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Interactional Diagnosis and Treatment Process

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Today is a big celebration and I think MRI deserves it because it changed the life of many patients and therapists. For this occasion, I wanted to present a first draft of a very big project my team and myself are working on, in collaboration with Giorgio Nardone's team in Arezzo, Italy. And this project has become possible thanks to all the research and experience accumulated for 50 years by people influenced by Bateson's and MRI's seminal work.

As the title indicates, it is a very ambitious project : nothing less than proposing an alternative to DSM, an interactional alternative. We refer to it as the « interactional diagnosis » but it is more than that because it includes specific indications for treatment for each category of problems and disorders. So, in fact it is a circular, self-corrective process, as I will explain later.

So, I know that the title of my presentation today seems ambitious, even presumptuous, but my intention is just to collect the fruits of 50 years of therapeutical experience since the introduction of cybernetics and system theory in our field and, second, you can understand that after the success of the approach in the social field in Belgium, I have no doubt about the success it will finally get in the clinical field which is the one in which it developped at the beginning.

Some preliminary remarks

The assimilation of psychological disorders to « organic deseases» has had very damaging consequences (that I can't present today) but, in any case, it slowed

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down the research of more adapted means to stop the psychological and interactional mechanisms that create psychological suffering.

I am perfectly aware of all the criticisms this initiative will raise. The first will probably be that technique is not the most important factor in the therapy process. That therapeutic relationship or alliance is essential. And it is true. That we have to take into account patients qualities and resources, expectations, motivation and resistance, and so on… And that the therapist's attitude toward the patient will set the context for the process of change (or the healing process). I agree, of course, with all that, and we must be careful, when training psychotherapists, to correct the tendancy of some therapists to use techniques « in spite of the patient ». But still, I think that it is important to propose an alternative to DSM, even if it will be necessary to advertise that it must be used with caution and that every therapist will have to learn how to use it effectively.

Maybe that, in the end, we will stay with some rebellious cases, maybe that for them, we will need another type of explanation, another type of treatment, maybe that for some cases we will have to incriminate the genes or the chemistry. But let's try the communicational way first and see what it has to offer.

The guidelines

This project is possible because we stand on the shoulders of giants, many of them coming from the « so-called Palo Alto School », in Europe :

— Gregory Bateson's theoretical work and the accent he put on the importance of a clear and explicit epistemology. This has provided us with a solid scientific ground thanks to which we are able to develop our whole approach in a coherent way, from epistemology to field techniques;

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— MRI's Brief Therapy model has given us the cornerstone of the « construction of a problem » with the concept of **Attempted Solutions**, So, thanks to Paul Watzlawick, John Wealand and Dick Fisch, Jules, Art,…

— Milton Erickson has provided us with creative ways of solving problems, has insisted on the importance of new experiences in the changing process and has developped the art of doing psychotherapy using an appropriate language of change.

— Many great family and /or strategic therapists have brought us a lot of therapeutic experience that has enriched our communicational approach. Don Jackson, Steve De Shazer, Jay Haley and all these great therapists present here for this celebration ; each of them has given many precious insights for the therapy process.

— More lately, Giorgio Nardone has « unfolded » the concept of attempted solutions and has shown the importance of the spontaneous unappropriate reactions to the problem ; notably, emotional responses or interfering thoughts. He also could show that the model revisited can be efficient to solve most of the usual « psychiatric cases » : phobias, panic attacks, obsessive-compulsive disorders, eating disorders, sexual desorders, depressions, and even presumed psychosis. He has collected thousands of completed treatments that he evaluated with great results (usually around 80 to 90 % of successful cases). And last but not least he has began to formalize the therapeutic interview by way of his « strategic dialog ».
This project owes a lot to Giorgio.

An « interface » between psychiatry and interactional approach

3 years ago, we celebrated another 50th anniversary, a rather strange one because it was the anniversary of the publication of an article written by G. Bateson and his team : *« Towards a theory of schizophrenia »,* first published in

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1956. We did that in La Sorbonne, the famous French university. For this occasion, I remembered talking with Mary Catherine Bateson and she asked me : « Why is this new way of looking at human behavior still so marginal ? How come it didn't make its way into the psychiatric field and even into the political field because it seems that this approach opens to new solutions for old problems and that it could alleviate a lot of suffering in this world. »
I don't have the final answer to this question but I think that the fact that this approach stands upon a new epistemology is probably a good part of the explanation. When Bateson was working with Jurgen Ruesch, he noticed that when it comes to thought premisses, people feel uncomfortable, they feel it is intrusive. So when you have to explain the interactional point of view, people get bored very fast and they stop listening to what you have to say. A sort of : « OK, get to the point, I have important things to do, I have patients suffering and I want to know how to help them. »
We could answer: « Look, we don't classify people, we don't need to put labels on patients. Every patient is different, just look at his attempted solutions and you will know how to treat him! We don't look for explanations, we look at the way the patient is dealing with his problem. »
But, you know, this position raises suspicion. Traditionnaly, science tries to give answers to the « why ? » question. So saying that we weren't interested in explanations seemed a little bit « light », not serious, not reliable. I think that this is not true, that we explain things but along different lines, according to a different epistemolgy as I will explain later.
Finally they said : « OK. So you cannot tell me how to treat a schizophrenic ? or « obsessive-compulsive disorder » ? And the general answer : « We first have to look at the interactions, see how the family functions, and so on… » well these answers were quickly disqualified.

At the same time, I had the impression that our reluctance to explain, to generalize (science is about the general, not the particular !), was detrimental not

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only to our therapeutic approach but also to ourselves, to the therapists. It was difficult to gain knowledge about some kinds of problems. I remember that I used to be uneasy with obsessive-compulsive disorders. I had difficulties to understand how their problem functioned and to really perceive their attempted solutions. So, I was intimidated as Dick and Karin would say, and so I wasn't very efficient with those cases.

Then I read Giorgio Nardone's book « Fear, Panic and Phobias ». In this book, Giorgio gives another explanation of the problem, an explanation based on the attempted solutions, of course, but also taking into account the emotional aspect of the attempted solutions and also more « cognitive » components interfering with the problem (by cognitive, I mean the interaction between me and myself, like when we say : « I am trying to get asleep, I am trying not to be scared, I am trying to urge myself to do my work, and so on »).
And I remembered that this helped me a lot. Not really thanks to the protocols of treatment he recommended but above all with the cybernetic explanation of the dysfunctional interactional mechanisms that were redundant in this kind of troubles.

At first, I was reluctant to get back to « pathological labels » for patients. I was very cautious to keep our non normative and non pathological stand point. But I realized that this wasn't contradictory as I hope to show to you later. For me, the question is : « can we help people who are labeled by psychiatry ? Can we alleviate their suffering ? » If it is the case — and therapeutic experience shows that it is ! — then we have to say it and show how.

So, as I was trying to fill the bridge between the two worlds : psychiatry on one side, and Brief Therapy and even systemic therapy in general on the other, I was thinking that it could be interesting to find a kind of **interface** between them. What I am trying to tell you is that I think that symptoms can be this interface ! Nobody denies that some redundant patterns of behavior usually

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generate suffering : obsessive thinking, constraining compulsive behaviors or rituals, binge eating, depression feelings, hallucinations, profound anxiety, and so on… So, up to that point, everybody agrees. Nobody denies the symptoms, the difference lies in the way of interpreting them and, as a consequence, of treating them. But, it is interesting to notice that many patients use very similar ways to react to the same type of problems. And I think that the time has come to list and classify them and expose to everybody how we can treat these dysfunctional patterns, what kind of manoeuvers can unblock their problems.

The epistemological premisses

Bateson said that information is a better explanatory principle than energy when it refers to living organisms. That, fundamentally, the way of describing living phenomena and all the questions concerning mind must be taken from the information side, that the physicians' way of treating mind issues and problems is epistemologically wrong. Bateson has shown us that « communication » is the social matrix of psychiatry and I would add of psychology in general. I think that, in the end, it will appear that medication is a very poor way of treating psychological problems of any kind.

To use a computer metaphor, it is a difference of logical levels, as the difference between hardware and software. For most physicians, mind problems can be explained by chemical or genetic defects. In my opinion, this is the same as if someone doesn't like the TV program he is watching and, to solve his problem, he blackens the image and lowers the sound. This will help in a way but won't change the program ! I am not saying that there is never hardware problems which can generate psychic problems or relational problems : we know « the needle and the damage done », for example. But what Bateson taught us is that mind's matters must be approached first from different premisses.

So, I think that we can and must have a scientific approach of the diagnosis issue. The problem is the same for all the therapists : we need a very careful and

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precise comprehension of the problem in order to do the best possible treatment. But Bateson showed us that when we are working with living creatures, we need other scientific premisses than the traditional ones.
— It must be **« information-based » (vs « energy-based »).** Bateson has showed how important this difference is for the description and the understanding of the living phenomena.
— **Information is an interactional concept** which connects the outside and the inside : « a difference that makes a difference ». As he said, the unit that we must take into account is « the individual + the environment ».
So, for example, when we describe a problem, we have to define what - in the environment - triggers the « dysfunctional pattern of response ».
— **The organisation of information is structured in logical levels**, like the levels of learning. We know that « relational logic » can be different from the logic of reinforcement : rewards and punishments. (big argument with Skinner) So that classes of contexts can trigger classes of responses. For example, a lack of self-confidence can be acquired and reinforced in different contexts : a work meeting, an encounter with new people, an exam situation, and so on.
— **Causality is circular :** a reaction can be good or bad according to the effect it produces. And not in itself ! And it is the individual appreciation which makes the difference.
And so on.
I also think that all the research that has been made since the double bind theory, be it in systemic therapy, ericksonian hypnosis, brief and strategic therapy, solution-oriented therapy, and all the derived approaches leaning on human communication of therapy will eventually intermingle and form a vast corpus of knowledge that will bring new solutions to mind's problems (in the sense Bateson gave to that concept of « mind »). And because I think that MRI's brief therapy model, thanks to its seminal concept of « attempted solutions » give a precise direction to therapeutic treatment and change.

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So I hope that, in the end, all of these different systemic and strategic schoools will be integrated into a very documented and very efficient **« communication Therapy »** that will include internal communication and communication with the environment and all the global communication net that we are part of.

Characteristics of this new type of « diagnosis » (draft !)

Before all, it will be a tool designed to help all « communication therapists » to help their patients.

— The Interactional Diagnosis is an operative description of a **dysfunctional interactional process**. We are not trying to define a « state » (the state of an individual) but the process of a dysfunctional interaction between the individual and his or her environment. This includes all the attempts to solve the problem coming from the indivual himself and the other persons who are also interfering in the regulation process. We describe what patients are experiencing, what they feel, what they think when confronted to the problem. We want to untie the relational, comunicationnal knots that prevent the problem's resolution.

— **Symptoms are seen as the consequences of attempted solutions**, that is, of inappropriate reactions to certain life difficulties. For example, to avoid feeling fear, I have to be careful all the time to notice the first signs of danger. So, I am always on the alert. As I think I am incapable of dealing with frightful situations, my fear intensifies. And I come to therapy with symptoms of panic attacks or phobia, for example.

— **Problems and disorders must be described in an operative way**, i e concrete, actual and interactional. The patient must be put in the center of action : it is what he does, or does not, that « causes » the problem (We don't care much about why he does it or not from the view point of an historical explanation). For example : *« when you deprive your body of food, you feel very hungry.The struggle not to eat becomes more and more invading. So you are trying to stern your need for food. But, when appears a little difficulty, a little*

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stress or frustration, you are overwhelmed and you binge to fill you up. So, the fast prepares the binging ! »

Or, *« more you try to avoid fear, more you have to be careful, you have to anticipate the least signs of danger,… and you create the fear of the fear : a fear without object and pervasive. »*

— **The diagnosis process must include operative indications for treatment**. In fact, for us, it is the solution which confirms (or not !) the diagnosis. The process must be circular and include regulation loops. (see the slide)

It is important that a diagnosis be not a way of masking professional ignorance. Because it is detrimental to patients. It is dangerous to say : *« this patient has got something but we don't know what exactly and we don't have a cure. For that reason, it must be serious ! »*

— ***Protocols, prescriptions and reframings.*** Therapeutic interventions must take into account the different aspects of attempted solutions : behavior of course, but also reflexive mechanisms that can increase the problems. And a lot of problems can come from the will to change them. I don't have the time to explain that in details but you all know the dangers of « conscious purposes »:

— wanting to control the future ;

— wanting to not feel an emotion ;

— Wanting to control the other ;

— wanting to hide completely an imperfection, a defect ;

— wanting to wipe out a memory that bothers us ;

— regretting not to be someone else ;

— denigrate oneself ;

— fight against a desire to eliminate it.

— and so on…

We also have to pay attention to the emotional aspects based on the main sensations (pleasure, pain, fear and anger). For example, if a man is jealous and becomes totally paranoïac, trying to control his wife's behavior all the time, it is

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clear that he must stop controlling her if he wants to save his couple but he won't be able to stop doing it because he is too anxious, so we have to take care of this *collateral damage* if we want to help him to stop controlling.
Protocols are just indications, a particular concretisation of the main strategic movement, direction. There are not the most important. We will also suggest the main reframings to change patient's perception of the situation and use family therapy techniques to change the relationships patterns (like in schizophrenia or anorexia cases, for example).
The issue is not to impose the one and only treatment possible but to show that we can pinpoint dysfunctional patterns and that we can propose classes of reframings and prescriptions that can block (or unblock) these patterns.
And we know that sometimes a little change can have big consequences :
— stop complaining ;
— stop imagining the future ;
— stop talking about our problems…

Interactional Diagnosis and Treatment Process

So, for each big category of troubles and disorders, we will propose the following steps:
1. **Identification of the symptoms and complaint**. Usually this is not the most difficult part : the patient gives us these informations when asked.
2. F**rom complaint and symptoms to the problem**, **from problem to attempted solutions** (and inappropriate reactions to the problem : thoughts, emotions), **from attempted solutions to corrrective messages**.
To transform complaint and symptoms into : the « problem that generates them » , is in fact transforming a vague or abstract complaint into an operational problem accessible to a solution. According to brief therapy criteria : the problem is defined from the patient's point of view, it must be described in concrete, actual (present) and interactional terms.

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[« When you are confronted to …, you react generally like this… and this doesn't help ! »]

This tranformation work is essential and the **strategic interview** must also be formalized — but I can't get into this today.

This strategic interview must lead to the description of the **dysfunctional pattern** of interaction between the patient and his or her environment.

3. Interactional mapping of the problem (multiple description of the problem):

What parts of the system (of the « mind », as Bateson could have say !) are trying to solve it ? We are interested in the way people regulate their relationship to their environment, so we have to take into account all the regulation loops !

In a way, it is the problem which determines the pertinent system to take into account. « Who is trying to solve the problem ? And how ?»

4. Evaluation of the « situation's potential » (The different levers that can be used to implement the strategic plan)

— list of the different actors

— how much does the problem bother each one ?

— How far are they wanting to take responsability for changing things,

— what do they do to try to solve the problem ?

— what is their position ?

— what is their goal ?

— degree of resistance

5. Elaborating the strategy for solving the problem

— what is needed to stop the attenpted solutions of every actor, from every point of view ?

— with whom to work ?

— what prescriptions may stop the attempted solutions ? (And this for every type of problems based on the « differential interactional diagnosis » — like Dr House !)

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— what kind of reframings can help them to let go their attempted solutions ?

6. Evaluation and regulation of the strategic plan (evolutive diagnosis : diagnosis must always be refined and completed according to the evolution of treatment).

— if symptoms decrease ---) go on with the prescriptions adapting them to the evolutions of the problem

— some symptoms decrease but other don't or other appear ----) new evaluation of the problem (or one aspect of the problem) ---) new prescriptions.

7. Consolidation step

New prescriptions, more adapted to normal life, in order to make the new learnings more permanent. People must get new habits that fit their new way of dealing with the problem and, sometimes, their life in general. Most of the time, people have the necessary ressources to go on with their lifes after the problem has been solved. Except maybe, some persons who had a very poor educational environment ; in this case, you must provide them with new possibilities of learning, of experiencing, … (Ex : children raised by junkies)

8. End of treatment.

The treatment ends when people are satisfied with their achievements.

Notice that in this case, **it is the solution that validates the diagnosis** !

(Labels « psycho-degradable »)

Illustration: a depressed young woman of 22 years old

To illustrate the process, let's take the case of a young woman, 22 years old. She is beautiful, dark hair and blue eyes, thin, brilliant, as her parents and older brother are too. Childhood and adolescence without any problem. She has had some boy-friends, lasting relationships — although she is young. And then she had to choose a career. She doesn't really know what to study, but, as she is successful in everything, she doesn't bother much : her parents are physicians, her older brother too… so she decides to do the same.

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After a few months, when she has to really study, she discovers that she is not very motivated and that to study physics and chimestry is diffcult for her. But she will be able to get over this small problem. And she stries harder. But she is not focused, she is distracted, and she tries to force herself. She becomes more and more stressed and the process of doubt begins. She looses her good sleep and, step by step, she becomes more and more exhausted. She doesn't sleep at all. Her parents are anxious about her : they try to encourage her : « You can do it, take it more easy, just relax. She takes sleeping pills that don't help. She has to take a break. But as soon as she gets better, she tries again, with great suffering but she does it in the end and she pass the first year with a very good grade. Everybody is relieved and happy and say : « you see, you don't have to worry, it was the first year, now the rest is piece of cake ! » Even she thinks so ! The problem comes back as soon as the second year begins. She realises that she will have to go through all this sufering for 6 more years ! And that she doesn't like medical studies at all. So, she begins to think : « OK, I don't like that but what do I like ? » As she is not feeling good, she is anxious, she has lost a lot of self confidence and she thinks : « I have to find what I like » . Of course, she doesn't find anything, so she tries harder, and think and think and think again to find an answer to his absence of motivation. Everybody is trying to help to find an answer : « what about Law studies ? Social work ? Litterature ? psychology ? and so on… »

She is more and more anxious and, in a few weeks, she doesn't sleep again. She goes to see psychologists and psychiatrists. She takes pills but that doesn' help. She wants to sleep and asks to go to an hospital to have a sleeping cure. It doesn't help neither because, after that, she still doesn't know what to do. Doctors think that she must be hospitalized because she is talking about committing suicide. So they send her to an hospital where she meets drug addicts, alcoholics, delirious people and a lot of very other strange people. The psychiatrist told the parents : *« Your daughter is not coherent. She complaints*

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that she is a failure, she is worthless, but as soon as she does something interesting, she says that it is pointless, stupid. There must be some pathology behind this picture ! » Well, I don't know, let's call it depression for example… She looses still more self-confidence seeing that she is now part of this kind of population. She is desperate and think that she will never be well again.
That is when she comes to see me.

Application :

So, let's apply the interactional diagnostic process.

1. Complaint and symptoms :

— The patient : — « I am a failure » , « life is awful », « I don't deserve to live », « I am anxious and have great difficulties to sleep », « it will always be like that, I am finished », … « I don't go out », « I feel very bad », « I a thinking in stopping that suffering if I don't find a solution », « people look at me differently now, eerybody can see how stupid and strange I am », « I am so weak that I envy everybody else : everybody is better thatn I am and I am and attemted solutionsmean… », « I am sick, I am lost », « I will never be the one I used to be, something is broken ! »

2. What is her problem and attempted solutions ? « I have to know what to do with my life but I feel so weak that I am affraid I am incapable of doing anything good »,-----) « I search for passed explanations to discover why this happened to me», « I ask for help but never get solutions,… So, I search for solutions, I look around me to find clues and I am always desappointed or envious » (hence the different symptoms !)

3. Interactional mapping of the problem :

— Parents :

* mother : very scared, stays home to watch her. Talks a lot with her : tries to reassure her daughter, tries to give her clues for the future, …

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* father and mother-in-law : very scared also, talks about hopitalisation or tries to stimulate her. Propose new ideas for the future.

With these symptoms, you will then look into the « New Interactional Diagnosis Manual » and go to the « Depression » chapter. You will find different sections:

1. - « radical depression » : people say that they have always been depressed (not the good category) ;
2. - « illuded - deluded » by others (this one neither !)
3. - the « moralist », victime of the world — the world is bad ! (not the good one neither)
4. « illuded - deluded » by him or herself.

This sounds to be the good category.

Inside this category, you will find :

— a description of the usual characteristics of this type of problem :

« he or she (in this case) is victime of herself, she used to think she was capable but a particular event has brought the « proof » of her incompetence and since, she thinks that she is really no longer what she used to be.

How does she globally react ? She renounces by giving up.

She usually complaints a lot to everbody. She has a lot of self denigrating thoughts. She thinks a lot about what to do but without believing that she can change. [These characteristics fit the description of our case]

Solution directions:

— 1st step : « stop complaining » (----) prescription : to her : « Stop talking about your problem (except maybe 1 hour a day) ». To parents: « You listen to what she says but without answering » (conjuration of silence)

— 2nd step : « What would you do if you wanted to deliberately worsen the situation ? » (To make her find out that her obsessive thinking is not only pointless but damaging)

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— Later : Worst fantasy (to treat her fears by confronting them : « what if she doesn't find her way this year ? What is the worst that could happen ?» ;
— then the « as if » prescription (little things to do during the day in order to have a better day ; this is meant to orient her towards action instead of thinking, …

Examples of reframings and metaphors :
— « Achilles tendon » (she is not invincible and she has discovered a weakness, so she has to think about how to take care of herself),
—« therapy must bring immunitarian reaction more adapted (you reacted too much because you never had to face problems before, so you have to develop more adapted immunitarian reactions to difficulties. And so on…

Well, I must say that this is exactly what I did with her. I just saw her yesterday (that is about 4 months after our first meeting) and she is doing very well. She has a new boy friend and she decided, with the agreement of her parents, to take a year off school to do some experiences while working to support herself. She knows now that she will have to find her own way, different from the rest of her family, but she is confident because she now can feel her own resources again.

[Of course, you can see the family together or separatly, you can use metaphors or more explicative language, you can use tehniques coming fro hypnosis, you can do it your way, as long as you reach your final goal : stop the attempted solutions patterns.]

And thanks to Giorgio Nardone, we have identified many patterns like that for a lot of different problems, enough to cover almost every category of DSM IV, enough to propose an alternative to the classification of DSM.

Conclusions

Of course this presentation focused only on « what to do ? » and I left aside « how to do it? ». And for this also we will need a lot of experience from many

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different people and approaches. I think that it is always important for the therapist no to be too much of an « activist ». Conscious purpose is probably the best way to fail in therapy. But I think that, paradoxally maybe, when someone is capable of defending himself, he doesn't need to attack. When we know the general direction of the intervention, when we have different concrete techniques at our disposal, when we have really well understood our patients' problems, then we can really be in contact with them and build a good and secure therapeutic relationship.
I think that we must declare our difference : our work is based on different premisses that are, acccording to us, more appropriate to our field of research and intervention, the human mind. We understand better how communication determines human behavior, how people are litteraly constructed through communication and relations. We are now capable of pinpointing regulation loops that can cause suffering and prevent adaptation to the environment, the traps in which our patients — and everybody else ! - can fall in, because they are recurrent and prevent people to stay in contact with their changing context. And we begin also to be able to use communication techniques or communication contexts that can correct these problems.

With this new type of diagnosis, we hope to stimulate the interest of a big number of professionnals. We want to send them a message : « if you are not pleased with the medical and pharmaceutical approach of mental disorders, if you are tired of drugs prescriptions and psychiatric confinement, if you want to know how to think globally and act locally to help people out, we have better than leads, we have specific methods to understand the problems, along other lines, and also a set of operational means and techniques that can help solving them. We don't have all the answers, and this will be a continuing process to be more and more efficient for our patients, but we can probably do a good job for a lot of « so-called difficult cases ».»

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The ambition of the project is not a personal one. A lot of people are suffering and don't have any other horizon than psychiatric wards. As Bateson said, there must not be competition in ignorance. If this project help bringing some relief, I think it is worth it, and I hope it will open the door to new research projects that will benefit to our patients.

Thank you very much.

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