Beginnings of a "HIPs and PIPs" Approach to Psychiatric Assessment[1]

Karl Tomm, M.D.
Family Therapy Program
The University of Calgary

In the spring of 1988, the Family Therapy Program at The University of Calgary was faced with external administrative pressures to use the DSM-III diagnostic framework in assessing the children and adolescents with emotional and behavioral problems who were to be seen in the program. It was suggested that the program use a DSM diagnosis as an intake criterion for the child's family to be accepted for treatment. As Director of the program, I opposed an imposition of the DSM framework for a number of reasons. My reservations about the DSM were outlined in the first issue of this newsletter. Central among these was a concern about the potential pathologizing effects of psychiatric "labeling" on children and adolescents. The social stigma associated with a psychiatric diagnosis adds a significant burden to the person so labeled and makes recovery more difficult. The labeling effects may be subtle but they tend to become increasingly pervasive and malignant as growing acceptance of the psychiatric label spreads through the professional and social networks of the child, and eventually becomes internalized as part of the child's identity. I was not willing to accept a diagnostic means that contradicted the therapeutic ends of the program.

At the same time, however, I felt that one of the concerns behind the request to use DSM diagnoses should be taken seriously. This concern resolved around the need to make socially responsible judgements about which families could be offered the therapeutic services that were supported with public funds. The administrative argument was that if there was a diagnosable mental disorder in a family member, then the use of publicly funded treatment resources was justified. My position was that a more therapeutic means to determine eligibility for public services could be developed by drawing upon the systemic understanding of mental problems that was emerging in the field of family therapy. Even though such a process could take years, I offered to embark upon developing such an alternative and am grateful that the administrators involved accepted my proposal. The result was to initiate a project in collaboration with the therapists and trainees in the Family Therapy Program to develop the "HIPs and PIPs" approach to psychiatric assessment.

The primary assumption on which this project is based, is that the patterns of human interaction in which persons are embedded have a major influence on their experiences and on their mental health. Some interpersonal patterns have "pathologizing" effects on the persons involved while other patterns have "healing" or "wellness" effects. The specific effect depends on the nature of the behaviors enacted in the interaction and the meanings attributed to those behaviors by the persons involved in the pattern. Once an interaction pattern becomes established, other individuals are more easily "recruited" into participating in it, and thus, they add to its effects. In other words, the mental health effects of a particular pattern may not just be recurrent and repetitive; they could be cumulative, and occasionally even become exponential.

---

[1]Originally published in ***The Calgary Participator***, pp. 21-24, Spring 1991.

An example of a basic Pathologizing Interpersonal Pattern (PIP) between two persons is "criticism inviting defensiveness, and defensiveness inviting further criticism, etc." As each person re-enacts their respective criticism and defensiveness, their behaviors become coupled in a cyclical or "circular" interaction pattern. Increased criticism triggers increased defensiveness and vice-versa. (See Figure 1) From a systemic perspective, the pattern seems to take on a "life" of its own and appears to "induct" the participants to continue in it. Over time, the pattern may become stabilized as a major component of an ongoing interpersonal relationship. If the relationship is an important one and the pattern persists for an extended period, it tends to promote "psychopathological" responses such as righteous indignation, chronic frustration, hatred, and aggressiveness "in" the criticizing person; and oppositional behavior, rebelliousness, paranoia, avoidance, isolation, and/or depression "in" the defending person. These individual effects then tend to be regarded as reflecting pathology within those persons. Yet, from a systemic perspective, the primary pathology lies in the interpersonal interaction pattern. The individual psychopathology, if it still can be coherently described as "individual," is only secondary. Nevertheless, the effects of the pattern of criticism/defensiveness can become extremely destructive in relation to persons and could even escalate to precipitate violence or suicide. It is because of these problematic effects that the pattern is referred to as "pathologizing".

Figure 1

PIP = criticism defensiveness

HIP = selective noticing of competence increased acts of competence

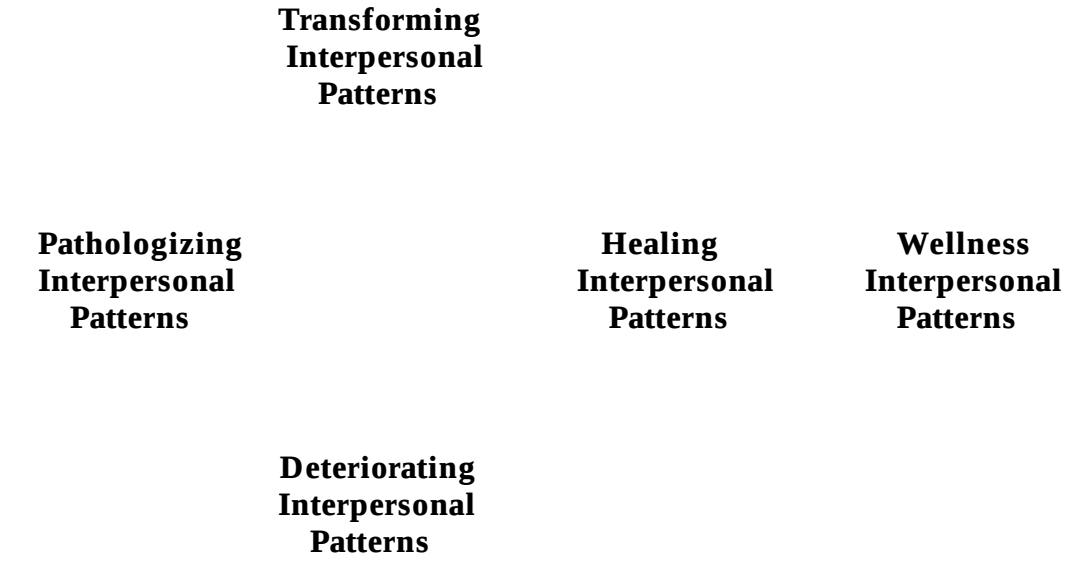
WIP = constructive feedback learning from mistakes

A Healing Interpersonal Pattern (HIP) that could serve as a specific antidote to the above noted PIP might be "selective noticing and acknowledgement of competence which invites more acts of competence, which, in turn, invites more noticing of competence, etc." In this circular pattern, the complementary behaviors clearly have positive effects including greater respect for the other in the first individual and greater self-confidence and appreciation of the other in the second. Most human beings have the potential for enacting this healing pattern simply by virtue of having experienced it in their own growth and development during childhood. Parents often spend hours watching their children for signs of achievement, for instance, in beginning to walk or talk, and heap praise upon the child when it makes progress which, of course, supports the child's efforts to continue to perform competently. This growth or "healing" pattern may, however, be quite difficult to initiate and maintain when the pathologizing pattern is well established and dominates the relationship. Under such circumstance, therapeutic input may be very important in facilitating a shift from the PIP to the HIP.

One of the reasons that a PIP may be difficult to interrupt and replace is that the participants in the pattern may be unaware of the fact that their behavior is actually perpetuating the pattern. Indeed, while one is immersed in a particular pattern, one tends to attend to the possible meanings of the specific behaviors being enacted (whether it is one's own behaviors or those of the other) rather than to the overall interaction pattern itself. Furthermore, many individual responses become habitual and/or are nonconscious. A conversation that invites the participants in a pattern to become aware of and recognize that they are, in fact, immersed in a PIP is often a first step in interrupting it. Additional conversation to identify a healing alternative opens the possibility of consciously and deliberately redirecting the interaction in a healing direction. Such a clarifying conversation would be an example of a Transforming Interpersonal Pattern (TIP) which enables a shift from a PIP to a HIP.

A Wellness Interpersonal Pattern (WIP) that could be associated with the above-noted HIP and PIP might entail "constructive feedback that invites the recognition of mistakes with new learning which invites further constructive feedback and greater learning, etc." In this pattern explicit help is offered, and is accepted as such by the other. Such a pattern often emerges in coaching and teaching situations. The efficiency of problem-solving is usually much greater in such a wellness pattern than in the healing pattern (of selective acknowledgment and growing competence), but to be actualized, the WIP requires more interpersonal trust and personal "strength" on the part of the participants. Thus, it is often necessary to temporarily replace a PIP with a HIP before a further progression to a WIP can be achieved successfully.

Figure 2



PIPs and HIPs generate, and are supported by, different emotions. For instance, anger and fear can become coupled in a pattern of interpersonal "emotioning" to sustain the behavioral pattern of criticism and defensiveness. Likewise love and pride can become

coupled to support a pattern of selective acknowledgement inviting competence and vice versa. When therapists take these emotions into account, they are usually more effective in introducing TIPs and facilitating a shift from PIPs to HIPs. There are, of course, also "slips" that occur from HIPs (or WIPs) back to PIPs. Any unexpected traumatic event may initiate such a regression. Another more subtle type of slip could be a Deteriorating Interpersonal Pattern (DIP) such as "lack of clarification inviting lack of awareness which invites further lack of clarification, etc." until something serious happens to reactivate the criticism and defensiveness. A schematic outline of some of the possible movements among these patterns (within an ongoing relationship) is illustrated in Figure 2.

It is assumed that any long-term relationship (with family members, friends, workmates, or professionals) evolves to include a wide "repertoire" of possible interaction patterns or complementary "couplings". Inevitably, certain patterns become more fully elaborated and deeply established than others. These patterns may be distinguished as PIPs, TIPs, HIPs, WIPs, or DIPs, depending on their effects. Whether a family, for instance, fosters pathology, healing, or wellness among its members, depends on which patterns dominate their daily activities and experiences. Obviously, a predominance of PIPs would be extremely undesirable. However, active participation in a pathologizing pattern is typically outside one's awareness at the time. Hence, its pathologizing effects are usually inadvertent. For instance, the original criticism may have been intended as constructive feedback rather than any form of hostility or aggression. And the original defensiveness may have been intended as self-protection rather than rejection, denial, or disqualification of the other. But when these behaviors become coupled and patterned into an ongoing interpersonal system, this discrepancy between intent and effect tends to be overlooked or misinterpreted. What becomes important in one's lived experience and to one's health is not only which patterns predominate, but also the intensity of the patterns and the flexibility in movement among them.

Because HIPs and PIPs influence the mental health of the persons participating in the patterns so significantly and do so in opposite directions, a focus on these patterns is considered highly relevant to any psychiatric assessment. Thus, as an initial step to develop an alternative to DSM diagnoses, my colleagues and I at the Family Therapy Program began to distinguish specific PIPs that generate or support the common mental problems that were referred to us. To date, approximately 200 differing PIPs have been distinguished. Many of these are similar and appear to overlap with one another but there are also some contrasting differences among them. We are still working on clarifying, classifying, and documenting these and other patterns. As a second step towards responding to the administrative concern about eligibility for publicly funded treatment, we have devised a severity scale to rate the intensity and tenacity of the PIPs identified in an assessment. The scale is divided into two components, an "experienced" severity rating and a "reported" severity rating. The experienced scale focuses on patterns of interaction experienced by the clinician in the here and now of the assessment session itself. The reported scale focuses on the patterns of interaction that are reported by the family (or by others) to have occurred prior to the session.

We feel that it is socially responsible to allocate limited treatment resources to interrupt PIPs that are actively producing pathology, regardless of whether one distinguishes an "individual" mental disorder or not. Indeed, if a diagnosable disorder is not yet evident, but

the PIPs are allowed to continue, a disorder may be expected to merge later. Thus, PIPs that are intense and severe should be given a high priority. This would be in keeping with a basic principle of triage: treat the most treatable first. In other words, it seems more justified to apply limited resources to interrupt PIPs that are occurring in the present than to treat an easily diagnosable “chronic” patient, who may be the victim or “end product” of PIPs that took place over an extended period of time in the past.

The process of clinicians assessing mental problems is, in itself, a culturally determined pattern of interaction which could have either pathologizing or healing effects. As already noted, when this process becomes one of sticking psychiatric labels onto persons, it can be pathologizing. Our alternative is for clinicians to distinguish, assess, diagnose, and label selected interpersonal patterns of interaction as pathological rather than the individuals involved in those patterns. This implies a fundamental shift in focus from the personal to the interpersonal. The pathologizing effect of labelling is thereby applied to the pathologizing pattern rather than to the person in it. In other words, labelling PIPs pathologizes the pathology, not the person. A further effect of labelling an interaction pattern is that doing so leaves space for the persons involved to disassociate themselves from the pattern which could be the beginning of healing. Finally, the distinction of a specific PIP implies the possibility of distinguishing a specific HIP as an antidote. These are all potentially constructive influences on the mental health of the persons involved in the patterns. Thus, the HIPs and PIPs “means” to assessment does not contradict the “ends” of the program, it contributes to them.

It is important to note that the diagnostic shift from the personal to the interpersonal is not the same as a simple shift in focus from the individual to the family unit. All families are assumed to elaborate a vast repertoire of interaction patterns, some of which are PIPs and others are HIPs. The qualitative mental health differences between families lie in which patterns predominate. Hence, there is no strong need to diagnose families either. Indeed, I am also opposed to labelling families as “psychosomatic”, “enmeshed”, “dysfunctional”, or “schizophrenogenic”. Insofar as one identifies with a particular family, the labels attached to that family also become attached to the self. The process of classifying and diagnosing families simply pathologizes more people.

Further developments in our “HIPs and PIPs” approach to psychiatric assessment are already underway. These include a clarification of the orienting effects of previously internalized interpersonal patterns, and the inclusion of the observer who distinguishes the pattern as part of a larger pattern. It is anticipated that these and other related issues will be reported in subsequent editions of the newsletter.