D. C. P. BULLETIN

Division of Clinical Psychologists, The Australian Psychological Society

Volume 4, Number 3 December, 1972

EDITORIAL

The two contributions to this edition of the bulletin came from psychologists involved in clinical practice and teaching. Dr. Cox outlines the course now available at the Royal Melbourne Institute of Technology and offers some views on the personal suitability of people involved in counselling work and of the sort of training he believes is relevant to counselling. Mrs. Tisher and Mr. Lang have been working with the method they describe for several years. The families they work with are not assessed by any formal psychological testing procedures first.

It seems that these contributions describe views and methods which are not at this stage commonly thought to be an integral part of the psychologist's training or role. In Australia the psychologist - and particularly the clinical psychologist - is perceived by those who employ his services mainly in a testing role rather than a primarily counselling or therapeutic role. It may be that there has been a too ready acquiescence to the testing image and not enough enquiry into alternative ways of using our specific discipline and training.

Currently the role of the clinical psychologist is being seriously reconsidered in other countries and in particular in the United States. If our discipline follows other fields we should find that ideas which are being rethought there will have impact here. In some leading universities in the States courses in clinical psychology (all at a post graduate level) have been dropped in favour of courses in Community Psychology. This applies to Harvard University and Yale and Stanford are seriously considering following suit, if they have not already done so. The impetus of this move arises from the particular social problems inherent in the social structure of the United States with an increasing realisation of the extent and implications of poverty and social disadvantage. The extremities of these problems may not apply to this country but there is growing community realisation that such problems exist in Australia more extensively than was thought a few years ago.

In the States there is a move for clinical psychologists to focus their training and endeavours on the economically disadvantaged and in particular to work in community "storefront" projects. The fact that major universities recognise this by deleting specific courses in clinical psychology is an indication of the extent of this change in focus. There, less trained people are now being assigned a testing role though it is to be hoped that such a step would be avoided in Australia. The more thoroughly trained psychologists are working increasingly either in an administrative role directing clinics and projects or working in community projects particularly with human relations.

It may be that clinical psychologists in Australia will have to reconsider what they do. Testing may become a less important aspect of the work and contact with those who want help or personal change may focus less on past history and more on the dynamics of the present. If a wider application of skills is required it is likely to come as a result of wider community recognition of what psychologists can do.

****

SOME PRELIMINARY THOUGHTS ON FAMILY GROUP THERAPY

We use the term “family group therapy” to refer to the situation where the therapist sees all members of the family together. In this paper we will discuss some fo our experiences with an experiential form of family group therapy

Families present at Bouveric Clinic through problems in the child members of the family. We consider it important to work with the whole family as the child’s difficulties are seen as closely tied to disturbance in the family, more specifically, to insufficient, distorted, indirect, conflicted communication patterns.

There are three aims in family group therapy:

a) To bring about in each member of the family a change in perception and feeling towards self and others, as well as related changes in actual behaviour
b) To make convert, indirect, distorted communication overt, direct and clear
c) To encourage members of the family to experience their feelings as fully as possible within themselves, to become fully aware of their feelings towards others and of others feelings towards themselves.

The aim or processes described above are closely related to each other; changes associated with any one of these inevitably involves corresponding changes with respect to the others.

The family as a "unit" is involved in treatment, and successful therapy leads to a general increased capacity of the family to cope with stress; each member of the family tends to turn to and rely on other family members for help, rather than on the therapist.

Therapy involves a "growth" or individuation" process for each individual being treated; within the context of family group therapy, such processes are associated with increased ability of the individual family member to recognize, accept and appreciate both his own identity as a person and the differences between himself and other members of his family, without feeling threatened by the possibility or perception of such differences.

Involvement of all family members in treatment enables direct assessment of changes in each individual member as well as of overall shifts or movements in communication patterns. The therapist sees the changes taking place in front of him and does not need to rely upon accounts of changes in family relationships from individual members of the family.

The overall focus of family group therapy is upon the "here-and-now" experience. The quality of such "here-and-now" experience at each moment in the interview; the question is the therapists mind is always "What is really going on here?" and the therapeutic processes associated with this orientation involve encouraging family members to experience their feelings as fully as possible and to relate **to** others in the room rather than to describe their feelings to the therapist **about** such others. Descriptions of the problem, complaints about others behaviour, accounts of past disagreements do not have this "here-and-now" quality, and the therapist may actively focus away from such phenomena.

For example: Child sits quietly, looking hostile.
Therapist comments "I notice you're looking angry".
Child to therapist: "Yes, but I can't see the point of saying anything – Dad doesn't give a damn", in a flat tone.
Therapist: "Could you say that to Dad"?
Child has some difficulty in looking at Dad, but with eyes averted says: "You don't care about me", and begins weeping. The child is now experiencing the feeling in the "here-and-now"; the time is no longer flat and hostilely indifferent, but involved and hurt.

By forcing the child to relate **to** father rather than describe his feelings to the therapist, the child was enabled to feel his underlying feelings. Further, by haring these feelings with others in his family, the previous defensive pattern of hostility and indifference was broken. Dad hears a real message (that the child's feels hurt and wants to be close to him) rather than the defensive message that he has heard in the past (of hostile indifference), and consequently is able to respond to the child with his real feelings also: "I've always card about you….I suppose you felt like that because I don't show my feelings easily….".

There are times when one or more members of the family are preoccupied with the past, or, put differently, when the past is actively present in the "here-and-now". At such times exploration of relevant past feelings is appropriate and often very valuable.

For example: Family consisting of Mother, Father, Sue (aged 14 years) asked for help because Sue had been staying away from home and being sexually promiscuous.

> Mother angrily to Sue: "I won't tolerate your behaviour – you're cheap and just a tart. Well brought up girls don't behave like this …"
> Sue: "I'm no different to my friends – what's wrong with it anyway?"
> Mother: "I won't talk about it – there's nothing more to be said."
> Sue shrugs her shoulders indifferently.
> Mother and Sue are deadlocked.
> Therapist: "You seem stuck."
> Mother: I can't understand why she's like that - I would never have talked to my mother like that."

Therapist: "Can you say some more about that?" The therapist notes mother's defensiveness and rigidity, and becomes involved briefly with mother in exploring her feelings.
Mother describes her own father's strictness and his threats to her as well as to her sisters should have become pregnant before marrying. Mother re-experiences some of the terror which she felt as an adolescent; specifically that she might have had some sexual experience before marriage. This enables her to tolerate such a possibility in Sue without pushing it away as strongly as before, and she relaxes considerably in relating to Sue. Sue sees mother's conflicts in this area, and that mother's rejection of her is partly to mother's rejection of her own childhood memories. This can be verbalised by the therapist (although usually this is not necessary).

There are a number of special techniques which may facilitate movement of family group therapy. These techniques are partly derived from psychodrama, and include "role-playing" (where, for example, the therapist role-plays a particular family member or the family members role-play what happened last week) and "role-reversal" (where family members may be asked to be "the other"). Another useful technique is for the therapist to sit next to a particular family member and repeat what he has just said ("doubling"). This is particularly appropriate when others in the family have not heard or responded to a statement: it also has the advantage that the family member who is being "doubled for" can hear himself in the therapist words. The therapist may choose to repeat the statement with intensified feeling. The therapist may also put into words what he felt the member was communicating non-verbally or perhaps state for the member what the therapist thought to be his underlying feeling.

Our opening remark in family group therapy may be "Could you discuss between you what the problem in the family is". Or "Who would like to start." Or I know very little about you, and I wonder if you could tell me why you are here." The focus is immediately on the "here-and-now", on what is bothering the family at this moment in time and how they are feeling in the present.

Mother may begin by describing the problem with the child. Father communication covertly or overtly that he feels mothers complaints are insignificant and that a big fuss is being made over nothing. Therapist picks up fathers feelings and draws attention to it, encouraging mother and father to confront each other about their disagreement. Mother and father may become involved in an argument, and marital disagreements or difficulties rather than the child's symptoms, become the focus of the family's problems.

Alternatively, mother may begin by complaining to the therapist about the child:
"He makes my life miserable, never does what he's told, steals and lies all the time…."
Therapist asks mother to talk to her child about this. Mother does so. Child does not respond, but sits silently. Therapist may do several things here.

1. He may pick up the child's feeling and comment "You look frightened/angry" or "I notice you're clenching your fists."
2. May speak or double for the child with appropriate feeling "I don't want to talk to you."
3. May ask child how he feels when mother says that.
4. May ask mother to answer the question for her child
5. May pick up mothers feelings and comment: "You're feeling helpless/don't know what to say/very angry."
6. May double for mother by repeating her statement to the child, perhaps with intensified feeling.
7. If mother is saying "Why do you keep doing this …." May ask her to turn her question into a statement, e.g. "I feel angry when you break windows."
8. May involve other members of the family: "How do you feel about whgats been happening?" This may open a new dyad, for example, father may come in and attack mother; 'You're always nagging at him – you at me too…you're impossible to live with…", and marital disharmony may become the focus.
9. May ask others in the family to speak for the child and/or the mother – "role-playing". Also "role-reversal" – "try being the other".

There are examples of the sorts of interventions which we commonly make. Any one or a combination of several could be considerably developed.

Interviews are usually spaced at fortnightly intervals, although the therapist remains flexible about this, bearing in mind such factors as the degree of resolution or movement experienced in any one session. The guiding principle is for all family members to attend regularly at each session, although occasion may arise where an individual or a dyed (e.g. marital couple) may be seen before or whilst continuing with family sessions. Siblings aged less than five or six years may sometimes be excluded, usually because they are too easily distractible or disruptive in an interaction which is mainly verbal.

The form of treatment we have described is for us still in its experimental stages, but already we find family group therapy to be more rapid and effective than working with the child and parents individually, as we used to do. Family group therapy presents many challenges and problem, and imposes considerable demands upon the therapist; nevertheless, we find it very satisfying and rewarding.

NOTE

We would be very interested in interchange of information regarding family group therapy. Further information about the way we work may be obtained by contacting us at Bouverie Clinic.

ACKNOWLEDGEMENT

Many of the thought presented above were originally introduced to us by Dr G.A. Goding, psychiatrist superintendent of Bouverie Clinic. We would like to acknowledge our very considerable debt to him.

Moshe Lang
Miriam Tisher

Bouverie Clinic
Mental Health Dept.
Victoria