CASEWORK CONSULTATION IN THE COMMUNITY CENTER *

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Meeting Point for Casework and Group Work

CASEWORK consultation in the community center primarily recognizes the need to bring together group work and casework skills and services on behalf of clients. Such integration has been proposed in a number of ways over the years and indeed we may be at the point where its advocacy has almost an axiomatic force. At the same time, like any consultative process, casework consultation presents varied questions in its use. While there have been proposals that it be established as a permanent service in centers and provided by the centers themselves, it has generally operated as a special service lasting a few years in one setting and then a few years in another. Yet there has been almost continuous agreement on both its need and its value. At the present time there is renewed planning on establishing casework consultation to the community center as a continuous aspect of coordinated services.

We are all of us, group workers and caseworkers alike, involved in providing service to the individual and his family. As Gisela Konopka points out, within both of our areas we need to approach the client as someone who throughout his living experience is not an entity apart from the groups of which he is a member.[1] He progresses from the primary group of the family to the secondary play group of childhood. From there he gradually moves to the common interest groups, such as the vocational, of adult life. Our work with him is geared to this.

Casework and group work come into contact with each other around specific clients. These may be children or adults who are being served in both settings or who are in the process of referral from the one agency to the other. Such referrals have implicit within them recognition of the validity of each other's function and service. Going beyond individual referrals, agencies have developed joint programs of activity over the years in specific areas of function.

The Agency Context for Consultation

The Madeleine Borg Child Guidance Institute of the Jewish Board of Guardians is one of those agencies with conviction about the validity of such cooperative services. S. R. Slavson did much of his pioneering work in group process and therapy within our agency.[2] Group techniques and group work consultations have been continuously utilized and developed within both our residential treatment and out-patient settings.[3] In turn, following an earlier program of consultative services to neighborhood centers such as Bronx House over a decade ago, we have over the past four years engaged in a program of consultation with community centers in three established Brooklyn neighborhoods. These centers are the East New York Y.M.-Y.W.H.A., the Coney Island Division of the Shorefront Y.M.-Y.W.H.A., and the Williamsburg Y.M.-Y.W.H.A.

This program exists with the support of a grant of the New York City Community Mental Health Board and provides for making available to the centers a clinical team for consultation and study including casework, psychological and psychiatric services. A caseworker is directly present at the center while the other team members are available for participation in studies of individual children and parents referred from the program. We are currently discussing the relative merits of bringing the psychiatrist and psychologist directly to the center further to enhance the consultative process.

Relationship to Community Needs

For us this program is part of an over-all approach to community mental health needs in which there is an early reaching-out to children and parents as their problems become manifest within their own community. Experiences vary with the needs of the particular center and neighborhood from which it draws its membership. Within all centers the basic needs determining this program are the same.

Williamsburg, East New York, and Coney Island are all older neighborhoods from which many of the currents of Jewish life in New York have developed. Today the widespread deteriorated housing of these areas serves as a background for new public housing projects. Traditionally predominant Jewish areas are giving way to an influx of new populations. These communities are confronted with the need to integrate in a way that will help maintain and develop mental health for both the old and new populations. In each neighborhood there has been expression of community concern with the problems of youth, as in the areas of delinquency and inadequate school and recreational facilities.

Within this social reality the community centers have an important and often difficult role to fulfill. Gertrude Wilson has pointed up the need, in dealing with social and individual problems arising in a community, to take those steps which can help break down the boundaries which separate the areas of specialization in our field.[4] One such step is that of providing consultation by the child guidance clinic to the community center.

Function of the Consultation Program

The consultation program functions in two basic areas. The first is that of contributing toward an increased understanding of developmental characteristics and problems of children as these emerge within programs. The second pertains to studies and consultation on individual children and families. Meetings and conferences in both areas are within a

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1 Gisela Konopka, "Social Group Work: A Social Work Method," *Social Work*, Vol. V, No. 4 (1960), pp. 53–61.

2 S. R. Slavson, *An Introduction to Group Therapy*, International Universities Press, New York, 1952.

3 Jerome M. Goldsmith, "Clinical Group Work in a Residential Setting," in Aaron H. Esman, ed., *New Frontiers in Child Guidance*, Jewish Board of Guardians, New York, 1958, pp. 93–106.

4 Gertrude Wilson, "Social Group Work: Trends and Developments," *Social Work*, Vol. I, No. 4 (1956), pp. 66–74.

spirit of mutuality in which our staff, too, has benefited through an increased understanding of community centers, group process and needs of particular communities which are served by the centers.

Meetings and conferences with group work and day-care staff in the centers have taken place along the following lines. Meetings with day-care staff have focused on the child's problems in separation from parents and the resulting reactions in his behavior and relationships within the day-care program. Topics such as timidity, withdrawal, aggression, and destructive behavior as evidenced by pre-school children, have been discussed with staff.

Discussions have been geared toward obtaining an increased staff sensitivity to expressions of insecurity in children. A child's need for reassurance through body contact with a staff adult has been evaluated in relation to the withdrawal from mother and the resultant feelings of deprivation. Motivation and play involvement have been examined on the part of the withdrawn child whose difficulties in these areas are enhanced by the relative adequacy of his peers.

With the group work staff there have been meetings and conferences geared to such areas as that of the withdrawn child who adapts but readily gets lost in program. Here discussions have evaluated how the child may be allowed some opportunity for withdrawal without being overwhelmed by contact. Such children seek to isolate themselves but often can be drawn in on a gradual or partial basis.

A series of meetings with one center staff dealt with acting-out children as they present management problems within the center. There has been consideration of means through which such children may be most actively involved on a positive basis so as to enable their continuance within the program. In one instance members of the board of a center were involved in an appraisal of the factors making for pre-adolescent and adolescent behavior problems. There was analysis of the dynamics of such acting-out with consideration of how the center could more adequately plan for such youngsters without the need to drop them from membership as sources of contagion. In this connection there has also been discussion pertaining to recognition of symptoms on a differential basis. This has been in terms of helping staff become more fully able to recognize the extent of disturbance suggested by varying behavior. In a number of instances staff discussions of this type led to planning as to how to handle such children within program and also led to individual referrals for counseling.

The group leader has unique opportunity for direct observation of the child as his personality pattern emerges in the group. The shy and withdrawn child who may drop out early or remain tentatively on the edge of the group without ever really entering, the rivalrous child who sets himself against the movement of the group out of fear of losing his own individuality, the self-negating child who seeks to buttress his position by conciliating and giving in at each point to his peers—these are some of the children familiar to each of us who has worked with groups.

It is a function of the consultation project to provide additional means for understanding such children more fully and to use this understanding for planning the use of the group or individual contact. The professional exchange may take place by the group worker and caseworker conferring on group and interview material provided by the group worker in relation to the child or it may require a supplemental study with child or parent or both. This may consist of additional interviews held by the group worker with the child and parents.

Alternatively, it may consist of casework interviews and possibly include psychological testing and diagnostic interviewing with the psychiatrist. Such data are combined with material available from the group worker's contacts. Throughout there is emphasis on mutuality of participation between group worker and caseworker in the consultation.

In a conference following the report there may be evaluation that the child requires referral for treatment, or, with respect to the program at the center, there may emerge suggestions for handling the child in a particular way within the group or in placing him in another and perhaps more appropriate group where it is available. In some cases it is seen that a child is not yet ready to utilize a group experience. Plans may be made for the caseworker to continue to see the child and parents. This may be on either a short-term basis within the center or in our clinic, or there may be a referral for long-term treatment. Incidentally let me say here that we believe that it is valid that our clinic lend every possible support to this program and that it give a high order of priority in its intake to cases referred from within the program. There is value for us too in treatment of "our own" families to have the cooperation of participating group work agencies.

We have often found that the group work center is approached by families as they might come to a family agency or child guidance clinic. They turn to the center as the resource which is natural for them. They are familiar and comfortable with its staff. They may be resistive to acknowledging a problem to the extent of bringing it to a casework agency, especially one which is outside of their immediate neighborhood. The caseworker here may act as consultant by planning and discussing with the group worker the latter's interviews with the family. This is generally for the purpose of helping to work through an appropriate referral. Through such discussions the caseworker may be able to contribute to the development of skills in individual interviewing on the part of the group worker. They may confer, for example, on specific problems which arise in the course of the interviews and discuss means of handling these. This may also include helping the group worker develop a greater knowledge of appropriate community resources rather than using family agencies in a general way even when a more specialized resource may be indicated. All of this depends of course on the relative experience and skills of the group worker and caseworker. The experienced group worker may already have a high level of such skills and be in less need of such consultation. On the other hand there are times when it is the least experienced who may have the greatest difficulty in using such help. Here it is necessary to be aware, as it really is throughout the program, that the caseworker is not present within the center to offer supervision but rather to offer consultation based on the needs of the particular client.

The caseworker is often involved in consultation or direct service with youngsters who through their delinquencies within the center make it questionable whether they will be able to continue within the program. This has included adolescents involved in physical aggression directed against other children within the agency. Here there was a delinquent sub-culture that required particular attention so that it could be worked out. Or there was the case of an adolescent boy involved in sex play within the center. Of course the problem that the center faces at some of these points, and to which the consultation program has a contribution to make, is that those children about whom there is the greatest question may be precisely

the ones with greatest need for the center.

Here we have had experiences where adolescents voluntarily sought out our worker for help with problems that were causing them some concern. An example of this is that of two teenage boys who knew of our worker through a friend of theirs whom she was seeing. The latter boy had been referred for short-term treatment at the center by the group work staff. One of the teenagers who sought our worker out had to say disparagingly that he was crazy too and maybe should be seeing a "head-shrinker." He proved to be a highly intelligent youngster whose underlying self-defeating patterns made for constant difficulties. He was able to utilize short-term casework treatment in relation to problems he was experiencing in regard to school. He was not able, however, to accept the suggestion for continuing long term treatment within our clinic. Instead he offered to compensate by bringing his girl friend to see the caseworker since he felt that she also had problems with which she required help!

Other services on the part of the casework consultant included observation of children within the lounge or within group meetings which the caseworker was invited to attend. Through these observations the caseworker was able to offer suggestions regarding children who appeared to evidence difficulty in functioning. Such suggestions were both in the area pertaining to handling within the group or in regard to establishing individual contact on the part of either the group worker or, if indicated, the caseworker. Here there have been understandable pros and cons regarding the caseworker's direct contact with the group. My own impression is that the group is initially thrown off balance by the presence of the caseworker but that equilibrium is reestablished. This is easier for the group if the caseworker has been within the center for some time and is a familiar member of staff to them. It is a useful activity in terms of helping sensitize staff to emotional problems evidenced by membership. It is also useful in terms of helping additional children receive the benefit of either consultation or treatment. The argument against it of course is that it interferes with group process and with supervision. This is an area which can be more fully discussed but where I believe the difficulties can be resolved.

Contact with Parents

At numerous points the caseworker consulted with the group worker on the latter's contacts with parents in relation to problems of children within the center. In other instances the parents were seen by the caseworker where this was considered appropriate. We had repeated evidence of the different ways through which children responded to the unconscious conflicts of parents and carried this over into their functioning within the group setting. As Helen Durkin points out, we need to remember in our contacts with parents that there are limitations to what can be handled in direct guidance with them. In some instances there is incorrect handling by the parents which can be consciously corrected. In many instances the parents' unconscious motives continue to present problems:

> "Unwittingly they often use their children as pawns in their attempt to reestablish their emotional balance. In turn the children have extra pressures on them and must adjust by finding solutions to the problems so created for them. Naturally these solutions are neurotic too."[5]

Some of the parents whom we saw were themselves competitive for status.

[5] Helen Durkin, *Group Therapy for Mothers of Disturbed Children*, Charles Thomas, Springfield, Mass., 1954, p. 8.

At this point they had to pressure their children to act as their delegates by competing for status within the center. This was often beyond the child's capacity and contributed to problems in his functioning.

There were also parents who, themselves, had had difficulty in establishing relationships on both a youthful and adult level. Now they sought to compensate through efforts to push their children in this direction.

Some parents were threatened by the satisfying experiences which their children were having within the group. There were complaints that their children spent too much time within the center. There was evidence that they felt the center personnel as their competitors in the relationships with the youngsters. This contributed to guilt and conflict on the child's part and, unless caught in time, made for poor functioning within the center and possible withdrawal.

Some parents were seen about their children's particularly difficult adjustment reactions to adolescence. It was necessary to help the parents deepen their understanding of their children and examine their own reactions to specific problems. At times it was necessary to help parents reevaluate particularly authoritative or overly permissive parental attitudes along the lines which Dr. Lawrence Frank has described in relation to adolescents in the Jewish community center.[6]

There are families which intensely need casework help but who resist referral because of various unresolved feelings. Only when such cases are very carefully processed in consultation between group worker and caseworker, does it become possible adequately to work through the parents' resistance to treatment. It also helps indicate how there can be continuing cooperation in services between the group work and casework agencies within a particular case.

The Day Nursery

The casework consultant in the "Y" is actively involved in the nursery located in that agency. Her role is a familiar one in terms of casework function within a nursery setting. She contributes in staff discussions to knowledge of child psychology and behavior within the 3–5 age range as discussed earlier in this paper. She also functions as a resource person for staff in regard to individual problems which may emerge for particular children.

The caseworker participates directly within the day nursery program through observing the child and then reading the teacher's material. Following this she will confer with both the nursery director and the Department of Welfare consultant. Initially there was a tendency to consult only on children who stood out with particular problems. Gradually, however, there were included the quiet and withdrawn children who, since they present no particular problem in handling, can easily become lost in a program.

In appropriate cases the caseworker meets with the parents within the nursery both to gain additional understanding about the child and family and to offer suggestions about handling. The caseworker has also conducted meetings with groups of mothers in which topics were discussed related to the care and understanding of children in this age range. While some parents initially reacted with suspicion and saw this service as an intrusion, it increasingly became accepted as a service on a positively received basis.

[6] L. K. Frank, "Adolescent Needs and Aspirations," *Teen Agers in the Jewish Community Center*, Report of National Jewish Welfare Board, New York, 1954, pp. 3–12.

Questions Pertaining to Casework Consultation

We of course are concerned with making the consultation project more effective and useful to the community center. There have also been questions on the part of both the group work and casework staff on developing the means for the effective functioning together. I would like to deal briefly with a few of these questions within general areas:

Is the child guidance clinic equipped to offer consultation to the staff of the group work center? The group worker repeatedly deals with the individual child or parent and brings knowledge of individual personality into his work. Bringing in the consulting caseworker at times stirs up question as to whether the same function could not be fulfilled by the group worker. I think that it is necessary to affirm here that the concept of casework consultation within the community center is based on factors which in no way have negative connotations regarding knowledgeability of the group worker. Nor is the caseworker equipped to be a consultant by sheer virtue of being a caseworker.

He participates as a member of the clinical team, psychologist and psychiatrist included, who are available for the consultation process. Secondly, he is effective when he himself has had the necessary level of clinical training and experience to bring in knowledge of individual personality; diagnosis of pathology, and dynamics. He is also effective to the extent that he is able to identify with the group work setting and to understand the nature of its structure, program, and group process. The consultation function needs to be maintained without converting the caseworker into a staff member having multiple casework responsibilities.

Should the consulting caseworker have direct contact with membership? Such contact is useful in helping him be more fully aware of the needs of particular members. Here, however, relative functions have to be kept in mind. If a caseworker utilizes this contact to take over functions which probably belong with the group worker or with the group leader, then that contact needs to be examined. If the membership has a troubled reaction to the caseworker or if their activities are inhibited by his presence, then that too bears deeper examination.

Helen Phillips is one of those who has questioned the ability to sustain individual relationships and individual contact in the social group work setting. She has affirmed the role of the group worker as a group worker and not as a caseworker using individual techniques.[7] In various areas the group worker does function however with individual techniques and it is in relation to some of these that the consulting caseworker has a consultative role to fulfill. Parenthetically, I would question the group worker undertaking short-term treatment within the group work setting. Even a very full knowledge of personality dynamics is not the same as a knowledge of individual treatment techniques. Short-term treatment is often quite as complicated as long-term treatment, if not more so in a number of cases. It requires an early diagnostic evaluation of the client and sectored goals, selected in terms of overall needs. I think there is general awareness of these facts but occasionally some question does arise. Needless to state, such a caveat on undertaking treatment does not preclude the group worker extending support while the child is in process of referral to a clinic.

There has been much creative work

[7] Helen U. Phillips, "Social Group Work, a Functional Approach," *The Group*, Vol. X, No. 3, pp. 3–7.

done with the small group in terms of therapeutic service to disturbed clients. I think that there is much further progress to be made through cooperative activity in which the caseworker works directly with the individual client while there is a cooperative group experience.

Should not the caseworker function directly as a full-time member of the group work staff? There have been experiences along these lines which have varied according to the setting, the nature of problems presented by the agency, and the qualifications of the particular worker. I believe that the central issue here is whether the question of consultation is viewed solely as a matter of the individual consultant's qualifications. In addition to the Jewish Board of Guardians' caseworker's participation as a member of the clinical team including psychologist and psychiatrist, he is also a representative of the agency. He has available to him the resources and thinking of the child guidance clinic in making consultation effective. He continues to receive clinical supervision where appropriate and has a continual involvement in clinical casework activity and training. The suggestion has been made that bringing treatment services directly into the community center may make it possible to reach clients who would otherwise not be involved in treatment. This is linked to having a full-time caseworker available within the center. I would be inclined to feel that this would bring with it a number of related problems having to do with clarity regarding function and with practice as a member of the team.

Does the staff of the group work center have the time to make effective use of consultation? It is true that very often the staff of a busy community center, dealing with a host of problems in rapid succession, may find it difficult to provide the necessary time. Material should really be prepared adequately for consultation and sufficient time set aside for conferences. Our experience has been that there is a reality pressure of time but also there is a question of conviction in the validity of the service and a question of what the group worker feels that he is able to obtain for his work with clients by participating in the consultative process. Here I think the burden falls upon the casework agency to provide seasoned, qualified personnel.

Have not the casework consultants placed too heavy an emphasis on individual diagnosis? Gertrude Wilson writes on this issue:

> "Diagnosis is the core of practice. It is not sufficient to be well grounded in understanding the dynamics of human behavior. The social group worker serving a 'growth-oriented' group, understands as much as he can about the specific problems of each member in the group he is serving. This involves a study of each individual to secure as much understanding of the meaning of his manifest behavior as the combination of accessible facts of his life experience and theory can provide." [8]

I believe that diagnosis, not only of the severely disturbed client but also of less disturbed clients whose personalities we wish to understand more adequately, is one of the areas in which the child guidance consultants have contribution to offer. Here again I would state the need to bring together this material with that of the group worker regarding the individual child and family.

Conclusions

The community center plays a vital role in meeting the mental health needs of its clients. Its activities provide the possibility of early detection of problems and the development of programming in relation to them. It constantly

[8] Gertrude Wilson, *op. cit.*

deals with client needs, both children and adults, on an individual as well as group basis.

In seeking to increase the effectiveness of this function, it has an ally in the child guidance clinic. Through such programs there is an integration on behalf of community needs. The collaboration of the professionals in both areas makes possible the development of more effective techniques and services on behalf of clients.

GROUP PSYCHOTHERAPY AND PERSONALITY FACTORS IN A WORK ADJUSTMENT PROCESS *

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The Choice of Group Psychotherapy Adjunctive to Work Adjustment

IN humans, work is related to and influenced by all three facets of the personality, id, ego and superego.[5] Therefore any discussion of ways of increasing employability or work tolerance must consider these personality factors as well as other related work variables. That these personality "structures" have a large unconscious basis must be considered in implementing any vocational rehabilitation process for the person with severe emotional problems.

Vocational counseling has long been used in guidance and rehabilitation processes with much benefit. However, those of us trying vocational rehabilitation of people having severe emotional problems have found that vocational counseling, a work adjustment program, or even work itself are frequently not enough to help the individual become employable. Though the individual may have good mechanical skills personality factors are disabling.

Group psychotherapy was chosen as the most feasible therapeutic medium for several reasons. These include the similarity of the group therapy situation to the interpersonal relationships in the work environment, the greater usefulness and effectiveness of a depth approach, and the economic factors of few staff and many clients.

Good interpersonal relationships are usually a prerequisite for satisfactory job adjustment. These relationships are in large degree a function of superego elements. That is, the early parental introjects during the identification process influence the individuals' reactions to associated figures in the work setting.[1] The problem then in therapy is to work through these unsatisfactory authority and sibling images and try to modify them in a positive way.

For many individuals whose emotional problems are not too limiting, the work adjustment process alone may be enough. However, people who are more deeply disturbed require an elaborated approach. Although work utilizes many id components, it is essentially an ego function.[3] In order to accomplish work satisfactorily, a modicum of ego resources is required. Individuals with severe emotional disturbances typically have large areas of ego dysfunction. These can be seen in such things as poor reality testing, perceptual distortion, thinking disorders, an increase in the number of defense mechanisms of a more primitive nature, and resultant loss of energy.

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