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DESCRIPTION AND QUANTIFICATION OF MULTIPLE FAMILY GROUP INTERACTION[1]

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SUMMARY

Multiple Family Group Interaction as a method of Family Therapy is reported with reference to its development, technique and procedure. A rating system for the categorization and quantification of the therapeutic processes is discussed. The main findings of analysis of 85 sessions are presented.

In the recent times, there has been a shift of psychotherapeutic focus from individual to his interpersonal milieu in family and outside. In this regard, Psychiatric Family Ward Treatment has been a land mark This treatment approach as developed at Family Psychiatric Centre (FPC), National Institute of Mental Health and Neuro Sciences, Bangalore, India, is reported elsewhere (Bhatti et al., 1980). It is an article of faith among Family Therapists that the family must be included in the treatment process. The reason behind this conviction is that the index patient is the result of family pathology. Accordingly, in F. P. C. all patients taken for treatment are admitted along with one or two family members. We have provision for the treatment of 19 families at a time and have so far treated a few hundred families. Any *functional* psychiatric condition maintained by and/or seriously complicating family interaction is taken for treatment. However, the treatment is largely applied to non-psychotic problems so far. Psychotic phenomena are managed by drugs in addition.

Usually all the families staying in the Family Psychiatric Center are strangers to each other before coming to this Center. Each family has a member who is having some emotional problems. All the families are interested in the treatment of their patient. Mostly, families are ready to co-operate in every sort of treatment plans. It is quite understandable that when two families are staying together there is a natural tendency to know each other, find out the problem as they understand and if possible, share the distress and help each other.

On observing such a spontaneous and informal interaction that was going on, it was thought that such a process can be exploited for therapeutic purposes in a planned fashion. Initially, we held Group Interaction sessions on experimental basis and soon found that there are certain special advantages in it.

MULTIPLE FAMILY GROUP INTERACTION: COMPARISON WITH GROUP THERAPY AND MULTIPLE FAMILY THERAPY

No doubt much of what is applicable to Group Therapy both in theory and

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techniques was found useful in our group interactional sessions. But what is of interest and potential therapeutic importance is the fact that what was going on was different from Group Therapy in both structural and functional aspects. Pattison (1973) quotes Cody Marsh's motto of Group Therapy: "By the crowd they have been broken; by the crowd they shall be healed." Foulkes and Anthony (1957) in their attempt to establish the essential attributes of group psychotherapy, pointed out that while the group itself is the main therapeutic agency the individual member is the object of treatment. They further said that "the group is treated for the sake of its individual members, and for no other reason". Even today this very essence of group-therapy is maintained in contrast to family therapy with its focus on the family as an interactional system. By virtue of this difference we can appreciate the difference between group therapy and family therapy.

From a different angle it can be said that Multiple Family Group Interaction resembles Multiple Family Therapy (Laquer, 1977) but here too there are significant differences between the two. For example, in MFT, 4-6 families ranging from 16-25 family members are included (Blinder et al., 1965). Contrary to this, in M. F. G. I. there are always a larger number of families. Secondly, the variety of problems dealt with at a time in Multiple Family Group Interaction ranges from minor marital conflicts to resolution of pathogenic interactions.

Therefore, Multiple Family Group Interaction is not a replica of Group Therapy and/or Multiple Family Therapy. Rather Multiple Family Group Interaction has several basic elements of both these treatment techniques besides incorporating some of the elements of individual psychotherapy.

Multiple Family Group Interaction is practiced by us in the context of an integrated model of family therapy. Presently, it is used as a special technique with in-patient families. Our treatment programme in general is short term and usually of the order of a couple of weeks.

Goals :

1. To help the members to enter into a treatment contract;
2. To provide a moral and emotional support in facing the crisis by mobilising the skills and resources;
3. To recognise the connection between disturbed interpersonal relationships in the family and the presenting problems of the index patient;
4. To clarify doubts and remove misconceptions about the nature of the problem;
5. To improve interpersonal communication;
6. To restore a healthy balance in the emotional system of the family.

Role of Therapist: The therapist will be actively participating in the group,

1. to help the group in recognition of the nature of the presenting problems;
2. to give a direction with regard to the problems in terms of giving possible practical alternatives;
3. to guide the group through special manouvers like role playing, family tasks, and problem solving exercises; and
4. to help the group to recognise and work through problems like resistances and scape-goating.

PROCEDURE

Apart from the patient and his/her family member/s, an attender, Psychiatric Nurse, Psychiatric Social Work Trainee and Consultant, Psychiatric Resident, and at times Consultant Psychiatrist participate in the group.

The total strength varies from 20 to 40 members including the treatment team.

Multiple Family Group Interaction (M. F. G. I.) is conducted on six days a week.

Each of the identified patient and his/her family member/s are given a briefing by the therapist on the purpose, process and schedule of M. F. G. I. before they are brought to the group.

The members of the group sit in a circle. As the membrship of the group changes rapidly, there usually is a new patient entering everyday. He along with relative/s is introduced to the group by the treating members of the team. Then as the group gets on to its task the members of the treatment team play an active role to promote verbalisation and abreaction in relation to significant life experiences of the identified patient and their relatives in their family life. Being a short-term group regression is rare to develop. It is also our policy to discourage excessive diversion from the current life situation. The focus is on the here and now.

Various manouvers like role playing, family tasks, and problem solving exercises are freely used to help the group to concentrate on the real existing issues in their families. Repeated narrations of symptoms and such other resistances are interpreted and positive change is reinforced by the group. Cliques and scape-goating within the group are detected early and pointed out for discussion and resolution by the group.

OBJECTIVES OF THE PRESENT STUDY:

1. To define the principal therapeutic processes in M. F. G. I. and evolve a system of rating them, and
2. To study the relative frequency and time-course of these processes in M. F. G. I.

METHODOLOGY

During the actual process of M. F. G. I. various psychotherapeutic processes were seen. There are various ways of identifying and categorizing them. Inspite of a variety of approaches there appears to be considerable common ground among the group therapy researchers. Yalom (1970) categorized the curative factors as follows:

1. Imparting information
2. Instilling hope
3. Universality
4. Altruism
5. Corrective recapitulation of the primary family group
6. Developing socialising techniques
7. Imitating adequate models
8. Interpersonal learning
9. Group cohesiveness and
10. Catharsis.

In our experience, since M. F. G. I. is used as a part of a comprehensive treatment programme, we find it more appropriate to consider 6th and 7th factors separately. The rest of the processes can conveniently be divided into two groups: (i) expressed by others to the patients, and (ii) expressed by the patient. In order to obtain an 'accuracy' (validity) and 'consistency' (reliability) of ratings these broader processes were defined as follows:

EXPRESSED BY OTHERS TO THE PATIENTS

Advice giving (includes suggestion and persuasion)

Any directive statement regarding a desirable course of action.

Insight Giving (includes clarification, confrontation)

Giving an understanding of the motivational basis of one's experience and/or behaviour.

Support Giving

All responses of ego-supportive nature (acceptance, emotional support, encouragement, reassurance, reinforcement).

EXPRESSED BY THE PATIENT

Symptom reporting

Consists of reporting symptoms and/or any disability arising there from.

Self Revealing

Expression of one's life experience which are self-revealing in nature.

Abreaction (includes Catharsis of pent up emotions, ventilation and clearing)

The release of strong emotions related to conflicts.

Keeping these definitions as a frame of reference, interactions in the group were assessed by a therapist. For recording the observations all the members of the group were identified by numbers. For example, patient 1 is advised by another patient no. 15, the scoring in the scoring sheet is done as 15 × 1 under the column Advice. Thus, every interaction is scored in this fashion and repeated as many times as the phenomenon occurs. The scoring format is shown in Table 1.

After the session, all the therapists, sit together to review and evaluate the entire session in terms of rating reliability and appropriateness of interactions.

Ratings were made on 11 patients who attended 85 M. F. G. I. sessions. The sexwise diagnostic break up of these patients is shown in Table 2.

TABLE 1—*Table for Scoring Therapeutic Processes*

Advice	Insight	Support	Symptom reporting	Self revealing	Abreaction

TABLE 2—*Sex and Diagnosis*

Diagnosis	Male (N=3)	Female (N=8)	Total (N=11)
Neurosis	1	7	8
Reactive Psychosis	2	1	3

The patients were young adults, most of them in their twenties while the relatives were older, mostly past middle age. For 5 patients the ratings have been made from the first session onwards whereas for the remaining the ratings have commenced after they have already passed beyond the initial phase.

FINDINGS

The principal therapeutic processes employed by the participants are shown in Table 3.

TABLE 3 – *Frequency of Therapeutic Processes*

	Advice	%	Insight	%	Support	%	Symptom Reporting	%	Self revealing	%	Abreaction	%
All Sessilns (11 patients)	130	74.71	22	12.6	9	5.1	8	4.6	5	2.9	0	0
Initial Sessions (5 patients)	R=52 G=7		11		2		6		3		0	
Middle Sessions (5 patients)	R=26 G= 9		6		2		0		1		0	

R=Receiving
G=Giving

It can be seen that Advice Receiving and Advice Giving are the most common processes. In order to study the course of this process during therapy, Advice Receiving and Advice Giving responses are calculated separately for the initial and middle phases on the data of the five subjects. It is evident (table 3) that during the initial phase (first four sessions), there is predominance of Advice Receiving over Advice Giving. This process is reversed in the middle phase (session five onwards) and gets consolidated during the last sessions. Symptom – reporting in these sessions was infrequent (4.6%) contrary to the impression that our patients and their relatives are interested only in talking about their symptoms. On the other hand, the interactions of insight are far more frequent (12.6%) and in fact were the second most common kind of interaction. Abreaction was not noted in any session, although this was probably on account of reservation of the rating to its more intense forms. Support interactions were the third most common suggesting that Advice, Insight, and Support were the principal processes in M. F. G. I. in that order of frequency.

DISCUSSION

It may be pointed out here that the cultural expectations in our set up during the psychotherapy sessions is mainly in terms of advice. However, this is not readily offered by the therapists as their own thinking and behaviour is conditioned by classical models of Western psychotherapy. We are trained to value insight giving and fight shy of giving any prescriptive advice. Thus, there is a lack of fit between our professionally acquired ideas of what is desirable in psychotherapy, on the one hand and what the patients desire on the other. This problem seems to be taken care of spontaneously when the patients are allowed to interact among themselves. They both seek out and give what seems to be the central ingredient of effective psychotherapy in our cultural milieu—"ADVICE" with its potential for restoration of morale. An optimal mix of Advice, Insight, and Support is important for a culture-appropriate psychotherapy in our setting. The appropriateness and efficacy of our treatment technique is borne out by facts. The duration of stay of our patients ranged from 12 days to 32 days (Mean = 20.3 days). This duration is much less than that of patients in other wards. In the majority of the patients the trend for improvement is evident by the second week of treatment.

To conclude, M. F. G. I. is a suitable and effective innovation in technique for family psychotherapy with our patients. Further the rating procedure offers new possibilities of monitoring and analysing the principal processes of therapy.

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