the author, I'd never heard of the book. But it was one that gave me great pleasure, I never quite knew why, because it was no great literature, and just recently I think I found the answer. The book briefly was the autobiographic account of a young adolescent Scottish lad in the Lowlands who lived in that grim period about the Depression years. I guess he was facing many things that young adolescents today are facing, but he found a great, great joy. He found that he learned the joy of climbing mountains, now I don't confess that I ever wanted to climb a mountain in quite the way he did. But he wanted to, and he did it, and he loved it, but he described so beautifully how the challenge of the mountain is there, and he sets out, and it's long climbing, it's tedious, it's exhausting, it's cold, it fills him with fear, and fills him with doubt that he'll make it, and sometimes it takes a long time to get there, and on and on and on it goes, but ultimately he makes it and then he comes down. Of course, mountains you have to get down, too. And that night, when he sits back, glowing, full of achievement, there he is, he has achieved what he set out to do, he's learned something of himself on the way, and all the memories of the cold, and the fear, and the anxieties, they dim, and it's a glow of satisfaction. But, of course, you can't stay like that too long, because there's always another mountain. And the book is called, 'Always a Little Further', and suddenly I thought perhaps one of the reasons I loved it so much, it somehow reminded me of social work. That is, a desire to know more, to try and gain more knowledge, more skills, it's long and tedious, it's exhausting and often the hours are very long, one faces fear whether one will achieve it, one has doubts of oneself, and on the way one has to feel and share the pain, the anguish and distress of the people one is trying to work with. If one allows oneself to be overwhelmed with this, one is rendered helpless. If one doesn't share it at all, one is impotent. And somehow, hopefully, one gets to the top of that mountain and one sits back in a glow of satisfaction, forgetting some of the things that happened on the way up, and feeling that one has learned something more about oneself, strengths and frailties, and it's a good feeling, but you can't stay there long, there's always another mountain.

So, to me, I have no regrets I chose the path I did, slight regrets that I didn't climb more mountains, but I'm glad I climbed the ones I did. And I guess that's my answer to the two questions, and there's only a third question left, which is being asked of me, 'What's next?' Frankly, I do not know. But I know that for me and for all of us, there are always more mountains, and if they look too bad, and too steep, well I guess there's always hills, but the one thing I do feel is that to settle for just the useful, practical, trivial things is not very rewarding and to stay always on the plains is safe and comfortable, but rather dull.

DEVELOPMENTS IN PRACTICE

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INTRODUCTION

'How do we understand that which we seek to act upon?' Theory puts things which we see or know or hypothesise about into a system in order to make sense of what otherwise would be inscrutable in order to spot gaps and biases, and also to challenge the illusion that we know answers which we do not yet have. Some people become very uneasy by the fact of multiple points of view or the absence of complete agreement. They choose one point of view and they seek to destroy or denigrate all others. Or they may repudiate all concepts and use only intuition, common sense it's called. I suppose that the middle ground might be meriting our attention. I don't think that in our complex field of human relations and services to parents and children that it is very easy to simplify. You remember the comment 'There's a solution to all human problems. It's neat, and it's obvious and it's wrong'. I think we have to live with the uncertainty and the constant need to keep searching, otherwise we'll be covered with apologies all the time, and that won't get us anywhere. I propose that a too early closure on too simple a framework or a search for a too narrow focus upon practice skills and new techniques only the skills and techniques will lead to malpractice, or else it may lead to inaction. My paper will suggest briefly, the development of one of our oldest conceptual frameworks used in social work, namely psychoanalytically oriented personality theory. I want to suggest the ways that social service over the decades has used or has been influenced by this growing body of changing theory. I am speaking from a U.S. perspective.

THE BEGINNINGS

From the turn of the century, interest in children and in children's psychology became apparent at home. Compulsory education was gaining ground, laws against child labour were passed, orphanages were established, charities and corrections were organised. Mary Richmond urged knowledge about family forces and about family circumstances before the family fell into economic difficulties. After World War I social workers became involved with families 'above the poverty line'. Early Freudian psychology, then, offered insights about puzzling behaviour. It was about that time that it came into the United States. This movement led in the 20's to further establishment of some Schools of Social Work, and it led to the development of Child Guidance Clinics. The theory as developed at that time ordered assessment of inner neurotic conflict in well developed children and work with parents and treatment aimed at conflict resolution.

MODEL OF EARLY CHILD GUIDANCE CLINICS

The original model of the child guidance clinic of its day was a trinity, the psychiatrist, the psychologist and the social worker. That became a classic, in fact in some quarters it became sacred, although in others it has been extended to include a variety of people relevant to the care and treatment of children. The young Turks, as they described themselves when they were old and grey, the young Turks of that day were working, you see, in a very innovative way, and they as Dr. Carroll described it, 'They were so full of pizazz', they organised the association of Ortho-Psychiatry in order to provide a channel for discussion wider than the team in their own clinic and also an interchange of ideas with a wider number of people. The Association is still going on today, struggling and fighting and arguing about ideas, and also extending its range far beyond the original group. Initially, however, rigid division of labour saw in the clinic the psychologist testing the child, the psychiatrist treating the child and the social worker sharing their recommendations and giving directions to the parents. Social workers in all this were learning the value of case study findings and assessment, but they had models which they followed without much question.

It was then the child guidance movement did an about face. The pendulum swung another way, and all parents were referred for personal therapy along with their child. The parents were seen by a member of the team. It should be noted, however, that usually only mothers came to the clinic. It took a long time until the innovation of family work in the last two decades for a broad parental spectrum to show up. However, as the social workers were carrying their full share of therapeutic work with the adults, their status went up. Practice was usually supervised by psychiatrists. No insights about different modes of therapy or different goals were defined for social work. No questions seem to have been asked about service coverage, by that I mean how many clinics should there be in a community, or should new clinics be organised in places where there were none, or are these clinics accessible to the clients whom we served? It was as if the community with a great burst of lay participation managed to set up a Child Guidance Clinic, and that was the end of the action. It seems there was no effort either to move out to other agencies

https://doi.org/10.1017/S1035077200904115 Published online by Cambridge University Press

concerned in various ways with the welfare of children, or for carrying a heavy responsibility for presenting children's needs to legislators or the lay public. That's where we were by the time that the late 30's arrived.

INTRODUCTION OF PERSONALITY THEORY

Now, interestingly, Schools of Social Work reflected some of this movement. They acceded to pressure to develop special curricula for the so-called psychiatric social workers, and then in turn for medical social workers, who themselves were carrying out those dynamic concepts about emotional stress in the face of illness. Special education was deemed desirable for these two groups, and the 'special' about it was the introduction of personality theory in face of stress and trauma and in the face of development. Then, it came about that only workers who had graduated from Schools of Social Work could be employed as social workers in clinics or hospitals. Picture how rigid and how locked-in this circular pattern was. You couldn't hire anybody who hadn't got that education, and the educators couldn't do anything if they weren't accessible and agreeing to the institutions who prescribed it. Fortunately, however, this rigid, locked-in, jealously guarded system did not prevail. And lest I sound as though all personality theory was confined to those closely concerned with the team, I would say that you must remember that Charlotte Towle about the time, the mid-30's was writing a book, she called it 'Common Human Needs', incorporating the same principles and the same concepts, but translating them for the public welfare and child welfare workers.

THE NEXT DECADE

World War II was a hallmark for change. In the decade following there was new learning about the significance of severe personality disturbances in adults and children. The acute and chronic schizophrenics who also suffered from affective disorders, were no longer relegated to back wards in every instance. It is true there were still back wards, but now it was considered that these should change. Treatment of these people became the hopeful concern of leading theoreticians. Social workers in substantial numbers brought their attention and services to such patients and their families, not only in institutions and clinics, but also in the community, in family agencies and community centres. So we began to learn about a different diagnostic category, we called upon different ideals. Now consultants were hired in community agencies to give service to such varied people and the first emergence of an idea of a differential diagnosis, a differential assessment, began to be essential in terms of standards. And the agencies took upon themselves the responsibility for updating education and knowledge in these areas. Adoption and foster home work tended, however, to focus more on technical procedures as a basis for help, even though they did open themselves to some of this growing body of knowledge about personality, such as Anna Freud's understanding of primary and secondary defences. The changing concepts I have suggested also changed the child guidance system. It deepened and extended the diagnoses and the differential focis for treatment. Severely disturbed parents clearly could not use methods appropriate to the relatively stable, neurotically conflicted individuals. Knowledge about the acutely disturbed or chronically psychotic parent led gradually to different treatment in the clinic.

EFFECT ON RESIDENTIAL SETTINGS

Child guidance clinics in my country did not challenge the old patterns of child care as they were experimenting with child therapy. They didn't challenge the patterns of orphanages, foster home care and so on. Maybe it was a matter of the absence of research about outcomes. Or maybe it was the segregation and separation into cells of beautifully skilled work as compared with other cells of work where other purposes and functions occurred. But things conceptually and theoretically certainly did develop. This development was left to innovative thereotician practitioners, with leadership, and such a theoretician practitioner was usually left to a psychiatrist. The need was recognised, for example, for well implemented residential treatment centres, with dynamically trained staff, for therapy for therapeutic and remedial tutoring, for spatial education, for social group work. A few of these residential treatment centres did appear, for example Bettelheim's Orthogenetic School in Chicago. There were others spotted about the country, but you could count them almost on one hand. They proved, however, surprisingly successful. Applicants for staff positions were asked, 'Are you prepared to stay at least seven or eight years? We count on having pretty good success, but it takes that long.' Nothing specific as to goals, we hope something good would happen, but nothing daring, not as ever as daring as to say, 'We are going to see what happens with this boundary of time'.

This development did not stimulate any other changes in these carefully designed, fully professionalised residential treatment centres. When did you last try to find a placement for a fourteen or fifteen year old acting out boy, severely disturbed? Or for a nine year old, who has been stealing they say since the age of three and setting fire since he could strike a match and by nine years has been in seven different spots back and forth between his family and other places, and no-one wants him. The question is 'Where can we find a solid, long-term residential therapy setting, with individual treatment and therapy for a little boy like that. Where?' Our knowledge makes this possible, it isn't knowledge that prevents us. We can't guarantee for each child the results, but our general premises would suggest that this probably should have been one of the options available long ago. I don't want that little nine year old to be behind the wheel of a truck, out in the Northern Territory someday when he's older, because we're failing him now.

Now to return to theoretical insights. There came to be greater understanding about a range of different disorders, and this led, as one might expect, to the eruption of different schools of thought. There was Rompf, and there was Young, and there was Horney, and there were quite a few others that I could name, you would know some of them. Now the frail base of knowledge led to loyalty to a leader. 'I am a Freudian', 'I am a functionalist', 'I am whatever and don't you dare say you're wrong and I'm right' kind of attitude. It was a very aggressive, argumentative period. There were violent attacks, since loyalty was to a leader or to a set of premises. The one professional gain, as I see it, in such struggles of the 40's and 50's was greater clarity about the nature of theory, after all if you're going to fight about it you have to know its boundaries. Deeper knowledge of its concepts, and greater appreciation of how to borrow from other concepts without changing the integrity of the theory.

The concept of personality theory became widespread in all professions by the end of the 50's. Nursing, education, vocational counselling and a dozen other groups each aimed to have skills in clinical practice and each were ready and willing to make their contribution to troubled people in the institutions where social work was already working. This led to boundary issues between disciplines.

THE THIRD AND FOURTH DECADES

To move on, in the 50's and 60's, we wouldn't have known ourselves. Anna Freud's formulation about defence both primary and secondary, was beginning to be understood in practice. Hartman's work on ego-structure and ego-quality and Erik Erikson's general formulations about developmental tasks broadens the view of ego-adaptation and identity. The functions of the ego were identified. This brought into perspective such dynamic elements of the environment as role, class, family structure and functioning. At the same time, other things were happening. Sullivan was focusing on the meaning of inter-personal relationships, as were many others, in sociology as well as in inter-personal psychological issues. Jackson and his colleagues worked on communication, Parsons on contributions in regard to socialisation and the interactional process, and there were other researchers adding theories on family life style and about the

https://doi.org/10.1017/S1035077200904115 Published online by Cambridge University Press

process of small groups. Each of these contributed to the knowledge explosion that has been going on in these decades, and eventually then, to clinical practice. By the early 70's systems theory began to seem to offer a way to integrate so many of these emerging constructs into some useful organised way.

THEMES

One should pause to use our perspective here in the 80's to acknowledge two results of the knowledge explosion and pressure of these previous periods. In the young profession of social work, and I guess in others also, the workers were slowly dealing with the essential task of rigorously integrating theory with practice for better service. Some embraced the new, or interested fads without question, some retreated, by permitting themselves only to be socialised into their own agency's tasks rather than retaining an active critical identification with the social work profession and its psychosocial focus and its problems. Other workers retreated from knowledge entirely, that is, from relevant theory, and ceased to read and said rather proudly, 'That's for the academics, I just use common sense'. Well, that's always been a theme once in a while. Or else they delegated their appropriate professional task without question to the layman. There was the approach that if there was any problem, or any need for service or anything, get the neighbourhood lady to come and do it, after all she lived right there, she knew what the problems were, she could be better able to serve the client. Never mind that that neighbourhood lady was a bossy soul that knew better, and she violated all the principles of practice that our therapeutic community believed in with respect to assessment and with respect to how you worked. But it was catching, it was like the measles, everybody got it, and if you weren't up to date with this . . .

Some workers justified one practice principle, only one, and they made that the centre for all their theoretical, conceptual organisation. Let me illustrate. For some people they took confidentiality, and they invoked this to justify isolation, to reduce professional teamwork, to avoid active reporting of social issues and policy problems to the public. You see they didn't discriminate between confidentiality for Joe Doakes, my client, and confidentiality in the face of work that the public indeed should know about. Self help, we thought, was good, but if it was so good, then there was no need to share knowledge of potential concepts or to turn to draw inferences about self help or to decide when it was indicated or contrary indicated. Now the second aspect of those decades to be noted is the emergence of more disturbed parents and children with indeed more complex problems. And these complexities were illuminated by our widening conceptual understanding about ethnicity, and about roles, and about family structure and functioning and about inner and outer problems, and about parenting. They were complex and we understood more clearly how serious they were. Patterns of isolation, avoidance, depression, agression, impulsively acting out and delinquent behaviours, only transient relationsips are only a small list of problems which were . Such clients can not voluntarily reach out for help, their use of time is faulty,.

ORGANIZATION OF SERVICES

At the same time, fragmentation of services had been occurring, limited financing, isolation of one agency from another, polarisation of services along policy, political or practice lines. We comment, hopelessly, about the desirability of having more resources or adding those that are now non-existent. But to move into action in the face of the individual's expectable broken appointments, or to do something about the destruction of a child's capacity for object relations when he's moved too much, or push collectively for enough specialised resources, these are professional tasks for which accountability must be keenly felt if we are not too sink into the morass of a dangerous decline in the quality of service.

CRISIS IN THE EIGHTIES

Hence, to be realistic, I would propose to you, that as we are in the 80's now, we are in a crisis in services to children and their parents. I say that for the United States. A crisis in the services to children and their parents. Now here are the concepts about ego-deficits and the borderline person which have emerged in recent period of time have greater and more hopeful usefulness. After Hartman and Erikson's research, investigations took two lines I may say, one moved toward the classification of symptoms (e.g. Gunther) and tried to classify along the diagnostic or medical model. The other line focussed upon ego-developmental patterns and hypotheses and also ego arrest. Mahler and others are leaders here, and this seems of particular relevance to those in the children and family field. The opening up of hypotheses and ideas.

Now we have a pattern in our practice, whatever the agency administration, of avoiding difficult, chronic, socially disturbed clients. For example, some children are placed in a foster home, and for many that's a good answer, but for others it is not. The child moves, to various places, many foster homes, in and out of his own home, in episodic, and what I must say look like random moves. The child with his frail capacity to manage object relationships may have these reduced and even destroyed. Now this need not be, if we use our emerging concepts about ego-development, if we are willing to work with that child, and to coach the foster or hostile parents and teachers and others, own parents, too, to open up and talk with the youngster about his feelings and about why he's so mad about such things.

CONCLUSION

Therapeutic work of this kind is difficult, it's taxing, it's frustrating. The children are deprived, disorganised, disadvantaged, distrustful, and so are their young parents. We get enraged by their unaccountability and the difficulty of holding them, and we don't do as well as I think our knowledge would suggest that we might. I've stressed these new insights because I think it leads to some optimism, and some greatly improved practice. But it also requires greater energy, to share such knowledge with a range of children's workers, and to reach the public with information about serious deficits in our resources, and about the crises which some of our children face that are really irreversible if we don't reach them when we should.

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