3. The therapy should be an intense involvement and a rapid disengagement rather than regular interviews spanning years. As soon as change occurs, the therapist can begin to recess and plan termination. The task is not to resolve all family problems, only the organizational ones around the problem young person, unless the family wants to make a new contract for other problems.

4. The therapist should occasionally check with the family to follow up what has happened and ensure that positive change continues.

In essence, the therapy approach is like an initiation ceremony. The procedure helps parents and offspring disengage from each other so that the family does not need the young person as a communication vehicle, and the young person establishes a life of his or her own. Two extremes have often failed. Blaming the parents as a noxious influence and sending the young person away from his family typically fails. The young person collapses and comes back home. The opposite extreme—keeping the young person at home and attempting to bring about harmony between child and parents—also fails. This is not a time of coming together but a time of disengagement. The art of the therapy is to bring the young person back within the family as a way of disengaging him or her for a more independent life.

A therapist can define the simple goal outlined here if he or she is able to think in simple organizational terms. Achieving the goal can be a complex endeavor and requires all the skill and support the therapist can develop.

Chapter 3

Social Control and Therapy

When young people are put in institutions, they have in common the fact that they are failures. They are not succeeding in work or school and must be supported. However, the problem they present when they come to community attention is not that of failure. They are locked up because they disturb the public with behavior that indicates hallucinations or delusions, take heroin or other illegal drugs, steal or otherwise break the law, or because their parents say they cannot control them. Some of them threaten to harm themselves or others, and some behave in lost, neglected, and helpless ways. All of them require that the community do something about them. The people who take that action are agents of social control, such as the police and the people who work in medical and psychiatric centers.

When a therapist takes on a severely disturbed young person, he usually finds agents of social control in charge. Doing therapy with mad young people means continually dealing with issues of custody, restraint, and medication. A major aspect of the therapy is negotiating with colleagues in social control settings, such as psychiatric hospitals, drug rehabilitation centers, halfway houses, jails, and juvenile halls. Problems can arise between the therapist who wishes to change people and the social control agents whose job it is to quiet, reform, custodize, or eliminate those people who offend society.

Young people are ingenious in finding ways to be deviant and live marginal lives, but relatively few of them make enough difficulty to announce their presence to social control agents or therapists. These young people

are generally put in one of two legal categories: they are either defined as criminals or labeled "mentally ill." The criminal offenders have committed some delinquent act and are put in custody for the good of the community, although it is also argued that custody has some rehabilitative purpose. The medical offenders called mentally ill are of two types: either they are troublemakers whose families cannot manage them, or they do nothing to support themselves and their families give up taking care of them. People are not usually put in mental hospitals because they have symptoms such as delusions and hallucinations, but because they make trouble or are apathetic and will not take care of themselves. In recent years the diagnosis of "manic-depressive" has become fashionable, possibly because there is now a treatment—lithium—that has been partially successful with some depressed people. Young people who are in this category manage to be at two extremes: they are troublemakers when manic and apathetic when depressed.

The legal offender and the medical offender are not clearly different kinds of people with different behavior. Sometimes the behavior is so similar that it is a mystery how one career was chosen rather than another. Often it seems to be the social situation rather than the acts of a person which determines whether he is called a criminal or a lunatic. A policeman may decide the category of the person by where he takes him for custody, and sometimes family and police collaborate. Often the choice is based on social class; the wealthy are more likely to be classed in the psychiatric domain while the poor become part of the criminal system. If a young person steals a car, it can be either a criminal offense or a symptom of "poor impulse control," depending on the wealth of the offender's family. There are also borderline instances where it is a toss-up whether the problem is criminal or medical, as in the case of drug and alcohol abuse.

One of the curious differences between the diagnoses of "criminal" and "mad" is the idea that a criminal is responsible for what he does and makes a free choice to misbehave. Even if he wastes his life going in and out of jail, that must be considered a rational decision; otherwise there is no point to a legal system that assumes he made crime a choice. He deliberately does his criminal acts; therefore his punishment is deserved. The staff of a prison can be severe with prisoners with an easier conscience than the staff of a mental hospital. The "mentally ill" are said not to be able to help what they do. When a patient misbehaves in a mental hospital, the staff can only punish him reluctantly, under the guise of help, since they define themselves as healers as well as community protectors. Drugs, shock treatment, deep brain probes, and lobotomies are always considered medical treatment, and it is denied that they are used for disciplinary purposes.

Because of the theory that the criminal made a conscious choice of what he did, penology professionals do not welcome traditional therapists. Therapy concerned with "unconscious" processes seems unwelcome among the keepers of criminals. They consider it their job to persuade the felon to misbehave no more; therefore they focus him on work or school. They are also usually reluctant to involve the criminal's family in a meaningful way. They prefer to believe that he made his own choice rather than that the crime resulted from difficulty in a family.

The criminal offender is usually tried in a law court under rules which society developed to protect both the community and the offender. When someone is defined as ill or mad, the task of the community is more complicated. Custody is used, as with criminals, but there are also chemical restraints in the form of medication. The dilemma is that something must be done about someone who makes the kind of trouble that does not allow a legal trial and sentence. The rules of justice are not easily applied when it is not clear that a crime was committed or when sanctions like those brought against criminals do not seem appropriate. If a young person strolls around a neighborhood in the nude singing nonsense verses, the police will be called and are likely to take him to a psychiatric hospital. The young person can be held in the hospital for what amounts to an indefinite sentence and might spend his or her life in custody essentially for being a public nuisance. A therapist who attempts to do something about the young person and his or her family must deal with social control agents, who have the responsibility for seeing that he or she does not bother the community again. The psychiatrists, nurses, aides, and social workers in the institution have their ways of dealing with the problem young person; a therapist oriented to the family has quite another way. Often the confusion between social control procedures and therapeutic acts causes conflict among the professionals in dealing with each other. Just as family members will struggle with each other over who is right and who is wrong in dealing with a mad offspring, so will professionals quarrel when they take on the problem. Success in therapy can be determined at least as much by what happens among professional colleagues as by what happens within the family.

The problems facing therapists in this situation can be described in terms of both the institutions they must deal with and the premises and theories evident in the community control approach.

Social Control Institutions

Therapists have different problems with different institutions. As a general rule, the more removed the institution from the community, the more difficult the therapeutic task.

The most impossible place to attempt therapy is in a total institution

where an offender is completely removed from the community. Except in large cities, these places are usually isolated from the community and far from the family and friends of the inmate. A socially oriented therapy is not practical in the abnormal situation of total custody. It can begin only at the point when the offender is being released.

Just as penitentiaries are usually far from the community, so are mental hospitals. These hospitals are usually large places where those unwanted by society are kept. Contemporary ideas enter with difficulty because of the size and rigidity of the staff. The institution tends to be staffed by professionals who are trained to work in hospitals and do not understand the point of doing therapy in the community. The emphasis is on persuading patients to join the culture of the hospital. Such a goal can be irrelevant to the ways the person must behave in ordinary life. A staff can forget, or never clearly understand, that the task is to change the person in the community where his problem is. Many of us used to sit and talk to patients in mental hospitals several times a week, for years, with the idea that the talk would somehow make them better able to live outside the hospital in the community. We had the idea that if we said the right things (those that gave insight and a corrected emotional experience) the person would go off and live a normal life.

As another illustration of the withdrawal from reality by the staff in mental hospitals, I recall two residents who reported to a staff meeting about the way they had established a therapeutic community on a ward. They discussed what they did, how the staff responded, the democratic processes, and so on. During the discussion period, someone asked them if more patients had been discharged from the ward since the therapeutic community was established. There was a silence, and the two young men looked stunned. It was not merely that they did not have the discharge figures; the idea had simply never occurred to them. Their actions on the ward were not in the context of the hospital as a place to change the ways people lived in the community.

Although mental hospitals are making brave attempts to reform and develop new approaches, they are hampered by the vast inertia which characterizes any large bureaucracy. For several years more contemporary psychiatrists have been attempting to involve families in the admission and discharge of mental patients, so that the life situations of the patients are brought into the hospitals.[1] One can watch such an attempt begin, and then vanish when its proponents leave that institution. The ward often returns to a traditional mode that has existed for a hundred years.

[1] Henry Harbin, "A Family-Oriented Psychiatric In-patient Unit," *Fam. Proc.*, 18: 281-291, 1979.

In recent years the state hospital population has been reduced as mental health centers have developed in the community and chemical restraints have been more widely used. At times the attempt to empty the hospitals has been a misfortune. People who were chronic cases, in that they had been locked up for years, were suddenly dumped into the community. They were often exploited, and some were incapable of caring for themselves, particularly when heavily dosed with medication. If clinicians were specially trained to return people to the community after years of institutional life, the task would be difficult enough; not to have trained clinicians and simply to put people out is inexcusable. I recall doing therapy with patients who had been locked up ten years or more. Their social inexperience was immediately evident when they went outside the hospital. For example, one man had not ordered a meal from a menu in a restaurant for ten years and approached the task with uncertainty, if not panic.

The inability to function in the community after being locked up is not necessarily related to "mental illness." A convict released from prison after twenty years is often a lost soul in the community, without family or friends, and he can seek to return to the institution.

The state mental hospital is hardly defensible as a form of therapy[2] but it is also not defensible to release chronic mental patients into the community without guidance. A basic goal is to succeed in therapy with young people to avoid locking them up, so that twenty hears later they will not be social misfits unable to live in the community.

An important difference for therapists between the criminal and the medical offender is that criminals do not voluntarily go into custody (unless one defines a badly carried-out crime as a search for custody). They are sentenced by the court. Medical offenders are classed in two categories: the involuntary and the voluntary. The involuntary class includes people committed by the state on the advice of psychiatrists. The line between involuntary and voluntary patients, as well as between open and closed wards, is not always clear, but the distinction is important to a therapist attempting to cooperate with a hospital. Locked custody tends to embarrass psychiatrists; thus a pretense can develop that it is not happening. The therapist attempting to deal with a patient in a hopsital must also deal with the pretense.

Both the legal and medical systems have experimented with part-time custody as a means of creating a better relationship between institution and community. Inmates in prison spend their nights in jail and work in

[2] Assembly Interim Committee on Ways and Means, California Legislature, *The Dilemma of Mental Commitments in California: A Background Document*, Subcommittee Mental Health Services, California, 1967.

the community during the day. Psychiatric institutions do the opposite; people are kept in the hospital during the day and sent to their homes at night. This keeps them occupied in something that is not self-supporting during the day, in contrast to the prison program, which involves inmates in normal work or school.

Another alternative to total custody is the halfway house, which is used in both the criminal and psychiatric systems. These are places where the person can recover from being in a total institution and slowly integrate into normal living again. Sometimes it is forgotten that they are halfway houses, and they become dead-end houses for some of the inmates, who become part of the culture and never quite return to normal community living.

Sometimes without custody, and often after it, the criminal offender is placed in the community under supervision. He is watched for a period of time, and if he avoids trouble he is set free. Medical offenders are on "parole" in visits home with their families and in trial visits before release. If the misbehavior recurs, the person is placed back in full-time custody.

Private Mental Hospitals

In the medical offender category there is a special class of institution which is a private enterprise. The criminal class does not enjoy private prisons, but the medical offender can be placed in a private hospital. These places tend to be for the rich who can pay high rates, or for those with appropriate medical insurance. Families feel less guilty about placing an offspring in a private hospital than in a public institution, because they feel he or she will be better cared for and because they will have more influence if they are paying the bill. A typical way for a family to stabilize is by paying someone else to restrain the problem young person, preferably somewhere far out in the country.

University Psychiatric Wards

Criminology departments in universities have not been allowed to have private prisoners in order to train staff to work with felons in a private place on campus. University departments of psychiatry, however, have been allowed to arrange a place for inmates for training purposes. These are private institutions, yet they are public in that the training is often funded by the government, or the universities are state supported. Usually the staff holds patients on a voluntary basis, but they can also use legal custody procedures. When the patients fail in such training institutions, the state mental hospitals receive them.

Unfortunately, training needs sometimes determine whether custody occurs or not. University wards, private hospitals, and state hospitals need a certain number of inmates for their training programs and to meet their overhead. When there are not enough patients, it can be decided that the ones currently available need total custody. In private hospitals, a public relations task is often done to persuade families to pay for the custody and therapy of a family member for as long as three years, which happens to be the time the residents need to train in doing "deep" therapy with the inmates. The financial condition of families and the insurance limits tend to set the length of hospitalization and the "depth" of therapy.

Psychiatrists and staff in hospitals do not like to think of themselves as agents of social control, but rather as healers of the sick. Their problems come when financial needs or community pressures require them to heal the sick whether the sick wish it or not. While accepting the burden, the psychiatric profession expresses the idea that they would rather not have responsibility for the marginal people of society. For humanitarian reasons, however, they would rather not let anyone else have that burden. Often they feel misunderstood, since they think of themselves as having the difficult task of dealing with mad people who threaten suicide or other violence, police who insist that something must be done, families who want members locked up, patients who insist there is nothing wrong with them, and civil libertarians and sociologists who are shocked at the conditions in hospitals and call them psychiatric penitentiaries. To be both a healer of the sick and a jailer is stressful and paradoxical, and the psychiatric profession suffers as much as it benefits from its obligations. It is a mad world inside the ward for both staff and patients.

Premises of Social Control

By definition, an agent of social control has the task of bringing peace to the community. Whether the agent acts in a kind and humane way or ruthlessly, when he is removing a troublemaker to protect the community, the primary goal is the peace of the neighborhood.

Certain assumptions are expectable in agents of social control. First of all, they assume that the problem is an individual rather than a social situation. The psychiatric diagnostic categories and the criminal classification system contain no social units larger than a person. If a whole family erupts in violence, or both spouses in a married couple act strangely, one person is typically selected to be diagnosed and quieted by custody or drugs. To put more than one family member in custody is unusual, just as medicating a whole family is unusual. The system is built on the idea that the source of trouble in a community is a troublemaker.

Generally social control agents not only focus on an individual but are antifamily. Sometimes the relatives are just ignored, and so the consequences of social control action on the total family group are not

noticed. A person will be plucked out of his family and hospitalized without any concern for what happens to that family when it loses a member, even temporarily. Or such agents will heavily medicate a troublesome woman without considering the effect on the way she raises her children. A man will be medicated so that he will quiet down and cause his wife less trouble; what will be ignored is that the medication can have unpredictable effects and cause him to be unresponsive in a way that gives him more difficulty with his wife.

Social control agents often assume the family is the noxious influence that caused the problem. Typically they are rescuers of family "victims." The antifamily stance of many drug rehabilitation centers is partly due to the fact that some of the staff are ex-addicts who are in difficulty with their own families and who therefore do not welcome family participation in therapy. They prefer therapy groups of peers, such as fellow addicts, rather than of relatives.

There are also psychiatrists who join families against eccentric offspring, assuming an organic or hereditary cause, who therefore do not blame the parents for poor parenting. They tend to sympathize with parents for having a child who will always be defective.

In summary, agents of social control represent the community, and their primary job is to do something to quiet troublemakers and other social deviants. Only secondarily is it their task to help the deviant. They tend to identify one person rather than a social situation as the problem, and they ignore the family or consider it a noxious influence. These premises, and the institutions which develop from them, handicap a therapist who seeks to bring about change.

Difference Between Therapy and Social Control

The goal of a therapist is to introduce more complexity into people's lives, in the sense that he breaks up repetitive cycles of behavior and brings about new alternatives. He does not wish to have a problem person simply conform, but wants to place in that person's hands the initiative to come up with new ideas and acts that the therapist might not have even considered. In that sense the therapist encourages unpredictability. The therapeutic job is to bring about change, and therefore new, often unanticipated, behavior.

The social control agent has quite the opposite goal. His task is to stabilize people for the community, thus he seeks to reduce unpredictability. He wants problem people to behave in expectable ways, like others in the community, so that no one is upset by them. It is not change and new behavior that he seeks, but rather stability and no complaints from citizens.

There is inevitably a conflict between a therapist whose job it is to

encourage people to behave in new ways and a social controller who wants them to behave according to society's rules in predictable ways. The therapist needs to take risks, while the social controller wants to reduce risks. When the therapist says, "Let us take this person out of custody, off medication, and back into the community," the social controller says, "Let us not be irresponsible, let us proceed with caution." Since there is a time and tide in the therapeutic enterprise, and the therapist must take advantage of timing, caution is not always welcome. Often there is an optimum moment when parents will accept an offspring back home or when a job opportunity arises, and the therapy can fail if action is not taken then.

A therapist needs flexibility in other ways. If medication is used, it is best to be free to give or withhold it, to change it, to use placebos, to medicate more than one family member, and so on. Medication should be part of the strategy of change, as should any form of restraint. If medication is used only to quiet someone, or because there is an administrative or ideological rule that such a person must always be medicated (or medicated for set periods of months), the therapy is in trouble. A typical situation is one where parents want the young person medicated because they cannot agree on how to control him. If the psychiatrist medicates because the parents want the young person quieted, it is different from medicating for strategic reasons; for example, as part of a bargain that the parents will cooperate in therapy.

Therapists need flexibility, whether it is in moving someone in and out of custody or on and off medication. The social controller feels a different responsibility. He does not wish to let a mad young person out of custody or off medication prematurely. The problem for the therapist is that cautious delay stabilizes the social situation and prevents change, because the family and community organize around the young person as an invalid, which makes the therapist's work more difficult. The longer he or she is in custody and treatment, the more the young person settles into the career of a mental patient, not only within his family but also with the deviants he associates with in treatment settings. There is also a stigma attached to anyone institutionalized; this affects job applications and school acceptance. The prophecy of social controllers that a person is handicapped and must remain in custody or on medication for life is often fulfilled by the "treatment," which socially handicaps the person for life. In time a mad young person becomes a professional patient just as other people become professional criminals. Institutionalization becomes his or her career.

Conversely, according to social controllers, some therapists rush too quickly into the normal situation, causing a relapse and making life more difficult for the patient and family. There must be rehospitalization, additional expense, and more time away from the ultimate job or school. The

therapist in turn argues that sometimes a relapse is a necessary part of the therapy. When a young person improves after a first offense, it does not mean that he will stay normal. As the problems in his family increase, he may relapse. If the family is helped to solve its problems at that point without social control, it is able to reorganize so that further relapses are unnecessary. Change, in the sense of getting past a stage of development, can be prevented by interventions intended to avoid relapses.

Another difference between therapists and social controllers is that the social controller welcomes other helpers, while many therapists do not. The therapist must deal with a problem young person's family, which can be difficult. If custody is used, he must also deal with the people in the institution. He has trouble both in getting the experts out of the situation and in getting the person back into community life in a normal situation. The social controller prefers to isolate the problem person from the community, and he values custody as a way of dealing with the person without family interference. He also welcomes all other experts, whether they are doctors, nurses, group therapists, art therapists, or any other experts who are willing to work in the hospital setting.

The attitudes of the therapist and the social controller differ in one other way. The person in a social control setting tends to develop a pessimism about anything being done with problem young people. He lives constantly with failures, seeing the recidivists who fail again and again. In that situation, one loses hope that anything can be done and welcomes a physiological theory that assures one the failure is not one's doing. The therapist, in contrast, has sufficient success so that he has hopes of improvement and looks forward to the possibility of normal behavior in problem young people. The therapist becomes exasperated with pessimists, since it is only people with hope who take those extra actions that sometimes make the difference between success and failure.

A Classification of Social Controllers

Although contemporary psychiatry and modern criminology argue that great advances have been made and that changes have taken place in the problems of institutions, a few people still feel that there is a quality of being back with the dinosaurs when dealing with social control. In that sense a classification is possible, which ranges from social controllers who are the most old-fashioned and difficult to deal with to the more modern staff members of institutions.

Pithecanthropus The most extreme form of social controller is the psychiatrist or penologist who accepts the premise that a problem young person has a physiological defect. This type argues that the problem is genetic, therefore nothing can be done. Worse, they implicitly suggest that nothing

should be done. The problem persons should be in custody where they will not breed and reproduce their kind. If forced by civil libertarians to release a person, this type prefers incapacitating medications, or, as Gregory Bateson put it, "chronic intoxication by chemotherapy." When a young woman was recently rehospitalized after a number of previous stays in that mental hospital, the doctor there said that she really should kill herself and get it over with. He expressed a typical view of the Pithecanthropus. This type has a similar theory about criminals, namely, criminal behavior has a physiological cause and is unchangeable. Attempts at rehabilitation are therefore pointless.

Therapists should avoid dealing with the Pithecanthropus and not attempt negotiations. To educate them is impossible. One can only do one's best to keep people out of their hands.

The Cro-Magnon This type assumes there is a genetic defect, and quite probably lifelong custody will be necessary. They also try to be more liberal, however, and suggest that perhaps in some cases there was really a miserable infantile experience that has scarred the person forever. This type is willing to release an inmate if he or she is heavily medicated. Reducing the medication is against his philosophy. Even when it is pointed out that the medication causes irreversible neurological damage, the Cro-Magnon says that that is better than life in the hospital; besides, the person is already physiologically damaged anyhow because of the genetic defect. This type will allow a therapist a chance to prove that therapy is pointless, but at crucial moments, such as when custody or medication is the issue, will prevent change. Therapists should avoid this type if possible, but when they must be dealt with, it is important to listen to them and appear naïve, so that they will let the therapist have a chance "to find himself wrong."

The Ancient This type always says there is probably a physiological or genetic cause for a severe disturbance in a young person, but he also likes to feel there is an intrapsychic cause, such as an Oedipal problem. He does conversational therapy inside an institution. The therapy is expected to take many years. Sometimes it is estimated that the therapy required for recovery takes as many years as the person is old when he or she enters the institution. Therefore, twenty years of therapy for a twenty-year-old is likely to be done. This type assumes that the problems can be solved in the institution, and only after the person is normal for a long time will he or she be discharged. Usually this type inhabits expensive private institutions where he or she does therapy with problem persons from rich families. In past times they avoided the use of drugs, but now they use medications to "make the person accessible to therapy" whenever the person makes trouble on the wards of the institution.

Usually a therapist with a family orientation is not involved with this

type, since they inhabit hospitals in out-of-the-way places. Claiming a client from one is difficult because the institution's solvency is at stake if the patients begin to leave and return to their families in the community.

The Pragmatist This type is quite common in the modern psychiatric hospital and essentially has no theory. He believes his teachers when they say there may be a genetic or biological cause to a problem, but he also believes his analyst who says the problem might be psychodynamic, and he likes an interpersonal theory that says a person's peers are important, and to keep up to date he reads a book on family therapy so he can talk about that if the subject comes up. Generally, in action, he simply medicates people and turns them out of the hospital as soon as he can. If they come back, he increases the medication and sends them off again, until ultimately they can hardly walk because they are so full of drugs. Mad behavior is a mystery to this type and, as with any mystery, superstition sometimes takes over. So he tries magic periods of time, such as three months' hospitalization before discharge, or six months on medication no matter what changes. Usually this type has been taught nothing in psychiatric training other than to listen to patients, encourage them to talk about anything, and make sure they take their medication.

This is the most helpful type of person in authority for a therapist to deal with. He will let a therapist take on a problem person as long as it does not make trouble for him or ask anything in particular of him.

Although these types of social control agents inhabit psychiatric hospitals and prisons, that does not mean there are not also therapists in such places. Many psychiatrists work with problem persons in the context of their families; they do not merely hope that a pill will solve human problems. Many social workers, psychologists, and nurses also have a therapeutic rather than a social control view, whether they work in hospitals or prisons. Total institutions, however, can organize everyone's behavior in unfortunate ways. Just as parents find themselves acting in nontherapeutic ways without wanting to, so can staff members find themselves acting in nontherapeutic ways without wanting to. Psychiatrists in particular can be forced into social control postures when that is their least interest. I recall one young psychiatrist who left a city and sought a job far away because he could not find employment other than the kind which forced him to give regular doses of medication to unfortunate people without doing anything else for them.

A therapist can be tempted to struggle against people in a hospital in order to save a problem person from agents of social control, but that is an error. To negotiate and clarify who is in charge is essential; to use the person as an excuse for a quarrel with a colleague, or to prove a point to him, produces the same kinds of conflicts as those in the family, where

members attempt to save the problem offspring from other members. Such conflict can create the problem the therapist is supposed to solve.

INCREASING THE PROBABILITY OF SUCCESS

Therapy with difficult families not only requires skill, it requires a situation which makes success probable. Certain circumstances increase the chance of success with a problem young person and are more important than chronicity or length of hospitalization:

1. With inmates in custody, a therapist should not begin therapy if there are no plans for immediate discharge. There have been many years of failure with inpatient therapy. To bring in the family once a week to talk with their incarcerated child in family interviews is not only untherapeutic, it can be pointlessly painful.

2. With inmates in custody, the therapist should have power from the upper administration to establish a therapeutic plan. It is best to respect the hierarchy in any organization. The lower-echelon people will cooperate when the upper administration approves.

3. Part of the plan for an inmate should be a discharge date set by a therapist and the family. Discharge should not be based on a ward rule, a set sentence, or a committee made up of the various in-house therapies. Ideally the therapist should be able to ask the parents to decide when to take their offspring home. That gives them the power in the situation in the view of the offspring, and they start with an advantage in their plan to take more charge of the young eccentric at home.

4. The therapist who begins therapy with the family inside the institution should carry on after discharge to the community. A change of therapists from inpatient to outpatient is often a problem. The family needs the support of the therapist who lays the plans out with them and follows through with them to success.

5. The therapist needs to control medication. Either the therapist must be a physician who can himself medicate, or the therapist needs a physician available who will medicate according to the needs of the particular therapy and its stages rather than according to some ideological dream.

6. The therapist needs to control rehospitalization. There should be cooperation from institutions not to rehospitalize without clearance with the therapist. If the family is to contain the problem and solve it, they should not be able to stabilize easily by hospitalization.

7. No other therapists should be involved with the family without the permission of the primary therapist. The family should not be pulled in different directions by different experts.

In summary, what is needed is simple: the therapist needs to be in charge so that no one in the family is placed in an institution and nothing is injected into a family member without permission. To put the family in charge, the therapist must be in charge of the family in the professional community.

A final case example illustrates one of the wrong ways for a therapist to deal with a fellow professional in power in a social control setting.

A twenty-one-year-old woman was hospitalized on a university psychiatric ward after she made an ineffectual suicide attempt. After two weeks in the hospital, a social worker therapist took charge of the case and met with the family to make plans with them for taking her home. The first family interview involved twelve people, including siblings and more remote relatives. The family agreed that she should go back to college immediately while living at home. They chose the following Friday as the day of discharge. The social worker thought she had administrative approval for this plan. At this point, however, a first-year psychiatric resident, recently put in charge of the ward, entered the picture. He declined to allow the patient to be discharged, saying that it was up to him, not the family, to decide when the girl should return home, and he felt she should stay in the hospital. He was not concerned about the threat of suicide. His objection was that the young woman refused to talk to him in her individual therapy interviews. She also would not participate properly in the group therapy and other treatment programs of the ward.

The social worker asked her supervisor to sit down with the resident and discuss the problem. They sat together and the young psychiatrist was adamant. He said the woman would not be discharged until she was willing to talk with him and to participate in ward activities. He offered the Catch-22 argument, namely, that only if she admitted she needed to be in the hospital would she be allowed to leave; if she did not think she belonged there, she would have to stay. The resident was rather supercilious and made it clear that his status in the situation gave him the power to determine what was to happen.

The supervisor became exasperated with what seemed an improper interference with a carefully made therapeutic plan. He advised the social worker to drop the case and obtain a different one from a different ward. The social worker canceled the therapy, and the young woman was discharged a few weeks later without a plan. The parents were uncertain about whether they would put her in the state mental hospital.

This example illustrates the basic dilemma of the therapist who must deal with colleagues who have social control power. To agree with their position can cause the therapy to fail. Yet to disagree and struggle against them produces the same kind of organizational conflicts one is trying to

change in the family. The unit for the therapist dealing with problem young people consists of the family *and* the professionals involved. The therapist must be as patient and ingenious in dealing with his colleagues as he is in dealing with difficult families. It is incorrect to get angry at a powerful grandmother and provoke her to pull the family out of therapy; that is also true about provoking a colleague with power.

In the case of this resident who would not release the young woman until she would talk with him, the villain in the situation was not the young resident. The fault was with the supervisor, who became irritated with the resident for not cooperating after the first steps with a family had been successfully taken. The supervisor, who was myself, could probably have persuaded the resident to release the young woman or could have exerted authority to have him do so, even if she wouldn't speak to him. Looking back now with a more objective view, I can see that I lost sight of the fact that the unit of therapy included not only the young woman and her family but the ward staff and myself as well. Not only was I irritated and impatient with the interference, but I fear I was also using the young woman to prove a point to the resident. It was the young woman who lost. If I had behaved more responsibly, there would have been less risk that she might ultimately spend her life in a state hospital. Professional experts have the responsibility to avoid conflicts among themselves which are similar to those in which families are involved. It should be kept constantly in mind that a major function of mad young people, whether within the family or among professionals, is to be a vehicle of struggle and to be sacrificed.