

Intra-psychic	Guilt at illegitimate birth of a child; fear of pregnancy
Spouse-spouse	Retirement of and therefore prolonged contact with a disliked spouse; intervention of a third party in marriage; disparagement by spouse.
Parent-child	Rejection and lack of love; blame for any lack of achievement; depreciation of child's worth.
Sibling-sibling	Birth of an unwanted rival; rivalry for parental affection.
Group conflict	Mother and sisters accept a new child; father and brothers reject it.
Family-society	Employer using his position to make sexual advances; working under a father who is antagonistic; angry teacher; teasing by schoolmates; critical neighbour.

Attitudes are conveyed in ordinary but often devastating phrases, such as : "Don't do that"; "Go to bed, for heaven's sake"; "Take that"; "You were wrong there"; "You won't go to heaven"; "God doesn't like that"; "If you don't do this, then . . . "; "You don't like me"; "I hate you"; "At one time you were so good"; "You are 100% selfish"; "Keep quiet or else"; "If you do that, you will upset your mother"; "Don't ask any questions but do as you are told"; to a plump girl – "You must be attending slimming classes"; to any middle-aged woman – "Your children must be quite grown up"; to anyone – "It is all your fault"; to a wife – "Other people's

homes are tidy"; "Your are ugly"; "I won't have a child by you"; "to a husband – "I once had a smart husband"; "Everyone gets promotion but you"; "You behave like your mother"; "Go to hell"; "Don't touch me".

Coping Devices

When the organism, individual or family, is under attack from psychic noci-vectors, it has to meet the attack and, if possible, contend successfully with it and defend the integrity of the "idea of self". Thus it has to cope by the use of a *number of devices* or expedients to meet or attenuate the effect of the attacking agent and repair its damage. Coping involves defence, adaptation, and reparation. It is the price the organism has to pay to preserve its integrity.

The coping devices may be completely or only partly successful. If partly successful, then the organism is left with a handicap. This may be general or focal, i.e. sensitivity to any stress or to one stress only, e.g. social intercourse.

Just as the psychic noci-vectors are acquired through experience, usually within the preceding family, so too are the coping devices. The child imitates, consciously or automatically, the devices adopted by his fellow family members of any age. Sometimes by chance he comes across a device that for him, in a particular circumstance, appears to work. This will be his special device until experience causes an adjustment or change. He may use it even at times when its employment is inappropriate. Thus some of the coping devices are employed in common by many people. Others are particular to a person, stamped on him by previous experience, and become his "stock in trade". The same applies to a family or to any larger group.

To contend with the opposition, the whole functioning of the organism may be called to action. This will include the endowment as well as the acquired aspects of the psyche. Not only does a coping device need an apparatus for its execution, but it consists of an attitude and is associated with a feeling tone or mood; mood is especially evident in the more acute and automatic reactions, e.g. aggression.

The acquired aspect of the psyche can react by use of either *automatic* or *directed* devices. The advantage of the automatic devices is that they are immediate and overwhelming. But they may be ill-directed, inappropriate, and diffuse. The automatic devices are primitive, e.g. anger and flight. The directed devices are slower, more acute, and sometimes highly sophisticated, e.g. sarcasm and carefully-thought-out acts. Animals are more dependent on automatic response and homo sapiens, on directed response.

In an acute attack, the organism may be forced to react by shock – the centres of defence become exhausted. This passive state has the advantage that the organism cannot grasp any further significance in the attack and thus its influence is reduced. Exhaustion of attention is an important merciful defence mechanism of the organism. It is likely to be reached earliest in acute trauma. In sustained trauma the threshold of exhaustion is seldom reached, hence the powerful effect of long-drawn-out stress.

The attack may be directed at one aspect only of the self and thus only a local defence is required, e.g. an attack on the person's social status. The attack may also be directed at a number of aspects or on the whole self, e.g the statement "I hate you".

A study of the ways by which well-adjusted people react to attack will expose devices that can be employed in therapy, e.g. forgetting is a fundamental biological coping device; yet at times in therapy we make forgetting impossible by repeated recollection of previous mishaps. Constructive phantasy, hope, is another healing device.

The use of a particular coping device may be dictated by the situation. The appropriate devices must be employed in a given situation and this may limit the choice or dictate the employment of one device, e.g. faced with a deaf-mute, a non-verbal response is essential.

The nature of the attacking agent may determine the most appropriate response; its source, the meaning conveyed, the senses used for conveyance, its dynamic qualities (strength, number, repetition, sequence), whether acute or chronic, short or sustained, the vulnerability of the organism to that trauma, and age are all elements which determine the response to stress. A source within one's own psyche has to be handled differently from an external source. Normally the defence involves the same senses as those used by the attacking agent, but not always. Usually, the more acute and severe the trauma, the more severe and automatic the defensive response. A sustained attack calls for a sustained defence. A repetitive attack calls for a discontinuous response – with the possibility of learning the most effective response in between attacks. A number of noci-vectors may have to be met by the psyche with an equal number of defensive vectors to match them.

In a well-balanced organism, the coping devices are usually controlled, well directed, and, usually, successful. The less-balanced organism has so many weaknesses that its response may be ill-judged. Excess of anxiety leads to inattention, dithering, indecision, and even to a misunderstanding of the nature of the attack. A balanced organism may suffer considerable attack and be able to respond appropriately. For example, a loved person is lost (almost like losing a part of the self). At first there may be a stunned response with apparently little reaction; this is followed by maximum grief; this fades as reparation sets in – forgetting plays a part and there is a realistic reappraisal of the situation and a deployment of its assets. In the unbalanced, guilt, anxiety, hostility, may be superimposed on grief.

In children, the coping devices, especially the directed, tend to be simple. They get more complex with age. They are crude in simple folk and sophisticated and subtle in the intelligent, e.g. the latter may believe it is better to have an adverse decision than no decision – at least it allows of a trial operation.

Psychic noci-vectors may be contradictory. The same psychic source may emit simultaneously two or more messages having conflicting or different meanings. Or the conflicting or different messages may come from a number of sources. This can cause bewilderment in the recipient, but not madness. This occurrence is so frequent in day-to-day life that organisms quickly develop obvious ways of coping with it. Given a number of different or contradictory messages, the recipient can:

1. Ignore them all, claim they show lack of agreement in the senders, and use them as an argument for following his own policy.
2. Behave according to the resultant of the forces bearing on him; his behaviour may please all his assailants or none.
3. Select the one message that most appeals.
4. Select the message that is most compelling or strongest.
5. Do nothing.

Coping involves establishing attitudes which are strongly held, these are attempts to adapt and they may clash with the attitudes of others and therefore be destructive and maintain the opposition of others. Such attitudes are difficult to change, as they are considered essential by the self as coping devices. They are easier to dissipitate if the coping becomes unnecessary, i.e. the threat is diminished and security increased. *Hence in therapy it is essential to produce security, or coping devices against insecurity must continue to operate.*

Examples of Coping Devices

The whole organism can be brought into action in any attack and one or many of the devices below brought into action. The devices can be divided into those that are *primitive* and automatic, and those that are *directed*.

Primitive

There are three groups:

1. Those involving aggression, such as verbal hostility (abuse, swearing, sarcasm, cynicism, etc.) or non-verbal (ignoring, depriving, punishing, tantrum, physical harm, homicide).
2. Withdrawal in verbal terms (silence) or non-verbal (to move away, to hide, to contrive not be noticed, apathy, sleep, suicide).
3. Anxiety – to be in an anticipatory state. The alarm mechanisms are kept on the alert – sometimes for a lifetime. Anxiety can be displaced on to objects, themselves harmless, which are associated by chance with the fear situation – thus phobias are created.

Directed

Any apparatus of the organism may be implicated:

Perception – any of the sensations from the five senses may be exaggerated or dulled, e.g. an inability to hear. In a state of heightened tension, meanings may be misconstrued and harmless objects regarded as the subjects of suspicion, leading to paranoid states. There may be partial or complete denial of meanings.

Memory – The normal machinery of forgetting is a healthy defence against stress and always comes into play in time. It may operate inappropriately and too early. In the process of remembering, events and meanings may be projected on to the wrong person.

Realistic Thought – Healthy reactions include apology, understanding, toleration, relating to previous experience, forgiving, diversion, avoidance and insightful rationalisation to find effective answers, rationalisation in humour.

Unrealistic Thought – Lying, attention-seeking and hysterical behaviour, attention-seeking by regression or illness, selfishness, meanness, overprotection arising from fear or guilt.

Phantasy – Daydreams, overcompensation leading to boasting, snobbery, etc., identification.

Behaviour – Overactivity (illusion of action), obsessions and compulsions (an attempt to control and predict events so that they can be anticipated), conformity, perfectionism, hypermorality, and artificial aids such as rhythmic activity, (thumbsucking), chewing gum, drugs, alcohol, excessive sexual activity.

Physical – The whole of the organic apparatus also responds protectively. Its responses may lead to psychosomatic illness – not to be confused with hysterical behaviour. In the former there is no contrived illness; it is an inevitable result of psychic trauma. In hysterical states there is a simulation of illness because of the overwhelming need of the organism to cope. Illness is a common method of avoidance and widely employed.

Damage to the Organism

General

Like all elements in the cosmos, human organisms – individual, family and society – are controlled by the formulas governing the universe; they are part of the "cosmic design". One of these formulas is the need to function harmoniously. The cosmos, the universe as an ordered whole, remains imperfect and therefore the possibility of dysfunction is still an essential ingredient in it. Evolution strives to reduce dysfunction. Our developing awareness of psychic matters and our striving for psychic self-improvement are parts of this movement onwards. As the universe evolved, man developed the capacity to evaluate life experience and change it, to produce harmony. Therefore, man is driven on by a need to be harmonious and this in action is creative. This creative capacity is part of the cosmic endowment. The origin of this process, its rules and its regulation is a mystery.

Evolution affects both physical and psychic matters. Each has equal worth in the universe and, furthermore, the physical and psychic are linked. For this last reason there is value in considering psychic matters in known physical terms, as long as it is appreciated that each has in addition qualities of its own – even if at opposite ends of an elemental spectrum. Just as a caress can lead to a pleasurable physical sensation, so psychic communication can lead to a pleasurable feeling. Psychic messages are needed to satisfy the intra-psychic processes of behaviour. In the cerebrum there is a sensitive highest level functional area that can function harmoniously or unharmoniously. It seeks pleasure and harmony. It has a capacity to want this, i.e. given an equal choice of harmony or disharmony it will select the former. Possibly there is a regulator or governor, imposed by the developing plan of the universe, that works towards harmony.

The organism moves through time directed by its place in the cosmic plan; the motivation of the organism is beyond its control, it dances to the tune set for it in the pattern of things. The organism has a capacity to understand and react to situations but this capacity is the result of previous events and is thus, again, controlled by the cosmic plan.

Homeostasis, maintaining the constancy of the internal environment, is one factor in good functioning – as it is in its other sense, maintaining the balance between internal and external environments. Homeostasis, in both its meanings, is not as fundamental as the need for harmonious functioning, but it is an indication of good functioning.

The organism has an endowment of a physical and psychical apparatus, e.g. an apparatus that allows it to think, an apparatus which has a number of properties that can be developed to an optimum capacity, i.e. a determined degree of intelligence for a particular thought apparatus. The human fabric, somatic and psychic, is complex and composed of multiple, different, but linked elements. Experience acts on this endowment. Experience can be beneficial or harmful, good or adverse. As the result of experience the organism accumulates added characteristics. ("Properties" denotes the endowed entities, "characteristics" denotes the acquired entities.) If the experience is beneficial, the organism manifests indications of good functioning; if adverse, it displays indications of malfunctioning. Usually, in its imperfect state, it shows indications of both.

The fabric of the organism, be it individual, family or society, is the area on which the psychic noci-vectors operate, its most vulnerable part being its acquired characteristics. Within the fabric is found the morbid process – either organic or psychic pathology. In both the organic and psychic areas there are not only changes due to the noxious agent, but also changes due to attempts to cope with the agent, when coping devices come into play. Thus what is seen in the

fabric following damage is due both to the damage caused by the noxious agent itself and to the attempt to cope with the agent; there may be great elaboration of the coping devices.

The organism is always under day-to-day fluctuating trauma, which can be neutralised, or can leave behind small blemishes, e.g. cat phobia, like a bunion, is inconvenience, but not a threat to the basic integrity of the fabric. Even so, the weakness can fare up, e.g. if a person makes a living by looking after cats, it would be a liability, or a bunion is a serious liability to a runner. Again, if a person with cat phobia married a woman who is fond of cats the strain on the relationship might be severe.

There are degrees of disability; few people are completely well and unblemished, e.g. at any time a twinge of indigestion under psychic trauma may become a stomach ulcer, perforate, and so threaten life.

Discussion will now be centred on the damaged fabric, as it affects the simplest organism, the *individual*, then the special aspects of family and society will be discussed.

The Individual

The organism consists of a somato-psychic apparatus. This is made up of its endowment and its acquired part. The organism is subdivided into a number of systems, each of which is served by an apparatus with properties and capacities. Here we are concerned with the psychic system, the organic substratum of the brain and the other systems that serve it. The cerebrum has a number of sections with apparatus, properties and capacity; some are associated with feeling tones or moods. The general aim of the organism is laid down by the "cosmic plan" of which it is a small part.

The organic brain makes psychic functioning possible. Sensations become percepts in its reception areas by consulting previous experience held in its memory areas. Percepts can pass to the thought areas and creative and original ideas can be formulated by manipulation of new material and old material stored in the memory. Action is initiated through the motor areas. This endowed machinery can be damaged. Intoxicants can disorganise it. (So, in the author's belief can the agent responsible for encephaloataxia, where the agent strikes at the endowed machinery of thought.) The "higher" properties of thought, imagination and creativity, transcend local areas and require the activity of a number of areas. The ultimate awareness of activity in a feeling tone is termed a mood; some moods are direct and easy to interpret, but others are mixed, complex, and difficult to describe.

The endowment interacts with the environment and through experience develops a number of acquired characteristics, e.g. attitudes (including a central "idea of self"), character, temperament, knowledge, etc. It is this acquired part of the organism which is predominantly damaged by adverse psychic experience.

Some attitudes are complex in that they are composites of a number of basic attitudes. One blends with another to form a composite attitude and this then blends with another basic or composite attitude to form yet another. The basic English vocabulary is of about 1,000 words, only some of which are verbs. The number of basic attitudes that can be covered by these words are few, but they are still sufficient to describe adequately the fundamental attitudes. Blending of attitudes leads to the use of more elaborate words. Exact words must be distinguished from those used merely to hide attitudes; anxiety is a great coiner of abstruse words, as they make the best smokescreen. Basic attitudes are the raw material of society and the produce of experience over time; these attitudes are available to families and individuals. We must differentiate an attitude from mood, e.g. to be aggressive towards someone and the

mood of feeling angry. The damaged "idea of self" may set up wrong attitudes in an attempt to cope. These may aggravate the situation by provoking the attacker to strike again.

The "idea of self" is acquired over time due to the interaction of the endowed psyche with the environment. This interaction produces the acquired aspect of the psyche. It is this "idea of self", built up layer by layer in its many aspects through experience over time, which is attacked by opposing attitudes. The "idea of self" is a summation of attitudes – ideas, beliefs, interests, values, conscience, character. It is complex and has many elements, all of which can be damaged. Some elements are fundamental and important, e.g. notion of self worth. Some are less important, e.g. the notion that one has very good hearing. Any aspect or the whole can be attacked and damaged.

People are hugely concerned to meet "nice" people. A "nice" person is he or she who does not antagonise the "idea of self", or, better still, actively supports it by praise, encouragement, appreciation, etc. "To be liked" is very important to people. A great deal of effort in social intercourse goes into establishing whether others are "nice'" or "nasty", for or against one, a support or a threat. A clash of attitudes leads to dislike and antagonism. Appreciation comes from others and thus there is a need for companionship, "belonging" and acceptance.

In a damaging interaction, the sequence of events is as follows:

Psychic noci-vector → awareness of attack (sometimes) → insecurity → attempts at coping → if failure to cope → damage. The chances produced by this total process – psychic noci-vector, damage, and coping – are what the subject notices in himself – symptoms, and what an observer can perceive – signs; these changes are termed indicators and include both signs and symptoms.

Why is there a need to attack? Attack is dictated by a clash between the attitudes held by the protagonist and attitudes believed or known to be held by the antagonist. Disagreement is often mutual. The incompatibility may be very basic and hidden behind superimposed and secondary disagreements. The basic clashing attitudes can be strongly held and have been created by lengthy exposure to experience in the past. The more basic attitudes are created within the family – usually the preceding families. The epitomes of the preceding families come into the present family with strongly held attitudes (sometimes amounting to strong needs – "I need to be loved", "I need to be protected").

Attitudes are expressed in the present family and may clash with those of the spouse, if he has equally strongly held but opposing attitudes. Children too, in the present family, soon come to adopt strong attitudes, e.g. "I need mother to love me". But if father holds the view, "I need all my wife's attention, as my mother gave me none", then there is an inevitable clash between father and child. Some of the attitudes are carried down the generations (we have yet to work out all the rules that govern this).

The attack may be aimed at one aspect or the whole of the "idea of self" of the antagonist. The one aspect is selected because:

1. It is the attitude of the "idea of self" of the antagonist which aggravates the protagonist most.
2. Attitudes of the "idea of self" known to be weaknesses may be selected because of their vulnerability.

The attack arouses insecurity and attempts to cope. The attempts to cope will meet with complete, varying, or no success, depending on circumstances. If the attack is acute, the coping will be assisted by the automatic arousal of mood, e.g. anger or fear. A more insidious attack is less likely to arouse mood. The response may be automatic at the behest

of mood. The advantage of this primitive response is that it is automatic, quick, and massive. It also has dangers in not being guided by forethought. Sometimes to interpret the aroused mood may be difficult as a number of conflicting moods may be aroused or they may be mixed and complex. A young woman finds herself unexpectedly pregnant and she may experience a number of moods: "I have done wrong" – guilt; "He imposed this on me" – anger; "Can I manage?" – anxiety. Thus, she may well say, "I don't know what I feel". Due to previous experience, people differ in the capacity for arousal of mood, which may vary from excessive arousal to lack of it. More often, thought takes over and directs the coping efforts, of which there are many. If the possibility of further attack persists, then the psyche remains in a state of expectant fear – anxiety.

Damage may be completely repaired, partially repaired, or permanent – unless contrary experiences eradicate it (a sudden loss of confidence may be repaired almost at once by sustained praise and encouragement by an ally).

If there is a failure in coping, then there will be damage to an aspect or aspects or the whole "idea of self", eg: (i) Depreciation of the value of self, "I am unworthy", leaves a mood of depression (which can be mixed with other moods, e.g. anger or anxiety at the same time). (ii) The thought that the self is to blame arouses a mood of guilt. (iii) That the "idea of self" is utterly worthless, "I cannot live with myself", leads to the action of self-destruction, either by a negative act of not protecting the self, or by positive destruction of self (suicide can go hand in hand with other attitudes – to be a martyr, to arouse attention, to punish others).

The counterpart of damage to one aspect of the "idea of self" in the organic part of the person would be damage to one organ. The counterpart of damage to the whole "idea of self" in the organic part of the person would be damage to the whole body. Death of the body is the counterpart of complete loss of the "idea of self"; they coincide. Damage to the "idea of self" is the essence of psychonosis, i.e. damage to the acquired part of the psyche primarily (in encephalonosis, including encephaloataxia, damage is to the cerebral apparatus of psyche – i.e. the endowed part).

Aspects of the "idea of self" may be vulnerable to special stimuli. These vulnerable areas have been produced in the past. There may be no awareness of them. They may not be adversely stimulated for long periods of time. Children are very susceptible to damage. This may handicap them in basic functions for the rest of their lives, e.g. abilities to express love to another, to have intercourse with a spouse, to parent children, to relate to people, etc, i.e. from damage and from coping have arisen attitudes which hamper these basic functions.

Severe emotional trauma leads to damage which is at once manifest in a number of ways: (i) The damage may be severe enough to allow the use of the words "shock" or "stupor". (ii) The coping mechanism must come to the fore and this negatesmore constructive efforts in our activities. (iii)There is the experience of an unpleasant mood, e.g. anguish, anxiety, depression, guilt. (iv) Organic functions and apparatus may also dysfunction. (v) The "idea of self" suffers damage.

Long-drawn-out engagements may produce an escalation of coping and damage. The engagements may only cease after exhaustion on one or both sides. The coping devices, physical and psychic, tire, thought tires of producing more countering arguments, the centres of mood are completely discharged, and the damage done demands a respite.

The physical response of the body is automatic, although it may be influenced by previous experience. Some responses are coping devices – the action of brain centres, the

autonomic nervous system and the hormonal pattern as a reaction to aggression and fear – to help fight or to aid flight. Primitive mechanisms prepare the person for either. With both there is an accompanying mood. Secondary ill effects can develop from using this machinery excessively. These ill effects may be local. The local response may be determined by a weakness in a particular system, which has been produced by previous psychic experience involving it, or by organic weakness, e.g. an existing arthritis gets worse. A local response may also carry the full weight of an idea, i.e. cerebral mechanisms may dictate a small lesion at a particular highly meaningful point, for example, blush associated with shame. In addition to the acute reactions, chronic stimulation over a long time can also have its physical counterpart – no psychic condition is free from a reflection in the physical sphere.

So close is the tie between the acquired and the endowed physical apparatus of psyche, the cerebrum and the nervous system, that damage to the acquired part is reflected in bodily change also. A depressed person shows physical changes – pale skin, lifeless faces, flaccid limbs, constipation and slow pulse (unless there is concomitant anxiety). Acute fear may cause perforation of the stomach, or the hair to turn white or voiding of urine. The physical change in a person may belie his insistence that he has no problems. *Again, we see the need to practise a medicine of the whole man and to assess the physical condition of a psychonotic sufferer.*

Here is an example of a traumatic exchange. The analysis of a brief statement by a daughter concerning a quarrel with her father a few minutes before displays how, on both sides, the attack is directed at the "idea of self" (both father and daughter are present in the interview):

Therapist: What happened in the last hour then?

Daughter: He was being 100% selfish. Driving along, he wouldn't let me open the window. He had the heating full on and I was suffocating and I was very tired. He swore at me and called me a yob and God knows what, because I wanted the window open.

Father's attack on daughter during quarrel:

He would not open window	- i.e. would not listen as she is unimportant – attacks her notion within her "idea of self" that she ought to be loved by father.
He kept the heating one	- i.e. he is overbearing – he attacks her notion of adulthood within her "idea of self".
He swore at her	- i.e. he debases her – attacks her notion of adequacy and self respect within her "idea of self".
He calls her a yob	- i.e. he makes her feel inferior – attacks her notion of self respect within her "idea of self".

Summary: He is aggressive, both verbally and non-verbally. His mood is of anger.

Daughter's attack on father during interview:

He was selfish - i.e. attack on the altruistic notions within his "idea of self".

He would not let me open the window -i.e .he is unreasonable – attacks his notions of a responsible adult within his "idea of self".

He had the heating full on - i.e. again unreasonable, as above

He swore at me - i.e. he uses bad language – attacks his notion of fairmindedness and rational notions within his "idea of self".

He called me a yob - i.e. he is unfatherly – attacks his notion of fair play towards adolescents within his "idea of self".

Summary: She retaliates after the event, she is verbally aggressive and hostile. Her mood is of anger. She conveys attack in two ways: (i) directly, and (ii) in statements of fact which carry implications of criticism.

Conclusion: Father attacks her during quarrel. She attacks him during interview. Both are aggressive and hostile and hurl hurtful attitudes at the other aimed at damaging the acq2uired "idea of self" of the other. The mood of both is anger.

The present exchange points also to the basic attitudes from which they spring. He dislikes her as a rival for the mother's affection. She fears him because of his continual attacks on her. At this moment she is stung into attack and hopes that in the presence of the therapist father is less likely to retaliate.

The Family

The fabric of the family must be briefly described before consideration is given to its damage, additional to that of the individual, by the psychic noci-vectors.

The family is a somato-psychic entity derived from somato-psychic fragments of preceding family entities. The endowed organic part consists of its individual members together with its collective possessions. Its endowed psychic part includes a cerebral apparatus in a number of individuals, which, collectively, allows of rapid communication amongst its members. Meanings are conveyed, percepts are formed, memory is consulted, thoughts are conceived and fresh ideas flow out through the motor systems, both to other family members and to the external world. The collective apparatus has a number of feeling tones – more complete and diverse than in the individual and more often an amalgam of feelings.

The family system continually changes due to interaction within itself and interaction with the environment outside. Thus, it acquires general characteristics – knowledge, attitudes (beliefs, values, interests), character, conscience, temperament, aims, skills, role playing, control and decision-making machinery, arrangement and climate.

The psychic noci-vectors can be aimed at any aspect of the integrated structure of the family. There is awareness of attack, insecurity is created, there is an attempt to cope and its failure leads to damage of some aspect of the family fabric. The family differs from the individual in

that the structure is looser and there can be conflict, giving rise to noci-vectors, between elements in the family. *Frequently, the noci-vectors arise from clashing attitudes brought by family members from preceding families.*

The "idea of self" is built up by the family over time and is a complex summation of characteristics – ideas, beliefs, interests, values, conscience, character, temperament. Any of these can be damaged. Roles may change, the controlling and decision-making machinery may fail or weaken, integration is lost, conflict is increased and the climate becomes tense, traumatic or hostile.

The threat of attack causes insecurity – long-drawn-out insecurity produces continual anxiety and tension; the whole family, or fragments of it, await renewed attack. Strong moods are generated – of guilt, anger, and fear. Shock may be the initial reaction. Efficiency, harmony, confidence and cohesion are lost. Fragmentation may occur and finally the family may break up completely.

Not only does the psychic part of the family react, but so does the somatic. Somatic illness springs up in various parts of the whole – in individuals or dyads or sub-groups. Sometimes the whole family is affected. The expression of the somatic illness may change its locus as the dynamics change – indeed therapeutic intervention on a locus often merely moves the somatic disorder to another part of the family.

Family members involved in a pathological family process become a part of it and, as epitomes of the family, move on to produce potentially pathological families in the future.

Social Pathology

Society, like the family and individual, is a somato-psychic organism. The somatic aspect consists of all individuals, families and groups within it together with its material possessions. The psychic endowment consists of the collective cerebral endowment of all its constituent parts together with the complex pattern of interaction between its multitudinous parts. Over time, like the family group, it has acquired an immense superstructure of attitudes, etc. It is this superstructure which is vulnerable to psychic trauma.

From the interaction of its parts – ethnic groups, political groups, families, individuals – can arise many areas of conflict producing potent psychic noci-vectors that threaten and harm it and its constituent parts. Society has yet to achieve the harmony which would fulfil the master plan devised for it. It has yet to find the correct pattern of functioning. Its parts are disharmonious and thus conflict and noxious vectors are inevitable. It has been especially unable to understand and control its psychic aspect.

Society is nearly always understood in economic, or material, or geographical terms. But the underlying psychic implications go unevaluated. Selfishness must lead to irresponsibility, "playing the market", and economic crisis. The crisis is studied, its toll in money is compounded, but its psychic origin remains overlooked. Hurt pride leads to a desire for revenge and self-expression which in turn can lead to war. As important as the statistics of wasted finance, the number of dead, and the economic consequences is the need to evaluate the psychic origin of war.

Society's psychopathology is essentially similar to psychopathology in the family. Any facet of society can be damaged. The noxious vectors may or may not be perceived. Insecurity is created. Attempts at coping are made and if they fail there is damage to some facet of society or to the whole of it. The controlling and decision-making machinery may fail, perverse roles are created, e.g. the Inquisition, McCarthyism, etc., integration is lost, conflict increases, and the climate becomes tense, hostile, and traumatic. Continual threats provoke anxiety and

tension. Strong moods are generated. Efficiency, confidence, harmony and cohesion are lost. Fragmentation leading to warring factions may be a feature. Finally, the whole society may disintegrate and perish. On a small scale, the impact of so-called "modern" or "developed" society on a different society, e.g. the Australian Aborigines, is a violent illustration of multiple, noxious, clashing vectors on a hitherto fairly harmonious society.

As in families and individuals, the somatic and material aspects of society are involved in the pathological process. The level of physical ill-health is one index of social pathology.

Naturally, the state of society is transferred to its constituent parts – its groups, families and individuals. **To understand and improve social pathology is a fundamental way of improving the state of families and individuals. Hence the importance of creating a salutiferous society.**

Associated Matters

Conflict is not damage. But it can lead to damage as trauma can arise from it. Conflict is a clash or difference between two attitudes. It can arise in a number of ways:

1. Conflict of attitudes within one person – "to steal or to be honest".
2. Conflict between two desirable alternatives.
3. Conflict between attitudes held by two person – "I want children. You don't want children".
4. Contradictory attitudes conveyed from one person to another - "I love you. I hate you".

Guilt is especially likely to occur in people of strong moral convictions when their actions are in contradiction to those ideals. Damage is done to the moral aspect of the "idea of self". There is an attitude of "I am blameworthy, I should be ashamed" and a mood of guilt. The feeling of being wrong may be so great that it cannot be tolerated: "Such an offensive object should not live and should be destroyed". Those continually blamed in the past are very vulnerable to blame now. In pure grieving there is a feeling of loss. If there was antagonism to the dead person in the past, there may be not only grief, but also a feeling of being "to blame" and of guilt.

The description given earlier of the functioning of the psyche puts reproductive and *sexual activities* in perspective. They are major activities of the person, but far from his total, or most important activity. A mood of sexuality is a potent motivator of action, but so are thirst – and many other activities. To explain psychic disorder in terms of sexual dysfunction alone is to limit grossly the knowledge of individual activity. Furthermore, sexual malfunction often arises secondarily to other psychic damage, e.g. in a state of depression there is a loss of desire to eat and also loss of desire for sexual activity. Again, frigidity may be secondary to an inability to express emotion for another person, or anxiety may make sexual performance impossible. Difficulties in sexual activity can cause consequential reactions, e.g. wife loses her mother and is disinclined to have intercourse, husband becomes irritable at her refusal and develops a gastric ulcer. To explain behaviour in terms of stereotyped sexual dogma is to grossly limit the range of human behaviour. It is also a serious error to impose adult concepts of sexuality upon children.

Security, fear and anxiety must be differentiated. In the absence of threat or stress to the self and in a state of optimum functioning and harmony, there is a complete *security. Fear* is aroused by something which is harmful to the self. The threat is seen and the mood of fear experienced. Fear can sometimes be displaced to harmless objects. It can be exaggerated by

introspection when allowed to hold the field of attention and push out ideas that would put the fear in perspective. It is a primitive response and has an attached physical apparatus. *Anxiety* is a state of anticipation of threat to the self. It is sustained. People talk of being in a state of tension. There is a continuous alerting of the associated physical apparatus. Chronic body changes may occur – loss of weight, moist skin, furrowed face, etc. Because of previous experience, some people expect stress – they are of an anxious disposition. They may react to a minimal stimulus. Such persons are at as great a disadvantage as those who are so non-sensitive to stimulation that their phlegmatic reaction puts them in danger.

Aggression is a primitive coping mechanism associated with a physical apparatus for its performance and a mood of anger in awareness. It has increasingly come under the control of thought. The physical apparatus can even be dictated to put on a sham demonstration of anger. Anger in performance or in threat is one way of contending with attack. Thus it is prevalent in those who are insecure. It can be stimulated by childhood experiences; some families regard it as the first choice when attacked, threatened or anxious. There is an *attitude* of hostility, an *activity* of aggression and a *mood* of anger.

Anomalous conditions of the person due to untraumatic experiences must not be confused with danger, e.g. lack or excess of emotional response (cold or volatile people). A person may display such anomalies without being disharmonious or dysfunctioning, if in an environment where the anomaly is acceptable. For example, a homosexual may be healthy, balanced and happy if in an environment that accepts his way of life; in a different hostile situation, he can become psychonotic, if he is the recipient of psychic stress.

Indicators

The man in the street, like a family or society, aspires to happiness, a state of psychic and physical harmony, which has its own indicators. Some of the indicators of harmonious psychic functioning are: loving, relating, co-operating, enjoyable sexuality, balanced self regard, security, self-confidence, responsible attainable goals, well-being, productiveness within capacity, hopefulness, creativeness (the capacity for self-improvement). These are associated with physical well-being, e.g. beneficial sleep, sound digestion and elimination, ample appetite, co-ordinated muscle action, sexual satisfaction, clear skin, etc.

In pathology, the psychic noci-vectors strike the psyche of the organism, which responds by deploying its coping mechanisms, and damage to the psyche may or may not occur. *This process displays itself by indicators.*

An indicator can be any part of the whole process – psychic noci-vector, damage, or coping mechanism. Taking the analogy of a car with dirt in the petrol makes this clear. The dirt in the pipe, i.e. the noci-vector, may cause an irregular movement of the car, the lack of petrol leads to defective combustion and hence loss of power, i.e. damage to its functioning, and the need to press hard on the accelerator to produce more petrol is an attempt to cope. The indicators, irregular motion, loss of power and excessive use of the accelerator, are all due to different parts of the whole process. All are useful indicators of the trouble and together give the experienced motorist a clue to the nature of the disorder. Similarly a piece of shrapnel causing a body wound has a number of indicators – the hardness is due to the noxious vector, the shrapnel, the loss of sensations is due to a cut nerve, and the warmth around the wound is due to the body's inflammatory coping device. The indicators are not the process itself, they are the parts that can be assessed. They warn the individual of pathology. To a trained observer they may demonstrate the nature of the pathology. Hence the need for a careful examination to identify as many indicators as possible and reach an accurate elucidation, diagnosis, of the pathology.

The organism subjected to the process, or an observer, notices a change in functioning, something different happens from the accustomed – pain, or anguish, or anxiety, or a rash, etc. The change that can be detected by the organism itself is termed a symptom. The change in the organism that can be detected by an observer is termed a sign. Damage to the psyche tends to lead to fundamental changes – grief, depression, withdrawal, guilt, anger, fears, etc. These changes in the self may be so obvious as not to escape the attention of the person. They may be very obvious also to the observer and so constitute signs. An indicator is the part of the process which is noticed – it is not more significant than the rest of the process and is not the whole of it. Indicators – signs and symptoms – are produced by the whole process and therefore all these factors which determine the choice of psychic noci-vectors, damage, or coping, determine the indicator.

The psychic noci-vector, as it influences the place and mode of attack, the damage done, and the responding coping devices, is a factor in determining the nature of the indicator.

The family's influence on choice of coping devices is great and hence it may also determine the indicator. Given a certain constellation of factors operating, conflict can be resolved only in certain definite ways. A particular form of coping and hence a particular indicator, is inevitable in given circumstances. This leads to diverse and sometimes extreme as well as fanciful ways of coping. No other way of coping is possible.

These coping devices, and hence indicators, can be passed on from one generation to the next. A grandparent copes with is social inferiority by fastidiousness in dress; his son adopts the same coping device – and so does the grandson. In the preceding family men meet attach with aggression, the men of the presenting family adopt the same device, which is also found in the succeeding family. Thus familial communication may be confused with genetically induced traits. Faced with the same psychic noci-vector as on previous occasions, the same coping devices are quickly employed and therefore the same indicators are seen. Repetition leads to a stereotyped process and hence to stereotyped indicators.

The psychic pathological process sometimes follows a general pattern, more or less common to many families. In that case, common indicators will be apparent. At other times, the process is special and unique to a family and thus the indicators are unusual.

The indicators of psychic pathology can be either psychic or somatic. Thus an examination of psychic and somatic functioning is required to make a complete assessment of the indicators. Any bodily system can be involved in the pathological process. Indicators of dysfunction in the soma are termed psychosomatic disorders – they are many and diverse. It is rare for careful examination not to expose some psychosomatic disorders when the organism has been subjected to psychic harmful agents. The psychosomatic disorder must be differentiated from the hysterical. The first is an automatic pathological response, e.g. abdominal pain due to bowel spasm at the thought of going to school where one is bullied by a classmate. The hysterical response is a simulated attitude because the need to simulate is great, e.g. the child simulates abdominal pain, which has no related bowel spasm, so as to avoid going to school. The term "hysterical" denotes a special attitude – one of simulation. But many attitudes are adopted without simulation and are not hysterical – the real situation is that a need exists to hold firmly on to an attitude. For example, a child refuses to eat – he cannot do otherwise while caught in a deadlock with father who state, "Just eat and I will not be cross". The child states "If you stop being cross, I will eat" – and thus cannot eat until father changes his attitude.

As in the field of organic pathology, a particular indicator may be shared by a number of different psychopathological processes. Inability to eat, for example, may arise from severe

depression, from a reaction to grief (Queen Mary Stuart's dog "pined away" and refused to eat after her beheading) from a conflict with the family when food is an issue, from concentration of interest elsewhere arising from severe anxiety and the need to be alert, or from gastric pain produced by acute anxiety. The same is true of organic pathology – dyspnoea (shortness of breath) may be seen in anaemia, in carcinoma of the lung, in pneumonia, and in cardiac failure.

When attempts are made to remove an indicator, the attempt may be successful, but the indicator is usually immediately replaced by another – the *substitution of indicators*. The process has not changed, but the therapy has produced an additional factor that pushes the process in another direction. This is very conspicuous in families when the presenting pathological member is given much assistance; he is soon replaced by another family member who has become sick.

Indicators of pathology must be differentiated from bad habits. Many attitudes are not the result of psychic noci-vectors, but are wrong attitudes inculcated in a non-stressful situation. To exploit others may be a way of life arising from that person's values, or it might be a coping mechanism indicating a pathological process. The first is of interest to sociologists, the second a matter for clinicians. This confusion leads to non-clinical procedures being advocated for clinical disorders and to armies of well-meaning citizens attempting a clinical role.

When the organism is fearful enough about its health, it will take one of its indicators as an excuse for seeking help. It may notice only this one conspicuous indicator. It may regard only that particular one as a sign of danger. It may feel it will lead to attention. This indicator is termed "the complaint", or the presenting symptom. It is crucial to appreciate that the presenting symptom is not the whole process, nor is it more significant than the rest of the indicators. There must be a global assessment to lead to adequate diagnosis. The importance of indicators is that they warn, they lead to seeking professional help, and, taken collectively, they often point the nature of the pathology to the clinician trained in reading the indicators and in systematic examination that allows of a total appraisal, leading to a discernment, diagnosis.

Indicators are not the psychopathological process and attempts to treat the indicators as if they were the process are futile. This can limit the usefulness of behaviour therapy. Similarly, a sign of a stressful process such as a rash, perhaps due to a hurtful marital situation, may be helped by an ointment but leaves untouched the process itself; it can only relieve any secondary stress caused by the rash. The process itself must be treated for effective therapy. The psychic noxious agents causing the process must stop operating or the coping devices must be strengthened, and the psychic damage must be repaired.

Indicators of morbid processes as they present in the individual, family and society will be briefly outlined.

Indicators in the Individual

Like the family and society, the individual reacts as a somato-psychic organism. Thus there are somatic as well as psychic indicators, signs and symptoms, and it is rare for this not to be the case. The somatic indicators are usually multiple and in the nature of the so-called "psychosomatic disorders". The choice of psychosomatic responses depends on a number of factors – previous trauma involving a particular organ with a reawakening of memory in relation to it; the organic mechanisms of reaction to stress may be over-stimulated, with damage to a weak organ; cultural suggestion, e.g. blushing in western society in an index of shame. The selection of the site where damage develops is probably determined centrally by the brain, as the lesions do not follow a segmental distribution, which would be the case in local damage to the central nervous system.

It is usual to subdivide emotional disorder in the individual into certain clinical categories – anxiety states, obsessional states, hysterical states, etc. This practice has grave weaknesses. It pays attention to the presenting symptoms, often elevates them to the status of a disease, and limits the description of the process. The process is all-important and cannot be covered by one or many labels. Each process is made up of such a combination of circumstances as to be unique.

Either psychic or somatic symptoms may be the first to be noticed and constitute the presenting symptom. Age influences the indicators. Hostility may be manifested in an infant by temper tantrums; in a child, by lying; in an adolescent, by rebellion; and in an adult, by criminality. A person is bound by the strength and range of his endowment at a given period of development. There may be resurgence of psychonosis, and hence indicators, at nodal points in development, e.g. school entrance, puberty, marriage, childbirth, menopause, retirement, etc.

Sex gender may influence indicators, e.g. a woman tends to develop signs in the reproductive system. Gastric and duodenal ulceration is commoner in men.

Examples of indicators from 25 patients are:

Vaginismus	Bouts of drinking	Indigestion
Nightmares	Screaming fits	Moodiness
Ill temper	Tremors	Irritations of skin
Epigastric pains or discomfort	Headaches	Fainting attacks
Chest pains	Numbness in the body	Violent behaviour to wife
Shyness	Fear of crowds	Cancer phobia and other phobias
Backache	Pumping in stomach	Worry
Bad temper	Giddiness	Wanting to run away
Nose bleeds	Globus hystericus	Lack of concentration
Forced pregnancy	Insomnia	Inability to go to work
Pains in the abdomen	Diarrhoea	Inability to go to school
Fearfulness	Muscular pains	Migraine
Dyspareunia	Belching	“Run down”
Frigidity	Palpitations	Cramps in the hand
Crying fits	Sweats	“Pins and needles”
Bed wetting	Loss of weight	Shortness of breath
Dyspepsia	Asthma	Loss of hair

Attacks of panic	Bouts of fever	Failing an exam
Frequent ill health, coughs, colds	Dysmenorrhoea	Colitis
Loss of appetite	"Bad heart"	Drug addiction
Depression		

As can be seen, the above can be divided conveniently into somatic and psychic indicators. In no patient did one group, psychic or somatic, exist alone. Depression of varying degrees is a very common symptom. This was also found to be so in an investigation of symptomatology shown by patients of Dr. John Hall, Shakespeare's son-in-law, 300 years ago.

Indicators in the Family

The family too reacts as a whole, with both its psyche and its soma. Rarely is a disturbed family without signs of somatic disorders and indeed this may be its most conspicuous feature – and its reason for seeking help. The total range of symptomatology in a family may be great. Indicators arise from the clashing attitudes within the family or between the family and its psychic environment.

Indicators can arise anywhere in the fabric of the family – in its individuals, in its external and internal communication system, in its physical structure (even to proneness to a streptococcal infection), and in its general characteristics. Careful examination will usually reveal that indicators appear in all its dimensions, especially if the disturbance is severe. However, a family group may not manifest dysfunction equally throughout its system. One aspect of it may show disproportionate dysfunction due to the "set" of emotional events at a particular time.

Indicators are strikingly apparent in problem families, because emotionally sick families carry a high degree of psychopathogenicity. In one family, consisting of mother and two children, the following were seen:

Dimension of the Individuals:

Mother-Aggression; rage; despair; depression; panic; lying; stealing; accident-proneness; excessive smoking; alcoholism; attacks of vomiting; fainting attacks; gastric ulcer; enuresis; shaking fits.

Child 1 - Tension; tearfulness; fear of the dark; nighmares; enuresis; lying.

Child 2 - Irritability; depression; enuresis; lack of confidence.

Dimension of Internal Communication:

Mother/Children - Over-protectiveness; rejection; hostility; depreciation; neglect; disparagement.

Dimension of General Psychic Properties

Two illegitimate children; low morality; shared symptom of enuresis; no aims or purpose; conflict.

Dimension of External Communication:

Isolation; truanting from school; exploitation of welfare agencies; quarrels with neighbours; poor school performance; mother unemployable.

Dimension of Physical Properties:

Poor diet; squalor; debts.

The choice of indicators is a reflection of family dysfunctioning. The individual's choice is dictated by his life experience in the family, e.g. an angry family evokes anger in a child. The choice of expression in a relationship is similarly determined, e.g. physical hostility may be taboo and verbal hostility alone possible. The material changes in the family can take place only within the limits set by its condition. Group manifestations are a family expression, e.g. sulking may be an expression of hostility in a particular family. The community interaction may determine the indicators, e.g. that fear be controlled by obsessional ritual or that sexual taboos be imposed. Again, gastric ulceration is a common indicator in Western civilisation, but not in primitive communities. No only do present events dictate choice of indicators, but so do events from the past. Every indicator has to be understood as a manifestation of past or present family dysfunction, or as a resultant of both.

It is fundamental to the doctrine of family psychiatry that psychopathology must always be thought of as an expression of dysfunction in a whole family group. A family can show manifestations, indicators, or dysfunction at any point in its system. Thus indicators appear in the five dimensions. Almost invariably they appear in all, although this may escape notice except on the closes examination. But the family group will not show manifestations of dysfunction to the same extent through all its aspects, e.g. the second child may show more manifestations than the first, or a girl more than a boy, or the family's external relations may be more disturbed than its physical conditions.

In the *dimension of the individuals*, each family member usually shows symptomatology. Naturally, this will not be exposed if examination concentrates on one person alone and overlooks the remainder of the family. But each individual does not show psychopathology of the same kind, nor to the same degree.

In the *dimension of internal communication*, each relationship will usually show disharmony. Naturally, this will not be seen unless each relationship is examined. In practice, the mother/child relationship often comes under far greater scrutiny than the father/child relationship; the marital relationship also receives a fair degree of attention, but not always from the psychiatric service. Each relationship will not show psychopathology of the same kind, nor to the same degree.

A disturbed relationship may give rise to any indicator in the physical or psychic fields, in both individuals of the partnership, e.g. an obsession in the wife and a rash in the husband. Sometimes the symptomatology is shared by both partners, e.g. impotence in both (a psychosomatic reaction); joint depression, suicide of *folie à deux* (affective changes), or overt quarrelling. Furthermore, some indicators tend to be associated with a particular relationship, e.g. a mal-relationship between husband and wife is often responsible for premature ejaculation, dyspareunia, impotence and frigidity.

Hence, too, family patterns may dictate choice of indicators, e.g. in some families open quarrelling is forbidden and its members sulk instead. Cultural pressure may also influence choice of indicators, e.g. sexual taboos increase the incidence of sexual disharmony.

That a particular relationship comes to the attention of a referral agency may be fortuitous. Quarrels between husband and wife may evoke the attention of friends; the faulty relationship between mother and infant may be picked up by the regular surveillance of a community "mother and baby" clinic; the relationship most under stress may come to attention , e.g. a marriage, due to the intervention of a third party. That indicators of faulty relationships come to attention rather than individual indicators is equally fortuitous.

Symptomatology in the *general psychic dimension* manifests itself in a pattern common to the whole family. Families may be prone to particular types of physical disability, e.g. accident proneness, stomach disorders, or speech disturbances. They manifest affective changes as a group, e.g. panic may be the group reaction to stress. The family's pattern of behaviour is shared by all its members, e.g. exploitation of neighbours. Choice of family group symptomatology may be influenced by cultural pressure; e.g. the culture may dictate that fear be controlled by obsessional ritual.

That group disharmony rather than individual or relationship disharmony comes to the attention of a referral agency is again fortuitous. Usually this is less likely to happen, as few agencies ascertain whole family patters of dysfunction. It is not inconceivable, however, that in time many more agencies will function as family agencies, e.g. in a number of countries the personal doctor operates more and more as a family physician.

Family dysfunction frequently manifests itself in the *dimension of physical properties*, e.g. poverty despite an adequate income; sloth resulting from apathy and disinterest; low income due to lack of application; loss of employment as a reaction to family emotional crises. Yet again it is fortuitous that adverse material circumstances are the manifestations that arouse attention in referral agencies, rather than individual, internal communication, or general disharmony. Most often these manifestations come to the attention of social agencies. But selection factors operate, as an agency may have a special function, e.g. a housing agency may ascertain sloth but overlook employment failure, or an agency may serve lower income groups only and overlook child neglect in a higher income group.

In the *dimension of external communication*, signs of dysfunction may arise at the three points of contact: individual-community interaction, e.g. stealing outside the home by a child; partnership-community interaction, e.g. parents' refusal to send a child to school; or family group-community interaction, e.g. quarrelling with the neighbours. The community influences the family by informal and formal means. Enforcement of the latter is entrusted to agencies with statutory powers, e.g. police, courts, health inspectors, child-care agencies, etc, and these, in addition to enforcement functions, may accept responsibility for ascertainment of dysfunction. Usually agencies with statutory powers are likely to observe signs of dysfunction in this dimension of family-community interaction.

Indicators in Society

Society, too, reacts as a somato-psychic entity with psychic and somatic indicators. Not only may there be high incidence of psychosomatic disorders, but also signs of psychic disruption, like social unrest, low morale, apathy, strife, war, corruption and fragmented incohesive public action. The indicators may follow a common pattern through a large population, e.g. the panic reactions common in the Middle Ages. Mass suggestion can affect the choice of indicators, e.g. the increase in drug addiction in adolescents forced by massive propaganda to display their adulthood in this fashion.

There may be an interplay of family and social factors in indicator production, e.g. alcoholism may be the accepted expression in a given population, but only those in disturbed families manifest it to a severe degree.

Some indicators are termed "social" problems, e.g. high divorce rate, high suicide rate, alcoholism, drug addiction, promiscuity, child neglect, etc. Some of these are "social" only in the sense that a large number of people are involved, like tuberculosis 50 years ago. Like tuberculosis, however, the eradication of these problems involves not only large scale preventive action, but also curative procedures at individual and family level. The preventive actions must be devised and guided by knowledge acquired through curative procedures.

A Note on Nosology

Nosology (*nosis* – disease, *logy* – word) in psychiatry and psychology can be confusing and variously employed in different countries. Part of the difficulty is due to an inability to establish agreed criteria for clinical categories.

Two main divisions are the fields of : 1. Neurosis; 2. Psychosis. Here the nomenclature is unsatisfactory. 'Neurosis' means 'disorder of neurone' implying a physical origin. But it is used to cover psychological states, emotional disorder, personality disorder. These states could strictly come under the term 'psychonosis', disorder of the psyche. The term 'psychosis' means 'disorder of psyche' implying a psychological origin. But it is used to cover states such as toxic psychosis, alcoholic psychosis, drug psychosis and schizophrenia. These states have a cerebral basis and could better come under the term 'encephalonosis', disorder of the encephalon.

The term 'insanity' is also not useful. It is derived from 'insanus', not sound in mind.

Sometimes strength of the disorder is used to determine nosology. Severe conditions are termed 'psychotic'; less severe conditions are termed 'neurotic'. This is contrary to clinical experience. Neurotic states can be very severe, ending in the death of an individual.

There are also mixed states, e.g. a personality disorder (neurosis) can be aggravated by a drug psychosis, sometimes making a very serious condition.

The term 'schizophrenia' – 'split mind', first used by Bleuler lacks proper descriptive value. Kreoplin's original term, *dementia praecox*, early dementia, is nearer the mark. When its cerebral origin is finally proved it may merit a term such as *enchaloataxia.*

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. The one developed at the Institute of Family Psychiatry is found in Appendix II.

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 evaluation of the life experience can be covered by a framework such as that described in Appendix III.

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 and summarised in Appendix IV.

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

It will be noted that Step II has involved the use of Appendices III and IV.

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.

A suitable chart of examination for (d-ii) and (d-iii) will be found in Appendix V.

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 such as that described in Appendix VII. It 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 (Appendix III) and his personality structure now (Appendix IV). 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 (Appendices III and IV).

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 and summarised in Appendix VIII.

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, as outlined in Appendix V.

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.

A suitable chart of examination is found in Appendix IX.

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. Further particulars are found in Appendix X.

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.

III - Family Psychology and Family Psychiatry - Psychotherapy

General

The term “family psychotherapy” means treatment of the family by any procedure that helps to restore health to the family. The term “family therapy” has sometimes been misused and employed in a wider sense to cover a family approach, or in a narrow usage to cover one treatment technique, family group therapy.

Psychonosis is a preventable disorder; severe states of psychonosis are difficult to cure; moderate states of psychonosis can be modified.

Thus, the greatest hope for the eradication of psychonosis and the improvement in the standard of emotional health lies in the promotion of emotional health rather than in direct procedures of cure. However, the two roads to health are parallel and complementary. From the curative field comes knowledge that can be applied on a wider scale in health promotion; curative measures offer a research area. At the same time, curative procedures make a small, but useful, contribution to improving the standard of emotional health.

The greatest bar to progress in therapy is not lack of personnel, or services, or efforts, small though these are; the main bar to progress is ignorance. The emotional and mental health services should not be judged by their therapeutic success; this is small. Their importance is that they exist. Because they exist they are a rallying point for the afflicted and the problem is exposed. Furthermore, they are a rallying point for a large number of dedicated and interested workers, who some day will collectively find the answer to psychonosis. Unfortunately, they are also the rallying point for an even greater number of workers who seek palliation of their own problems through working with others in a similar state; to select healthy workers, the product of healthy families, is one of the greatest organisational problems facing all the professions in this field.

Ignorance is the true bar to progress. The field is complex. Research is difficult because of the many variables. The work is highly emotive and lends itself to

misconception and wishful thinking. Many workers are dedicated, but their grasp of scientific principles is rudimentary. Thus, vague notions of a quality that can be termed mystical offer great appeal; the appraiser, aware of his own ignorance, assumes that the mystic has greater knowledge and that his own lack of ability prevents him seeing the truth. Thus, he assumes the truth to be there, when in fact he is faced with intellectualised wishful thinking.

Ignorance is prominent in psychopathology, a vital but most difficult area. Only understanding of the pathological process can lead to rational therapy. But, here, ignorance is at its greatest. Explanation has been invented rather than sought in carefully planned investigation. Invention has relied heavily upon thinking by analogy. Analogous phenomena are assumed to have all the same characteristics of the phenomena with which they are compared. Thus, picturesque illustrations are assumed to have causal links; links made so readily in the illustrations are assumed to apply in the life situations with which they are compared. That such obvious misinformation is allowed to go uncorrected soon makes it clear that heavy personal emotional bias is at work. For example, it is stated that children are brought up by mothers, when simple observation shows that they are brought up in a group – and yet uni-object relation therapy is sacrosanct. Psychopathologies do not tally with reality, or with experience. Such is the ignorance of psychopathology that it is not surprising that therapy is largely ineffective. With irrationality dominating the principles on which it is based, therapy must be ineffective. Cults have replaced responsible investigation. The way into the cult has often been through sickness. The patient becomes the therapist. Later still the therapist becomes the teacher. The blind and weak lead the weak and blind. The cult wards off attack by defences built on a dogma that cannot be understood, and thus cannot be attacked, by the uninitiated.

Emphasis has been given above to the understanding of psychopathology. It is important also to emphasise the importance of diagnosis. One must understand before one can treat effectively. Similarly, if one does not differentiate between diagnosis and therapy much of what happens in the process of diagnosis is assumed to be therapy. Almost all the films on “family therapy” (ie family group therapy) are, on careful evaluation, nothing more than diagnostic exercises. The family and the “therapist” (in truth a diagnostician) learn a great deal about the history and psychic tribulations of the family. But nothing changes. Revelation is not therapy. Insight is not enough. Let me illustrate: An account is given in one publication of about 50 “therapeutic” sessions involving a mother and son. In the last session, the mother is able to reveal that the pregnancy which resulted in the birth of her son was the cause of her unhappy marriage. She hates the husband and his son and rejects both. The cause of the son’s vivid adolescent misdemeanours is now clear. The therapy is now assumed to have come to an end; revelation has been made. But the mother does not thereby stop hating. Nor does the damage done to her son over the last 15 years urgently repair itself. All that we witnessed was an encounter which allowed rapport to develop very slowly (a sympathetic friend would have reached this stage as quickly) to the point when the woman could reveal to a therapist something she already knew. The sharing of knowledge is a prelude to therapy, but it is not itself therapy.

One of the major lessons of diagnosis is to reveal the way in which somatic pathology runs parallel with psychic pathology. It is rare for psychonosis in an individual or in a family not to show itself in some somatic pathology. Only global examination exposes how common is this link between somatic and psychic pathology, and often

the severe, and life threatening, nature of the somatic pathology. Diagnosis establishes the case for somatic and psychic therapy to run together.

Diagnosis must be accepted as a separate, if sometimes parallel, exercise from therapy, otherwise we shall not appreciate what little therapy takes place. It is matters such as this which lie behind the comment of an honest and particularly experienced therapist, both as psychoanalyst and family therapist. He was told by a prominent family sociologist, “I feel the need for the therapist to explain himself, what he did, how, when, and why, with a particular family”. Nathan Ackerman comments, “Again and again, I try to do this but I am never sure that I succeed”.

Would the populace be worse off if there were no psychotherapy? A protagonist might say that surely effort must stand for something. But the massive blood-letting perpetrated in the past in somatic medicine was also effort; it was based on wrong ideas of pathology and did much harm to those it was trying to help. We cannot contemplate the therapeutic scene in psychiatry today with equanimity. More harm than good in therapy may easily be the order of things. Psychotherapy is practised on a wide scale, with great enthusiasm, in many guises, by almost anyone. It is often insufficiently realised that bad practice is worse than no practice. No surgery is infinitely to be preferred to bad surgery. No one, least of all the patient would accept a situation where an enthusiastic first aid worker was allowed to practice major surgery. But surery of the psyche based on bizarre rationale is everyone’s practice. Inactivity at least allows the organism’s natural defence mechanisms to have their sway. Intervention may prevent this, eg loss in divorce, like loss by death, goes through a number of natural stags ending in resolution, helped by forgetting, which is the main defence mechanism; but misplaced “psychotherapy”, by analysing the breakdown in detail over many months, merely succeeds in preventing the natural process of forgetting from playing its therapeutic part.

To prove that a procedure is therapeutic, it has to be established: (i) that a change has taken place; and (ii) that the change is for the better (it could be for the worse).

To often we are content to delve to the point of understanding events and then we hope that “something will happen”. The change must be shown to be constructive and fashioned to this end.

But not all is lost. Some practitioners of psychotherapy, the better trained, proceeding with caution, recognise the limits of knowledge, and practice within these limits. Furthermore, some practitioners have the precious gift of a harmonious personality; this exercises itself to the patient’s benefit, whatever the dogma held.

Psychotherapy is in a parlous state. The road to retrenchment is clear. We must return to the data of life, the facts of reality, to life experience as it is. If we can study, dissect, understand the life experience, we can learn how to reverse the psychopathological process. Therapy can then have a proven rationale and a predictable course. Already much progress has been made, data are available and, fortunately, the way to ameliorate through health promotion is already open.

The Task of Family Psycho-Therapy

Psychopathology, discussed in detail earlier, will be briefly outlined here so as to define the adverse experiential process and make it possible to draw general conclusions about the reversal of its effects, ie the benexperiential process.

The adverse experiential process:

It is easier to understand the psychopathology of the family, and the means of its improvement, by looking at the historical development of the "collective group psyche" of the present family. Each family is the product of two previous families, the preceding families of each marriage partner. Each marriage partner has been habituated to act in the way he or she does by the dictates of his or her family. Thus each carries his own imprint (the "imprint" is used not in a special ethological sense but in its ordinary usage of "stamp" or "mark") of life in the preceding family into the present family. Harmony results from the capacity of the two families, as represented by their members, to integrate. A clash produces disharmony,

The adverse experiential process starts in the preceding family of the adult members of the present family. Psychic noci-vectors adverse to a particular family member arise in his preceding family; these noxious agents can arise from one, several or all his fellow family members in that family. In later years they may be supplemented by adverse experiences outside the family. Psychic noci-vectors can operate in one overwhelming experience in time, but, much more commonly, they operate over a sustained period of time. This adverse experience may make the person sensitive to one or many psychic noci-vectors; he may be so vulnerable as to be in a permanent state of anxiety – always "on guard". The psychic noci-vectors create weaknesses in the psyche; the essential damage is done to the "idea of self". To cope with the adverse experience, the self adopts the coping devices that are possible in those circumstances. Later in life, with similar threats, the same coping devices are employed and the attitudes engendered by these coping devices may cause more trauma and thus damage by clashing with the attitudes of others. The most immediate, sensitive, and powerful clashes are likely to occur in the family where he is a founder member, husband or wife. The indicators of dysfunction in the past or in the present arise from this adverse experiential process in his preceding family; they are not the process itself.

As part of his imprint, each person carries: (i) a way of life with attitudes capable, or not capable, of adjusting to the way of life of a partner; (ii) a degree of psychonosis, dictated by past damaging experiences, largely in the preceding family, with damage to the psyche, especially to the "idea of self"; (iii) sensitivity to *general* psychic noci-vectors because of past experiences, largely in the preceding family; (iv) sensitivity to *particular* psychic noci-vectors because of past experiences, largely in the preceding family; (v) a tendency to react to psychic noci-vectors by the development of coping devices, which are often dictated by the set of circumstance in the preceding family – these devices are likely to operate in the present when faced by psychic noci-vectors; (vi) indicators of dysfunction used in the past which may be imitated in the present.

The individual, the epitome of his preceding family, moves through time, his formative years having been spent mostly in his preceding family. As he advances he gathers new experiences, some of which will clash with the attitudes he has already acquired and will create more stress and damage; on the other hand, he may meet ameliorating situations. At each stage, what he has gathered from the past interacts with his immediate situation. Thus, he reaches the present and he is what a lengthy experience has made him. Depending on the climate in which he finds himself, he is either again in a stressful environment, or in an ameliorating situation. If the latter, he probably will not seek the help of the psychiatric services.

The imprint in the life of an adult family member may be reinforced or changed by continuing interaction with his preceding family. In therapy this reinforcement or change may be encouraged or discouraged. It is relevant to mention that improvements, sometimes dramatic, occur spontaneously as the result of the demise of a member of the preceding family. The change, beneficial or damaging, may wrongly be credited to coincidental therapy.

The liabilities brought to the present family by an adult member may be overt or covert, either to the member who brings them or to the other family members. To add to the problems of assessment by each other, standards of conduct will be judged by the family imprint of each, and these standards may deviate not only from the average standards in the community, but also from those of the other family members.

The imprint produces needs which may or may not be satisfied by the imprint of the partner, eg an individual, because of experience in the preceding family, may react by hostility if ignored. The partner's imprint may be able to deploy assets and allow him or her to contain this. Thus harmony results. An inability to contain brings disharmony. The great advantage of family therapy over individual therapy is the possibility of enlisting not only the aid of assets possessed by the therapist, but also the aid of the assets of the family members themselves. Harmony may be possible by building coping devices to the imprint deficiencies of the other. These new coping devices are possible if the antagonist's family imprint allows of it, eg to withdraw when hurt and refuse retaliation. Circumvention is a mechanism insufficiently exploited in therapy. An example of circumvention would be accepting a deficiency in a partner, and planning the way of life of the present family in such a way that the deficiency has little or no opportunity for expression. Therapy must employ all these natural procedures in a systematic fashion – deploying assets, building new coping devices and circumventing deficiencies. Success will largely depend, given the best of all therapists, upon the qualities of the imprints facing one another; there are occasions when they allow of no resolution.

While the imprints from the preceding family are of basic importance, it must not be ignored that the present family is also developing a course which is superimposing an imprint on the fused imprints of the marriage partners. Again, children of the marriage are in the process of imprinting in the present. The collective group psyche, at first composed of two fused imprints, expands as it embraces the children and all the new experiences it meets. The past impressions of the parents, however, are always paramount, even if hidden, simply because they result from a long-lasting experience in the preceding families during sensitive formative years. A family group composed of adult members imprinted with gross deficiencies does not necessarily collapse. The deficiencies may be complementary, eg an excessive need to be mothered in one partner may satisfy an excessive need to mother by the other partner. Again, deficiencies in an adult family member may produce marital clash, but not be inconsistent with excellent parenting; indeed, occasionally, a parent may "wall off" himself or herself with the children in an enclave that protects them from the onslaught of the family imprint of the other partner.

The Benexperiential Process

From the above account, and more detail in the section on psychopathology, a number of conclusions can be drawn which have implications for the reversal of the pathological process in therapy:

1. The pathological process seen now is often the result of adverse experience in the past. It can only be undone by a reverse active process – a beneficial experience which undoes the pathological process and establishes harmony. It must be active, and positive. Merely abolishing present stress is not enough. Similarly, in the physical field a deformity produced by excessive pressure on a limb in childhood, for instance, is not corrected by merely removing the pressure years later. Positive active corrective procedures have to be initiated. In general, therapeutic procedures have to emphasise the opposite of the pathological.

2. Damage caused by an adverse experiential process in the past can be aggravated by continuing trauma in the present: sometimes the adverse process is set up by present trauma alone.

   The individual may be vulnerable now to the same psychic noc-vectors to which he was habituated in the past. To influence psychic noci-vectors in the present is easier than to reverse the effects of psychic noci-vectors in the past.

   Psychic noci-vectors in the past have usually ceased to function; thus attention has to be directed, not at them, but at the damage that ensued. However, knowledge of past damaging vectors may help to plan an ameliorating beneficial process in the present. To know, for instance, that a negative psychic noci-vector, the absence of touch in the past, is the basis of frigidity now, may allow the necessary positive agent to be activated. This principle is employed in benexperiential psychotherapy and in vector therapy. A psychic noci-vector can be affected by: (i) reducing its strength; (ii) changing its direction; (iii) reducing the time over which it operates; (iv) changing its quality; (v) opposing it by a contrary vector.

   Some present psychic noci-vectors are active in the imagination. A person has the capacity to dwell on a trauma in his thoughts. It can thus dominate perception, and do so to such an extent that it is not possible to give the trauma its correct evaluation, as nothing in perception is available to compare with it. Thus a person has a feeling that his thoughts are out of hand, he cannot break the vicious circle, and cannot see his problems in perspective. Strong measures may be required, including forced thinking, to break the vicious circle and bring perspective.

3. There is value in dealing with the sources of adverse experiential process in the preceding family by bringing them together with the presenting family member in therapy. This is easier with adolescents and young adults, but occasionally is possible with older adults. Should this prove impossible, the same situation must be dealt with in the absence of the preceding family – a more difficult task.

1. To re-experience previous traumatic situations is not necessarily beneficial; it may reinforce the effects of the previous trauma. It could be especially so if the preceding family is brought into the re-experience. To be therapeutic, the re-experience must be constructive and within the capacity of the individual and his therapist to make it so, whether it takes place with the preceding family or in its absence.

2. The effects of an adverse process are recording in the memory apparatus; change must be directed at changing the memories laid down in it. The approach is through the same sensations which produced the memory, ie auditory, visual, motor, olfactory, gustatory, etc, or a perceptual experience which is an amalgam of some or all of these sensations.
3. An adverse process has usually operated over a period of time. The reverse ameliorating process must also operate over a period of time. Rarely does pathology arise in a nuclear incident; rarely will catharsis relieve damage. In therapy, time is important and this will play its part whether the benexperiential process is achieved by psychotherapy or vector therapy. In psychotherapy it will operate with general procedures as well as with specific procedures.
4. Not all the damage done in the past creates difficulties in the present family situation or, in the case of a single person, in the present individual situation. Therefore, focal or partial amelioration may be employed, directed at the damage that creates difficulties in the present situation only. A partial task is clearly less time-consuming than a complete task and may bring an adequate functional result. The complete repair of a severely damaged person may be a massive undertaking.
5. There are *levels* from which a disturbing process can arise and can be changed:

    (i) In the preceding family – previous trauma.

    (ii) In the present and preceding families – present trauma acting on previous damage.

    (iii) In the present family – present trauma only.

    (iv) In the present and succeeding family – present stress acting on the children, who will form the succeeding family.

    Therapy at level (i) is the most difficult. At levels (iii) and (iv) it may be possible to deal with the present situation so that the process does not pass to the succeeding families or, if it does, reaches them in an attenuated form. *Herein lies the best opportunity for the eventual production of emotional health in society. Should therapy never operate at levels (i) and (ii) it would only deny the possibility of relief to the present generation of sufferers. If measures at level (iv) could be certain of success, they would by themselves guarantee a steady permanent improvement in the standard of emotional health of society.*
6. The essential part of the psyche to be damaged is the “idea of self”. To support and reconstruct the “idea of self” is central to any benexperiential therapy.
7. To know the nature of the psychopathological process can lead to precise therapeutic measures. Without this knowledge only general blanket measures can be, and often are, employed. These general therapeutic measures, the G factor, may help, but not as quickly or effectively as more specific measures.
8. Positive vectors are just as powerful as negative vectors. Love is as powerful as hate.

Positive vectors should be employed in therapy. These include praise, appreciation, encouragement, kindness, affection, respect, a sense of belonging, hope, security, worthiness (the opposite of guilt).

It is known that negative vectors do damage according to their power, repetition, and the length of time over which they operate. Equally, the effects of positive vectors used in therapy gain by their power and vividness, repetition, and by being allowed to operate over a lengthy period of time. Whenever possible, they should be precisely directed. However, even in a general blanket form they can be valuable.

In an imprecise non-directed form these positive elements in therapy are often present. They constitute a general factor, G factor. This factor is therapeutic, but not precise. Therapy should be directed and be more than the chance operation of the G factor. Therapy is often no more than this, and sometimes less, if, for instance, the therapist suffers from an unsatisfactory personality.

9. Trauma produces insecurity and the need for defence. Theefore, therapy must not involve the threat of trauma and must produce security. The insecure cannot reveal the intimate situations that lie at the core of the damage to the "idea of self". Precise evaluation of damage is the start of effective therapy. Attitudes change more readily when they are not necessary for the defence of the self. If insecure, the organism will cling to old attitudes. The family "on guard" cannot build new and better coping devices. This applies in reparative measures within or outside the interview.
10. In pathology, the indicators are what the name implies – signs of the process of dysfunction. The process cannot be changed by changing the indicators; if the process remains the same and the indicators are changed, they will be replaced by a new set that are possible in the new circumstances. The process itself must be changed and only then will the indicators disappear. Thus, symptomatic relief is not enough and is desirable only to ameliorate the secondary effects of the symptoms.
11. The damage did not occur in an interview situation. It does not necessarily need to be ameliorated in an interview situation; the right marriage partner, for instance, may achieve more than a therapist. Thus, though therapy can employ interview measures such as psychotherapy, it can use also extra-interview measures, such as vector therapy. Both may be necessary and are complementary.
12. Attitudes from the past which clash in the present can arise from: (i) mechanisms for coping with trauma in the past, eg withdrawal; (ii) different living habits, eg different ideas of role of father. (ii) tends to alter more easily than (i), as habits are not based on the need to defend the self.
13. There is a limit to the effectiveness of therapy. Some adverse experiential processes may have been so severe and damaging that their effects can only be ameliorated by very prolonged and powerful measures, if at all. To spend valuable resources on only a few people may bring minimal relief to society. Constant attention must be given to deploying resources where they can be most effective, eg the young respond more easily than the aged. Vector therapy and the salutiferous society bring the best value. We must practice the art of the possible.

14. to contend with *present trauma* from noci-vectors, the therapist must assist the patient to use new, healthy efficient coping devices, eg:

    (i) Putting the trauma in true perspective by applying standards and judgements and not exaggerating its power.

    (ii) Making realistic targets, thereby reducing the risks of trauma.

    (iii) Avoiding trauma that it is unnecessary to face.

    (iv) Side-stepping the trauma by a variety of techniques.

    (v) Deploying assets, eg using past success to compete with present failure ("Look, you are good because you can do that").

    (vi) Deploying support elsewhere, eg use of husband to share a potentially hurtful situation.

    (vii) Supporting, eg "We, you and I, will make a plan for coping with the situation.

    (viii) Forgetting, eg refusing to make a traumatic matter the topic of conversation.

    All these, and more, are devices in *directed* therapy – not leaving possible improvement to the chance of the G factor.

    N.B. ALL THIS IS CONCERNED WITH REAL LIFE EXPERIENCE. NO INTERPRETATION IS NECESSARY. NO FALSE AND FANTASTIC PICTURES ARE CREATED. ALL IS TRUE TO LIFE. THIS IS OF THE ESSENCE OF BENEXPERIENTIAL THEAPY.

15. To relieve past trauma, it is best, as has been said earlier, to bring the preceding family into therapy. Attitudes are exposed, guilt is relieved, the "idea of self" is improved. The patient is older and does not need to accept the omnipotence of parents. But thee is a limit to effectiveness. It is not possible to make a family love when it does not; but it is possible to minimise the effect of the trauma this produces. Any result can sometimes be reinforced by limiting contact between the present family member and his preceding family, while mobilising help from his present family.

    But the past may need management in the absence of the preceding family. The following steps are necessary:

    (i) The damaging noci-vectors in the past and the ensuing damage must be revealed.

    (ii) The effects of the noci-vectors in the past must now be met by the opposite quality, eg if a man is sensitive to being ignored he must now be given the opposite – attention.

    (iii) The present family must stop reinforcing the power of damaging vectors, eg it must also cease to ignore and give attention instead.

    (iv) Any assets in the present family must be deployed to help a vulnerable family member. Usually, success will depend on the health of the family, but even a psychonotic family may have some assets that by chance fit the situation, eg a husband is incapable of

taking the initiative in sexual intercourse; the wife changes roles and takes the lead in sexual intercourse.

(v) Situations can be relived in the interview situation with a therapist who represents not past figures but a positive person – the best of emotional influences. Positive vectors are generated in strength, over time, and with repetition.

The above can and does happen in daily life, but haphazardly without discernment. The aim of therapy is to practice it in a directed and precise fashion.

N.B. ALL THE ABOVE IS REAL LIFE EXPERIENCE. THERE IS NO INTERPRETATION. THERE IS NO FANCIFUL INVENTION. IT IS THE STUFF OF LIFE.

19. The therapist must not only use the G factor, but also apply *directed activity* – all the techniques described for the management of present and past trauma. The capacity to undertake this precise directed activity distinguishes the trained therapist from others. His skill springs from the following attributes:

(i) He is trained in ascertained psychopathology in a sure and systematic fashion.

(ii) He is knowledgeable about the nature, variety, and form of psychic noci-vectors.

(iii) He has great knowledge of the unusual.

(iv) He can make balanced judgements.

(v) He has great capacity to produce security through relationship.

(vi) He is knowledgeable of his field.

(vii) He is a positive person in his own right, and not just a figure on which other values are projected.

(viii) Long exposure in a medical training to the anguish and pain of many and varied forms of serious illness will have inculcated, in the right person, the response of caring in an immediate fashion.

20. The preceding adverse experiential process will usually have taken place in the preceding family. Occasionally the family will be anomalous and have the features of a large group. In this case, this is the group that is the significant contributor from the past. Again, the present family group may be anomalous, but of no less significance.

Conclusion

The major aim of therapy is clear from our knowledge of experiential psychopathology. The adults come into the present family after suffering an adverse experience in their own preceding families. This adverse experience must be reversed in both parents to effect a harmonious family climate, so that it epitomes, going forth to succeeding families, will make a healthy psychic contribution to those families. The adverse process can be ameliorated by three main approaches: (i) Benexperiential Psychotherapy; (ii) Vector Therapy; and (ii) the creation of a Salutiferous Society.

The three approaches are complementary and should be used together. Each will be discussed in turn.

Benexperiential Psychotherapy

General

Psychotherapy is the treatment of the psyche, individual or group, by any means. A psychotherapist is the person in immediate direction of the treatment.

In benexperiential psychotherapy, treatment consists of the use of a new beneficial experience. The advantageous experience is the therapy. Psychonosis, in an individual or in a family, is the result of malexperience, adverse experience in the past, adverse experience in the present, or the interaction of both. In contrast to the adverse psychonotic process, benexperiential psychotherapy utilises an experience which is to the advantage of, favourable to, the individual or family psyche – hence "benexperiential" therapy.

The general aim of benexperiential therapy, as in all forms of family therapy, is to produce a harmoniously functioning family in the situation within which it lives. What is harmonious in one situation may not be so in another. The standards in relation to "harmony" depend on what is regarded as harmonious or healthy at the present time in a given culture; today's "healthy" family may well be regarded as "unhealthy" by future standards, or in other cultures.

All programmes of benexperiential therapy must make a flexible use of all the types of treatment available. All the types to be mentioned shortly can be used together. The type predominant at a particular moment is the one that best meets a particular situation. This flexibility extends also to the simultaneous, or successive, employment of vector therapy. Benexperiential psychotherapy and vector therapy (also an experiential therapy) are complementary.

One of the lessons of family diagnosis, as well as of family psychotherapy, is the realisation that psychic events precipitate organic pathology. That psychotherapy aims at offering psychic help should not be allowed to overlook the need to offer somatic help. Psychotherapy and somatic therapy should go hand in hand. Naturally, our interest here is in psychotherapy.

Many defences are offered against revealing ignorance about psychotherapy. In discussion one may be met with the question, "What do *you* do?" which allows the questioner to avoid offering his techniques for scrutiny. Other defences evoke the use of a flood of vague, ambiguous intellectualisations which bemuse, befog, or overawe the listener. Yet another escapes to the select circles and the dogma of certain schools of psychopathology. Yet another meets any information with "I do all that". Here reliance is made on a simple exposition of the principles of benexperiential psychotherapy – revealing some knowledge and some deficiencies. The latter will be made good in time.

Types of Benexperiential Therapy

The best diameter to take is that of the period in time from which psychopathology arises. This could be: (A) at the level of the preceding family; (B) at the level of the present famil; (C) at the level of the succeeding family.

In each type, the therapy is linked with the time at which the events occurred, past (antecedental), present (actual), or future (anticipatory).

ANTECEDENTAL THERAPY

Therapy concerned with the resolution of events that occurred in the past. These are antecedental events, hence "antecedental" therapy.

ACTUALITY THERAPY

Therapy concerned with the resolution of events in the present. These are present events, actual, hence "actuality" therapy.

ANTICIPATORY THERAPY

Therapy concerned with the resolution of events that could occur in the future. These are anticipated events, hence "anticipatory" therapy.

(A) ANTECEDENTAL THERAPY

Therapy turns around resolution in the adult family members of the present family attitudes springing from the preceding families. Therapy is conducted with the preceding family or in its absence, by discussion concerning it.

The aim can be:

1. *Complete resolution*. A state of complete emotional health is restored to at least one partner of the presenting family. An example is:

> A wife presents with depression. Examination exposes many other symptoms, both organic and psychic. Exploration reveals a difficult marital situation which has come to a head recently. It has been precipitated by a change in family circumstances, whereby it had been agreed that husband should emigrate in order to obtain a higher standard of living. The attitudes at work were – husband's inadequacy, husband's anger, husband's sensitivity to being ignored, wife's ambition, wife's withdrawal. Briefly, the sequence of events was – wife's ambition demands a higher standard of living, husband agrees to emigrate; his inadequacy is appalled at the risk he is taking and in his insecurity he becomes angry; husband's anger makes wife withdraw; her withdrawal, because of his sensitivity to being ignored, makes him more insecure and angrier; the situation escalates, until she collapses with psychonosis in which depression is a marked feature.
>
> The attitudes at work here spring from their respective families. Husband is the product of a family where the mother left the father because of his belligerence and so the patient was thrown into the care of this angry father. His father's anger frightened him and yet this was better than his father's ignoring of him in preference to his older brother. From this situation came inadequacy, his sensitivity to being ignored, his anger as a coping device.

His wife came from a family where the father ran off with the maid and subsequently married her. He lost his fortune. He became alcoholic. Standards of living fell. Quarrels were acute between husband and wife. The little girl coped by withdrawing and thus not being involved. Her father was kind to her and she identified with his aspirations. From this situation came her ambition to retrieve the family fortune and to withdraw from anger.

Each marriage partner represents his or her past and the weaknesses of each have to be played out in the present family. Further exploration revealed more handicaps, as well as assets, in both.

Therapy began by resolving the present immediate situation provoked by the decision to emigrate. This restored harmony to the standard of the pre-breakdown level. Stopping at this point would have left therapy at the level of dealing with the trauma in the present. Therapy could have gone a stage further; by dealing with the elements causing disharmony in the marriage, what is termed “focal resolution” (below) would have been achieved. In this case it was decided to go beyond this and to deal with all the unsatisfactory elements in both marriage partners arising from the preceding families. The aim was an ambitious one. Both were to receive a substantial guarantee against breakdown in most situations. Both were to be “made whole”. Technique is to be discussed later.

It is important to emphasise that even the wealthiest of communities and the best provided are only occasionally able to undertake this time-consuming enterprise which is so expensive of resources.

2. *Focal resolution.* Here the purpose is to effect a resolution in only one, two, or several elements coming from the preceding family and causing disruption in the present family or in the life of any one individual. An example is:

A wife presents with frigidity of one year’s standing. In addition she is depressed, she has anorexia, insomnia, amenorrhoea, etc. Furthermore, her husband is irritable, lacks concentration and his standard of work has deteriorated to the point where he has been warned that he may lose his position. Psychonosis in the children can be surmised from the boy’s enuresis and the girl’s asthma, starting in the last year.

Sequence of events becomes clear only with the exploration of the preceding families. In the mother’s family she was the only child of an agitated, hypochondriacal, rejecting mother, and a kind but withdrawing father. Faced by rebellion in adolescence by her daughter, mother used two weapons against her – feigning illness and making her feel to blame for it. These would always precipitate anger and depression in her daughter. Father came from a family with considerable emotional assets.

The immediate situation turns around a quarrel between the maternal grandparents. Grandfather threatens to give up his job and this threatens his wife’s standard of living. Maternal grandmother develops ulcerative colitis. She turns to daughter for help and daughter reacts as she did in adolescence to her mother’s illness – she becomes depressed. She loses appetite for life, food and sex. Husband, not understanding, reacts to her rejection of him. Marital tension and mother’s state leads to disturbance in the children.

> Here, the resolution turns around two elements – guilt and sensitivity to mother's illness. Grandparents are seen together, the quarrel is resolved. The ulcerative colitis clears up in maternal grandmother. Mother has no maternal grandmother illness to react to and her depression immediately clears up. Sexual intercourse is restored. Father responds. The whole family climate improves.
>
> To guarantee against future breakdown, mother and grandparents meet to resolve mother's feeling of guilt springing from use of illness by maternal grandmother. Parents of the present family, and then the whole family, meet to discuss the process that led to the impact on their relationship together with the children. Vector therapy is now possible – they ask advice as to whether the position is advanced by their moving to another town. This is advised, subject to discussion with grandparents, as it will reduce and formalise contact. Grandparents can tolerate the move, but want assurance about contact from time to time with grandchildren.

Here, the therapy is limited – only some elements coming from the past are resolved. The parents are not "made whole", but the elements from the past that disharmonise family functioning are eradicated. You will note the flexible employment of therapeutic platforms – individual interviews with mother; dyadic interviews with maternal grandparents; family group interviews involving mother and her preceding family; dyadic interviews with parents; family group interviews with present family; vector therapy.

The above illustration involves a family. Occasionally, focal therapy is a matter for an individual alone. An illustration is:

> In the course of family group interview, it emerged that the father had a disturbing secret never before discussed with anyone other than his wife. This was that he found it impossible to urinate if someone else was within hearing. This defect was of no concern to the family, but it was highly inconvenient to him. He asked for help. Exploration in individual interviews revealed that as a young child he had a very irritable, aggressive and hated governess. She would sit him on the pot in front of her chair and from behind coerce and demand that he pass water. He found great difficulty in doing so and the same difficulty has continued whenever anyone is within earshot. At school he contrived to get round it by asking to be released from the classroom during lessons, so that the toilets would be empty of other children.

Here, the focal therapy is continued with an individual alone.

It follows from the above examples that any of the following interviews can be employed – individual, dyadic and family group as circumstances determine. In addition, multiple family or general group therapy may be indicated. Furthermore, any of the above can go hand in hand with vector therapy.

It can be seen that A (2) above is a much more manageable operation than A (1).

(B) ACTUALITY THERAPY

At this level concern is primarily with happenings in the present family. Therapy is concerned with handling psychic trauma arising within and without the family in the present.

Psychic noci-vectors may arise in the global family transaction, in a relationship between two family members, and from outside the family. The present psychic noci-vectors act on a sensitivity coming from the past.

A few illustrations are given:

> A mother presents with depression, the onset of which can be dated exactly. Her daughter has married into a much higher social set. Her patronising attitude distresses mother. The depression dates to the minute when her daughter telephoned that she had "arranged" a Christmas vacation for her mother and father.
>
> A child finds himself bullied at school or unfairly accused of some misdemeanour.
>
> A third party intervenes in a marital relationship.
>
> A mother finds herself in employment where she is aware of pilfering by a fellow employee and is caught between loyalty to management or to fellow employee.
>
> A father is all set to be ordained in the Church and then unexpectedly finds that he has received homosexual attention from a number of men, begins to suspect the nature of his own sexuality, has grave doubts about his suitability for ordination and develops a psychosis with acute anxiety.

Treatment at this level restores the family or individual to its pre-trauma standard. In some families this standard of health is very high and they were reacting to a massive or uncommon trauma. Other families have varying degrees of psychonosis resulting from the past. The management of present trauma does not of course change this pre-trauma standard.

The above may be practised in conjunction with therapy of the preceding family, eg in the last example above, father's oversensitivity to homosexuality may be due to misplaced ideas of sexuality in his preceding family and this may require resolution.

The above can also go on in conjunction with vector therapy to be discussed later.

(C) ANTICIPATORY THERAPY

Here, the intention is to concentrate special attention on guaranteeing the health of the children who will be the participants in, and founders of, succeeding families. Children, as they represent the future and are more amenable to change, should always be given help. However, there may be times when therapy may be possible only at their level; eg the parental problems may be intractable, or intractable with the facilities available, or the parents may be unco-operative. Thus, for a variety of reasons, a situation has been reached when one must "cut one's losses" and treat where one can.

An illustration is as follows:

> A woman loses her husband in World War II. In her loneliness she marries a man a great deal older than herself. She quickly realises her mistake. Her elderly husband anticipates her possible desertion and makes her pregnant. She stays "for the sake of the child", but rejects the child at birth – indeed she propels him out at the first uterine contraction with consequent cerebral haemorrhage in the newborn child and resulting limb paralysis.

> Following birth she rejects her handicapped child, who presents as a highly psychonotic and physically disabled child at the age of three. The family situation for a variety of reasons proved to be intractable. Father was unco-operative. Mother had no interest in the child. The child required urgent and considerable help, which was given in terms of individual therapy for him, general supportive interviews for mother, leading to vector therapy at the earliest opportunity, whereby the interviews with mother made it possible for her to accept that the child be brought up in a foster home.

In the next illustration the family is investigated as a whole, but therapy again concentrates on the child who represents a succeeding family of the future.

> A man attempts suicide. An inadequate man, he married a balanced, kindly woman. He began to profit from her care. Then she became pregnant, in response to which he developed an urticaria and was ill in various ways for most of the pregnancy. He displayed no interest in the child other than intense jealousy. Christmas came and with it the maternal grandparents to bring gifts for the baby. Husband locked himself in the kitchen and when he eventually emerged two days later, demanded that the baby should be given away. She refused. He attempted suicide. He is adamant – she must now choose the baby or him. Interviews with both separately, then together, support her in making the only decision possible – she must keep her baby and is well able to look after him on her own. (Supportive help for mother and advice on remarriage will still be helpful, if resources allow it.) The future in terms of the child has the highest claim.

Work at this level can go on in conjunction with work at the two previous levels and in conjunction with vector therapy. It may be useful to emphasise again that treatment at this level, if always effective, could guarantee the health of succeeding families and thus of society in the future. Clearly, this can only arise by a steady improvement over a number of generations as therapeutic efficiency and resources increase. The work will be speeded up by using extra-interview procedures in vector therapy.

Yet again it may be necessary to emphasise that what is possible may not be dictated by the tractability of the situation, but rather by the resources available. It is unlikely that the highly skilled resources required to operate at level A (1) for all will ever be forthcoming; by that time work at level (C) will have made them unnecessary. To have, as in the present situation, ill-trained people handling the resources available is not only ineffective, but dangerous.

SUPPLEMENTARY THERAPIES

1. *Indicator Therapy.* From time to time an indicator, a sign or symptom, of psychonosis, will itself be sufficiently life-threatening, inconvenient, painful or giving rise to such serious secondary issues as to require management or therapy in its own right. This can happen to an indicator of a psychonosis arising at any of the levels mentioned above. The indicator may be somatic or psychic.

In the case of a somatic indicator, measures can range from an hypnotic drug to relieve crippling insomnia to emergency major surgery for a perforated gastric ulcer.

The following illustrates a psychic indicator requiring help in its own right because of its social repercussions:

An adolescent boy presents with a propensity to steal women's clothing from washing lines in his neighbourhood. With these he masturbates while conjuring up images of the desirable young woman to whom the clothing belongs. Soon he is caught in a police trap. The court seeks help in his management. The indicator of his disturbed behaviour, the stealing of clothing, has serious social and personal secondary effects – it promotes shame and guilt, and may affect adult sexual behaviour.

Exploration reveals that there is a severe father/son conflict. Father deplores most of the customary behaviour of an adolescent. The son's behaviour is a coping device inevitable in this family situation. His father, because of an anomalous upbringing by a maiden aunt, deplores any sexual expression in adolescence. His mother on the other hand is a passionate, warm, outgoing person. The mother implies the need for strong heterosexual expression, the father makes it impossible. Thus, the boy is forced to resort to strong covert behaviour.

While there are other manifestations of disturbance, the presenting indicator of itself warrants attention because of the secondary effects. Thus a family interview is employed to relieve the son's shame and guilt. Both therapist and mother emphasise again and again the inevitability of the son's behaviour in the circumstances. Time, repetition, and insistence achieve the goal. Normal sexual expression is desirable. After a number of interviews, the therapist and the co-therapist, the mother, slowly and gently bring father to a position of security and relatedness where he can allow his son a dispensation – he can behave as other adolescents do and bring girlfriends home. No further sexual misdemeanours occur. The son still has other disturbing behaviour arising out of the father/son relationship, eg insomnia, a rash, panic attacks, lack of confidence. Having dealt with the damaging indicator, the father/son conflict is largely resolved through vector therapy – the son pursues his education away from home – a situation also of advantage to his newly gained freedom to behave in a normal fashion in heterosexual activity. Indicator therapy has been followed by therapy at levels (B) and (C) above. Lack of resources may, however, limit the management at any stage.

Occasionally indicator therapy can be achieved through behaviour therapy based on learning theory. While sometimes valuable, its limitations can be seen in the example above. To put the boy through a procedure that would prevent him stealing women's clothing, eg by aversion therapy, while useful in avoiding the social repercussions, would still have left him with his sexual frustration, and the disturbed behaviour arising out of the negative and destructive father/son relationship. Aversion therapy does not resolve the psychopathological process. But there are times when it can help in indicator therapy – even if, as sometimes happens, there is a substitution of indicators; the new indicator may be more tolerable than the old.

2. *General Supportive Therapy.* All persons and all families respond to encouragement, support, hope, praise, affection, interest and comradeship.

This may be all that can be offered in a particular situation and often in the past it has been the only ingredient of therapy, referred to earlier as the G factor. In all the measures mentioned to date, it is an essential and valuable component and, when the resources are denied, it may be the only measure possible.

Attention will now turn to further aspects of therapy. The *therapist* is considered first; this is followed by consideration of the *organisation of therapy*; and finally consideration is given to some *elements in technique.*

The Therapist

Selection

The blacksmith had this to say in Ronal Blythe's *Akenfield*(1) – "I always look at the parents before I take an apprentice. If you know the home, you already know the son." Family meets family – this is the essence of the encounter in benexperiential psychotherapy, not an individual therapist meeting the family. The therapist is the epitome of his own family. Thus, the meeting is between his family and the family under treatment. Selection of therapist then means selection of the therapist's family.

The therapist's preceding family is the area for exploration when consideration is being given to choosing a trainee therapist. Success in his own family will go a long way to guaranteeing success with families in treatment. Great care must be given to this task. A therapist requires an exceptionally harmonious personality; it is this which is going to make it possible to stand up to the strain of contact with very disturbed people, coping with persons with varying problems, giving security when it is required, withstanding hostility, offering toleration, charity and affection. All these qualities can be provided only by the product of an exceptionally harmonious family.

It is sometimes thought that training will overcome deficiencies of personality. It never does. Even new methods of therapy will not guarantee success by a therapist with severe personal deficiencies; the old therapies have been markedly unsuccessful both in training and in clinical work. Furthermore, it is far better for available training resources to be concerned with inculcating expertise in those of sound basic personality. It is sometimes argued that to have undergone a number of breakdowns adds insight into the process. This notion does not stand up to examination. Persons predisposed to breakdowns have suffered through the trying home situation that have denied them those qualities essential to help others. Of these qualities one of the most essential is the capacity to give emotionally; this is the very quality lacking in the emotionally ill.

Selection of therapists should turn around careful evaluation of preceding family climate followed by an apprenticeship to a master in psychotherapy. These in turn should be married to experience – experience of the world as it is. Therapists should ideally have been cast in many economic roles, roughed it around the world, had class, education, religion, cultural and other biases rubbed off in the hard school of life.

Success in psychotherapy depends upon: (i) the experience of a harmonious family; (ii) on having been exposed to a broad life experience; (iii) training under a master craftsman in psychotherapy.

In this chapter it is better to aspire to describing the ideal therapist; in practice we may have to settle for less.

Personality

In the therapist one looks for qualities such as toleration, with the capacity to understand and be charitable to a wide range of human failings; the ability to be unbiased and unprovoked by the less beautiful aspects of life; a capacity not to blame

or moralise. The therapist must be friendly, kindly, understanding. He must be able to make warm relationships with a great variety of people. Indeed, the greater his adjustment, the wider his spectrum of affectivity.

Chairman and convenor

The therapist has the task not only of convening the meeting, but also in general terms of directing his efforts. After all, the family has come for therapy, not for a pleasant afternoon's discussion of contemporary social events. Thus, his presence or his words must continually remind the family group of the task on hand. He must be sensitive to the topics that the family needs to discuss and, furthermore, can discuss at that moment. Sometimes, the family has not as yet the capacity to tolerate a topic. He must give everyone in the family the right to speak and to do so in security.

Catalyst and releaser

Expectation, and sometimes silence, provokes the family towards a discussion of events which are embarrassing, hurtful or painful to them, matters which they would wish to avoid. He instigates an exchange where necessary. On the other hand, he teaches the family members that an interchange can take place without aggression, hostility and fury. He himself indicates and teaches that rational discussion can bring the resolution of problems. Above everything, he is expectant; his non-verbal behaviour conveys a deep and sustained interest in his patients.

Community representative

The healthy therapist brings with him the values and the opinions of the community; a man of the world, he sees life as it is and accepts the best of it. The family may not conform to the attitudes and principles in the community outside, but can acquire these from the therapist. Explanation may sometimes be called for. The therapist inculcates an attitude by example rather than by direct teaching. It behoves the therapist to have adequate community values of his own and be secure enough to recognise and discard outdated values.

Conciliator

The attitude of the therapist is always that of conciliator, when faced with hostility or aggression of one family member to another. His aim is to create a climate where constructive work can proceed. He is not a judge, but a conciliator. He should avoid taking sides. Indeed, he has loyalty to all the members of the family and this will be tested time and time again. He must truly be a benevolent, security-giving figure to every member of the family.

Protector

No one within the family group should, if possible, be hurt through the family discussion. Thus, to some extent, the therapist is a protector. This is particularly true in relation to the younger or weaker members of the family. In the eyes of the therapist, everyone is equal, everyone deserves support, everyone has equal rights. His loyalty is to the family group and thus to all.

Diluter

Even if he does nothing else, the therapist, by bringing a healthy attitude into the family group, quantitatively dilutes the psychopathology of the group. The only effective argument for having more than one therapist is that the dilution process is even greater. However, as will be seen, this can have disadvantages.

Absolver

Embarrassing, belittling, hurtful attitudes and experiences are exposed within the family discussion. The toleration of the therapist removes the sting from all these experiences; in particular, guilt is relieved.

Revealer

The therapist reveals and clarifies. He does not interpret (translate) into other terms. The only valid term is life experience, factual and unadorned. Revelation must not occur too soon or be used to hurt. It must never be more than can be endured – and the capacity for this depends on the degree of security. Benevolence creates increasing security and increasing endurance. Naturally, revelation itself does not produce change, but is a prelude to change.

Attitudes

The therapist's main task is to reveal to the family its collective group psyche based on the family imprints from the past. This is analysis only. Reconstruction must follow. Thus, as will be discussed later, he then has to mobilise the assets within and without the family to overcome its liabilities. He needs to build new healthy coping devices and he needs to find ways to circumvent deficiencies produced by the preceding families. Handicapped family members have usually experienced unhappy family relationships in the past. Now they are in touch with a benevolent family figure. This figure, however, exercises no power. Indeed, one of the lessons he has to teach the family is not to use force, power or authority. He aims to create a situation of security wherein the family can reveal itself, work towards resolution and thus change.

Craftsman

A therapist is a craftsman, a trained expert. A therapist should not appear to be a god, it is said, and should therefore admit weaknesses – it makes him human. Patients do not expect their therapists to be gods, but they do expect them to be craftsmen. To admit having weaknesses, of any considerable degree, is a negation of expertise. Affection can be expressed without the admission of weaknesses. This attitude of apparent honesty relieves the therapist of feelings of guilt at inadequate performance; an even more honest attitude would be to admit the need to change vocation. The therapist is fundamentally an expert and a craftsman, who uses the warmth given him by his family as an affective and effective tool in his task.

A figure in his own right

Therapists are not necessarily parent figures. Though in child development literature prime place is given to mother, in therapeutic literature father often comes into his own as an all-powerful, supportive father figure. But this is a distortion of events. Father, mother, uncles, aunts, brokers, butchers, jockeys p all can have personal qualities of the highest emotional quality. Indeed many jockeys are also fathers. What people crave for at all times from others is an affectionate relationship. This is more important than its sources, even if the latter are the parents. Love is more important than parenting. Parenting may or may not supply it. Others may or may not. Thus a therapist is not just a parent figure – he can be a figure in his own right. A therapist is not a good mother or father figure, but a good therapist.

Security-inducing figure

A number of therapists fail because they are constantly at war with the family under therapy; there is a need to outwit, manipulate, score off, feel omnipotent towards, or crush with hostility. At best this is bad technique, at worst this reflects the therapist's experience in his preceding family. Consider the following extract from the literature:

> As D. X suddenly flipped from his *mimicking* involvement with the family to being *sarcastic*, you had the feeling that the family was suddenly being *cut apart*. I think it is necessary at times *to hurt* in order to get at the pathology, in the same way that you can't get at the appendix unless you go through the skin and belly. And then he got *sneaky*, as a master *manipulator*, and the rest of the film, to me, could be lumped in this area. (Author's italics.)

Here, we have mimicking, sarcasm, to cut apart, hurt, being sneaky, manipulation. This is not therapy but war – and of a dirty variety. The analogy with surgery is unfortunate; great surgeons are renowned for the minimum of trauma, effortless technique and absence of drama. The above is not analogous to surgery but to butchery. Confrontation is at its height in films and public performances of therapy. The insecure therapist needs to exert himself, there is much blood about, the drama is great – but the family bleeds. And the audience, all would-be therapists, identify with the powerful therapist and soon the family has ceased to be as it is. It is a thing apart, responding to different roles, with different feelings, a savage dangerous thing. But it is not really different. Its members are as we are. They are us.

Hostility brings insecurity and the need to defend – even by force. Thus it maintains the unhealthy coping devices. Security is an essential precursor of change.

Therapist/parent interaction

The essential confrontation is between the family of the therapist and the family under treatment (and their preceding families) or preceding family of the individual patient. Both father and mother in their preceding families and children in the present family have undergone a holistic experience – an interaction between child and father or child and mother. (In the literature on child psychiatry, because mother comes to clinics with the child, there is an emphasis on the mother/child relationship. In literature on what is termed "transference", as the therapist is often a male, there is emphasis on the father/child relationship. Both are artefacts.)

The therapist also represents a family, complex and multidimensional, a family of the best kind. He is the amalgam of a superb G factor plus special skills. He is himself. Patients are not in touch with a phantom of their own making, but with a real person. They react to the therapist as the life experience to date, especially in their families, has taught them.

The way they interact with the therapist is personal to them and their experience and speaks of it. Thus it is helpful in diagnosis. But this is diagnosis and not therapy. It is not correct to interpret (ie translate); one should reveal. Any knowledge from the interaction reveals the preceding family; no interpretation is required, but simply the revelation of facts about the preceding family.

The best therapist will be aware of some weaknesses in himself – real ones from his family – and will make allowances on this account. The patient is not interested in this. To expect help from a patient is ridiculous. The therapist must go elsewhere for any help, or in the event of marked weaknesses, seek other work than therapy. In the past, the analysis of "counter transference" has been a substitute for a sound therapist.

"Transference" and "counter transference" are a part of the interaction between patients and therapist. To claim that they are the whole, the major part, the more important part, of the interaction gravely limits the interaction and its potential.

Diagnosis is not therapy. The therapeutic element depends not on the analysis of the communication, but the capacity through the communication to give a new constructive experience, ie a benexperiential therapy. This is not achieved through an interaction with a projected image imposed by the therapist. The ideal therapist has an easy time – much of the time he automatically does and says the right thing.

Non-verbal communication

The greater part of the communication between therapist and patient occurs at a non-verbal level – an intensely affective level. Eyes, face, posture, gesture and movement convey interest, encouragement, praise confidence, security, toleration and the expectation of change. It has the added advantage of being time-saving. Time consuming verbal communication alone is almost exclusive to the insecure family group.

Effective therapy takes place in tranquillity, peace and orderliness. Drama is for the ineffective.

Organisation of Benexperiential Psychotherapy

Here, the discussion will be concerned with the interview termed "family group therapy". This is the basic interview in family psychiatry. Nevertheless, other types of interviews will be employed from time to time. Work should be flexible. The appropriate interview procedure is employed according to the dictates of the situation at a particular moment in time. Flexibility is the keynote. Circumstances may sometimes dictate that only a particular interview procedure is possible, but one aspires to the most appropriate at a particular time in a particular situation.

Types of interview

These are:

(i) Individual interviews.

(ii) Dyadic interviews involving any two people and the therapist.

(iii) Family group interviews involving the whole family (this may sometimes be a partial family group).

(iv) Multiple family groups – the present family may get together with related families, such as preceding, collateral or succeeding families.

The group may consist of a number of unrelated families.

(v) General groups – these consist of members of unrelated families and have many variants, depending on gender, vocation, type of problem, etc.

Comparison of Family Group Therapy with Individual Therapy

Family group therapy has some features in common with individual therapy. But in family group therapy the number of relationships is greater, the therapist is part of a web of communication and he addresses himself to the "collective psyche" of the family. The great advantage of family group therapy is that in the group there is a built-in corrective to misinformation by an individual by the sifting and re-evaluation

of the others. Furthermore, it is possible to deploy assets not only in the therapist, but also in the family itself.

Comparison between Family Group Therapy and General Group Therapy

General group therapy treats together a number of individuals from unrelated families. Groups may be male, female or mixed. They may meet formally for intensive therapy, or informally in a club setting. One or more therapists may be employed, and the clinical material is interpreted according to the school of thought of the therapists. The aim is to bring profit to each *individual* in the group.

The family group has a strong identity which reaches from the Past and extends into the Future. It existed as a group before therapy, and will go on after it. It is a heterogenic group of both sexes and of all age groups. It is subject to strong influences from the extended family group. Its members have learnt rigid patterns of behaviour and communication, in relation to one another. Each member of the family has strong meaning for the others. Powerful emotions can be aroused in it, for good or evil. The strength and cohesiveness of a family group often become strikingly apparent when it is attacked from outside. The aim of therapy is to change the *collective psyche* of the family.

Flexibility in therapy

It must be emphasized that family group therapy is but one procedure of benexperiential psychotherapy, which in turn is only one part of family therapy. The use of family group therapy alone seriously limits the treatment of the family. Benexperiential psychotherapy, vector therapy and preventive psychiatry are complementary, and the most effective family therapy employs all these procedures simultaneously.

The therapeutic needs at a given moment can be met by a flexible approach ready to utilise whatever is appropriate. Thus, individual and family group psychotherapeutic procedures may be employed together, or family group therapy and vector therapy, or family group therapy and dyadic therapy, etc. Whenever possible, the whole family must be involved in the treatment process; this does not mean just for family group therapy alone, but applies to all the therapies appropriate to the task at that time.

Treatment may have to proceed with an individual, or with only a part of the family; this may be so because of inability to involve the whole family or because of the dictates of the treatment situation at that moment. But if only a part of a family is under treatment, the rest of the family is not overlooked, and the aim does not change; to adjust the whole family is still the target.

With the consent of the family group, family members can see the therapist alone, but with the understanding that, whenever possible, material relevant to family life must be reintroduced to the group. The therapist applies no pressure; he concentrates on producing security which makes revelation possible to the rest of the family. The therapist, of course, does not allow himself to be used against the family, or to show special favour to any one member. Whenever misunderstanding threatens, it pays to subject the situation to the scrutiny of family discussion; capacity to understand is often greater than imagined. There is no doubt that an experienced family therapist is more comfortable in family therapy than in individual or dyadic therapy, where there is always anxiety lest unseen family members are not taken into account.

The following illustrates the need to be flexible in family group therapy and to allow fragmentation when required:

> A father, mother and daughter meet together for family group therapy. At one moment father becomes silent, anxious and restless; the group makes no progress. The father then asks that he be allowed to see the therapist alone. When he does so, he relates that some time ago he had an involvement with a third person. He ends by wondering whether this information should be imparted to the family group.
>
> Discussion may show that two plans should be considered: (i) that the material imparted is of no significance to the rest of the family or (ii) that it is of significance to the wife, who, the patient feels, may suspect the situation. He asks for a meeting between the therapist, the wife and himself, as he feels that the matter needs resolution. Husband, wife and therapist meet – dyadic therapy. Again the couple wonders whether the information should be imparted to the family group. They decide that the event has no significance for the adolescent daughter, and they do not wish to introduce the material to the group. Or they may decide that the daughter may already suspect this relationship, is worried about it, and the matter should be divulged. Thus, the therapist, mother and daughter meet to discuss the situation. Thereafter, family group therapy continues.

Selection of families

Few units are so well staffed as to be able to apply family group therapy to all their families. Thus, selection becomes necessary. In general, units deploy their facilities to give optimum value to the community. Therefore the families selected are those with a degree of disturbance likely to respond, in a reasonable period of time, to the treatment offered by the facilities available. Families with young children have a degree of priority. They have young parents; young parents have not been emotionally ill as long as older people, and thus respond more readily to treatment. The younger the children when treatment is established, the more they profit. The number of children in the family is a factor in selection; the greater their number, the greater the benefit that will accrue to society by improving their emotional health. In all families, whatever the degree of disturbance, efforts should always be made to bring relief to the children, the young generation and the generators of new families; we must invest in the future.

To make priorities when so many require help is a trying matter. But if the number under therapy exceeds the resources of a particular institution the standard of therapy can deteriorate to the point that no one receives effective therapy. When allowance has been made for administration, staff contact, meetings (and excessive conferencing is a sign of inexperience and inefficiency), reports, course attendance, teaching and investigation, a possible therapeutic weekly period of 40 hours can easily become 20 hours. This means that ten families receive two hours from a therapist if seen weekly, or 20 families if seen fortnightly – less contact than this is not valuable. Thus, interview therapy is exceedingly expensive of time and money. A clinic with five therapists might have 400 families referred to it, but be able to offer therapy to 100 families for two hours a fortnight or 50 families for two hours a week. If a clinic is wasteful enough to use two co-therapists, the number of families receiving treatment would drop to 50 families if seen fortnightly, or 25 families if seen weekly. Thus, selection of families is imperative.

It is still a matter for amazement that some clinics aspire to give all patients a complete form of psychotherapy; they end up in a scramble to cope that means superficial, wasteful therapy.

Normally, the best deployment of facilities involves selecting a few families for complete antecedental psychotherapy, a larger number for focal antecedental psychotherapy, and the largest number for actuality psychotherapy and vector therapy. Vector therapy has revolutionised the effective use of time and is usually the procedure that gives the best rewards for the time and resources available. However, the lengthier methods continually unearth new knowledge and techniques that can then be applied to the shorter methods.

Some “hard core” or “problem” families in small number are invaluable as teaching media for trainees. Thus a few should be in the treatment programme. Some help is given and the reward for this in understanding the mechanics of family life is enormous.

Senior staff members of an institution should constantly remind staff of the cost of time. Endless discussion and counterdiscussion, often purposeless, can go on. The greater the time spent on this, usually the less effective the therapists. It is a measure of the need to question whether the right staff members have been selected. Naturally, some time must be spent on structured, fruitful staff communication.

Home or clinic setting

Family therapy usually takes place in an out-patient clinic. Few clinics offer a service in the family’s home. It is held by some that therapy in the clinic is a less artificial situation than therapy in the home, where it creates embarrassment to the family by provoking the interest of neighbours, and where distractions are many. Therapists feel safer in their own clinic setting and claim that it offers a controlled environment, which makes diagnosis easier. Others claim that the home, as the family’s natural setting, is more revealing, that it is easier to collect family members together there, and that it offers less distractions than a clinic. Probably the main determining factor in choice of setting is the time factor; it saves therapeutic time to bring the family to the clinic and this time is always at a premium. The family doctor, family nurse and family social worker, on the other hand, may find the home to be the best platform.

Home versus clinic setting is not a key factor in therapy. Given the right therapist, the all-important communication can ensue in any setting.

The clinic setting

The family group usually meets in the clinic setting. They can meet informally in a comfortable circle of chairs, or seated round a table. All members of the family of any age group, including infancy, are present. Less than one-and-a-half hours is unlikely to be worthwhile, and more than two-and-a-half hours is likely to be exhausting. About two hours is the average period for a group meeting. Family groups should, if possible, meet once a week and no less frequently than once a fortnight. There are times when a longer meeting with rest pauses may be indicated – even for a whole day. These longer sessions are useful for dealing with a crisis, or when the family has reached a point where it feels able to resolve a particularly difficult situation. This is a modification of the multiple impact therapy developed by the Galveston, Texas, group of workers; they brought a family into a residential setting for a once-and-all therapy with a stay of two to three days.

The room should be restful and quiet. Lighting should allow easy visibility, while being subdued and not harsh or revealing. All the chairs should be of equal height and size; the therapist claims no privilege. There should be playing material and reading material for the children. All need access to a toilet. A profitable arrangement can be to plan evening sessions for families unable to get together during the day.

Size of group

In family group therapy, concern should be with individuals who have emotional significance as a group. This, most commonly, is the nuclear family. But a blood tie is of secondary importance to an emotional tie. The family group in therapy should consist of those who are involved together in an emotionally significant way. Thus, the functional rather than the legal or physical group is important. For example, in a particular set of circumstances a lodger may be a more important father figure than a husband; a nanny may be a more important mother figure than the natural mother. Thus, added to the nuclear family, there may be grandparents, siblings, relatives, neighbours, friends, acquaintances, servants, etc. Always, the approach should be flexible – in the course of therapy the group may need to shrink or expand.

Confidentiality

This applies at two points. Firstly, retaining information in the family group and, secondly, dealing with confidence as it concerns one family member within the group.

Families need to be assured that information will be kept confidential. Information must be assumed to belong to the person who gives it. It is imparted because only in so doing can the help needed be received. If it is communicated to others outside the family by the therapist, it must be with the clear understanding and permission of the family or the particular family member. Thus any recordings or notes must be made with their agreement and the anonymity of the family must be protected when they are used outside the immediate therapeutic situation, eg in teaching and writing. To fail means poor communication and ineffective therapy.

Within the family group, an individual may have information he wishes to impart to the therapist only. Similar “special information” relationships develop naturally within the family. The need for this is respected. While a particular family member’s right to communicate alone with the therapist must be maintained, its handicapping effect on therapy must be pointed out. With increasing confidence, more and more information is thrown into the common pool by the family members. Especially in early interviews, the family group cannot produce complete security and thus complete communication. To force it beyond what the relationship in the group can stand creates greater insecurity and impedes progress.

Recording information

Given the agreement of the family, the interview can be recorded by sound or video tape. As a means of expediting day-to-day therapy, recording on tape and video has a limited part to play. Seldom does a therapist have time to consult a two-hour tape before engaging on another session. If this were done as a routine the number of families helped by a team of five therapists in one year and seen once fortnightly could shrink by half to 50 families! However, there are times when a family will profit from having a previous session played to it on tape and discussing it. More usually, the part played covers some especially significant part of the interview. Thus, any of its tapes should be accessible to a family, but the playback used with discrimination, eg a family member may not yet be secure enough to stand the

revelation that in an interview he gives himself away so clearly. Again, one family member may use a section of tape to score off another member. Therapy aims to teach that such hostility is unnecessary.

The great value of recording interviews is in research and teaching, and not in routine therapy.

Communication

The prime channel of communication within the family group is speech. However, much more occurs which has meaning to the family. The seating arrangements can reflect divisions and coalitions in the family. Posture and gesture may convey what is felt and perhaps what an individual might wish to do, or how he would like to be regarded, his aspirations, and his defences. At first the therapist may find it difficult to understand both the verbal and the non-verbal communications, as families have idiosyncrasies. He must, with time, become attuned to the language of that family. The role of non-verbal communication has already been stressed as a major part of the skills of the therapist.

One or multiple therapists

Another matter of organisation is that concerning the choice of one therapist or several. Usually, economy dictates the choice of one only. At first, therapists new to the field have difficulty in shifting loyalty from one person to a group. Yet, all have had experience of such a loyalty within their own families; such a shift is possible once the group idea is grasped and habit given time to work. Having a number of therapists carries the danger of each forming an attachment to an individual family member and setting up rivalries. On the other hand, if more therapists are introduced there is more dilution of family disturbance. It has been argues that a number of therapists are collectively wiser and more skilled. But an experienced individual therapist should have the skill to manage alone. The greatest problem in having multiple therapists, and the final argument for one therapist, is maintaining adequate communication between a group of therapists; one therapist is usually of one mind, and comes from one preceding family.

Much profit comes in teaching from bringing a trainee into a family interview if this is tolerable to the family. Skills can be maintained by therapists playing video tapes of their therapy to colleagues for comment.

Preceding families

When a family has a member with psychopathology springing from a preceding family, then that preceding family should always be involved if it is accessible. It is much easier to resolve difficulties in the past if the past can be made present. Resolving the past through the imprint of the past life in the individual is more difficult. The preceding family is seen with its family member from the present family or jointly with the present family – depending on what is required. Even two preceding families or collateral families may be included. This latter is a form of multiple family therapy.

Prognosis

The effectiveness of family group therapy is dependent on a number of factors: (i) The less the degree of family disturbance, the more rewarding, of course, is the therapy – with our present knowledge, even the best therapists may have difficulty in resolving a severe degree of family emotional disorders. (ii) Problems of the Present

resolve very satisfactorily – problems with deep roots in the Past are resistant. (iii) In general, the younger the family members, the more effective the therapy. (iv) Recent acute situations resolve more easily than long-standing, chronic situations.

Even in the most resistant families, family group therapy can be a valuable technique in conjunction with vector therapy; insight can develop to the point when the family can accept adjustment which will change the pattern of intra- and extra-family dynamics in its favour.

Equally good results can be obtained with all clinical categories, including the psychonotic, the psychopath, the alcoholic and the delinquent. In the writer's experience, family group therapy is not a profitable procedure for "process" schizophrenia.

What constitutes resolution will depend on the target set. Targets could be:

1. Relief of the presenting symptom in the presenting family member.
2. Resolution of psychonosis in the presenting family member.
3. Resolution of psychonosis in all family members to make the family harmonious in present circumstances.
4. Resolution to the point when the contribution of this family to the foundation of succeeding families will be healthy.
5. Complete resolution of psychonosis throughout the family to guarantee harmony under all ordinary circumstances.

Clearly (1) is much easier to achieve than (5), which is only occasionally attempted.

A routing follow-up contact with the family can reinforce previous procedures, offer continuing support, and may, with the detachment of time, allow a realistic appraisal of the extent and techniques of clinical effort. If investigation and diagnostic procedures are carefully followed, the family indicators will have been carefully recorded before therapy. Following therapy, the family can be reassessed as to the state of its indicators and a comparison made with its pre-therapy phase.

There are few good follow-up studies of family group therapy. Problems of evaluation, which are considerable in individual psychotherapy, are even greater in family psychotherapy. Often family group therapy amounts to an evaluation of family dynamics without any clear benefit to the family, analysis without reconstruction. Allowance must also be made for the fact that factors change by time alone; chance may change the pattern of adverse vectors to their advantage and the longer the therapy (and thus, time) the more likely this is to happen.

However, careful research could show that family group therapy is not only the most potent form of therapy, but also has, in most situations, a clear advantage over individual therapy.

Individual interviews

There are a number of indications for the use of individual interviews.

1. An individual person is the referred patient and the rest of the family refuse to co-operate.
2. The referred patient is a single person and it is not immediately possible to involve the preceding family.

3. The referred patient is an individual with a problem that does not involve the rest of the family – but later it may be necessary to involve the preceding family.
4. The referred patient does not see at first that the present family is involved.
5. Having started with a family or dyadic interview, a family member requests an individual interview for clarification of what appears to him to be a personal problem.
6. One family member may alone show psychonosis of a severe degree. To cope with his experience in his preceding family, individual interviews run alongside the family group therapy. This may be a prelude to involving his preceding family.

It is not necessary to elaborate on the procedure of an individual interview here, as its main features are similar to those of family group therapy. Usually, interviews last 50 to 60 minutes but may be usefully prolonged at significant points in the therapy. The individual may be of any age group = child, adolescent, middle aged or of old age.

It may be useful to briefly outline the steps in the therapy of children.

In the Institute of Family Psychiatry, a child psychotherapist undertakes the investigation and treatment of the child patient in collaboration with the family's psychiatrist. Together psychiatrist and child therapist outline the project for a particular child.

The first aim is usually to establish rapport by the use of much play material. Thereafter, systematic observation of the child takes place in the play situation; this gives a base line for comparison later on.

Play diagnosis follows. The aim here is to encourage the child to reveal his problems as he knows them and also to express what he knows about himself and his relationships within the family, the school and the neighbourhood. A young child can only communicate through play; an older child may spontaneously verbalise to the therapist. The play medium appropriate to the child's age, sex and inclination is supplied. It is usual to corroborate information obtained through one medium by that disclosed by another. There is a systematic evaluation of the child's family life.

Play therapy is the final technique and is employed for one of the following reasons: (i) to support the child while the parents are receiving treatment; (ii) to support the child when the family environment cannot be changed, or when he cannot be separated from it; (iii) to help separate the child from his family, either for short or lengthy periods; (iv) to make a lasting change in the child's personality. The relationship between therapist and child is the most potent therapeutic medium. Within the safety of this relationship, the child expresses his fears, guilt, hate, and, sharing these with the therapist, is encouraged to healthier reactions.

Child psychotherapy is at its most effective when undertaken as part of family therapy.

Adolescents are particularly sensitive to such matters as being regarded as adults, confidentiality, and the relationship between the therapist and their parents. It is often

wise to commence therapy with the adolescent in individual interviews. When rapport is established the advisability of a family group interview is discussed. He will need reassurance that any matter that has passed between therapist and adolescent can be kept confidential as long as he wishes. The aim and organisation of the family group interview is also the subject of preparation.

Dyadic interviews

A dyadic interview is an interview that includes a dyad in the family – these can vary greatly, but the commonest of those that include the marital couple, parent and child, or two siblings.

Indications for a dyadic interview include:

1. The referred patient may be a couple and it may be necessary to start with them before including the rest of the family as they do not see that the rest of the family is implicated.
2. They may alone be available. They may have no children or immediate relatives.
3. Other family members may refuse to co-operate.
4. At a given moment in family group therapy a particular relationship may require special attention.
5. A dyad may have a problem that does not include the other family members.

Sometimes before embarking on dyadic interviews it is wise to see each person individually. The right moment to bring them together can be gauged after preparation. Again when the situation requires it, they can receive individual interviews and this is made clear to them in the preparation. The bringing together must not be over-hasty. Some interviews may be too traumatic – one or the other member may not be ready for harsh revelations, rapport may suffer or he may move out of therapy. Family members sometimes cope with one another by being secretive, withholding information or saying little. These coping mechanisms must not be pushed aside until both partners are secure enough to deal with the consequences.

Multiple family therapy

Here, a number of families come together for therapy. Multiple family therapy is of two types:

1. The families are related, eg starting with the present family, either a preceding family or collateral or succeeding families are brought in. They can be immensely valuable in either benexperiential psychotherapy or in vector therapy. The clan has assets and resources, and these can come into play. Naturally, the process is not undertaken without the understanding and preparation of the presenting family.
2. Unrelated families. These are less useful. Each family has its unique historical background and a psychonosis arising out of it. These preceding families are not available and the crucial past situations cannot be dealt with. Each family is anxious to receive help for its own problems.

Such groups are most useful when discussing general problems of living which are of common interest. It has been argued that disturbed families can help one

another. In general, disturbed families, like disturbed individuals, are not effective therapeutic agents. The other families are particularly prone to pick up the unhealthy reactions. Such families are not very understanding, and less so than a well selected and trained therapist. Normally, families profit from contact with healthy families. There would be more profit in mixing healthy and unhealthy families – with a preponderance of healthy ones. But healthy families usually see no good reason for being used in this way. It should be remembered that the larger the group, the more diluted it is. Furthermore, the larger the group, the less often can one member of it talk in a given period of time. As in all groups, there is an optimum size for useful communication. The group should probably not exceed seven persons.

General group therapy

These groups include a number of people from different families. They are organised in various ways:

1. By age – groups of children, or adolescents, middle aged, aged.
2. By sex – groups of men or women.
3. Mixed sex groups.
4. Economic, social or religious groups.
5. Groups, all of whom have common syndromes, eg agoraphobia, asthma, fetishism, etc.

Activities can be very varied – some groups revolve round discussion, or dancing, teaching, art, etc. Some groups have a number of activities and take on the features of a club. All are of value in a supportive way.

The most useful groups are those in which a number of healthy people are able to exert a precise effect on a small number of sick people. Naturally, the younger the patients the more rapid the change. Thus groups are especially useful for infants (day nurseries, play groups, children's clubs, adolescent's clubs, etc.). Here we impinge on vector therapy, to be discussed later.

Even larger groups are useful (i) for their supportive effect, (ii) for discussion of general problems of living, and (iii) as a means of diagnosing and having access to vulnerable people.

However, they are not a very potent therapeutic milieu for advanced ill-health because:

1. Each member of the group has a different preceding family unique to him.
2. Attitudes from the past interfere with the present family, who cannot be dealt with as that family is not there – nor its preceding family.
3. Each member is an epitome of its own family and each strives for expression.
4. The amount of collective psychopathology is great, but there is no common interest in dealing with it.

At this point we also touch on group relations in in-patient care, and this will be discussed under vector therapy.

Elements of Technique in Benexperiential Therapy

In the discussion that follows it is assumed that the standard interview is the family interview; most of the information would also apply to other types of interviews.

Major principles.

Insight. To confront is a hostile exercise. To reveal is untraumatic. Revelation is tolerable in the security of a sound relationship with a therapist. Insight implies the understanding of the significance of psychic events as they relate to that person or family. It leads to an awareness of the psychic noci-vectors that led to the damage to the "idea of self" in the past, the vulnerabilities there were produced, and the coping devices employed. It allows awareness of the psychic noci-vectors operating today on vulnerabilities produced by the past.

Insight is only a prelude to therapy.

Psychic noci-vectors now. The psychic noci-vectors or vectors must be identified. They may be operating on a sound personality or on a vulnerable personality, which, on removal of the vectors, can only return to its pre-traumatic state.

The following procedures, alone or together, are employed against the noci-vectors:

1. Resolve the conflict of attitudes from which the vector comes. Thus the quality of the vector can change.
2. Reduce the power of the vector. Frequently, preoccupation with it allows it to dominate thought and appear more threatening than it actually is. Thus putting it in perspective will reduce its power.
3. Reduce the time over which the vector works.
4. Arouse assets in the individual to measure up to it. Self-confidence allows of healthy coping.
5. Share the experience with the patient and allow other constructive people to do the same.
6. If it is not essential to his interests to meet it, allow the patient to side-step the vector without loss of face.
7. Counter the vector with opposing vectors of greater strength, repeated, and of long duration.

Damage to "idea of self" in the past. The damage is repaired by putting the self through a benevolent new experience. This is a process. A process is a "continuous series of events", eg guilt, with its damaging feeling of unworthiness, having been exposed, is countered. The security of the relationship with the therapist or others and the reduction in damage allow maladaptive coping devices to be put aside and be replaced by new healthy devices – usually imitated from the therapist or others and the reduction in damage allow maladaptive coping devices to be put aside and be replaced by new healthy devices – usually imitated from the therapist or others. Special attention should be given to the more powerful coping devices listed previously. Insight allows identification of previous damaging vectors; to use benevolent vectors of reverse but greater power than the damaging vectors is central to success.

It is crucial to understand that a process requires time over which to operate. The greater the damage and the longer it has been operative, the longer the period of therapeutic time required. Intensity of therapeutic process can reduce this period.

The greater the damage, the greater the number of unsatisfactory elements in self, and the greater is the therapeutic effort required.

It is fundamental to understand that the therapeutic process need not take place exclusively in the interview situation. The following are possible:

1. An exclusive interview process. This is necessary for very damaged people and calls for frequent interviews over a long time.
2. Guidance by therapist and use of others, especially the family, as allies in therapy.
3. Vector therapy, guided by the therapist. Benevolent influences in the family and outside are utilised to repair the damage to self; they can also be used to counter any psychic noci-vectors in the present.

The importance of the process and the use of extra-interview therapists can be shown by two brief illustrations, one from ethology and one from clinical practice.

Harlow (2) and his colleagues have been conducting for many years a series of intriguing experiments with monkehy. This work passed through a number of phases and has now reached the ultimate in interest. The sequence of events was as follows:

> A number of young neurotic monkeys were produced by deprivation situations. Some grew up and the females were mated. They became neurotic mothers and rejected their infants. So severe was the deprivation of the infants left with their mothers, that they had to be rescued. The workers now sought some means of treating these second-generation disturbed infants. They tried behaviour therapy in vain. They tried the care of adult monkeys – but these punished the infants and there was no success. They then paired a disturbed monkey with a healthy monkey. The older monkey did not threaten the younger, nor did the younger impose rules on the older. The relationship prospered and in six months there was a marked improvement in the older monkey. The workers concluded that the young monkey was effective, even though it had never read about psychotherapy!

Here is a therapeutic process at work – and effective. To understand this process is to know the full nature of therapy. We now know a great deal and can hasten and enrich this process. But, even without full knowledge of its nature, the right process can still work.

> Mr. X is an angry man. His father was an angry man. His father made him very insecure and damaged his “idea of self”. His father ignored him and he is very sensitive to being ignored. It makes him angry – this is the device he adopted from his father as a means of coping. Mr. X is quickly angry – not only with men but with women, his wife, his son, his daughter, his friends. Ignore him and he is angry, and it matters little who ignores him. He feels “little inside”, unworthy, despised. Mr. X has help. His preceding family is not available. A strong secure relationship allows him to talk without shame or fear of his early deprivations. But that alone does not make him less angry. The relationship passes into its constructive phase. In a long, intense companionship he is given attention, his assets are realistically emphasised, is

self-appreciation improves, and his most sensitive vector, being ignored, is negated by attention.

Others are encouraged to enmesh him in the same pro-Mr. X experience – ie benexperiential therapy. Thus therapy was shortened by the use of the extra-interview therapists.

Fallacies

It may be useful to outline some of the major shortcomings of some methods of therapy used at present:

1. *Listening* is not enough. There has been a tendency to regard the therapist's role as being a passive one of listening. This is far from the case. In the diagnostic formal phase there must be active questioning with much participation by the interviewer. In the elucidation of psychopathology the role is less active, but direction is required to cover the whole area and active clarification of data may be required. As we have seen, the therapist has a highly active role in therapy, even if non-verbal; guidance, experiential process work and decision making are essential parts of his role.
2. *Decision making* is an essential part of therapy. It is held that the therapist must never make decisions or even be involved in the decision-making process. This at worst is a deliberate avoidance of responsibility, at best it is bad technique. In surgery such a situation would be unacceptable. Take a moment of decision in psychiatry, eg the decision by marriage partners to seek a divorce. This requires involvement. The formula is not "I will make the decision for you", but rather, "We will explore the situation together and my skill will clarify the issues for you better than you can do on your own. In the light of this, you and I will be able to arrive at conclusions. If you and I disagree, I shall make my view clear to you and you have a right to follow the course you wish without my concurrence as to its wisdom, but still with my support. If we agree, you will be able to carry on with my concurrence." Support is never withheld, there is no upset at advice not followed, blame and guilt are not part of the transaction, and for the patients to change their mind later is a possibility. But the therapist does not shirk being involved in decision making. Skill cannot develop in situations where there is avoidance of responsibility.
3. *Diagnosis* must precede therapy and not be confused with it. To garner information, to develop insight are elements of diagnosis. But diagnosis and information collecting must proceed to the point of relevance only. To avoid decision making, it is easy to slip into a situation where it can be said "but we have too little information". This puts off the evil day of decision making. It is not usually relevant to know the colour of the maternal great grandmother's hair before coming to a conclusion as to whether William should live with his father or his mother.
4. *Insight* is not enough. To explore a situation and reveal why a trauma was suffered is not of itself therapeutic. Insight is a prelude to the constructive phase which of itself is therapeutic. To be aware that one's finger hurts because it has turned septic does not of itself open the abscess, but it is an essential prelude to effective therapy. In psychotherapy, the constructive phase is much more difficult and hence there is a tendency to be content with insight.

5. In decision making, the family or individual has no greater *wisdom* than the therapist; if the latter is competent, he should have considerably more wisdom than the patient. To shirk responsibility it is easy, when convenient, to say, "The patient knows best and can make the decision". But it is the patient's confusion that has brought him looking for help. Psychopathology is a complex field for the most experienced; the patient is usually lost in it and the more disturbed he is, the greater his confusion.

The warming-up period

In every course of therapy, there is an initial phase of warming-up which may extend from a few minutes to several interviews. This is inevitable, as the therapist and the family have to get to know one another. The family has to go through a period of convincing itself that it can allow the therapist to join the family, that it can trust him, have confidence in him, and confide in him as an equal partner. To some extent every interview starts with a warming-up period. The therapist must be sensitive to the need for a warming-up period.

Explanation

It is valuable, at the start of therapy, to explain to the family the expected organisation in general terms. It is possible also to explain to them in outline the rationale of therapy, as sated above. Furthermore, it is wise to point out some of the rules under which the family is meeting; for instance, every member of the family has equal voice, whether it be child or grandparent. Not all these working rules will be acceptable at first. Again, the family will go through a testing-out period, but the attitude of the therapist continually reminds the family of the working rules.

The facts and no interpretation

Interpretation in family group therapy is in a sense a contradiction in terms. The only truth is the truth of an event within the life experience of a particular family member or a particular family itself. The event does not need interpretation, it is a fact. Thus, a therapist enslaved by interpretation theory will be less effective. It is only the family who know the facts at first.

It can be educative to hear three experts discussion information conveyed by a patient. They can radically disagree amongst themselves, biased by their personal experiences and their school of interpretive psychopathology, but the only true meaning of the information is that given by the fourth person, the patient himself. Broadly, people's experiences follow the same pattern, but the significance of events is unique to each person. Stereotyped interpretations have little significance. The therapist must constantly be on guard against assuming that other people's life experiences are like his own and have to be interpreted in the same context.

The greatest errors are made because of dogma – situations and words are distorted to fit in with the creed. Let me illustrate. A therapist is helping a husband and wife with their marital problems. Discussion turns to sex and they reveal a most unsatisfactory situation in the physical act which has steadily deteriorated since the start of the marriage. The therapist, by his canons, traces everything back to sexual disharmony. Yet data are produced to show that both partners have had satisfactory sex relationships before marriage, succeeded early in marriage and do now on the rare occasions when they are happy together. The partners insist that their problem is one of personal incompatibility. The therapist insists it is sexual incompatibility. They seek help for their relationship as they are convinced, and know, that given harmony

the sexual intercourse would be satisfactory. But they are offered advice for the sexual disharmony alone.

Some regard objects and even words as having special significance and always to be rigidly interpreted in a particular way, eg one therapist equates “dog” with “prostitute”. Any mention of a dog carries this hidden meaning. For some people in special circumstances this might be so, but for a large number of people a dog is a dog. The term “gas” by the same therapist is equated with the anus and hides anal eroticism. The word “piece” is equated with an “attractive woman”, whenever it is mentioned.

We can see how remote from reality the explanations become when we study this brief extract from an interview:

> Father picks at his nails. Therapist observes this and calls attention to it. At this point son, in defending his father, is critical of his mother as the mother has said this is a disgusting habit. Therapist then makes the remark to son, “What kind of piece would you like to pick out of your mother?”

The therapist claims he made this remark to bring out son’s erotic interest in his mother, ie mother is a “piece”. But he is arguing from analogy, and very approximately at that, and giving special meanings to words. It is father who picks at his nails and not son, even if we accept that to pick at one’s nails is hostility. But it is son who is hostile and he is not “picking”. Hostility and picking are given to the son when hostility alone belongs to him. The therapist in his mind then links picking with a “piece”; piece is equated with “attractive woman” (when it could just be a piece of nail or anything). But the word “piece” was first used by the therapist and might reflect his views, but hardly those of the son. Then it is further assumed that the son has an erotic interest in the mother, even though he did not use the term. This is sheer fanciful invention decreed by dogma and takes us away from the facts. The true meaning is simpler and more direct; the son wishes to support his father against the hostility of the mother and the therapist, who has made a partnership with her/

Again, take statements based on preconceived ideas such as: “The child is in love with its mother. This is why he is hostile to his father.” But he may love both. Or: “This child (of three) always wants to go to the parents’ bedroom in the mornings. He wants his father out of his mother’s bed, so that he can have intercourse with his mother.” An interpretation is put upon a situation which is not proven; many other explanations are possible. Furthermore, as ideas are based on sexual pathology alone, adult notions are transferred to the child. Situations are made to fit fixed ideas. Chance associations are given casual significance. This distorts the truth.

Patients, individuals and families, do not always find it easy to grasp the significance of events. They are not psychopathologists. They more readily see the significance of a chain of material, rather than of emotional, events. They wish to forget what is hurtful, embarrassing and damaging to the “idea of self”. Thus, they must be led to the truth and the truth lies in real events. To misinterpret adds to their difficulties. (But they can come to believe the misinterpretation.) The exercise is only necessary and justifiable if it can lead to what they want – help. Thus, it is necessary to point out, explain, clarify, underline, reveal – but not to distort.

The therapist, equally, may not know. He has not the capacity to know simply by wanting to. He is dependent on data. He must have facts and the facts must be real. The facts are concerned with the people he helps. The therapist may, by his greater

knowledge of similar situations, arrive at the truth before the family. He should guide them to the truth – by revelation, clarification, explanation, and sometimes by repetition. Explanation must be in words they can understand. If a family comes to the truth in terms of a dogma, then it is likely that the therapist is imposing foreign notions upon them.

There is a time and a way of making a revelation. It should add to security and not take away from it. It should not be a confrontation or a display of hostility. It should be so judged that the family can cope with it, without upset, and it should be used constructively. A statement can be attenuated and pitched at a level which is acceptable at that time. There has to be a delicacy about these things based upon experience of life and a need not to hurt others. Damage can easily be done – a brutal statement to a lady that she is getting old, however true, is unconstructive.

But truth never emerges without rapport; the darker the secret, the deeper the rapport needs to be, and rapport makes for security.

Degree of insight

Insight is the understanding by the family of the mechanisms of the emotions. The greater the disturbance in the family, the less the insight. The developing understanding of the significance of emotional events takes longer with a more disturbed family, but time spent on insight is essential. Understanding, however, is not therapy. It is discernment, diagnosis. Having seen the course of events, it is essential to re-experience and to reconstruct.

Intelligence has no correlation with insight. Dull, undisturbed people can have remarkable insight. Very intelligent, highly disturbed people may have no insight. Intelligence can help or retard interviews; insight has great relevance to the speed of progress.

Silence

The family has to learn that silence on the part of the therapist is an invitation to talk. The easiest interview for the family is when the therapist does all the talking, but this interview is the least worthwhile. The greater the security of the family, the more silent their therapist can be; the greater the skill of the therapist, the more silent also will he be. The therapist moves to non-verbal communication, significant and time-saving. Silence is the biggest and yet gentlest pressure that the therapist can put upon the family to get it to work. However, the family may need to be silent from time to time. During this silent period it is working in contemplation; afterwards may come a true move forward in the family's affairs.

Interruption

The aim should always be to interrupt as little as possible; interruptions result in a break, an artificial break, in the flow of the family's thinking; the wrong comment or question may cause it to go off on a line of thought of less significance, or may give it an opportunity to avoid discussing something which is relevant. Direct questions very rarely bring profitable results. Far better to ask indirect questions, which will inevitably lead to the area being discussed. For example, it is of little value asking an individual, "How did you get on with your mother as a child?" It would be much more profitable to suggest topics which will inevitably throw light on the relationship between mother and daughter.

The above does not contradict the need to guide. The therapist can pick up cues from what has been said and lead the family to an area requiring exploration. Sensitive areas may be avoided or skirted at first. The therapist makes a note of these and guides the family back to them on a later occasion. This may need several excursions. As rapport and security improve, so the sensitive, but highly significant areas, are dealt with.

Allies in the family

The most disturbed of families has assets. These are of two kinds: (i) Disturbed family members have elements in their personalities that are beneficial to other disturbed members. (ii) A family may have a comparatively healthy member who, given new cues and insight, can have a beneficial effect – even when there is no formal therapy. A therapist must evaluate the assets of the family and use them to the full. Thus family members can be allies in therapy.

Avoidance

Families are naturally uncomfortable when embarrassing, hurtful material springs up. Thus, there will be not only avoidance of such topics, but invention of apparently good reasons for not discussing them. They miss interviews, are late so as to allow little time for discussion, keep silent, raise superficial, irrelevant topics, attack the therapist for his inadequacy, etc. This behaviour is based upon insecurity. Avoidance is hanging on to old coping devices. These are moments for particular patience and tolerance. Even more effective than discussion of this behaviour is to raise topics that will deepen the rapport. As this improves the avoidance melts away.

Family swings

During the course of therapy, the mood of various family members will change; as one improves, another deteriorates, and so forth. These swings are to be expected in the course of therapy. Indeed the mood of the whole family in normal circumstances is a variable entity.

Danger to the family

Management of severe, acute situations in the present or re-enactment of material from the past naturally provokes acute symptomatology. The therapist has a responsibility to control matters in such a way that the risk is reduced to what is reasonable. Family members prone to being epileptic (10% of the population) may have epileptic attacks; others may become accident prone; ulcers perforate; cerebral thrombosis and coronary thrombosis are a possibility; suicidal attempts are made. A careful eye must be kept on the somatic and emotional health of the whole family. Danger must not rise above a manageable limit. Irrelevant, but highly traumatic events, eg war experiences, are sometimes best circumvented and left encapsulated in their coping defences. It is not effective therapy irreparable to harm or kill the family – or have the family kill others.

Acting to real trauma and not the object of stress

Some of the trauma in the present is evoked by trauma in the past, eg a husband's attitude reminds the patient of mother or father. But the patient reacts to the image of father or mother only if the husband's behaviour is like that of the father or the mother. The behaviour is the stimulus and not the conveyor of it. Thus, a man who behaves aggressively provokes a bigger response in a person sensitive to aggression

than does a man who looks like the patient's aggressive father, but who is not aggressive.

Levels of discussion

The family moves through certain levels of experience in the course of therapy. At first, its concern is with superficial matters of the moment, then it moves to transactions in the present family, then it moves back to its experiences from its early days as a family and, lastly, it moves to the preceding families. The most fundamental therapy takes place at the last level.

Family events

Much profit comes from getting a family to describe actual instances in its own immediate life experience and, as time goes on, in its past life experiences. This is description without interpretation. In this way, a far more factual picture is obtained of real family events and its reactions to them. Subsequently the therapist and the family together can give significance to the events.

Closure

Therapy ceases when the aim outlined at the start has been achieved. Usually there is a weaning-off period which may last for either a few minutes or several hours of therapy, depending upon the family, its needs, and its degree of disturbance and thus of dependence.

Somatic therapy

This must go hand in hand with psychic therapy.

The individual or family reacts as a whole to psychic noci-vectors – thus the soma is affected. Rarely does psychonosis in an individual or family present without somatic complaints which may be severe and life-threatening.

Somatic therapy will be required for:

1. The somatic disorders produced by the psychonosis. Any system in the body may be affected. Examples would be: migraine, ulcerative colitis, thyrotoxicosis, gastric ulceration, asthma, coronary thrombosis, cerebral thrombosis, etc. Furthermore, existing somatic disorders, eg multiple sclerosis, epilepsy, will be aggravated by psychonosis. Psychonotics, especially the elderly, eat badly and therefore dietary and vitamin deficiencies may need correction. There may be anaemia for the same reasons.
2. Iatrogenic disorders. These are conditions precipitated by therapy, anc can include any of the above.
3. Symptomatic relief. Tranquilizers reduce tension, anti-depressants make depression more tolerable, sedatives and hypnotics guarantee a night's sleep, etc. All these medications carry with them emotional elements – hope, a gift from the therapist, encouragement of something done, suggestive value, and a bridge with the therapist. Drugs must nonetheless be used with caution. In some patients, as they fear any drug medication, they may have a deleterious effect. Also drugs may produce toxic states in some patients and confuse diagnosis.

Features of Benexperiential Psychotherapy

It may be useful to tabulate some of the main features:

1. Benexperiential psychotherapy utilises an experience which is favourable to the individual or family psyche.
2. It is based upon experiential psychopathology.
3. The “idea of self” is the essential target of therapy.
4. The diagnostic procedure is separated from the therapeutic process.
5. Interpretation is not employed. The experience is all. Thus there is no dogma.
6. The process of re-experience is central to therapy either within or without the interview.
7. Confrontation is not employed; security is encouraged.
8. Decisions are made.
9. It is complementary to vector therapy.
10. Being experiential, it opens therapy to the scrutiny of research procedures.

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IV - VECTOR THERAPY

Neurosis (personality disorder; psychonosis; emotional disorder) does not originate within psychotherapeutic interviews. It thus follows that, if neurosis originates outside the psychotherapeutic interview, measures taken outside these interviews might aid the resolution of neurosis. It is claimed that this is possible with Vector Therapy, a form of psychotherapy which is extra-interview, though guided from the interview. The value of interview psychotherapy is not denied; Vector Therapy is complementary to it, but, in the right circumstances, can be more effective than interview psychotherapy.

Theoretical Background

Vector Therapy arises from fundamental, social and clinical observations, and is supported by them.

At the fundamental level, we find that creativity through evolution is essentially a re-patterning of phenomena in such a way as to allow a more harmonious functioning of those phenomena. A hurtful biochemical agent can become a drug of great benefit by a re-patterning of its elements. In the evolutionary process, re-patterning occurs by chance and the resulting new pattern survives because it is more harmonious with the developing changes occurring around it. However, man's increasing insights, themselves a product of evolution, also allow for directed changes of phenomena. Vector Therapy has this fundamental capacity of reshaping phenomena, in its case psychic phenomena, and does so in a systematic directed fashion.

The second observation concerns neurotics in society. As neurotic individuals are studied in society, it is noticed that their condition fluctuates – sometimes it deteriorates, sometimes it improves and sometimes it resolves completely. Therefore the capacity to improve without psychotherapeutic intervention is there. Indeed, on study (Frank, 1961) showed that the neurosis of more than half of the patients under observation resolved spontaneously while their appointments remained on a clinic's waiting list for one year. What causes this spontaneous improvement? What circumstances are at work outside interview psychotherapy? If we knew the answer, we could utilise the responsible therapeutic factor or factors. Vector Therapy has gone a long way towards finding an answer and utilising it in treatment.

The third observation springs from clinical work which daily produces examples of **spontaneous changes** in neurosis. To quote but a few examples taken from recent meetings with families:

Family 1. The family entering the room consist of father, mother, maternal sister, a young child and an infant. The infant is the referred patient for his refusal to feed. The infant, held in his mother's arms, enters the room crying. The family sits down. The crying increases and with it the annoyance of those present. Then there is an intervention; maternal sister puts out her arms and takes the infant, who immediately ceases to cry. The infant is responding to a new pattern of vectors, which indeed brings relief to the whole group.

Family 2. The family recalls their adolescent son's turbulent life. There was only one period of respite remembered with satisfaction by parents and boy. This was when the parents were abroad for six months and the boy, aged ten at the time, stayed behind

and was looked after by his paternal grandparents. In their care his disturbance seemed to fall away from him. This boy too responded to a new pattern of vectors.

Family 3. A husband presents with depression. The whole family comes for treatment. Therapy has hardly begun, when the son of 25 is transferred to a post abroad. The family reports a sudden improvement in father's depression which lifts dramatically. It emerges later that he was locked in conflict with his son. Here we had a spontaneous alteration in the pattern of the vectors to father's advantage.

The examples are legion.

History

During 25 years, work with families at the Institute of Family Psychiatry, Ipswich, England, brought to light cases in which the morbid process of neurosis was resolved or improved by extra-interview procedures complementary to, or divorced from, interview psychotherapy. Clinical work and research supported the hypothesis that therapeutic factors were at work outside the psychotherapeutic interview and efforts were made to identify these factors. Careful assessment supported the belief that the most significant pattern of forces is that within the family, although occasionally the pattern outside the family may also be powerful. When a pattern of forces were producing psychopathology, changing the pattern would remove or attenuate the trauma. Thus, more emphasis was placed on the therapist's capacity for reshaping the pattern of forces in the life space of an individual or a family in a systematic and purposeful fashion. Having arrived at a rational theory of Vector Therapy, its application developed into a useful and economical technique.

Definition of Vector Therapy

A vector denotes a quantity which has direction. Force, including emotional force, is a quantity with direction and therefore can be represented by a vector. Neurosis results from an experience, of short or long duration, whereby an individual's psyche suffers damage by noxious, stressful, emotional forces, termed noci-vectors, coming from an emotional source – another person. They are in contrast to health giving, benevolent vectors.

A benevolent vector can be illustrated as follows: A young couple look with admiration at their room full of new furniture. The husband exclaims "I will always sit on this settee, dear". Wife expresses surprise, "But why on the settee?" The husband replies "Because then I can always sit next to you, dear". Those few words are a benevolent communication, a benevolent vector, which will cause the wife to glow with emotional and physical pleasure.

We meet the same couple some years later. One night, after intercourse, the wife turns to her husband and exclaims "You did not have a climax". He replies "No. I am keeping that for someone else". These few words are a noxious communication, a noxious vector. The wife is likely to respond with despair and could even be physically sick.

Often the individual in his daily life is beset by one or many of such noxious emotional forces, and frequently by a pattern of harmful forces. Clinical and experimental work support the belief that the most significant and most dramatic pattern of forces is that which occurs within the family. The time of greatest impact is

in the years of personality development, infancy and childhood, when long-lasting damage can be affected and vulnerabilities to events in later life can be established. Occasionally, the adverse set of forces arise outside the family – in surrogate families, institutions, schools, work situations or social milieu.

A neurosis can resolve spontaneously. If our formulation on psychopathology is correct, the spontaneous change happens because the adverse pattern of forces changes and the change produces an attenuation of the trauma; the degree of change reflects the degree of reduction in trauma. If we can identify ways by which the pattern **spontaneously** changes, then we should be able to **direct** the forces causing these changes to take place. Vector Therapy relies upon our capacity to change patterns of forces, not haphazardly, but in a systematic directed fashion.

Vector Therapy identifies the pattern of the vectors inside and outside a family and adjusts the pattern of the emotional forces within the life space to bring improvement to the individual or family within the life space. Vector Therapy improves on nature by directing rather than leaving to chance the re-patterning of fields of psychic forces. (Howells, 1963.)

Psychotherapy means treatment employing psychic, or emotional, influences. Thus Vector Therapy is a psychotherapeutic procedure. Thus Vector Therapy is a psychotherapeutic procedure. But the beneficial psychic influences operate outside the interview; the interview is employed to assess and guide the psychotherapy in progress outside the interview. Thus Vector Therapy is an extra-interview psychotherapy.

Illustrations

It may be useful to mention a few clinical applications. Simple and therefore clear illustrations will deliberately be selected so that the principle can stand out. Of course, in practice the situations are often far from simple and make great demands on the skills of the most experienced of psychiatrists.

Situation 1. We have a simple nuclear family of three – a healthy father, a highly neurotic mother, and a disturbed child. The mother and child are locked in an intense, disturbing relationship. Father has been taught by his own family that children should be brought up by mothers. He is concerned, but does not think it right to intervene and moves away to the calm of extra family activities. Vector Therapy can now intervene. The father is brought into an individual interview and he learns that fathers can assist in bringing up children; he unlearns his own family's rearing practices. Then the nuclear family meets an over a number of interviews comes to accept father as the main parenting agent. The new pattern of vectors brings an immediate improvement in the state of the child. It would still be possible for the disturbed young mother to received psychotherapy; the two therapies are complementary.

Situation 2. A young wife presents with anxiety and depression. Exploration of the family situation reveals that the young couple live close to the paternal grandparents. The paternal grandmother is a hard, harsh, dominating woman. She sweeps into the house everyday and always has something to criticise. The young wife cannot even anticipate at what time of the day her mother-in-law will descend upon the house. Her life is full of tension and expectant anxiety. The birth of her child offers more opportunities for criticism to the mother-in-law.

Over a number of interviews the young couple, and husband in particular, are strengthened to the point when, without precipitating a quarrel with the grandparents, they can move some distance away. The husband is also supported to the point when he makes arrangements for his parents to visit infrequently and at expected times. The young wife's anxiety and depression lifts. Should the situation dictate it, it would still be possible for the young wife and her mother-in-law to receive psychotherapy.

Situation 3. A 14-year-old adolescent girl presents with aphonia, anxiety and insomnia. Exploration reveals over-protective parents, unable to support their daughter in meeting the normal trials of everyday life. The girl is quarrelling persistently with her schoolmates. Their retaliation depresses her. Her school work suffers. Further family exploration shows daughter looks back with pleasure to a three month period spent with the paternal grandmother, a widow, who apparently shared her pleasure. The girl is transferred to the care of her grandmother with an almost immediate relief in her symptomatology and a marked improvement in her school record. Should it be required the parents and the adolescent could still receive psychotherapy.

Three brief comments must be offered on these examples. Firstly, to say that father must look after his child, that mother-in-law must not visit, and that an adolescent must live with her grandmother is equivalent to a surgeon saying very forcibly "This appendix must come out". But a child cannot be torn out of his family any more than an appendix can be casually torn out of his body. To make a psychiatric, or a surgical, diagnosis, calls for experience and understanding of pathology, careful assessment (sometimes over a long period of time), the capacity to evaluate the essentials of a mass of data, the ability to formulate clear advice, an empathic relationship that dissolves the fears of the patient, and sometimes the patience to wait until the patient is secure enough to adopt the remedy that will bring relief. Vector Therapy is an exacting psychotherapeutic procedure. It may call for brave decision-making and sensitive management of the patient, his family, and the many agencies that can assist in the re-patterning of the vectors.

Secondly, in each of the examples given, interview psychotherapy could also be of assistance. Thus, Vector Therapy and interview psychotherapy are complementary. Indeed, the best results are obtained when they are employed together.

Thirdly, the change takes place not in the pattern of physical forces inside and outside the family, but in the pattern of psychic emotional forces.

Successful Application

Careful assessment of an individual can bring to light the pattern of adverse forces that brought, and maybe still brings, trauma into his life. The main areas of exploration are threefold – the patient's life experience in his preceding family, the patient's life experience in his present family, and the patient's experience outside the family circle. An invaluable procedure for this exploration is to meet the patient together with his family – either his preceding or present family – a procedure termed Family Group Diagnosis (Howells, 1975). A particular development is worth mentioning here. Hitherto, the usual procedure in the exploration of the preceding family has been to invite an individual patient to remember and relate his experiences in it. How full of errors is this procedure! Far better is to adopt the practice, whenever

the preceding family is available, to put it with the patient and observe the adverse process at work. We have found this practice of great value at our Institute.

Starting with Family Group Diagnosis, it may be useful to summarise the essential steps in the application of Vector Therapy. Each step is concerned with assessing psychic factors or effecting psychic changes. The steps are:

1. A careful assessment through family group interviews to clarify the pattern of the emotional forces at work in a particular family, i.e. Family Group Diagnosis
2. To bring understanding of its particular set of forces to the family
3. To help the family, through a supportive relationship, to accomplish a change in the pattern of its adverse set of forces
4. When necessary, to put the family in touch with community agencies that can facilitate the change
5. To create community agencies able to effect changes in family psychic patterns. The agencies bring not material relief, but emotional relief, to the family. This may involve adjusting present community agencies or establishing new agencies.

Vector Therapy can be effective when facilities for interview psychotherapy are absent or scarce. This is a situation common in many countries. When resources are limited, Vector Therapy has the added advantage of being economical. It demands the same degree of skill in the psychiatrist as interview psychotherapy, but it saves the psychiatrist's time because it utilises less interview time as change is produced by monitored therapeutic situations outside the interview.

Vector Therapy can also be effective when there are facilities for interview psychotherapy, but they are unlikely to be availing; an example would be the treatment of a hard core or problem family. Again Vector Therapy can be utilised when the situation demands an urgent solution, when someone may be damaged or endangered during the interval before interview psychotherapy becomes effective, e.g. when an infant at risk of being battered in his own home has to be urgently removed to a safer mileau. Given ideal resources, the quickest and best results are obtained by combining interview psychotherapy and Vector Therapy.

Vector Therapy throws into relief the value of facilities in the community that can bring beneficial influences to bear on families. Thus around a family, particularly when its children are young, is a pattern of positive emotional forces. Over generations a system so developed creates a health promoting, salutiferous society.

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V - A Salutiferous Society

The third approach to experiential family therapy calls for consideration of the concept of a salutiferous, health-promoting society (1). In the long term this is the most effective help to society, the family and the individual.

The family is the basic organism in society. As a constituent of society it contributes to society. Equally, society contributes to it. Each family relates to all the other families that make up the psychic environment outside itself; it can equally suffer. The more health-promoting, salutiferous, is society, the more will its families benefit.

Thus it is essential to examine society for its health-promoting potential. Should the functioning be inveterate, set and permanent, this would be a wasteful exercise. Its malignant permanence would have to be accepted. Fortunately, society, like the family and the individuals, is endowed with the capacity to change. Its infinite pattern of functioning can be restyled; herein is society's capacity for health. In the final hierarchy of phenomena, the pneumococucus is as significant as a person. In some circumstances, it might even have greater importance than a person. In our set of circumstances, the pattern has to be moulded against the pneumococcus and in favour of man. Man has the capacity to develop awareness to the point when he can, within the limits allowed him, reshape the pattern of functioning to his advantage. Hitherto, his predominant endeavour has been concentrated on adjusting his material environment. With this task largely accomplished in developed countries, there should now be resources to re-pattern the psychic sphere of living.

The author sees society as a vast field of forces in which elements are loosely defined – culture, community, neighbourhood, family, individual; essentially each element has equal significance. The emotional forces within the life space produce degrees of well-being or harm and they can be re-patterned to promote either. Understanding of this potential for change in either direction allows the conscious selection of patterns of emotional forces toward bringing well-being to society and to the elements within it. Thus, through generations, a reshaping of the emotional self-improvement.

Much thought and print has been expended in attempting to define health. It is easier to feel it than to define it. Its correlates are easy to delimit and describe – emotional and physical well-being, the capacity to adjust to life's stresses, the ability to co-operate with others, unselfish actions born of security, efficiency, and productivity. All these indicate harmonious functioning in the individual – what he feels is the comfortable state of "being well".

Most definitions of health are in terms of the individual; it may be more realistic to attempt it in terms of society, which ultimately dictates the state of its elements, families and individuals within it. It might be thought that society is sick only in the sense that it contains a number of sick people. It is more correct to say that society itself is sick and therefore must contain a number of sick individuals. At the moment, forces within society are arranged in a pattern that provokes emotional ill-health, which flows from one generation to the next. Society carries within it the capacity for health because its fields of force carry the potential for rearrangement. This fact makes clinical endeavour worth while. Health and "normal" behaviour of course must not be confused. The normal, usual, statistically average state of emotional functioning in society is far from "health". With each succeeding generation it is

hoped that the emotional norm will increasingly approximate to health – a state of affairs being achieved slowly and with difficulty in the field of physical health.

The clinician's endeavour is the production of health. In family psychiatry the goal is a healthy family, with, of course, healthy individuals, a task always limited by the fact that social ill-health pulls the family towards conformity to its norms. Over the generations, small gains in the rearrangement of the vectors will have a cumulative effect on society. Gains can be made at individual, family and social levels, and the process is indivisible. For the present, the family is the vantage point. Progress can be made only at the speed with which knowledge develops. But clinical effort carries the prospect of new insight; research and clinical work go hand in hand.

It is one of the central themes of this writing that discernment must come before change, diagnosis before therapy. So it is with an effort to make society health-promoting, or salutiferous. It is necessary to know what is required for healthy human functioning – bit it individual, familial or social. The lessons of health often emerge from a study of ill-health. Thus, the first step is a massive assessment of dysfunctioning in society. It can operate at three levels: (i) what accounts for the dysfunctioning in society as an organism (where do its harmful leaders, movements, collective aggressive acts, etc, spring from); (ii) what accounts for the contribution of society to the dysfunctioning of the family (what harmful values, habits, restrictions, etc does it impose on the family); and (iii) what accounts for the involvement of society in the dysfunctioning of the individual (what harmful psychic noci-vectors spring from its institutions – schools, industry, neighbourhoods, etc).

Central to any evaluation is to establish standards. Paradoxically, standards of health often emerge only after an examination of ill-health. The absence of ill-health is easier to ascertain than the presence of health. Over time, sometimes as the result of trial and error, the pattern of optimum functioning for a salutiferous society will emerge. A further complication is added by the fact that what is optimum functioning at one moment in history is not optimum functioning at another. Fortunately, change takes place in collective human functioning at such a slow rate that this is unlikely to be a serious complication. It might be supposed that change in society takes place very rapidly today. But this would only be true of material change; the level of general psychic well-being in the most materially developed of societies is often not only very low, but lower than in materially poorly endowed societies.

It may be useful to contrast briefly what is being said about the creation of a salutiferous society with what is termed "social psychiatry". This latter has been the subject of much confusion, especially concerning such aspects as "therapeutic communities", "therapeutic milieu", "community psychiatry", etc. The first two are concerned with the climate of psychiatric institutions, a humanising movement that allows of more patient involvement, greater freedom, and a constructive group feeling; they are a reaction to the rigid institutionalisation of the last two hundred years, and only partly ameliorated, here and there, by the efforts of Pinel, Chiarugi, Conolly, and Tuke in the 19th century. Community psychiatry has affinity with social psychiatry and the terms are often used synonymously. It is a movement that wishes society to take a larger share of the care of the mentally ill, who, according to it, should remain in the community. Thus, it emphasises the need for day hospitals, hostels, etc, to keep patients in the community rather than in hospitals and the need for "after care" agencies to facilitate their discharge from hospitals. All the above are elements, but only a few, within a health-promoting society, a salutiferous society.

The salutiferous society is concerned not only with the management of the identified ill, but much more with identifying influences that encourage dysfunctioning, and then re-patterning social living so that the level of emotional, and not “mental”, functioning improves. It has to do not only with the management of the alcoholic, for instance, but with all the adverse practices in society that set up the particular combination of psychic noci-vectors that precipitate alcoholism.

The salutiferous society has affinity with the preventive movement in the physical field that has made such a significant contribution to the improvement in the standard of physical health. It is more useful to talk of the promotion of health, than the prevention of ill-health. It is easier to persuade a person to win a race than persuade him not to lose it. Hence, health promotion and the term “salutiferous”. The salutiferous society could be said to embrace both psychic and physical health; here it will be employed as it relates to the former. Indeed the two are indivisible, as change for the better in one encourages an improvement in the other. In preventive organic medicine there has been a systematic analysis of those elements in life which are antagonistic to physical health. The tubercle bacillus was isolated, it was shown to have a bovine form, the bovine form was transferred by the milk of affected cows to children and hence bovine tuberculosis that was responsible for such deformities in children in the past. The understanding of this process led to large-scale preventive procedures largely by promoting the health of cows. (As in physical medicine, so in psychic medicine, the understanding of pathology is the key to health promotion.) It will be noticed that curative and health-promoting medicine go hand in hand. Clinical work led ultimately to the isolation of the tubercle bacillus; preventive measures then took over. Curative medicine is both a palliative and a research endeavour. Similarly, there is no contradiction between curative and preventive psychic medicine. They complement each other. Psychic medicine has its palliative and research functions and leads to large-scale health promotion efforts.

Satisfaction of material needs to a large degree, together with the recognition of emotional phenomena, makes it now within our grasp to enter this new phase of social action. A perceptible improvement may be all that can be achieved by community action in one generation, but this will have a cumulative effect over the generations. Individuals are most susceptible to emotional influences in their early, formative years, and special attention should be paid to this fact when planning community measures. Thus the psychiatric service for children has a duty to make its findings on the emotional life of the child known to those agencies able to effect improvements in community living.

To conclude, the concept of the salutiferous (health-promoting) community is based on the idea that the whole emotional stratum of society should promote healthy emotional living. Thus, following an examination of the field of forces, a re-patterning of the forces takes place, which will encourage optimum conditions for emotional health. The programme calls for an examination of every aspect of social functioning, its standards, roles, institutions, organisation and aims. Every one of its multitudinous facets should be examined to assess its value in promoting emotional health. Those which are conducive to health should be retained; those that are antagonistic to health should be changed. The concentration is not on a sick person, the patient, but on the emotional self-improvement of the whole society. Over the generations, increasing self-improvement will result in a salutiferous society that supplies optimum conditions for emotional health in itself and its elements – culture, community, neighbourhood, family and individual.

Towards a Salutiferous Society

It is outside the scope of a book devoted to principles, to explore every avenue of social functioning. Thousands of instances from hundreds of areas would be necessary to approach a complete account. A few areas, and a few elements within them, will be taken for the purposes of illustration.

Values

Much harm comes to people from a common tendency in society to be critical of others to the point that they feel worthless, culpable and guilty. Some social institutions, for instance some religious movements, mistakenly regard this as a pathway to salvation. Underlying this widespread failing is a feeling of inferiority – others are blamed, cut down to size, so that the critics can feel superior. The widespread employment of this mechanism leads to immense unhappiness. Its removal would be a positive step towards happiness. It is clearly insufficient to expect that awareness alone will alter this practice. But it is a first step. The underlying inferiority also needs management.

Again, force and coercion, despite centuries of historical lessons pointing to the value of the reverse, are employed as instruments of social policy on an international, national and local level. “Force from force will ever flow”, in the words of Shelley, is a truth. Force evokes insecurity, inferiority, bitterness, hostility and a determination to react, if possible, with greater severity. Even if there appears no alternative to force, an avowal to use as little as is necessary to accomplish the task would be a valuable contribution. Just as force is a step backwards in interview psychotherapy, so it is in social action.

Competition has the virtue of encouraging creativity, effort and achievement. But it must be balanced by the right motives and be aimed at the common good. There is an optimum degree of competition which, if exceeded, becomes destructive to others and the individual, family or community. In education, children are frequently encouraged to be in severe academic competition with one another. Some obtain an excessive idea of their prowess. Some lose hope forever. At the same time an attitude of selfishness is inculcated which makes for sharp antagonism to others in many walks of life at a later date and fosters a disinclination to co-operate. An excess of the competitive spirit is destructive.

Legislation

Laws are ultimately created by the regulators of society, leaders, or by public opinion, to put into practice what is thought to be right for the common good. But some of the precepts on which legislation is based are themselves harmful. Whether or not the examples given below are correct is immaterial. The lesson to be drawn from them is that legislation should be evaluated for its emotional effects on society.

Divorce is sometimes regarded as an attack on the family and thus it is made difficult. It is thought that excessive divorce could kill the family. Yet a high divorce rate does not mean fewer families. Men and women are strongly attracted to each other and, following divorce, often come together in new unions. Should these new unions be satisfactory, they will not terminate, but will produce well-adjusted epitomes who will

go forth and found stable succeeding families. We should endeavour to steer the divorced partners towards healthier unions. Again, it is supposed that highly incompatible partners should stay together "for the sake of the children". But this practice is an attack on the family. It must create such a climate of disharmony that it produces disturbed children, who will in time found unstable succeeding families with a tendency to break up.

There has been much discussion in recent years on the advantages or otherwise of extending the control of childbirth into the first three months of pregnancy by allowing termination of pregnancy on the request of the mother. Some of the discussion (2) has turned around the philosophical issue of when the foetus can be regarded as a human entity; religious and legal bodies can hold vividly differing viewpoints, from the opinion that conception is the moment when life starts, to the opinion than an intrauterine age of 36 weeks indicates viability and independent existence. Even the Roman Catholic Church, in its long history, has found this decision of great complexity and, in the mid-19th century, changed its definition to its present attitude. But to the woman such discussions are irrelevant. To her the moment of psychological acceptance that she has a child is the crucial moment. Some develop an image based on willing acceptance at conception, to most it comes with "quickening" at about the 16th week, to others at birth – and for some acceptance is never achieved. The latter do not wish to nourish and produce an unwanted entity. Nor is it desirable to society that they should do so. Unwanted children are at risk emotionally. Thus it could be argued that to extend birth control into the first three months of pregnancy is highly desirable in that the mother has a last chance of preventing the birth of an unwanted child. The control of conception is now, but only now, universally regarded as desirable. Indeed the controversy over termination has suddenly underlined the value of birth control. But those who now oppose termination previously opposed the use of the "pill" and, before that, of contraception in general. This faces us with another subject for close study in a salutiferous society: What determines rigidity of attitudes? Those rigid in one direction are invariably so in another.

The subject of divorce leads to a consideration of another aspect of legislation. This is the tendency in law in many countries to give preferential consideration to the mother. The unique value of parenting by mother has been emphasised as an element in the extraordinary doctrine of psychoanalysis. In divorce proceedings in some, but not all, countries custody of the child is invariably given to the mother. Often this is correct. But each situation should be carefully evaluated and, in some circumstances, the child, and hence his succeeding family, would benefit from custody by his more loving father.

Authority

A society requires control and regulation. The regulation should arise as a willing acceptance by people that its laws are apposite and in the public interest. A basis of public support makes law enforcement much easier. Nevertheless, a machinery is necessary for law enforcement and this is usually placed in the hands of the police. The police can be regarded as friends and allies, but all too often they are regarded as a threat and as enemies. Thus there can be hostility between the public and its servants. The attitude of the police in these circumstances is crucial. Unnecessary force and belligerence lead to hostility and rear in return. Guns are met by guns. The greater the public hostility, the more insecure the police and the harsher their actions

in self defence. From this confrontation come insecurity, fear and damage to a large number of people – no less to the police. Yet the right partnership can easily be developed. And it can start in childhood. By incidental help over small matters, children can grow up firmly convinced of the value of the police as friends. This can be enhanced by the police being actively involved in positive welfare programmes.

Societies need a machinery for massive collective action, they need a government. The control of this machine means wielding massive power. The machinery should be so constructed that its power is always at the behest of the people, or delegated to those under the public's control. Those who wish for personal power naturally regard governmental machinery as a ready access to power. The misuse of power can deploy the whole of national organisation into a pattern of stress for its people. Probably no country has yet achieved an ideal prescription for the control of the collective national power.

The control of power can be the subject of early experience. Most children attend an institution, the school, where power has to be exercised. A number of people have rights - parents, head teachers, teachers and pupils. The school is far more than just a platform for the acquisition of knowledge. It is a slice of life. Thus, the way in which power, leadership, group relations, regulation, beliefs and logic are dealt with makes an indelible impression on children. The functioning of our schools and their advantageous or disadvantageous contribution to a salutiferous society is worthy of study.

Organisation

Some methods of organisation lead themselves to personal satisfaction, others to inferiority, disillusionment and the misuse of power. The inflexible use of the pyramidal structure is such a method. Essential in some situations, it is destructive in others. The pyramid consists of workers at the periphery with a hierarchy of power, usually termed "administration", above. This is highly damaging in any situation in which the focal point is at the periphery and where the aim of the organisation is to give maximum service at the periphery. This is especially true of the helping professions. In them, there should be satisfaction in personal communication and the best people should be deployed. However, the best people, whether or not they have administrative gifts, are pulled away from the periphery up the pyramid by higher rewards and a refusal to be supervised by those less adequate than themselves. However, it is possible to create just as effective a system by a horizontal organisation, ie rewards and power going equally to all. Those with administrative flair are encouraged to organise, but with no greater rewards, and no more prestige or status, than their colleagues. The old guild system was very effective. An apprentice, or a trainee, learnt the craft and aimed to be a master craftsman; the journeyman was awaiting a master post or falling short of the necessary skill; the master had equality with all other masters.

Mention has already been made of the deployment of the invaluable, emotionally healthy section of society. Emotionally, the healthy are the salt of the earth. They have an invaluable asset, the capacity to communicate health to others. As a part of the programme of vector therapy, they must be deployed to act as a curative force for the psychonotics. In a salutiferous society, they must be deployed at key points – nurseries, homes, schools, the helping professions; they promote health and thus raise its standard.

Groups of people have an optimum size and structure for the most effective functioning. This applies not only to small groups, but also to estates and townships. It has been shown, for instance, that to create a township of young people leads in time to heavy demands for child care, which must be supplied, and ultimately leads to an aging population that can receive no support from the young.

Practices

People are more important than parents. More important for a child than right care from a parent is right care from somebody. The right care does not necessarily depend on the person supplying it being a “parent”. Yet the assumption that only parents can give the right care denies children help from many ready sources.

Again, some people, due to happy childhood experiences, have great capacity as parents. But some have none, others very little. Yet once designated as parents, persons have heaped on them complete and continuous responsibility for supplying loving care, and utter condemnation for failing in their responsibility if they are unsuccessful. We should be realistic and accept the varying capacities for parenting. Once this is accepted without blame, it becomes possible for parents lacking capacity to share responsibility with others without a feeling of failure or guilt. This in turn would make much easier the task of the helping professions and allow for the fortunate public with great parenting capacity to come helpfully forward without a feeling of competitiveness with the natural parent.

Knowledge is slowly being gained about the factors that control selection of complementary marriage partners. This can lead to a much higher prevalence of happy marriages. Basically, the more balanced people are, the greater the choice. Again, families should have a hand in selection. Happy family members choose those that conform to their families. Thus family selection in the old days was often successful. A formal test should be a deep and lengthy pre-marriage experience. Formal engagement should be replaced by trail marriage.

For a child to love a brother, sister, mother, aunt, nanny, teacher of playmate is acceptable. It is felt that a number of loving relationships are a virtue and an asset. Yet the same child, once grown up and married, must deny close loving to others outside the family circle. This is an artificial constraint, often not accepted in practice, but a widely held delusion. Again, it is supposed that the future of the family is protected by hostility, jealousy and deceit. Once families are secure, they will be able to add to their own strength and security by a pattern of loving, interlocking relationships.

Teaching

Teaching conveys facts; it does not change attitudes. Many essential functions in life are easily carried out; but there may still be a failure to do this because of underlying emotional attitudes. Mental defectives can manage intercourse; a university professor, because of attitudes that inhibit him, may be unable to do so. Educating him about the procedures of intercourse, giving him data he probably already possesses, does not overcome his emotional block. Thus there is a limit to what can be achieved by education in health matters. But where there is ignorance, education can overcome it, and it can extend the range of those people already adjusted enough to be able to make use of further data. Education is most effective with well-adjusted people, those who are already the best performers. It is less effective with the emotionally ill, those in most need of assistance.

To convey right information is a small but valuable part of a salutiferous society; many countries devise schemes for teaching mental hygiene. Slowly, knowledge is garnered about some of the nodal points in the life experience of a family – birth, sexual practices, preparation for marriage, childbirth, preparation for death, bereavement. But, notoriously, experts can be wrong. There is no greater fool than an expert fool. Because of emotional biases extraordinary errors can be made – for example, preoccupation with the breast feeding experience, instead of the infant's whole waking experience; an almost total absence of interest in fathering; unchecked hypotheses about the child's sexual life; separation being accepted as synonymous with deprivation, and the "natural home is better than any other home" philosophy; the mother-child relationship overvalued and the father-child relationship undervalued. False propaganda does harm. Much of the propaganda handed out during "mental health days" is ill-conceived. Little attention is paid to the meanings conveyed to the public. For example, the impression is often given that the mentally sick are peculiar and extraordinary. While this may attract some monetary help to these unfortunates, it also perpetuates the fear of mental illness. The terms "insanity" and "emotional disorder" are not clearly differentiated or understood by the public. Furthermore, the confusion causes the emotionally ill to be reluctant to seek help lest they be classed with such peculiar and extraordinary patients. Sometimes the emotional needs of the propagandists militate against a healthy approach.

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