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FOULKES' NETWORK THEORY AND THE SCOPE OF GROUP ANALYSIS IN FAMILY THERAPY[1]

ILLUSTRACIÓN: KARINE DAISAY

There are very few group psychotherapists indeed that have contributed to the blooming modern development of family group therapy. There is an exception though, a true pioneer in the field. His main interest and publications in the development of Group Analytic Therapy have resulted in that his ideas on family are not as well known by family therapists as they would deserve. I am talking of S.H. Foulkes. As early as the end of the thirties he was already interviewing families conjointly for diagnostic as well as therapeutic purposes. It took him two steps, though, to overcome prejudices that had been imbued in him by his psychoanalytic training.

1) To see people - strangers - jointly in a group;

2) To see people - relatives with blood ties between them - at the same time and as a group.

His work with strangers, in a small group, led him to discover Group Analysis. The military hospital at Northfield and later The Maudsley, a teaching hospital, were to be the seeds of "therapeutic communities" the one and of the most creative schema on research, treatment and training in group psychotherapy the other. His work with families, although limited to family interviewing, was creative inasmuch as it led him on the one hand to conceptualize his "Network Theory of Neurosis" - one of the cornerstones of Group Analytic Theory - and on the other to inspire his followers - mostly Robin Skynner - to set up the Introductory Course in Family Therapy, whose offspring is the Institute of Family Therapy (London).

The courage it takes for a psychoanalyst to move from the transferencial sanctuary of the psychoanalytic situation into the open arena of conjoint family therapy and to overcome the ideological resistances built up through his psychoanalytical training and practice - mostly private practice - is something to be admired. But to do so single-handed, without the support of a group, and not to fall

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into the trap of "systems" forgetting about the unconscious, takes the stamina and the power of thinking that only very few men in a century have. It is my tenet that the way - the analytic way- that goes from psychoanalysis to family therapy cannot be taken safely unless one uses the knowledge, the expertise and experience, the stepping stone that Group Analysis provides. I shall try to show this in the present paper and where it leads to.

The Coordinates of Therapy

All psychotherapy, all mental treatment -the one that uses psychological means for treating the ills of individuals and groups- is rooted in interaction, the interpersonal influence through expanding communication, of people belonging to diametrically differentiated social categories: therapists and patients, the ones who treat and the ones who are being treated. In ancient days the ones who treated were shamans, kings or priests, but they doctored the sick of the tribe just the same.

With recognized expert knowledge and specialized training today's professionalized psychotherapists are inclined to disregard the fact that they belong to this part of the "tribe" that has been invested with the "power to cure". The rest of the community, of course, go to them for help when under distress, when they do not find meaning for what happens to them and when they no longer know what to do about it. That therapy - psychoanalysis, group therapy, family therapy - is a valid response to treat the ills of the unsound is a cultural artifact, an ideological position that changes - in content - throughout times, but nevertheless it gives power to those who are entitled to treat.

In this sanctioned role as expert it is the therapist who is to set the limits of the therapeutic situation, the one to decide who is to be in and who to be out of its boundaries, what is to be done, said or not said, and how within this social enclave. In this regard modern psychotherapy does not much differ from traditional ways. What was done then in the name of religion, superstition, for fear of ghosts or to appease gods, today we do in the name of science. The barrier between theory and practice, between technique and art in psychotherapy is a very thin one and still less clear is which one comes first. As a rule major theoretical breakthroughs have followed technical innovations that, by the way, were discovered by the patient more frequently than by the doctor. That was the case for example with Freud's "free association", it holds true for Foulkes' "free-floating discussion" and I would not be surprised if it did not also for many a technique on which hangs the theorizing in modern family therapy. Witnessing the wide array of competing theories and techniques in that field, contemplating the battles between "psychoanalytical purists" and "systems purists", one cannot but wonder if family therapy is yet today something more than a practice in search of a theory.

No doubt the insights gained from psychoanalysis are to be of help towards theory building in family, as will be the ones that come from systems, but jumping straight from individual dynamics into systems without passing through the group will be helpful. The tribe of therapists, the supposed agents of change, has their own rules on how not to change themselves. Institutionalized theoretical blinkers more often than not lead them into blind alleys and foreclose innovations which could have been of great utility. That is exactly what happened to Freud in his battle with the family business. After he had already discovered that *"the natural opposition of the relatives to the treatment* – an opposition which was bound to appear sooner or later" - was so insurmountable that it provoked one of the most disheartened remarks of his career: *"As regards to the treatment of relatives (of patients in analysis) I must confess myself utterly at loss, and I have in general little faith in any individual treatment of them"* (Freud, 1912), coming to this paradoxical conclusion: *"The external resistances which arise form the patient's circumstances, from his environment (the patient's relatives) are of small theoretical interest but of the greatest practical importance"* (Freud, 1917). For a person to whom the theoretical

understanding of clinical facts was of paramount importance it is amazing that he could blatantly discharge these so prominent clinical findings. How to explain that mishap without entering deeply into Freud's biography and the vicissitudes of the "Cause of Psychoanalysis" would be difficult. One cannot but wonder what it was that stopped Freud at the point of becoming the first family therapist after having treated Little Hans and spelled out in Totem and Taboo the postulates that could have laid the foundations for a systematic family theory and therapy. As Anthony points out in his History of Group Psychotherapy, he had already stated: 1) that there is a family psyche whose psychological processes correspond fairly closely to those of the individual; 2) that there is a continuity of emotional life in the family psyche from one generation to the next, and, 3) that the mysterious transmission of attitudes and feelings through generations is the result of unconscious understanding that makes the latent psychic life of one generation accessible to the succeeding one. Those principles were the cornerstone for building a dynamic and developmental family psychopathology. What then really stopped Freud at that critical point? Anthony suggests that it was Freud's intense interest in individual intrapsychic conflicts - his own - that superseded everything else. By the same token it could be said that they were his family problems or the ones of his plexus - the psychoanalytic tribe - that impeded him to go on. Nobody will ever know, but what is certain is that this attitude of Freud's, addressed at keeping unpolluted the transference situation of psychoanalysis, was the base for the psychoanalytic prejudice, which foreclosed for many years the psychoanalytic exploration of the family group.

Freud's views have to be contrasted with those of one of his followers, Foulkes (1975) , a few years later: *"However, the psychodiagnostic value of those meetings (family sessions) can hardly be overrated; while fascinating from a theoretical point of view they are of great importance also from a point of view of a practical method'*. Foulkes' fascination with the theme was the basis for his **Network Theory of Neurosis**. However, he always thought that in order to transform this knowledge into a powerful therapeutic tool, some preconditions had to be achieved: *'" I have become more and more convinced that the patient whom I see is himself only one symptom of a disturbance which concerns a whole network of circumstances and people. It is this network... which is the real operational field for effective and radical psychotherapy. Perhaps it would be more correct to say it will be so in a future. This would be group therapy in a natural group with the persons primarily involved in the conflict themselves as members of the therapeutic group. Under present circumstances it is very difficult to put such a multipersonal therapy into operation. It would be necessary for this work that it could be shared by a team of therapists who would have to be trained in both psychoanalysis and group analysis*".

I am one of these generations of people that having come after Freud and after Foulkes and had a chance to be trained in psychoanalysis as well as in group analysis. I fortunately took both. To my disgrace however, in the country where I live and work neither the State not the Compulsory Health Insurance System as yet consider mental health and the training of mental health professionals to be of their concern. Being mostly in private practice and private research and teaching, my views and my experience will be tinted by those unfortunate environmental circumstances, which, by the way are not by any means the best ground for the analytic treatment of the family group. As a matter of fact, most of family therapy as well as of group psychotherapy in contrast to individual psychoanalysis has developed from agencies, low-cost clinics, or hospitals or where not privately paid for by the patients.

The Family and the Doctor: Perspectives of the treatment of the family group.

The family physician, this old institution that modern health systems are trying helplessly to revive, was the primordial model of family-doctor relations. All the tradition of medical care has gone that way. The link between them, the cornerstone of that relationship, was the actual or possible sick patient. For the

family, their GP, their family physician is the one to whom they go for help when one of their members is ill or who to ask for advice in matters of health. For the doctor, on the contrary, his patient is the one who he is treating and the rest are just the relatives. In family therapy the nature of the relation patient-doctor and family-doctor becomes radically changed: the individual patient vanishes or fades away while the family, as a whole, becomes the patient - that is to say the basic unit for diagnosis and therapy.

This movement, from a conception of therapy centered in the family implies a change that is to be resisted by both parties. It means a threat to the old doctor as well as to the new patient: the family itself. As far as the doctor is concerned, this movement goes counter to what has been so far the "normal" development in medicine, in psychiatry, in psychoanalysis and of all those new helping professions which were inspired in the clinical medical model. The tendency was towards polarization, to specialize progressively into smaller fields of activity and in techniques each day more concrete.

To devote oneself to family therapy implies a de-specialization, a re-generalization, to start with for which the professional is not conceptually or technically prepared and that on top threatens his professional identity. For the family, this new outlook means also a great change; unexpectedly it finds itself under the focus of medical attention and, having lost the patient where they identified their problem, is made to feel itself sick when treated by the doctor that way.

Most likely this change in orientation will have serious implications in the organization and functioning of professionals and services in the medical care of the future. For the time being the most affected have been those which belong to the **Psy-club** and mostly the ones in the field of mental health and social services. Balint's (1957) observations regard the doctor's responses as an organizer of the patient's offer of illness are applicable pari pasu at the level of the family. There we know that the sheer medical examination, the labeling of the illness, the prescription of medication for the symptoms offered by the patient is the most important single fact in determining the doctor-patient relation, and the relation of the patient with his own illness. The medical diagnosis and treatment of the identified patient offered by the family will equally condition this patient's career as well as the attitudes the family adopts regarding problems of communication, interaction and understanding or misunderstanding that concerns the whole family, and of which the symptoms of the patient and the patient as a symptom are result and proof of a failed attempt of resolution and expression. Depending on the doctor's orientation and the way he understands and reacts to the family problem, is how the family will try to solve their own problem.

My purpose here is to examine the nature of the family-therapist relation regardless if only one of the members is in therapy - in case of individual psychotherapies or of group psychotherapies in stranger groups - or if it is the whole family as a group which is in treatment. My starting point is to consider the family network, the plexus of the patient, as S. H. Foulkes used to say, as a life group that functions and reacts as a group, and my conviction is that when such a powerful change agent as the therapist impinges upon the group, the latter cannot but react as a group. Family therapy, in a broad sense, as understood by me, has as its function to clarify with the aid of an expert and to work through a problem that was previously defined by the family in terms of illness and health and that affects the whole family. This problem, however, is not seen with the same eyes from the perspective of the family as from that of the therapist.

The Family Illness Behaviour

When a family looks for a therapist, rarely if ever it thinks that it is the family who is sick. They are in need of help, but it is one of its members who is unwell, who is sick, or who makes them all sick. He is

the one who suffers and the others who suffer for or because of him are just the relatives. In biological medicine and dealing with just bodily ills, that may be true, or nearly true. When we are dealing with "mental illness", or the functional aspects of medical care, the matter turns out to be much more complicated. The patient - diagnosed as such by the family - is the one who confronts them with a problem of behaviour. He doesn't know, nor does the family, what has gone wrong with him. Self and mutual understanding and "common sense" has been lost. He is nuts, crazy, a lunatic or just odd, has his or her ways, is nervous or even plainly bad or perverse. He feels what he shouldn't, he doesn't think straight, and he says or does things which are not proper. In sum, he does not behave.

These ugly patients do not inspire the same sort of sympathy than the poor ones who are just plain and "honestly" sick. What those of his kin expect from the doctor, what they want from him, is to bring the patient back to his senses, make him behave, and if nothing can be done since he is plainly crazy, grant the family permission to disown him as a member, put him away, and even if it is to put him into hospital, to get rid of him. In traditional psychiatry the therapist makes the family's demands his own: he becomes an ally of the relatives and gives his treatment to the patient, or else, he takes over for the mistreated and misunderstood poor patient and crusades to free him from his wicked family. As in a battle, he ends up always by taking sides.

In the case that the family finds a family therapist, they are in for trouble. To start with, there is no agreement and most likely they will end up by clashing. The medicalized, psychiatrized concept with which the family diagnosed the patient is not fully held by the therapist. He has his own mind as to patients and mental health. What most modalities of family therapy do have in common is to have transcended the individual model and to have adopted a psycho-social one by which the family group is seen as a whole and where the family becomes the basic unit for diagnosis, for therapy and, consequently is treated. In what family therapists differ is in the ways the family and its problems are understood and treated. Some of them still think that their task is to treat the "sick patient", of course with the relatives help. Others, on the contrary, view the family as if it were a single patient of which the patient is the symptom. Finally, there are those who see the family in terms of a group, where treating the group is treating all of them conjointly.

Those of the first type are the most gentle. They are still close to the shared medical model. Sooner or later they discover that their assistants are of little help, that they rather sabotage the treatment than cooperate. That is what led Sigmund Freud to such a pessimistic view about the good intentions of the relatives. The walls erected around the psychoanalytic situation were to protect the patient's analysis from the attacks of the relatives and the force of the transference counteracts the resistance of the family. But to no avail, they kept on breaking the contract and putting their noses into it.

Although the second group of therapists arrives by different ways and rationales and, depending on the conceptual frame of reference from which they depart, there are several clinical findings that force the therapist to think in family terms. Quite often a successful treatment and cure of the patient is followed by a family that breaks apart or another relative who falls ill in turn. More frequent still are the cases that drop out of individual therapy under the stress of family resistance. Both factors, plus the economical problem implied in dealing with and luckily solving the problem of treatment of the neurotic family by only one therapist and at the same time, acted as a great stimulus for conjoint family therapy. Not without reason, it was in public clinics or psychiatric institutions with limited manpower where the pioneers of family therapy initiated their work. With those therapists, the family is taken by surprise, has a shock. Not only they suddenly have lost their patient, but they have to start anew and clarify what their problem is. Curiously enough, and regardless of the initial frustration and of having lost the defensive role that the patient plays in family dynamics, most of those families hold onto treatment. Very few of them refuse as long as the therapist is convinced enough. That does not mean, of course,

that they drop their resistances by pure chance, but now they are out in the open and can be dealt with by the therapist.

The third alternative, the one proposed by Group Analysis and which I adhere to, departs from another very different conceptual framework and orientation. There is no need to isolate the patient from the family in order to treat him. Neither is it unavoidable to physically include the whole family, just because there is a patient in the midst of them. You take the family as it comes. You listen with equal attention to the one who talks as to those who are silent. The mind is broader; it goes farther than what fits within a single skull and under one skin. Regardless if it is a single individual or the whole family who comes for treatment, you try to understand what and whose problem it really is. You don't settle for appearances, you want the real thing. You try to clarify which is the network of disturbance and who are the people dynamically implied in it. You carefully evaluate the resources for change present and try to secure the cooperation of those who are able to contribute and who agree to become part. This open attitude - analytic attitude - of the therapist enables the family to join in. The problem originally brought in terms of illness and health is redefined in terms of the potential for change of the family group and of each of its members. The free and honest discussion of the problem at all possible levels, open as well as latent, is what makes possible to translate the autistic message of the symptom into an articulate, conscious (con-scire = "*to know with"...* the others), shareable communication.

It is quite obvious that this is where the boundaries of the therapeutic situation are and the degree of permeability and flexibility of those boundaries is what makes the above described models different. In the first, we have a group (therapist plus relatives) treating an individual; in the second, the therapist single-handed is treating a group - the family; in the last, it is the group (therapist cum family) which is treating itself, or better, who is trying to understand and to solve the problem they have as a group.

S.H. Foulkes contribution to the development of my family therapy

Foulkes' main concern was the understanding of psychotherapeutic process and he saw the group as the most adequate tool to study it. This is what led him into the development of Group-Analytic Theory. His two most outstanding discoveries were the concept of **Matrix** and the **Transpersonal Network Theory of Neurosis**. It was his conviction that neurosis and other mental disturbances are of a multipersonal nature, and that it is this network of communication and disturbance that integrates the therapeutic situation, the object of treatment that serves as base for all group analytic psychotherapies. When he talks of life groups, of which the family is a prime example, he takes care to clarify, however, that it is not kinship or blood links that count but the psychodynamic bonds that hold the network together.

Such a network, in psychological terms, includes persons who are not in the ordinary sense members of the family, which can as well include others of the proper family who are not implicated in the problem at hand. It is trying to trace the boundaries of that active psychodynamic network, how I came upon the main idea on which I have been working for years. Foulkes' idea of plexus - short for complexus - the intimate dynamic network which is of the therapist's concern, pushed me to include in it the therapist himself when a family is or has one of his members in therapy.

In what is meant by plexus, Foulkes (1975) defines it as "*a relatively small number of people, which includes the family, who group themselves dynamically as the process of treatment proceeds around the central person - the patient - especially in connection with his conflicts which are significant for the disturbance for which he has come to consult us*". And, he adds: *"From the point of view of method it is at this stage important for us that we do not construct or anticipate such complexus of people and call them together for treatment. What happens is that we build up from what may be called the central*

patient, we then follow the psychodynamics as we become aware of them to a group of people around him who turn to have an essential connection with his basic conflict, symptoms and problems". In group-analytic diagnostic, as in group-analytic family therapy, the members of the plexus are seen in various constellations as the psychodynamic progress of the treatment commands. The individual patient - the central patient by family decision - is seen as the nodal point, merely a symptom in essence of a disturbance of the equilibrium in the intimate network of which he is part.

It becomes clear then that it is the plexus that is to be treated. But, as I have pointed out before, in the case of Freud, the therapist himself has his own plexuses - the one of his own family and the one of his professional network - and it is mostly through this last one that he is going to organize his practice and to do his task, “boundarying” the therapeutic situation according to them.

From my own point of view, every time that a member of a family consults a therapist, or more still, if he enters into treatment, the status quo, the equilibrium reached by his family, regardless of how unstable or pathological it was, gets unsettled. If we think in terms of the network of communication and disturbance, there is a major break of intimacy, a leak in communication and a brutal introduction of meaning through the boundaries of the family system with its environment, with the result that the family feels threatened. No wonder they resist. To me, any manifest disturbance within a bio-psycho-social system, at the same time that it shows suffering and pains it also is a cry for help, for health and has to be listened to and attended. Depending on how the social and professional environment responds to this call of the family, we will either help the individual, the family and society to solve their problem, or, instead, we will iatrogenically aggravate or perpetuate it. That is the way I think about "sick families" and "families in therapy".

The Family's Patient Career

My basic ideas are as follows. The family is a life group which remains in equilibrium and performs some task under some given conditions. At some point in its life cycle or because of an unexpected event, it gets out of balance and starts to show signs of suffering or dysfunction. One of its members starts with psychological or even physical pain and his behaviour changes, or else within the family start up some interpersonal conflicts between some or all of its members. This can be just a temporal crisis or it can become absorbed in the family as a new way of equilibrium. They will cope with it as they can. But, once their own coping resources are exhausted, they will call for outside help; it could be a neighbor, a friend, the extended family or a priest, a lawyer, a physician, who knows. If they, or one of them consults a psychotherapist or if the advice is to do so, the problem is reframed in psychological terms, becomes psychologized. From that moment onwards, according to the response of the therapist, the family homeostasis will take another route. The family has as its function not only to generate, to foster and to convey pathology but also a morphogenetic one: to generate growth, maturation and change. A sheer diagnostic procedure or accepting the proposed patient as such can as well make the family abdicate this function or reinforce it in that direction. The expert’s opinion not necessarily has to be spelled out in words. It is enough to accept one or to exclude another from the interview, as for confirming or challenging the structural arrangements and pre-established dynamics or else to induce a positive or negative change in the family system. That is why I think the first contact with the family is paramount as it implies to be aware of the previous attempts the family has been making so far at solving their problem.

Once treatment starts - just the same for one single member as for all of them - and as long as he, she, or they are in treatment, the family with the therapist or therapists constitute a group that dynamically interacts. That can be formulated in terms of transferences-counter-transferences, as in psychoanalysis,

or in terms of the changing family and personal matrix of the plexus as in group analysis; the truth is that the network of communication and transactions within the socio-psychological group changes along with the degree to which the unconscious conflict becomes conscious and they are able to work it through.

When we are in conjoint treatment, and while we are in a session, the dynamics of this group are there to be seen. In between sessions by contrast, the family functions as an alternate group without therapist. The role of the latter is to become a sort of catalyst which helps a new culture to crystallize, a culture where to say openly on a verbal, symbolic level what otherwise would go through an untranslated symptomatic level. The family gets healthier as long as it achieves autonomy; as far as having activated its potential capacity for self-regulation and self-direction, it can dispense with external help and containment. That is how, having learned to dialogue, it can assume anew its biological, psychological and social functions and responsibilities regards the family group itself - and each of its members - and regards the open community to which they all belong.

Going back to the relatives' resistance which so much bothered Freud for his individual centered psychoanalysis, in group-analytic terms those external resistances become internal resistances of the family plexus, or better said, interpersonal defenses against a threat to change by just one of its members. What I want to stress here is the importance that for the course of therapy is the fact that the therapist be aware that under the couch of the patient in analysis and around the circle of the small group of strangers who are in therapy with him, there are hiding and flying the family members they left home. In other words, all together they form a psychic group that is being affected in its internal equilibrium and at the level of the network of communication and disturbance by the therapy that is taking place. Besides the difficulties that ignoring that fact brings along, an eye should be kept on how and why the relatives are being affected. Had Freud taken that into account, maybe he could have thought, since it was hopeless to try to treat them individually, to give them a chance by treating them collectively?

It is my conviction that many individual analysis or group psychotherapies that fail, where the patient reaches a deadlock or drops out of therapy without significant changes being achieved, do so because the family network dynamics on diagnosis were not taken into account. Of course, there are cases where with a successful treatment of the patient not only the patient but his whole family gets cured, but those cases are rare when they are approached without a previous appraisal of the family context. It was just luck or sheer intuition that they hit on the right patient, more frequently they don’t, and then one after the other or all of them at the same time have to go into individual therapy. For not having proceeded to a family treatment - most likely the right indication - or for having chosen the wrong patient, the whole family becomes an "interminable analysis" that goes on through generations of patients and analysts, as was the case with Freud's "Rat man".

These considerations are of importance also for the conjoint treatment of families. It has become customary in the field to compulsively see the whole family together - at least those who live under the same roof. Some family therapists go so far as to refuse to see the families if some of the members are not present. Regardless of how expedient and convenient ideally it could be, in many cases it is not possible to have certain members present. Most likely, it is internal conditions between members that foreclose the possibility for the kind of frank, open, deep and complete communication that is required from all of them. In those circumstances there is no other solution than to exclude from therapy or from the meeting that part of the family which is unfit, unable or unwilling to join in the uncovering analytic process that is required for a groupanalytic family treatment. The solution is to concentrate on those who understanding themselves and understanding the family can better facilitate a change - that can be done with a group-analytic family orientation even when only one patient is present. As a matter of fact,

in a consultation or in the first session with an individual patient, that is what I mostly have in mind during the evaluation phase.

There is one other reason why many family therapists abdicate from treating the family analytically and feel compelled to move into action methods and systems thinking. What is adduced is that there is a cultural and social barrier between doctor and patient. According to many, the low class populations who go to free clinics and hospitals are unfit for an analytical approach. The culture of poverty, of margination and hunger is not for talking and symbolic thinking but for action and experiencing: that is why active techniques, interpersonal manipulation, and paradoxical interventions are needed so much to change family systems. That may be quite true, but it is not fair to reach these conclusions when not enough time and dedication has been put into exploring the possibilities of an analytic treatment of the family group. Foulkes said, as I quoted above, that in order to put into practice such multipersonal therapy - **group therapy of the natural group** - this work could be shared by a team of therapists trained both in psychoanalysis and in group analysis. Maybe the time is not ripe yet, since few therapists are trained that way and still less had the chance of working with families as a team. Until such time arrives, however, it is useful to use family interviewing with the group-analytic orientation here described, since it saves time and many hours of painful and useless -when not dangerous - treatment to individuals and families. Besides, it gives a chance to re-orientate the course of treatment when either the therapeutic modality chosen at the beginning was not the most adequate one or else when, because of the progress of therapy, the family dynamics are changed and a shift of modality is required.

There is a word of caution, however, for those psychoanalysts and group analysts who feel tempted to venture into family therapy the group-analytic way. Try not to do it alone, by yourselves. It is better to take the route with a team of colleagues. The mermaids of action methods will tempt your analytic attitude and you can be shipwrecked. Even with the help of your friends, the seas of family therapy are stormy, and when you learn to navigate through them don't expect that when you go back to the more calm shores of the couch and the circle they will feel the same. Changing families in a group changes the therapist as well. From now onwards, when you deal with individuals, even if in an analysis five times a week, you will find yourself keeping an eye open to the phantoms of the family who are haunting you both.

...And those who treat families?

Along this presentation I feel I raised more questions than I offered answers to them. I think I made quite clear which is my idea about family health and the ways, in consequence, I think they should be treated and why. I will try to share and reason with you some of my experiences of the family as a member of the clan of analysts.

The first analyst I saw doing family therapy was Ackerman himself. It was at the end of the fifties at the Jewish Family Services in New York. He was not as much into systems as the people of his Institute are today. I had just started my psychoanalytical training was looking for a job and was going to be interviewed by Ackerman on those grounds. Instead of interviewing me for the job, he invited me into a family session he was conducting. At the end of the session I said to him: Thanks! I don't want the job! We both knew why. I was not ready yet to get into family therapy.

I finished my training, first in analysis, then in group analytic psychotherapy. I had some experience with families, but none in family therapy as such. I went home and there I found myself in charge of a Psychiatric Unit in a Children's Hospital. I could not avoid families any longer. Besides, there I set up a training program following the lines of Foulkes' Outpatient Unit at the Maudsley. The classical ortho-

psychiatric team approach - Child Psychiatrist, Social Worker and Clinical Psychologist - which I had taken in from America, in our Unit would not work. I was very analytic in those days; I think I still am, but in a different way. We started to do groups of children on one side, of mothers on the other, and of mothers and children together. With fathers we could not run groups because they did not want to come, and before we knew it we were interviewing families together. I say “together" and not just "conjointly" because the therapeutic team plus the family were all in the same group. What was started as a Child Psychiatry Service after some years looked more like Family Psychiatry. Unfortunately, circumstances had it that I moved to the Medical School to train physicians. In private practice, though, as a consultant psychotherapist I had plenty of opportunity to do family interviewing.

What is more, it became practically my routine procedure to meet patients for the first time. Some of those patients I treated in conjoint therapy for a long time. Along with a growing familiarity with the family and the use of this double-barrel sort of thinking, I dared to combine both methods: family group and individual analysis with a member of the same family simultaneously. At one point, more than half of my practice was in family groups. Most of the ideas above exposed come from that experience. I must confess, though the experience was exciting, it was painful as well. At one point, there was so much cross-fertilization between family and analysis that I was tempted to give up analysis and get full time into family work.

Fortunately, I had my group-analytic friends from London to help me out: The III Workshop in Group Analysis, January 1976, "Change and Understanding", was dedicated to the theme of insight versus activity techniques, and it gave me a safe ground to think through my problem with the family. Today I am quite happy with what I do. What are my conclusions by now?

1. Family interviewing as a diagnostic tool for the indication of therapy is a must.
2. The open field of conjoint or combined group-analytic family therapy is promising enough not to be shied away from by psychoanalysts and group analysts. Let us make sure that it doesn't apply to group analysis what Balint (1965) said happened to psychoanalysis in reference to group psychotherapy: *"Although Freud himself adumbrated some allowing of the pure gold of psychoanalysis in order to make it suitable for the psychotherapy of broad masses, and although almost all of the pioneers of group therapy were trained psychoanalysts, we, as a body, refused to accept responsibility for its further development - in my opinion to the detriment of everyone concerned, above all of our own science. It is others who are now gathering a rich harvest in this important field and we have lost perhaps an irretrievable opportunity to obtain first-hand clinical observations on the psychodynamics of collectivities"* - in that case of the family group I would say here instead.
3. As a measure of security, this work should be done in teams, as I already said, but what is more, I think of teams of therapists not only out of caution but also for the sake of efficiency and for the sake of their own mental health they should apply to their own relations and as a group the same principles and outlooks they use with the families. I have done so as a consultant to "families” or "clans" of group and family therapists and I can tell you that it may be of help. I wish I had had that opportunity myself. On second thought, I think it would be still better if the team as a group of colleagues can discuss between them the work they jointly or separately do. Co-therapy is not the only answer. Besides, who can afford it, if not institutions or the State?
4. Psychoanalysts or group analysts have more families than ordinary people. On top of their family of origin and the one they constitute, by training and association they become part of the analytic family of the Institute. As Martin Grotjahn (1960) used to recommend, some family therapy with their own real families would do them a lot of good, and some group psy-

chotherapy for the incestuous analytic family of analytic societies would do them no harm. Maybe that way we could find better ways to solve our "theoretical problems" by separating from the old family. That way the analytic family pathology will not be transmitted to their offspring. Just like in the real family!

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