



Forum Sam Kutash

A Critique Of The Systems Theory Approach To Group Therapy

Reuven Bar-Levav

Medicine generally is practiced on the basis of the traditional Medical model of a sick, suffering patient whose illness is diagnosable and treatable with specific curative agents which the physician is qualified to administer. The disease process takes place within the patient who is the focus of the physician's attention. Some psychiatrists, on the other hand, are enamored of a newer, more glittering model that did not exist before computers, the Systems Theory model. While the former is based on the fact that the patient has a set of symptoms that constitute a syndrome which is treated with the aim of restoring homeostatic balance, the latter model considers the individual and his symptoms as part of a communication within the social system, with "feedback" between himself and the group of which he is part. In other words, what is considered normal behavior on the part of an individual may not be so considered by his group. Normality, thus, is a relative concept, which depends to a large extent on its definition by someone outside of the individual, and is different from time to time and from location to location. This model does not allow for any objective, finite definition of mental health or mental illness, since both are relative to the society in which the individual finds himself.

The Medical model considers man as a self-contained entity who is basically "inner-directed." The Systems Theory model, on the other hand, regards the person as a part of a larger whole, not complete in itself, "outer-directed." The individual as such does not exist and, instead, the degree of his successful functioning is measured in terms of the most complex organization of which he is part . . .

According to the Systems Theory model, going to a psychiatrist or the fact that a person is diagnosed as having some emotional difficulty would necessarily effect some change in his relationships with others, . . . affecting the "feedback" between himself and those around him, depending on the value systems and the prejudices of others with whom he comes into contact. According to this model, the psychiatrist must do all he can to keep such potentially change-producing information secret. Hence the justification for the two separate doors and similar practices. . .

The minimum we can ask of ourselves as a profession is that we examine our own true reasons for behaving in such irrational ways. Is it possible that some of us became psychiatrists as a desperate counter-phobic move? Since the etiology of mental illness is not as clearly established as that of bacterial or viral diseases, it may well be. . . because some of us fear mental illness and powerful emotions as much as our patients often do.

The attraction that the Systems Theory model holds for many is that it seems to show a great deal of respect for the integrity of the patient and for his right to decide

consciously what information about himself he wants to reveal. Some claim that the Systems Theory model shows a greater degree of sensitivity to the individual in a difficult situation, ignoring the fact that the wish to hide may well be a manifestation of resistance rather than reality. . .

Unfortunately, this line of argument is based on mental acrobatics involving moral and value systems that equate health with good and sickness with bad. It knocks the props out from under our claim that we are a medical specialty and that patients come to us not for moral judgments, but instead for diagnosis and treatment of painful conditions from which they suffer. The Systems Theory model of psychiatry assumes that we as psychiatrists would live according to the prejudices, value systems and insanities of those who are afraid of mental illness. Since "they" see mental illness as bad and would hold it against the patient, we as psychiatrists would adjust our behavior accordingly. Acceptance of this model requires that we sacrifice our autonomy and the reality principle. . .

Unless and until we act openly, consistently and repeatedly within the framework of the Medical model, we probably contribute to the perpetuation of the stigma that is associated with psychiatry. . .

Regardless of objective indications of its usefulness, group psychotherapy has not made many inroads against this stigma, in part because it necessitates exposing patients to each other.

*Excerpted from "The Stigma of Seeing a Psychiatrist".

(Editor's Note: Cf. several discussions of "The Medical Model" in *International J. of Psychiat.*, (1970), vol. 9, pp 13-31.)

MARATHON ON SEXUALITY AND SEX ROLES

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behind. We then re-ran the "fishbowl" — having each couple stand in the center and describe for each other how they were feeling non-verbally. Signs of tension and holding back, such as hugging without touching below the shoulder blades had now disappeared — the hugs were full-bodied, the nonverbal expressions more melting, rather than restrained and pushing off.

We then (5½ hours after the start of the marathon) went into a new area of potential conflict: jealousy. We suggested two private encounters, 30 minutes each, with someone other than the partner. Choices were made by one person asking and the asked responding by saying "yes" or "no", or "maybe" until everyone was selected.

This time, when the entire group, reformed, we asked for each partner to describe his fantasies about his absent partner. Some were almost precisely accurate, others wildly off base; but both kinds of fantasies offered a great deal of

material for work. We then asked each person to describe what actually did happen, and saw how two people can each have a very different experience of what happened.

The next encounter assigned was longer, for the original couples: to describe for each other by hands as well as words how they liked to be made love to, how they liked to be touched, and to ask specifically for what they wanted the other person to do.

Several couples, married for many years, learned that they both wanted more sex play and variety, but had assumed that their partner was interested in just "getting it over with."

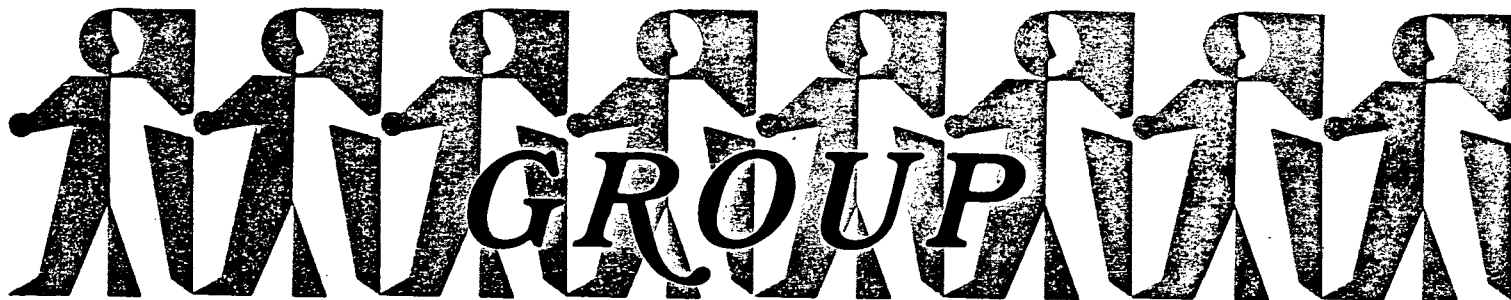
The final hour of unwinding and integrating started with asking for feedback-reactions about what had happened, resentments about what didn't happen, what participants felt that they could use later. We then had a "hot seat" exercise, with each person in turn sitting on a pillow in the middle of the room and listening, without verbally responding, to whatever the other participants wanted to say to them. We ended with getting everyone out of their chairs or positions on the floor

and circulating, with the instruction to finish any unfinished business.

Over all, we felt the marathon was very good. I was sorry that we did not provide time for the intra-couple encounter, a very important means of support for a couple. Making more daring strides at the beginning would have allowed for this at the end; our hesitations proved unwarranted by the group experience. Also, airing of conflicts between the therapists proved very effective for both participants and therapists.

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POSTGRADUATE WORKSHOP:

**Termination:
Analyzable And
Unanalyzable**

Peter J. Schlachet and Peter Buirski

To terminate or not to terminate: that was the question which the members of the Postgraduate Center's Group Department met to debate on.

The 40 participants broke into two separate subgroups on the first of the two-day workshop, led by Jerry Leff and Marv Aronson; the next morning the entire group, to summarize and extract the essentials of the previous day's discussions, and to terminate. We were successful in the former, and successful in evading the latter.

But that was not surprising. The weekend might more accurately have been entitled "Belonging," for that was the underlying real theme, occasionally articulated as such, despite the extensive discussion about various aspects, facets and kinds of termination. The family really came together, and more than one person felt a new sense of comradeship with the group.

Perhaps that accounts in part for the rambling and disorganized quality of much of the discussion. The resistance here, as everywhere, has a sort of compelling logic. And indeed, the group had difficulty terminating after Sunday morning's discussion. There was no organized ending of the proceedings; they just sort of stopped. And then, the milling and the mixing, and the discussing and the socializing. The reluctance to deal with separation and termination in thought was acted out in fact: after the lunch break, a number of members of each group were missing. Some of them had announced their impending absence, some had not. What resulted was a great deal of anger at the missing members for deserting the group, for violating its integrity, and for betraying the sense of belonging of the remaining members. Themes of trust and intimacy came up, as well as a reluctance to let go. Fantasies about them abounded: they were out playing in the afternoon sunshine while the remainder were working. It was a lesson on the necessity of preparation for loss. The anger was acted out in both groups: in one a couch was accidentally burned, in the other a

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THE FAMILY: Nina Fieldsteel

Techniques Of Family Art Therapy

Selma H. Garai and Joseph E. Garai



Figure 1

(Editors Note: This is from a forthcoming book on Group Art Therapy.)

Hanna Yaxa Kwiatkowska's work and research have laid the foundation for the increased recognition of family art therapy in recent years. In her work with schizophrenic and hysteric families, she developed a very effective technique of family evaluation based on an initial drawing of whatever comes to each family member's mind, followed by a drawing of an abstract family portrait. ("Family Art Therapy and Family Art Evaluation" (Psychiatry and Art, 1971, Vol. 3, pp. 138-151).

The most valuable contributions of art therapy to the improvement of the practice of family therapy consist in its effectiveness as a tool for the uncovering of primary process material, the breaking down of resistances in a minimally threatening manner, and the promotion of more spontaneous and honest patterns of communication based on genuine feelings rather than on expected role projections. Repressed feelings related to sexual, aggressive, and competitive drives and strivings frequently emerge quite spontaneously in symbolic expression in the creative act.

To illustrate these points, we are presenting several drawings made by members of the Gonzales family with whom Selma Garai worked for a period of eighteen months. It consists of Mrs. Gonzales, the mother, aged 29, Robert aged 13, Fred aged 8, and Francine, aged 7. Mrs. Gonzales had sought therapy because she experienced her son, Robert, as increasingly unmanageable. She had been divorced a year before, her husband having practically deserted the family after the first child. She portrayed herself as the

ideal mother sacrificing her life for her children. Robert had become the family scapegoat, in the moralistic atmosphere of the family. But Robert voiced fears that his mother would kill him, having beaten him up during her temper tantrums.

Mrs. Gonzales is an attractive woman who looks more like a teenager than a 29-year old mother. Constant prohibitions and reluctance to grant any freedom from maternal supervision aroused strong frustrations and resistance in the children.

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