III - Family Psychology and Family Psychiatry - Psychotherapy

General

The term “family psychotherapy” means treatment of the family by any procedure that helps to restore health to the family. The term “family therapy” has sometimes been misused and employed in a wider sense to cover a family approach, or in a narrow usage to cover one treatment technique, family group therapy.

Psychonosis is a preventable disorder; severe states of psychonosis are difficult to cure; moderate states of psychonosis can be modified.

Thus, the greatest hope for the eradication of psychonosis and the improvement in the standard of emotional health lies in the promotion of emotional health rather than in direct procedures of cure. However, the two roads to health are parallel and complementary. From the curative field comes knowledge that can be applied on a wider scale in health promotion; curative measures offer a research area. At the same time, curative procedures make a small, but useful, contribution to improving the standard of emotional health.

The greatest bar to progress in therapy is not lack of personnel, or services, or efforts, small though these are; the main bar to progress is ignorance. The emotional and mental health services should not be judged by their therapeutic success; this is small. Their importance is that they exist. Because they exist they are a rallying point for the afflicted and the problem is exposed. Furthermore, they are a rallying point for a large number of dedicated and interested workers, who some day will collectively find the answer to psychonosis. Unfortunately, they are also the rallying point for an even greater number of workers who seek palliation of their own problems through working with others in a similar state; to select healthy workers, the product of healthy families, is one of the greatest organisational problems facing all the professions in this field.

Ignorance is the true bar to progress. The field is complex. Research is difficult because of the many variables. The work is highly emotive and lends itself to

misconception and wishful thinking. Many workers are dedicated, but their grasp of scientific principles is rudimentary. Thus, vague notions of a quality that can be termed mystical offer great appeal; the appraiser, aware of his own ignorance, assumes that the mystic has greater knowledge and that his own lack of ability prevents him seeing the truth. Thus, he assumes the truth to be there, when in fact he is faced with intellectualised wishful thinking.

Ignorance is prominent in psychopathology, a vital but most difficult area. Only understanding of the pathological process can lead to rational therapy. But, here, ignorance is at its greatest. Explanation has been invented rather than sought in carefully planned investigation. Invention has relied heavily upon thinking by analogy. Analogous phenomena are assumed to have all the same characteristics of the phenomena with which they are compared. Thus, picturesque illustrations are assumed to have causal links; links made so readily in the illustrations are assumed to apply in the life situations with which they are compared. That such obvious misinformation is allowed to go uncorrected soon makes it clear that heavy personal emotional bias is at work. For example, it is stated that children are brought up by mothers, when simple observation shows that they are brought up in a group – and yet uni-object relation therapy is sacrosanct. Psychopathologies do not tally with reality, or with experience. Such is the ignorance of psychopathology that it is not surprising that therapy is largely ineffective. With irrationality dominating the principles on which it is based, therapy must be ineffective. Cults have replaced responsible investigation. The way into the cult has often been through sickness. The patient becomes the therapist. Later still the therapist becomes the teacher. The blind and weak lead the weak and blind. The cult wards off attack by defences built on a dogma that cannot be understood, and thus cannot be attacked, by the uninitiated.

Emphasis has been given above to the understanding of psychopathology. It is important also to emphasise the importance of diagnosis. One must understand before one can treat effectively. Similarly, if one does not differentiate between diagnosis and therapy much of what happens in the process of diagnosis is assumed to be therapy. Almost all the films on “family therapy” (ie family group therapy) are, on careful evaluation, nothing more than diagnostic exercises. The family and the “therapist” (in truth a diagnostician) learn a great deal about the history and psychic tribulations of the family. But nothing changes. Revelation is not therapy. Insight is not enough. Let me illustrate: An account is given in one publication of about 50 “therapeutic” sessions involving a mother and son. In the last session, the mother is able to reveal that the pregnancy which resulted in the birth of her son was the cause of her unhappy marriage. She hates the husband and his son and rejects both. The cause of the son’s vivid adolescent misdemeanours is now clear. The therapy is now assumed to have come to an end; revelation has been made. But the mother does not thereby stop hating. Nor does the damage done to her son over the last 15 years urgently repair itself. All that we witnessed was an encounter which allowed rapport to develop very slowly (a sympathetic friend would have reached this stage as quickly) to the point when the woman could reveal to a therapist something she already knew. The sharing of knowledge is a prelude to therapy, but it is not itself therapy.

One of the major lessons of diagnosis is to reveal the way in which somatic pathology runs parallel with psychic pathology. It is rare for psychonosis in an individual or in a family not to show itself in some somatic pathology. Only global examination exposes how common is this link between somatic and psychic pathology, and often

the severe, and life threatening, nature of the somatic pathology. Diagnosis establishes the case for somatic and psychic therapy to run together.

Diagnosis must be accepted as a separate, if sometimes parallel, exercise from therapy, otherwise we shall not appreciate what little therapy takes place. It is matters such as this which lie behind the comment of an honest and particularly experienced therapist, both as psychoanalyst and family therapist. He was told by a prominent family sociologist, “I feel the need for the therapist to explain himself, what he did, how, when, and why, with a particular family”. Nathan Ackerman comments, “Again and again, I try to do this but I am never sure that I succeed”.

Would the populace be worse off if there were no psychotherapy? A protagonist might say that surely effort must stand for something. But the massive blood-letting perpetrated in the past in somatic medicine was also effort; it was based on wrong ideas of pathology and did much harm to those it was trying to help. We cannot contemplate the therapeutic scene in psychiatry today with equanimity. More harm than good in therapy may easily be the order of things. Psychotherapy is practised on a wide scale, with great enthusiasm, in many guises, by almost anyone. It is often insufficiently realised that bad practice is worse than no practice. No surgery is infinitely to be preferred to bad surgery. No one, least of all the patient would accept a situation where an enthusiastic first aid worker was allowed to practice major surgery. But surery of the psyche based on bizarre rationale is everyone’s practice. Inactivity at least allows the organism’s natural defence mechanisms to have their sway. Intervention may prevent this, eg loss in divorce, like loss by death, goes through a number of natural stags ending in resolution, helped by forgetting, which is the main defence mechanism; but misplaced “psychotherapy”, by analysing the breakdown in detail over many months, merely succeeds in preventing the natural process of forgetting from playing its therapeutic part.

To prove that a procedure is therapeutic, it has to be established: (i) that a change has taken place; and (ii) that the change is for the better (it could be for the worse).

To often we are content to delve to the point of understanding events and then we hope that “something will happen”. The change must be shown to be constructive and fashioned to this end.

But not all is lost. Some practitioners of psychotherapy, the better trained, proceeding with caution, recognise the limits of knowledge, and practice within these limits. Furthermore, some practitioners have the precious gift of a harmonious personality; this exercises itself to the patient’s benefit, whatever the dogma held.

Psychotherapy is in a parlous state. The road to retrenchment is clear. We must return to the data of life, the facts of reality, to life experience as it is. If we can study, dissect, understand the life experience, we can learn how to reverse the psychopathological process. Therapy can then have a proven rationale and a predictable course. Already much progress has been made, data are available and, fortunately, the way to ameliorate through health promotion is already open.

The Task of Family Psycho-Therapy

Psychopathology, discussed in detail earlier, will be briefly outlined here so as to define the adverse experiential process and make it possible to draw general conclusions about the reversal of its effects, ie the benexperiential process.

The adverse experiential process:

It is easier to understand the psychopathology of the family, and the means of its improvement, by looking at the historical development of the "collective group psyche" of the present family. Each family is the product of two previous families, the preceding families of each marriage partner. Each marriage partner has been habituated to act in the way he or she does by the dictates of his or her family. Thus each carries his own imprint (the "imprint" is used not in a special ethological sense but in its ordinary usage of "stamp" or "mark") of life in the preceding family into the present family. Harmony results from the capacity of the two families, as represented by their members, to integrate. A clash produces disharmony,

The adverse experiential process starts in the preceding family of the adult members of the present family. Psychic noci-vectors adverse to a particular family member arise in his preceding family; these noxious agents can arise from one, several or all his fellow family members in that family. In later years they may be supplemented by adverse experiences outside the family. Psychic noci-vectors can operate in one overwhelming experience in time, but, much more commonly, they operate over a sustained period of time. This adverse experience may make the person sensitive to one or many psychic noci-vectors; he may be so vulnerable as to be in a permanent state of anxiety – always "on guard". The psychic noci-vectors create weaknesses in the psyche; the essential damage is done to the "idea of self". To cope with the adverse experience, the self adopts the coping devices that are possible in those circumstances. Later in life, with similar threats, the same coping devices are employed and the attitudes engendered by these coping devices may cause more trauma and thus damage by clashing with the attitudes of others. The most immediate, sensitive, and powerful clashes are likely to occur in the family where he is a founder member, husband or wife. The indicators of dysfunction in the past or in the present arise from this adverse experiential process in his preceding family; they are not the process itself.

As part of his imprint, each person carries: (i) a way of life with attitudes capable, or not capable, of adjusting to the way of life of a partner; (ii) a degree of psychonosis, dictated by past damaging experiences, largely in the preceding family, with damage to the psyche, especially to the "idea of self"; (iii) sensitivity to *general* psychic noci-vectors because of past experiences, largely in the preceding family; (iv) sensitivity to *particular* psychic noci-vectors because of past experiences, largely in the preceding family; (v) a tendency to react to psychic noci-vectors by the development of coping devices, which are often dictated by the set of circumstance in the preceding family – these devices are likely to operate in the present when faced by psychic noci-vectors; (vi) indicators of dysfunction used in the past which may be imitated in the present.

The individual, the epitome of his preceding family, moves through time, his formative years having been spent mostly in his preceding family. As he advances he gathers new experiences, some of which will clash with the attitudes he has already acquired and will create more stress and damage; on the other hand, he may meet ameliorating situations. At each stage, what he has gathered from the past interacts with his immediate situation. Thus, he reaches the present and he is what a lengthy experience has made him. Depending on the climate in which he finds himself, he is either again in a stressful environment, or in an ameliorating situation. If the latter, he probably will not seek the help of the psychiatric services.

The imprint in the life of an adult family member may be reinforced or changed by continuing interaction with his preceding family. In therapy this reinforcement or change may be encouraged or discouraged. It is relevant to mention that improvements, sometimes dramatic, occur spontaneously as the result of the demise of a member of the preceding family. The change, beneficial or damaging, may wrongly be credited to coincidental therapy.

The liabilities brought to the present family by an adult member may be overt or covert, either to the member who brings them or to the other family members. To add to the problems of assessment by each other, standards of conduct will be judged by the family imprint of each, and these standards may deviate not only from the average standards in the community, but also from those of the other family members.

The imprint produces needs which may or may not be satisfied by the imprint of the partner, eg an individual, because of experience in the preceding family, may react by hostility if ignored. The partner's imprint may be able to deploy assets and allow him or her to contain this. Thus harmony results. An inability to contain brings disharmony. The great advantage of family therapy over individual therapy is the possibility of enlisting not only the aid of assets possessed by the therapist, but also the aid of the assets of the family members themselves. Harmony may be possible by building coping devices to the imprint deficiencies of the other. These new coping devices are possible if the antagonist's family imprint allows of it, eg to withdraw when hurt and refuse retaliation. Circumvention is a mechanism insufficiently exploited in therapy. An example of circumvention would be accepting a deficiency in a partner, and planning the way of life of the present family in such a way that the deficiency has little or no opportunity for expression. Therapy must employ all these natural procedures in a systematic fashion – deploying assets, building new coping devices and circumventing deficiencies. Success will largely depend, given the best of all therapists, upon the qualities of the imprints facing one another; there are occasions when they allow of no resolution.

While the imprints from the preceding family are of basic importance, it must not be ignored that the present family is also developing a course which is superimposing an imprint on the fused imprints of the marriage partners. Again, children of the marriage are in the process of imprinting in the present. The collective group psyche, at first composed of two fused imprints, expands as it embraces the children and all the new experiences it meets. The past impressions of the parents, however, are always paramount, even if hidden, simply because they result from a long-lasting experience in the preceding families during sensitive formative years. A family group composed of adult members imprinted with gross deficiencies does not necessarily collapse. The deficiencies may be complementary, eg an excessive need to be mothered in one partner may satisfy an excessive need to mother by the other partner. Again, deficiencies in an adult family member may produce marital clash, but not be inconsistent with excellent parenting; indeed, occasionally, a parent may "wall off" himself or herself with the children in an enclave that protects them from the onslaught of the family imprint of the other partner.

The Benexperiential Process

From the above account, and more detail in the section on psychopathology, a number of conclusions can be drawn which have implications for the reversal of the pathological process in therapy:

1. The pathological process seen now is often the result of adverse experience in the past. It can only be undone by a reverse active process – a beneficial experience which undoes the pathological process and establishes harmony. It must be active, and positive. Merely abolishing present stress is not enough. Similarly, in the physical field a deformity produced by excessive pressure on a limb in childhood, for instance, is not corrected by merely removing the pressure years later. Positive active corrective procedures have to be initiated. In general, therapeutic procedures have to emphasise the opposite of the pathological.

2. Damage caused by an adverse experiential process in the past can be aggravated by continuing trauma in the present: sometimes the adverse process is set up by present trauma alone.

   The individual may be vulnerable now to the same psychic noc-vectors to which he was habituated in the past. To influence psychic noci-vectors in the present is easier than to reverse the effects of psychic noci-vectors in the past.

   Psychic noci-vectors in the past have usually ceased to function; thus attention has to be directed, not at them, but at the damage that ensued. However, knowledge of past damaging vectors may help to plan an ameliorating beneficial process in the present. To know, for instance, that a negative psychic noci-vector, the absence of touch in the past, is the basis of frigidity now, may allow the necessary positive agent to be activated. This principle is employed in benexperiential psychotherapy and in vector therapy. A psychic noci-vector can be affected by: (i) reducing its strength; (ii) changing its direction; (iii) reducing the time over which it operates; (iv) changing its quality; (v) opposing it by a contrary vector.

   Some present psychic noci-vectors are active in the imagination. A person has the capacity to dwell on a trauma in his thoughts. It can thus dominate perception, and do so to such an extent that it is not possible to give the trauma its correct evaluation, as nothing in perception is available to compare with it. Thus a person has a feeling that his thoughts are out of hand, he cannot break the vicious circle, and cannot see his problems in perspective. Strong measures may be required, including forced thinking, to break the vicious circle and bring perspective.

3. There is value in dealing with the sources of adverse experiential process in the preceding family by bringing them together with the presenting family member in therapy. This is easier with adolescents and young adults, but occasionally is possible with older adults. Should this prove impossible, the same situation must be dealt with in the absence of the preceding family – a more difficult task.

1. To re-experience previous traumatic situations is not necessarily beneficial; it may reinforce the effects of the previous trauma. It could be especially so if the preceding family is brought into the re-experience. To be therapeutic, the re-experience must be constructive and within the capacity of the individual and his therapist to make it so, whether it takes place with the preceding family or in its absence.

2. The effects of an adverse process are recording in the memory apparatus; change must be directed at changing the memories laid down in it. The approach is through the same sensations which produced the memory, ie auditory, visual, motor, olfactory, gustatory, etc, or a perceptual experience which is an amalgam of some or all of these sensations.
3. An adverse process has usually operated over a period of time. The reverse ameliorating process must also operate over a period of time. Rarely does pathology arise in a nuclear incident; rarely will catharsis relieve damage. In therapy, time is important and this will play its part whether the benexperiential process is achieved by psychotherapy or vector therapy. In psychotherapy it will operate with general procedures as well as with specific procedures.
4. Not all the damage done in the past creates difficulties in the present family situation or, in the case of a single person, in the present individual situation. Therefore, focal or partial amelioration may be employed, directed at the damage that creates difficulties in the present situation only. A partial task is clearly less time-consuming than a complete task and may bring an adequate functional result. The complete repair of a severely damaged person may be a massive undertaking.
5. There are *levels* from which a disturbing process can arise and can be changed:

    (i) In the preceding family – previous trauma.

    (ii) In the present and preceding families – present trauma acting on previous damage.

    (iii) In the present family – present trauma only.

    (iv) In the present and succeeding family – present stress acting on the children, who will form the succeeding family.

    Therapy at level (i) is the most difficult. At levels (iii) and (iv) it may be possible to deal with the present situation so that the process does not pass to the succeeding families or, if it does, reaches them in an attenuated form. *Herein lies the best opportunity for the eventual production of emotional health in society. Should therapy never operate at levels (i) and (ii) it would only deny the possibility of relief to the present generation of sufferers. If measures at level (iv) could be certain of success, they would by themselves guarantee a steady permanent improvement in the standard of emotional health of society.*
6. The essential part of the psyche to be damaged is the “idea of self”. To support and reconstruct the “idea of self” is central to any benexperiential therapy.
7. To know the nature of the psychopathological process can lead to precise therapeutic measures. Without this knowledge only general blanket measures can be, and often are, employed. These general therapeutic measures, the G factor, may help, but not as quickly or effectively as more specific measures.
8. Positive vectors are just as powerful as negative vectors. Love is as powerful as hate.

Positive vectors should be employed in therapy. These include praise, appreciation, encouragement, kindness, affection, respect, a sense of belonging, hope, security, worthiness (the opposite of guilt).

It is known that negative vectors do damage according to their power, repetition, and the length of time over which they operate. Equally, the effects of positive vectors used in therapy gain by their power and vividness, repetition, and by being allowed to operate over a lengthy period of time. Whenever possible, they should be precisely directed. However, even in a general blanket form they can be valuable.

In an imprecise non-directed form these positive elements in therapy are often present. They constitute a general factor, G factor. This factor is therapeutic, but not precise. Therapy should be directed and be more than the chance operation of the G factor. Therapy is often no more than this, and sometimes less, if, for instance, the therapist suffers from an unsatisfactory personality.

9. Trauma produces insecurity and the need for defence. Theefore, therapy must not involve the threat of trauma and must produce security. The insecure cannot reveal the intimate situations that lie at the core of the damage to the "idea of self". Precise evaluation of damage is the start of effective therapy. Attitudes change more readily when they are not necessary for the defence of the self. If insecure, the organism will cling to old attitudes. The family "on guard" cannot build new and better coping devices. This applies in reparative measures within or outside the interview.
10. In pathology, the indicators are what the name implies – signs of the process of dysfunction. The process cannot be changed by changing the indicators; if the process remains the same and the indicators are changed, they will be replaced by a new set that are possible in the new circumstances. The process itself must be changed and only then will the indicators disappear. Thus, symptomatic relief is not enough and is desirable only to ameliorate the secondary effects of the symptoms.
11. The damage did not occur in an interview situation. It does not necessarily need to be ameliorated in an interview situation; the right marriage partner, for instance, may achieve more than a therapist. Thus, though therapy can employ interview measures such as psychotherapy, it can use also extra-interview measures, such as vector therapy. Both may be necessary and are complementary.
12. Attitudes from the past which clash in the present can arise from: (i) mechanisms for coping with trauma in the past, eg withdrawal; (ii) different living habits, eg different ideas of role of father. (ii) tends to alter more easily than (i), as habits are not based on the need to defend the self.
13. There is a limit to the effectiveness of therapy. Some adverse experiential processes may have been so severe and damaging that their effects can only be ameliorated by very prolonged and powerful measures, if at all. To spend valuable resources on only a few people may bring minimal relief to society. Constant attention must be given to deploying resources where they can be most effective, eg the young respond more easily than the aged. Vector therapy and the salutiferous society bring the best value. We must practice the art of the possible.

14. to contend with *present trauma* from noci-vectors, the therapist must assist the patient to use new, healthy efficient coping devices, eg:

    (i) Putting the trauma in true perspective by applying standards and judgements and not exaggerating its power.

    (ii) Making realistic targets, thereby reducing the risks of trauma.

    (iii) Avoiding trauma that it is unnecessary to face.

    (iv) Side-stepping the trauma by a variety of techniques.

    (v) Deploying assets, eg using past success to compete with present failure ("Look, you are good because you can do that").

    (vi) Deploying support elsewhere, eg use of husband to share a potentially hurtful situation.

    (vii) Supporting, eg "We, you and I, will make a plan for coping with the situation.

    (viii) Forgetting, eg refusing to make a traumatic matter the topic of conversation.

    All these, and more, are devices in *directed* therapy – not leaving possible improvement to the chance of the G factor.

    N.B. ALL THIS IS CONCERNED WITH REAL LIFE EXPERIENCE. NO INTERPRETATION IS NECESSARY. NO FALSE AND FANTASTIC PICTURES ARE CREATED. ALL IS TRUE TO LIFE. THIS IS OF THE ESSENCE OF BENEXPERIENTIAL THEAPY.

15. To relieve past trauma, it is best, as has been said earlier, to bring the preceding family into therapy. Attitudes are exposed, guilt is relieved, the "idea of self" is improved. The patient is older and does not need to accept the omnipotence of parents. But thee is a limit to effectiveness. It is not possible to make a family love when it does not; but it is possible to minimise the effect of the trauma this produces. Any result can sometimes be reinforced by limiting contact between the present family member and his preceding family, while mobilising help from his present family.

    But the past may need management in the absence of the preceding family. The following steps are necessary:

    (i) The damaging noci-vectors in the past and the ensuing damage must be revealed.

    (ii) The effects of the noci-vectors in the past must now be met by the opposite quality, eg if a man is sensitive to being ignored he must now be given the opposite – attention.

    (iii) The present family must stop reinforcing the power of damaging vectors, eg it must also cease to ignore and give attention instead.

    (iv) Any assets in the present family must be deployed to help a vulnerable family member. Usually, success will depend on the health of the family, but even a psychonotic family may have some assets that by chance fit the situation, eg a husband is incapable of

taking the initiative in sexual intercourse; the wife changes roles and takes the lead in sexual intercourse.

(v) Situations can be relived in the interview situation with a therapist who represents not past figures but a positive person – the best of emotional influences. Positive vectors are generated in strength, over time, and with repetition.

The above can and does happen in daily life, but haphazardly without discernment. The aim of therapy is to practice it in a directed and precise fashion.

N.B. ALL THE ABOVE IS REAL LIFE EXPERIENCE. THERE IS NO INTERPRETATION. THERE IS NO FANCIFUL INVENTION. IT IS THE STUFF OF LIFE.

19. The therapist must not only use the G factor, but also apply *directed activity* – all the techniques described for the management of present and past trauma. The capacity to undertake this precise directed activity distinguishes the trained therapist from others. His skill springs from the following attributes:

(i) He is trained in ascertained psychopathology in a sure and systematic fashion.

(ii) He is knowledgeable about the nature, variety, and form of psychic noci-vectors.

(iii) He has great knowledge of the unusual.

(iv) He can make balanced judgements.

(v) He has great capacity to produce security through relationship.

(vi) He is knowledgeable of his field.

(vii) He is a positive person in his own right, and not just a figure on which other values are projected.

(viii) Long exposure in a medical training to the anguish and pain of many and varied forms of serious illness will have inculcated, in the right person, the response of caring in an immediate fashion.

20. The preceding adverse experiential process will usually have taken place in the preceding family. Occasionally the family will be anomalous and have the features of a large group. In this case, this is the group that is the significant contributor from the past. Again, the present family group may be anomalous, but of no less significance.

Conclusion

The major aim of therapy is clear from our knowledge of experiential psychopathology. The adults come into the present family after suffering an adverse experience in their own preceding families. This adverse experience must be reversed in both parents to effect a harmonious family climate, so that it epitomes, going forth to succeeding families, will make a healthy psychic contribution to those families. The adverse process can be ameliorated by three main approaches: (i) Benexperiential Psychotherapy; (ii) Vector Therapy; and (ii) the creation of a Salutiferous Society.

The three approaches are complementary and should be used together. Each will be discussed in turn.

Benexperiential Psychotherapy

General

Psychotherapy is the treatment of the psyche, individual or group, by any means. A psychotherapist is the person in immediate direction of the treatment.

In benexperiential psychotherapy, treatment consists of the use of a new beneficial experience. The advantageous experience is the therapy. Psychonosis, in an individual or in a family, is the result of malexperience, adverse experience in the past, adverse experience in the present, or the interaction of both. In contrast to the adverse psychonotic process, benexperiential psychotherapy utilises an experience which is to the advantage of, favourable to, the individual or family psyche – hence "benexperiential" therapy.

The general aim of benexperiential therapy, as in all forms of family therapy, is to produce a harmoniously functioning family in the situation within which it lives. What is harmonious in one situation may not be so in another. The standards in relation to "harmony" depend on what is regarded as harmonious or healthy at the present time in a given culture; today's "healthy" family may well be regarded as "unhealthy" by future standards, or in other cultures.

All programmes of benexperiential therapy must make a flexible use of all the types of treatment available. All the types to be mentioned shortly can be used together. The type predominant at a particular moment is the one that best meets a particular situation. This flexibility extends also to the simultaneous, or successive, employment of vector therapy. Benexperiential psychotherapy and vector therapy (also an experiential therapy) are complementary.

One of the lessons of family diagnosis, as well as of family psychotherapy, is the realisation that psychic events precipitate organic pathology. That psychotherapy aims at offering psychic help should not be allowed to overlook the need to offer somatic help. Psychotherapy and somatic therapy should go hand in hand. Naturally, our interest here is in psychotherapy.

Many defences are offered against revealing ignorance about psychotherapy. In discussion one may be met with the question, "What do *you* do?" which allows the questioner to avoid offering his techniques for scrutiny. Other defences evoke the use of a flood of vague, ambiguous intellectualisations which bemuse, befog, or overawe the listener. Yet another escapes to the select circles and the dogma of certain schools of psychopathology. Yet another meets any information with "I do all that". Here reliance is made on a simple exposition of the principles of benexperiential psychotherapy – revealing some knowledge and some deficiencies. The latter will be made good in time.

Types of Benexperiential Therapy

The best diameter to take is that of the period in time from which psychopathology arises. This could be: (A) at the level of the preceding family; (B) at the level of the present famil; (C) at the level of the succeeding family.

In each type, the therapy is linked with the time at which the events occurred, past (antecedental), present (actual), or future (anticipatory).

ANTECEDENTAL THERAPY

Therapy concerned with the resolution of events that occurred in the past. These are antecedental events, hence "antecedental" therapy.

ACTUALITY THERAPY

Therapy concerned with the resolution of events in the present. These are present events, actual, hence "actuality" therapy.

ANTICIPATORY THERAPY

Therapy concerned with the resolution of events that could occur in the future. These are anticipated events, hence "anticipatory" therapy.

(A) ANTECEDENTAL THERAPY

Therapy turns around resolution in the adult family members of the present family attitudes springing from the preceding families. Therapy is conducted with the preceding family or in its absence, by discussion concerning it.

The aim can be:

1. *Complete resolution*. A state of complete emotional health is restored to at least one partner of the presenting family. An example is:

> A wife presents with depression. Examination exposes many other symptoms, both organic and psychic. Exploration reveals a difficult marital situation which has come to a head recently. It has been precipitated by a change in family circumstances, whereby it had been agreed that husband should emigrate in order to obtain a higher standard of living. The attitudes at work were – husband's inadequacy, husband's anger, husband's sensitivity to being ignored, wife's ambition, wife's withdrawal. Briefly, the sequence of events was – wife's ambition demands a higher standard of living, husband agrees to emigrate; his inadequacy is appalled at the risk he is taking and in his insecurity he becomes angry; husband's anger makes wife withdraw; her withdrawal, because of his sensitivity to being ignored, makes him more insecure and angrier; the situation escalates, until she collapses with psychonosis in which depression is a marked feature.
>
> The attitudes at work here spring from their respective families. Husband is the product of a family where the mother left the father because of his belligerence and so the patient was thrown into the care of this angry father. His father's anger frightened him and yet this was better than his father's ignoring of him in preference to his older brother. From this situation came inadequacy, his sensitivity to being ignored, his anger as a coping device.

His wife came from a family where the father ran off with the maid and subsequently married her. He lost his fortune. He became alcoholic. Standards of living fell. Quarrels were acute between husband and wife. The little girl coped by withdrawing and thus not being involved. Her father was kind to her and she identified with his aspirations. From this situation came her ambition to retrieve the family fortune and to withdraw from anger.

Each marriage partner represents his or her past and the weaknesses of each have to be played out in the present family. Further exploration revealed more handicaps, as well as assets, in both.

Therapy began by resolving the present immediate situation provoked by the decision to emigrate. This restored harmony to the standard of the pre-breakdown level. Stopping at this point would have left therapy at the level of dealing with the trauma in the present. Therapy could have gone a stage further; by dealing with the elements causing disharmony in the marriage, what is termed “focal resolution” (below) would have been achieved. In this case it was decided to go beyond this and to deal with all the unsatisfactory elements in both marriage partners arising from the preceding families. The aim was an ambitious one. Both were to receive a substantial guarantee against breakdown in most situations. Both were to be “made whole”. Technique is to be discussed later.

It is important to emphasise that even the wealthiest of communities and the best provided are only occasionally able to undertake this time-consuming enterprise which is so expensive of resources.

2. *Focal resolution.* Here the purpose is to effect a resolution in only one, two, or several elements coming from the preceding family and causing disruption in the present family or in the life of any one individual. An example is:

A wife presents with frigidity of one year’s standing. In addition she is depressed, she has anorexia, insomnia, amenorrhoea, etc. Furthermore, her husband is irritable, lacks concentration and his standard of work has deteriorated to the point where he has been warned that he may lose his position. Psychonosis in the children can be surmised from the boy’s enuresis and the girl’s asthma, starting in the last year.

Sequence of events becomes clear only with the exploration of the preceding families. In the mother’s family she was the only child of an agitated, hypochondriacal, rejecting mother, and a kind but withdrawing father. Faced by rebellion in adolescence by her daughter, mother used two weapons against her – feigning illness and making her feel to blame for it. These would always precipitate anger and depression in her daughter. Father came from a family with considerable emotional assets.

The immediate situation turns around a quarrel between the maternal grandparents. Grandfather threatens to give up his job and this threatens his wife’s standard of living. Maternal grandmother develops ulcerative colitis. She turns to daughter for help and daughter reacts as she did in adolescence to her mother’s illness – she becomes depressed. She loses appetite for life, food and sex. Husband, not understanding, reacts to her rejection of him. Marital tension and mother’s state leads to disturbance in the children.

> Here, the resolution turns around two elements – guilt and sensitivity to mother's illness. Grandparents are seen together, the quarrel is resolved. The ulcerative colitis clears up in maternal grandmother. Mother has no maternal grandmother illness to react to and her depression immediately clears up. Sexual intercourse is restored. Father responds. The whole family climate improves.
>
> To guarantee against future breakdown, mother and grandparents meet to resolve mother's feeling of guilt springing from use of illness by maternal grandmother. Parents of the present family, and then the whole family, meet to discuss the process that led to the impact on their relationship together with the children. Vector therapy is now possible – they ask advice as to whether the position is advanced by their moving to another town. This is advised, subject to discussion with grandparents, as it will reduce and formalise contact. Grandparents can tolerate the move, but want assurance about contact from time to time with grandchildren.

Here, the therapy is limited – only some elements coming from the past are resolved. The parents are not "made whole", but the elements from the past that disharmonise family functioning are eradicated. You will note the flexible employment of therapeutic platforms – individual interviews with mother; dyadic interviews with maternal grandparents; family group interviews involving mother and her preceding family; dyadic interviews with parents; family group interviews with present family; vector therapy.

The above illustration involves a family. Occasionally, focal therapy is a matter for an individual alone. An illustration is:

> In the course of family group interview, it emerged that the father had a disturbing secret never before discussed with anyone other than his wife. This was that he found it impossible to urinate if someone else was within hearing. This defect was of no concern to the family, but it was highly inconvenient to him. He asked for help. Exploration in individual interviews revealed that as a young child he had a very irritable, aggressive and hated governess. She would sit him on the pot in front of her chair and from behind coerce and demand that he pass water. He found great difficulty in doing so and the same difficulty has continued whenever anyone is within earshot. At school he contrived to get round it by asking to be released from the classroom during lessons, so that the toilets would be empty of other children.

Here, the focal therapy is continued with an individual alone.

It follows from the above examples that any of the following interviews can be employed – individual, dyadic and family group as circumstances determine. In addition, multiple family or general group therapy may be indicated. Furthermore, any of the above can go hand in hand with vector therapy.

It can be seen that A (2) above is a much more manageable operation than A (1).

(B) ACTUALITY THERAPY

At this level concern is primarily with happenings in the present family. Therapy is concerned with handling psychic trauma arising within and without the family in the present.

Psychic noci-vectors may arise in the global family transaction, in a relationship between two family members, and from outside the family. The present psychic noci-vectors act on a sensitivity coming from the past.

A few illustrations are given:

> A mother presents with depression, the onset of which can be dated exactly. Her daughter has married into a much higher social set. Her patronising attitude distresses mother. The depression dates to the minute when her daughter telephoned that she had "arranged" a Christmas vacation for her mother and father.
>
> A child finds himself bullied at school or unfairly accused of some misdemeanour.
>
> A third party intervenes in a marital relationship.
>
> A mother finds herself in employment where she is aware of pilfering by a fellow employee and is caught between loyalty to management or to fellow employee.
>
> A father is all set to be ordained in the Church and then unexpectedly finds that he has received homosexual attention from a number of men, begins to suspect the nature of his own sexuality, has grave doubts about his suitability for ordination and develops a psychosis with acute anxiety.

Treatment at this level restores the family or individual to its pre-trauma standard. In some families this standard of health is very high and they were reacting to a massive or uncommon trauma. Other families have varying degrees of psychonosis resulting from the past. The management of present trauma does not of course change this pre-trauma standard.

The above may be practised in conjunction with therapy of the preceding family, eg in the last example above, father's oversensitivity to homosexuality may be due to misplaced ideas of sexuality in his preceding family and this may require resolution.

The above can also go on in conjunction with vector therapy to be discussed later.

(C) ANTICIPATORY THERAPY

Here, the intention is to concentrate special attention on guaranteeing the health of the children who will be the participants in, and founders of, succeeding families. Children, as they represent the future and are more amenable to change, should always be given help. However, there may be times when therapy may be possible only at their level; eg the parental problems may be intractable, or intractable with the facilities available, or the parents may be unco-operative. Thus, for a variety of reasons, a situation has been reached when one must "cut one's losses" and treat where one can.

An illustration is as follows:

> A woman loses her husband in World War II. In her loneliness she marries a man a great deal older than herself. She quickly realises her mistake. Her elderly husband anticipates her possible desertion and makes her pregnant. She stays "for the sake of the child", but rejects the child at birth – indeed she propels him out at the first uterine contraction with consequent cerebral haemorrhage in the newborn child and resulting limb paralysis.

> Following birth she rejects her handicapped child, who presents as a highly psychonotic and physically disabled child at the age of three. The family situation for a variety of reasons proved to be intractable. Father was unco-operative. Mother had no interest in the child. The child required urgent and considerable help, which was given in terms of individual therapy for him, general supportive interviews for mother, leading to vector therapy at the earliest opportunity, whereby the interviews with mother made it possible for her to accept that the child be brought up in a foster home.

In the next illustration the family is investigated as a whole, but therapy again concentrates on the child who represents a succeeding family of the future.

> A man attempts suicide. An inadequate man, he married a balanced, kindly woman. He began to profit from her care. Then she became pregnant, in response to which he developed an urticaria and was ill in various ways for most of the pregnancy. He displayed no interest in the child other than intense jealousy. Christmas came and with it the maternal grandparents to bring gifts for the baby. Husband locked himself in the kitchen and when he eventually emerged two days later, demanded that the baby should be given away. She refused. He attempted suicide. He is adamant – she must now choose the baby or him. Interviews with both separately, then together, support her in making the only decision possible – she must keep her baby and is well able to look after him on her own. (Supportive help for mother and advice on remarriage will still be helpful, if resources allow it.) The future in terms of the child has the highest claim.

Work at this level can go on in conjunction with work at the two previous levels and in conjunction with vector therapy. It may be useful to emphasise again that treatment at this level, if always effective, could guarantee the health of succeeding families and thus of society in the future. Clearly, this can only arise by a steady improvement over a number of generations as therapeutic efficiency and resources increase. The work will be speeded up by using extra-interview procedures in vector therapy.

Yet again it may be necessary to emphasise that what is possible may not be dictated by the tractability of the situation, but rather by the resources available. It is unlikely that the highly skilled resources required to operate at level A (1) for all will ever be forthcoming; by that time work at level (C) will have made them unnecessary. To have, as in the present situation, ill-trained people handling the resources available is not only ineffective, but dangerous.

SUPPLEMENTARY THERAPIES

1. *Indicator Therapy.* From time to time an indicator, a sign or symptom, of psychonosis, will itself be sufficiently life-threatening, inconvenient, painful or giving rise to such serious secondary issues as to require management or therapy in its own right. This can happen to an indicator of a psychonosis arising at any of the levels mentioned above. The indicator may be somatic or psychic.

In the case of a somatic indicator, measures can range from an hypnotic drug to relieve crippling insomnia to emergency major surgery for a perforated gastric ulcer.

The following illustrates a psychic indicator requiring help in its own right because of its social repercussions:

An adolescent boy presents with a propensity to steal women's clothing from washing lines in his neighbourhood. With these he masturbates while conjuring up images of the desirable young woman to whom the clothing belongs. Soon he is caught in a police trap. The court seeks help in his management. The indicator of his disturbed behaviour, the stealing of clothing, has serious social and personal secondary effects – it promotes shame and guilt, and may affect adult sexual behaviour.

Exploration reveals that there is a severe father/son conflict. Father deplores most of the customary behaviour of an adolescent. The son's behaviour is a coping device inevitable in this family situation. His father, because of an anomalous upbringing by a maiden aunt, deplores any sexual expression in adolescence. His mother on the other hand is a passionate, warm, outgoing person. The mother implies the need for strong heterosexual expression, the father makes it impossible. Thus, the boy is forced to resort to strong covert behaviour.

While there are other manifestations of disturbance, the presenting indicator of itself warrants attention because of the secondary effects. Thus a family interview is employed to relieve the son's shame and guilt. Both therapist and mother emphasise again and again the inevitability of the son's behaviour in the circumstances. Time, repetition, and insistence achieve the goal. Normal sexual expression is desirable. After a number of interviews, the therapist and the co-therapist, the mother, slowly and gently bring father to a position of security and relatedness where he can allow his son a dispensation – he can behave as other adolescents do and bring girlfriends home. No further sexual misdemeanours occur. The son still has other disturbing behaviour arising out of the father/son relationship, eg insomnia, a rash, panic attacks, lack of confidence. Having dealt with the damaging indicator, the father/son conflict is largely resolved through vector therapy – the son pursues his education away from home – a situation also of advantage to his newly gained freedom to behave in a normal fashion in heterosexual activity. Indicator therapy has been followed by therapy at levels (B) and (C) above. Lack of resources may, however, limit the management at any stage.

Occasionally indicator therapy can be achieved through behaviour therapy based on learning theory. While sometimes valuable, its limitations can be seen in the example above. To put the boy through a procedure that would prevent him stealing women's clothing, eg by aversion therapy, while useful in avoiding the social repercussions, would still have left him with his sexual frustration, and the disturbed behaviour arising out of the negative and destructive father/son relationship. Aversion therapy does not resolve the psychopathological process. But there are times when it can help in indicator therapy – even if, as sometimes happens, there is a substitution of indicators; the new indicator may be more tolerable than the old.

2. *General Supportive Therapy.* All persons and all families respond to encouragement, support, hope, praise, affection, interest and comradeship.

This may be all that can be offered in a particular situation and often in the past it has been the only ingredient of therapy, referred to earlier as the G factor. In all the measures mentioned to date, it is an essential and valuable component and, when the resources are denied, it may be the only measure possible.

Attention will now turn to further aspects of therapy. The *therapist* is considered first; this is followed by consideration of the *organisation of therapy*; and finally consideration is given to some *elements in technique.*

The Therapist

Selection

The blacksmith had this to say in Ronal Blythe's *Akenfield*(1) – "I always look at the parents before I take an apprentice. If you know the home, you already know the son." Family meets family – this is the essence of the encounter in benexperiential psychotherapy, not an individual therapist meeting the family. The therapist is the epitome of his own family. Thus, the meeting is between his family and the family under treatment. Selection of therapist then means selection of the therapist's family.

The therapist's preceding family is the area for exploration when consideration is being given to choosing a trainee therapist. Success in his own family will go a long way to guaranteeing success with families in treatment. Great care must be given to this task. A therapist requires an exceptionally harmonious personality; it is this which is going to make it possible to stand up to the strain of contact with very disturbed people, coping with persons with varying problems, giving security when it is required, withstanding hostility, offering toleration, charity and affection. All these qualities can be provided only by the product of an exceptionally harmonious family.

It is sometimes thought that training will overcome deficiencies of personality. It never does. Even new methods of therapy will not guarantee success by a therapist with severe personal deficiencies; the old therapies have been markedly unsuccessful both in training and in clinical work. Furthermore, it is far better for available training resources to be concerned with inculcating expertise in those of sound basic personality. It is sometimes argued that to have undergone a number of breakdowns adds insight into the process. This notion does not stand up to examination. Persons predisposed to breakdowns have suffered through the trying home situation that have denied them those qualities essential to help others. Of these qualities one of the most essential is the capacity to give emotionally; this is the very quality lacking in the emotionally ill.

Selection of therapists should turn around careful evaluation of preceding family climate followed by an apprenticeship to a master in psychotherapy. These in turn should be married to experience – experience of the world as it is. Therapists should ideally have been cast in many economic roles, roughed it around the world, had class, education, religion, cultural and other biases rubbed off in the hard school of life.

Success in psychotherapy depends upon: (i) the experience of a harmonious family; (ii) on having been exposed to a broad life experience; (iii) training under a master craftsman in psychotherapy.

In this chapter it is better to aspire to describing the ideal therapist; in practice we may have to settle for less.

Personality

In the therapist one looks for qualities such as toleration, with the capacity to understand and be charitable to a wide range of human failings; the ability to be unbiased and unprovoked by the less beautiful aspects of life; a capacity not to blame

or moralise. The therapist must be friendly, kindly, understanding. He must be able to make warm relationships with a great variety of people. Indeed, the greater his adjustment, the wider his spectrum of affectivity.

Chairman and convenor

The therapist has the task not only of convening the meeting, but also in general terms of directing his efforts. After all, the family has come for therapy, not for a pleasant afternoon's discussion of contemporary social events. Thus, his presence or his words must continually remind the family group of the task on hand. He must be sensitive to the topics that the family needs to discuss and, furthermore, can discuss at that moment. Sometimes, the family has not as yet the capacity to tolerate a topic. He must give everyone in the family the right to speak and to do so in security.

Catalyst and releaser

Expectation, and sometimes silence, provokes the family towards a discussion of events which are embarrassing, hurtful or painful to them, matters which they would wish to avoid. He instigates an exchange where necessary. On the other hand, he teaches the family members that an interchange can take place without aggression, hostility and fury. He himself indicates and teaches that rational discussion can bring the resolution of problems. Above everything, he is expectant; his non-verbal behaviour conveys a deep and sustained interest in his patients.

Community representative

The healthy therapist brings with him the values and the opinions of the community; a man of the world, he sees life as it is and accepts the best of it. The family may not conform to the attitudes and principles in the community outside, but can acquire these from the therapist. Explanation may sometimes be called for. The therapist inculcates an attitude by example rather than by direct teaching. It behoves the therapist to have adequate community values of his own and be secure enough to recognise and discard outdated values.

Conciliator

The attitude of the therapist is always that of conciliator, when faced with hostility or aggression of one family member to another. His aim is to create a climate where constructive work can proceed. He is not a judge, but a conciliator. He should avoid taking sides. Indeed, he has loyalty to all the members of the family and this will be tested time and time again. He must truly be a benevolent, security-giving figure to every member of the family.

Protector

No one within the family group should, if possible, be hurt through the family discussion. Thus, to some extent, the therapist is a protector. This is particularly true in relation to the younger or weaker members of the family. In the eyes of the therapist, everyone is equal, everyone deserves support, everyone has equal rights. His loyalty is to the family group and thus to all.

Diluter

Even if he does nothing else, the therapist, by bringing a healthy attitude into the family group, quantitatively dilutes the psychopathology of the group. The only effective argument for having more than one therapist is that the dilution process is even greater. However, as will be seen, this can have disadvantages.

Absolver

Embarrassing, belittling, hurtful attitudes and experiences are exposed within the family discussion. The toleration of the therapist removes the sting from all these experiences; in particular, guilt is relieved.

Revealer

The therapist reveals and clarifies. He does not interpret (translate) into other terms. The only valid term is life experience, factual and unadorned. Revelation must not occur too soon or be used to hurt. It must never be more than can be endured – and the capacity for this depends on the degree of security. Benevolence creates increasing security and increasing endurance. Naturally, revelation itself does not produce change, but is a prelude to change.

Attitudes

The therapist's main task is to reveal to the family its collective group psyche based on the family imprints from the past. This is analysis only. Reconstruction must follow. Thus, as will be discussed later, he then has to mobilise the assets within and without the family to overcome its liabilities. He needs to build new healthy coping devices and he needs to find ways to circumvent deficiencies produced by the preceding families. Handicapped family members have usually experienced unhappy family relationships in the past. Now they are in touch with a benevolent family figure. This figure, however, exercises no power. Indeed, one of the lessons he has to teach the family is not to use force, power or authority. He aims to create a situation of security wherein the family can reveal itself, work towards resolution and thus change.

Craftsman

A therapist is a craftsman, a trained expert. A therapist should not appear to be a god, it is said, and should therefore admit weaknesses – it makes him human. Patients do not expect their therapists to be gods, but they do expect them to be craftsmen. To admit having weaknesses, of any considerable degree, is a negation of expertise. Affection can be expressed without the admission of weaknesses. This attitude of apparent honesty relieves the therapist of feelings of guilt at inadequate performance; an even more honest attitude would be to admit the need to change vocation. The therapist is fundamentally an expert and a craftsman, who uses the warmth given him by his family as an affective and effective tool in his task.

A figure in his own right

Therapists are not necessarily parent figures. Though in child development literature prime place is given to mother, in therapeutic literature father often comes into his own as an all-powerful, supportive father figure. But this is a distortion of events. Father, mother, uncles, aunts, brokers, butchers, jockeys p all can have personal qualities of the highest emotional quality. Indeed many jockeys are also fathers. What people crave for at all times from others is an affectionate relationship. This is more important than its sources, even if the latter are the parents. Love is more important than parenting. Parenting may or may not supply it. Others may or may not. Thus a therapist is not just a parent figure – he can be a figure in his own right. A therapist is not a good mother or father figure, but a good therapist.

Security-inducing figure

A number of therapists fail because they are constantly at war with the family under therapy; there is a need to outwit, manipulate, score off, feel omnipotent towards, or crush with hostility. At best this is bad technique, at worst this reflects the therapist's experience in his preceding family. Consider the following extract from the literature:

> As D. X suddenly flipped from his *mimicking* involvement with the family to being *sarcastic*, you had the feeling that the family was suddenly being *cut apart*. I think it is necessary at times *to hurt* in order to get at the pathology, in the same way that you can't get at the appendix unless you go through the skin and belly. And then he got *sneaky*, as a master *manipulator*, and the rest of the film, to me, could be lumped in this area. (Author's italics.)

Here, we have mimicking, sarcasm, to cut apart, hurt, being sneaky, manipulation. This is not therapy but war – and of a dirty variety. The analogy with surgery is unfortunate; great surgeons are renowned for the minimum of trauma, effortless technique and absence of drama. The above is not analogous to surgery but to butchery. Confrontation is at its height in films and public performances of therapy. The insecure therapist needs to exert himself, there is much blood about, the drama is great – but the family bleeds. And the audience, all would-be therapists, identify with the powerful therapist and soon the family has ceased to be as it is. It is a thing apart, responding to different roles, with different feelings, a savage dangerous thing. But it is not really different. Its members are as we are. They are us.

Hostility brings insecurity and the need to defend – even by force. Thus it maintains the unhealthy coping devices. Security is an essential precursor of change.

Therapist/parent interaction

The essential confrontation is between the family of the therapist and the family under treatment (and their preceding families) or preceding family of the individual patient. Both father and mother in their preceding families and children in the present family have undergone a holistic experience – an interaction between child and father or child and mother. (In the literature on child psychiatry, because mother comes to clinics with the child, there is an emphasis on the mother/child relationship. In literature on what is termed "transference", as the therapist is often a male, there is emphasis on the father/child relationship. Both are artefacts.)

The therapist also represents a family, complex and multidimensional, a family of the best kind. He is the amalgam of a superb G factor plus special skills. He is himself. Patients are not in touch with a phantom of their own making, but with a real person. They react to the therapist as the life experience to date, especially in their families, has taught them.

The way they interact with the therapist is personal to them and their experience and speaks of it. Thus it is helpful in diagnosis. But this is diagnosis and not therapy. It is not correct to interpret (ie translate); one should reveal. Any knowledge from the interaction reveals the preceding family; no interpretation is required, but simply the revelation of facts about the preceding family.

The best therapist will be aware of some weaknesses in himself – real ones from his family – and will make allowances on this account. The patient is not interested in this. To expect help from a patient is ridiculous. The therapist must go elsewhere for any help, or in the event of marked weaknesses, seek other work than therapy. In the past, the analysis of "counter transference" has been a substitute for a sound therapist.

"Transference" and "counter transference" are a part of the interaction between patients and therapist. To claim that they are the whole, the major part, the more important part, of the interaction gravely limits the interaction and its potential.

Diagnosis is not therapy. The therapeutic element depends not on the analysis of the communication, but the capacity through the communication to give a new constructive experience, ie a benexperiential therapy. This is not achieved through an interaction with a projected image imposed by the therapist. The ideal therapist has an easy time – much of the time he automatically does and says the right thing.

Non-verbal communication

The greater part of the communication between therapist and patient occurs at a non-verbal level – an intensely affective level. Eyes, face, posture, gesture and movement convey interest, encouragement, praise confidence, security, toleration and the expectation of change. It has the added advantage of being time-saving. Time consuming verbal communication alone is almost exclusive to the insecure family group.

Effective therapy takes place in tranquillity, peace and orderliness. Drama is for the ineffective.

Organisation of Benexperiential Psychotherapy

Here, the discussion will be concerned with the interview termed "family group therapy". This is the basic interview in family psychiatry. Nevertheless, other types of interviews will be employed from time to time. Work should be flexible. The appropriate interview procedure is employed according to the dictates of the situation at a particular moment in time. Flexibility is the keynote. Circumstances may sometimes dictate that only a particular interview procedure is possible, but one aspires to the most appropriate at a particular time in a particular situation.

Types of interview

These are:

(i) Individual interviews.

(ii) Dyadic interviews involving any two people and the therapist.

(iii) Family group interviews involving the whole family (this may sometimes be a partial family group).

(iv) Multiple family groups – the present family may get together with related families, such as preceding, collateral or succeeding families.

The group may consist of a number of unrelated families.

(v) General groups – these consist of members of unrelated families and have many variants, depending on gender, vocation, type of problem, etc.

Comparison of Family Group Therapy with Individual Therapy

Family group therapy has some features in common with individual therapy. But in family group therapy the number of relationships is greater, the therapist is part of a web of communication and he addresses himself to the "collective psyche" of the family. The great advantage of family group therapy is that in the group there is a built-in corrective to misinformation by an individual by the sifting and re-evaluation

of the others. Furthermore, it is possible to deploy assets not only in the therapist, but also in the family itself.

Comparison between Family Group Therapy and General Group Therapy

General group therapy treats together a number of individuals from unrelated families. Groups may be male, female or mixed. They may meet formally for intensive therapy, or informally in a club setting. One or more therapists may be employed, and the clinical material is interpreted according to the school of thought of the therapists. The aim is to bring profit to each *individual* in the group.

The family group has a strong identity which reaches from the Past and extends into the Future. It existed as a group before therapy, and will go on after it. It is a heterogenic group of both sexes and of all age groups. It is subject to strong influences from the extended family group. Its members have learnt rigid patterns of behaviour and communication, in relation to one another. Each member of the family has strong meaning for the others. Powerful emotions can be aroused in it, for good or evil. The strength and cohesiveness of a family group often become strikingly apparent when it is attacked from outside. The aim of therapy is to change the *collective psyche* of the family.

Flexibility in therapy

It must be emphasized that family group therapy is but one procedure of benexperiential psychotherapy, which in turn is only one part of family therapy. The use of family group therapy alone seriously limits the treatment of the family. Benexperiential psychotherapy, vector therapy and preventive psychiatry are complementary, and the most effective family therapy employs all these procedures simultaneously.

The therapeutic needs at a given moment can be met by a flexible approach ready to utilise whatever is appropriate. Thus, individual and family group psychotherapeutic procedures may be employed together, or family group therapy and vector therapy, or family group therapy and dyadic therapy, etc. Whenever possible, the whole family must be involved in the treatment process; this does not mean just for family group therapy alone, but applies to all the therapies appropriate to the task at that time.

Treatment may have to proceed with an individual, or with only a part of the family; this may be so because of inability to involve the whole family or because of the dictates of the treatment situation at that moment. But if only a part of a family is under treatment, the rest of the family is not overlooked, and the aim does not change; to adjust the whole family is still the target.

With the consent of the family group, family members can see the therapist alone, but with the understanding that, whenever possible, material relevant to family life must be reintroduced to the group. The therapist applies no pressure; he concentrates on producing security which makes revelation possible to the rest of the family. The therapist, of course, does not allow himself to be used against the family, or to show special favour to any one member. Whenever misunderstanding threatens, it pays to subject the situation to the scrutiny of family discussion; capacity to understand is often greater than imagined. There is no doubt that an experienced family therapist is more comfortable in family therapy than in individual or dyadic therapy, where there is always anxiety lest unseen family members are not taken into account.

The following illustrates the need to be flexible in family group therapy and to allow fragmentation when required:

> A father, mother and daughter meet together for family group therapy. At one moment father becomes silent, anxious and restless; the group makes no progress. The father then asks that he be allowed to see the therapist alone. When he does so, he relates that some time ago he had an involvement with a third person. He ends by wondering whether this information should be imparted to the family group.
>
> Discussion may show that two plans should be considered: (i) that the material imparted is of no significance to the rest of the family or (ii) that it is of significance to the wife, who, the patient feels, may suspect the situation. He asks for a meeting between the therapist, the wife and himself, as he feels that the matter needs resolution. Husband, wife and therapist meet – dyadic therapy. Again the couple wonders whether the information should be imparted to the family group. They decide that the event has no significance for the adolescent daughter, and they do not wish to introduce the material to the group. Or they may decide that the daughter may already suspect this relationship, is worried about it, and the matter should be divulged. Thus, the therapist, mother and daughter meet to discuss the situation. Thereafter, family group therapy continues.

Selection of families

Few units are so well staffed as to be able to apply family group therapy to all their families. Thus, selection becomes necessary. In general, units deploy their facilities to give optimum value to the community. Therefore the families selected are those with a degree of disturbance likely to respond, in a reasonable period of time, to the treatment offered by the facilities available. Families with young children have a degree of priority. They have young parents; young parents have not been emotionally ill as long as older people, and thus respond more readily to treatment. The younger the children when treatment is established, the more they profit. The number of children in the family is a factor in selection; the greater their number, the greater the benefit that will accrue to society by improving their emotional health. In all families, whatever the degree of disturbance, efforts should always be made to bring relief to the children, the young generation and the generators of new families; we must invest in the future.

To make priorities when so many require help is a trying matter. But if the number under therapy exceeds the resources of a particular institution the standard of therapy can deteriorate to the point that no one receives effective therapy. When allowance has been made for administration, staff contact, meetings (and excessive conferencing is a sign of inexperience and inefficiency), reports, course attendance, teaching and investigation, a possible therapeutic weekly period of 40 hours can easily become 20 hours. This means that ten families receive two hours from a therapist if seen weekly, or 20 families if seen fortnightly – less contact than this is not valuable. Thus, interview therapy is exceedingly expensive of time and money. A clinic with five therapists might have 400 families referred to it, but be able to offer therapy to 100 families for two hours a fortnight or 50 families for two hours a week. If a clinic is wasteful enough to use two co-therapists, the number of families receiving treatment would drop to 50 families if seen fortnightly, or 25 families if seen weekly. Thus, selection of families is imperative.

It is still a matter for amazement that some clinics aspire to give all patients a complete form of psychotherapy; they end up in a scramble to cope that means superficial, wasteful therapy.

Normally, the best deployment of facilities involves selecting a few families for complete antecedental psychotherapy, a larger number for focal antecedental psychotherapy, and the largest number for actuality psychotherapy and vector therapy. Vector therapy has revolutionised the effective use of time and is usually the procedure that gives the best rewards for the time and resources available. However, the lengthier methods continually unearth new knowledge and techniques that can then be applied to the shorter methods.

Some “hard core” or “problem” families in small number are invaluable as teaching media for trainees. Thus a few should be in the treatment programme. Some help is given and the reward for this in understanding the mechanics of family life is enormous.

Senior staff members of an institution should constantly remind staff of the cost of time. Endless discussion and counterdiscussion, often purposeless, can go on. The greater the time spent on this, usually the less effective the therapists. It is a measure of the need to question whether the right staff members have been selected. Naturally, some time must be spent on structured, fruitful staff communication.

Home or clinic setting

Family therapy usually takes place in an out-patient clinic. Few clinics offer a service in the family’s home. It is held by some that therapy in the clinic is a less artificial situation than therapy in the home, where it creates embarrassment to the family by provoking the interest of neighbours, and where distractions are many. Therapists feel safer in their own clinic setting and claim that it offers a controlled environment, which makes diagnosis easier. Others claim that the home, as the family’s natural setting, is more revealing, that it is easier to collect family members together there, and that it offers less distractions than a clinic. Probably the main determining factor in choice of setting is the time factor; it saves therapeutic time to bring the family to the clinic and this time is always at a premium. The family doctor, family nurse and family social worker, on the other hand, may find the home to be the best platform.

Home versus clinic setting is not a key factor in therapy. Given the right therapist, the all-important communication can ensue in any setting.

The clinic setting

The family group usually meets in the clinic setting. They can meet informally in a comfortable circle of chairs, or seated round a table. All members of the family of any age group, including infancy, are present. Less than one-and-a-half hours is unlikely to be worthwhile, and more than two-and-a-half hours is likely to be exhausting. About two hours is the average period for a group meeting. Family groups should, if possible, meet once a week and no less frequently than once a fortnight. There are times when a longer meeting with rest pauses may be indicated – even for a whole day. These longer sessions are useful for dealing with a crisis, or when the family has reached a point where it feels able to resolve a particularly difficult situation. This is a modification of the multiple impact therapy developed by the Galveston, Texas, group of workers; they brought a family into a residential setting for a once-and-all therapy with a stay of two to three days.

The room should be restful and quiet. Lighting should allow easy visibility, while being subdued and not harsh or revealing. All the chairs should be of equal height and size; the therapist claims no privilege. There should be playing material and reading material for the children. All need access to a toilet. A profitable arrangement can be to plan evening sessions for families unable to get together during the day.

Size of group

In family group therapy, concern should be with individuals who have emotional significance as a group. This, most commonly, is the nuclear family. But a blood tie is of secondary importance to an emotional tie. The family group in therapy should consist of those who are involved together in an emotionally significant way. Thus, the functional rather than the legal or physical group is important. For example, in a particular set of circumstances a lodger may be a more important father figure than a husband; a nanny may be a more important mother figure than the natural mother. Thus, added to the nuclear family, there may be grandparents, siblings, relatives, neighbours, friends, acquaintances, servants, etc. Always, the approach should be flexible – in the course of therapy the group may need to shrink or expand.

Confidentiality

This applies at two points. Firstly, retaining information in the family group and, secondly, dealing with confidence as it concerns one family member within the group.

Families need to be assured that information will be kept confidential. Information must be assumed to belong to the person who gives it. It is imparted because only in so doing can the help needed be received. If it is communicated to others outside the family by the therapist, it must be with the clear understanding and permission of the family or the particular family member. Thus any recordings or notes must be made with their agreement and the anonymity of the family must be protected when they are used outside the immediate therapeutic situation, eg in teaching and writing. To fail means poor communication and ineffective therapy.

Within the family group, an individual may have information he wishes to impart to the therapist only. Similar “special information” relationships develop naturally within the family. The need for this is respected. While a particular family member’s right to communicate alone with the therapist must be maintained, its handicapping effect on therapy must be pointed out. With increasing confidence, more and more information is thrown into the common pool by the family members. Especially in early interviews, the family group cannot produce complete security and thus complete communication. To force it beyond what the relationship in the group can stand creates greater insecurity and impedes progress.

Recording information

Given the agreement of the family, the interview can be recorded by sound or video tape. As a means of expediting day-to-day therapy, recording on tape and video has a limited part to play. Seldom does a therapist have time to consult a two-hour tape before engaging on another session. If this were done as a routine the number of families helped by a team of five therapists in one year and seen once fortnightly could shrink by half to 50 families! However, there are times when a family will profit from having a previous session played to it on tape and discussing it. More usually, the part played covers some especially significant part of the interview. Thus, any of its tapes should be accessible to a family, but the playback used with discrimination, eg a family member may not yet be secure enough to stand the

revelation that in an interview he gives himself away so clearly. Again, one family member may use a section of tape to score off another member. Therapy aims to teach that such hostility is unnecessary.

The great value of recording interviews is in research and teaching, and not in routine therapy.

Communication

The prime channel of communication within the family group is speech. However, much more occurs which has meaning to the family. The seating arrangements can reflect divisions and coalitions in the family. Posture and gesture may convey what is felt and perhaps what an individual might wish to do, or how he would like to be regarded, his aspirations, and his defences. At first the therapist may find it difficult to understand both the verbal and the non-verbal communications, as families have idiosyncrasies. He must, with time, become attuned to the language of that family. The role of non-verbal communication has already been stressed as a major part of the skills of the therapist.

One or multiple therapists

Another matter of organisation is that concerning the choice of one therapist or several. Usually, economy dictates the choice of one only. At first, therapists new to the field have difficulty in shifting loyalty from one person to a group. Yet, all have had experience of such a loyalty within their own families; such a shift is possible once the group idea is grasped and habit given time to work. Having a number of therapists carries the danger of each forming an attachment to an individual family member and setting up rivalries. On the other hand, if more therapists are introduced there is more dilution of family disturbance. It has been argues that a number of therapists are collectively wiser and more skilled. But an experienced individual therapist should have the skill to manage alone. The greatest problem in having multiple therapists, and the final argument for one therapist, is maintaining adequate communication between a group of therapists; one therapist is usually of one mind, and comes from one preceding family.

Much profit comes in teaching from bringing a trainee into a family interview if this is tolerable to the family. Skills can be maintained by therapists playing video tapes of their therapy to colleagues for comment.

Preceding families

When a family has a member with psychopathology springing from a preceding family, then that preceding family should always be involved if it is accessible. It is much easier to resolve difficulties in the past if the past can be made present. Resolving the past through the imprint of the past life in the individual is more difficult. The preceding family is seen with its family member from the present family or jointly with the present family – depending on what is required. Even two preceding families or collateral families may be included. This latter is a form of multiple family therapy.

Prognosis

The effectiveness of family group therapy is dependent on a number of factors: (i) The less the degree of family disturbance, the more rewarding, of course, is the therapy – with our present knowledge, even the best therapists may have difficulty in resolving a severe degree of family emotional disorders. (ii) Problems of the Present

resolve very satisfactorily – problems with deep roots in the Past are resistant. (iii) In general, the younger the family members, the more effective the therapy. (iv) Recent acute situations resolve more easily than long-standing, chronic situations.

Even in the most resistant families, family group therapy can be a valuable technique in conjunction with vector therapy; insight can develop to the point when the family can accept adjustment which will change the pattern of intra- and extra-family dynamics in its favour.

Equally good results can be obtained with all clinical categories, including the psychonotic, the psychopath, the alcoholic and the delinquent. In the writer's experience, family group therapy is not a profitable procedure for "process" schizophrenia.

What constitutes resolution will depend on the target set. Targets could be:

1. Relief of the presenting symptom in the presenting family member.
2. Resolution of psychonosis in the presenting family member.
3. Resolution of psychonosis in all family members to make the family harmonious in present circumstances.
4. Resolution to the point when the contribution of this family to the foundation of succeeding families will be healthy.
5. Complete resolution of psychonosis throughout the family to guarantee harmony under all ordinary circumstances.

Clearly (1) is much easier to achieve than (5), which is only occasionally attempted.

A routing follow-up contact with the family can reinforce previous procedures, offer continuing support, and may, with the detachment of time, allow a realistic appraisal of the extent and techniques of clinical effort. If investigation and diagnostic procedures are carefully followed, the family indicators will have been carefully recorded before therapy. Following therapy, the family can be reassessed as to the state of its indicators and a comparison made with its pre-therapy phase.

There are few good follow-up studies of family group therapy. Problems of evaluation, which are considerable in individual psychotherapy, are even greater in family psychotherapy. Often family group therapy amounts to an evaluation of family dynamics without any clear benefit to the family, analysis without reconstruction. Allowance must also be made for the fact that factors change by time alone; chance may change the pattern of adverse vectors to their advantage and the longer the therapy (and thus, time) the more likely this is to happen.

However, careful research could show that family group therapy is not only the most potent form of therapy, but also has, in most situations, a clear advantage over individual therapy.

Individual interviews

There are a number of indications for the use of individual interviews.

1. An individual person is the referred patient and the rest of the family refuse to co-operate.
2. The referred patient is a single person and it is not immediately possible to involve the preceding family.

3. The referred patient is an individual with a problem that does not involve the rest of the family – but later it may be necessary to involve the preceding family.
4. The referred patient does not see at first that the present family is involved.
5. Having started with a family or dyadic interview, a family member requests an individual interview for clarification of what appears to him to be a personal problem.
6. One family member may alone show psychonosis of a severe degree. To cope with his experience in his preceding family, individual interviews run alongside the family group therapy. This may be a prelude to involving his preceding family.

It is not necessary to elaborate on the procedure of an individual interview here, as its main features are similar to those of family group therapy. Usually, interviews last 50 to 60 minutes but may be usefully prolonged at significant points in the therapy. The individual may be of any age group = child, adolescent, middle aged or of old age.

It may be useful to briefly outline the steps in the therapy of children.

In the Institute of Family Psychiatry, a child psychotherapist undertakes the investigation and treatment of the child patient in collaboration with the family's psychiatrist. Together psychiatrist and child therapist outline the project for a particular child.

The first aim is usually to establish rapport by the use of much play material. Thereafter, systematic observation of the child takes place in the play situation; this gives a base line for comparison later on.

Play diagnosis follows. The aim here is to encourage the child to reveal his problems as he knows them and also to express what he knows about himself and his relationships within the family, the school and the neighbourhood. A young child can only communicate through play; an older child may spontaneously verbalise to the therapist. The play medium appropriate to the child's age, sex and inclination is supplied. It is usual to corroborate information obtained through one medium by that disclosed by another. There is a systematic evaluation of the child's family life.

Play therapy is the final technique and is employed for one of the following reasons: (i) to support the child while the parents are receiving treatment; (ii) to support the child when the family environment cannot be changed, or when he cannot be separated from it; (iii) to help separate the child from his family, either for short or lengthy periods; (iv) to make a lasting change in the child's personality. The relationship between therapist and child is the most potent therapeutic medium. Within the safety of this relationship, the child expresses his fears, guilt, hate, and, sharing these with the therapist, is encouraged to healthier reactions.

Child psychotherapy is at its most effective when undertaken as part of family therapy.

Adolescents are particularly sensitive to such matters as being regarded as adults, confidentiality, and the relationship between the therapist and their parents. It is often

wise to commence therapy with the adolescent in individual interviews. When rapport is established the advisability of a family group interview is discussed. He will need reassurance that any matter that has passed between therapist and adolescent can be kept confidential as long as he wishes. The aim and organisation of the family group interview is also the subject of preparation.

Dyadic interviews

A dyadic interview is an interview that includes a dyad in the family – these can vary greatly, but the commonest of those that include the marital couple, parent and child, or two siblings.

Indications for a dyadic interview include:

1. The referred patient may be a couple and it may be necessary to start with them before including the rest of the family as they do not see that the rest of the family is implicated.
2. They may alone be available. They may have no children or immediate relatives.
3. Other family members may refuse to co-operate.
4. At a given moment in family group therapy a particular relationship may require special attention.
5. A dyad may have a problem that does not include the other family members.

Sometimes before embarking on dyadic interviews it is wise to see each person individually. The right moment to bring them together can be gauged after preparation. Again when the situation requires it, they can receive individual interviews and this is made clear to them in the preparation. The bringing together must not be over-hasty. Some interviews may be too traumatic – one or the other member may not be ready for harsh revelations, rapport may suffer or he may move out of therapy. Family members sometimes cope with one another by being secretive, withholding information or saying little. These coping mechanisms must not be pushed aside until both partners are secure enough to deal with the consequences.

Multiple family therapy

Here, a number of families come together for therapy. Multiple family therapy is of two types:

1. The families are related, eg starting with the present family, either a preceding family or collateral or succeeding families are brought in. They can be immensely valuable in either benexperiential psychotherapy or in vector therapy. The clan has assets and resources, and these can come into play. Naturally, the process is not undertaken without the understanding and preparation of the presenting family.
2. Unrelated families. These are less useful. Each family has its unique historical background and a psychonosis arising out of it. These preceding families are not available and the crucial past situations cannot be dealt with. Each family is anxious to receive help for its own problems.

Such groups are most useful when discussing general problems of living which are of common interest. It has been argued that disturbed families can help one

another. In general, disturbed families, like disturbed individuals, are not effective therapeutic agents. The other families are particularly prone to pick up the unhealthy reactions. Such families are not very understanding, and less so than a well selected and trained therapist. Normally, families profit from contact with healthy families. There would be more profit in mixing healthy and unhealthy families – with a preponderance of healthy ones. But healthy families usually see no good reason for being used in this way. It should be remembered that the larger the group, the more diluted it is. Furthermore, the larger the group, the less often can one member of it talk in a given period of time. As in all groups, there is an optimum size for useful communication. The group should probably not exceed seven persons.

General group therapy

These groups include a number of people from different families. They are organised in various ways:

1. By age – groups of children, or adolescents, middle aged, aged.
2. By sex – groups of men or women.
3. Mixed sex groups.
4. Economic, social or religious groups.
5. Groups, all of whom have common syndromes, eg agoraphobia, asthma, fetishism, etc.

Activities can be very varied – some groups revolve round discussion, or dancing, teaching, art, etc. Some groups have a number of activities and take on the features of a club. All are of value in a supportive way.

The most useful groups are those in which a number of healthy people are able to exert a precise effect on a small number of sick people. Naturally, the younger the patients the more rapid the change. Thus groups are especially useful for infants (day nurseries, play groups, children's clubs, adolescent's clubs, etc.). Here we impinge on vector therapy, to be discussed later.

Even larger groups are useful (i) for their supportive effect, (ii) for discussion of general problems of living, and (iii) as a means of diagnosing and having access to vulnerable people.

However, they are not a very potent therapeutic milieu for advanced ill-health because:

1. Each member of the group has a different preceding family unique to him.
2. Attitudes from the past interfere with the present family, who cannot be dealt with as that family is not there – nor its preceding family.
3. Each member is an epitome of its own family and each strives for expression.
4. The amount of collective psychopathology is great, but there is no common interest in dealing with it.

At this point we also touch on group relations in in-patient care, and this will be discussed under vector therapy.

Elements of Technique in Benexperiential Therapy

In the discussion that follows it is assumed that the standard interview is the family interview; most of the information would also apply to other types of interviews.

Major principles.

Insight. To confront is a hostile exercise. To reveal is untraumatic. Revelation is tolerable in the security of a sound relationship with a therapist. Insight implies the understanding of the significance of psychic events as they relate to that person or family. It leads to an awareness of the psychic noci-vectors that led to the damage to the "idea of self" in the past, the vulnerabilities there were produced, and the coping devices employed. It allows awareness of the psychic noci-vectors operating today on vulnerabilities produced by the past.

Insight is only a prelude to therapy.

Psychic noci-vectors now. The psychic noci-vectors or vectors must be identified. They may be operating on a sound personality or on a vulnerable personality, which, on removal of the vectors, can only return to its pre-traumatic state.

The following procedures, alone or together, are employed against the noci-vectors:

1. Resolve the conflict of attitudes from which the vector comes. Thus the quality of the vector can change.
2. Reduce the power of the vector. Frequently, preoccupation with it allows it to dominate thought and appear more threatening than it actually is. Thus putting it in perspective will reduce its power.
3. Reduce the time over which the vector works.
4. Arouse assets in the individual to measure up to it. Self-confidence allows of healthy coping.
5. Share the experience with the patient and allow other constructive people to do the same.
6. If it is not essential to his interests to meet it, allow the patient to side-step the vector without loss of face.
7. Counter the vector with opposing vectors of greater strength, repeated, and of long duration.

Damage to "idea of self" in the past. The damage is repaired by putting the self through a benevolent new experience. This is a process. A process is a "continuous series of events", eg guilt, with its damaging feeling of unworthiness, having been exposed, is countered. The security of the relationship with the therapist or others and the reduction in damage allow maladaptive coping devices to be put aside and be replaced by new healthy devices – usually imitated from the therapist or others and the reduction in damage allow maladaptive coping devices to be put aside and be replaced by new healthy devices – usually imitated from the therapist or others. Special attention should be given to the more powerful coping devices listed previously. Insight allows identification of previous damaging vectors; to use benevolent vectors of reverse but greater power than the damaging vectors is central to success.

It is crucial to understand that a process requires time over which to operate. The greater the damage and the longer it has been operative, the longer the period of therapeutic time required. Intensity of therapeutic process can reduce this period.

The greater the damage, the greater the number of unsatisfactory elements in self, and the greater is the therapeutic effort required.

It is fundamental to understand that the therapeutic process need not take place exclusively in the interview situation. The following are possible:

1. An exclusive interview process. This is necessary for very damaged people and calls for frequent interviews over a long time.
2. Guidance by therapist and use of others, especially the family, as allies in therapy.
3. Vector therapy, guided by the therapist. Benevolent influences in the family and outside are utilised to repair the damage to self; they can also be used to counter any psychic noci-vectors in the present.

The importance of the process and the use of extra-interview therapists can be shown by two brief illustrations, one from ethology and one from clinical practice.

Harlow (2) and his colleagues have been conducting for many years a series of intriguing experiments with monkehy. This work passed through a number of phases and has now reached the ultimate in interest. The sequence of events was as follows:

> A number of young neurotic monkeys were produced by deprivation situations. Some grew up and the females were mated. They became neurotic mothers and rejected their infants. So severe was the deprivation of the infants left with their mothers, that they had to be rescued. The workers now sought some means of treating these second-generation disturbed infants. They tried behaviour therapy in vain. They tried the care of adult monkeys – but these punished the infants and there was no success. They then paired a disturbed monkey with a healthy monkey. The older monkey did not threaten the younger, nor did the younger impose rules on the older. The relationship prospered and in six months there was a marked improvement in the older monkey. The workers concluded that the young monkey was effective, even though it had never read about psychotherapy!

Here is a therapeutic process at work – and effective. To understand this process is to know the full nature of therapy. We now know a great deal and can hasten and enrich this process. But, even without full knowledge of its nature, the right process can still work.

> Mr. X is an angry man. His father was an angry man. His father made him very insecure and damaged his “idea of self”. His father ignored him and he is very sensitive to being ignored. It makes him angry – this is the device he adopted from his father as a means of coping. Mr. X is quickly angry – not only with men but with women, his wife, his son, his daughter, his friends. Ignore him and he is angry, and it matters little who ignores him. He feels “little inside”, unworthy, despised. Mr. X has help. His preceding family is not available. A strong secure relationship allows him to talk without shame or fear of his early deprivations. But that alone does not make him less angry. The relationship passes into its constructive phase. In a long, intense companionship he is given attention, his assets are realistically emphasised, is

self-appreciation improves, and his most sensitive vector, being ignored, is negated by attention.

Others are encouraged to enmesh him in the same pro-Mr. X experience – ie benexperiential therapy. Thus therapy was shortened by the use of the extra-interview therapists.

Fallacies

It may be useful to outline some of the major shortcomings of some methods of therapy used at present:

1. *Listening* is not enough. There has been a tendency to regard the therapist's role as being a passive one of listening. This is far from the case. In the diagnostic formal phase there must be active questioning with much participation by the interviewer. In the elucidation of psychopathology the role is less active, but direction is required to cover the whole area and active clarification of data may be required. As we have seen, the therapist has a highly active role in therapy, even if non-verbal; guidance, experiential process work and decision making are essential parts of his role.
2. *Decision making* is an essential part of therapy. It is held that the therapist must never make decisions or even be involved in the decision-making process. This at worst is a deliberate avoidance of responsibility, at best it is bad technique. In surgery such a situation would be unacceptable. Take a moment of decision in psychiatry, eg the decision by marriage partners to seek a divorce. This requires involvement. The formula is not "I will make the decision for you", but rather, "We will explore the situation together and my skill will clarify the issues for you better than you can do on your own. In the light of this, you and I will be able to arrive at conclusions. If you and I disagree, I shall make my view clear to you and you have a right to follow the course you wish without my concurrence as to its wisdom, but still with my support. If we agree, you will be able to carry on with my concurrence." Support is never withheld, there is no upset at advice not followed, blame and guilt are not part of the transaction, and for the patients to change their mind later is a possibility. But the therapist does not shirk being involved in decision making. Skill cannot develop in situations where there is avoidance of responsibility.
3. *Diagnosis* must precede therapy and not be confused with it. To garner information, to develop insight are elements of diagnosis. But diagnosis and information collecting must proceed to the point of relevance only. To avoid decision making, it is easy to slip into a situation where it can be said "but we have too little information". This puts off the evil day of decision making. It is not usually relevant to know the colour of the maternal great grandmother's hair before coming to a conclusion as to whether William should live with his father or his mother.
4. *Insight* is not enough. To explore a situation and reveal why a trauma was suffered is not of itself therapeutic. Insight is a prelude to the constructive phase which of itself is therapeutic. To be aware that one's finger hurts because it has turned septic does not of itself open the abscess, but it is an essential prelude to effective therapy. In psychotherapy, the constructive phase is much more difficult and hence there is a tendency to be content with insight.

5. In decision making, the family or individual has no greater *wisdom* than the therapist; if the latter is competent, he should have considerably more wisdom than the patient. To shirk responsibility it is easy, when convenient, to say, "The patient knows best and can make the decision". But it is the patient's confusion that has brought him looking for help. Psychopathology is a complex field for the most experienced; the patient is usually lost in it and the more disturbed he is, the greater his confusion.

The warming-up period

In every course of therapy, there is an initial phase of warming-up which may extend from a few minutes to several interviews. This is inevitable, as the therapist and the family have to get to know one another. The family has to go through a period of convincing itself that it can allow the therapist to join the family, that it can trust him, have confidence in him, and confide in him as an equal partner. To some extent every interview starts with a warming-up period. The therapist must be sensitive to the need for a warming-up period.

Explanation

It is valuable, at the start of therapy, to explain to the family the expected organisation in general terms. It is possible also to explain to them in outline the rationale of therapy, as sated above. Furthermore, it is wise to point out some of the rules under which the family is meeting; for instance, every member of the family has equal voice, whether it be child or grandparent. Not all these working rules will be acceptable at first. Again, the family will go through a testing-out period, but the attitude of the therapist continually reminds the family of the working rules.

The facts and no interpretation

Interpretation in family group therapy is in a sense a contradiction in terms. The only truth is the truth of an event within the life experience of a particular family member or a particular family itself. The event does not need interpretation, it is a fact. Thus, a therapist enslaved by interpretation theory will be less effective. It is only the family who know the facts at first.

It can be educative to hear three experts discussion information conveyed by a patient. They can radically disagree amongst themselves, biased by their personal experiences and their school of interpretive psychopathology, but the only true meaning of the information is that given by the fourth person, the patient himself. Broadly, people's experiences follow the same pattern, but the significance of events is unique to each person. Stereotyped interpretations have little significance. The therapist must constantly be on guard against assuming that other people's life experiences are like his own and have to be interpreted in the same context.

The greatest errors are made because of dogma – situations and words are distorted to fit in with the creed. Let me illustrate. A therapist is helping a husband and wife with their marital problems. Discussion turns to sex and they reveal a most unsatisfactory situation in the physical act which has steadily deteriorated since the start of the marriage. The therapist, by his canons, traces everything back to sexual disharmony. Yet data are produced to show that both partners have had satisfactory sex relationships before marriage, succeeded early in marriage and do now on the rare occasions when they are happy together. The partners insist that their problem is one of personal incompatibility. The therapist insists it is sexual incompatibility. They seek help for their relationship as they are convinced, and know, that given harmony

the sexual intercourse would be satisfactory. But they are offered advice for the sexual disharmony alone.

Some regard objects and even words as having special significance and always to be rigidly interpreted in a particular way, eg one therapist equates “dog” with “prostitute”. Any mention of a dog carries this hidden meaning. For some people in special circumstances this might be so, but for a large number of people a dog is a dog. The term “gas” by the same therapist is equated with the anus and hides anal eroticism. The word “piece” is equated with an “attractive woman”, whenever it is mentioned.

We can see how remote from reality the explanations become when we study this brief extract from an interview:

> Father picks at his nails. Therapist observes this and calls attention to it. At this point son, in defending his father, is critical of his mother as the mother has said this is a disgusting habit. Therapist then makes the remark to son, “What kind of piece would you like to pick out of your mother?”

The therapist claims he made this remark to bring out son’s erotic interest in his mother, ie mother is a “piece”. But he is arguing from analogy, and very approximately at that, and giving special meanings to words. It is father who picks at his nails and not son, even if we accept that to pick at one’s nails is hostility. But it is son who is hostile and he is not “picking”. Hostility and picking are given to the son when hostility alone belongs to him. The therapist in his mind then links picking with a “piece”; piece is equated with “attractive woman” (when it could just be a piece of nail or anything). But the word “piece” was first used by the therapist and might reflect his views, but hardly those of the son. Then it is further assumed that the son has an erotic interest in the mother, even though he did not use the term. This is sheer fanciful invention decreed by dogma and takes us away from the facts. The true meaning is simpler and more direct; the son wishes to support his father against the hostility of the mother and the therapist, who has made a partnership with her/

Again, take statements based on preconceived ideas such as: “The child is in love with its mother. This is why he is hostile to his father.” But he may love both. Or: “This child (of three) always wants to go to the parents’ bedroom in the mornings. He wants his father out of his mother’s bed, so that he can have intercourse with his mother.” An interpretation is put upon a situation which is not proven; many other explanations are possible. Furthermore, as ideas are based on sexual pathology alone, adult notions are transferred to the child. Situations are made to fit fixed ideas. Chance associations are given casual significance. This distorts the truth.

Patients, individuals and families, do not always find it easy to grasp the significance of events. They are not psychopathologists. They more readily see the significance of a chain of material, rather than of emotional, events. They wish to forget what is hurtful, embarrassing and damaging to the “idea of self”. Thus, they must be led to the truth and the truth lies in real events. To misinterpret adds to their difficulties. (But they can come to believe the misinterpretation.) The exercise is only necessary and justifiable if it can lead to what they want – help. Thus, it is necessary to point out, explain, clarify, underline, reveal – but not to distort.

The therapist, equally, may not know. He has not the capacity to know simply by wanting to. He is dependent on data. He must have facts and the facts must be real. The facts are concerned with the people he helps. The therapist may, by his greater

knowledge of similar situations, arrive at the truth before the family. He should guide them to the truth – by revelation, clarification, explanation, and sometimes by repetition. Explanation must be in words they can understand. If a family comes to the truth in terms of a dogma, then it is likely that the therapist is imposing foreign notions upon them.

There is a time and a way of making a revelation. It should add to security and not take away from it. It should not be a confrontation or a display of hostility. It should be so judged that the family can cope with it, without upset, and it should be used constructively. A statement can be attenuated and pitched at a level which is acceptable at that time. There has to be a delicacy about these things based upon experience of life and a need not to hurt others. Damage can easily be done – a brutal statement to a lady that she is getting old, however true, is unconstructive.

But truth never emerges without rapport; the darker the secret, the deeper the rapport needs to be, and rapport makes for security.

Degree of insight

Insight is the understanding by the family of the mechanisms of the emotions. The greater the disturbance in the family, the less the insight. The developing understanding of the significance of emotional events takes longer with a more disturbed family, but time spent on insight is essential. Understanding, however, is not therapy. It is discernment, diagnosis. Having seen the course of events, it is essential to re-experience and to reconstruct.

Intelligence has no correlation with insight. Dull, undisturbed people can have remarkable insight. Very intelligent, highly disturbed people may have no insight. Intelligence can help or retard interviews; insight has great relevance to the speed of progress.

Silence

The family has to learn that silence on the part of the therapist is an invitation to talk. The easiest interview for the family is when the therapist does all the talking, but this interview is the least worthwhile. The greater the security of the family, the more silent their therapist can be; the greater the skill of the therapist, the more silent also will he be. The therapist moves to non-verbal communication, significant and time-saving. Silence is the biggest and yet gentlest pressure that the therapist can put upon the family to get it to work. However, the family may need to be silent from time to time. During this silent period it is working in contemplation; afterwards may come a true move forward in the family's affairs.

Interruption

The aim should always be to interrupt as little as possible; interruptions result in a break, an artificial break, in the flow of the family's thinking; the wrong comment or question may cause it to go off on a line of thought of less significance, or may give it an opportunity to avoid discussing something which is relevant. Direct questions very rarely bring profitable results. Far better to ask indirect questions, which will inevitably lead to the area being discussed. For example, it is of little value asking an individual, "How did you get on with your mother as a child?" It would be much more profitable to suggest topics which will inevitably throw light on the relationship between mother and daughter.

The above does not contradict the need to guide. The therapist can pick up cues from what has been said and lead the family to an area requiring exploration. Sensitive areas may be avoided or skirted at first. The therapist makes a note of these and guides the family back to them on a later occasion. This may need several excursions. As rapport and security improve, so the sensitive, but highly significant areas, are dealt with.

Allies in the family

The most disturbed of families has assets. These are of two kinds: (i) Disturbed family members have elements in their personalities that are beneficial to other disturbed members. (ii) A family may have a comparatively healthy member who, given new cues and insight, can have a beneficial effect – even when there is no formal therapy. A therapist must evaluate the assets of the family and use them to the full. Thus family members can be allies in therapy.

Avoidance

Families are naturally uncomfortable when embarrassing, hurtful material springs up. Thus, there will be not only avoidance of such topics, but invention of apparently good reasons for not discussing them. They miss interviews, are late so as to allow little time for discussion, keep silent, raise superficial, irrelevant topics, attack the therapist for his inadequacy, etc. This behaviour is based upon insecurity. Avoidance is hanging on to old coping devices. These are moments for particular patience and tolerance. Even more effective than discussion of this behaviour is to raise topics that will deepen the rapport. As this improves the avoidance melts away.

Family swings

During the course of therapy, the mood of various family members will change; as one improves, another deteriorates, and so forth. These swings are to be expected in the course of therapy. Indeed the mood of the whole family in normal circumstances is a variable entity.

Danger to the family

Management of severe, acute situations in the present or re-enactment of material from the past naturally provokes acute symptomatology. The therapist has a responsibility to control matters in such a way that the risk is reduced to what is reasonable. Family members prone to being epileptic (10% of the population) may have epileptic attacks; others may become accident prone; ulcers perforate; cerebral thrombosis and coronary thrombosis are a possibility; suicidal attempts are made. A careful eye must be kept on the somatic and emotional health of the whole family. Danger must not rise above a manageable limit. Irrelevant, but highly traumatic events, eg war experiences, are sometimes best circumvented and left encapsulated in their coping defences. It is not effective therapy irreparable to harm or kill the family – or have the family kill others.

Acting to real trauma and not the object of stress

Some of the trauma in the present is evoked by trauma in the past, eg a husband's attitude reminds the patient of mother or father. But the patient reacts to the image of father or mother only if the husband's behaviour is like that of the father or the mother. The behaviour is the stimulus and not the conveyor of it. Thus, a man who behaves aggressively provokes a bigger response in a person sensitive to aggression

than does a man who looks like the patient's aggressive father, but who is not aggressive.

Levels of discussion

The family moves through certain levels of experience in the course of therapy. At first, its concern is with superficial matters of the moment, then it moves to transactions in the present family, then it moves back to its experiences from its early days as a family and, lastly, it moves to the preceding families. The most fundamental therapy takes place at the last level.

Family events

Much profit comes from getting a family to describe actual instances in its own immediate life experience and, as time goes on, in its past life experiences. This is description without interpretation. In this way, a far more factual picture is obtained of real family events and its reactions to them. Subsequently the therapist and the family together can give significance to the events.

Closure

Therapy ceases when the aim outlined at the start has been achieved. Usually there is a weaning-off period which may last for either a few minutes or several hours of therapy, depending upon the family, its needs, and its degree of disturbance and thus of dependence.

Somatic therapy

This must go hand in hand with psychic therapy.

The individual or family reacts as a whole to psychic noci-vectors – thus the soma is affected. Rarely does psychonosis in an individual or family present without somatic complaints which may be severe and life-threatening.

Somatic therapy will be required for:

1. The somatic disorders produced by the psychonosis. Any system in the body may be affected. Examples would be: migraine, ulcerative colitis, thyrotoxicosis, gastric ulceration, asthma, coronary thrombosis, cerebral thrombosis, etc. Furthermore, existing somatic disorders, eg multiple sclerosis, epilepsy, will be aggravated by psychonosis. Psychonotics, especially the elderly, eat badly and therefore dietary and vitamin deficiencies may need correction. There may be anaemia for the same reasons.
2. Iatrogenic disorders. These are conditions precipitated by therapy, anc can include any of the above.
3. Symptomatic relief. Tranquilizers reduce tension, anti-depressants make depression more tolerable, sedatives and hypnotics guarantee a night's sleep, etc. All these medications carry with them emotional elements – hope, a gift from the therapist, encouragement of something done, suggestive value, and a bridge with the therapist. Drugs must nonetheless be used with caution. In some patients, as they fear any drug medication, they may have a deleterious effect. Also drugs may produce toxic states in some patients and confuse diagnosis.

Features of Benexperiential Psychotherapy

It may be useful to tabulate some of the main features:

1. Benexperiential psychotherapy utilises an experience which is favourable to the individual or family psyche.
2. It is based upon experiential psychopathology.
3. The “idea of self” is the essential target of therapy.
4. The diagnostic procedure is separated from the therapeutic process.
5. Interpretation is not employed. The experience is all. Thus there is no dogma.
6. The process of re-experience is central to therapy either within or without the interview.
7. Confrontation is not employed; security is encouraged.
8. Decisions are made.
9. It is complementary to vector therapy.
10. Being experiential, it opens therapy to the scrutiny of research procedures.

REFERENCES

1. BLYTHE, R. (1969). *Akenfield*. Harmondsworth: Allen Lane. The Penguin Press.
2. SUOMI, S.J., HARLOW, H.F. and McKINNEY, W.T. Jr. (1972). Monkey psychiatrists. *Amer.J.Psychiat., 128,* 927-932.