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ABSTRACT

This paper describes a treatment modality for the seriously disturbed adolescent involving simultaneous family and adolescent group therapy. This model of treatment is based on the premise that the disturbed adolescent is the symptom bearer for both marital and family pathology. Another important theory underlying the treatment modality is that every family plays out a theme and subthemes that characterize its style of operation. Each family member's role is an enactment of an aspect of the major and minor themes. Focus on the adolescent's behavior and idiosyncracies by the family serves to hide the marital and family pathology. Only when the family has made some strides in defocusing their attention from the adolescent and is able to begin dealing with the hitherto denied pathology in the family is the recommendation of group therapy for the adolescent made. The fact that the family's therapist is one or the other of the two group co-therapists facilitates the defocusing process. This also assures a continuity of approach. (Author/KJ)

ADOLESCENTS AND THEIR FAMILIES:

A Treatment Model Combining Family and Group Treatment

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INTRODUCTION

This paper describes a model for the treatment of symptomatic adolescents and their families which involves a combination of simultaneous family and group therapy. Over a three year period the authors, in their private practices, have been using this approach with families and their adolescents on an out-patient basis. During this time 14 families and 17 adolescents have been treated.[1] We have worked alone with the families and as co-therapists with the teen groups. The adolescents do not enter group therapy until the family therapy is well underway. A condition for their participation in the group is their parents' commitment to continuing in long-term couple or family therapy.

The combination of treatment modalities began as an experiment arising from growing concern with treatment complications which too frequently occurred in some family therapy cases. These involved work with families presenting severe acting out or other severe symptomatology in an adolescent member as the primary problem at referral. The family therapy approach we use is based on the theory that in intact families an underlying marital neurosis is at the core of all family pathology. In many disturbed families the marital neurosis is obscured by the high visibility of a symptomatic child and underdeveloped psychological boundaries between the generations. In practice this means that the first phase of family treatment is concerned with a mutual disengagement process between parents and children. Sooner or later all of the children are excluded from interviews all or most of the time. Parents are then seen jointly and their marital neurosis becomes the primary subject of the treatment.[2]

With families where a pre-adolescent child was the presenting problem, we found this approach to work quite well. Even in cases where severe pathology exists in a child; e.g. in two cases of long-term treatment of parents of autistic children, significant, continuing improvement occurred in the children even though they were not frequently present in interviews. Too often, though, in families of adolescents, both parents and adolescent proved to be highly resistant to the mutual disengagement process and to the exclusion of the teenager from the treatment. A frequent treatment complication in these cases involved the recurrence of persistent, severe acting out by the adolescent shortly after his physical exclusion from interviews (i.e. after he and his family had achieved some success with psychologically separating the generations).

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[1]The adolescents outnumber the families because three sibling pairs are included.

[2]C.H. Kramer, B. Liebowitz, R. Phillips, S. Schmidt, and J. Gibson, Beginning Phase of Family Treatment, Oak Park, The Family Institute of Chicago, 1968.

When the adolescent was able to enter group therapy in conjunction with his exclusion from family interviews, treatment complications in further work diminished considerably.

Both families and adolescents in this treatment group presented severe pathology at referral. A majority of the teenagers were long-standing family scapegoats who were presenting serious social, behavior, interpersonal and academic problems; e.g. fire-setting, incapacitating phobias, compulsive sexual promiscuity, suicide attempts. The majority, in other words, were not "making it" in a big way: they were very unhappy youngsters with little self-esteem who often experienced a serious degree of depression or had developed some complicated defense against it. We have found the combination of family and adolescent group therapy to result in a significant degree of improvement in both family and individual functioning. In addition, our observations of and experiences with adolescent patients in two different kinds of settings have proved to be a rich source of data about the specific ways in which family processes are carried over and acted out in the extra-family world of the adolescent.

DESCRIPTION OF THE APPROACH

1) Theoretical Basis

The rationale for this approach begins with the premise that the disturbed adolescent is the symptom bearer for his family. The relationship between individual pathology and family processes has been well described in the family therapy literature of the last decade. The specific processes by which one family member becomes and remains symptomatic for the benefit of his whole family have been particularly well delineated by Bowen[3] and Kramer.[4] In their terminology, families in which one member in particular serves as the primary target for the projections of the other members can be said to be functioning as intense and very rigid projection systems. The member who is the primary target of the family projection system is also the most symptomatic person in the family.

Historically and dynamically, the roots of adolescent symptomatology can be traced to the marital relationship system between his parents. Their individual intrapsychic conflicts have been more or less converted into an interpersonal, mutual projection system. Just as the marriage is the core of the family, so is the marital pathology at the core of the family pathology. Children become primary targets for parental projections when parents reach a tacit, and largely unconscious agreement that their relationship

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[3]Murray Bowen, "Family Psychotherapy with Schizophrenia in the Hospital and in Private Practice," in Intensive Family Therapy, edited by I. Boszormenyi-Nagy and J.L. Framo; New York, Hoeber, 1965.

[4]See Footnote 2.

cannot survive unless the bonds of intimacy between them are diluted. The child who develops symptoms, in effect, has become a primary target for parental projections of threatening impulses, feelings and needs. The child "receives" impulses and feelings which parents feel cannot safely be expressed in the marriage. For example, one of the ways this process is manifested is in a mother's intense resistance to a child's realistically lessening needs for her and the father's active and passive encouragement of the mother-child conflict which helps to keep his wife "off his back." Both parents, consciously, are quite concerned with their child and his behavior and devote an extraordinary amount of their "thinking time" to him as compared to each other.

A basic dynamic in this process of the development of a marital neurosis and the concomitant use of an identified patient-offspring as a means of camouflaging parental difficulties is a fear of direct confrontation with each other. Parents expect and find that it will be easier to deal with each other when they have a common external object or objects as a focus. The fear may be of exposing a deep sense of emptiness, concerns around sharing and giving, problems in controlling and taking charge, concerns about being controlled, etc. Projecting these concerns onto an offspring allows the concretizing of underlying fears and fantasies about self and sets up a psychologically more comfortable means of dealing with them. Externalizing, projecting and focusing upon an identified patient-offspring also provides gratification for parents -- both the vicarious gratification derived from the misbehavior of the offspring and the gratification in the experience of the parents getting together and doing something as a couple when they focus jointly on trying to control the child.

Thus a very important family function of an offspring's psychopathology is the protective, defensive cover it provides for the parents' marital neurosis. At the same time that the child's symptoms camouflage the marital relationship system difficulties, they also bring the parents together in joint concern over a mutual external problem. This stabilization of the marriage, in turn, is an essential ingredient in stabilizing the family and the parents' individual equilibriums.[5]

Children are active participants in their family systems and have their own stake in maintaining the status quo when they become primary targets of a family projection system. Symptomatic children are accustomed to receiving an inordinate amount of parental attention and become anxious and then depressed when it is withdrawn. They have had insufficient encouragement and experience in independent functioning. The child's adolescence, however, inevitably places an additional stress on what may already be a precariously balanced family relationship system. Relatively stabilized patterns of dysfunctional interaction which may have produced only mild to

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[5]See Footnote 2; pp. 16-19.

moderate symptomatology in a pre-adolescent offspring often erupt into severe problems when he goes into his teens. The adolescent's strivings toward greater autonomy and a separate identity, and the re-energized oedipal situation, tend to generate more serious conflict for him and for his family. This is because they conflict with the adolescent's neurotic need to remain highly dependent on his family and the family's neurotic need for a symbiotically attached child to stabilize the parents and their interrelationship.

2) Implications of Theory for Treatment

Viewing adolescent symptomatology from this point of view, we see conjoint family interviews as the most promising and logical way to begin the treatment process. Our working clinical assumptions are that the marital pathology is at the core of the family pathology and that the adolescent's individual symptomatology is a reflection of both. Diagnosis and treatment proceed from the adolescent's symptomatology, to the process and patterns of intra-family conflict, and then to the marital neurosis. That is, treatment proceeds along the reverse developmental line of what we see as the developmental line of pathology in the child.[6]

In practice, what this means is this: In the beginning phase of treatment the family's view of the problem must be challenged; i.e. it must be brought to their attention that it is not the problem of an individual but a family problem that they are confronted with. For example, in the case of Bella T., a 13 year old who was acting out all over the community, family interviews easily demonstrated that a high level of intra-family conflict existed along with Bella's and the parents' conflicts with the many authorities in the community with whom Bella got in trouble (police, neighbors, school officials et al.). Concomitantly, the family must be offered help in moving their attention from the adolescent and his misbehavior outside of the family to the family relationship system problems and conflicts.

Primarily it is the parents who need help in decreasing their over-attention to the adolescent and increasing their tolerance for gradually confronting the covert problems in the marriage. The adolescent, in turn, needs help with his ambivalent and at best ineffectual efforts to extricate himself from his neurotic involvement in the family relationship system. The middle phase of treatment begins when parents are ready to focus more on themselves and their interrelationship and the adolescent is no longer so central in the family conflict. In other words, the middle phase begins when both parents and adolescent have experienced success in reducing the intense symbiosis still operating among them. This is a very relative matter as families vary widely in their degree of

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[6]See Footnote 2; pp. 12-13.

rigidity and the range that family members are allowed in their functioning with each other, how seriously impaired the marriage is (and therefore how threatening to the stability of the family it is for the child to move out of a central position between the parents), etc. However, it is only at the point at which the parents have been successful in reducing their over-attention to the adolescent and their consistent need for him as a primary projection target, that we seriously consider a separation of the generations in the treatment process. Only then does it make sense that the adolescent move into group therapy.

3) Characteristics of Treatment Group at Referral

In the majority of cases in this treatment group, the adolescent was the most symptomatic family member at referral. He or she was presented by the parents as the major, if not the only problem in the family, and certainly the only one who required professional help. Many of the adolescents had long histories of serious acting out, several had histories of placement including one boy who had been in a state mental hospital for almost a year. In almost every case placement was seriously considered by the parents periodically during the treatment. A substantial number of the teenagers had prior histories of unsuccessful individual treatment. Lola C., for example, bragged about how she had worn out the patience of a previous therapist by chewing gum and reading comic books during a year of individual treatment sessions. In every case, no matter how severe the problems pre-adolescence, there was a significant increase in symptomatology coinciding with the onset of puberty.

The families of the adolescents also presented a severe degree of dysfunction. In some there were openly conflictual marriages in which threats of separation or divorce were continually in the air. At the other extreme there were parents who insisted they had never seriously disagreed openly in 15-20 years of marriage. In early interviews, these united-front-facade parents were extremely adept in avoiding any direct interaction with each other and seemed only able to relate to each other around and through the symptomatic child. Parents presented a wide range of (from mild to severe) individual symptomatology and moderate to severe character problems. However, almost universally, their major discomfort centered around their child who was usually seen as the only family member requiring professional help.

Thus in the majority of families in this treatment group the adolescent member was a deeply entrenched target in his family's projection system and his maturation was being experienced as highly threatening to the family's equilibrium. The adolescents, themselves, appeared to be highly unmotivated for help. At the time of referral all were so poorly differentiated from their families that they were unpromising candidates for either individual or group therapy at that time. Quite often the symptomatic adolescent was functioning as the weakest, least adequate family member and, therefore, the least able to begin the process of modifying the

virulent family processes he was a part of. To illustrate:

Genevieve Y. was a 15 year old girl referred because of a severe school phobia. She had other incapacitating phobias set in what was already a severe obsessive-compulsive personality disorder. Locked into an intense symbiosis with her mother, Genevieve was rarely verbal during early interviews and neither parent saw anything wrong with the mother's speaking for her. Mrs. Y. was a chronically depressed woman who felt her major reason for living was her daughter's need for her. Mr. Y. suffered from severe fears of failure in spite of his consistently high success as a business executive. Both considered their marriage "a lost cause." It was learned that the parents had not been speaking to each other for some time prior to the referral. They did talk together about their daughter's problems in their first interview with the therapist, however.

4) Technique

The first in-person contact with every family consisted of a conjoint interview with the parents in which an agreement was reached to proceed with an exploratory-diagnostic evaluation. During this evaluation (4 to 6 interviews) all of the family members living in the household were seen in various combinations. Family members were expected and encouraged to interact with each other. The therapist encouraged movement away from an excessive preoccupation with the presenting symptoms and problems to a focus on the family relationship system. In addition to beginning to bring to the members' attention the emerging patterns and issues of conflict in the family, the therapist during this phase was also quite concerned with the beginning development of a therapeutic alliance with the parents as a couple. Ongoing treatment plans were discussed, primarily with the parents, at the end of the evaluation period.

All of the families were seen weekly. In some cases the beginning treatment format consisted of total family interviews. In others only the parents and identified patient-offspring came in. In another a mother and daughter were seen together for several weeks before the stepfather joined them. Treatment formats were worked out with each family and tailored to what seemed to fit best for them. In every case, however, it was clearly understood from the start that both parents would be expected to participate regularly in the treatment process.

The idea of group therapy for the adolescent was introduced to the family at different points in each case. In some cases it was held out as a future possibility from the beginning, in others it may not have been introduced until the family had been seen for at least 4 to 6 months. In a few cases it was not the adolescent but a younger child in the family who had been the referred patient. As the family interviews proceeded, however, problems around the adolescent emerged and so he became a candidate for the group.

Groups have been time-limited (9 to 10 months) and consisted of five to eight patients who met weekly with the two therapists. The most productive groups consisted of members who started at the beginning and continued throughout the life of the group. This meant that group members must come from families who were far enough along in treatment so that the parents had reached the point where they were committed to treatment as a long-term process in which they must participate regularly. Thus they could, with a reasonable degree of comfort, agree to the condition that both they and the adolescent would be continuing over the expected time period. After several unsuccessful experiences with allowing adolescents to continue in the group after their parents did decide to drop out of treatment themselves, it was decided that ongoing involvement in treatment by the parents was an absolute requirement.

The serious possibility of group therapy for the adolescent was raised by the family's therapist around a time when the parents seemed ready or almost ready (often spontaneously recognized by the family themselves) to be seen, at least part of the time, as a couple without other family members present. Although recommended by the therapist, it was a family and primarily a parental decision to make. The majority of the adolescents in this treatment group still had very weak motivation for treatment on their own at this point in the process and were still highly dependent on cues from their parents. Discussion of whether the adolescent should or should not enter the group might go on over a period of many interviews and often usefully served to highlight the separation of the generations issue in the family.

Once the adolescent entered the group he might or might not continue to participate on some basis in interviews with his parents and other family members. However, whether he did or not, it was at his discretion whether he shared anything about his experiences in the group with other family members. It was clearly understood that the therapist would maintain strict confidentiality with three exceptions: 1) attendance problems; 2) behavior which in the therapists' opinions was of sufficient danger to the adolescent or others that it needed to be brought to the parents' attention despite the adolescent's refusal to do so; 3) when the teenager himself requested, and his family's therapist agreed, that a specific issue be taken up by the therapist with the parents. Conversely, the parents' treatment sessions apart from the adolescent were also held confidential. In the therapist's experiences to-date it has never been necessary to exercise their option to break confidentiality.[7]

As the group approached its termination date, each family decided whether it wanted a conjoint meeting to evaluate the

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[7]The subject of confidentiality in this treatment model is a fascinating one and deserves much more space than can be given in this paper. Other important aspects of the experience such as co-therapy and full details of treatment outcomes also will not be covered here.

experience or whether parents and adolescent preferred to do this separately. Another issue at this time was whether the adolescent should enter the next group which would begin in several months. Not surprisingly group termination and beginning dates were times when the parents in these families took serious stock of their own treatment. Four of the adolescents did participate in two or more groups.

THEORY OF FAMILY AND GROUP THEMES

Every family tends to display a stylistic and fairly constant identifiable pattern of communication among its members. These patterns of communication are designed, as it were, to maintain each family member in a stable role. The more pathological the family, the more rigid and inescapable the role. The healthy family allows communication that is open, honest, and direct. Consequently, there is more opportunity to test out other roles and partial roles and to integrate new experiences from both within and outside the family into one's primary role.

These family roles are based on two concurrent and ever-present processes -- the identifications of children with their parents and the projective identifications of parents with their children. In this context, projective identification refers to a process which involves: (1) the parental wish and need to perceive a child as a part of self (e.g. the "good me", the "bad me," etc.); (2) the parental behavior and communication with the child which transmits the parental wish and need; and, (3) the parental reactions to the child's responses to this process. These two processes, identification and projective identification, are part and parcel of all family living, both normal and pathological. In a pathological family situation, the roles are rigid and inescapable; i.e. the opportunities for identification are limited to integrating disturbed styles of behavior and the projective identifications discount reality and are promoted despite reality. For example, when a parent sees his child as the "bad me" and as all bad, this represents a pathological and rigid projective identification wherein parental behavior can result in a self-fulfilling prophesy; i.e. the more a parent expects a child to be "bad", the more likely that he will be. When the "bad me" projective identifications in a family are largely focused on one child in particular, he ergo is assigned the family role of "the disturbed child."

The process of projective identification is an integral part of the family projection system. All children participate in the system, but in many disturbed families often one child becomes the primary target. He or she is the one usually seen by the family as the identified patient. It should be noted, however, that the primary target of a family projection system can change over time or may remain stable, depending on many factors, e.g. number of children in a family, their ages and sex, etc.

Family roles of all members, including roles the parents learned in their own families of origin, are organized around a

family theme.[8] In fact the roles are a playing out of the various aspects of the theme characterizing a family. A family theme represents the dominant family conflict that is both expressed on the interpersonal level and, also, stamped indelibly on intrapsychic structures. The role a person assumes, because it is the result of the twin processes of identification and projective identification, contains in it two elements: the unique expression of the family conflict as experienced by the person and his temporary or not so temporary solution to the conflict. Family roles differ because each individual's reactions to the family conflict as he experiences it intrapsychically differ.

Each family also has minor or subthemes characterizing its style of operation. These subthemes are intimately related to the major themes in complex ways, which will not be discussed here.

In actual day to day living the major theme is expressed and reveals itself in the assumptions, both implicit and explicit, the family members hold about the nature of their family -- their goals, how the family should function, how and why the family functions as it does, how needs are to be met, etc.

A major theme characterizing a family in this treatment group, the Minors, centered around the conflict involving impulse expression (particularly sexual) and the fear of the consequences of such expression. Need and impulse expression were experienced as deviant and were to be hidden from view. Deviancy included any behavior that attracted attention, any disagreement or hostile exchange with other family members, any undue show of either excellence or failure, etc. Each family member was in intimate touch with society's norms and standards of conduct; albeit a society that was Victorian. Even when society did approve a particular form of expression, e.g. having fun, some worn-out "more" forbidding this was quoted. The father's role in the family was the expression exemplar of this theme -- he was colorless, drab, unemotional, undistinguishable. Mother was verbally all caught up with this theme but in a highly anxious, excitable fashion. Whereas father's role seemed to be that of the "normal, drab male", mother's role of the "normal, drab female" was constantly threatening to fall apart. Their only child, the identified patient, Joe, was a boy of fourteen who dramatized the parental fears of what deviancy, i.e. the consequences of impulse expression, looked like. Nothing about him "looked" normal. First of all, he was conceived through artificial insemination, and, the notion of the "bad seed" was usually invoked to explain his misbehavior. His symptomatology included serious and frequent instances of firesetting, enuresis, poor school performance, head tics that were very disturbing to everyone around him, involvement in Rube Goldberg-type activities, continual disobediance of parental rules. The family communication pattern reflected a process in which mother, trying anxiously to maintain herself as the "normal female", derived a great deal of vicarious gratification from her son's impulsivity but couldn't control it in its extreme form. She also found gratifications in her relationship with her son which were lacking in the husband/

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[8]R.D. Hess and G. Handel, Family Worlds; Chicago, The University of Chicago Press, 1959.

wife relationship. Father allowed the son free rein. The son's deviancy served as an acting out of his rage at his wife for her attempts to control everyone around her (especially the father). Mother's extensive and desperate need to control others was in the service of her efforts to maintain a role as "a normal woman". Allowing the son his deviancy was also the father's revenge at the son for being able to enlist the sexualized interest of his wife, something he feared to do in his role as the "normal drab male."

Both parental projective identifications involved seeing their son as the embodiment of impulses and of the consequences of impulse expression, namely deviancy and strangeness. At the same time both derived much vicarious gratification from his behavior.

In maintaining Joe as the primary target of the family projection system the parents were able to avoid feeling serious problems in their marriage involving any need and impulse expression and reciprocity. The father's intrapsychic solution to this conflict was the development of a repressive, passive-aggressive compulsive style culminating in the role of "the normal drab male." Mother's intrapsychic solution utilized subdued hysterical defenses and reaction formation culminating in the overconcerned mother who is just a "normal female."

When an individual enters a non-family group (be it group therapy, a club, etc.) that maintains its existence over time, the family role he has learned is carried over in somewhat modified fashion. The role still represents an expression of the family theme and his personal solution to the conflict implicit in the theme. However, other group members also bring their family roles into the new group. What results is a group thematic structure unique for that collection of individuals. Whitaker and Lieberman[9] have developed the notion of group focal conflict similar to what has been discussed here in terms of the family. However, what we want to emphasize here is that each person's role with respect to the group or family conflict also contains within it a personal individual solution learned within the family matrix. Entering a therapy group, however, forces the individual to come into contact with other people whose roles and conflict solutions are novel and often strange to him. In a therapy group the individual is forced to deal with others and with their roles. The group thematic structure thus allows and encourages the testing out of new roles, the experiencing of new and different feelings and the learning of new assumptions about human behavior. As these new roles are taken back and expressed in the family setting via a process of "trial identifications", i.e. a pattern of attitudes and behavior not yet fully integrated, the family thematic structure is challenged in a way never before encountered. The group therapy experience for the adolescents we've treated has the effect of bringing "new

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[9]D.S. Whitaker and M.L. Lieberman, Psychotherapy Through the Group Process; Chicago, The University of Chicago Press, 1964.

blood", a fresh whiff of air, into the family. As the family reacts to the new behavior of the adolescent and attempts to undo what he is struggling to learn, the adolescent goes back to the group both to test out the "objections" parents have raised and also to seek support for his new learnings. This process going on between the family and the group can be characterized as a "feedback loop" in which group issues are tested out in the family, the family reacts to the adolescent doing the testing, the adolescent goes back to the group to test out the family's reactions, etc.

The therapeutic success of this combined treatment modality depends on several factors -- one is sufficient defocusing from the symptomatic adolescent (as discussed earlier), and second is the establishment of a therapeutic alliance between family and therapist. The family, by allowing their adolescent to enter the group, experience this decision as relinquishing parental responsibilities in a new way never before encountered. They are saying that they will permit their adolescent to make a mini-break from the family. Often they experience the group akin to a "sheltered workshop" led by a therapist they are learning to trust.

CLINICAL ILLUSTRATION

The following clinical vignette has been chosen to illustrate the relationships between the family and group thematic structures. The major focus will be on the fifth group session of one ongoing group and on the therapy session of one family that occurred that same week. The group session was chosen because it seemed to crystallize the group themes of the previous sessions. The family was chosen because of the dramatic dynamic shift that occurred during that time period. The Minor family mentioned earlier is the family we'll be discussing here. The family therapy sessions included mother, father, and their son, Joe.

The eight months this family had been in treatment had been very slow. The extreme difficulty the parents had in being able to talk about themselves and their marriage made for a very slow defocusing process. Any slight show of affect between them about themselves and their relationship was immediately followed by intense concern about Joe. However, progress was being made and Joe was beginning to look and act like a less bizarre boy. Since the defocusing process seemed sufficiently along, Joe was included in the group. However, family sessions corresponding to the first four group sessions reflected regression to an all-inclusive focus on Joe. The parents worried about his association with the other teenagers in the group whom they saw as incredibly impulsive and uncontrolled. They implied that the therapists were irresponsible for allowing the kids to smoke, swear, etc.

The adolescent group consisted of seven members -- three girls and four boys, plus the two therapists. In the initial group session there was intense vocal competition around who could make out the best case for not wanting to be present. Then

competition mobilized around group leadership, particularly among the boys. In the following three sessions, the boys openly vied with each other and with the male therapist. Two of the girls seemed to be playing more of a waiting game. Genevieve (age 16), still locked into an intense symbiotic bond with her mother, was the least active group member. Bella (age 14) was still much preoccupied with her mother's presence in the waiting room and on several occasions withdrew from interaction with the other kids when teased about her inability to forget her mother's presence outside. Lola (age 15), on the other hand, was fairly comfortable with the situation and had few qualms about wanting to be seen and treated as the most attractive and desirable girl present. Group process seemed to be moving in the direction of vying among three of the boys, much encouraged by Lola, for her attention, a move toward pairing off by Joe Minor (15), the most passive of the boys, and Bella, while Genevieve was moving into a position of isolation.

In the fifth group therapy session the boys continued in their vying for group leadership. Fears connected with seeking leadership went unexpressed verbally. One boy seemed to be winning and the anger and jealousy the other boys felt towards the "victor" was quite evident. Competition was expressed in the form of who could get the most people to laugh at his jokes, who could take out after the male co-therapist the most expeditiously and cuttingly, and who could bring up the most fascinating and/or daring and/or provocative incident to relate. The prize of the competitive struggle was Lola. Barry (age 16), the boy who was "victor" made it clear he liked her and, in effect, openly invited Lola to share his throne. Lola however, began to show concern about being the prize. She began to talk about how jealous and possessive her boyfriend is. She mentioned being in a movie, thinking that she saw Joe Minor there, and her boyfriend's upset at this. Joe looked embarrassingly flattered at this comment by Lola but could not respond. He continued to be quietly responsive to the more subdued interest shown in him by another girl in the group (Bella). In the next group session, the sixth one, Joe moved into a more active alliance with Bella who all along had been reluctant to openly compete with Lola. It was as if both Joe and Bella refused to just take a backseat in the power struggle going on. They began to whisper to each other, excluding everyone else.

Simultaneously the Minor family's sessions around this time opened up dramatically. For the first time sessions dealt with Joe wanting to go outside the family and become involved. Fears about the trouble Joe would get into were expressed by the family, Joe included. Joe also openly and directly competed with his father for the first time -- who was going to have the last word about what was to be discussed in the family sessions, who would get the better office chair, etc. For the first time also, Joe's mother began to express concern about her sense of fading femininity and how she wanted to be a different kind of woman. Mr. Minor remained passive in the face of Joe's challenge to his being the head of the family and impervious to his wife's desires to change and her unspoken concern about his reactions to this.

In the next session while Mrs. Minor reported even more striking changes in Joe's extrafamilial behavior (e.g. joining a discussion group, becoming interested in a school subject, etc.), Mr. Minor returned to an old theme of his: he wasn't getting his money's worth. "Family and group therapy are ethereal, wordy intangibles, and no concrete results are evident." He discounted Joe's progress and pointed to the boy's continued poor school work. Mrs. Minor then changed her tune and chimed in about Joe worrying her by not calling up to tell her he'd be late because of a meeting. This denial of change in the family and attempts to return to the old patterns proved to be a last-ditch stand however. The next two family sessions saw for the first time open and affectful disagreement between the parents.

The parents continued in conjoint couple interviews and Joe in group therapy eight months longer. Occasionally Joe joined his parents in interviews. Termination of family work was initiated by the parents and coincided with the group stopping for the summer. Joe's symptomatology by this time was negligible if not completely absent -- firesetting, enuresis, head tics, bizarre "projects," social isolation, and "disobediance." Whereas before he would impulsively do what he wanted in defiance of his parents, Joe now directly confronted the parents with their confused and garbled communication to him about what they wanted him to do. The most resistant symptom, low school performance, for the first time in Joe's academic history began to yield and dramatically so, i.e., from near failing to B grades. This success was too much for the parents to cope with. They "ran" from treatment as Joe's lack of symptoms forced the parents to focus on themselves to a degree which was too threatening to them. The Minor's were becoming more aware of basic conflicts and feelings between them that had been repressed or denied for so long that they lacked the confidence and motivation necessary to continue their confrontation of these issues.

DISCUSSION OF CLINICAL ILLUSTRATION

The family theme of "drab normality" as the ideal way of life and the projective identification of Joe as the very embodiment of deviancy, i.e. the outcome of impulse expression, was sharply challenged by Joe's participation in the group. The group theme of competition and the rewards of competition ran headlong into Joe's usual role operations. Coming into the group playing the role of the abnormal deviant who is hiding, Joe all of a sudden was openly and directly seen as a likely competitor for a girl.

Joe's behavior in the next family sessions was a direct testing out of whether he could openly compete with father. Further Joe was experiencing the feeling for the first time that just maybe he could "make it" with females outside of the home setting. Whereas in the past he never doubted his mother's joking reference to him as "a boy only a mother could love", he began to do so now. This in turn challenged his mother to decrease her attention to Joe -- he no longer was playing her game of mother as a boy's best

girlfriend. She was then able to glance at herself and her femininity. Joe's competitive challenge to his father in the family sessions met with an increase in Mr. Minor's focusing on Joe and his wife "gladly" went along. However, a critical wedge was driven into the projection system and the next sessions involved a dramatic confrontation between the husband and wife.

Joe was out of his central position between his parents more than ever before. They in turn were more able to relate to each other directly rather than through their son. An essential separation of the generations took place in this family which enabled their adolescent son to resume his development in a more normal fashion. Though the husband and wife chose to discontinue their quest for a more intimate relationship prematurely, they were still able to allow their son to grow and to begin developing a life of his own outside of their orbit.

SUMMARY

We have described a treatment modality for the seriously disturbed adolescent involving simultaneous family and adolescent group therapy. This model of treatment is based on the notion that the disturbed adolescent is the symptom bearer for both family and marital pathology. Focus on the adolescent's behavior and idiosyncracies by the family serves to hide the marital and family pathology. Only when the family has made some strides in defocusing their attention from the adolescent and is able to begin dealing with the hitherto denied pathology in the family is the recommendation of group therapy for the adolescent made. The fact that the family's therapist is one or the other of the two group co-therapists facilitates the defocusing process. Among other things a continuity of approach is assured.

Several other important advantages accrue to the families and adolescents because of the nature of the treatment modality. Because the group co-therapists are also the therapists of the families, the therapeutic alliance between therapist and family includes the co-ed group as well. This enables parents to take the chance of permitting their adolescents new growth-producing experiences that may and usually do challenge the family styles and assumptions. Secondly, these very challenges (e.g., in the form of new behavior by the adolescent, more direct and open challenging of roles and assumptions, etc.) introduce "new blood" into a hitherto closed system, promoting even more growth on the part of the family.

Another important theory underlying the treatment modality is that every family plays out a theme and subthemes that characterize its style of operation. Each family member's role is an enactment of an aspect of the major and minor themes. These roles can be seen as resulting from the identifications of children with parents and the concomitant projective identifications of parents with their children.

Family therapy in combination with adolescent group therapy highlights family themes and roles in a very special way. These combined modalities have proven to us to be a more powerful force in challenging the assignment to and acceptance of negative roles by adolescents than family treatment alone.

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