RELATIONAL DIAGNOSIS: AN ESSAY REVIEW

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I filed an insurance claim recently using a family/conjoint therapy code. In response came a “Provider Request for Information” with the handwritten note: “When billing for family or conjoint therapy please include the names of each family member, their diagnosis, the length of session, and the total charges for all individuals in the session.” I answered stating that the charge is for the session regardless of how many are present, so I billed only one person.

Therapy is not harder with several people in the room, it’s just different. Since you can’t x-ray a family or listen to it with a stethoscope, “managed care” is slow to catch on. Must we complete several forms, one for each person in the room, dividing the charge into fractions so as not to name an index patient? I decided not to use family codes if everyone needs a diagnosis. Is this unethical? Unscientific? Healthy adaptation to bureaucracy? I give families/couples some choices in dealing with this.

Managed care hasn’t figured out the difference between families and groups. In groups, too, there is occasion for relational diagnosis in the here-and-now. But families are collective entities before we con-
vene them. And most family groupings are intergenerational. Relational diagnosis looks for patterns that have gone on for a long time, as well as rare traumatic events.

Families let us observe them because they are in pain, in need of help, and—if we are to succeed—because they accept our way of engaging them. Diagnosis goes both ways. It helps us help them if they approve of what we do. The way family therapists judge and are judged is central to the process of learning and healing.

There is little if any unconditional love in the real world, and I cannot imagine a relationship completely free of judgment. Infants and mothers, teachers and students, healers and patients, friends—all form judgments in relationships. All learning, all feeling, partakes of judging.

As therapists we want to be loving, fair, constructive, and unprejudiced. With one possible exception this book helps us judge relationships therapeutically, ethically, scientifically. It is like the first model of a ship. Exploring it is exciting, illuminating. Is it seaworthy?

David Reiss offers an excellent foreword which is squeezed into very small type (the largest type is saved for the index)—why? Reiss groups the approaches into disorders of relationships, relationship problems associated with the individual disorders, disorders that require relational data to be fully described, and individual disorders where the course is greatly affected by relationship. He comments on the limits of DSM-IV, as do many of the authors. And he addresses the four chapters which question the wisdom of diagnostic classification at all.

Florence Kaslow's courage about this is admirable. It's risky to put skeptics and believers side by side in the front pews. It's exemplary: Family therapists have to be constructive risk-takers.

The overview chapters are solid, generally conservative: ethical and reimbursement issues, reconciling individual and relational diagnosis. Then come chapters on models. David Olson's on his circumplex model is splendid, a rich, concise, creatively diagrammed presentation of a well-tested approach. I started the chapter on Structural Analysis of Social Behavior (SASB) with enthusiasm: Paul Florsheim, William Henry, and Lorna Benjamin present an impressive scheme based on her work of two decades on attachment disorders. It's a ship fitted out with all the equipment we have, but it has yet to move out of the bay of theory into the sea of relationships to prove itself.

Having struggled with two big models we are jolted by the iconoclasm of Kenneth Gergen, Lynn Hoffman, and Harlene Anderson in a