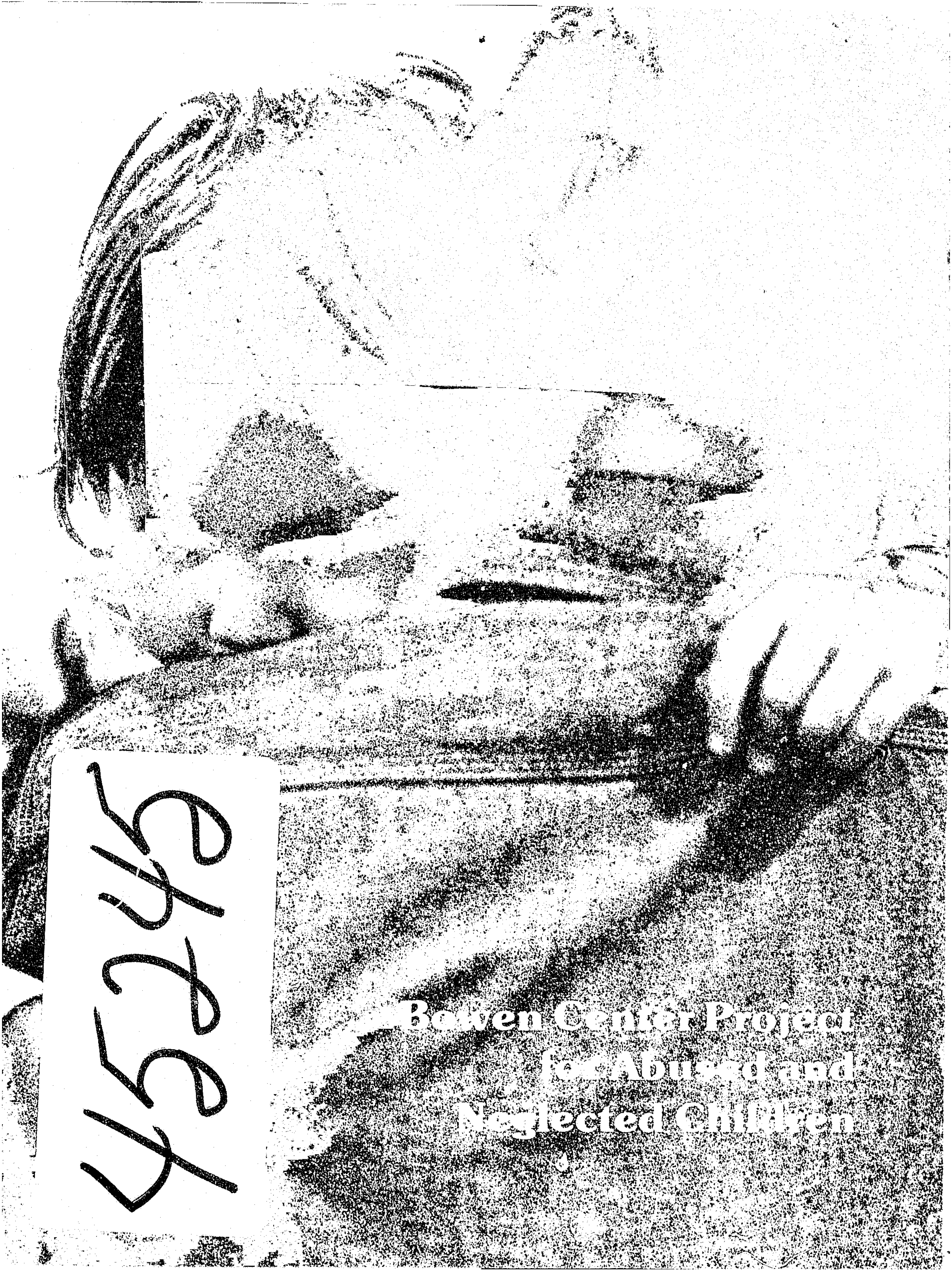

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Bowen Center Project
for Abused and
Neglected Children

BOWEN CENTER PROJECT FOR ABUSED AND NEGLECTED CHILDREN

Report of a Demonstration in Protective Services

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development Services/Administration for Public Services
DHEW Publication No. (OHDS) 77-02002

The Bowen Center Project, sponsored by the Juvenile Protective Association, Chicago, was funded by Grant No. D-208(R), later Grant No. 87-P-80040, U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau (later Public Services Administration).

FOREWORD

Federal concern for neglected children reaches back over half a century when, in 1917-18, the Children's Bureau launched a nationwide series of studies of State and local provisions for the care and protection of dependent children, including both foster family and institutional care.

The end of World War I saw the beginning of phenomenal social, cultural, and technological changes in this country. However, as the complexity of family life increased as a result of these changes, so, too, did the number of abused and neglected children increase.

In 1973, the Department of Health, Education, and Welfare placed the problem of child abuse and neglect among its top priorities. The President, in 1974, signed into law the Child Abuse and Neglect Act which led to the establishment of the National Center for Child Abuse and Neglect. As required by this law, a broad spectrum of research related to child abuse and neglect has been carried out; training materials for persons working with and for abused and neglected children and their families have been developed; and technical assistance has been provided to State and local public social service agencies and other agencies to help them improve or develop services for these children and their parents.

Largely hidden by this avalanche of activity was one child welfare research and demonstration project -- funded by the Department in 1965 for a 5-year period -- which is as relevant today as it was in the sixties. Nothing quite like it had ever been tried before.

The project, known as the Bowen Center, was undertaken by the Juvenile Protective Association of Chicago -- a voluntary agency with a long history of innovative efforts to improve services to abused and neglected children and their parents. The agency had learned that neglected, and in some cases abused, children could be cared for in their own homes, with minimal danger from their parents, IF a variety of services could be provided immediately to all members of the family.

Many of the children in the "Bowen Center families" were so emotionally and socially damaged that foster care placement, the only alternative, was doomed to failure. Community agencies, appalled by the incredible needs of these families, had given up. Thus, the next generation of maladjusted parents and children -- with a disproportionate number of delinquents, alcoholics, criminals, and prostitutes among them -- was essentially guaranteed. What made the difference between the low level of living that characterized all of these families and the positive changes that took place in the family members between 1965 and 1971 was the Bowen Center Project, with its dedicated staff under the direction of G. Lewis Penner.

The Public Services Administration believes that this report will be valuable not only to persons directly involved in the provision of services to abused and neglected children, but also to persons working in the areas of child development, parent education, and delinquency prevention and treatment -- indeed, to all persons concerned about the well-being of abused and neglected children and their families.

Michio Suzuki

Michio Suzuki
Acting Commissioner
Public Services Administration

PREFACE

THE STORY OF THE BOWEN CENTER PROJECT concerns what happened between 1965 and 1971 when a variety of services was developed and offered to severely dysfunctional Chicago families with children. These services were provided not only in a specially equipped center but in the homes of the clients as well. This report describes how programs and services were created to respond to the multiple needs of the children and their parents and how they, in turn, responded to our services -- and to us.

When designing the program, we were acutely aware that it should produce practical results which could be applied in other areas and through other agencies involved in child neglect and abuse programs, although we realized, of course, that other clusters of neglectful and abusing families might require a quite different mix of services. However, we hope that this report may help readers to visualize useful applications of our experiences in other settings. Our setting was in one of the most impoverished districts of Chicago's North Side.

The story of the Bowen Center is not, however, a story of charity. Nor was it ever permitted to become the breeding ground for cynicism. (This writer believes volumes could be written showing the relationship between cynicism and failure in the great bulk of human service.) The stance of the Bowen Center -- if it can be described in one sentence -- was to be so well fortified by the support of like minded colleagues, that one could afford to look at the client closely and empathically, regardless of the behavior he or she manifested at the moment, and not recoil. That is the heart of the matter.

In retrospect, the project has been a profoundly meaningful encounter, not only in relationships among staff, parents, and children, but also among a variety of disciplines and specialized agencies.

We are especially grateful to Mrs. Katherine B. Oettinger, then Chief of the Children's Bureau, and to Dr. Charles S. Gershenson, Director of Research for the Bureau, for their belief in the project which made the first grant possible, and for their continued support and encouragement as the project's program of services developed.

We are also indebted to Miss Marion J. Spasser who directed the project both during its demonstration period (1965-71) and also in its final phase as a training center. To an extraordinary degree, the project owes its success to her immensely capable and imaginative leadership.

We are equally indebted to Professor Mary E. Sullivan, of the Jane Addams School of Social Work, who served as program consultant to the project from its inception in 1965 and who drafted much of this report. Miss Sullivan has been of immeasurable help in shaping services to meet the needs of clients.

Dr. Merlin Taber, Professor of the Jane Addams School of Social Work, joined us after the project was under way and gave us invaluable help, especially in developing a qualitative description of the service.

We appreciate our relationship with the State of Illinois, and we are grateful for their funding of the program so that it might continue after the demonstration period ended.

Special mention should be made of the deep interest of the Board of Directors of the Juvenile Protective Association, and of the editorial services of Dr. Norman A. Polansky, our good friend. Miss Mildred Arnold and Mrs. Virginia White of the Public Services Administration, Social and Rehabilitation Service, DHEW, contributed to our success by providing constant encouragement during a most difficult undertaking.

We also thank our Technical Advisory Committee for giving so generously of their time and concern. Members included Mr. Arnold M. Levin, Chairman; Ralph Baur, Rowine Brown, M.D., Mrs. Geddes W. Carrington, Arthur S. Freeman, Mrs. Ethel Verry Knight, John P. O'Brien, George L. Perkins, M.D., Ms. Lillian Ripple, Ms. Esther Schour, and Mrs. Thelma G. Thompson.

Lastly, our thanks to Ms. Jan Linfield who drafted the original proposal for the project. And we feel under great obligation to the project staff members who functioned as a remarkable unit throughout, and who worked with such unusual enthusiasm and spirit that they left an exciting imprint on the entire operation.

G. Lewis Penner

G. Lewis Penner, ACSW

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INTRODUCTION

THE CONCEPT for the Bowen Center Project evolved gradually during the more than 6 decades in which the Juvenile Protective Association (JPA) has been seeking out and helping mistreated or neglected children.

The agency, which was founded by the great social service leaders of modern times -- Jane Addams, Julia Lathrop, Mrs. Joseph Bowen (for whom this project was named), and their friends -- has, from its beginning, been innovative. It was not a carbon copy of any of the other social welfare agencies then in existence, and it still, in its program operations, maintains a characteristic independence in order to sustain a strong position of advocacy for the child, in addition to its therapeutic functions.

Throughout its history, JPA has conducted studies to reveal social practices harmful to children: exploitative child labor, the involvement of children in prostitution, commercial baby farms, devastating punishment following juvenile law violations, and other destructive practices to which children were subjected. In fact, the undertaking through which JPA later became organized as an agency was the promotion -- together with the Chicago Bar Association -- of the first juvenile court in the United States (in Cook County).

Although a number of institutions for the care of homeless children existed in Illinois in the 1930's, a survey of the child welfare scene at the time presented a depressing picture of how little had been done that was rehabilitative. Subsequently, the juvenile court itself became simply one more instrument for the "processing" of unhappy children. And the small probation staff felt overpowered by the dimensions of the human sorrow and tragedy with which they had to deal. In addition, because the court was not clear as to how to balance its helping vs. its punitive functions, the therapeutic community tended to avoid use of the judicial system whenever feasible.

JPA -- A DIFFERENT KIND OF AGENCY

As time passed, JPA focussed increasingly on the child's care at home -- or, more specifically, on the lack of it. From the beginning, as we provided services for the children, we recognized that parents who mistreat their children need help too; to prosecute them solved nothing.

These views, plus our independent outreach to homes where children were reported to have been mistreated, gave us a character and range beyond that of other community agencies. We were not *just* a family counseling agency; not *just* a child care agency. We certainly were not a police agency; we did not prosecute bad parents. Nor were we exclusively devoted to social action.

Because JPA *was* different, we functioned in cooperation with but, in a sense, outside the therapeutic community. Our primary concern was the gap between the needs of the city's high risk families and the manner in which social services were being provided; that is, in a way which failed to reach the high risk families.

Generally speaking, counseling services, provided by most agencies were geared to families who were aware of their problems, who had the initiative to come regularly for office interviews, and whose ego strengths were sufficient to more or less regulate their lives. Services in the home were usually limited by standards of acceptability and "decency" set by the agencies, thus bypassing many of the neediest cases.

Child care agencies provided substitute care for children referred to them by the court only *after* family life had disintegrated. In between counseling and day care was a vacuum. To be useful here required the interlacing of a wide variety of services and specially trained personnel. What was needed was an agency that would not hesitate to take the initiative to reach a client and that was willing to accept responsibility for setting outer limits of parental behavior in the care of children. This, in our opinion, was the proper role for the Juvenile Protective Association.

More than once, JPA found itself operating in violation of the accepted practice, if not the canons, of the social service establishment as these evolved in the early decades of the current century. Social workers were quite properly taught not to be authoritarian, not to play God. But they were not taught how to mother a lost and motherless soul who, despite the bearing of children, had herself remained a child. This large although invisible segment of society was commonly dismissed as untreatable. We were determined not to be influenced by that attitude.

JPA did not seek motivation, civility, or willingness to change as criteria for working with families. On the contrary, the greater the problems presented, the more eager we were to work with them.

It is not true that everyone wants self-improvement. An enormous number of people live an entire lifetime without an awareness of their degree of deprivation, or any desire to rise above it. Others, having experienced little humanity in their childhood, grow older with tremendous incapacities. If they produce children, chances are they project their own impulse-ridden anger, hate, and self-depreciation on their offspring.

Only in the last 2 decades have pediatricians recognized the existence of a parental wish to kill. And only recently have psychiatrists demonstrated how large a segment of our population is composed of adults and children who are functionally and socially crippled by a deep and overwhelming sense of worthlessness. Thus, it is important to differentiate the special group of families served by a protective services agency.

Basically, what separates protective services cases from other types of cases served by a child welfare or a family service agency is the presence of neglect or abuse of children to such a degree that the child's physical safety is in jeopardy, and/or his or her opportunity for normal growth and development is endangered. In such cases, the decision to provide help cannot be based on the wish of the parents. This means that:

1. Referrals are made by someone other than the parent; and

2. Parents are unaware of or indifferent to the problems and are unwilling or unable to seek help.

The protective services agency must initiate contact with the neglecting family and sustain it until the agency is satisfied that the children are receiving adequate care -- whether or not the family accepts any need to cooperate.

The JPA Approach

As in all treatment situations, diagnosis and treatment begin with the first contact. However, JPA seeks to determine not only the validity of the report of abuse or neglect but also the involvement for good or bad in the case of the person making the report.

When a report has substance, we visit the home. The initial visit is usually followed by a series of visits to evaluate the danger to the child, to diagnose the home conditions, and, most important, to encourage and develop the trust that must underlie any hope of improving the functioning of the client.

Through the home visit, the caseworker becomes familiar with the family, observes the interaction between various members, and then determines the priority of needs. To do this effectively requires not only a high order of professional skill and an orderly mind, but a genuine love of people. The worker's warmth has to penetrate the cold diffidence of many neglecting parents; stability and calmness in the face of chaos should be reassuring; firmness should help resolve any indecision the parents may feel. Most of all, kindness should win their confidence. What we hope all this will do, of course, is involve the family in appropriate treatment and rehabilitative services.

FAMILIES WHO NEED PROTECTIVE SERVICES

Families in need of protective services are usually confused, disorganized, combative, or even shy. Their needs are legion and overlapping. For these reasons, a multiservice agency has an excellent opportunity to identify their varying needs and to work out with the family a program that could help to overcome their problems.

In some instances, the caseworker may conclude that the danger of parental mistreatment is so severe that irreversible damage might occur to the child or children. She must then have the wisdom and will to recommend placement, hoping to do so with the consent of the parents.

As a general rule, the grossly dysfunctional family has had numerous contacts with the police, the courts, and with the public aid department. However, its contact with the community's social services is less frequent. In contrast to popular belief, these families do not "eat up" the social service resources of the community. In fact, they may be grossly ignorant of services to which they are entitled and which might help them.

A parent who neglects or abuses his or her child is typically the product of a deprived childhood in which normal growth-producing experiences were denied. Fixated at an early emotional level, the individual seeks desperately to fill his or her own unmet needs, often through avenues which further deplete his/her life -- drinking, sexual promiscuity, criminal behavior, exploitation of spouse or children. Lacking any consistent experience of dependency gratification, the parent is unable to meet the valid dependency needs of his/her children. In fact, the parent may choose to abuse or neglect the children as a means (perhaps the only means the parent knows) of personal fulfillment.

The caseworker needs to help this kind of parent to move beyond the point of interruption of his/her own development toward adulthood and responsible parenting.1/ To

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1/ Reiner, B. and Kaufman, I. CHARACTER DISORDERS IN PARENTS OF DELINQUENTS. New York: Family Services Association of America, 1959. (A psychodynamic formulation tested and verified by the Juvenile Protective Association.)

accomplish this, the caseworker must be willing and able to establish a relationship in which some of the deep-seated needs of the parents themselves are satisfied. Despite the client's initial distrust and hostility, the worker must be able to persist and convey acceptance of the parents, of the wish to help them, and of belief in their capacity to change. She must be equally able to express the community's expectation that their children do not suffer. Without seeming to threaten, she must make clear her responsibility to effect the removal of the children from the home if the parents are unable or unwilling to strive toward improvement. Indeed, a high level of professional skill is required to involve the client in the first steps toward change.

Child neglect is never seen in isolation. It is usually accompanied by such problems as marital instability (desertion, frequent change of partners, promiscuity or prostitution, births out of wedlock); poverty (deteriorated housing, inadequate income due to lack of vocational preparation or illiteracy, poor management of money, or vulnerability to exploitation); physical or mental illness; antisocial behavior (excessive drinking, gambling, drug addiction, physical violence, or actual criminality).

WHY COMMUNITY SERVICES FAIL

The protective services worker must deal with the chaos and recurrent crises which neglectful families create or experience, if treatment is to be effective. It is precisely in these areas that community services most often fail.

Several reasons account for this failure:

1. The availability of social services differs in different communities, resulting in, at best, a patchwork quilt of agencies offering specialized services. Some find the client; some do not. The overall impact is diluted, fragmented, uncoordinated services.

2. The family in need of protective services is typically disorganized, poorly functioning, and ill-equipped to seek out agency services. The parents usually reject referrals because they fear criticism by their peers, are unwilling to make contacts with social workers they do not know, and back away from seemingly complicated intake procedures.

3. The community agencies themselves are oriented toward serving relatively responsive families -- i.e., those who show some motivation, who will accept daytime appointments,[2] and who are willing to come to the office for interviews. Staff are often bitterly disappointed and frustrated by the neglecting client's self-defeating behavior (e.g., excessive demands, passivity, hostility, provocativeness, and/or extreme narcissism). They may give up trying to work with the family or to provide the needed service.

4. When a supportive service is needed for a protective services case, it is often in a family crisis, such as eviction, emergency hospitalization, a runaway child or absent parent, and the service must be available immediately or it is of limited use. Again, agency application procedures, eligibility requirements, and waiting lists often make it impossible for the family to receive the service in time.

DEVELOPING THE BOWEN CENTER

We, therefore, consulting one with the other, determined that a protective services center with a wide range of supporting services -- a center organized and integrated within a single administrative unit -- might be the way to remedy the service lacks in the community. It was certainly worth the try.

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[2] Penner, G.L. "An Experiment in Police and Social Agency Cooperation." Annals of the American Academy of Political and Social Sciences, Vol. 32, March 1959.

One of the most traditional patterns of providing protective service is to work to change parental attitudes. Our approach was to concentrate on meeting the needs of the parents first -- to avoid pushing them prematurely toward meeting the needs of their children.3/ Agencies that follow this method may have to accept a prolonged period of parental neglect of the children. Also, the strain this places on the worker may lead to outbreaks of irritation toward the parents or to unrealistic expectations of what they are able to do. Such a dilemma need not exist if the protective services worker is able to offer services to meet some of the child's needs while she is concentrating on emotionally needy parents.

In developing the Bowen Center, we thought in terms of a comprehensive plan -- in the Center and in the child's home or neighborhood -- which would increase the physical and emotional nurture in the child's life by means of, for example, a day care center, a homemaker, a foster mother, a tutor or group worker. This interim measure of "supplemental parenting" would make it possible to work with some families where heretofore the degree of neglect or abuse was so severe that it would have been impossible to allow the child to remain in the home.

The severely abused or "battered" child is a case in point. Many persons who have worked with parents of battered children feel that immediate placement of these children is necessary.4/ Our position was, however, that with additional protective services, some of these families (selected on the basis of careful diagnosis) could be worked with successfully. Furthermore, with the current surge of interest in the battered child and with all States having passed mandatory reporting laws,

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3/ Bishop, J.A., Burton, B.W., and Bourke, W.A. AN INTENSIVE CASEWORK PROJECT IN CHILD PROTECTIVE SERVICES. Denver: American Humane Association, 1963. 34 pp.

4/ Young, L. WEDNESDAY'S CHILDREN: A Study of Neglect-Abuse. New York: McGraw-Hill, 1964.

--- Delsordo, J.D. "Protective Casework for Abused Children." Children, 10:6, 213-218, 1963.

we felt most strongly that it was a charge and a challenge to the protective services agency to develop more effective ways to treat this group of families, rather than to assume a priori that child placement was necessary.[5]

In our preliminary planning, therefore, we determined that equal diagnostic scrutiny be applied to the needs of the neglected child as well as to those of the neglecting parents. We intended that the Bowen Center staff would be able to regard the client closely and with empathy and to work with the parent regardless of his/her behavior or past history; in short, not to give up, no matter how difficult or unreasonable or irrational the client might be.

On the other hand, protective services assumes that the client will fail to function in a wide variety of areas that bear on his/her welfare. Hence, the service must be geared to meet these needs until the client learns, haltingly, to meet them. The eye of the therapist must be on the client, on each member of the client's family, and on the client's environment.

JPA has always been concerned with the tendency of society to dump to the bottom of the heap those who cannot cope. Some of our resources are always applied toward getting public support in order to correct gross inequities. But to put all our weight into a social action program would, in our view, have been simplistic because of the intricate interaction between the client's external and internal worlds. We felt that no amount of community improvement would help the hurt parent or child unless we, ourselves, first thoroughly understood neglecting, abusing families as dysfunctioning individuals who needed our help. The Bowen Center Project was to experiment with and demonstrate ways of helping them.

It takes years to ruin a child, and we had no illusions that the multiple damage of years of abuse or neglect could be healed in a few weeks, months, or even years. When neglect is severe enough to come to public

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5/ Maas, H.S. and Engler, R. CHILDREN IN NEED OF PARENTS. New York: Columbia University Press, 1959. 462 pp.

attention, both the attractiveness and coping ability of the neglected child have probably already been destroyed. By means of intensive therapy, however, we hoped that, if we could not totally erase the effects of gross mistreatment, we might at least ameliorate the damaging parent-child relationship and, above all things, find ways of keeping the family together.

This report avoids discussion of both the social malaise that results in neglect and also the incidence of neglect and abuse. Responsible people working in this field agree that, although the indices point to an enormous problem, nobody has reliable figures to show just how many children suffer from severe neglect or abuse. Dr. Vincent De Francis of the American Humane Association places the national figure at between three and four hundred thousand, and Dr. Norman A. Polansky, one of the Nation's leading experts on child neglect, indicates that at any one time a million American children are victims of neglect or abuse. In the Juvenile Protective Association, we find a ratio of about seven neglect cases to each abuse case. In any event, the problem of child neglect/abuse is becoming more and more identifiable.

Severely disorganized families produce most of the Nation's crime and much of its mental illness. If we wish a better society, we have a moral obligation to learn to improve the functioning of legions of frightened, lonely, confused, unhappy children and their equally unhappy and confused parents. Hopefully, the experiences of the Bowen Center will point to ways to do so.

CHAPTER I

A NEW APPROACH TO THE NEGLECTED CHILD

FOR AT LEAST A DECADE, workers in child protective services agencies have been alarmed by the rapid increase in the numbers of identifiable cases of child neglect and abuse. Although definitive studies have not yet been conducted on a broad enough scale to provide accurate nationwide figures, responsible authorities agree that all indices point to an enormous problem.6/

Like many other large cities, Chicago has a sizable proportion of families in need -- neglecting parents, neglected children. Despite valiant efforts, the single service agencies seemed unable to help the neediest of these families. At the Juvenile Protective Association, we saw what was happening and concluded that a multiple-service program, offering a range of integrated services, might be more effective than the uncoordinated resources existing in a community, or by social work intervention alone.7/

It seemed to us that neglecting families were touched by many agencies and institutions, yet not fully involved by any. They were people who engendered in most caseworkers the feeling of hopelessness and helplessness that they themselves experienced.8/ Their urgent and multitudinous needs and their overwhelming demands for service had frustrated agency after agency, many of whom simply dropped these clients as being beyond help. A new approach was needed.

6/ Fontana, V.J. SOMEWHERE A CHILD IS CRYING: Maltreatment -- Causes and Prevention. New York: Macmillan, 1973. 268 pp.

7/ Polansky, N.A., Hally, C., and Polansky, N.F. PROFILE OF NEGLECT: A Survey of the State of Knowledge of Child Neglect. Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Public Services Administration, 1975. 57 pp.

8/ Polansky, N.A., Borgman, R.D., and DeSaix, C. ROOTS OF FUTILITY. San Francisco: Jossey-Bass, 1972.

TARGET POPULATION

Two depressed neighborhoods on Chicago's North Side seemed to be getting no services at all. We chose these neighborhoods for the Bowen Center Project because we found there the most socially and emotionally impoverished families in the city. They had been singularly unresponsive to the interventive measures and, consequently, had been eliminated from the records of community agencies. Even existing health and welfare programs, for the most part, had been unsuccessful in reaching them with sufficient impact to save the children from repeating the pattern of former generations.9/

We believed it to be crucial to achieve greater understanding of such families and to find ways of interrupting their depressive plight. We also thought that knowledge gained through working with the seriously dysfunctional and neglectful families could be adapted to assist less disabled families in a variety of settings.

From the two districts, 35 families, characterized by pervasive and chronic dysfunction in almost every area of their lives and whose children were at high risk, were referred by other agencies or the community. They were families who had not "made it" in the traditional framework of the community's institutions and service agencies. Our object was to help them "make it" by offering a whole package of services.

The primary criteria for family selection were the presence of substantial child neglect and serious limitations in family functioning. (We planned the project without a control group because we believed the study families themselves would offer sufficient evidence of the effects of nonservice vs. services.) The neglect had to consist of parental acts of commission or omission in the physical and emotional care of the children to a degree that their safety and chances for

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9/ Levitan, S. "Alternative Income Support Programs." /In/ POVERTY AMERICAN STYLE. H. Miller, Ed. Belmont, Calif.: Wadsworth, 1966. (pp. 166-186) normal development were in constant jeopardy.10/ The limitations in family functioning had to reveal physical, mental, or social breakdown, ineptness, immaturity, insecurity, and a general lack of concern.

At the outset, it was decided that families in the project area who met such criteria would be accepted in chronological order of referral until the maximum number that could be served (35) had been reached.

It proved to be all too easy to acquire the target population, as all the families referred to us had a long history of chronic and pervasive dysfunction combined with severe child neglect. Another factor contributing to the ease with which we obtained our desired sample was our decision that no referral would be rejected because of the seriousness of the problems presented by the family. Any attempt to screen out families because they might seem too difficult to handle, we believed, would limit the project's opportunity to test the use of the support system of services upon the total continuum of family dysfunctioning. In fact, the presence of crisis at intake, however grim, frequently allowed the staff to give an urgently needed service immediately, thereby building a relationship that otherwise would have been extremely difficult to achieve.11/

We were also fortunate that the community agencies were eager to refer families, for the project was recognized as possibly the very last hope to reach them. Our most common sources of referral were hospitals or health clinics where nurses or social workers saw evidence of abuse or knew that serious health and emotional needs of children were being repeatedly ignored. Other sources were public assistance agencies, urban progress centers, schools, private agencies, and some private citizens. All of these sources had seen these families fail time and again, regardless of extensive attempts to help them.

10/ Giovannoni, J.M. "Parental Mistreatment: Perpetrators and Victims." Journal of Marriage and the Family, 33:649-658, 1971.

11/ CRISIS INTERVENTION: Selected Readings. H.J. Parad, Ed. New York: Family Services Association of America, 1965.

The ultimate population of the Bowen Center consisted of 222 persons -- 162 children and 60 adults -- members of the 35 different families.

Since such descriptive terms as "multiproblem," "economically deprived," and "inner-city families" cover a wide range of situations and levels of functioning, it is necessary to clarify that the group selected for service was not representative of all poor urban families but, rather, those at the very lowest end of the continuum.[12] Yet even within this group, a range in the number and severity of disabling problems could be anticipated.

FAMILY CHARACTERISTICS AT TIME OF REFERRAL

Of the 35 families, 15 were second generation Chicago white families of various ethnic origins; 11 were Appalachian families who had come to the city within the past 7 years; 5 were black families, 4 of which were second generation Chicagoans. In 3 of the remaining 4 families, one of the parents in each family was Mexican; and in the fourth, both parents were Puerto Rican. In 13 families, the parents were in their early twenties; the ages of parents in the other 22 families ranged from 30 to 40 years.

Although there were slight differences in degree, all of the families shared these characteristics at intake: They were living on irregular and inadequate incomes, insufficient to meet their needs. The minimal amount of money available to them was made more inadequate by their inability to manage what little they had. They lived in housing that ranged from very poor to what would be considered by most people as completely uninhabitable. The children were deprived of the minimum necessities, such as adequate food, clothing, and

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12/ Geismar, L. 555 FAMILIES: A Social Psychological Study of Young Families in Transition. New Brunswick, N.J.: Transaction Press, 1973.

physical care. Neither the parents nor the children received consistent health care, and they frequently failed even to follow through on clinic appointments. Most were in need of dental work, and other chronic health problems existed. The families lived in a chaotic clutter of broken furniture, filth, and confusion. Children usually slept wherever they could as there never were enough beds. Frequently, children were away from home at night and not missed at all by their parents.

As was pointed out in the Introduction, families such as these cannot be expected to make progress toward healthy family living in a few weeks or months. The norm was for families to have several members involved with the Bowen Center program over a period of years. Only 10 of the 35 families were known to us for less than a year; 14 of the 35 were involved with the program for 3 or 4 years.

Most of the households (25) were headed by two parents. This may be misleading, since so many of the fathers and mothers were almost completely nonfunctional as parents. One household was the home of four siblings living by themselves.

A most significant characteristic was the presence of an unremitting series of crises, ranging from common, everyday happenings, such as gas and electric shutoffs, eviction notices, and lack of heat and food, to physical and emotional illnesses, accidents, quarrels and separations, and entanglements with police and the courts. A feature of these crises was their almost predictable repetition. Although the nature of the crisis might change, there was a sameness in terms of precipitating factors and of the adult response to them.

Finally, the families had a history of long-term, chronic dysfunction, with no evidence of there ever having been a "better" time. The question was not one of rehabilitation to a former adequate level of functioning but, rather, one of working with a family toward a process of stabilization and growth not hitherto known.

The Parents

All of the parents had serious marital problems. Thirteen of the families at intake were composed of only the mother and children. The marriages had been broken by desertion or divorce; in three instances, the children were born out of wedlock. Four other families at intake had taken steps toward separation, following a long history of previous separations. Parents in the remaining families continued in marriages marked by constant conflict, lack of communication, and other types of marital pathology. These spouses had minimal ability to understand or respond to each other's needs. In many situations, the children were exposed to sexual acting out on the part of one or both parents. In some families, the children were sexually molested.13/

Throughout their developmental years, both fathers and mothers had experienced extreme physical and emotional deprivation, frequently complicated by abuse, placement away from home, or other serious problems. They had had little opportunity for development of even the most minimal and basic personality structure necessary to continued growth, learning, and future parenting. With two exceptions, the current level of ego functioning of the parents could only be described as grossly immature and childlike. They had not achieved the level of development necessary to mature thinking, anticipating, and planning. They were unable to cope with even the routine and ordinary demands of life. Anxiety over their feelings of helplessness was manifested in denial and in such "running away" activities as drinking, leaving home, or withdrawing from reality. Many sat aimlessly throughout the day, while their chaotic worlds swirled about them. They communicated with each other and their children through action, mostly inappropriate, rather than words.

These parents had some concern for their children, but they frequently did not have the energy either to be aware of or responsive to their children's needs. The parents' relationship with their children could best be described as "peer-like" and competitive. They

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13/ Bernard, J. and Densen-Gerber, J. "Incest As A Causative Factor in Antisocial Behavior: An Exploratory Study. Contemporary Drug Problems, IV:Fall, 322-340, 1975.

looked to their children for emotional support and for meeting their needs. In addition to neglect and inconsistency in their relationships with their children, some parents, because of poor impulse control, were cruel and abusive when frustrated, angry, or drunk.

In seven families, the father was a chronic and acute alcoholic. In eight families, both the father and mother were alcoholics.[14] The fathers in two families had definitely established delinquency patterns and made their livings illegally. In four other families, there was occasional evidence of delinquent behavior; two of these fathers had had previous periods of incarceration. However, with the other two, the delinquency was more a consequence of other problems, such as lack of impulse control and excessive drinking rather than an established delinquency pattern.

The most surprising finding was the high incidence of severe mental illness in this relatively small population.[15] The mothers in six families were psychotic; four of them had had previous psychiatric hospitalizations (and periods of rehospitalization while participating in the project). Their functioning ranged from minimal capacity in periods of remission to more active psychoses. A seventh mother was mentally retarded and had been reared in a State institution for the retarded. Her retardation was complicated by problems of impulse control and violent behavior toward her children and others.[16]

The Children

The majority of the families, 20 of the 35, had preschool age children as well as children in early and late latency; 11 also had older children (late adolescents or married). In the remaining 15 families, the children were of preschool age or in early latency at the

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14/ Fox, R. THE EFFECT OF ALCOHOLISM ON CHILDREN. New York: National Commission on Alcoholism, 1972.

15/ Pavenstedt, E. "An Intervention Program for Infants from High Risk Homes." American Journal of Public Health, 63:393-395, 1973.

16/ Henshel, A.M. THE FORGOTTEN ONES. Austin: University of Texas Press, 1972.
--- Pavenstedt, op. cit.

time of initial contact. As the children were all to be extensively involved in the Center's programs, the age range provided an excellent, although somewhat sad, opportunity to observe the progressive nature of the developmental and behavioral problems resulting from massive deprivation. While it was anticipated that the children would be developmentally handicapped with resulting behavioral or learning problems, the degree and consistency of their difficulties were much greater than we ever envisioned.

The married children in these families had made very poor adjustments. Several were unemployed and already repeating the patterns of their parents. Of the older adolescents, several were in and out of the home, engaged in delinquent activities. One son was in a correctional institution. Only four of the older adolescents were in the home on any consistent basis, and they neither worked nor attended school.

The older latency children, ages 11 through 14, presented the most serious developmental and behavioral problems. Their intellectual development was retarded, ranging from several years below grade level to the inability to read and write. Truancy was a common problem and many did not attend school at all. Most were engaged in delinquent activities, such as stealing, prostitution, and gang fights. They came and went as they pleased and were frequently away from home for extended periods.

As was to be expected, when this group became involved in the Center's groups and activities, they were extremely impulsive and hyperactive. They had great difficulty with peer relationships and participation in group activities. They very much desired adult attention but simultaneously proclaimed their own power and lack of need for others. It became increasingly clear that their displays of omnipotence masked their tremendous anxieties and fears.

The older latency group initially responded to the necessary limits and expectations of the program with outbursts of rage and destructive behavior. Ten of the boys in this group presented such a serious combination of learning and behavioral problems that an educational therapy program had to be established at the Center at the end of the first year. These boys had not and would not attend school; further, they had such serious learning problems that they were unable to meet minimal school expectations. Our all-day program gave us the opportunity to provide these children with the kinds of controls, the developmental experiences, and the educational program necessary to any serious attempt at intervention.

The younger latency children, ages 6 through 10, showed similar traits. However, their defenses and delinquency patterns were less well established, making it easier to involve them in Center activities. They were hyperactive and had difficulty with peer relationships. Their frustration tolerance was low and their self-esteem poor, and this limited their ability to sustain or complete tasks. They required a great deal of adult attention in groups and exhibited behavioral and learning problems. In some instances, they would refuse to go to school as a type of identification with their older siblings. Their most pervasive and prominent characteristic was immaturity.

The preschool children tended to be several years behind in most developmental norms. Some, at 3 or 4 years of age, were unable to speak or communicate. All were generally unable to relate to their peers or to adults. Instead, they were fearful and had little capacity for play or pleasure. Distance perception was poor. Some were quite withdrawn and showed certain autistic features (such as rocking) and an inability to respond to children, adults, or environmental stimuli. Other children were quite aggressive and self-sufficient in certain areas, yet unable to cope with ordinary experiences appropriate to their ages.

The older members of this preschool group tended to be preoccupied with various types of frightening fantasies filled with demons, witches, and monsters. They showed great anxiety about sleeping and were usually unable to take naps for the first months after entering the program. The greater number of preschool children were physically neglected and needed a great deal of "mothering," such as bathing, dressing, feeding, and care during illnesses. For all of these reasons, these children needed much individual attention and frequently could only be involved gradually in activities with other children. In spite of these initial handicaps, however, of all the age groups, the preschool children made the most consistent and visible progress in the shortest amount of time.

There is no universally accepted, simple definition of child neglect. Even the experts disagree over the controversial issue. And although many attempts have been made to produce a legal definition, the lack of consensus illustrates the complexity of the problem. There is agreement, however, that neglect occurs in a variety of physical and emotional dimensions and that bad environment and differing sociocultural norms are factors to be considered in any discussion of the subject. And all combine to compound the problem of defining the term. (Dr. Norman A. Polansky, see Acknowledgments, addresses this issue in the chapter on "Definition of Neglect" /In/ PROFILE OF NEGLECT: A Survey of the State of Knowledge of Child Neglect, U.S. Department of Health, Education, and Welfare, Public Services Administration, 1976.)

Inadequate income, unemployment, overcrowded schools, poor housing, discrimination, and the unavailability of community supports to family life are all too evident in poverty areas throughout the country.17/ The question can well be raised as to whether changes in these conditions would alter or correct the neglecting situation. When child rearing practices are in question, the issue of sociocultural standards and value judgments also makes the determination of neglect more controversial.

For the purpose of the Bowen Center Project, the Juvenile Protective Association defined neglect as a parental-home situation in which "deficiencies in the quantitative and qualitative aspects of the physical and emotional care of the child (would) exist to a degree that interfered with his safety and development." The neglect would be in such critical areas as feeding, medical care, protection, discipline, school attendance, and lack of adequate adult emotional nurture. Such neglect would be both pervasive and chronic.

17/ Lewis, H. "Parental and Community Neglect: Twin Responsibilities of Protective Services." Children, 16:3, 114-118, 1969.

--- Lowe, C.U. and Alexander, C.F. "Health Care for Children." /In/ CHILDREN AND DECENT PEOPLE. A.L. Schorr, Ed. New York: Basic Books, 1974. (pp. 143-161)

Both public and voluntary protective services agencies respond to the more self-evident, objective manifestations of child neglect. These are circumstances in which care and treatment in the home are clearly below the most minimally acceptable standards necessary for a child's protection and development. The neglect is usually multidimensional in that it is present to a serious degree in several areas.18/ Whether the neglect results primarily from a grossly deficient environment or from a combination of environmental deficits plus parental dysfunction, interventive services are necessary if the child is to have the opportunity for normal growth.19/

PROJECT OBJECTIVES

Serious child neglect is but one symptom of serious family malfunctioning. Thus, treatment offered neglectful parents should relate to the specifics of each situation. It should start with environmental improvements to stabilize the individual's capacity for parental functioning, and go on to sociological and psychological measures which will help parents and children as well.

When we designed the Bowen Center Project, therefore, our basic objective was to deliver crucial services to effect gradual improvement in family functioning. Experience with such families as those chosen for the project had shown that, after years of marginal functioning, it was impossible to make them over in a brief period of time. Indeed, some adults could not be helped at all. We hoped to see in the project, however, some maturation of the adults (especially greater capacity to direct their own lives and those of their children), and of course we were concerned with providing increased opportunity for the physical, emotional, and intellectual development of the children.

18/ Polansky, Borgman, DeSaix, op. cit.

19/ Meier, E.B. "Child Neglect." /In/ SOCIAL WORK AND SOCIAL PROBLEMS. N.E. Cohen, Ed. New York: National Association of Social Workers, 1964. (pp. 153-199)

To achieve these results, we proposed:

1. To develop and deliver a range of interventive services to parents and their children.
2. To help the parents achieve a level of stabilization and parental functioning which would permit their children to remain at home.
3. To enable the children to develop, in spite of continuing parental deficits, through the provision of supplemental parental services and corrective experiences.
4. To help parents and children with severe emotional and social problems by developing remedial measures which might be adapted for use in other settings and programs.

In the process of working through these objectives, we hoped to gain an increased understanding of factors which contribute to the achievement of adequate ego functioning as well as those which limit such realization. This insight seemed a prerequisite to the successful design and delivery of future interventive and preventive services.

Our objectives, however, raised some important questions:

1. Would it be possible to deliver the qualitative and quantitative services needed by family members? Could the parents be sufficiently involved to utilize the services, and would they permit their children to participate in the programs?
2. How could treatment methods best be adapted to effectively engage family members who were fearful and distrustful of relationships, unaccustomed to verbalization, unaware of their feelings, and often limited in their ability to think or plan ahead?

3. In those families in which the parents were unable to make necessary changes, could placement of the children be averted through sufficient staff services? Could the children continue to grow at home through the provision of supplemental parental services, educational experiences, and treatment?

4. Where the children continued to be in serious jeopardy, what were the most effective and least traumatic ways for both parents and children of effecting placement?

The project itself, we believed, afforded the best means to answer these questions and to demonstrate the practical results of services applied to carry out our major objectives.

GUIDING PRINCIPLES

Several principles guided the design and implementation of the Center's program:

1. The delivery of a range of integrated services.
2. Focus upon the total family.
3. Utilization of the ego psychology knowledge base.
4. Full commitment to innovation in the development of treatment strategies and adaptation in their use.

1. Unified Delivery

A range of critical services is necessary but insufficient, if supplied one by one, to respond to the multiple needs of seriously dysfunctional families. The better solution would be a unified system of delivery that permits the provision of services under the auspices of a single administrative structure and which is integrated within a single program.

We assumed that the integration of a range of services within a unified program would result in a more extensive and optimal service delivery system. Further, we believed that a common staff orientation, derived from a single program offering a range of services, would serve to focus on the total family and would encourage flexibility in meeting the individual and collective needs of family members.

Similarly, we envisioned a degree of flexibility in the roles of professional, paraprofessional, and volunteer staff that would permit anyone available to respond consistently and competently to clients' needs.

In brief, the range of services and the method of delivery were designed to afford adaptation to the changing circumstances of the families rather than on the expectation that the families would accommodate their problems to existing programs, services, and staff.

2. Focus on Total Family

The idea of an integrated service program for the total family was an effort to remedy the shortcomings of fragmented service delivery. Indeed, the structure of the Bowen Center Program would be determined by individual and collective family needs. We proposed to make every effort to adapt and create services responsive to the needs presented by both parents and children.

Focus on the total family meant that no member would be excluded from available project services because of obstreperous behavior or severe limitations. On the contrary, we were determined not to put pressure on any family members and to accept almost anything they did, thus giving them no excuse to reject or withdraw from the program.

By concentrating on the whole family, we believed we could avoid favoring the children at the expense of the parents and vice versa. It seemed logical that if we could help parents to achieve a degree of emotional maturity, we could then encourage them to take more interest in and be more responsible for the well-being of their children. This concept, we felt, would stimulate staff to develop imagination and a spirit of experimentation in the development of new treatment methods.

3. Ego Psychology

We were guided by the ego psychology knowledge base in providing opportunities for family members to develop their capacities for growth. This psychological framework enhanced our understanding of the effects of severe emotional and social deprivation in such critical areas as identity formation, object relationships, adaptive coping structures, and anxiety levels.

Knowledge of the developmental deficits underlying the dysfunctional behavior of parents provides direction in the creation of treatment strategies designed to support individuation, self-esteem, self-direction, sublimation, and the capacity to sustain relationships. These achievements are vital to the development of individual stability and improved parental functioning. Use of the ego psychology framework would also facilitate realistic expectations of staff and the sustained attitudes of patience and acceptance necessary for work with families whose progress is slow, limited, and fraught with crises.

Use of ego psychology, however, would not exclude close attention to the negative social factors which contribute to family suffering, especially the damaging effects of intolerable social conditions upon the development of ego capacity and self-realization.

4. Innovation and Experimentation

Obviously the success of the project would require our staff to be fully committed to experimentation, to use of creative ways of achieving particular ends, to using their own knowledge and skills in new ways, and to adapting and modifying traditional strategies to a different setting and delivery scheme. Without such commitment, the project could be no more than a futile effort to seek new treatment modalities. It would not attain its primary objective: a unified, totally family-oriented delivery system.

OPERATIONAL PLAN

The foregoing principles led to the conviction that our program structure must be fluid, developmental, and geared to what the parents and children needed and could use.

Obviously, casework and family counseling were needed for older children as well as for parents; so were homemaker services and temporary shelter. We would need to offer tutoring, if not a full educational program, and to provide for foster care, emergency financial assistance, and assistance in obtaining health services.

To do the job properly, we needed a single building or a complex of contiguous buildings that could house an umbrella agency, regardless of the kinds of services it provided. Moreover, the job called for a complement of professional and paraprofessional personnel, varied in their skills, and a corps of volunteers. Volunteers could help stretch the project's dollars by assisting in a myriad of client relationships; they would serve through dedication and for the sake of an enriching human experience rather than for money or career development.

Because of the developmental nature of the service, we thought we should have an advisory body to give guidance and to serve as a sounding board and review group for our plans and proposals.

A PLACE TO WORK

After determining our target population, we had to find a place where we could set up shop. Because the two neighborhoods in which our target group lived were not adjoining, we sought a location that would be relatively accessible to each.

After a considerable search, we found an excellent site which gave us enough space to operate a multiple service program. It was relatively accessible to our two districts but, even so, some busing of parents and children would be necessary.

The buildings consisted of a vacated church and a connecting three-storey parsonage. The church building had several large community rooms, a kitchen, and a basement which, when creatively and extensively remodeled, provided room for a day care center, a recreational area, and offices.

The third storey of the parsonage was converted into an emergency shelter; the second, into an apartment for a staff foster mother; and the first floor, into offices, small group rooms, and a napping area for young children. Ultimately, every inch of space was utilized: the coal bin became a quiet room; the roof, a playground; and the basement, a school.

Although the remodeling of the facility took considerable time, it was possible for the staff to occupy the premises within a few months, working around and under the ladders and scaffolding. The place was ideal for what we wanted to do.

SELECTING STAFF

The Bowen Center Project was relatively small, and it had time limits. The few staff who could be hired would need to be prepared to function, from the beginning of the project, within our conceptual framework.

The social workers and teachers had to have unique competence in their own specialties, as well as offer leadership throughout the project. The other staff -- child care workers, homemakers, foster parents, clerical staff, and community volunteers -- similarly had to be well functioning in their particular assignments. All staff members would need to be committed to working with neglecting families -- with full knowledge that the demands of their work would be great and their rewards, limited and slow to come by.

Because this was an innovative action project, all staff would need to be flexible, creative, willing to try the untried, and to modify what was old and traditional. Especially important would be the need to be adaptable, ready at any point to do what had to be done without regard to the regular job assignment. All would need to accept working in a setting where the emphasis would be on versatile functioning rather than on rigid role definition.

These were our considerations in hiring the staff.

Eleven months after taking possession of the site, the full complement of staff was on hand. In addition to the Project Director, it included three caseworkers, a group worker, a day care supervisor, a nursery school teacher, two child care workers, a foster mother, two homemakers, and a research director. The support staff included a janitor-driver, a cook, and secretarial staff.

The Project Director was responsible for the overall administration and supervision of programs, services, and staff. Regular consultation was also available in the areas of program, treatment, and research, while other specialists were called in as needed.

Almost miraculously, but with continuing orientation, the staff did work as a team and began to function as had been hoped. They had endless energy; they were able and willing to cope with crisis after crisis, night and day. They needed no prodding. They just did what had to be done.

The (resident) foster mother, for instance, in addition to foster parenting, participated in homemaking services, in various aspects of the day care program, and in the mothers' group sessions. The caseworkers undertook homemaking tasks in their visits to the families, helped in family outings, and supervised at camp. And it was not unusual for the Director (and friends) to dash at midnight to the psychiatric ward of a hospital to hold the hand of a mother or a child during a critical psychiatric episode.

In the second year, as services became fully operative and the caseload began to increase beyond the reach of the current staff, a manna-like gift came from the Federal Government. An application to VISTA was accepted and six VISTA volunteers joined the staff. (After serving with us, some became so interested that they reenlisted to continue in the Center's program for another 2 years!)

The VISTA volunteers were bright young people eager to make a contribution. With varied backgrounds, they came from all parts of the country to be a part of "social change," to be of service wherever they were needed. Undaunted, they could and would cope with whatever confronted them. Every morning, they went to get the Johnnies or Marys out of bed -- to dress them, feed them, and get them to school, knowing full well that the parents could not do these things themselves. The parents came to trust them and leaned on them. They became the instruments of real change, not only for the children but for the parents as well. They became advocates, big brothers or sisters, recreation leaders, traveling companions, counselors. They added the constancy in a service program that otherwise would not have been provided.

Obviously, the VISTA workers gave way beyond the call of duty. In their own words, however, they said that they gained immeasurably from their experiences at the Center, while having an opportunity to do "their thing" in a world of change.

Tutorial staff had to be introduced as the need for educational therapy became increasingly obvious. The children of our families had either failed in school, had never attended, or attended so irregularly that going to school was a dismal and futile experience. Without stimulation at home or in the community, they were virtually "dropouts" before they ever enrolled. If they were to make any educational progress, it had to be offered outside the regular school system.

An educational therapy program was accordingly conceived, and an accredited teacher and a child care worker were added to the staff. These two persons, with the help of the other staff and several community volunteers, helped develop an "on-campus" program. This served an educational purpose as well as a medium for therapy in individual and group relationships.

In staffing the project, a wide variety of persons -- by age, training, experience, and skill -- were utilized very effectively in multifunction teams. While the social workers and teachers were expected to contribute expertise and direction, the interfacing and joint planning of professional and paraprofessional staff enabled the latter to carry out tasks with a degree of competence that would otherwise not have been possible. The VISTA volunteers and other paraprofessionals provided individual and supportive services to children who could not have received such attention had we relied only on our professional resources.

CHAPTER II

GETTING STARTED

WHEN THERE IS NO cut and dried formula for operations and, in fact, the project itself is seen as a means of learning how to deal both flexibly and effectively with dysfunctional families, getting started poses quite a challenge. We had to strike out almost in the dark, so to speak, to try out various measures of providing a range of services in order to meet different needs. We had a plethora of ideas -- some might work, some might not.

It was important from the outset to anticipate how clients might overtly or covertly express needs and to try to choose modes of action that would be acceptable to the families <u>and</u> effective. This meant knowing the kinds of people we were going to work with and the general conditions and resources of the neighborhoods in which they lived.

From the start, the staff was actively involved, along with Administration, in the planning and execution of every aspect of the program. They shared in the making of major decisions, ranging from determining the use of Center space to developing intake procedures. For example, the group worker selected the necessary furniture and equipment. One caseworker interpreted the project to the surrounding community, while another made a thorough study of the cultural composition and incidence of neglect in various areas of the city.

Before the official opening of the Center, each staff member carried a protective services case and attended in-service training sessions to review existing knowledge regarding poorly functioning and neglecting parents. Both orientation approaches served to establish a base of common knowledge from which the staff of each service could operate. Finally, there were frequent staff meetings during this early period to facilitate continual program planning.

It was not all smooth sailing. Meetings were often fraught with argument, and resolutions evolved only after considerable debate. However, in the interactive process, staff were encouraged to express and test their ideas and to explore ways of working together.

Although considerable cohesion was achieved during the planning phase, it was by no means consolidated by the time the first clients arrived. The metamorphosis into a unified team, bound by a common purpose and perspective, was a developmental process that emerged -- through continuous interactive group participation and consultation -- only after months of actual operation.

THE FIRST FAMILY ARRIVES

The services of the project were formally begun on September 9, 1966. The first family referred was composed of a mother, a father, and their seven children. We welcomed them with open arms because we were eager to start to work.

During the planning phase, however, we had made a deliberate effort to avoid establishing premature, structured methods of operation. Program specifics had to be developed "on the spot," and they had to be related to the families' needs, as they were presented and as they were recognized by staff. Thus, in planning for the children of the first family, the nature and number of services were not preconceived but, rather, were determined during the experience of working with the family. As the second family was being moved into our emergency shelter, we worked out procedures for using the shelter as we frantically made beds, bought food, and welcomed the mother and her four children.

It is exciting but understandably difficult to make decisions continually in the absence of prescribed methods of operation. But it is the price exacted for a commitment to innovation and experimentation.

A few times, staff became so anxious in the face of family crises that they demanded a procedure for further action before they could go on. Also, experienced staff members instinctively turned back to old and familiar solutions in the face of new problems. It took considerable conviction on the part of the Project Director to maintain a position against rigid structures, pat answers, and quick solutions, and to hold out for determining a course of action totally predicated upon family need rather than on tradition.

Commitment to flexibility and innovation was the keynote in attaining our goals. To preserve that commitment required administrative understanding and encouragement in the face of sometimes monumental difficulties and disappointments encountered by the staff.

THE FIRST YEAR

Shortly after its opening, the Center was alive with children, parents, staff, students, and visitors. By the end of 6 months, 106 persons were receiving intensive services. At the very least, these included weekly contacts with the parents, attendance at the day care center for the preschoolers, weekly participation in group programs for the latency age youngsters, and individual contacts with a number of the children by various staff members.

Regardless of the lack of client motivation, the staff grew determined to assume responsibility for designing and delivering services needed by family members. And as family availability was necessary if the members were to derive the benefits from the various programs, providing transportation became a vital but demanding part of the services.

Each morning, sufficient staff members set out to help parents if necessary, and to awaken and dress their children before busing them to the Center for the day care program. As only outright parental refusal to allow children to board the bus deterred the day care staff from bringing them to the Center, the children experienced -- perhaps for the first time in their lives -- a degree of predictability and continuity in their daily activities and relationships with peers and adults. Mothers were also encouraged to come in on the bus with their children for Center appointments and activities.

The transportation arrangement permitted supplemental observations and communication between parents and staff beyond that afforded through contact with the social workers.

As our staff became increasingly skillful in adapting services to meet the needs of family members, such traditional procedures as requiring sick children to remain at home were abandoned. Instead, in the absence of parental competence, the child was brought to the Center as usual where he/she received the medical, physical, and emotional care appropriate for his/her illness. Those children who appeared too seriously disturbed to participate in small group activities were scheduled to spend individual time with the foster mother in the security of her Center apartment rather than to be excluded from any service.

The first year of life at the Center can best be described as surviving from crisis to crisis. Some crises were engendered by the flexibility of the program, but most were induced by the clients themselves. Although it was difficult at times to maintain a focus during the constant whirl of activity, the staff gradually became more comfortable with the repetitive crises evoked by client acts of omission or commission; they became accustomed to the instant reshuffling that was required in order to provide competent and consistent services. As we learned to understand and anticipate the repeated eruptions, predictions and appropriate responses became routine in the Center's activities.

By the end of the first year, the frenzied activity and constant decisions of the planning phases subsided, and a period of relative stabilization gradually emerged. The project by this time had achieved a direction in terms of flexibility and adaptability to client need. There was no longer a question of whether or not a service would be given but, rather, in what manner it could best be designed and implemented. This degree of program maturity was in no small measure fostered by the families who allowed the staff the time to understand their needs and to observe their growth in response to tentative, interventive measures.

THE ENSUING YEARS

During the ensuing years, utilization of the Center expanded in ways not dreamed possible at its inception. From weekly group meetings for the mothers came family outings, holiday celebrations, parent dinners, and therapeutic groups devoted to recreation and education. As the activities increased, the mothers came more frequently, sometimes daily, enjoying their lounge and assuming a proprietary attitude toward the Center as they helped in its operation.

As the parents moved through phases in their ability to utilize and benefit from the therapeutic environment of the Center, the flexibility of staff increased, and this, in turn, enhanced the potential effectiveness of a variety of integrated services offered in a single setting.

It became evident that the Center afforded a transitional community in which families who previously had been so alienated from the world around them could learn how to participate in that world. As they became part of the "Bowen family," most were able to extend their relationships to others beyond the Center, as though the Center provided them a lifeline to the community at large. The evolution was slow, even obscure at times, for development does not proceed in a straight, uninterrupted line but in little steps -- forward, backward, and forward again.

Throughout the life span of the project, the administrative, consultative, and supervisory staff had to be constantly alert in order to keep all services working in unison and to avoid the tendency toward separatism and (very human) power struggles. Each service at times viewed its contribution as the most important, vying for space and personnel. Nonetheless, with administrative direction and consultative perspective, the staff developed a good-humored attitude when speaking of "my program" or "my kids," so that it was possible to maintain an integrated staff which delivered a range of services to the total family.

The flexible structure of the Center -- in which staff were involved in all service programs in addition to their own areas of specialization -- helped enormously to counteract overidentification with either the children or the parents.

The day care staff had constant and extensive contact with the parents in the course of busing the children or when participating in evening activities reserved for parents. The social workers were relieved to see the care of children supplemented at the Center, so they did not prematurely push for parental competence and consequently suffer disappointment. The participation of all staff in planning our integrated program was also very beneficial in developing sensitivity to the needs of both parents and children without neglect to either.

During the course of the project, acceptance of all family members for service occasionally precipitated a staff crisis. It was difficult (but possible) to adhere to the no-decline policy when one 9-year-old boy in the educational therapy program injured other children or even staff members. The boy's sister had been so intimidated by his behavior that she required individual care by the foster mother for 2 years before being able to join the small groups in day care.

While it was recognized that we might not be able to work with some persons because of their severe pathology, we tested every possible avenue of approach before exclusion was considered. This continued determination to provide service to all family members created a motivating force for staff innovation and adaptation. In fact, as the program continued, the staff not only became increasingly able to survive the clients' difficult behaviors but quite adept in finding ways to meet the latent needs underlying their manifest expressions.

The nature of the families selected for service, as well as the operation conceived to serve their needs, placed an enormous demand on the staff. Yet, in spite of the hard work, low pay, and lack of dramatic movement in these seriously disorganized families, the staff turnover was minimal.[20] The social workers and day care director remained through the life of the project and embarked on its second phase. Some of the VISTA volunteers reenlisted, and students frequently became staff members. For the most part, new personnel readily contributed their ideas and energy as they, too, were asked to participate in the ongoing program planning. Stability of staffing meant that the underlying conceptual framework of the Center was not repeatedly and fundamentally challenged but, rather, permitted to flourish and mature in the light of continued staff investment, regardless of temporary crises.[21]

A CLIMATE FOR STAFF SATISFACTION

In view of the fact that both public and private programs devoted to abused and neglected children and their troubled parents frequently suffer considerable turnover as the staff become discouraged, it may be valuable to discuss those factors which appear, in retrospect, to have helped us avoid this dilemma.

The participation of the professional and paraprofessional staff in the planning and decisionmaking processes was critical to maintaining staff integration and enthusiasm. It engendered an extremely beneficial degree of mutuality founded on shared appraisal and responsibility. Emphasis on innovation also included a serious commitment to allow staff the freedom to develop and test out their ideas regarding treatment approaches. In this atmosphere, it was still possible for the Project Director to maintain responsibility for the direction of the Center in a manner that was consonant with the principles derived from experience. Understanding the difficulties encountered by

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[20] Kadushin, A. CHILD WELFARE SERVICES (2nd Ed.) New York: Macmillan, 1974. 753 pp.

[21] Polansky, Hally, and Polansky, op. cit.

the staff and the ability to give them support for their efforts required conviction, tolerance for anxiety, and a considerable measure of humor.

In addition to administrative support, the experimental nature of the project provided a built-in opportunity for the growth and development of both paraprofessional and professional personnel. From the beginning, the paraprofessionals and students were viewed as members of the teams and grew to identify with the leaders. They were given active assignments, learning through their participation as well as by observation and supervision, and these were supplemented by attendance at staff meetings and planning sessions.

Finally, the availability of consultation contributed a degree of encouragement for the entire staff as it added a dimension of perspective in the face of persistent and difficult symptoms. It is easy to lose sight of gains or fail to recognize discouraging behavior often indicative of growth in the course of day-to-day routine. Through increased understanding derived from consultation, the staff became very attuned and appreciative of the small changes in the dreary lives of the parents and children. Dramatic successes were not anticipated; nor, if they occurred, did they constitute the major source of gratification. The staff achieved its sense of excitement and security from knowing they were providing sources of opportunity and enjoyment for the Bowen Center families.

The staff, living as close as they did to the pleasures and pains of the families, had the good fortune to know the children and their parents in a way not possible in traditional protective service agencies. This intimacy, combined with the constant quest for greater understanding of the deleterious etiological factors involved in child neglect and the consistent efforts to create treatment strategies to actualize potential for growth, contributed enormously to staff competence in working with such poorly functioning families.

CHAPTER III

FAMILIES AT INTAKE

THIS CHAPTER WILL ILLUSTRATE some of the ways in which the characteristics of neglecting families were manifest in specific families at intake.

Following the initial period of contact, usually comprised of three interviews, a staffing was held on each family to do an evaluation and to plan treatment. As part of the assessment process, each family was rated according to one of four levels of family functioning. Since poor family functioning and child neglect were the basic criteria for admission to the project, the levels represented a continuum in degree and pervasiveness of these criteria when all past functioning and current ego strengths and problems were considered.

In general, Level _A_ was to include families in which the areas of dysfunction and/or neglect were either mildly serious or not pervasive. In this group, we sought discernible areas of ego strengths and positive family functioning, either in the past or present.

The _B_ Level covered families in which there was some serious, current family dysfunction in child care. However, assignment to this group required evidence that other areas existed in which neglect was not present or that usable ego capacity existed on the part of one or the other parent.

Level _C_ was to include families in which current functioning was seriously impaired and pervasive. However, the families do not evidence such severe pathology, abuse, or neglect as to suggest that placement might be necessary at an early date.

The _D_ Level included those situations in which the current family dysfunction and child neglect were serious and pervasive. In addition, there was little evidence of capacity for parental change because of the presence of extreme pathology, such as mental illness, alcoholism, or serious retardation. The families assigned to this level could be subdivided into two groups:

1. Families in which pathology was so extreme and the children in such jeopardy that early placement might be necessary; or
2. Families in which the parents had such impaired functioning as to make change a very limited possibility; yet, for various reasons, it was thought that the children, usually older ones, might be helped while remaining in the home.

In effect, the emphasis was to be to work with the parents toward stabilization while the children were provided necessary services.

None of the 35 families was placed in Level A. Three were placed in Level B, 10 in C, and the remaining 22 fell in Level D. The category to which each family was assigned was neither part of the case record nor a determinant in selection of the treatment approach. Utilization of these categories was only for the purpose of project evaluation on the final assessment of change in family functioning.*

THREE FAMILIES AT DIFFERENT LEVELS OF FUNCTIONING

A "B" Family: Dysfunction in Child Care -- Potential Capacity

The R. Family.--This family was composed of Mr. and Mrs. R., ages 26 and 20, respectively, and their two children, 4-year-old Fernando and Maria, 4 months.**

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* Although none of the 35 families was classified as "A," this description was kept in the report because other agencies, seeking to experiment as we did, may find some families in their target population who fit these requirements.

** Children's names are fictitious.

They were referred to us by the Infant Welfare Clinic because the children needed medical care and the parents did not follow through on appointments. The clinic indicated that the children were poorly cared for and malnourished. Mr. R. was said to drink excessively and failed to contribute to the family's support.

The family lived in a filthy, vermin-ridden flat in a dilapidated, substandard building. The furnishings consisted of one bed, in which the parents and two children slept, and a few chairs. Mr. R. worked as a truck driver but gave no money to the family; sporadically, he bought small amounts of such foods as rice and beans. In the interim, Mrs. R. and the children subsisted on such small donations as she could beg from friends and relatives who were also impoverished. They were frequently hungry.

When we first made contact with the family, Mr. R. was living with another woman with whom he shared most of his time and money. His work record was poor because of his excessive drinking. Mrs. R. said her husband rejected her and also the children.

Fernando had speech and hearing problems as a result of a chronic ear infection. He had very little speech at 4 years and his behavior was extremely infantile.

Mrs. R. was a passive, fearful woman who was completely overwhelmed by her situation. She was unable even to exert minimal control in the care of her children, and Fernando in particular was demanding and aggressive both to her and the baby.

We saw Mr. R. only briefly during the initial contact as he did not speak English and evaded us.

The couple were married when Mr. R. was 20 and Mrs. R. 14. Mrs. R. stated her father had forced her to marry Mr. R., saying if she did not he would send her to a girls' correctional school. The families had known each other in Puerto Rico where they had lived in the same village. Several of Mr. R.'s brothers married Mrs. R.'s sisters. Mrs. R. described her brothers-in-law as being like her husband -- brutal men who hit their wives and failed to support them. Mrs. R. depicted her own marraige as being somewhat better in the beginning but becoming progressively worse. There was little communication between them.

Mrs. R. described her father as being very similar to Mr. R. Her memories of her own parents were of continual conflict and violent quarrels. They sent Mrs. R. to a married, older sister in Philadelphia when she was 9 because they wished to get rid of her; they said she had "witches under her bed." Her parents were advised by a fortune teller that sending her away would rid their house of the evil spirits which would also be unable to follow Mrs. R. to the States. The parents and other siblings moved to Philadelphia several years later.

Mrs. R.'s description of her life prior to marriage was one of poverty complicated by feelings of rejection and fear. When she occasionally sought refuge in thinking about leaving her husband and returning to her parents, she was immediately overwhelmed by the realization that she could not face life with her father and mother.

Mr. R.'s family, who lived in Chicago, was very similar in most respects to Mrs. R.'s family. The family members were very close, and the parents and married brothers and sisters always lived in the same or adjacent buildings. When they moved, they moved as a group. Mr. and Mrs. R. had moved 6 times in the 18 months preceding contact.

Despite the limitations in functioning apparent in both parents, the family was assigned to the B Level because of nonpervasive child neglect and evidence of usable ego capacity. Mrs. R., although depressed and immature, gave evidence of considerable intellectual capacity. In addition, she had affection for her children and was concerned about them. Considering her age at marriage and lack of opportunities for mature emotional functioning, she showed more integreation and basic potential than might have been anticipated.

This, then, was an example of one of the three "best functioning" families at the time of initial contact.

Two "C" Families:
Pervasive dysfunctioning; Placement not indicated

With few exceptions, the families at this level tended to be large, with histories or chronic dysfunction. There were 56 preadolescent children in the 10 C category families.

<u>The P. Family.</u>--Consisting of Mrs. P., age 25, and her four children, Jack 4, Gloria 6½, Ann 8, and Peter 10, this family was referred by Mrs. P.'s sister because of critical living conditions and extreme neglect of the children. Mrs. P. and the children were living with Mrs. P.'s common-law husband, Mr. A. (who was Jack's father) in one room in a run-down northside hotel. They were on the verge of eviction, having been evicted from a series of hotels in the past several years. The children were without food and clothing and did not attend school. The children received practically no care or supervision as both parents drank heavily. Neither was employed, and Mr. A., who had not worked in several years, was physically deteriorated.

The initial contact was at a point of crisis: the children were to be placed by the court which Mrs. P.'s sister had also called.

As an alternative to placement, the family was brought to our emergency shelter for study and interim planning. During the first week in the shelter, prior to the evaluation, Mrs. P. was extremely nervous and hyperactive. She left the children alone for long periods while she went back to see Mr. A. who had refused to join the family. She was greatly attached to him and devoted all her energy to this involvement. She had little concern or energy for the children. The children showed many signs of their lack of nurture and care. The two boys in particular were hyperactive and immature. Jack was cared for in the preschool day care program where he had much difficulty in relating to the other children as well as to the caretaker; he had violent spells of screaming and temper tantrums.

Mr. A. and Mrs. P. had lived together for the past 5 years. They had met when they were both members of a traveling band in which Mrs. P. was a vocalist and Mr. A. played an instrument. In the early part of their relationship, they had lived with Mrs. P.'s father who subsequently died. While there was little evidence of their ever having had a stable living situation, Mrs. P. described the last few years as growing progressively worse, as Mr. A. drank more and they had no regular income.

Mrs. P.'s marriage to the father of her three older children had ended in divorce. (Mrs. P. left Mr. P.) While her first marraige had had considerable conflict and many separations, Mrs. P. looked back on it as being "not so bad."

Mrs. P. was the older of two daughters. Her parents were divorced before she was of school age, and she had very little memory of the time in which they were together. Her mother was an alcoholic and her father, among other problems, was addicted to narcotics. While there was money in the father's family to provide the basic necessities of life, Mrs. P. and her sister lived in one temporary situation after another, including boarding schools and with a series of relatives. In late adolescence, they joined their father.

Mrs. P. remembered no happy or stable period during her early years; rather, she recalled being afraid, insecure, and unhappy. She "adored" her father but described him as unreliable and, at times, seductive in his relationship with her. She married very early to get away from the home situation.

Following her separation from her husband, Mrs. P. and the children lived with her father and sister. During the times that Mrs. P. was traveling with the band -- which was the greater part of this period -- the children were cared for by a series of caretakers. Mrs. P.'s relationship with her sister and her mother, who is still living, has been ambivalent and marked with conflict in recent years.

We were unable to learn much about Mr. A.'s background.

Mrs. P. was an impulsive, immature woman who showed limitations in her capacity for judgment and mature functioning. Although young and basically attractive, she was grossly overweight and unkempt in her appearance. She was inclined to be very dramatic and somewhat hysterical in her communication. Although she professed affection and need for the children, she seemed to run away from assuming responsibility for them. Since Mrs. P. herself had been drinking heavily with Mr. A., it was not known how well able she was to control this behavior in order to provide a stable environment for the children. Although it was recognized that placement for the children might become necessary, the initial effort was directed toward providing all possible support to Mrs. P. and the children to determine if she were able to move toward greater stability.

In spite of the pervasiveness of problems in social functioning, the family was assigned to the C rather than the

D grouping because of Mrs. P.'s positive response to the opportunity to obtain help for her children. In addition, she was intelligent and able to recognize the negative implications of her situation for the children.

The D. Family.--This family was one of the first families referred to the Center in 1967. This black family, who had come to Chicago from the South 6 years before referral, consisted of Mr. and Mrs. D., who were in their thirties, and their seven children: Wilma 16, Nadine 12, George 10, John 8, David 7, Mark 4, and Mary 2.

The family lived in an almost indescribably vermin-infested apartment in a dilapidated building scheduled for demolition. It was located in one of the most impoverished and crime-ridden areas in the city.

Mr. D. was a chronic alcoholic who became violent when drinking. He worked sporadically, and of the little money he earned still less was available for family needs. Mrs. D. worked in a factory from 3:00 to 11:00 p.m. Her meager income was all that was available to meet rent and food expenses.

The children were without clothing, food, and sufficient supervision. Wilma had a history of delinquency and at the time of initial contact had been sentenced to a correctional institution for a year. Nadine, who attended school irregularly, was in a class for the mentally handicapped. The school considered George and John dull; they were making little or no progress. David, who had just started school, also was not attending regularly. Nadine provided such care as she was able to the two preschool children who were neglected in almost every respect.

Mrs. D. seemed depressed, overwhelmed, and withdrawn. She found it impossible to care for the home and deal with the constant confusion and crisis caused by Mr. D.'s drinking. His behavior included frequent outbursts of rage, during which he was abusive to the children, and regressive states in which he urinated and defecated on the floor. The police or other men frequently brought him home in a drunken stupor -- after his money had been stolen. Mrs. D. had given up calling for police help as they refused to continue coming to the home.

The D. family had experienced poverty and conflict caused by Mr. D.'s drinking throughout their married years in the South. However, his drinking had increased and the problems had mounted since coming to Chicago. Both Mr. and Mrs. D. came from large, impoverished families in which they had suffered deprivations and lack of opportunities while growing up. Mrs. D., however, seemed to have a more stable relationship with her mother and siblings than did Mr. D.

The reality problems with which this mother was confronted were so extensive that it was the concensus of the staff that she would have to be helped with these before we could evaluate her. In spite of her poor functioning in some areas, real concern for her children was evident in her attempts to work and in other less concrete forms of behavior. Therefore, despite the pervasiveness of neglect and dysfunction, this family was assigned to the C rather than to the D category.

The Center's treatment approach to this family is described below, beginning p. 111.

Three "D" Families: Serious and pervasive dysfunction and neglect

In this category, family dysfunctioning and child neglect were not only serious and pervasive but further complicated by the presence of serious pathology in the parent, such as psychosis, retardation, or acute alcoholism.

The C. Family.--A judge of the family court referred the C. family -- consisting of Mr. and Mrs. C., both age 40, and their children, Dorothy 14, Paul 10, Earl 8, and Patricia 4½ -- because of complaints regarding the abuse of Paul. The family was receiving public assistance under the Aid to Families with Dependent Children (AFDC) program.

Mr. C., who had a serious arthritic condition and many other physical complaints, looked much older than his stated age. He had assumed responsibility for housekeeping tasks, including the cooking and care of the children. In addition to his physical problems, Mr. C. was paranoid and given to violent rages.

Mrs. C. had been hospitalized a number of times for schizophrenia which was in a state of temporary remission at the time of referral. She was unusually quiet, childlike, and completely uninvolved in the family situation. She spent most of the day sitting by the window watching the street. Her verbalization tended to be disconnected and irrational.

Dorothy, who was retarded and in a class for the educationally handicapped, attended school irregularly and spent most of her time with "friends." Paul and Earl were impulsive, acting-out boys who were involved in minor delinquencies. They did not attend school and spent most of their time in the streets, staying home as little as possible.

Patricia, at 4½, did not speak. She, too, was hyperactive and totally unable to relate either to adults or children. She showed little recognition of what went on about her and either engaged in autistic behavior, such as rocking and masturbation, or ran about in an aimless, distracted manner. The father had kept her tied up to prevent her running away, and there was evidence that she had been abused either by the parents or the older children. In view of the extreme deprivation and circumstances of her physical care, it was difficult to assess whether this child suffered organic impairment in addition to the emotional retardation.

It was difficult to obtain any information regarding the early years of the parents' marraige or the onset of Mrs. C.'s illness. Mr. C. maintained that she had always been this way. This white Appalachian family had come to Chicago about 7 years prior to contact. Little is known regarding their previous life experiences except that they had come from poor families and had had little educational opportunity. Mr. C. had been married before and had two older children with whom he had not maintained contact.

The K. Family.--Mr. and Mrs. K. were in their early thirties and had eight children ranging in age from 3 weeks to 10½ years. The family was referred by the Infant Welfare Society because of Mrs. K.'s apparent emotional illness and inability to care for the infant. The agency also had questions about the physical health care provided the three preschool children.

This family was found to be living in housing so indescribably bad that the children's lives were endangered. The dwelling was rat-infested and without heat and plumbing. Mr. K., although still working, was on the brink of losing his job because of frequent absences. He showed evidence of alcoholic deterioration and usually came home intoxicated. He provided very little money for basic necessities.

Mrs. K., who had had a number of previous hospitalizations, was delusional and unable to care for her children. She had withdrawn from touching the infant because she was afraid of killing her. Two children had died during infancy and Mrs. K. believed she had been responsible for the death of at least one. Her other persistent delusion concerned her being constantly followed by a man who wanted to harm her and the children. The children shared in these fears and were very frightened. They were all malnourished and in need of physical and health care. The school age children were without clothing and unable to attend school.

Although there was some indication that this family had had periods of better functioning during their married years, they had had serious problems from the onset. These had become progressively worse with the demands of a large family and Mrs. K.'s episodes of mental illness. Mr. K. had also had a period of hospitalization several years earlier at which time the diagnosis was schizophrenia complicated by alcoholism.

Both parents were from northern Illinois families. Mr. K.'s brothers and sisters were described as hard working, relatively stable people who initially had attempted to help the K. family but had given up. Mrs. K. had at least one sibling who was also mentally ill. Her mother was an ineffectual woman who seemed overwhelmed by the demands of life and resisted becoming involved with the K.'s. However, Mrs. K.'s family evidenced more marginal functioning than did Mr. K.'s.

The treatment approach to this family is described below, beginning p. 121.

The L. Family.--This family -- composed of Mrs. L. age 36, Jane 16, Donald 13½, and Mark 5½ -- was referred simultaneously by several agencies because of Mrs. L.'s violent behavior, her inability to function, and the problems presented by the children.

Mrs. L. was a mentally retarded, emotionally disturbed woman who functioned in the "borderline psychotic" range. Not only was she unable to provide care and direction for her children, to whom she related as a peer, but was also unable to assume any of the ordinary adult responsibilities such as management of money, shopping, cooking, and housekeeping. Because of poor impulse control, she frequently became violent and aggressive when angry. She was unable to manage her AFDC allowance, and she was well known to programs in the community from which she sought food and money.

Jane, who had dropped out of school the previous year, was engaged in prostitution and other delinquent activities. She lived with various men but was in and out of the home frequently. On these occasions, she quarreled violently with her mother and took whatever money she had.

Donald did not attend school and was involved in prostitution and stealing. During the period of our initial contact, he was sent to a special school on a truancy petition. When he was brought into the Center program upon his release from the school, he was found to be impulsive, hyperactive, and extremely aggressive in relationship with peers. He stole money from the staff and encouraged the other children in acting-out behavior. In spite of apparently adequate intelligence, he was unable to read or write and generally was unable to engage in educational activities.

Mark, who had been born out of wedlock, was so impulse-ridden and retarded in his general functioning that there was real question as to whether he was psychotic. He could not relate to peers or adults and needed the constant control and attention of an adult.

Mrs. L. was reared in a State institution for the mentally retarded and married shortly after her release at age 16 or 17. Not much could be learned about her early family life. She had one sister with whom she maintained minimal contact. She described Mr. L. as being an unfaithful man who had failed to support her. He had left the family after a violent physical quarrel when Donald was an infant, and Mrs. L. never saw or heard of him again. Mark's father was a transient acquaintance who, according to Mrs. L., got her drunk and then impregnated her. She had a great deal of shame about this incident, particularly because Jane and Donald were aware of the circumstances and frequently taunted her about it.

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While each of the 35 families presented individual characteristics, problems, and potentials, the foregoing examples illustrate the degree of impairment in functioning which characterized families at each of the four levels at the time of our first contact with them. As noted above, a later chapter will give examples of our treatment approach to typical clients.

CHAPTER IV

WORKING WITH CLIENTS

THE SERVICES PROVIDED through the Bowen Center Project evolved from application of our underlying principles to the changing needs of the client-families, and from our gradual acquisition of experience and knowledge about severely impaired family life. As we worked with families, we learned much about the process of personal and family growth and how to foster it.

In the design and implementation of services and treatment, we focussed our major effort on providing opportunities to achieve increased personal security and competence. For the children, the hope was to supply sufficient supplemental physical care and emotional nurture, as well as social and intellectual stimulation, to permit them to overcome their developmental deficits. For the parents, the objectives were to strenghten and maximize their innate potential to assume adult and parental responsibilities.

We were particularly concerned that our clients advance toward stabilization of the home situation and an enhanced self-concept. We hoped to open up avenues for sublimation of sustainment of each of their achievements, however small. Our methodology included casework with the parents, group work programs for both parents and children, preschool day care, an educational therapy program, temporary foster care, an emergency shelter, and homemaker service. Through the flexible use of staff, it was also possible to offer many supplemental services, such as making arrangements for medical care and for provision of emergency financial assistance.

"REACHING" THE PARENT

Contact with parents was initially established by a caseworker through home visits. Although other staff members eventually provided the necessary services, the social worker remained the constant and primary source of support. Having one person consistently in touch proved particularly

vital in helping parents whose life experiences had never afforded them the opportunity for an ongoing and stable relationship.[22]

Initially, the social worker worked with the family to provide tangible help to meet obvious gross needs. Beyond assuring that the children were maintained in the Center's program, the worker helped the parents to obtain food, clothing, shelter, and financial assistance, since meeting such needs of daily living was frequently far beyond what the parents could do for themselves.

In the course of such activities as doing the family laundry with their social workers at the Center, the mothers in particular grew more comfortable in the setting and came to know other staff who could then become involved with the family and provide additional services. Although the parents became the "Bowen Center family" in this process and enjoyed an expanded world of human relationships, the social worker remained for them the primary helping individual, consistently relating to their needs and feelings.

Advice and direction were given as needed. Every effort was also made to help the parents to talk, not on a deep interpretive level, but in relation to who they were, what they felt, and what they wanted. In this manner, the individualized work with the parents proceeded from helping them to survive the many crises of their lives, to encouraging the emergence of their identities and promoting their sense of self-worth.

In addition to individual counseling, marriage counseling was provided in the home for some couples where extreme marital discord and frequent separations were common. In some instances, it was possible to stabilize the marriages without further serious disruptions.

Couples whose lives were so barren of pleasure were encouraged to share the enjoyable experiences provided through the Center's activities. These ranged from family outing days, birthday parties, and holiday celebrations to bimonthly parents' nights. Parents enjoyed dinner and

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[22] Young, L., op. cit.
--- Bandler, L. "Family Functioning: A Psychosocial Perspective." /In/ THE DRIFTERS. E. Pavenstedt, Ed. Boston: Little, Brown, 1967. (pp. 225-254)

recreational activities, and their children were cared for by the day care staff.

Our group work program offered an additional dimension to the total treatment approach.[23] The groups were expanded and changed in accordance with the needs, interests, and abilities of the mothers. The first mothers' group provided recreational and educational experiences which might ameliorate the misery of their home situations and compensate for the lack of opportunity to develop their interests and talents in their past and present lives.[24] Later, a second concurrent group was established specifically to help the mothers develop and use their capacities for parenting. In both groups, we continually sought ways to provide opportunities for sublimation and to engender belief in their ability to to things.

When necessary, we offered use of the emergency shelter, homemaker service, and temporary foster care -- services which were themselves closely interrelated.

EMERGENCY SHELTER

The emergency shelter consisted of living and sleeping quarters as well as a kitchen equipped with cooking and laundry facilities. This "haven" provided immediate housing for those families faced with grossly inadequate living arrangements or none at all.

Frequently, families new to the Center program were living in such deplorable situations as to require the use of the shelter until suitable housing could be found. During this period, the family's proximity allowed the Center staff to gain a more immediate and complete understanding of the needs and problems impinging upon the parents and their children. It also permitted family

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23/ Ambrose, B. PATIENT REHABILITATION AND ENRICHMENT PROJECT. New York: School of Social Welfare, State Univ. At Albany, 1976. (Processed.)

24/ Gant, G., Yeakel, M., and Polansky, N.A. RETRIEVAL FROM LIMBO:: The Intermediary Group Treatment of Inaccessible Children. New York: Child Welfare League of America, 1967.

members to become engaged in the treatment programs very early in their contact with the Center. While the staff were helping the parents find an adequate apartment, the children participated in day care and group work programs. In this way, parents and children became immediately involved with the staff, retaining meaningful ties to the Center when they moved to their permanent residence.

The use and benefits of the shelter can be illustrated by the case of a disturbed mother who was evicted from a hotel with her four children because of excessive drinking. While housed in the shelter, the life situation of this family was stabilized and their involvement with the Center assured before the family was helped to move to a neighborhood apartment.

The shelter was also used for families who were neither new to the Center nor in need of substitute housing. Rather, they were in a state of such deterioration that they required intensive care and supervision of the total family to prevent further disorganization. The needed quality and constancy of service would not have been possible without the availability of the shelter; nor would the services of a homemaker been sufficient in the face of the chronic and pervasive problems encountered. In the shelter, however, the homemaker was able to add her skills to the other remedial and rehabilitative services provided.

On one occasion, the shelter housed a mother in a severe depression who could not be left alone, and a schizophrenic father unable to cope with his children and wife. In another instance, a mother and her children lived in the shelter during a period of separation from the father. The children experienced a degree of continuity through their participation in the Center's program while reconciliation was being effected between the parents.

The foster mother, whose apartment was on the floor below, provided overall supervision of the homemaking tasks in the shelter and helped the mothers with their chores when necessary. This flexible use of staff and the integration of the shelter into the total program demonstrate how service delivery can be maximized without requiring additional personnel. (Only two positions were authorized for the shelter services.)

HOMEMAKER SERVICE

Because the homemaking needs of the Center's families were far greater than could be met by the efforts of our two homemakers, the social workers, VISTA volunteers, and day care staff also helped with household chores at various times.

In one such instance, a psychotic mother with seven children required the assistance of several staff members. They went to her home early in the morning to prepare breakfast, to take the older children to school, and to bring the infant to the foster mother for care.

When the mother's illness required hospitalization, we made an all-out effort to keep the younger children at home with the father. We provided continued participation in the Center's program, as well as all housekeeping tasks -- cooking, shopping, cleaning, and laundry. Our attempts were great, but they proved insufficient; the father went downhill rapidly and could not cope.

Homemakers provided customary homemaker services, with the assistance of the mothers whenever possible. In addition, they cared for the children in their homes during times of family crisis or in the temporary absence of the parents, frequently bathing, feeding, and dressing the children.[25/] Because of previous experiences, it was possible for one homemaker to assume responsibility for negotiating a health care program and to keep track of clinic appointments for both parents and children. In this way, a crucial but supplemental service was again provided by utilizing to the maximum the talents of existing staff.

Although the recognized tasks were performed, Bowen Center homemakers frequently had to improvise beyond the traditional teaching model of a homemaker service. It was not so much a lack of knowledge that prevented the mothers from maintaining their homes as it was their inability to use capabilities which had stagnated under the stress of past and present social and emotional deprivation. Their needs dictated that the chores be

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[25/] Polansky, Borgman, and DeSaiz, op. cit.

carried out for them when they were unable to share the work. However, by encouragement and gradual involvement, we were often able to reawaken and sustain their ability to accomplish things for themselves. For example, as the mothers' groups cooked for parents' night, we were able, with the assistance of the foster mother, to discuss diets and menus.

FOSTER HOME SERVICE

The provision of temporary foster care was, in many ways, the most crucial service in the care and protection of the Center's neglected children. The foster home, located on the second floor of the parsonage, provided a permanent residence for the foster mother in addition to space adequate for the care of four children. This arrangement permitted the foster mother to provide substitute and supplemental parental care to children at risk during both the day and night.

Foster day care was provided young children whose extensive immaturity and disturbance made it impossible for them to cope with even the protected milieu of the day care program. Frequently, the children needed the opportunity to relate to a single nurturing adult; they needed the security derived from the intimacy of physical care before they could venture into small groups for even short periods. These children enjoyed the island of safety afforded by care in the apartment of the foster mother before being gradually introduced to the increased demands imposed by other children and divided attention inherent in day care. One such 4½-year-old little girl, who could not tolerate groups of any kind, was hyperactive and without speech or bladder and bowel control. She was cared for each day by the foster mother for a year. Then, she developed a beginning capacity for relationships and communications, and periods of small group care became feasible.

The foster mother also provided overnight foster care for those children whose parents were unavailable because of such emergencies as hospitalization or temporary desertion. Insofar as the foster mother was a familiar person to all the children and parents and was clearly identified with the Center, placement in her care was effected without the trauma and upset that usually accompany separation. Indeed, the parents felt relieved and the children privileged when they came to stay with the foster mother while they enjoyed the continuity of participation in other Center services. Their experiences in temporary foster care were very beneficial in easing their transition to permanent placement if this became necessary.

As we had not anticipated how frequently and extensively the services of the foster mother would be required, no plans unfortunately had been made for her relief. It was difficult but possible to compensate somewhat for this oversight only by enlisting the help of other staff members who took the children on evening excursions, weekend trips, and visits to their own homes.

DIRECT SERVICES TO CHILDREN

Some services were specifically designed for the preschool and latency-aged children to aid them in overcoming the deprivations of their earlier experiences and to encourage their progress along the developmental life-line. Efforts to help in their physical, emotional, social, and intellectual growth were embodied in services utilizing wide-ranging group and individual treatment modalities.

PRESCHOOL DAY CARE

The day care program was the basic service designed to meet the needs of the preschool children. It was staffed by a director and assistant who were trained in nursery school education, by preprofessional staff who were interested in caring for young children, and by our VISTA volunteers. The program was expanded and enhanced by other staff members, such as the foster mother and homemaker who provided special, supplemental parenting.

The preschool program focused on encouraging developmental and cognitive growth, while recognizing that meeting a child's earliest needs is a necessary prerequisite for learning.

As in other day care programs, days proceeded with active play, structured activities, educational projects, quiet periods, music, and games. The staff also attempted to offer these experiences to the children in a protective, consistent, yet flexible structure. However, the day care program differed from other endeavors in the degree of supplemental nurturing, physical care, and attention to early developmental tasks required by these children. This emphasis was dictated by the retarded ego development shown by the children's lack of self-individuation and identity, as well as by their gross deficits in age-level capacities for relationships with adults and peers, for spontaneous play, and for communicative speech.[26]

The children were picked up by staff each morning and brought to the Center. Often it was first necessary to find their clothes and to help them to dress. They were also taken home in midafternoon, except for some older children who were permitted to stay at the Center until closing because of the deterioriated condition of their families. (The additional hours with us would help them more than going home.)

In many instances, basic toilet training and regular eating routines were established in the day care program. Food and feeding were emphasized and naps scheduled but not enforced if the child was too insecure to sleep.

In addition to the never-ending demand for "Band Aids," these children enjoyed taking aspirin and cough medicine, and soaking an infection. This attention to their physical needs communicated the staff's acceptance of the children as valuable individuals as well as their willingness and ability to take care of them.

To help each child progress in self-delineation and self-esteem stretched the imagination of the staff. Every available opportunity was employed, such as bathing the children, helping them to feel attractive, and constantly

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[26] Mahler, M. ON HUMAN SYMBIOSIS AND THE VICISSITUDES OF INDIVIDUATION. New York: International Univ. Press, 1968.

emphasizing their individuality. One child, who had appeared autistic at intake, took her first step forward by announcing to all who would listen, "I'm Georgie Gal."

As all the children were fearful and distrustful, they needed a great deal of individual attention, but especially in the beginning of their contact with the day care staff. It became routine to have a staff member assigned to a new child as long as was necessary until the child could safely enter group activities.

Those children who required intensive and extensive parenting spent periods of time with the foster mother in her apartment. As some of the preschoolers were seriously withdrawn or impulsive, daily individual treatment sessions in the playroom with a social worker or experienced day care workers were provided. By means of staff conferences, the professional and paraprofessional staff developed the skills to help the child with learning problems through the reduction of anxieties and, most important, by enabling the child to expend energies in fun, exploration, and sublimation.

The varying emotional and cognitive needs presented by children ranging from under age 2 to over 6 necessitated several day care groups. This was possible because the hub of day care was a huge room, readily divided by partitions and surrounded by several small rooms.

A program was initiated for toddlers and their mothers as it became evident that these very young children needed great amounts of help and stimulation if they were to avoid the deficits of their older siblings. Once the gap narrowed, greater emphasis was placed upon preparing the youngsters for school through the use of educative and cognitive materials.

Children who were not emotionally and intellectually ready for kindergarten at the appointed year continued without interruption in our day care program; this gave them the extra time and the feeling of security they needed to master preparatory skills. Children who entered kindergarten on a half-day basis were brought back to the Center to still another day care group in order to help them in their transition to their ever-expanding world.

As the children enrolled in elementary school, our continued interest in their school accomplishments also gave them the support that their parents were often unable to provide. Every effort was made to involve the parents in the planning for and programs of their children; this included the staff accompanying the parents to school conferences. As a result of the day care efforts, these children had a more positive attitude toward academic achievement and performed more successfully than their older siblings. In spite of the tremendous investment required by the preschool day care programs, they were the most gratifying because the children made such visible and continuous progress.

GROUP PROGRAMS FOR SCHOOL AGE CHILDREN

The latency age children were all involved in small group programs creatively designed to meet the serious challenge these children presented. Their needs and inordinate immaturity were revealed by grossly impulsive behavior, learning difficulties, and poor peer relationships. As our limited staff made it impossible -- and perhaps it was not desirable -- to provide continuing individual treatment, a modified group program was developed. Such a program may be replicated in other settings.

A total of six to eight groups -- each composed of four or five children and two adult leaders -- were established to respond to the range of latency age needs. The staffing demands presented by this extensive group program were met by the three available professional social workers augmented by day care staff, VISTA volunteers, and other paraprofessional personnel. The integrative approach of the Center provided supervision and consultation through staff conferences and specific program supervision.

Maximum involvement of all available personnel made it possible for even these children to have considerable individual attention when necessary. Thus, a child might work on a project with one leader while the other group members participated in activities with a second staff member. These individual relationships often emerged spontaneously as a group leader developed a particular interest in a given child and as the child selected his or her special adult.

It was common for a staff member to spend an afternoon, evening, or weekend with one or two children who needed special care or experiences. In addition, with professional guidance, especially gifted paraprofessional staff regularly saw some children individually. These contacts provided substitute parental support and positive models for identification.

The use of staff in this group program illustrated the efficacy of developing and utilizing the talents of paraprofessional workers to permit expansion of service delivery.

The children participating in the small group program were picked up after school, brought to the Center, and taken home in the evening, 4 days a week. During school and summer holidays, the Center increased its activities to full-day programs, as neither the families nor the community were responsive to these children's needs.

During the first year, all activities were generally interspersed with looking for certain children throughout the Center and neighborhood since they handled their anxieties by flight. The contagion phenomenon, poor impulse control, and lack of ability to tolerate minimal frustration required that each child have a great deal of individual attention. This was possible because of the size of the groups and of the staff employed. Initially, in fact, the groups resembled individual children who happened to be in varying degrees of proximity. They quarreled with each other endlessly and were given to tantrums at the slightest provocation.

Although the activities planned eventally appeared similar to other group programs, they initially required great modification. In time, a range of projects, games, athletic events, movies, and outings were utilized, but the beginning efforts involved very simple, time-limited tasks designed to develop the children's impulse-control and sense of mastery. Only as their attention span, ability to tolerate demands, and capacity to cooperate increased were the more complex educational and recreational activities implemented.

Activities were also expanded to meet the advancing age-appropriate interests of the children, as (for example) when the older latency girls indicated their inclination to learn to cook and dance. At varying times, tutoring groups, staffed by volunteers with education backgrounds, were instituted for those children having difficulties in school.

As the children became able to venture forth from the sheltered environment of the Center, available community resources were used -- parks, swimming pools, camps, and museums. In contrast to early efforts to meet the children's needs through Center programs, later efforts were directed toward helping the children use such community resources as neighborhood centers and scout programs. Through the efforts of a former VISTA volunteer, it was even possible during the final year of the project for the older groups to attend a 2-week, out-of-State residential camp.

In addition to the ability of the latency age children to move more from the Center to community-based activities, all children served in the small group program made substantial progress in socialization, peer relationships, and in the development of interests which allowed them to derive greater satisfaction and benefit from the experiences available to them at school.

EDUCATIONAL THERAPY

The educational therapy program, which continued for 3 years, was designed as a full-day alternative school for 10 older latency age boys who were extraordinarily impulsive and unable to achieve in school if, indeed, they attended at all.

This program, the most original effort of the Center, affords the potential for a most significant contribution to theffield, insofar as it demonstrated the efficacy of an alternative model of care. At a time when sufficient residential teatment centers were unavailable and correctional institutions inappropriate to children presenting gross emotional, behavioral, and educational problems, it was gratifying to see the children progress in response to a full-day program of educational therapy.

The program was also our most difficult endeavor as the wildly aggressive and delinquent patterns of these boys exhaustively and continually tested the limits of the Center's resources and commitment.

The two basic and interrelated objectives of this program were:

1. to help these older children tolerate inevitable frustration and develop impulse control, peer relationships, and self-growth; and
2. to help them achieve basic academic skills which, for some, meant even learning to read and write.

These objectives necessitated an agreement with the Board of Education by which the children were excused from public schools yet were required to attend the Center's program.

This arrangement gave the staff the necessary leverage to insist, at all costs that the children regularly attend the program. Likee the children in small group programs, those in educational therapy frequently ran away, and much staff time was spent finding them and returning them to the Center. This effort, however fatiguing for the staff, ensured that the children were available; it also provided desperately needed structure and controls that helped decrease the children's anxieties. Our persistent insistence was mightily resisted. However, much later, these children were able to express that the staff's efforts communicated to them that they were really wanted at the Center.

General treatment approaches were also developed and implemented with ever increasing skill in response to the boys' violent outbursts, assaults, and flights. Their behavior reflected their intense desire for, but fear of, entering into a close relationship with an adult in that it necessitated the abandonment of their omnipotent self-direction. The staff learned to respond to the distressed child empathically while setting firm and consistent limits.

As the children were initially unable to think or speak about their feelings, the staff verbalized these feelings of frustration and unhappiness. Over a long period, most of these children grew able to express their anger and other feelings verbally with a subsequent reduction in their aggressive, violent behavior. The program approach utilized on-the-spot discussions in the "life-space" interview method.[27]

Discipline was a major problem which required many conferences. The boys already tended to view all adults as mean. Deprivation of privileges was initially very difficult as they had so few pleasures, and Center events were necessary to their educational program. It was necessary not only to limit the nature of the discipline but its duration as well; the child simply became more angry and upset if the punishment lasted too long. In order for him to understand and carry over the relationship between his behavior and the discipline, it had to be instituted immediately. In time, the boys were even able to suggest their own punishment and to understand its rationale.

The educational therapy program was under the direction of an experienced, creative teacher who was interested in developing learning approaches appropriate to older, educationally handicapped children. In addition, the staff consisted of several child care workers and VISTA volunteers. Other available personnel were called upon when the children's behavior became seriously disruptive.

Every effort was made to promote the children's growth and learning through the development of a therapeutic milieu. This required the use of structure and controls combined with a degree of flexibility to deal with the boys' overriding anxieties. The program included periods of study, recreation, and group activities, as well as a generous provision of food.

The overall resistance to learning necessitated relatively short periods devoted to academic endeavors. This was particularly true of the early years when projects and experimental materials were primarily used, as these children were unable to relate to traditional teaching techniques and text books. There were projects devoted to science, history, drama, art, and photography and live-in experiences derived from periodic camping trips.

Outings helped develop good relationships between the boys and the educational therapy staff. They also accelerated

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[27] Redl, F. and Wineman, D. CONTROLS FROM WITHIN. Glencoe, Ill.: The Free Press, 1952.

the children's adjustment as they planned for adventures, participated in camping duties, and became more cooperative with each other.

Gradually, it became possible to introduce longer periods of academic work and to promote reading and arithmetic skills through individual tutoring.

Many activities were planned to support the educational endeavors of the program and to promote the children's identity, self-worth, and participation. Birthday and holiday parties became traditional and shopping trips for clothes a favored event. As the boys entered adolescence, two weekly evening recreational programs were instituted in the hope of competing with street life. A work program was also initiated in which the boys were paid for successfully completed elected tasks. Although this initially required considerable staff perserverance to help the boys finish their jobs, they were given increasing responsibility to complete the jobs independently. They came to learn that if they did not work, they would not get paid on Fridays. (The Center's secretary served as "banker.")

The boys not only learned to count money, but some even saved their earnings to buy Christmas gifts for their parents. As with the other children, some of the boys in this program received periods of individual treatment, and frequently those whose home lives were especially barren were taken on camping trips or other excursions by favorite staff members.

All of the boys, with the exception of one seriously disturbed child, made substantial progress. It was revealed in increased impulse control, greater frustration tolerance, and improved peer and adult relationships. Delinquent behavior became virtually nonexistent. All of the children developed academic skills ranging from minimal ability to read and write to grade level achievement. The three oldest boys remained at the Center's school after its official termination until age 16, in an effort to keep them off the streets and to consolidate their gains. Of these, two were able to enter vocational programs and one to enter high school.

The most outstanding achievement of the educational therapy program was the provision of care and an experience in living for children who were otherwise destined to commitment to correctional institutions.

CHAPTER V

TEN SERVICES

THIS CHAPTER describes quantitatively the services provided to Bowen Center families.

Our mission was family reconstruction. Toward this goal, an average of 25 workers delivered 10 different services to our 35 families. The kinds and number of services varied according to the varying needs of the family members. The total cost for the 5-year program was about $1 million.

The formula for the success of any human service is: _input_ plus _treatment_ equals _results_. In the Bowen project, _input_ was comprised of hours of attention, the counseling, the teaching, the talking, and the busing -- along with the material goods provided. The process of _treatment_ included casework, group work, special education, etc. The _results_ desired were better family functioning and better health and personal development.

The input, treatment, and results of our project can be described. But it is almost impossible to provide any research evidence to support what happened. In the major human services -- mental health, corrections, child welfare, for example -- there are no accepted measurement techniques for any of the three factors involved; i.e., service programs, treatment process, or outcome.

Input is described in this chapter by means of the 10 services provided to Center families. Other sections of the report deal with the Center's daily operations. The treatment process, for example, is illustrated through use of case examples and detailed descriptions of working techniques. Project results can be seen in case examples also, evaluated by clinical judgment.

The basic 10 services provided were:

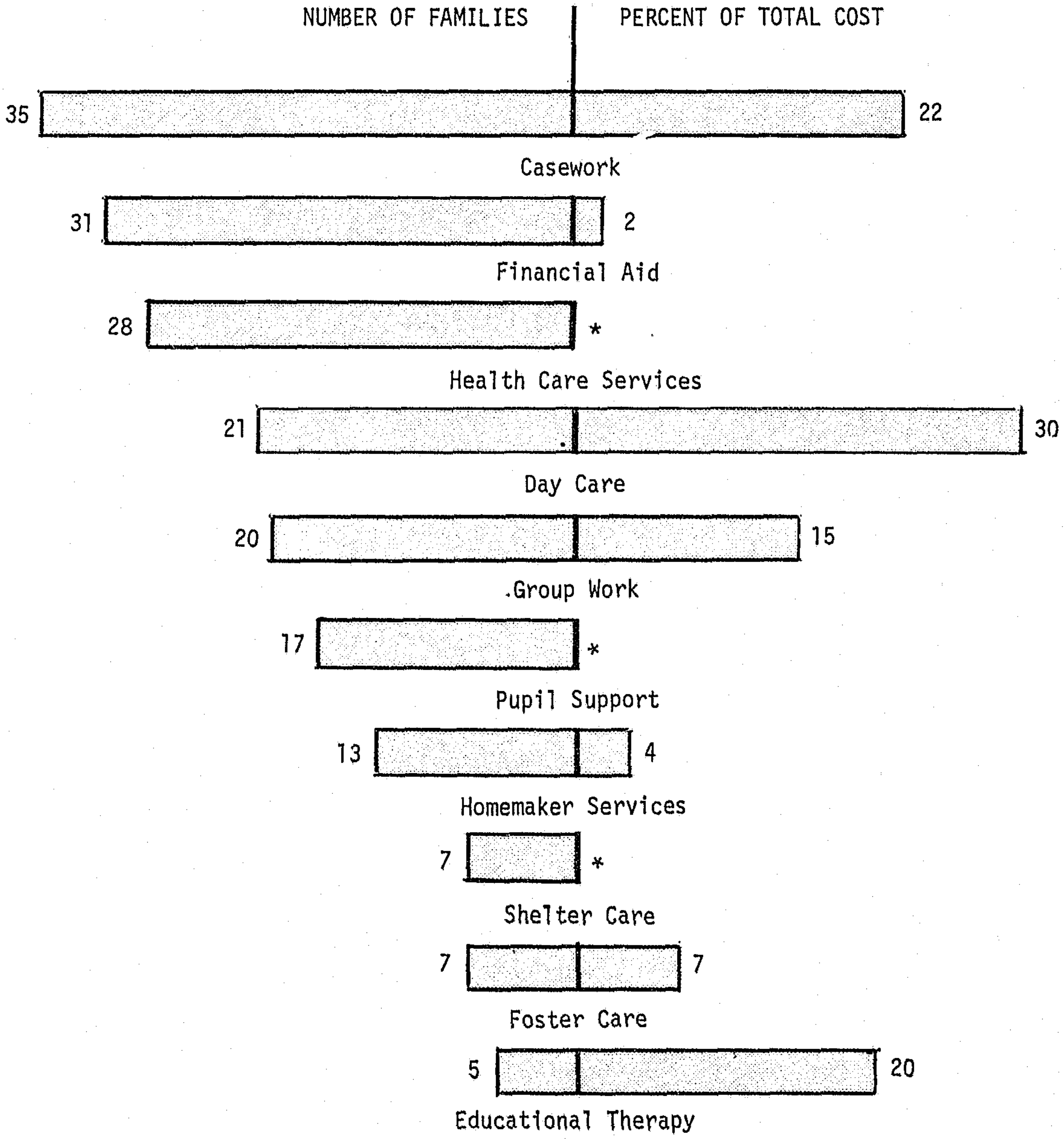
1. Casework
2. Financial aid
3. Health care services
4. Day care
5. Group work
6. Pupil support
7. Homemaker services
8. Shelter care
9. Foster care
10. Educational therapy

Figure 1 shows the extent to which these services were used by our 35 families and the percent of the total cost of each service.

The figures shown under "Number of families served" (See Fig. 1) do not tell the whole story. For example, there were about 5 children in each of the families. While the day care program served only 21 families, almost 100 different children received day care services at one time or another and usually for long periods.

It should also be noted that figures for "Total Cost" are not available for the entire 4½ years of operation. The cost figures were computed for fiscal years 1969 and 1970, a period during which the program had not only matured but was, we believed, quite representative of the entire project operation. (Federal service costs during this period can be found in Table 4, beginning p. 93.)

FIGURE 1 NUMBER OF FAMILIES USING EACH BOWEN CENTER SERVICE, AND PERCENT OF TOTAL COST



* Costs subsumed elsewhere (see text).

From Fig. 1, several conclusions may be drawn:

- Casework is the master service. Every family received casework service in order to assess their problems, to interpret our program, and to involve them in the Bowen Center. Of most importance, the casework service included the planning and timing of the use of all the other services.

- Financial aid and health care services, while involving little money, were utilized by almost all of the families. The professional salaries and travel costs for helping with health problems -- i.e., transporting clients to and from hospitals, clinics, and other health service centers -- were $20 to $30 thousand.* This amount was subsumed under "Casework," as it was usually the caseworker or an aide who provided escort services. Hence, the cost figure is not shown under health care.

  The widespread use of financial and health services suggests a long history of multiple problems which remained unsolved by community services until the Bowen staff interceded on behalf of the families.

- In terms of costs, it is immediately obvious that day care, casework, and educational therapy were programs that required major effort; in fact, they accounted for almost two-thirds of the total project cost.

- Educational therapy, smallest in number of families involved, was one of the most expensive.

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* This is a crude estimate, achieved by multiplying 1,300 health care episodes by 3 to 4 hours of a volunteer or professional worker's time and adding travel and telephone expenses. The figure does not include the cost of medical services, drugs, or appliances, as these items were paid for by the families or were provided through a free medical program.

CASEWORK

At least one adult in every family received casework services. In all, intensive casework was provided to 45 adults and 31 children. Throughout most of the project, our professional staff consisted of five workers, including the Director. They conducted 4,301 casework interviews during the 4½ years of the project. About 2,700 were held at the Center and about 1,600 away; most of the latter were held during home visits. To estimate costs, Center interviews were weighted as "one" interview session; home visits were "two;" and medical health care trips were "three" interview sessions.

The bare statistics cannot show the amount of time spent, the acute difficulties encountered, or the special techniques required to work with our problem families. For example, to complete home interviews, the worker commonly made several attempts to find the family at home and might make several attempts before being admitted. Once inside, it was common to find neighbors, children not in the family, and a general scene of disorder. In one extreme case, the worker visited in a household for 3 months before being able to sort out various members and determine that actually three different families were living together in the apartment. In short, the "home visit" in the Bowen program was typically a complex excursion which required 3 to 4 hours of time and usually involved talking with several family members.

Many home visits involved accompanying clients to the hospital, to court, to school, or to other social agencies to act as their advocate and to ensure that they availed themselves of other community services. With 10 of the Bowen Center families, no casework interviews were held at the Center; all sessions were held in the home.

In fiscal year 1970, 674 of 1,077 casework interviews, or almost two-thirds, were held at the Center. The Center interview, however, still did not approximate the traditional casework treatment situation. For example, in order to have one or both parents come to the Center, it was standard practice to make an appointment, remind clients of the appointment, provide a babysitter, and then provide transportation to the Center for the parents. In addition, an interview often involved making arrangements for the client to meet with other service providers. Support and advice to the client and extended negotiation with other providers were also part of these interviews.

Obviously, advocacy interviews lasted much longer and were more complicated than the conventional casework interview. But all of this effort was considered worthwhile because it stimulated significant gains in the parents' ability to handle their situations in verbal and symbiontic ways and to participate in some coherent discussion and planning regarding their problems.

The Bowen Center staff believe that this part of the Center's service was crucial because intensive advocacy was absolutely necessary to enable adults in the Bowen families to begin to negotiate with and make use of all the key community services.

A third kind of casework interview provided advocacy and practical help to the parents in dealing with community agencies and institutions. Almost one-fourth of all casework interviews (939) were such client-community sessions.

The next most frequently used service was related to health care. The caseworkers handled 318 medical interviews with 95 different persons. In addition, over a thousand other health-related needs involving 102 people were met by volunteers and other staff aides. Birth control education and gynecological referrals were an important part of these medical services; a measure of success in such efforts might be that only two pregnancies occurred among the Bowen Center families while under treatment.

The legal contacts also merit special note. Court hearings for delinquent juveniles and the shepherding of clients through legal aid were two common kinds of legal contacts. Placement contacts refers to the agonizingly detailed process of study and court hearings involved in the foster placement of children and changes in custody. The effectiveness of this effort is shown by the fact that the court removed children from only eight Bowen Center families.

The other areas in which social workers acted as advocates -- housing, financial aid, school, camp, and employment -- represented the kinds of advocacy and intervention with community institutions needed by these severely disorganized families.

Cost estimates for different years of the project indicate that the per unit cost of casework varied from about $15 to about $25 at different times during the project.

FINANCIAL AID

Financial aid was used at one time or another by 31 of the 35 families. While this service was considered to be very important, the total cost was relatively small: $9,296 over the entire project.

We offered two types of financial aid: loans in moderate amounts and small outlays to cover specific expenditures which could not be met otherwise. Money for holiday gifts and birthday presents was also provided. While the average amount of financial aid for a family was about $300, the range was actually very wide and ran from a high of $1,811 to a low of $1.

In general, financial aid was a means of "first aid" for these families, a way of meeting a short-term emergency, such as delay in a welfare check or a short-term layoff at work. One mother who depended on alimony for part of her income repeatedly borrowed from the fund when her alimony check was late.

Other kinds of material aid developed as a natural part of the Bowen Center operation. Occasionally, if the kitchen had a surplus of food, the excess would be distributed to families if it would not keep. A clothing room was stocked and frequently used by families. Downtown merchants and one of the volunteers often organized gifts of toys or clothing for the families.

The significance of the financial aid service provision is not in its total amount but rather in its clear demonstration that for families who have no money cushion, it is essential to have small amounts available to help them cope with emergencies.

HEALTH CARE

Health care did not mean the provision of medical services or home health care. Rather, it was the active intervention necessary to help or to prod parents into taking a minimal level of responsibility for their children's health.

In 28 of the 35 families where health care services were provided, there was virtually complete failure to seek out medical services. We referred more Bowen families to health facilities than to any other community services. Medical contacts alone accounted for a third of the 939 client-community interviews.

Assistance with health care meant identifying an unmet health need, making an appointment, arranging for treatment in a free clinic or payment for the treatment in some health facility, arranging babysitting if necessary, providing transportation, helping to negotiate the health care system, and followup to be sure that medication was taken and other recommendations carried out. In fact, the matter of health care was so important and so soundly neglected by the Bowen families that the Center posted a master calendar of all community health care services. Thus, a schedule of available health activities was visible to the client as well as to the caseworkers, teachers, and clerical staff.

A time study conducted during 1969 revealed that medical services involved the Bowen staff on an average of 5 times per 7 working days.

Most of the health services were for children. Only 5 percent of the more than 1,300 health service units rendered were for adult heads of households who comprised 16 percent of the client population.

The 1,300 health service units delivered to Bowen Center families represent the number of different episodes or visits. As might be expected, a small proportion of the children required much of the health service. Twelve of the Bowen children were taken for medical visits over 22 times each in less than 3 years. One preschool child with numerous allergies and ear infections had 59 outpatient appointments and another, with a difficult-to-diagnose neurological ailment, had 56.

Health service activities were subsumed under casework time primarily, as well as under day care, group work, and educational therapy. In other words, the staff of those programs identified the needs, transported the family members to and from appointments arranged by our workers, and did the necessary followup. In addition, VISTA volunteers and other volunteers spent many hours in similar services. Over two-thirds of the 1,300 episodes were taken care of by volunteers rather than by professional staff.

DAY CARE

Day care services, as shown by Fig. 1, were the fourth most frequently used service, with 21 families having children in the program. Day care was, however, by all odds, first in cost; it was also first in the space occupied in the Bowen Center and first in the time and attention required for its successful operation. In the opinion of the staff, it was probably also first in its impact on the development of Bowen Center children.

The cost of the day care program for the 2 years during which cost estimates were derived was about $60,000 per year. A total of almost 100 children participated in the program for an aggregate of 8,070 day care sessions during the 4½ years of operation of Bowen Center. Seven families were represented on the day care rolls for 3 years, seven for 2 years, and six for 1 year.

Day care at Bowen Center required fully as much adaptation, improvisation, and development of special techniques as did all the other Bowen services. In addition to traveling to the home to pick up the children, washing and dressing them, and discussing plans for the day with parents, day care also involved personal grooming and health care at the Center.

The children received breakfast, and special diets were provided when necessary. Child play was observed, and special treatments were developed in staff meetings with psychiatrists and other consultants. There were field trips to parks and museums and specially designed learning experiences in language, independent functioning, and manual skills. In short, for these children from families where the parental function had almost completely broken down, it was necessary within the day care program to try to meet all the needs and provide the activities and planning which go into the complex matter of "socializing the young."

The kind of parenting and remedial day care treatment service we provided seemed to be an absolute necessity for these children to prepare them for public school attendance and further learning. The average cost per day per child was around $20 to $25, meaning that the annual cost per child was $5,000 to $6,000 for day care. While this cost is high, it is comparable to other intensive treatment programs for children which offer similar services.

GROUP WORK

Bowen families did not know how to relate comfortably and effectively with other people in face-to-face situations. The basic skills of verbalization, planning, agreeing and disagreeing -- all essential for playing and working with others -- were almost completely absent. Accordingly, we organized a variety of both activity- and problem-centered group experiences. We began with the children and added groups for adults later.

To show the scope of group work services, the basic unit of count used was "children-sessions;" i.e., the attendance of a child (or an adult) at one session, which might be anywhere from 2 hours to an entire day. We had one full-time group worker. Because the children were unsocialized, it was necessary to provide additional professional staff and volunteers to maintain a ratio of one staff member to two or three children.

The total amount of group work services delivered to Bowen families was almost 7,000 "person-sessions." For the period in which the cost study was made, the cost of the service per unit (person-session) was about $14.

About three-fourths of the group work activity was in the afternoon program for school age children. This began with pickup at school dismissal time. Following refreshments at the Center, each group separated for age-appropriate activities. Crafts, arts, games, and play skills were introduced during the cold winter months. In the spring and summer, outdoor sports were more common. With the high staff-to-child ratio, it was possible to oversee the activity and use the program for teaching both manual and academic skills.

During the school year, then, the group work program consisted of five or six groups engaged in special projects, play, or sometimes tutoring within the Center for about 2 hours each afternoon. During the summer, group work services for school age children consisted of a day camp program for 30 to 40 children. Two of the 4 days a week in the summer program were spent at nearby public parks and forest preserves and in hiking, camping, crafts, and sports. One day a week was reserved for special trips, swimming, and for visiting State parks and similar places. On the fourth day, there was recreation within the city, or shopping, or a free movie. Among the older groups, both the boys and girls camped out overnight with staff.

In short, the bulk of the group work service was a socializing and personality-developing range of experience throughout the year for 46 children who were attending public schools and for their families.

An important group work service during the last 2 years of the program was the establishment of a mothers' group for about a dozen of the most isolated and immature of the mothers. Seven mothers became enthusiastic about the group and spent 1 day a week together on shopping expeditions, birthday celebrations, museum visits, summer visits to parks, etc.

There were 261 person-sessions in this group program for mothers in the last 2½ years of operation. During the final year of operation, this program for mothers was stepped up to two meetings a week: one, for a pleasant and social experience; the other, for teaching about child care and adult-child interaction. These teaching sessions were joined by senior day care staff and consisted of roundtable discussions with demonstrations of how to handle problems of child behavior and development.

The cost of the group work services ran about $30,000 per year for a comprehensive socialization program.

PUPIL SUPPORT

Pupil support, an activity that was not originally planned, emerged as a real necessity when, during the first year of operation, the staff observed the school difficulties of Bowen Center children.

Successful school performance for the middle-class child is supported by constant attention, constructive criticism, approval, and practical help with homework, negotiation with teachers, planning discussions, and the like. For Bowen Center children, none of these supports was available at home.

During the first year of the project, we developed four types of pupil support services: visits to the classroom, tutoring, lunches, and transportation. In addition, we provided constant encouragement, approval, advice, and practical help in order to supply the motivation and direction these children did not get in their own homes.

In Fig. 1, no cost estimate is given for pupil support. These activities were such an integral part of Bowen Center operations that it was impossible to segregate them for a cost estimate. However, during the project, 54 students from 18 different families were given extensive attention of this kind.

In the opinion of Bowen staff, the visits to teachers and other school personnel were probably the most valuable of the pupil support services in helping children negotiate the school system. About 200 school visits were made during the project, half by the casework staff and half by others. School visits were always for some practical or immediate purpose, ranging from registration of the child in September to exploration of the child's learning problems in school, or to exchange information with the teacher concerning the problems of a particular child.

"Transportation" simply meant transporting the children from eight different families to school on a daily basis. Transportation for these children and lunches for another six children were arranged on an ad hoc basis when it became clear that children would not continue in school unless these services were provided. We served 426 lunches at the Center to these six public school children.

Tutoring services could well have been expanded, had that been possible. We provided 112 tutoring hours for three youngsters who were having especially severe difficulties in school.

Center staff believe that any serious effort to improve social functioning in disorganized families would have to include something like our pupil support services. Just as with the health services of the community, it is necessary to intervene with practical help and advocacy so that these families may become able to use the community educational institutions effectively.

HOMEMAKER SERVICE

Like other Bowen programs, the homemaker service became quite different from the conventional pattern as the project developed. At first, the homemaker was sent to households to relieve a mother temporarily or to demonstrate and teach effective homemaking.

Later, the locale for the homemaker activity shifted to the Center and, in a group context, discussion of homemaking techniques and obligations developed more freely.

Cooking, sewing, and laundry were the most practical activities pursued under the Center roof, although decorating arts were also encouraged. The teenage daughters in two families became involved in these sessions and benefitted greatly in terms of their own homemaking skills.

For one family with three children and a psychotic mother, the homemaker maintained an active presence in the home as this was the only way to avoid breaking up the family.

Homemaker services were provided by the homemaker, the foster mother, and also by professional and paraprofessional staff. Several important functions were carried out for different families: one function was help through emergencies; a second was practical help in homemaking; a third was a continued presence in the home to avoid the necessity of breaking up the family and placing all the children.

SHELTER CARE

The third floor of the parsonage was turned into an apartment and furnished in a manner comparable to others in the immediate neighborhood. This apartment was used as an emergency shelter for 8 different families during the project, being occupied by as many as 7 persons at one time.

The 8 families used the shelter for a total of 635 days. The longest stay was 297 days while the shortest was 8 days. Like many of the other Bowen Center services, the shelter care program provided practical help to keep the family together and also was an important adjunct to treatment. It was possible to assess family operation and engage the family in treatment much more effectively during the time they were "living in."

No cost estimate is shown for the shelter in Fig. 1. It was created by adapting space already available and was supervised by various staff members according to plans made with individual families. To establish a program similar to the Bowen project, we believe that the availability of emergency shelter space would be essential. The cost would be roughly the cost of renting, furnishing, and maintaining an apartment.

FOSTER CARE

Foster care services were provided by a competent foster mother who lived in an apartment on the floor beneath the shelter home.

During the last 3 years of the program, foster care was provided for 16 children from 7 different families, for a total of 2,026 resident nights. In addition, however, the foster mother performed other tasks. She provided day care for children who were not able to engage in group activities; prepared breakfast for a young brother and sister who were beginning school in the neighborhood; helped with grooming and emergency health care of many of the children in the day care program; and, during the last year of the project, was an important member of the mothers' group meetings.

Several children stayed in the Center's foster home from 1 to 3 years. More commonly, the foster home was used for temporary care of children when there was a crisis at home.

The cost of foster care services -- which includes food and supplies for the shelter, as well as for the foster home, and the foster mother's pay -- was approximately $14,000 per year. The cost per day of foster care was over $20 per child during the 2 years of the cost study. This figure is somewhat inflated, including as it does some of the shelter cost, as well as a diversity of mothering and direct care activities for the younger children during the day.

EDUCATIONAL THERAPY

During the first year of operation, there were a number of 8- to 12-year-old boys among Bowen families who were completely alienated from school, whom the school authorities refused to have in the classroom, and who were well on their way to becoming delinquent. These boys were hyperactive, destructive, and virtually uncontrollable.

An educational therapy program was established for them in the basement of the building adjoining Bowen Center.

The violence, the alienation, and unfocussed nature of behavior among these boys is described in Chapter IV. Fig. 1 shows the way their physical and emotional demands translated into service dollars.

One of our most dramatic discoveries was to find that this group of totally unsocialized, out-of-control, agitated youngsters was helped at an annual cost of $6,000 per child -- half the amount spent by established residential treatment centers in the community. We delivered approximately 1,500 to 2,000 "education days" to these children at an annual cost of about $40,000. The average daily cost per child was about $25.

This program was highly individualized in order to permit each boy to achieve his greatest potential for ego control, self-confidence, and academic skill so that he would ultimately be prepared to enter public school. We provided 3,857 child days of educational therapy to the boys (10 boys from 5 different families) during the school year, and 641 summer days as well. The program continued for 3 years.

COSTS AND SERVICES

Table 1 summarizes the cost and nature of the services provided Bowen families. The bulk of our energy was put into practical, direct services to meet the problems of everyday life and to correct some of the deficiencies and deficits of these clients in health, behavior, and emotional support. This large outlay of energy was essential to the success of our long-term teaching and corrective missions.

A lesser amount of energy went into accelerating child development, family life training, and increasing interpersonal skills. These functions were served by such activities as Center interviews for treatment and planning purposes; the preparation of the children for public school and the day care and educational therapy program; the problem-solving and teaching sessions for both children and adults in the group work program. Even in the homemaker program, we see the same mix of objectives: it was necessary to provide homemaker services simply to maintain families and permit life to go on; but another important function of the homemaker was to develop homemaking skills among selected children and parents.

Table 1 also illustrates the wide variety of skills and services available to Bowen families in one location. Only through constant interaction and planning among personnel in our various services was effective family treatment possible. Even if these services had been available for Bowen families in scattered locations, the logistical problems of moving clients about, the inevitable and necessary paperwork, and the endless negotiations between separate organizations would have made the integrated provision of services quite impossible.

Table 2 presents an overall picture of our manpower requirements. As there was constant staff turnover, and as the Bowen program did not "mature" until after the first 12 to 18 months of operation, Table 2 shows the maximum number of staff members within each category who were employed in each of the last 3 years of operation.

CONTINUED

1 OF 2

Table 2 also shows the variety of skills and specializations necessary to operate a comprehensive family treatment center for demoralized families. The largest number of staff were needed and the largest costs incurred for professionally qualified specialists, predominantly in the areas of child care and teaching. However, it would not be proper to think of the nonprofessional staff as "support" staff. About half of them were engaged in providing direct services or care to children and were an essential part of family treatment; the same is true of the volunteers.

TABLE 1

SUMMARY TABLE: TYPE, AMOUNT, AND COST ESTIMATES FOR SERVICES TO BOWEN FAMILIES, FISCAL YEARS 1969 AND 1970

Service Provision Units	Number of units	Cost per units*	Total cost*
1. DAY CARE "CHILD DAYS"	5,388	$23	$125,777
All day program: transportation, meals, individual planning for developmental, personal, health, grooming, and other needs.			
2. CASEWORK "INTERVIEW"	4,477	21	93,853
Center interview units (1 unit each),	1,182		
Home visit units (2 units each).	2,720		
Medical care trip units (1 unit each).	525		

Service Provision Units	Number of units	Cost per unit*	Total cost*
3. EDUCATIONAL THERAPY "CHILD DAYS" All day program, boys 8-12: special educational, social, recreational, health planning, etc., "one-to-one" basis.	3,286	$25	$82,807
4. GROUP WORK "PERSON SESSIONS" Typical session -- 2 hours after school, groups of 4-6 school age children; transportation, group discussion, programmed activities. Other sessions were all day camping, museum visits, etc.	4,950	13	63,024
5. FOSTER CARE AND SHELTER CARE - CHILD OR FAMILY DAYS 24-hour care of children at Center; day care and emergency mothering; shelter as temporary residence for families.	1,239	23	28,441

Service Provision Units	Number of units	Cost per units*	Total cost*
6. HOMEMAKER SERVICE Emergency homemaking in homes; teaching homemaking skills at Center; assumption of special tasks to maintain home, on continued basis.	-	-	$15,045
7. FINANCIAL AID - DOLLARS PER FAMILY Emergency cost of food and clothing; temporary loans; purchase of gifts, other special needs.	4,648	$309	4,648
8. HEALTH CARE TRIPS Identify need for health care; arrange medical service and payment for service; make appointments, provide transportation, negotiate with health professionals as necessary; followup.	848	No cost estimate possible; costs subsumed elsewhere.	
9. PUPIL SUPPORT SESSIONS	No estimates available; costs subsumed elsewhere.		

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* Cost figures for entire project period are halved to make them comparable to 2-year basis of other estimates.

APPROXIMATE COST PER FAMILY PER YEAR: $10,000
APPROXIMATE COST PER PERSON PER YEAR: $ 1,600

TABLE 2

BOWEN CENTER STAFFING PATTERN:
TYPICAL STAFF* IN EACH CATEGORY
FOR EACH OF THE LAST 3 YEARS OF OPERATION

	Year 2**	Year 3**	Year 4**
PROFESSIONAL STAFF: TOTAL	9	9	10
Director	1	1	1
Social workers	5	4	4
Teachers	3	4	5
OTHER PAID STAFF: TOTAL	14	16	16
Clerical workers	5	5	5
Child care workers	5	6	6
Other (cook, janitor, homemaker, etc.)	4	5	5
VOLUNTEER AND UNPAID STAFF: TOTAL	9	15	15
VISTA volunteers	6	10	12
Social work students	3	5	3

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* Maximum staff is the highest number employed in each category in any quarter each year. "Averages" would be about one person less in most categories.

** The Bowen Center program operated for 18 quarters or 4½ years. "Year 4" in this table is actually the 15th through the 18th quarters, etc.

The Bowen Center cost study for fiscal years 1969 and 1970, plus examination of cost in other years, indicate that the cost of comprehensive family treatment ranged from $8,000 to $12,000 per year per family. Like most averages, this one conceals great variation.

Table 3 indicates the different kinds of "packages" which were worked out with different Bowen families. The "X's" in the body of the table show which of the 10 services were received by each of the 35 families (indicated by code numbers) at any time that they were known to the Center. The two columns at the right of the table indicate the wide range among different families both in the number of different services used and in the length of time they were under treatment.

Almost 20 of the Bowen Center families used 6 or more of the 10 services provided for comprehensive family treatment. The families who were known to the Center for 3 or 4 years used the widest variety of services. Obviously, the total number of services used by the 8 or 10 largest and most needful families was several times the average number of services for families, in general.

At the other extreme, there was a group of a half-dozen families who received several of the basic services for 2 or 3 years but, either because of their level of functioning or because of family size, did not require many additional services. A half-dozen families used only 2 or 3 of the services, usually for only 1 or 2 years of program operation.

Program Changes

Because it was learning and growing, the Bowen program changed over the 4 years of its operation, and so did its clientele and staff.

Figure 2 shows the number of staff related to the number of clients for the last 3½ years of operation.

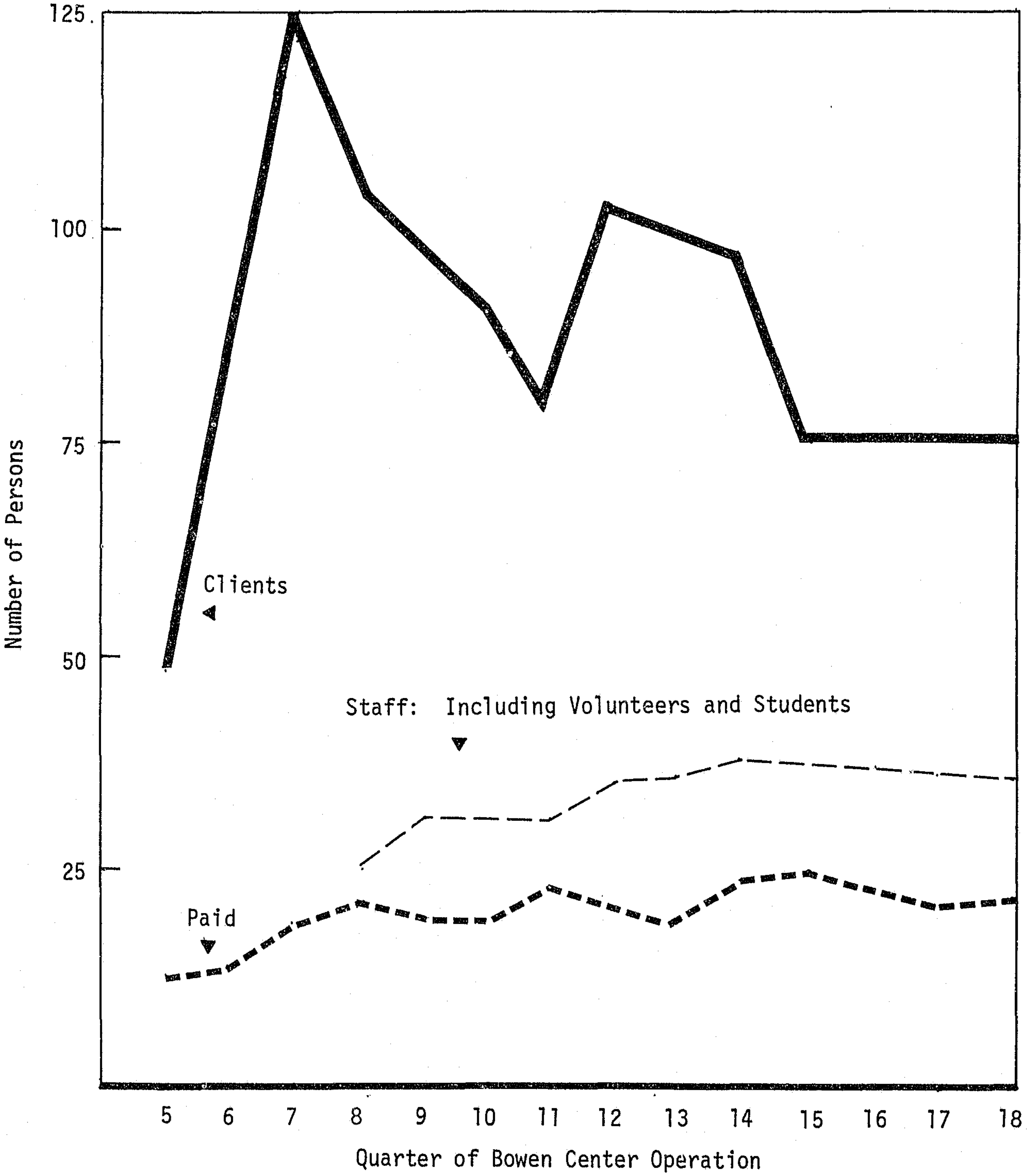
TABLE 3

PATTERN OF SERVICE PROVISION TO 35 BOWEN CENTER FAMILIES

Family code number	Services provided and number of families receiving each service										Total number of services used	Number of years known to project
	Casework 35	Financial aid 31	Health care 28	Day care 21	Group work 20	Pupil support 17	Homemaker 13	Shelter care 7	Foster care 7	Educational therapy 5		
21	X	X	X	X	X	X	X	X	X	X	10	4
12	X	X	X	X	X	X	X	X	0	X	9	4
11	X	X	X	X	X	X	X	X	0	X	9	4
8	X	X	X	X	X	X	X	0	X	X	9	4
25	X	X	X	X	X	X	0	0	X	X	8	3
23	X	X	X	X	X	X	X	0	0	0	7	3
13	X	X	X	X	X	X	X	0	0	0	7	2
26	X	X	X	X	X	X	X	0	0	0	7	3
15	X	X	X	X	X	X	X	0	0	0	7	1
5	X	X	X	X	X	X	0	0	X	0	7	1
32	X	X	X	X	X	X	0	X	0	0	7	2
10	X	X	X	X	X	X	0	X	0	0	7	4
34	X	X	X	X	X	0	X	0	X	0	7	2
9	X	X	X	X	X	X	0	0	0	0	6	4
30	X	X	X	X	X	X	0	0	0	0	6	2
28	X	X	X	X	X	0	X	0	0	0	6	2
33	X	X	X	X	X	0	0	0	X	0	6	2
27	X	X	X	X	0	0	X	X	0	0	6	1
22	X	X	X	X	0	0	0	X	X	0	6	3
17	X	X	X	0	X	X	0	0	0	0	5	3
29	X	X	X	X	0	0	0	0	0	0	4	2
18	X	X	X	0	0	0	X	0	0	0	4	1
2	X	X	X	0	0	X	0	0	0	0	4	3
1	X	X	X	0	X	0	0	0	0	0	4	3
14	X	X	0	0	X	X	0	0	0	0	4	3
3	X	X	X	0	0	0	0	0	0	0	3	2
24	X	X	0	0	X	0	0	0	0	0	3	1
35	X	0	X	X	0	0	0	0	0	0	3	1
20	X	0	X	0	0	0	X	0	0	0	3	1
19	X	X	0	0	0	0	0	0	0	0	2	1
31	X	X	0	0	0	0	0	0	0	0	2	1
7	X	X	0	0	0	0	0	0	0	0	2	2
4	X	X	0	0	0	0	0	0	0	0	2	2
16	X	0	X	0	0	0	0	0	0	0	2	1
6	X	0	0	0	0	0	0	0	0	0	1	2

FIGURE 2

NUMBER OF CLIENTS AND STAFF FOR EACH OF THE LAST 14 QUARTERS OF BOWEN CENTER OPERATION



Our first year was spent orienting staff, involving a few families in service, and continuing to develop essential programs. After that first year, beginning in quarter 5 (Fig. 2), there was a rapid rise in clients as additional families were studied and accepted. By the eighth and ninth quarters, some of these families who could benefit only from short-term service or who simply refused to become involved in the Bowen program fell away.

During the twelfth quarter, some additional families were accepted for treatment. The number of persons receiving services stayed approximately the same throughout the rest of the project, because it was originally established as a 5-year project and because the staff had, by this time, identified a group of families who became extensively involved in and remained with the Bowen program.

Aside from the pattern of change over a period of time, Fig. 2 shows that the client-to-staff ratio was about three to one. Obviously, this ratio was closer to that of a high quality mental hospital or special educational facility than to the average family service agency. We were pleased with that.

Figure 3 illustrates another characteristic of the Bowen Center program. The Bowen Center did not carry a large nominal caseload with little activity in many of the cases. Rather, our families were selected as those needing service. If we found that they did not need service or were unwilling to be involved, then those cases were closed. A high proportion of all members in all "open cases" were actively involved in some kind of service provision each quarter of the program operation.

One final point about change: As noted, casework interviews in the home were more common during the first part of our operations, while casework interviews at the Center were more common during the last year. This change is a very important one since it reflects the ability of families to mobilize themselves and to carry their part of a treatment relationship.

FIGURE 3

TOTAL NUMBER OF INDIVIDUALS IN BOWEN CENTER FAMILIES, AND NUMBER AND PERCENT ACTUALLY RECEIVING SERVICE FOR LAST 15 QUARTERS OF PROJECT

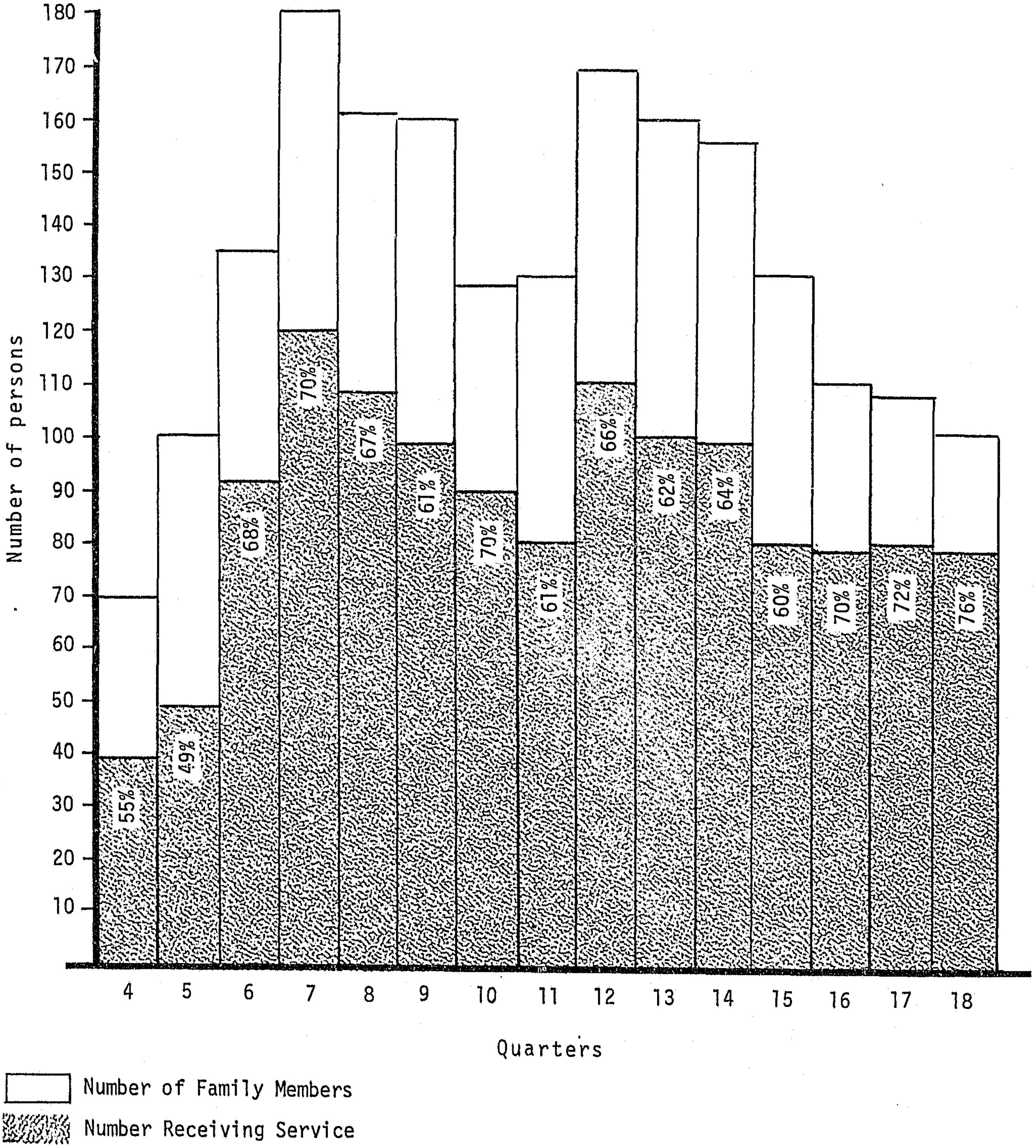


TABLE 4

COST DATA (Condensed)
(Covering Federal direct costs for two 12-month periods)

A. COST BY PROGRAM BREAKDOWN:

FIRST PERIOD
(June 1, 1968 - May 31, 1969)

Casework	Group work	Day care	Educ. therapy	Foster care	Home-maker	Research	TOTAL
$42,092	$33,383	$59,158	$41,188	$14,539	$7,209	$10,386	$207,955

SECOND PERIOD
(June 1, 1969 - May 31, 1970)

$51,751	$29,641	$66,619	$41,619	$13,902	$7,836	$15,045	$226,423

B. SELECTED DIRECT SERVICE DATA AND UNIT COST CALCULATIONS:

1. Casework	First Period		Second Period	
Office interviews	431 (one unit)	431	751 (x1)	751
Home visits	847 (two units)	1,694	513 (x2)	1,025
Medical care trips	115 (three units)	345	60 (x3)	180
Total units		2,470		1,957
Average cost per unit		$17.04		$26.45

Center interviews are rated as one unit, home visits as two units, and trips taking clients to hospital or clinic and back as three units. Not included in above are the following supplemental services:

	First Period	Second Period
a. Medical care trips by non-casework personnel.	400 trips	273 trips
b. Telephone calls, court appearances, conferences with school personnel, and other collateral visits.		

2. Group work

Daily child sessions	1,794	3,156
Average cost per child	$18.61	$9.39

(A session ran from 2 hours after school, including pickup and delivery, to all day in summer or holidays. Not included are 4 annual camping trips, each involving over 20 children.)

3. Therapeutic day care

Child days	2,724	2,664
Average cost per child	$21.35	$25.00
Average annual cost per child	$5,338	$6,250

Day care in most instances covered all day care, breakfast, snacks, individual therapeutic attention, pickup and delivery, and often baths and nursing care.

4. Educational therapy

Child days	1,554	1,732
Average daily cost per child	$26.50	$24.00
Average annual cost per child	$6,625	$6,000

All day program focused on therapeutic and cognitive needs, pickup and delivery, meals, and individual attention.

5. Temporary foster care (Includes families in shelter, counting family as unit.)

Child (or shelter family) days	493	746
Average cost per day	$29.49	$18.64

	First Period	Second Period
C. FAMILIES SERVED PER PERIOD	24	18
Adults	44	35
Children	103	79
Average annual cost per family	$8,665	$12,579
Elimination of research item reduces cost of service per family as follows:	$8,232	$11,742

D. COMPARABLE COST DATA FROM OTHER CHICAGO AGENCIES

Included here are data (where available) from agencies giving comparable service in their ongoing programs. Although the agencies selected for comparison are among the most prestigious private agencies in the city, it is recognized that these comparisons are not totally valid.

1. Casework

Cost per office interview with client. (Agencies selected for comparison all provide skilled professional counseling.)

a.	Agency A.--(Provides therapeutic counseling to highly motivated adolescents.)	$ 20.00
b.	Agency B.--(Provides family counseling.)	30.00
c.	Agency C.--(Provides individual and family counseling.)	25-35.00
d.	Agency D.--Outpost Centers. (Provides office or home counseling and transportation; all management costs included.)	40.00

2. Group work

Our group work program had groups with two leaders for each group of 4 to 6 children, including pickup and delivery, and sometimes dressing the youngsters. It included over 100 tutoring sessions in the first period, 21 home visits in the first period and 41 in the second. It included 444 deliveries to public schools the first period and 686 the second period. It included 4 all-day camping trips each year. There was no comparable program in the city, and no efforts were made to get comparable cost data.

3. Day care

Our children were greatly deprived and damaged, and the only valid day care costs would be with other centers maintaining a therapeutic program of high quality. Even the programs cited below counted on parents to deliver and pick up their children, whereas we transported them both ways, often dressed them at home, bathed them at the Center, and provided them with clean clothes.

Cost per child per annum:

Agency E	$6,629
Agency F	3,333
Agency G (1971 estimate)	6,000

4. Educational therapy

The nearest comparison to the type of therapy and cognitive learning we gave to the children in our educational therapy unit is that provided by residential treatment centers of other child welfare agencies. In fact, nowhere can we make our case more dramatically to show the advantages of a program that permits the home to remain intact than this program. Here the cost given is the annual reimbursement per child by the Illinois Department of Children and Family Services.

Cost per child per annum:

1.	Residential Center H	$13,651
2.	Residential Center I (boys)	14,325
	Residential Center I (girls)	13,101
3.	Group homes for adolescent girls, J	12,629
4.	Residential Center K	11,753
5.	Residential Center L	9,565

5. Foster care

Foster care is admittedly high because we maintained a facility which could have accommodated more children. Two of the most prominent private foster care facilities gave their annual cost as $3,805 and $3,395, respectively. The State Department of Children and Family Services, however, stated that in group homes where adequate personnel must be employed, the cost has skyrocketed.

CHAPTER VI

APPLYING OUR LEARNING EXPERIENCE

WHEN WE LAUNCHED the Bowen Center Project, we hoped that, as we pursued our objectives, we would also acquire increased understanding of the parents. Such understanding was essential if we were to fully recognize the sufferings and anxieties underlying their neglecting and self-defeating behaviors. We also wished to learn more about their lives in order to identify how societal deprivations or failures and how their earlier experiences had contributed significantly to their present plight. We were aware that simply advocating the proliferation of a group of services, however necessary, would not be sufficient. Hence, understanding in depth would not only enable us to devise effective treatment but would aid us as we worked out practical methods of prevention.

Fortunately, a substantial body of knowledge already existed in this field, the results of the efforts of many investigators to whom we are indebted.[28] In many ways, our experiences corroborated their findings.

The project provided an excellent opportunity to know the parents and their children intimately over a longer period of time than is usually the case with such families. It is our hope that we can, in some small way, contribute to the existing pool of knowledge.

WHAT WE LEARNED ABOUT THE PARENTS

Initially, the constant crisis, the chaos, as well as the seeming indifference of the parents to the needs of their children and to their lives in general made it difficult to understand them or their behavior. As they became engaged gradually in our program activities, however, the almost frozen facade and apathy diminished. They began to develop individuality. While collectively they shared many things in common, each began to display his or her unique personality and problems.

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[28] Pavenstedt; Reiner and Kaufman; Redl; Polansky et al. (See citations.)

The initial period, or "the phase of engagement," took a great deal of effort on the part of the staff. It was not that the parents were resistant to efforts to help them, but that they were frequently only available in a group rather than singly. They accepted services brought to them, allowed their children to be entered in the programs, but participated little in our efforts fo involve them in decisionmaking.[29/] They accepted help in tangible ways (such as finding housing and obtaining food), but real trust was very slow in developing. It was as though they could not believe that our interest in them was genuine, and the slightest incident could interrupt the process of "reaching" and helping them.

We employed a variety of communicative techniques to try to aid the parents in achieving increased security and mastery of their life situations. Certain principles guided us: First, we used our understanding of the lifeline development relative to human maturation and adult functioning. We have found this to be a realistic approach in attempting to identify the discrepancies between individual developmental functioning and age-level expectations. It has been clearly demonstrated that the intricate abilities to deal with life situations, generally referred to as ego functions, gradually develop in line with the state of maturation and environmental influences from birth to maturity.[30/] Thus,

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[29/] Polansky, N.A., DeSaix, C., and Sharlin, A. CHILD NEGLECT: Understanding and Reaching the Parent. New York: Child Welfare League of America, 1972.

[30/] Erikson, E.H. "The Problem of Ego Identity." Journal of American Psychoanalytic Assoc., 4: 56-121, 1956.

Growth and Crisis of the Healthy Personality. /In/ "Identity and the Life Cycle." Psych. Issues, 1:1, 1959.

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--- Wasserman, S.L. "Ego Psychology." /In/ SOCIAL WORK TREATMENT. F.J. Turner, Ed. New York: Free Press, 1974.

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it is possible to identify those areas of development which have been arrested at an immature level and which limit the individual's capacity to deal with the reality demands of his/her life.

This assessment is of inestimable value in several ways: it permits meeting the individual "where he/she is," in terms of personal resources and the current life situation. It mitigates against placing excessive expectations for accomplishments that are not realistic and would prove frustrating both to the person and to the worker. Even more important, it provides some direction to the efforts to assist the individual in moving toward increased maturity by focusing on those aspects in which arrested development seriously limits his/her progress.

Also, our approach was not one of depth-oriented psychotherapy in the usual sense. However, careful attention to the parents' behaviors and needs shaped our general response and activity. We attempted to accept the necessary dependency of the parents and to relate to their needs, while at the same time preserving and supporting their autonomy to the fullest extent possible.

Even when the parents seemed totally unable to administer minimally to the physical and emotional needs of their children, requiring extensive supplemental parenting from the agency, we continued to involve them in the decisionmaking and planning to the fullest extent they could accept. It was gratifying, indeed, to see an enlarging degree of autonomy develop in many of the parents as they assumed responsibility for various facets of their lives and the lives of their children. Although restitution cannot be made for all the deficits of the past, it is possible, however, to find opportunities in the current life situation in which dormant strengths can be awakened. In this sense, our approach contained certain aspects of symbolic parenting.

THE INITIAL PERIOD

This period varied from a number of months to a year and was marked by continuing crises and disasters. Very gradually, the parents were able to ask for help or to anticipate a crisis. This was almost the first sign that they recognized the availability of the workers and of their continued response to their troubles.

As the frequency of the crises and chaos ameliorated to some extent, the parents began to reveal more personal aspects of themselves. The most common of these were: tremendous feelings of inadequacy; inability to make decisions; and inordinate fears of almost every task that is normally taken for granted (such as keeping medical appointments, cashing checks, handling bills, going to the welfare office, using public transportation, etc.). Some parents continued to use "running away" (through fights, drinking, etc.) as an escape from the anxiety these acts generated in them.

Most of the parents were unaccusomed to verbal communication except as it related to the specific and immediate situations which bothered them, and, even about these incidences there was little carryover from one contact to another. One crisis was immediately displaced by another, and the worker, geared to following through on a plan formulated in the last contact, found it either superseded by a new concern or completely forgotten. Even appointments requested by the parent might result in the worker arriving only to find the parent absent.

Such verbal communication as the mothers engaged in, usually regarding their sad and devastating experiences, was presented in a matter-of-fact, affectless manner. They seemed disinterested and almost oblivious to the ways in which the staff attempted to help their children get to school or handle them in day care.* In spite of our efforts to involve them in spending time in day care or other children's programs, they avoided these whenever possible. (Parenthetically, later contact revealed that they had been much more aware and observant than was apparent but that they felt so inadequate they could not tolerate involvement.)

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* Polansky, DeSaix, and Sharlin (op. cit. pp.22-23) point out that, "It may be hard to distinguish the symptoms of Apathy-Futility from depression. However, in depression the client's feelings are awful, but she does feel. In Apathy-Futility there is numbness. She seems to be saying, 'I will feel nothing, and then I cannot be hurt.' She is no more able to show love than she is able to show real anger. The attitude that 'nothing is worthwhile,' in other words, is a way of avoiding the involvement that would lead to experiencing her emotions more vividly...."

The parents responded most favorably to efforts directed toward their personal care. They enjoyed only group programs in which they were fed and provided entertainment. Such programs obviously helped to relieve their dreary existence.

The social workers, taking their cues from the explicit and implicit needs of the parents at this phase, reponded by providing support and tangible help in accordance with the parents' wishes. The members of the Bowen Center staff were available, visible, and responsive to the many tangible concerns and unhappy experiences of the families. This initial period was, indeed, a crucial time for them.

SUBSEQUENT DEVELOPMENTS

It is difficult to designate a specific time phase that would be applicable to all of the parents in terms of when it was possible to detect changes in their overt functioning, as well as in the significant ways in which they brought aspects of their anxieties, fears, and problems to us. With the exception of those relatively few clients who showed significant progress in self-direction and independence in the first phase of contact, it can be generally stated that, for most of the parents, these changes occurred in the second year. It is not possible to give any general, sequential description of the various levels of problems presented during the period when the parents became more involved in the Center's programs. We can present, however, some of the more common problems and underlying aspects that we observed.

The most significant characteristic that emerged was the parents' ability to gradually increase their verbal communication. This enabled us to discuss a number of important concerns that apparently had been dormant and which gave our workers the opportunity to focus their interest and support at a different level. In other words, the relationship between the worker and the parents became more meaningful, and there was something to discuss in relation to the individuals themselves rather than to the constant situational occurances.

From the beginning, the treatment approach had been to attempt an empathic response to feelings related to the events and happenings described by the clients. Their total lack of affect or feelings associated with even the saddest situations reveals that they had to massively deny and repress their feelings because of the overwhelming anxiety associated with them.

Our experience indicates that the problems in verbal communication at the affective level not only involves a lack of experience in talking or having the requisite vocabulary, but are also the result of an incapacity to tolerate anxiety.* Therefore, anxiety is discharged in a range of activities. The approach taken by the workers was one of constant attention to feelings that should be expected to be related to disappointments, hardships, and exploitation by others. These were expressed empathically.

This method of intervention certainly involves an active posture on the part of the worker. However, we found that a continuing effort to connect parents' feelings to events from which they had been isolated gradually enabled them to become increasingly free in their awareness and expression.

Parents frequently were much better able to express anger and negative feelings than those of sadness, unhappiness, or needs. One mother, who was tied to an abusive, provocative husband with whom the only interchange was one of constant depreciation, recognized her dilemma. She advised the worker that even though she loved her husband very much, she couldn't think of one positive thing to say to him.31/

EXPERIENCE WITH THE MOTHERS

The increased capacity for verbal communication, combined with greater security in the worker-client relationship, allowed the parents, particularly the mothers, to reveal many important concerns. They confided details of their current experiences and past situations which were much

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* For a similar conclusion in the tradition of ego psychology, see also Polansky, DeSaix, and Sharlin; Wasserman; op. cit.

31/ Polansky, DeSaix, and Sharlin, op. cit.

more serious and devastating than we had anticipated. Such as, the mother in one of the families revealed that the father was sexually molesting all of their five children and that this had been a problem for many years.[32/]

Long-suppressed memories of experiences in which the mothers' own families had been abusive to them seemed to return. Many of the mothers spontaneously connected these experiences to their current life situations and to their relationships to their own children. While no intensive focus had been placed on the early life experiences of the women, the information they conveyed regarding their past experiences enabled the workers to help differentiate the past from the present and was of great assistance in furthering the correction of poor self-concepts.

An almost universal personality aspect that came to light as the mothers talked was a basic feeling of "badness" and self-reproach. Although they had not developed what is commonly regarded as an adult internalized conscience or super ego, they had moral and rigid expectations of themselves; they believed they were bad mothers and, indeed, bad people to whom nothing good should happen.[33/] This attitude was related to their negative, early, experiences and was held to tenaciously. Through supportive, corrective experiences, it was possible to bring about some amelioration of these feelings but, in our opinion, certain deep aspects of this self-concept remained.

As we got to know the parents, especially the mothers, another phenomenon that was almost universal was the prevalance of rather severe depersonalization experiences and anxiety states. These were not new; in most instances, they were chronic and had been experienced over many years. Frequently, they had never been discussed with anyone before, and usually there had been massive attempts to deny them through the usual vicissitudes of daily survival.

[32/] Wathey, R. and Densen-Gerber, J. INCEST: An Analysis of the Victim and Aggressor. (Presented at Third Annual National Drug Abuse Conference, March 1976.)

--- Giarretto, H. "The Treatment of Father-Daughter Incest: A Psycho-Social Approach." Children Today, 5:4, 2-5, 1976.

[33/] Klein, M., Heimann, P., Isaacs, S., and Riviere, J. DEVELOPMENTS IN PSYCHOANALYSIS. London: Hogarth Press, 1972.

In most cases, the discussion of these anxiety states -- that is, bringing them out into the open -- seemed to afford some relief. Certainly, they became less a matter of concern in our discussions with mothers.

Perhaps the most serious underlying problem common to these mothers was depression. This was a basic component which was well covered by the behaviors described earlier and only surfaced when the mothers' preoccupation with survival lessened. While it has long been postulated that a poorly organized, ineffectual person may display a facade that covers a depressive core resulting from early deprivation and neglect, we were nevertheless impressed by the clear evidence of its presence in these mothers. In fact, a number of them had periods of depression, ranging from severe to mild manifestations. In the others, the depressive underlay became apparent in their response to improved conditions.[34/]

It is important that workers in this area be aware of this depressive core. Such awareness, which contributes to greater empathic understanding, should be a factor in treatment planning and expectations. In our experience, it was possible for the mothers not only to survive the severe depression but to effect some lessening of their negative influence. However, certain residuals of the depressive condition continued to exist and, we believe, limited the progress made, at least in the time available to us.

Closely related to the foregoing problems, and perhaps encompassing them, was a serious arrest in development. This problem in its psychological importance is less overtly apparent than the manifestations of depression, etc.; it gradually becomes very clear in treatment responses and behavioral manifestations.

The crucial aspect of developmental failure in the Bowen Center mothers was the lack of having achieved an internalized separate identity, with a resulting feeling of incompleteness.[35/] This was manifested in many ways; e.g., by clinging to their children, by the presence of abusive and unfulfilling relationships, and by an inability to tolerate being alone. As their treatment progressed, it also showed in their fear of taking

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34/ Reiner and Kaufman, op. cit.
35/ Erikson, op. cit.

responsibility or of making decisions -- in fact, in taking any next steps, even in the most gratifying or self-rewarding endeavors.

There seemed to be a tenacious and binding tie to the past, with an accompanying, repetitive compulsion factor in behavior. Spurts in progress were frequently followed by a return to the "safety" of self-destructive activity.

Awareness of this dilemma of the parents provides a basic framework for the interventive treatment approach. The worker's acceptance of dependency is necessary if any breakthrough is to be made in the bind in which these individuals are caught. The opportunity to be dependent in a nonpathological relationship gradually enables the individual to move forward toward separateness and increased self-identity and independence.[36]

Most of the mothers and some of the fathers made visible steps in the direction of self-concept and independence. Needless to say, it was necessary to be alert to maintain the support of independence and the gradual raising of parental expectations.

A positive manifestation of progress is the identificatior that takes place with the worker. This is shown in outward signs of dress, hairstyling, etc., but, more importantly, in changes in the thinking process and in attitudes toward children and others. One mother became very interested in helping "save" children in the neighborhood who she thought were neglected or mistreated. She kept an appointment book similar to that used by the workers, brought children to the Center for lunch or care, and talked about the parents being "like I used to be."

A different and more difficult manifestation for workers to live through is the display of rage and anger. When this occurs, it usually follows a long period of relative progress. The workers have gone through a great deal in the initial phases and are able to withstand the disappointments associated with backsliding and acting out. They have accepted slow progress and usually have been pleased with the developing capacities of the client. There is evidence of a strong working alliance. However, the rage, when it comes, is so overwhelming and persists for such a

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[36] Polansky, DeSaix, and Sharlin, op. cit.

long period that it threatens the continuation of treatment. We believe the rage to be a transference phenomenon which frees the individual to move on in his/her progress. It is, therefore, a necessary part of the working-through of the ambivalent tie to the past.

All the mothers, except those with psychotic conditions, made considerable progress. They took more interest in themselves, became more interested in the life around them, and were able to achieve some gratification from their children. Most were able to be a little more empathic with their children, with a resulting improvement in the quality of the parent-child relationship. But the most visible outward changes had to do with their self-concepts which improved markedly.

In spite of these achievements, for most, there still remained major deficits in sustaining independence in the assumption of parental responsibility. They needed continued help in this area, although at a different level in quantity and quality of staff input. A few, by the end of the project, had achieved greatly improved stability in managing their homes and caring for their children.

EXPERIENCE WITH THE FATHERS

We are not able to report what we learned about fathers in as much detail as our report on mothers.

Although we believe our service components are equally applicable to fathers, it was not possible (with a few exceptions) to engage the fathers as early as the mothers with the same degree of continuity. From the beginning, we made tremendous efforts to involve the fathers in the two-parent families through joint interviews in the homes and in programs at the Center.

The fathers were much more fearful of becoming involved and were not as available as the mothers, who more commonly attended the children at home. They were unaccustomed to verbal discussions, and their acting out, in terms of marital separation, of not giving money to maintain their families, of unemployment, coupled with frequent abuse of wives and children, interfered with the engagement process. In addition, they needed to maintain an omnipotent show of strength.

It seems that in our culture, generally, certain male role expectations make it difficult for fathers to seek help and to participate fully in situations that involve dependent relationships.[37/] The economically and socially deprived male, in particular, has to defend against his feelings of helplessness and insecurity by a show of bravado and pseudo-security, and any seeming dependence would serve to threaten his feelings of being in command, however unrealistic this may be.

We were able to get most of the fathers involved, and provided tangible help to them; but this happened gradually through certain crises in the families and as a side effect of the mothers' becoming more aggressive and being able to bring the fathers in to participate in Center events. However, there were several fathers whose severe problems demanded individual treatment. In these fathers, as with the mothers, we saw the same anxieties and fears underlying their inability to assume adult roles. Gradually, as we sought ways of involving the father, we found that they were pleased to do some work at the Center (fixing the cars, painting, etc.). This work was, to them, a much more acceptable way of becoming part of the total program, for it enhanced, rather than threatened, the male image -- hence their self-esteem.

EXPERIENCE WITH THE CHILDREN

We have described the serious developmental lag and the behavioral and learning problems evidenced by all the children in the project families. The most striking aspect was the progressive seriousness of these manifestations at each age level.

There were also several severly disturbed or autistic children at the preschool level. The most seriously disturbed children were members of families in which parental functioning was grossly impaired. For these children, the

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[37/] Slater, P.E. THE PURSUIT OF LONELINESS: American Culture at the Breaking Point. Boston: Beacon Press, 1970. 154 pp.

Center had to assume major parenting responsibility, as well as corrective intervention, over a longer period of time than was required for the other children.

As we came to know the children, certain aspects of their problems and behaviors became clear. In spite of frequently contradictory overt behavior, they were extremely fearful and had many anxieties. Each new experience, however pleasurable in anticipation, produced extreme anxiety.

Initially, the children had little capacity for fun and enjoyment. Their participation in activities was of an anxious, demanding, quarrelsome nature. Their facial expressions usually denoted frustration and anxiety rather than pleasure.

The older children, in particular, were extremely fearful of relationships with adults and, like their parents, remained hesitant and apprehensive for a long time. They reacted to any prohibition or refusal of their demands as a rejection or as an attack. They all showed a strong sense of failure, their feelings of shame connected to their inadequacies in learning and other areas of achievment.

In spite of much overt conflict between parents and children and frequent absences from home on the part of older children, there was evidence of a strong, binding tie between the child and parent, particularly between child and mother. The relationship, however, seemed to be more infantile in nature than is usual in children of the same ages. This was demonstrated in the children's demands to be taken care of and in their fear of separation, even during short trips.

Uncontrollable, oppressive outbursts suggested both the presence of a high degree of aggression and the absence of defenses or controls to deal with it. The violent outbursts of the older children were similar to the temper tantrums of their preschool siblings, but were of a more serious nature and harder to deal with.

In general, working with the children -- which lasted 2 to 3 years for most of them -- was one of the areas in which there was demonstrable progress. The children learned to handle their aggressions in a more sublimated fashion and had fewer aggressive outbursts. The boys tended to look back on these outbreaks with some degree of puzzlement and concern. On a recent visit to the Center, one of the older group, who is now 17, commented, "I used to be a very violent person. I would suddenly throw anything at someone who I thought gave me a dirty look."

In addition to their aggresive outbursts, the children handled all fears and frustrations throught "running away" activity or by engaging in disruptive behavior, such as breaking windows, stealing, etc. As they became better able to talk, to express their feelings, and to trust others, these activities decreased.

In spite of all their resistances, the children had a tremendous desire for relationships, for gaining approval, and for giving and receiving emotional responses. It was this that enabled us to work with them at the outset and which greatly facilitated their progress.

CHAPTER VII

FIVE FAMILIES AT INTAKE

THE CASE EXAMPLES in this chapter illustrate the Center's treatment approach to both parents and children. The cases were selected to show the ranges in parental capacity and the Center's attempt to focus services in relation to needs. Our experience would strongly support the position that it is inadequate to the treatment process to provide services to parents in severe neglect situations without concommitant services for the children.

Two examples are typical of cases in which substantial improvement was realized, both in the parents' functioning and in the children's progress. At the end of the project, final review showed no areas of neglect. However, a difference remained in the amounts and kinds of services needed by each of the two families and in their rates of improvement. The D. family, although requiring a massive input of tangible services, responded much more quickly to intervention and the mother demonstrated clear capacity for independent functioning. In contrast, the parents in the B. family had many serious personality problems, requiring intensive treatment over a long period of time, and improvement came at a much slower rate.

The D. Family

The condition of the D. family at the point of intake was described in Chapter III (p. 45).

The Center provided immediate services to this family. The two preschool children, ages 2 and 4, were entered in the full day care program, which allowed Mrs. D. to change from night work to a daytime schedule. The school age children were engaged in the 4-day per week group work program, as well as in other activities. The social worker assisted Mrs. D. in establishing eligibility for supplemental public assistance.

When intensive efforts to find a suitable apartment failed because of the family size, the family moved into the Center's emergency shelter. They remained in the shelter for 2 months until a large apartment became available through the Chicago Housing Authority. The Center secured furniture from various voluntary sources to help furnish the apartment.

A male social worker was assigned to work with Mr. D. because of his continued drinking, physical problems, and lack of employment. Mrs. D. became increasingly insistent that he not be in the home when drinking because of his effect on the children. Although it was not possible to help Mr. D. to make substantial changes (because of his advanced deterioration) effort was directed toward his care and protection, such as seeing to it that he had a place to live, food, and carfare. He frequently came to the Center and was included whenever possible in its activities.

We believed that this investment in Mr. D. was of value not only to him but to the children. They were aware of our commitment to protecting them from their father's abuse while witnessing an acceptance rather than a rejection of him.

The two preschool children developed well in day care and subsequently entered public school at grade level. The four latency children, however, exhibited many behavioral and developmental problems and made no progress in school. Therefore, the three boys were entered in the educational therapy program. Ultimately, they were able to enter public school at grade level; they made continuous progress in their studies and in extracurricular events. The older girl got along well in the group work program and other activities.

While this family required and utilized a large amount of project services, all family members achieved significant growth. Mrs. D.'s capacity to care for her children and manage her responsibilities within the limits of the realities of her situation became evident at the end of the first 3 months. In this respect, she differed from a number of the parents who were more severely limited in their development. She related to her children as children and not as peers, and she was able to establish appropriate controls and protection of them. This case and others like it suggest that, where a person's early experiences have not been overwhelmingly devastating and limiting, the inherent strength of the individual as a parent will be apparent shortly after the provision of needed service.

The B. Family

The B. family, which consisted of the parents and 8 of their 11 children, ranging from preschool age to adolescence, were referred by every agency and school in the deteriorated area in which they lived.

This family had come to Chicago from a southern Appalachian area several years prior to referral. Only one of the children attended school and most had not been in school at all. The older latency children could not read or write. The father had worked very little since coming to the city; the mother worked only now and then. The family moved frequently within the same general area, and the home could only be described as complete chaos. Sleeping arrangements and facilities for food preparation were totally inadequate. The apartment was frequently filled with a variety of teenagers whom the parents could not control, and even the younger children spent nights away from home without being missed.

Mrs. B. was completely overwhelmed and depressed. Although verbalizing interest in the children's going to school, etc., she was not able to follow through on any plan. Mr. B. was preoccupied with maintaining a dependent relationship with Mrs. B., and both parents were so involved in their conflict with each other that they had little time or energy left for the children.

Mrs. B. frequently left Mr. B. for many hours or even for days at a time. Because he had paranoia to a considerable degree and was unable to function when his wife was gone, the Center had to assume almost a total parenting role for the children. The older boys were in the educational therapy program and the younger children in the day care program throughout the first 2 years.

The repeated crises and lack of progress in this family made placement a constant consideration. A major factor against placement, however, was the children's strong family identification. Also, they were so lacking in socialization that foster family placement seemed doomed to failure. Another positive was that, in spite of her behavior and problems, Mrs. B. showed some areas of strength: she developed a close relationship with the worker, had considerable warmth and affection for her children, and, despite repeated separations, always returned to them. But it required almost daily contact of two social workers and the support of homemaking and other services to avoid placement.

Very gradually, the parents became able to involve themselves in family treatment and individual casework conferences. Mrs. B., in particular, made marked progress in her ability to verbalize her feelings and to move toward a more planned resolution of her life situation. Mr. B. was able to secure steady employment with the help of the worker and to move away from his paranoid preoccupation (i.e., jealousy of Mrs. B.).

The family reestablished their home on a much sounder level, and, to date, no further separations have occurred. The quality of the home life improved remarkably in terms of housekeeping skills, orderliness, and overall interest in the appearance of their home and of themselves. This new stability was of great value to the children, although lack of care had left its imprint. While they are doing much better than we had anticipated, we believe that earlier intervention, particularly with the older children, would have facilitated their intellectual achievements to a greater extent. However, the younger children are currently doing well in school, and the older children, several of whom are now married, are functioning adequately.

The family members keep in touch with the Center, and Mrs. B. expresses her belief that the Center was the one positive, helpful experience in her life. She frequently comes back to appear on television or meet with reporters to express support for the need for such services as she received from the Center.

The F. and L. families are two cases representing the group in which (because of serious and chronic mental illness on the part of at least one parent and poor functioning on the part of the other) improvement in parental functioning was from the beginning not anticipated. However, for various reasons, it was necessary to maintain most or all of the children in their own homes. As in many similar families, the older children had strong ties to the parents and their behavioral problems were such that substitute care was neither feasible nor available.

A great deal of help was provided to the parents in these two families simply to maintain a more stable environment. For the most part, the parents were cooperative and the children made remarkable progress, considering their inherent handicaps. However, the Center had to invest a tremendous amount of substitute parenting to help these children.

The F. and L. families were similar in their degree of pathology but presented interesting contrasts. Mrs. F. was a withdrawn psychotic woman, while Mrs. L. (see p. 48) was a volatile, acting out person who required almost total attention and patience from large numbers of staff.

The F. Family

From the onset, the F. family severely tested the staff's commitment to provide service to the most dysfunctional families. Mrs. F. had had several psychiatric hospitalizations; Mr. F. was paranoid and given to violent rages.

During treatment, the serious degree of pathology in both parents and their total inability to provide even the most minimal care for their children became increasingly evident. In addition, positive relationships between family members were nonexistent.

These limitations, combined with the serious nature of the problems presented by the children, indicated the need for immediate placement. However, implementation of placement confronted the staff with a frequently experienced dilemma. Although Mr. F. welcomed the help provided by the Center and complained about his inability to care for his children, it was clear that he would violently oppose placement. While critical of his children's behavior and abusive in his relationship to them, Mr. F. interpreted complaints about the children as a personal threat and "mobilized for battle." Therefore, the anticipated traumatic experience for the children of prolonged and contested court action, as well as the unavailability of appropriate placement resources, were important considerations in our planning on behalf of this family.

Eleanor, a very disturbed young child, presented the most critical need for a treatment-oriented placement. However, her hyperactive-aggressive behavior, inability to relate to others, lack of speech, and general retarded level of functioning virtually eliminated the possibility of admitting her to one of the few existing institutional programs in the Chicago area. In view of her current functioning and poor prognosis, the best placement that could possibly be effected was an institution for the mentally retarded.

Bill (age 11) and Andy (9) also had little chance of acceptance into institutional programs because of their impulsive behavior, delinquent activities, and poor school records. Certainly, they could not be maintained in foster homes even if these were available. The boys seemed destined for commitment to a correctional facility, although this affords no adequate means of helping children in need of long-term care and treatment.

The F. children were truly the children nobody wants. Therefore, it was decided that while placement was imperative for Eleanor and desirable for the boys, the Center's initial efforts would be devoted to providing as much supplemental parenting and corrective treatment experiences to these children as possible. To enable the children to utilize the Center's services, it was hoped that sufficient stability could be maintained in the home through the provision of tangible help and support to the parents in their daily endeavors. No improvement in parental functioning was expected.

Despite Mr. F.'s distrust of all outsiders, it was possible for staff to establish and maintain a positive relationship with him. He permitted the Center to care for his children, although he continued unable to collaborate in our efforts. As he was rarely able to leave his home, Mr. F. usually seemed delighted by the worker's visits. During these contacts, he was garrulous and rambled about his past exploits in which he had outwitted or beaten someone up. On rare occasions he discussed an event of his past life or revealed his disappointment that his sons from his previous marriage were not in contact with him. Although obviously in pain, Mr. F. resisted all attempts to provide medical care for him. Occasionally he asked for help in filling out papers or in dealing with public assistance and other financial problems. He was generally uninterested in our efforts to provide him with more recreational opportunities, but he did enjoy those occasions in which the child care staff included him on fishing excursions.

Basically, Mr. F. preferred not to be bothered by his children, tending to ignore them until critical situations arose, such as when the boys got into trouble in the community. He then became belligerent, abusive, and threatening to the children and staff. However, gradually, he did come to ask for more help with Eleanor and to request that she be kept in the temporary foster home when he was burdened by family crises.

Mrs. F. was essentially uninvolved in the care of the children. She was limited in her conversation and persistent in the delusion that she was pregnant. During our third year of contact, Mrs. F. suddenly became acutely psychotic. With the help of the Center, she was hospitalized in an agitated, violent, and extremely delusional state. No precipitant was identifiable beyond a hysterectomy performed several months earlier. Mrs. F. had emerged from the surgery more withdrawn and never again mentioned her pregnancy. We can only speculate on the function performed by the delusion of pregnancy in warding off the underlying psychosis.

Eleanor's need for complete physical care, as well as her disturbed and retarded level of functioning, required an investment of time and energy that is difficult to describe. During her 4 years in the program, she was provided total day care in order to reduce her time in the home. For 3 years, she required the complete attention of one person. During the first year, she was cared for by the foster mother in her apartment at the Center.

At the age of 4½, Eleanor allowed herself to be bathed and fed by the staff. Very gradually, her frightened and frantic behavior lessened. She developed minimal speech, and toilet training was established. Very slowly, she engaged in limited play with some enjoyment. In the second year, she was gradually exposed to day care activities but still required the complete attention of one adult. Medication was somewhat useful in reducing her anxious and hyperactive behavior. Although the possibility of severe organic impairment remained, Eleanor had made some progress by the end of the second year. She began to distinguish one adult from another and to relate to one or two of them. Her vocabulary had also increased. In brief, at 6½, this child was functioning as if she were about 2½ years old.

Eleanor's limited progress and periods of regression were discouraging to the day care staff. Her need for occasional overnight or weekend care and her routinely restless and distractable behavior were exhausting. Therefore, at times, there was considerable pressure to place Eleanor in an institution for the mentally retarded where physical care would be assured. However, such placement was resisted as undesirable, and staff reaffirmed their commitment to provide this child every opportunity for growth as long as the project continued.

During our final year and a half, Eleanor made substantial gains in every aspect of ego functioning. While still far behind in developmental norms, she had established a positive self-concept and appropriately related to others. She participated in all activities and developed beginning academic skills. During this period, she spent an increasing amount of time in the Center's foster home. Following Mrs. F.'s hospitalization, Mr. F. requested we assume total care for Eleanor.

It was one of the dramatic and satisfying outcomes of the project that this child progressed sufficiently to be accepted into a good treatment-oriented institution for children with emotional disturbances. She made a very good adjustment, and we were pleased that she was ready for a desirable placement at the time her mother had to be hospitalized permanently.

Of all the latency children at the Center, Bill and Andy presented the most difficult behavioral problems. During the second half of his fourth year at the Center, Bill entered a work/study program in the public schools. He did well and graduated from the eighth grade at the end of the year. He was rightfully proud of his accomplishment and celebrated his success with staff members who were important to him. Bill continued on into high school. Not only is he uninvolved in delinquent activities, but he was recently cited as a "hero" for restraining a burglar until police officers arrived on the scene.

Andy made less dramatic progress than either Bill or Eleanor. He continued to be extremely hyperactive and had little energy for learning. He was less favored by his father than was Bill, and it is our belief that a residential treatment center might have been a more desirable plan for him than staying in the home. However, in spite of State guardianship, an appropriate placement was never found. He has managed to quit his delinquent behavior and, at 17, is involved in a work/study program. He is a seriously handicapped young man, but we believe the years at the Center did provide a degree of security and enjoyment that he had not previously experienced.

The E. Family

The E. family was composed of the mother, son, George, age 14, and Teddy, 5½. An older, late adolescent daughter had been prostituting for some time and was in and out of the home.

Mrs. E. was mentally retarded and emotionally disturbed. George was delinquent and Teddy was essentially psychotic, functioning at a borderline range. Despite their severely disturbed level of functioning, family members were tied to each other, albeit in a negative, dependent way. Mrs. E. and the children were frequently engaged in violent altercations in which one or the other was injured. Simultaneously, Mrs. E. was extremely seductive toward the boys. It was therefore apparent that if the boys were to be permitted to develop as individuals, Mrs. E. would have to have her needs met in order to compensate for the losses implicit in the children's participation in the Center's program and in Teddy's eventual placement.

Although there was some indication that Mrs. E.'s intellectual capacity was greater than suggested by her diagnosis of retardation, her extremely immature level of ego development was evidenced by her poor reality testing, lack of judgment, low frustration tolerance, and minimal defensive structure. As a result, she was explosively angry and lived in utter chaos, frequently without food and often under the threat of eviction. In addition, Mrs. E. related to her children as a peer, breaking their toys or refusing to allow them to come to the Center if she were angry with them or if her own needs were unmet.

The initial provision of services to this family included a homemaker who cleaned the apartment, handled the money, and shopped for groceries. Mrs. E. participated in these tasks to a small extent. By the end of the project, she had learned to manage her household more effectively, and the Center no longer had to parcel out her food stamps and public assistance grant on a daily basis.

When Mrs. E.'s original worker left after 3 years, the Project Director assumed responsibility for her treatment because no one was willing to. Mrs. E. came to the Center daily. She also formed a meaningful relationship with the Director's secretary who made an effort to meet Mrs. E.'s expressed desire to get a job. In spite of her terror and occasional flight during the extensive evaluation process, Mrs. E. began to work at a sheltered workshop. She learned how to take public transportation to the facility and came to enjoy the work. Her hard won achievement was tragically interrupted by a terminal illness.

While the initial and continuing plan for this family included placement of Teddy, we had little hope of achieving placement for George because of his age, uncontrollable behavior, delinquent activities, and ties to his mother. Each defended the other against any imagined slight lurking in the world. This was also one of the families in which the boys had to be awakened frequently and dressed and fed each morning before the Center's bus came to pick them up for school. Inevitably there was a struggle with both children and mother before the boys were gotten out of the home.

George was admitted to the educational therapy program where his wild, delinquent behavior and his drive to dominate the other boys presented almost insurmountable problems. He and Bill (of the F. family, p. 115) posed a real threat to the continuation of the program. At times, George's violence required that a staff member hold him until control of his behavior resumed. During the first year, it was necessary and possible to provide him with individual casework, but this was not feasible in later years because of the number of children in need and the limitation of time. It is likely that he could have used more intensive treatment. He was, however, assigned a VISTA volunteer who provided him individual weekend camping trips over a 2-year period and to whom George became very much attached. As he grew able to express his misery about his home and his desire to get away, George was given a great deal of support. We feel this prevented his return to his old neighborhood to engage in delinquent behavior.

Our efforts on George's behalf, as well as the care and attention his mother received, seemed to sufficiently reduce his anxiety so that his behavior became more socialized, and his capacity for relationships increased during his second and third years at the Center. In spite of his difficult behavior and continuing problems, including ambivalent sexual identity, George was a bright, personable youngster whom the staff liked.

Teddy's age and problems presented an immediate and dire need for residential placement. Nonetheless, his seemingly psychotic functioning at the time of intake made placement exceedingly unlikely without an interim investment of services. Following several years of treatment and care, Teddy was accepted at an excellent residential treatment center. This coincided with his mother's illness, and she was pleased to have him cared for. He has continued to make excellent progress and keeps in touch with staff members he knew at the Center.

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The K. family case (see p.47) is one in which it was necessary to seek long-term placement because of the serious mental illness of the mother and the equally serious alcoholism of the father. This family posed new and different problems for the Center staff.

The K. Family

Mrs. K. -- living in deplorable housing with Mr. K. and eight malnourished children, including an infant she was delusionally fearful of caring for -- greeted the worker on her initial visit. The same day, the worker returned with the foster mother and homemaker, since the Center's underlying philosophy, combined with the range of integrated services, permitted an immediate response to crises. The foster mother assumed care for the seriously neglected infant while the homemaker and worker shopped, cooked, and cared for the remaining children. Mrs. K., who recognized her inability to control her fears and care for her children, responded eagerly to the help. When Mr. K., a sad and deteriorated man, returned from work, he was pathetically anxious to help in the efforts.

In spite of the discouraging picture this family presented, there was evidence that a close relationship had once existed between parents and children. Neither parent was abusive and both expressed some concern for their offspring. Mr. K. was considered a valuable employee and earned an adequate income when his drinking did not interfere with his job. Nonetheless, it was recognized that these parents would require continued and substantial help in the care of their children. If the mother's condition improved, there was the possibility that, at best, the home could be maintained for the older children who were closely identified with their parents and each other. In any event, it was thought desirable to establish a relationship with the children in order to provide stability and support, should placement become necessary.

Following the initial contact, the foster mother took care of the infant in the temporary foster home at the Center. For several weeks, the homemaker cared for the needs of the other children from early morning until the evening when Mr. K. returned from work. The social worker also participated in the efforts to stabilize the family, even including scrubbing, shopping, and procuring clothes for the children. As the dwelling was intolerable, the worker and Mrs. K. searched for a more adequate apartment; this took considerable time to locate.

Gradually, the four school age children -- Peter (10½), Marie (9), Julia (7½), and Jennie (6) -- were enrolled in school and the after-school program at the Center. Initially, they were fearful, anxious children who seemed slow in their ability to grasp ideas. Although Peter was quite withdrawn, he seemed attached to Mrs. K., and there was considerable closeness between the three girls.

Mrs. K., who had been conditionally discharged from a State mental facility, was taken for her outpatient appointments. After resuming her medication, there was some limited improvement in her mental status. Although she remained unable to participate in the care of her children, she expressed more interest in planning for them and became more involved in cooking. She spent some time visiting the baby in the foster home but, because her fears that she might kill the baby persisted, she did not wish to assume responsibility for the child's care. However, in a relatively brief time, Mrs. K.'s psychotic symptoms became more pervasive and she requested rehospitalization. By this time, a child welfare agency was involved and a foster home placement was available for the infant and the four preschool children.

During the next 2 months, every attempt was made to maintain the older children in the home as they were fearful of placement and desperately wished to remain with Mr. K. The homemaker continued to provide for their care during the day and they began to adjust to school and improve in the program. However, Mr. K.'s condition deteriorated rapidly. As his alcohol consumption increased, he frequently failed to return home at night or brought his drinking partners home with him. He did not pay the rent and, in an unsuccessful effort to remedy this situation, the Director met him each payday to ensure that the rent was paid before he otherwise spent the money.

As Mr. K. continued unable to manage money or to come home by evening, the children were brought to live at the Center's temporary foster home. They were well acquainted with the foster mother and staff, so this was not a very traumatic move for them. Because the children lived in the foster home on a continuous basis, various staff members assisted by providing excursions and supplemental relationships on weekends. In addition to foster care, the children received casework and group work services; they were also included in recreational activities.

For a time, Mr. K. was brought to visit his children, but he soon lost his job and disappeared. Beyond a few letters, he remained unavailable for the duration of our involvement with the family. When Mrs. K. had weekend hospital passes, she, too, was brought to the Center. However, she made little improvement during her 2-year hospitalization and remained unresponsive to the children.

The preschool children continued in placement. Their older siblings, who lived at the Center, presented many problems related to the impact, during their developmental years, of the parents' difficulties and of the traumatic dissolution of the family. Peter, at 10½, was a passive, regressed boy. For several years after our initial contact, he remained inert. He had great difficulty sleeping because he shared his mother's delusion that a man was chasing them. He functioned at a retarded level and was frequently teased by his sisters for being stupid.

As he was essentially nonverbal and without any basic academic skills, Peter was included in the educational therapy program. Despite his limited progress, he was maintained in the program because of the unavailability of an adequate institutional setting and the contraindications for foster home placement, given his minimal capacity to relate and his poor functioning. Eventually, a paternal aunt and uncle became more interested in Peter and he spent his summers with them. However, as these relatives tended to be critical and hold up unrealistic expectations, Peter, for some time, resisted their wishes that he live with them. In addition, he still had hopes of being reunited with his mother. Gradually, however, Peter began to enjoy his visits with his relatives who had a farm on which he felt comfortable. Finally, he moved into their home.

At 16, Peter had achieved some basic academic skills which permitted him to enter the local public school. Followup visits indicated that he feels accepted and comfortable in his new home, although he remains somewhat sad and withdrawn.

Peter's younger siblings were less seriously disturbed and they responded to earlier intervention with substantial progress. Marie, at 9, was withdrawn but better able to achieve in school. At times, however, she had alarming periods of confusion and disorientation. It was later learned that Mrs. K., just before her first hospitalization, had attempted to strangle Marie when she was 2 years old, an incident which lent some reality to Mrs. K.'s delusions. Jennie and Julia, although immature, exhibited less severe residual limitations than did Marie. The youngest had rheumatic fever which, neglected by the parents, required considerable medical care and a period of hospitalization during her stay at the Center's foster home.

With the provision of medical, physical, recreational, and treatment services, these three sisters made good progress in the neighborhood school and gradually blossomed in response to the nurturing relationships afforded them. At the end of the first year, when the mother's lack of progress was evident, it was decided that the children would continue to live at the Center's foster home where they were well established. This also permitted the staff to wait for three openings in a very good treatment-oriented small institution which had agreed to accept them.

This placement, which was not effected until the children had spent 2 years in the Center's foster home, was considered desirable for several reasons. The sisters were closely identified with each other, and it was therefore important that they remain together. Their continuing need for help, and their ties to their natural parents, suggested the inadvisability of a regular foster home placement. Finally, the paternal relatives, who had become interested in the children and looked forward to a continuing relationship with them, were more comfortable with the idea of their nieces living in a residential school rather than in a foster home.

When placement became available, the children were well prepared, and the transition to the institution was an easy and positive experience. Followup visits with the facility and the children give every indication that they are now relatively happy, well-adjusted girls who continue to develop their emotional, social, and intellectual potentials.

Regardless of the extreme parental dysfunction and the dissolution of the home, the children's developmental achievements and adjustment to placement suggest a successful outcome that justified the Center's provision of intensive services.

CHAPTER VIII

A SUMMING UP

FAMILIES PARTICIPATING in the Bowen Center Project were in a critical condition; almost every area of their functioning was impaired. The situations we encountered were chronic, with little or no evidence that the families had ever had a really stable period in their lives.

Our task was to help the parents achieve improved parental capabilities and to facilitate the children's mastery of appropriate developmental achievements for their ages. We attempted to achieve this by means of supporting small steps on the road to independence. For such a broad undertaking, the actual length of client contact (1½ to 3 years) was relatively short. The project ran a little over 5 years, but the first year was devoted to planning and the last few months, to transition to a different program.

PLACEMENT

At the time of referral, the plight of the children was so critical that placement planning had already been contemplated for some of them. Without our help, the children in all of the families would have needed placement. Although one of our major objectives was to help the families to care for their children at home, we recognized that appropriate placement might, of necessity, be the only treatment plan for some. By learning to understand the strengths and potentials of each family, we were able to make a careful decision about placement. When no other choice was open to us, we managed to arrange an appropriate placement with the least amount of trauma to the parents and children.

We entered each family situation without any preconceived idea of placement. Our policy was to give the family an opportunity to see what improvement could be made with treatment. The services of the Center made it possible to provide care and protection to the children, thus reducing the need to rush into placement.

During active contact with these families, only 8 situations called for placement -- 27 out of 162 children and involving 11 out of 60 parents.

In one case, both parents were alcoholic and stayed away from home for long spells. The children were without parental care, and parental stability was impossible to achieve.

One mother with a baby born out of wedlock was both retarded and an alcoholic; adoptive placement was effected in compliance with her wish. In four other situations, the mothers were single parents and mentally ill; in three of these, there was evidence of severe abuse of the children.

ANALYZING OUR EXPERIENCE

The children who were able to stay at home all made substantial progress in social and cognitive development. Improvement in parental functioning, however, came much more slowly, ranging from substantial to minimal.

Families That Did Not Improve

In six families, parental functioning did not improve, but the children were, nevertheless, maintained in the household. This was often because the age of the children or other factors made placement impractical. Usually, such families included older children who strongly identified with their parents. Among others, the younger children had acute problems and could not be placed. Parents with minimal or no change were those in whom diagnosed mental illness or other serious pathology had been evident early and/or for whom substantive change could not be anticipated.

These families required a massive investment of service on a continuing basis, including almost total parenting responsibility for the children. With this effort, it was possible to reduce chaos in the home and to achieve sufficient minimal stability so that the children could remain in the home and still make consistent progress.

It is valid to ask whether children should be kept in the home under such serious and irreversible conditions. Part of the problem is related to resources. Some of the older children, while making progress, had severe limitations resulting from the deprivations they had endured from birth. Their plight points to the need for appropriate, early intervention. For some, the best plan would have been residential placement with restitutive treatment. However, such treatment resources were not available. Also, most community agencies cannot invest the time and intensive services necessary on a long-term basis. Hence, the availability of the Center program enabled this particular group to benefit considerably.

The older children developed sufficient controls and interests to give up their destructive delinquent behavior. Equally important, they formed relationships with the staff which sustained them through the inevitable tragedies and anxieties associated with their parents' behavior. They maintained an informal relationship with the Center after the project was over and sought help in periods of crisis such as the illness, death, or hospitalization of a parent. In addition, the younger children profitted sufficiently from the care and treatment received at the Center so that some of them could be accepted in appropriate placement facilities when the parent or parents were not able to care for them. (This happened three times after the project was terminated.)

Families That Made Substantial Improvement

A small number of families made substantial improvement in both parental functioning and in the progress of the children. At the time of final review, there were no signs of neglect, although these families were severely neglectful at the time of intake and required extensive service during most of the project period. However, we were able to see consistent changes beginning in the early stages of treatment. We could identify parental capacity and maturity despite situational problems or, in some instances, emotional problems. The parents were able to assume increasing responsibility for independent parental functioning and their relationship with the Center became more participatory. They no longer needed the type of complete support and intervention that was true of most of the families.

The In-Between Group -- The Majority

By far the largest group of families fell between these two extremes. These families needed help in every area of their lives. They were neither able to give emotionally to their children, nor to provide controls and care. Progress was slow and uneven. However, despite these pervasive limitations, there was intermittent evidence of growth potential and of positive feelings for the children. Although suffering from deep character defects, they were more intact (less fragmented) than the parents in the first group. They were gradually able to relate to the staff and to utilize the services of the Center for their children and themselves. The efforts of the Center were unquestionably toward maintaining these children in their homes, with some expectation of improved parental functioning.

By the time the project terminated, most of the parents were functioning at an improved level, and the nature and amount of services needed had changed. They had more self-esteem and felt more secure, and the neglecting symptoms had been substantially ameliorated. However, they were still somewhat shakey in independent functioning. Even under improved circumstances, a few, who had the most serious personal limitations, needed some supportive help in parenting until the children were older. Others just needed a longer period of time in which to stabilize their gains.

With regard to the children, a factor often overlooked is that children who have experienced so much early deprivation need far more sustenance than their parents are able to provide.

The Bowen Center Project experience convinced us that families with serious problems of neglect can be helped to move to a level of functioning sufficient for the children to continue to live in their own homes. Unfortunately, societal expectations are linked to the concepts of total independence and self-sufficiency. If that were not so, more effort could be made to provide center-type care on a long-term basis to maintain developmental gains and to preserve the integrity of the family.

FOLLOWUP

We reviewed the status of 13 of the project families during the last 3 months of 1974. The groups selected for followup were the large families in which the parents and children received extensive service and which were active cases at the time the project was terminated. We did not review families in which all of the children had to be placed at an early date and in which the parents, because of alcoholism or mental illness, had not been available for treatment. In addition, some families had left the city.

Our followup task was relatively easy because, in most cases, the parents and children have maintained some kind of informal contact with the Center and were readily available.

In those families in which one or both parents were maintaining homes at the close of the project, there had been consistent stability and improvement in household management. In other words, they had maintained family relations on a higher level without regression. In two families (described earlier), the death of the mother in one and the hospitalization of the mother in another required the placement of two younger children. This was accomplished by the project staff shortly after the termination of the original project. Followup shows that these two children are doing exceedingly well in good placement institutions.

In the case where the mother died (see p. 119), the family situation had been such that the mother and two boys had required many staff services over the 4½ years of the project. The Center's relationship with these boys typified a number of instances in which the Center served as an extended family. In this case, the relationship proved to be of great value when the mother became ill. Staff members visited the mother during her long terminal illness. Even though the older boy was 17 and on his own, the relationship continued to have great meaning for him.

Both boys turned to the Center for support in their grief, and the staff accompanied them through all the stresses of the funeral and the attendant problems of their mother's death. The younger boy, who had been placed in a residential treatment center about the time his mother became ill, thinks of the Center as his family and is particularly close to two staff members. Recently, he asked one of them, the Project Director, to be his sponsor at his confirmation. In spite of his past severe learning and behavioral problems, he has made an outstanding adjustment and is developing very well in the program. The older boy recently married and returns to the Center periodically to discuss his plans and future.

Among the children who remained with their parents in the other 11 families, there has been, considering their past history, consistent adequate to good adjustment. The 10 boys who were in our educational therapy program are now in late adolescence or early adulthood. Several have finished school. The older boys are now working. None of them has been involved in delinquent activities in the past 4 years. This is particularly significant because they were all in conflict with the community and known to juvenile authorities for problems ranging from stealing and vandalism to such serious offenses as burglary and mugging.

With one exception, the older girls in the 11 families finished school, as did the other boys in the group programs who were not in the educational therapy program.

The younger children in the families, most of whom had been in the day care program, are all in school and, for the most part, are doing well. Several of the children present some emotional problems (resulting from past deprivation) and require treatment. However, the families are cooperating and the children are making progress.

CONTINUATION ACTIVITY

During the last period of the project, the Department of Health, Education, and Welfare gave us an interim grant for a continuation project to be devoted to younger families and preschool children. We then added a number of families from the rolls of the major children's hospitals and public health nursing programs.

By this time, we had learned much about how the Center and its staff could be used most effectively. The older families collaborated with the staff in bringing the newer ones into the Center's activities and groups. While the new families were younger, they were no less in need of services; their children were badly neglected and some were far more psychotic than had been the case of the earlier group.

The new families were quickly assimilated into Center activities, with gratifying results. The day care program was expanded, and we found ways to adapt to the specific needs of the new children and parents. One example was two young parents with an autistic 4½-year-old child and an infant. The parents were immediately involved in treatment. They made considerable progress, and the autistic child, through the specialized program in day care and individual treatment by one of the trainees, is now in first grade and doing very well.

One of the unique dividends of the project was the opportunity to continue operation after the Federal grant expired; this was made possible by funding from the Illinois Department of Children and Family Services. The purpose was for enabling the Center to offer a teaching and training program, with particular focus on young families and preschool children.

With the new grant, the Center was consequently able to add four young families to its clientele. These families already had serious problems in marital and parental functioning, and their children were even more seriously damaged than had been true of our earlier families. We were, therefore, enriched by the new experience of responding early to the needs of parents and children.

The parents were included in all of the Center's services, and the children, who were in the initial stages of severe impairment, were closely observed through the period between day care and school entry. This provided us with an unparalleled opportunity to explore the potentials of this time span in assisting children in their developmental tasks and in seeing them through the initial stages of latency.

In spite of the fact that one mother was a borderline psychotic and another had had long periods of depressive illnesses, it has been remarkable to observe the progress the youngsters of these mothers made in coping with the realities of their lives, as well as to watch their development. Three children of one mother (who is in and out of a psychosis) are making significant progress in school and in socialization generally. They have received individual treatment and after school group experiences. In spite of the relatively bizarre nature of their home experiences, they are developing well and performing at grade level. In another family, in which the mother has periodic psychotic episodes, the children have been able to respond to both group and individual treatment. By now, they are well into latency and have achieved considerable independent stability; their progress, we believe, would have been impossible except for the opportunity we had to work with them.

The continuation of the Center program permitted us to test out our original concepts in a wide variety of situations. Also, during this time, ways in which the Center could be used to facilitate the growth and special needs of the client were expanded.

Before the final phase of the project concluded, a large Mexican family had a confirmation party for one of the daughters. Complete with band and many guests, the party was very meaningful for the mother who had not had the opportunity to have such a party herself and who had dreamed of having a traditional, cultural ceremony for her daughter. It also had special significance for her to have the party at the Center.

Another important event was a wedding party for a couple who, after several years of contact with the Center, decided to be married. The staff put together a beautiful party attended by staff members and the couple's three children. Their only guests were other clients at the Center and the groom's parents. The wedding party had tremendous significance to this family as it represented the resolution of years of uncertainty and strife.

APPLICATION TO BROAD FIELD

Throughout the project, we gave much thought to ways our experience could be adapted for use by other agencies and applied to the broad field of child neglect and abuse. Naturally, we developed some judgments as to essential service needs during the operational years, but we believe it is too early to make a complete or final assessment.

During the first 4½ years of the basic project, we learned from the clients (and from the staff) how to better understand and respond to the needs and the dehumanizing plight of the parents and children. We learned how to coalesce the various learnings and contributions of the staff, and how to make maximum use of our rather shabby and meager physical facilities. As we went along, we learned a great deal about training, since we had students from schools of social work, VISTA volunteers, community volunteers, and anyone else we could interest. We also learned that such a joint effort can best be achieved by a democratic, cooperative, on-the-job experience, supplemented by staffings, administrative support, and supervision.

We firmly believe that a process in which there is purpose and commitment involves individuals in the learning process in a way that cannot be taught academically alone. We had the rewarding experience of seeing both students and paraprofessionals become involved in the program -- to the extent that they, themselves, contributed to the innovative extension of services.

During the initial period, staff members collaborated with other agencies by offering training and consultation, institutes, and lectures. In addition, we had opportunities to meet with people from other programs, both in and out of State; these occasions enabled others to observe our programs in action and gave all of us the chance to exchange ideas.

Television and press presentations were among the most rewarding of our experiences in interpreting the program in the community. Our clients participated willingly. This involvement not only added to their sense of self-purpose but offered evidence of their own achievement and understanding; it was a real source of pride to them.

We also made available our knowledge of the problems of neglecting families and treatment approaches, for use in developing curriculum content in schools of social work and other teaching institutions.

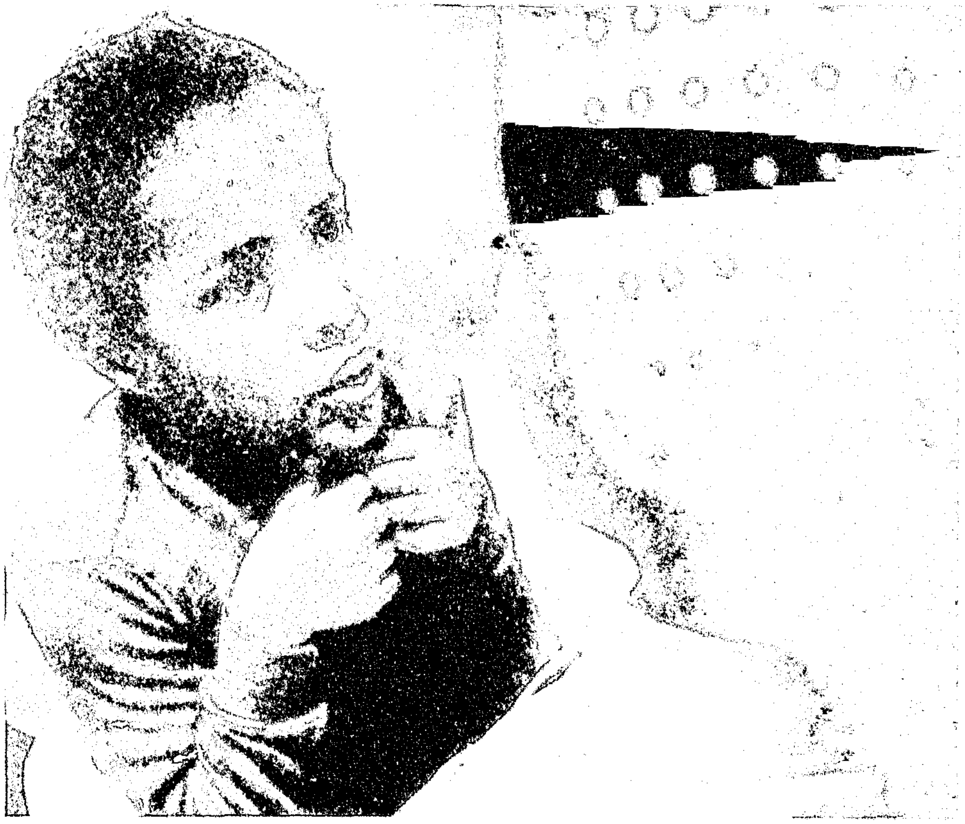
The training program financed by the Illinois Department of Children and Family Services not only gave us a closer working relationship with the larger public program but also allowed the Center to continue accepting the most serious child neglect problems for study and service.

During the first 2 years of the State-sponsored program, 4 units or teams of 9 members each, were trained at the Center for 6-month periods. They carried cases and were fully involved in all of our activities. When the 6 months of training were completed, each team was assigned to one of 4 district offices in the Chicago area to carry out the protective service function of the department. The Center staff continued to provide a consultative function to these teams and their immediate superiors who were following their assignments back in the public agency. The program was highly successful, not only in the training, which was received enthusiastically, but also in terms of putting our comprehensive service principles to work in the general public welfare program. The teams functioned very well and many more people were reached.

During the last 2 years of this program, the problems of child abuse were added, broadening our service from neglect to outright flagrant physical mistreatment. Thus, we were aligned with the national concern for the abused child and with the trend in most States to enact legislation to permit apprehension of and corrective measures for offenders.

The Bowen Center Project, we believe, effectively demonstrates what intensive care services can accomplish, at least in one setting, toward keeping families together and in improving the growth in self-confidence and responsibility of both parents and children.

* U.S. GOVERNMENT PRINTING OFFICE : 1977 0-730-392/1587



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