

# The Diagnostic Home Visit: An Aid in Training and Case Consultation

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*The home visit has long been recognized as a useful vehicle for diagnosis and therapy. It has a potential for another useful function in that home observations can provide the teaching therapist and consultant with the vivid details of family interaction necessary to useful supervision. Parents may be poor observers and/or reporters of problem situations; they may also be reluctant to describe for various reasons. The student therapist may become bewildered, frustrated, and discouraged over the lack of material or inability to help. This report describes how supervisors can then use home observations as a source of fresh diagnostic hypotheses, and as a basis for reformulation of treatment goals or of technical approaches.*

Interest in the home visit as a vehicle for diagnosis has waxed and waned in the history of the mental health professions. Ackerman (1956) and his group restored the home visit to respectability with his sensitive and lively descriptions of family interactions and with his insistence that diagnosis must take place within the context of family and society. There has been an even more recent acceleration of interest in the home visit which has been implemented by the development of behavior modification as a therapeutic technique and by a recognition of the potential of the home visit as a clinical research technique—a potential exploited to good effect by Jules Henry (1972) in his “live-in” study of families with children hospitalized for emotional problems, and by Bermann (1973) in an intensive and extensive study of one family in crisis. Bloom (1973) has described the wide range of useful functions in home visits as she utilized them at Children’s Psychiatric Hospital, University of Michigan, on an inpatient service.

## **A Training and Consultation Aid**

The home visit has use as an aid to those who train mental health professionals and those who provide consultative help to agencies which work with families. A commonly occurring difficulty involves a student therapist who is often quite young, quite inexperienced, and so unable to round out a client’s description of family interaction from his own experience. The experienced or consultant therapist has a sense of typical family behaviors in stressful situations and will strive to help learning therapists to develop an eye for them. This is necessary in order to measure and assess the reactions of his clients in a way that is indispensable for the kind of on-going diagnosis necessary for effective treatment.

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As the therapist learns to ask effective questions which explicate family patterns, the parents often learn to be better observers. Optimally, their cooperation is enlisted by the therapist and a mutually satisfying collaboration ensues.

There are many other outcomes which are less than the optimal one just described: The parents can respond to questioning as cross-examination and can learn to parry and to report only the most exemplary parent-child interactions. If the parents are articulate and intellectually alert to culturally approved definitions of good parenting, and if the parent therapist is a beginner, this can be a considerable problem. The problem for the consultant is that of gaining access to data which will help him deliver to his student an understanding of the real problems between these parents and their child. Frequently the only data available are those reported by the parents. For example such parents may ask a question which is not a question. "Should we send Jim to his room if he hits his brother?" The therapist elicits details of the quarrel and in proper therapeutic fashion helps the parents to delineate alternative ways, including sending-to-room, of handling problem behavior. At the end of the hour, he may find that seclusion in the bedroom is and has been a well accepted and effective disciplinary technique for managing hitting and also one which is infrequently necessary. The student therapist has been pursuing a mirage-problem all through the hour. The parents may present a consistent pattern of opening for discussion only those areas in which they already feel confident.

On the other hand, a crucial problem area can be subtle and yet so pervasive that the parents do not perceive it, perceiving instead the small abrasions of intimacy. Therapists can be quite puzzled by the apparent competence of the parents, the innocuousness of the parent-child incidents as contrasted to the degree of behavioral upset manifested by the child. One sometimes concludes correctly that the child's pathology results from historical traumata rather than from current incompatibilities. One sometimes concludes this incorrectly. It is at this point of diagnostic confusion and training dilemma that the home visit can serve as a useful diagnostic and teaching technique.

While canny, articulate, middle-class parents can pose a problem to the learner because of his lack of therapeutic sophistication, some lower-class parents are difficult to work with because their cognitive-expressive style is often so different from that necessary for patient-therapist collaboration. Such parents may respond to questions as cross-examination and then become sullenly withdrawn, miss appointments, and break off treatment. A serious problem quickly becomes evident in the early hours of contact with them: They are poor observers of behavior and poor reporters and describers of interaction. This contributes to a continuing problem in understanding the pathological aspects of the parent-child interaction.

Conversely, such parents, full of good will and friendliness, may sit in the therapist's office ready to cooperate, puzzling over exactly what is wanted of them, and still be unable because of their cognitive-expressive style to provide it even if they are helped to understand. With such parents also, diagnostic home visits can implement helpful and clear reporting and can give the student therapist a foundation for inference and interpretation when verbal reporting is scant and vague.

Case material from training at the Children's Psychiatric Hospital, Ann Arbor, will be presented illustrating uses of the diagnostic home visit with both types of families described above. Home visits were utilized after rapport had been established. Child-care staff from an inpatient unit had a brief training in observation and reporting. Parents were consulted and were prepared for the fact that observers would be in the home to observe and that, although it

would be awkward, they should not be considered "company," i.e., involved in conversation, included in meals, and so forth. Three visits were utilized to give the awkwardness time to dissipate and to give the observers time to become accustomed to the family's style and to pursue with closer attention areas observed in cursory fashion in the earlier visits. After discussion with a supervisor, feedback was given to the parent therapist who, in turn, gave the parents some general information about the observations. The families, without exception, were pleased about the observations, seeing them as evidence of our interest and concern about them.

### **Case Material**

Susan was an 11-year-old girl originally accepted for treatment after her expulsion from kindergarten five years earlier. She presented a stunning array of symptoms which included hyperactive, disruptive, exhibitionistic, and, at times, self-destructive behavior. Her parents complained further of her speech disorder, enuresis, thumb-sucking, temper tantrums, and public masturbation. They felt quite unable to control her. The focus of the work with the parents was their inability, in fact their unwillingness, to attempt to control Susan and her older brother also. The therapeutic effort was concentrated on providing a structured environment with firm controls, along with individual intensive psychotherapy, first on an outpatient basis, later in residential treatment. The very long and very intense therapeutic effort had minimal results.

The work with the parents paralleled the problem situation presented earlier in this paper. They were sophisticated and articulate clients. There was no denying the very real interest, concern, and affection the parents felt for their children. Given their heavy investment in the children and high expectations for achievement and good behavior, one might not have been surprised at evidence of neurotic perfectionism and anxiety in the children. Indeed, the older brother did present such a picture. But how to explain Susan's wild (and usually public) flaunting of all standards for a proper middle-class child? It could not be correctly described as an angry negativism; the behavior was too primitive and too driven for that. She presented a picture of an intractable behavior disorder and at times seemed psychotic rather than neurotic, although there was no evidence of a thought disorder.

In play therapy, Susan began to express concerns via imaginative play. The persistent theme in her therapy hours had to do with a grownup woman, and her mother and father. She would move away, into her own apartment, away from her "nosey-posey" parents. She would grow lonely and invite someone to live with her. They would quickly get into difficulties as Susan smilingly exerted an intolerable degree of control over her "roommate:" "What we like to eat," "Which movie we go to," "What we should wear," and "How we are feeling." Susan would tolerate no opposition and the "roommate" therapist would voice more and more indignation over her bossiness. Susan would then "kick her out" of the apartment, the only alternative to complete agreement being total separation. Susan vacillated from a sense of being submerged in the mother's identity and a fear of being lonely and uncared for.

Susan's struggles with the issue of separation and individuation were dramatized with considerable intensity over months of psychotherapy. Casework with the parents focused exclusively on the differences the mother and father experienced in their ideas about discipline. There was no hint of a wish to keep Susan bound to mother. There was, however, some evidence that the mother wished to see Susan as a much more disturbed and incompetent child than she was and, further, to depict her as such to neighbors, family, friends, and teachers.

Susan as a “handicapped” and “emotionally disturbed” child was tolerable to her mother who bent her efforts to helping and improving her with an array of remedial procedures: tutoring in reading, speech therapy, psychotherapy, and physical examinations to ascertain whether or not drug therapy would help. The only other version of Susan which her mother could accept was Susan as a super-competent child. Susan’s mother, an upper-middleclass club woman, was haunted by the specter of “bad blood.” Her own family had been very poor and her mother had been institutionalized with a severe psychosis. Susan, a child with an IQ in the borderline range, awakened old concerns in the mother about being swept back into an impoverished, despised background.

A series of three diagnostic home visits occurred at two week intervals over six weeks. The observers report the following incidents: Susan was occupied during the first visit with stringing rather large wooden beads. As she would finish a string, she would hand her mother the needle and thread and her mother would thread it for her. (Susan was an efficient seamstress both manually and by machine at the hospital.) The observers commented on a large and elaborate antique dollhouse, prominently displayed in the living room. It had delicate miniature furniture and tiny oriental rugs. Susan never played with it. The mother elaborated that “playing with it” for the most part involved cleaning it. Six weeks later Susan took the observers to the basement. She had bought a dilapidated dollhouse at a garage sale and was involved in decorating it the way *she* wanted, she confided. We felt that the showy but nonfunctional dollhouse was an indication of how the mother wished to present her family to a critical society: impressive, expensive, and unreal.

Susan’s mother usually answered questions directed at Susan. When Susan faltered momentarily in an explanation, the mother quickly completed it. She decorated Susan’s room in a fashion designed to please a typical teenager although Susan was an immature pre-teenager, preferring dolls and dollhouses to Beatles’ posters. The mother showed the visitors Susan’s extensive and lovely school wardrobe (Susan had had no part in the selection), holding each item up to Susan as if she were a paper doll, and inviting the visitor’s opinions and comments. Although the mother talked most of the time, she never talked to Susan, never directed a question to her, or invited her opinion. In three home visits there was not a single verbal interchange. After the home visits, it was much clearer that the mother had many ways of conveying to Susan her vast disinterest in what Susan might really be and her preference for a myth of a model teenager or conversely for a deficient and disturbed child.

The mother was surprised at the feedback provided her from the home visits. The interactions described were so much a part of the warp and woof of daily life that she was not at all aware of them. She was receptive to suggestions and innovative in amplifying and enlarging them. Follow-up visits eight months later revealed a much more healthy intimate interaction and more mother-daughter bickering which siphoned off Susan’s anger. Susan formerly had built up anger in her periods of “paper doll” behavior, alternating with eruptions of “disgraceful” behavior at public times when her mother could not ignore it. Only then could the mother be made to feel the humiliation and sad, furious impotence Susan was otherwise made to feel: She did not “measure up” either; she was as much a failure at “mothering” as Susan was at “daughtering.”

The second kind of family represented the polar opposite of Susan’s family. This family was large, poor, and lived in severely overcrowded conditions which fostered a cognitive style of straining out excess stimulation—necessary to maintain sanity it seemed. George, a six-year-old son, had been sent to resi-

dential treatment for a severe asthmatic condition, present since the second year of life. The pediatricians had become convinced that the asthmatic liability was much exacerbated by psychological distress. George was a small thin child with a perpetual expression of alert apprehension on his face and a very rigid posture. His individual therapy hours focused on his constant fear of his own aggressive feelings and his fantasy of death by drowning at the hands of some much-provoked father figure. Therapeutic strategy involved a permissive milieu setting with an emphasis on considerable freedom of expression. The goal in individual treatment was an examination of George's fantasy explanations of his asthma as punishment for aggressive and oedipal-striving with a view to making him less constricted and inhibited in his life style.

The parents were worried about George and loved him obviously, openly, and inarticulately. They very much wanted him home, but they wanted him home and able to function, rather than incapacitated by his asthma. The mother was terribly frightened at the first sign of a wheeze; understandable, we felt, since he could become so dangerously sick so quickly. The father felt that his wife's nervous preoccupation with George's health "wasn't good for him" and tried to counter by pretending that he was a normal boy, fond of dander-filled pets, and wild exertion. The parents' treatment hours were filled with disagreement about how sick George "really was." There were many missed appointments, becoming more frequent as the parents became more bewildered by the therapist's questions: They could not remember what happened on the weekend except in the vaguest and most general terms. George "got along good" with his siblings. He just "played around and stuff." The student-therapist leaped too eagerly at any material which had the least promise, often then making too much of too little. The parents then added to their bewilderment, considerable alarm, and a sense of grievance at being misunderstood. Home visits were scheduled to obtain material which would be useful without increasing the parents' feeling that they were bad, ineffective people.

The data contributed by the home visits provided surprises and motivated a change in direction for the milieu treatment plan. The frightened, inhibited little patient was most emphatically a small tyrant in his own home: for example, he was playing a board game with his slightly older brother and cheating outrageously. The brother began to object angrily and the older sister intervened, sent the objector out of the game, and benevolently allowed George to cheat and win. There was no limit upheld against George's testing from "Wash your hands before dinner," to "No one can have candy until dessert time." He was constantly coddled and infantilized. Additionally, the mother had abdicated to a considerable extent—out of fear of making a mistake—her role as parent to George in favor of her teenage daughter. When the mother would move to impose minimal controls on George, he would turn to his older sister who would argue then or would "help" George as she had in the game. His sense both of a frightening lack of controls on his behavior and of the suppressed anger in family members seemed to lead to a panicky reaction. (He was not, however, observed to wheeze during the home visits.) Subsequently, George's parents were able to "borrow" the observers' descriptive skills. As incidents observed in their home were described, they were able to report fears of upsetting George or of making him feel that they did not love him if they opposed him at all. His treatment plan at the hospital was altered to provide for higher expectations and a structured classroom situation. George quickly seemed more relaxed, outgoing, and spontaneous than previously. Therapists had, of course, seen George's fear of the power of his aggression and of retaliation, and they had treated them as intrapsychic, internalized problems without understanding and working with the contemporary factors which were reinforcing and vitalizing his neurotic

conflicts. Six months post-discharge, George had had none of the serious complications from asthma which previously had brought him so frequently to the hospital. His school attendance was very good and his peer relationships satisfactory.

### Summary

The home visit provides an excellent opportunity for naturalistic observation of family interaction which yields useful diagnostic-therapeutic information from vivid, contemporary material. Such material can serve three important functions. First, it can "flesh out" a learning therapist's understanding of the emotionally significant details of family life.

Second, it can be an invaluable source of data for a consultant or supervisor who is often in the position of being far too remote from the kind of material he needs to be helpful. Family incidents—the raw material of parent counseling—have to happen, to be noticed by the parents, remembered by them and described by them in a fairly articulate way to a therapist, who also has to notice and remember and articulately describe if he utilizes a supervisor or consultant. Much significant detail can be lost in these successive siftings. The use of trained observers provide useful samples of family interaction which is much less vulnerable to forgetting and reworking.

A third and perhaps most important function of the diagnostic family visit is that it can provide vivid real life examples which help considerably to clarify for parents exactly what it is in their well intended efforts that might be reinforcing their child's tendency to react pathologically. The home visit may supplement the parents' own perceptions which can be dulled by long habit or it can supplement their observational or descriptive skills, thus adding considerable focus and efficiency to therapeutic efforts.

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