

Direct Treatment of Children in the Family and Children's Agency: Toward An Integrated Practice*

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Our commitment to a merged practice has deprived us of the comfort of selection of modality and client-unit based on training, bias, or agency mission and setting. It has, as we have illustrated, forced us to select criteria for more appropriate clinical dispositions geared to achieving maximum growth both for the child and for the milieu in which he thrives—most often, his family system. We are attempting no longer to cling to either the child as foreground, or the family as foreground. It is almost as if we have lost a simpler day of more automatic clinical choices, of clear preferred modalities. Now we have to struggle, be more creative, and accept ambiguity and uncertainty.

Introduction: They Said it Couldn't be Done: The Story of a Merger

We assume that we owe the invitation to present a paper at this conference on this specialized subject of child treatment in a family and children's agency to the fact that our organization is a newly merged agency of two old and honorable separate family and children's agencies, the Jewish Family Service of New York, and the Jewish Board of Guardians. We also assume that some sadistic joy must dwell in the hearts of our hosts who also must know something of the merger process, and that it brings with it more than harmony and unanimity of opinion among its "unbiased" professionals. Mergers have a choreography peculiar to their process—not unlike marriage itself—with a honeymoon period (only in a pre-marital state) emphasizing similarities and a post-honeymoon state (when all is legal and the ties are made) emphasizing the differences.

In the midst of such experience, the issue of whom to treat directly—child or family—was an early question, if not crisis, demanding a clarity of decision-making at the intake desks or, at the least, after assessment and diagnosis.

And therein lies the problem. Our family service work rested heavily on the *process*, highlighting an existential view of the therapeutic encounter as an intervention in the family's milieu geared toward change and problem-solving. In working with children, *diagnosis* and its structure weighed heavily as a major concern in appraising the problems of children in the period of early engagement.

Because of our workers' different commitments, derived from their histories and training emphases, a greater demand for logic in decision-making took over. As we faced the diverse problems people brought to our agency, certain principles emerged as practical guidelines in making decisions about whom to treat and how.

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First, we unburdened ourselves of one central notion—that there was always a *clear* and obvious route. More often it seemed one could choose either direction, but guidelines did begin to emerge as we yielded and gave up our special biases and devotion to a “sacred mission.” We will be examining the slow evolution of these guidelines, within the context of the development of mental health services to children in the family and child agency sphere of practice.

Historic Evolution of Roles and Function

Mental health services to children in the social work field have evolved in a manner which closely mirrors the historic conflict and polarization present in the parallel development of child psychiatry, and the more recent development of family systems theory and practice, as we shall examine in some depth. Basically, family service agencies have been viewed as “general practitioners”¹ to the community, concerned with the stabilization and restoration of sound family functioning. In contrast, child guidance clinics and child treatment agencies evolved to meet the ever-pressing needs of emotionally troubled youngsters whose level of pathology required the care of specialists. Sidney Green defined this traditional differentiation of function as:

The family service agency has a primary interest in maximizing the adequacy of total family functioning and elects to work initially with those individuals deemed most likely to help achieve this goal. Its primary aim is to help those individuals in terms of improved social adaptation in the home and in the community at large. The child-guidance clinic is primarily concerned with restoration of healthy internal emotional stability in individual children and is concerned with family life mostly to the extent that family life interferes with or supports the conduct of the child's psychotherapy. . .²

¹ Rena Schulman, “In the Interest of Children,” *Children* Vol. 5, No. 4, July-August 1958, p. 150.

² *Ibid.*, p. 150.

But, surely, family agencies deal with children, and child agencies deal with families. A leader in the family service field, Sanford N. Sherman, poses the differentiation in these terms: “The nub of uncertainty is in the question what children, what kinds of problems, and on what level should family agencies treat *directly*?”³ While supporting the specialization of function “family agencies usually do not undertake direct treatment of structured pathology in children unless they have a specialized child guidance unit.”⁴ Sherman also points out that family agencies *do* view the direct treatment of children “as parts of families”⁵ as one of their functions, and makes a plea for increased recognition of the need to see fragments of families in relation to the whole.

Still, these differentiations leave the clinician concerned with fragmentation. For example, if a child being seen as “part of a family” in a family agency needs intensive individual treatment, must he be referred to a child guidance clinic or to a department of child psychiatry? If a family whose child is in treatment at a child guidance clinic develops marital or reality problems, must they be referred to a family agency? Our agency practice experiences make these possibilities all too likely in the context of generalist vs. specialist approaches to human services.

All of us would probably opt for comprehensive care for families and children, in one integrated setting. Yet a true integration of family services and child therapy services seems fraught with difficulty. For example, one paper dealing with parent-child counseling, states that the family agency being described was founded in 1942 to develop and deliver a comprehensive program which would include the child guidance function

³ Sanford N. Sherman, “Family Treatment: An Approach to Children's Problems,” *Social Casework*, June 1966.

⁴ *Ibid.*, p. 369.

⁵ *Idem.*

in an undifferentiated staff. Interestingly, this "multi-service" concept was soon abandoned as unworkable, and a separate unit for "children and youth" was established.⁶ This pattern of structuring services has been the predominant one, based in part on the underlying assumption that the specialized knowledge so necessary for the direct treatment of children could only be maintained and preserved if separated and enclosed. Many recent mergers of family agencies with child treatment agencies have maintained this separation of function, albeit under the same roof, resulting typically in a "Family Services Department" and a separate "Child Guidance Unit." We are interested in this phenomenon, specifically as it impacts on differential treatment planning for children and their families.

The Merger of the Jewish Board of Guardians and the Jewish Family Service: New York City, 1978

The 1978 merger of the Jewish Board of Guardians, a pioneer in the child guidance movement, and the Jewish Family Service, one of the founders of family therapy in the United States, provided us with a living laboratory for the examination of some polarized positions in mental health practice with children, as well as with the opportunity to put into practice a strong conviction about comprehensive and unified services for families and children. We consciously sought to design an integrated model of services for families and children which would *not* follow the predominant pattern of separated services and separated staff. We were convinced that separation of function, although simpler and less stressful to staff, would result in treatment decisions based on theoretical bias and experience, rather than in the best interests of child and family. In one sense, both agencies represented somewhat polarized positions, which often unwittingly determined treatment of

choice for children in one direction or another. As Cohen perhaps overstates:

The clinician's identification with a specific ideology or with one highly favored treatment modality can act as a potentially limiting and constraining aspect to his freedom of choice. For instance, if one begins the formulation process with the bias or assumption that the child has no emotional life separate from the adults who care for him and that his behavior can be understood and changed only within the "family system," then a system approach to management based on some variation of family therapy is almost a foregone conclusion. Conversely, if the treatment of choice is almost always assumed to be the resolution of internalized conflict, then this will slant the priorities for treatment in the direction of individual psychotherapy.⁷

In reality, pre-merger practice with children in JBG favored individual interventions. In JFS, the preferred approach for treating children was via family therapy. JBG staff were trained to perform careful assessments of children and saw etiology through a linear lens. JFS staff saw children's symptoms as often a way for a family to "signal" family dysfunction, and interventions were based on a transactional understanding of behavior. JBG's child-centered approach sometimes viewed families as rather noxious influences, difficult to change on behalf of their children. JFS's family-centered approach sometimes "lost" the individual child in its family view of pathology, which often saw the child's difficulties as reactive to family stress and disequilibrium. Pre-merger practice also included referral of disturbed children to JBG by JFS, and referral of disturbed families to JFS by JBG. Often families applied to one or the other by chance, but their treatment was frequently pre-determined by theoretical set and experience.

In examining the theoretical underpin-

⁷ Saul Hofstein, "Parent-Child Counseling in a Multiple Service Agency," *Mental Hygiene*, Vol. XL, No. 3 (July 1956), pp. 438-439.

⁶ *Ibid.*, p. 370.

nings of psychoanalytically oriented work with children, and family therapy based on psychodynamic and systems concepts, we begin to more fully appreciate the forces which have kept the approaches based on them so separated in practice. Time does not permit an extensive review of these issues, but one must understand that we are dealing with profound differences in the perceived nature of causation and of change itself. In one framework, change is viewed as a response to internal shifts, to insight into unconscious processes, to the effects of a long and intensive corrective object relationship provided in the one-to-one therapeutic experience. In another lens, change is defined as the result of a different sequence of behaviour among intimates. These differing perceptions of the nature of change lead to specialized techniques to achieve the desired goals.

One might also view the different approaches as offering concentrations on different *parts* of the intervention—one, focusing sharply on diagnosis and assessment to determine causation and potential goals; another, focusing on the psychology of change and the process of working-through, changes in relationships, and altered perceptions.

In our merger, we decided that our professional staff would be encouraged to confront these issues, and to integrate, as best possible, the approaches now in our clinical repertoire, based on the needs and availability of our clients. Haley, among others, said it couldn't be done: "If a therapist partially adopts a family view and partially an individual view, he is in continual confusion and begins to talk in an odd manner."⁸ Would our staff go mad? Would we? Would our clients retreat in confusion? We had *willingly* elected to face

the "undeclared war between child and family therapy,"⁹ to confront the long-standing internal/external dichotomy and the fruitless nature/nurture controversies which had long bedeviled the behavioral sciences.

Integrating Structures: The Design for Service Delivery

We were convinced that an either/or rigidity in treatment approaches was too simplistic to deal with the complexities of troubled children and families. Our first task was to insure a *structure* which would foster consideration of diverse clinical views, in a constructive climate of a search for treatment criteria. Thus, we designed "Disposition Conferences," to be held by an integrated team following the initial intake interview for all cases seen in our community offices. These teams were to consist of experienced child and family therapists, from both pre-merger agencies. In addition, these interdisciplinary teams would include group therapists, educational specialists, etc., whenever possible, to insure a comprehensive judgment as to treatment of choice. Our aim was to insure *early* input of different points of view, so that the case would be "tracked" into one of many available modalities based on its own merits, rather than based on the theoretical "blindness" of the individual therapist.

Early "Disposition Conferences" served as arenas, sometimes stormy ones, for the elaboration of treatment rationales. Staff were encouraged to confront issues directly, to "cross-fertilize" each other and to keep an open mind. We also attempted to convey to staff that it was acceptable to remain a specialist in family *or* child therapy and that we held no expectation that all staff would be able to use all modalities. Nonetheless, we expected all staff to be exposed

⁸ "Case Formulation and Treatment Planning," Richard L. Cohen, *Basic Handbook of Child Psychiatry*, Vol. I, pp. 633-645, Joseph D. Noshpitz, Editor, Basic Books, Inc., 1979, New York.

⁹ Jay Haley, "Why a Mental Health Clinic Should Avoid Family Therapy," *Journal of Marriage and Family Counseling*, January 1975, p. 6.

to new clinical modes in our in-service training. Former "family service" staff deficient in knowledge of child development and child therapy techniques were exposed to this specific training. Former "child guidance" staff lacking knowledge of transactional dynamics, systems concepts, and family interviewing techniques were exposed to these areas of learning. As our experience has continued, we have found that a *minority* of staff can learn to be equally proficient in child *and* family therapy, a "new breed," perhaps. The majority find that they prefer and develop depth in one or the other, and this can be usefully utilized by the agency. The major benefit from this kind of training "cross-fertilization" is the stimulation for staff, which ideally acts to "stretch" clinical grasp of complex treatment issues.

Our basic design has a "generalist" front door, via "Quick Response," or rapid intervention teams.¹⁰ Early "tracking" of cases is based on a family-oriented assessment which includes a family group interview for diagnostic purposes in all cases, as well as an individualized assessment of children. Selection of the treatment of choice is done, at least tentatively, after the "Disposition Conference," although this early decision may change during the course of treatment. Cases assessed as needing crisis intervention or planned short term treatment are kept within the Quick Response Units; cases requiring longer term care are transferred to continuing service workers whose specific skills match the needs of the cases. However, what is important to note, is that we do not structure in separate family therapy or child therapy *units*. We maintain specialization *by staff person*, rather than unit. Thus, we encourage our various "side by side" specialists to be

influenced by their peers, and to feel free to try out varying approaches to families. We provide specialty supervision and advanced training in both child and family therapy to help staff learn at least one modality well. But within this climate, we foster a respect for flexibility and an openness of mind which cut through the tendency in this field to become a "true believer."

Interestingly, one finds a growing plea in the field and in the literature for a more balanced approach to treatment. Framo, in a recent communication, looks for more integration, pointing out that "it is the *relationship* between the intrapsychic and the transactional which is central."¹¹ In other words, *both* exist, an idea some family and child therapists have attempted to deny during the last decade. McDermott and Char look forward to a comprehensive theory, wedding the "developmental" with the "transactional"¹² and to "genuine family and child experts."¹³ Perhaps these voices, and there are many others, are in reaction to the polarization of recent years which had grown to absurd proportions.

Emerging Criteria for the Direct Treatment of Children: Treatment of Choice

Although we are just at the beginning of developing data on the impact of our merger on practice with children, our agency can be viewed as a most fascinating laboratory for practice. We have found it quite difficult to "shake loose" from the years of our training and experience, to truly take an unbiased view of the needs of children and their families, and we are certainly not yet where we want to be. Yet we have begun to isolate some general

¹⁰ John F. McDermott, Jr., M.D., and Walter F. Char, M.D., "The Undeclared War Between Child and Family Therapy," *Journal of Child Psychiatry*, Vol. 13, 1974, p. 435.

¹¹ See Judith Lang, "Planned Short Term Treatment in a Family Agency," *Social Casework*, June 1974.

¹² James L. Framo, "Guest Column," *The Family Center Report*, Georgetown, January-March 1980, p. 5.

¹³ John F. McDermott, Jr., M.D., and Walter F. Char, M.D., *op. cit.*, p. 435.

concepts which are useful in practice, although they are simply ideas at this stage, not formal criteria. We are here defining "direct treatment of children" as treatment either *individually or within the family unit*, as long as the child is treated directly by the therapist via a group or an individual mode.

One notion we find helpful is that of aiming for the "*least restrictive*" *treatment modality*. The concept of "least restrictive" treatment is generally used in discussion of strategies to avert placement or institutionalization. We use it here simply to reflect our desire to provide the shortest and least disruptive treatment approach. Thus, we have learned to assess a true reactive disorder of childhood and to aim our intervention at modifying the familial environment *as a first effort*. In many instances, the child improves as a result of the family intervention and does not require individual treatment and thus labeling as "identified patient." We have found brief family interventions to be indicated when there is a clear precipitating event, and a clear family life cycle developmental crisis present, within a basically sound family structure. In addition, family interventions may be indicated when there is a shared sense that the presenting problem is clearly related to a family event or impasse which is affecting all family members, and when a commitment to each other and motivation to work together is present.

Two case illustrations follow:

Mrs. R., age 38, a single parent, applied for help for her two children, Don, age 12, and Suzy, age 10, who were "constantly fighting with each other." The worker soon discovered that in three months Mrs. R. was to remarry, and the family was scheduled to move to a distant borough. The worker viewed the children's irritability as related to their growing anxiety, fear about mother's remarriage and perceived loss of attention to them, fear of loss of their visits to their father because of the move, and generalized anticipated loss of extended kin, friends, school and neighbor-

hood. The treatment plan was to offer this family, including the fiancé, short term family treatment to deal with this disruption and its meaning to all. Family sessions helped to prepare all members for change, facilitated open communication, and helped them plan concrete steps such as a visit to the new neighborhood and school, to deal with the changes. The children's anxiety diminished and the quarreling between them returned to normal, pre-crisis levels within six weeks of a treatment contact.*

Mrs. Z. applied for help because Marcy, age 13, was "underachieving" in school. Mr. Z. had died just six months prior to this application, leaving Mrs. Z. with Marcy, age 13, Billy, age 11, and Peter, age 9. The worker viewed this family as one with many strengths, but its "stiff upper lip" style of dealing with loss was not working. Mrs. Z.'s initial request for "testing" for Marcy was viewed as a displacement and an effort to deny the real sense of loss—and resentment—she carried. Her anxiety over now being the head of the household was reflected in her increased pressure on all three children to achieve in school, so that they could win admission to free special high schools. Thus, her anxiety about the future centered on her oldest child, Marcy. The family was offered short term family therapy, were seen flexibly for nine family sessions and five individual sessions, and experienced great relief as they were able to grieve together, and were encouraged to draw on the support of their Rabbi, as well, in this process. Follow up showed the family to be functioning well and maintaining gains.*

Another guiding principle which is evolving out of our merged practice is the concept of *working from the outside in*. We opt for an early comprehensive study and treatment of the whole family, wedding sound assessment to treatment right from the start. This family-oriented approach with individual sessions as needed, gives us a richer understanding of the *child-in-context*. Thus, we explore the *meaning* of the child's presenting symptomatology as

* Caseworker: Winifred Vetter

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related both to diagnostic issues and to family dynamics. We are then able to assess and experience "in vivo" the symptom-maintenance features of the family, if present, and to assess whether the family unwittingly supports the child's symptoms while overtly distressed about them. This early family lens enables us to ask important clinical questions: is the child "needed" as scapegoat, to preserve and protect another relationship or fragile family member? Does the child show marked differences in behavior in and outside of the family? If so, why? Are the child's symptoms still fluid and reactive? Or does one see evidence of conflict and pathology already internalized, entrenched and repetitive? How responsive are all parts of the family, and what is the capacity and readiness for change and growth?

Once the worker has made this kind of assessment within the beginning stage of treatment (and not separated from treatment), treatment goals and planning can proceed in a more informed way. This approach differs markedly from both the child guidance approach, with the child viewed as "identified patient" from the start, and from the family therapy approach, which would view the family as "patient." We will leave our options open, but prefer to understand the whole before moving to the specific, whenever possible.

Thus, if we find the family unit responsive to help, and note positive shifts in the child's behavior, which we begin to understand as reactive to family stress and/or pathology, we may elect to treat the family as a unit. If, on the other hand, we assess and experience the child's symptoms as the outward manifestation of a more internalized pathology, resistive to shifts within the family, we may elect to treat the child individually, recognizing that we will need to draw on the intensity of a one-to-one corrective objective relationship, and to provide the opportunity for the child, within a healing relationship, to deal directly with

his pain and conflict. Sherman suggests that a family therapy approach to entrenched childhood pathology may not be directly curative, but that it may "peel away the reinforcing overlay" and so reduce the level of interpersonal conflict as to either "suffice as an ameliorative measure, or at the very least, set the most auspicious conditions for further and direct individual therapy."¹⁴ An exploration of the inner pain of a disturbed child, and a reliance on the individual therapeutic relationship as curative, need *not* preclude a comprehensive view of that child *in context*, and a continuing examination of the intricate tangle of forces within the family which help to shape and give meaning to his behavior.

Another emerging criterion is *accessibility*—what is the *most accessible part of the system* at the time of application for help? We view a family as a system of interlocking parts. Transactions between persons are part of a larger system; *change at any point in the system can affect any or all of the components of it*. In some families, we may be faced with responsive parents and a wary, resistive child. It may be necessary to enter the system first via the parents, but as they begin to change, changes ripple into the parent-child sphere as well, and these changes may make the child's involvement possible. In the reverse situation, a youngster may show himself to be responsive and accessible, but at the point of entry his parents are reluctant to become involved. Because we are operating out of a flexible and pragmatic framework, we may choose to enter first via that most accessible part of the family. Evaluation of accessibility is directly related to the timing of interventions. Timing, however, is a fluid notion, as family systems—and children—present differently at various points. One needs to develop a finely tuned and flexible response which meets the "client family"

¹⁴ Sherman, *op. cit.*, p. 370.

where it is. The K. case illustrates this concept.

Harold, age 12, was referred by a local community center. He was described as a lonely child with no friends, who withdrew to his room and talked loudly to himself. He was anxious and depressed. His parents, Mr. and Mrs. K., who were owners of a small and failing business, were observed at intake to be depressed, angry, suspicious people who saw no role for themselves in "Harold's problems." Their attitude remained secretive, withholding, and distrustful: "Just fix Harold." Their perception of Harold's problems as externally caused (by a bad neighborhood, etc.) was not directly challenged by the worker. Periodic family sessions were rejected by all family members, but Harold was seen individually, and his parents conjointly, for two years. During that period, Harold, diagnosed as "Behavior Disorder of Adolescence-withdrawing Type," developed a close relationship with his therapist. He was able to ventilate the rage he felt towards his disturbed and limited parents, and gradually, no longer needed to act this out by getting poor grades in school. His parents gradually warmed to an educational, supportive approach and were very slowly helped to view Harold as an adolescent and to accept his growth and separation from them. The basic family constellation of the rageful, inadequate father and psychotic fragile mother did not change dramatically, but the family's ability to trust allowed for generalized growth. The worker made excellent and well timed use of Jewish Camp and "Y" experiences as socialization and identity mechanisms. Harold was helped to get back on the adolescent "developmental track," to develop sublimations and to experience social hunger. Father-son activities were encouraged, unsuspected family strengths emerged, and the family depression lifted. The family, in fact, developed an "institutional transference" to the agency as a new and more benign "Jewish family," one which permitted and supported growth.

In the above case, the worker assessed Harold initially as the most receptive part of the system, and *joined* the early family resistance rather than challenging it directly, which might well have resulted in early

drop-out. The self-esteem of all family members was raised, thus stimulating a positive feedback cycle, which produced unexpectedly good results.*

It has been our experience that a *general flexibility of approach* helps us more quickly change direction when our early treatment planning proves faulty. For example, we may begin with family approach, come to the conclusion it is not effective, and try a more individualized approach, or vice versa. Our pre-merger clinical stances often bound us, unwittingly, in therapeutic impasse situations for far too long. At this early point in our merger, we have no hard and fast criteria for determining treatment of choice. As a matter of fact, it is not unusual that two well-trained workers can give equally matched but diametrically opposed treatment plans and rationales for the same case. Thus, we shift from dogmatism to pragmatism, and trust that criteria will begin to emerge more sharply as we continue to gather experience.

The decision to treat a child individually may be related to *the family's capacity for change*. In some situations, it becomes clear that parents and other significant family members are simply too limited to be able to make the kinds of changes required for growth. This is a difficult, but necessary, judgment to make, as the following illustrations demonstrate.

In the A. case, Randy, age 9, was referred by his school. Randy was described as withdrawn and a "daydreamer," a child who unpredictably was alternately passive and quiet, or loud and disruptive in class. Mrs. A., a divorced Israeli woman, age 40, was barely managing on a meager welfare allowance. When contacted, she was interested in dealing with her concrete problems of living, but did not view her son as troubled. Initial mother-child interviews revealed Mrs. A. to be cold and unrelated to Randy, and strikingly unaware of his needs. She had a history of severe, episodic depres-

* Caseworker: Myrna Weinstein

sions, and had placed Randy in a foster home from age 3 to age 7. Randy's father had abandoned the family when the child was born. No other family or community supports were available, and the agency quickly became a substitute extended family. Treatment planning included individual intensive therapy for Randy, supplemented by individual supportive help for Mrs. A., focused on her many reality problems.

The one-to-one therapeutic relationship for Randy with a male therapist was geared to provide a corrective object relationship for him, as well as to further assess his potential for growth. After one year of treatment, Randy spent a summer in a therapeutic camp, his first camp experience. At present, planning is underway for day treatment for Randy as he continues to evidence severe disturbance and an inability to learn in a regular school setting. Mrs. A. has been helped to accept these plans for Randy as in his best interest, and in addition, has been able to utilize her caseworker's help in stabilizing her living situation. Randy's individual psychotherapy, evaluated as useful but not sufficient, has been expanded by utilization of other therapeutic supports.*

In the following case, Mrs. G., too, might initially have been assessed as too limited and damaged to serve as the "therapeutic change agent" for her daughter, Cindy. Yet, this case illustrates an effective conjoint approach which tapped unexpected reserves of strengths.

Mrs. G., age 41, a divorced single parent, and a recovered alcoholic, applied for help with Cindy, age 8. Cindy's teacher suggested treatment for her, as she had many verbal arguments with peers, and academic problems as well. Cindy was an interracial, out-of-wedlock child who had been rejected overtly by her mother since birth: "I had no feelings for her whatsoever!" Despite evidence of early maternal rejection and neglect, the worker saw strengths in Mrs. G.'s ability to find a good private school for Cindy, and a previous day care foster family service. She also sensed motivation and a latent capacity for change.

Cindy was viewed to be friendly, spunky and energetic, as well as anxious, unrelated and withdrawing into fantasy.

Treatment was exclusively conjoint and the focus was on treating the mother-daughter relationship. The worker was able to take seeming negatives, such as "I have really only 20 minutes a day to give to that child!", and convert them into positives. The "20 minutes" was structured into warm physical contact—a back rub for Cindy. The worker identified separation/individuation issues as central, and worked conjointly on differentiation of self through creative use of mutual picture drawing, joint story telling, and role reversal.

In addition, Cindy received a psychological evaluation which did confirm a suspected mild learning disability, as well as profound identity issues. The center of change, however, remained the fostering of a "corrective emotional experience" between mother and daughter. Mother's new found ability to set limits, be more evenly responsive, recognize Cindy's school problems as the result of some impairment (rather than "stupidity"), and to hear and accept Cindy's questions about her natural father resulted in raised self-esteem for both, and gains in both Cindy's peer relationships and grades. Thus, Mrs. G. was able to move from maladaptive to adaptive mothering responses, trying out "in vivo" new, more positive ways of responding to her daughter, and receiving immediate feedback from the therapist.*

We have begun, partly as a result of our clinical merger, to experiment with forms of *combined* treatment. The E. case which follows is illustrative of how effectively a combined approach to children's problems can bridge the theoretical and clinical chasm.

Mr. and Mrs. E., both professionals and working parents, applied for help for Charles, age 8, who suffered severe headaches (medical findings negative), enuresis, reading difficulties in school and infantile, immature behavior.

An examination of Charles' presenting symptoms, from both an individual diagnostic viewpoint and from the perspective of the

* Caseworkers: Linda Ariel
Andrew Steglitz

* Caseworker: Tamara Engel

meaning of these symptoms within the family system, revealed Charles to be an anxious youngster with inadequate defenses, whose attacks of headache served a classical "conflict detour" role within the family. Charles' symptoms, while in part the result of internalized conflicts, and overwhelming anxiety, were also viewed as maintained within the family system because they helped to support the current family homeostasis. Frequently, Charles developed a severe headache when his parents were headed for direct battling. Mother's solicitous attention to Charles as her "sick little boy" then "detoured" the emerging marital conflict, and peace was restored to the family. It was decided to treat Charles both individually and within the family, to deal with his own conflicts directly, and to encourage direct verbalization, as well as to attempt to disentangle him from this "sacrificial" role within the family.

A turning point in the course of treatment occurred when the therapist, with Charles' consent, and even encouragement, played a tape recording of Charles' individual session *within the family session*. This tape revealed an almost stream-of-consciousness "story" told by Charles, which vividly portrayed his "caught in the middle" role in the family. This enabled the therapist to help the entire family, including the formerly "triangulated" brother, age 13, to deal with the need the parents had to distance and detour their hidden conflicts, through the children, at great cost to their growth and development.

Mr. and Mrs. E. were able to begin work on long denied and buried marital conflicts, and the combined treatment continued most productively.*

Summary

Our commitment to a merged practice had deprived us of the comfort of selection of modality and client-unit based on training, bias or agency mission and setting. It has, as we have illustrated, forced us to select criteria for more appropriate clinical dispositions geared to achieving maximum growth both for the child *and* for the milieu

in which he thrives—most often, his family system. We are attempting to cling no longer to either the child as foreground or the family as foreground. It is almost as if we have lost a simpler day of more automatic clinical choices, of clear preferred modalities. Now we have to struggle, be more creative, and accept ambiguity and uncertainty rather than conviction and sureness of approach.

It is still not totally clear as to what role model will finally emerge for our caseworkers. Our multi-dimensional perspective reflects a changing, fluid process which characterizes our current working tasks. We are now in the phase of training skilled *generalists*, workers with a holistic approach, eager to select rational criteria for their decisions about direct treatment of children. But it is apparent to us that *specialization* will emerge as we refine the needs, and the requisite skills, without endowing the role of specialist beyond its value or depriving the generalist of its utility.

The culture vs. personality discussion has had ample forum by the great social analysts (Kluckhohn, Parsons, Bales, and so many others). Does man change the system or does the system change man? Both are obviously true. The value for the therapeutic world lies in the wisdom of when to use either side of that equation towards the promotion of growth.

We have left much uncovered in this early report of our experience. We have not discussed the fascinating area of promoting separation/individuation in the adolescent client and its attendant controversies of family versus individual modes of treatment. We have failed to consider the factor of age, and its impact on treatment planning for children. And most importantly, we have left untouched the central issue of our Jewish auspice and its influence on the treatment process for Jewish families and children. Time has not permitted a broader exploration, and we have chosen to focus

* Caseworker: Robin Brinn

on our most urgent task of practice integration. But our process has begun and

will go forward. We are convinced that it is in the best interests of child and family.