News and Views

The Community Living Room

Steven P. Segal and Jim Baumohl

Steven P. Segal is Professor and Director, Mental Health and Social Welfare Research Group, School of Social Welfare, University of California, Berkeley, California. Jim Baumohl is Hotel Project Director and Member, Board of Directors, Berkeley Support Services, Berkeley, California.

This article describes a program called the "community living room" after one of its principal functions, which is to provide a place for the easy socializing from which help often derives. To the authors' knowledge, no program exactly like it exists anywhere; the community living room is a composite of programs that have been visited and studied by the authors and those in which they have worked. It is also the product of imagination, informed by years of research and practice with the chronically mentally ill, street people, and the homeless and poor in general. The existing program that is perhaps closest to this ideal is Berkeley Support Services, in Berkeley, California, but there are doubtless others of a similar nature. Indeed, the term *community living room* was suggested ten years ago by a staff member of an agency in Richmond, Virginia, called The Daily Planet.

The goal here is to be useful rather than original. The program envisioned is one that serves as an effective link between society's byzantine system of formal aid and those individuals who are in serious need of assistance but whose tolerance of protocol is severely limited. That this program owes much to settlement houses, runaway centers, hotel outposts, streetwork agencies, and other programs should be obvious and is gratefully acknowledged.

The Clients and the Context

The community living room is for all comers, but it is designed with the homeless poor and the chronically mentally ill foremost in mind because it is a program intended to address the basics of survival and to foster connection and trust where there is often isolation and suspicion.

The term *homeless poor* is used in a broad sense. It does not refer merely to those undomiciled individuals who, without regular abode, take up residence in transient shelters, box cars, well-concealed shrubbery, or under bridges. The lack of a domicile is an important indicator of homelessness, useful mainly because it permits some estimate of magnitude. For instance, Ellen Baxter and Kim Hopper, summarizing the reports of social welfare and mental health agencies in five Eastern cities, estimated that the undomiciled run to thirty-six thousand in New York, five to ten thousand in the District of Columbia, four to eight thousand in Boston, eight to nine thousand in Baltimore, and over three thousand in Philadelphia.[1] Still, if a house is not a home, neither is a home merely a house. A home is a representation of important relationships with family, friends, even institutions. In the most important sense, a home is a place that represents desirable and highly valued attachments.[2]

In pursuing this broader notion of homelessness we are led to the rooming houses and residential hotels which afford and compound the social isolation which is at the core of homelessness. Indeed, there are sections of the city—skid rows, tenderloins, and the like—where family ties are minimal, friendships brittle and short-lived, and secure living space hard to come by. Although there is scant quantitative evidence, numerous field studies strongly suggest that a great deal of urban

1. Ellen Baxter and Kim Hopper, *Private Lives/Public Spaces: Homeless Adults on the Streets of New York City* (New York: Community Service Society, 1981).

2. Theodore Caplow, Howard M. Bahr, and David Sternberg, "Homelessness," in *International Encyclopedia of the Social Sciences*, ed. David Sills (New York: Macmillan, 1968), vol. 6, pp. 494–99.

Social Casework: The Journal of Contemporary Social Work

poverty is characterized by transience and isolation.[3]

Some unknown but presumably high percentage of the homeless poor consists of chronically treated mental patients. A recent study of Manhattan shelter residents found that 34 percent had been hospitalized for psychiatric problems.[4] A one-month survey of young lodgers in a forty-five-bed Berkeley shelter found that more than 40 percent had been hospitalized for psychiatric problems at some time,[5] and a week-long survey of 295 patrons of a Berkeley emergency food dispensary found that 22 percent had been psychiatric inpatients at some point.[6] Stuart R. Schwartz and Stephen M. Goldfinger, summarizing an unpublished study by Chafetz conducted in 1979, reported that:

"In a study of 420 randomly selected patients seen in the same emergency services and similarly diagnosed, 20.9 percent were found to have no local residence. An additional 53.5 percent claimed residence in a district of San Francisco noted to have no single-family residential homes, with 89 percent of the residences hotel rooms or "studio apartments."[7]

In the absence of adequate community care, this result was predictable. For better or worse, the mental hospital no longer provides long-term, life-sustaining services for the mentally ill. Today's chronic patients face a different set of social and economic contingencies than did their counterparts twenty years ago. The reorientation of mental health services to the provision of community-based care has recast the nature of chronicity. Whereas autonomous adaptation to chronic mental disorder was atypical until the mid-1960s, it is now an established fact of life to which the mentally ill and their potential benefactors must adjust. Unfortunately, the adjustment of the human service community has been slow and ineffective; the social and material support of chronic patients, previously provided by mental hospitals, has been neglected. Thus, today's chronic patients are not only chronically disordered but chronically poor. This is a direct result of changes in the United States's system of mental health care.[8]

Today's chronic patients also represent a generation of mental health clients who are young (average age about thirty-five years) and whose relationships with institutions have been formed in an era of civil rights and consumerism. Few have experienced long-term hospitalization, and few exhibit the apathy, lack of initiative, or the resignation that numerous studies found to characterize the long-term mental hospital resident. These "new" chronic patients have not been socialized to docility, to the role of acquiescent mental patient; they do not use services in the tractable fashion of their predecessors but rather as wary, often angry consumers demanding response to their broad needs for social and economic support. Furthermore, numerous clinicians and researchers have observed that today's chronic patients, especially in the younger age range (eighteen to thirty-five years), tend to resist the contention that they are mentally ill.[9] They often define their distress as derivative from their poverty or their isolation or, in some cases, their denial is incorporated into an elaborate system of

3. See, for example, Leonard U. Blumberg, Thomas F. Shipley, Jr., and Stephen F. Barsky, *Liquor and Poverty: Skid Row as a Human Condition* (New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1978); Elliot Liebow, *Tally's Corner* (Boston: Little, Brown and Co., 1967); Steven P. Segal, Jim Baumohl, and Elsie Johnson, "Falling Through the Cracks: Mental Disorder and Social Margin in a Young Vagrant Population," *Social Problems* 24 (February 1977): 387–400.

4. Stephen Crystal, Mervyn Goldstein and Rosanne Levitt, *Chronic and Situational Dependency: Long-term Residents in a Shelter for Men* (New York: Human Resources Administration of the City of New York, May 1982).

5. Berkeley Support Services, Berkeley, California, "Memorandum" (November 1977).

6. Jim Baumohl and Henry Miller, *Down and Out in Berkeley* (Berkeley: City of Berkeley-University of California Community Affairs Committee, 1974).

7. Stuart R. Schwartz and Stephen M. Goldfinger, "The New Chronic Patient: Clinical Characteristics of an Emerging Sub-Group," *Hospital and Community Psychiatry* 32 (July 1981): 471.

8. Steven P. Segal and Jim Baumohl, "The New Chronic Patient: The Creation of an Underserved Population," in *Reaching the Underserved: Mental Health Needs of Neglected Populations,* ed. Lonnie R. Snowden (Beverly Hills, CA: Sage Publications, Inc., 1982), pp. 95–116.

9. Bert Pepper, Michael Kirshner, and Hilary Ryglewicz, "The Young Adult Chronic Patient: Overview of a Population," *Hospital and Community Psychiatry* 32 (July 1981): 463–69; Schwartz and Goldfinger, "The New Chronic Patient"; Segal, Baumohl, and Johnson, "Falling Through the Cracks."

delusions. Thus they approach services with mistrust and fear of confrontation about their psychiatric status.

Of this new chronic population, and the homeless poor in general, the younger members especially have the vices of their agemates, in particular their use of illegal drugs and alcohol. Their sometimes prodigious consumption of drugs complicates their psychiatric status, erodes their social functioning, and contributes mightily to their difficult relations with human services.[10] In addition, heavy drinking, illicit drug taking, and sexual activity are difficult to accommodate in community-based sheltered care.[11]

The community living room is designed with these issues and conflicts in mind. Moreover, it is conceived with full awareness that a typical pattern of service utilization among the poor and among impoverished, free-living chronic mental patients is their selective use of "therapeutic stations" for purposes that differ from the stated mission of the institution. The hospital, for example, is not viewed as a site of treatment but as a site of temporary refuge; nor is the mental health clinic perceived as a site of treatment but rather as a safe place to make contact; the caseworker is not seen as a therapist but as an advisor, mailman, safe deposit box, moneylender, or source of access to a telephone.[12] This modest manipulation of the system enables people to fulfill dependency needs or needs for economic resources and sociability without sacrificing control of their circumstances and without necessarily accepting themselves as mentally ill or as subjects of charity. By preserving their own definitions of their plight and circumstances, they get what they need without obligating themselves to the institution's purposes.

This description provides a background for considering the community living room.

The Community Living Room

There are four primary functions of the community living room. First, it provides a place to be; second, it offers survival services; third, it is a point for case finding and case management; and fourth, it offers food and shelter. In most communities it is probably not desirable to combine the shelter element on the same site as the others. It may also be useful to spread one function over several sites. Much will depend on available facilities and management problems pertaining to certain spaces. The community living room should be thought of as a constellation of related activities rather than as one program operating from an imposing building in which all is combined.

A Place to Be

The simple object here is to provide a place to do things or to "hang out," people with whom to do things or with whom to "hang out," and the material resources necessary to such activity. In some respects, then, this suggests a simple recreational element with some useful amenities. Typically, this is a storefront or church or synagogue basement with couches, a pool table, a pingpong table, card and game tables, a television set, and an area for reading or small talk with a pot of coffee brewing. It would also be useful if there were a shower, perhaps a washing machine and dryer, and a kitchen with a small dining area. The important idea is to provide a gathering place where life can be less boring and can be made easier by access to practical necessities. Clearly, the furnishings should not suggest the sort of elegant living room forbidden to small children.

Unlike an office, this element of the program does not require or imply that a visitor have a particular purpose in mind. Nonetheless, the staff of this component should have more in mind than shooting pool or keeping order. In the authors' experience, it is in this sort of nondirected setting that the worker gains the most intimate knowledge of his

10. Jim Baumohl, "The Organized Constraint of Drug Dealing: Moral and Political Choice in a Residential Hotel" (Paper delivered at the Thirty-fifth Annual Meeting of the American Society of Criminology, Denver, Colorado, 12 November 1983); Pepper, Kirshner, and Ryglewicz, "The Young Adult Chronic Patient"; Schwartz and Goldfinger, "The New Chronic Patient."

11. Steven P. Segal and Uri Aviram, *The Mentally Ill in Community Based Sheltered Care* (New York: John Wiley, 1978).

12. On the concept of therapeutic stations see Jacqueline P. Wiseman, *Stations of the Lost: The Treatment of Skid Row Alcoholics* (Englewood Cliffs, NJ: Prentice-Hall, 1970); Dan A. Lewis and Rob Hugi, "Therapeutic Stations and the Chronically Treated Mentally Ill," *Social Service Review* 55 (June 1981): 206–20.

"clients" by listening to them describe their circumstances and their triumphs, failures, or daily indignities. It is also in such settings that worker-client relationships can be formed gradually and candidly with minimal role distance interfering. Here, unencumbered by intake and assessment protocols that ritually confirm clienthood, worker and client may become known to each other through a process of gradual disclosure.[13]

There is a further value to working with people in such a setting. To the extent that people have friends who provide them with support or to the extent that they can develop such relationships during the course of "hanging out" in the community living room, the worker can support these ties by helping to resolve inevitable disputes and by being alert to ways in which cooperative action can solve problems. This is particularly important in circumstances where the law fails those without the desire or the resources to use it.[14]

Survival Services

Whether or not combined on a common site with the recreational component, the core of the community living room consists of a multiservice center that provides one-stop shopping for human service needs. This does not mean that all human services need to be represented on site but that any client ought to be able to sit down with a worker and, based upon a thorough appraisal of present needs, work out a detailed plan for using existing systems of aid to provide for those needs. In sum, it is a place where a client may sit with a worker and develop a detailed plan in aid of survival. The multiservice center should offer the following sorts of services:

First, the center should provide a safe place to receive mail (including checks) and messages, store belongings, and use the phone.

Second, the multiservice center should provide public assistance advocacy. Stephen Crystal and his colleagues observed that "dealing with public assistance is perceived as extremely difficult and troublesome by a significant number of these [shelter] clients, [thus] the advisability of stronger encouragement and assistance in following through with public assistance applications. . . ."[15] Workers should be able to assess a client's prospective eligibility for various sorts of programs (for example, general assistance or home relief, Aid to Families with Dependent Children, Social Security, food stamps, Medicare, unemployment insurance), work out a detailed plan for securing the necessary documentation, provide assistance in filling out the necessary forms, and serve as an advocate in the event of hearings or appeals.

Third, the multiservice center should offer money management (including representative payee) and check-cashing services. Where appropriate, client and worker should develop a money management plan that assures that the client's basic needs are met, that the client is being trained to manage his or her own money, and that a savings system is devised.

Fourth, the center should offer a mental health brokerage service which provides referral and follow-up for psychotherapy and monitors and acts upon the availability of board and care beds, space in sheltered workshop programs, and the like. It will be useful for the center to organize a referral network of therapists who are adept at cases involving loneliness, depression, and drug and alcohol abuse.

Fifth, the center should offer paralegal services (or have a staff attorney) to help clients deal with small-claims court cases, matters of debts and bankruptcy, tenants' rights, name changes, and uncontested divorce proceedings. Similarly, voter registration and tax preparation are matters for attention.

Finally, the center should provide a casual labor service and monitor the available space in public employment and training programs or supported work projects.

Emergency Shelter

This is an extremely important component of the community living room, and it is probably the most difficult to manage properly. Not since the municipal lodging houses of the Depression era have there been so many ill-

13. Steven P. Segal and Jim Baumohl, "Engaging the Disengaged: Proposals on Madness and Vagrancy," *Social Work* 25 (September 1980): 358–65.

14. Baumohl, "The Organized Constraint of Drug Dealing."

15. Crystal, Goldstein, and Levitt, "Chronic and Situational Dependency," Appendix A.

conceived shelters for the homeless poor. Only political and financial expedience recommend the warehousing currently in vogue. The conversion of armories and hospital wards to shelters is not desirable, especially if residence in such a shelter replaces cash grants for public assistance, thereby creating a new sort of poorhouse;[16] or if conditions are such as to warrant comparison with prison.[17]

An emergency shelter should provide safe, clean shelter and food for as short a period of time as possible to as few people as possible. Lengthy stays in large shelters that are most often spatially and socially isolated from the wider community provoke the despondency, apathy, and dependency called "shelterization" by Edwin H. Sutherland and Harvey J. Locke;[18] and "institutional dependency" by many observers of mental hospitals and other large-scale residential institutions.[19] In the authors' view, emergency shelters should be small, located within the mainstream of community life whenever possible, and their activities should be closely coordinated with those of the multiservice center described above.

Emergency shelters of relatively small size are important for several reasons. First, small size mitigates the need for regimentation and police presence that often creates a captive/captor relationship between residents and staff. Second, small size facilitates the use of groupwork techniques to promote mutual aid among residents and to resolve the disputes that inevitably arise when people live cheek by jowl for any period of time. Third, small size facilitates the participation of residents in the maintenance and operation of the shelter, thus allowing them to feel less like subjects of charity and more like responsible participants in the solution of their dilemmas. Only incidentally does resident work reduce the operating cost of a shelter or serve as a quid pro quo for free lodging.

Shelters must also be designed with families and couples in mind. Currently, very few shelters can provide private rooms for parents and children or rooms where couples may sleep together. Crowding families and couples into dormitories or separating their members are serious disorganizing influences on lives already at loose ends.

Clearly, short stays in emergency shelters can be accomplished only if one function of shelter or multiservice center staff is to monitor the availability of other sorts of housing and housing assistance programs. In many cases, residents of emergency shelters resolve their immediate problems of income only to be relegated to a shelter because they can find no affordable permanent housing or because they cannot piece together the last month's rent and security deposits required. While the authors agree with Thomas J. Main that "the purpose of the shelters should be to act as a safety net for . . . people until they can be reintegrated into a . . . social service program,"[20] it is bewildering that he fails to recognize structural sources of homelessness, preferring instead to treat it as the outcome of individual pathology. Like unemployment, "unhousing" is a problem of political economy not amenable to simple tinkering with the victims. Society must build vastly more low-income housing and must put significant resources into saving what remains of a dwindling supply of residential hotel units.[21] Without such efforts, shelters will become long-term encampments of the poorest citizens regardless of social work intervention. Condemned to long stretches of abject impoverishment, many of the homeless poor will develop precisely those characteristics deplored by Main and will play out their strings in the badlands between the criminal

16. See Steven P. Segal and Harry Specht, "A Poorhouse in California, 1983: Oddity or Prelude?" *Social Work* 28 (July/August 1983): 319–23.

17. See Crystal, Goldstein, and Levitt, "Chronic and Situational Dependency."

18. Edwin H. Sutherland and Harvey J. Locke, *Twenty Thousand Homeless Men* (Chicago: J.B. Lippincott Co., 1936).

19. For a discussion, see Steven P. Segal and E. William Moyles, "Management Style and Institutional Dependency in Sheltered Care," *Social Psychiatry* 14 (December 1979): 159–65.

20. Thomas J. Main, "The Homeless of New York," *The Public Interest* 72 (Summer 1983): 24.

21. For specific suggestions and a review of current projects see Bradford Paul, "Testimony Before the House of Representatives Committee on Banking, Finance and Urban Affairs, Subcommittee on Housing and Community Development," in *Homelessness in America* (Washington, DC: U.S. Government Printing Office, 1983), pp. 694–778.

justice and mental health systems, whose representatives will manage their own helplessness by denouncing their clients.

A Commonsense Approach

The allied services that comprise the community living room represent a practical, commonsense approach to the intertwined problems of poverty and mental illness. There is nothing about the community living room which is particularly innovative or daring; its components are social work staples and reflect a commitment to organizing and providing services in a manner that suits the problems of consumers rather than the needs of a labyrinthine system of social and mental health services. It is a form of help that "begins with the client" and resists the divorce of mental health problems from the duress of everyday life. It relies upon patience, rapport, and support rather than on expedience and coercion, the hallmarks of a declining charity.

Book Reviews

Voluntarism and Social Work Practice: A Growing Collaboration. Edited by Florence S. Schwartz. New York: University Press of America, 1984. 234 pp. Cloth $33.75; paper $20.75.

An enigma of significant proportions confronts and challenges professional-lay relationships in the practice of social work in the United States. In the public and private sectors of social service delivery, there are long-standing and valued patterns of productive practitioner-volunteer collaboration in providing qualitative social programs and services. In contrast, the professionalization of social work education and the specialization of social work practice have tended to diminish the credibility of professional-volunteer teamwork. Serious questions have emerged at a time when populations-at-risk are multiplying, fiscal constraints heighten competition for increasingly scarce service dollars, and political attacks on social programs are continuous and caustic.

Voluntarism and Social Work Practice: A Growing Collaboration provides a timely framework for building community and for conducting an urgently needed reexamination of basic beliefs and professional training. The book is based on a number of articles compiled earlier for a special issue of the *Journal of Voluntary Action Research.* It represents one of a number of outcomes of an interagency task force convened by the Association of Junior Leagues to examine "how people volunteer." The volume is the product of a project underwritten by the Lois and Samuel Silberman Fund and directed by the editor, Florence S. Schwartz. The project focus was "to build increased understanding of volunteers and their role in social agencies, and to encourage the inclusion of material on volunteers in the social work curriculum." With clarity and rigor, this series of articles systematically addresses an array of myths, misunderstandings, and myopic-dichotomous thinking shared by large numbers of professionally trained social workers. The primary thrust is to offset a pervasive practice-wisdom and provide a balanced analysis of the volunteer as a valued resource and colleague in social service provision. Most importantly, it showcases a variety of examples of the exciting and pragmatic potentialities of carefully conceptualized and activated professional-volunteer partnerships.

This work deftly "responds to a gap identified ...as—'a dearth of well researched and well prepared professional writings that can be used as part of curricula in courses, field work and special projects that will help expand the education of social workers regarding the broad range of volunteer programs, the history and role of voluntarism in our society, and the special techniques and guidelines professionals need to learn to deal with voluntarism.' " While both the National Association of Social Workers (NASW) and the Council on Social Work Education (CSWE) have given token recognition to voluntarism and the volunteer, these first steps are insufficient. A case in point is the Summer 1984 first national conference on health, held in Washington, D.C., and sponsored by NASW. The conference theme "Policy, Politics, and Practice" highlighted over 140 institutes and workshops, a lobbying happening on Capitol Hill, and an extensive display of NASW literature. Conspicuous by its absence was explicit or implicit reference to volunteers or to the resources provided by voluntarism. A recurrent motif of the conference centered on pleas for increased fiscal resources, education, and advocacy. Significantly, these areas directly relate to what volunteers are doing in policy-making, direct service, innovation, and initiation of new funding and services throughout the United States. Another brief case in point is the recently distributed CSWE monograph entitled *Education for Primary Prevention in Social Work.* Characteristically, not one article provides in-depth attention to the role of volunteers in advocating for, or contributing to, the development of preventive work in mental health. Why this hiatus in NASW and CSWE in regard to voluntarism and the volunteer as colleague and partner in social services?

Explanatory insights and relevant answers to the foregoing question are found in the excellent, well-documented analyses in this book. The contributors to this seminal work of seventeen articles include distinguished professional leaders in academia and in public and private social work practice. For the undergraduate and graduate educator there is a plentitude of conceptually rich and relevant material for course modules, bibliographies, and course assignments in every area of the curriculum.

The lead article presents a provocative political-economic analysis. The thesis of Michael Reisch and Stanley Wenocur suggests that the changing relationship between voluntarism and professional social work has been one of dynamic, evolving tensions in response to shifting political, social, and economic realities on the national scene. Within a historical context, the authors describe the potentials to be found in a realignment of volunteer-professional partnerships in the postindustrial era. The content of this book breaks new ground in

not covering "the more familiar volunteer programs in traditional agencies such as hospitals and family and children. Rather it challenges social workers and their helping organizations to develop and expand volunteer programs to meet new and changing ways of delivering service." Adrienne Ahlgren Haeuser and Florence S. Schwartz describe processes for developing social work skills for work with volunteers. Louis Lowy examines the components of cooperation of volunteers and professionals in social services. Schwartz puts into perspective definitions and meanings associated with the conceptualization of voluntarism, volunteers, and social work practice. Social work education and voluntarism are assessed by Winnifred Herington.

Attention is given by Mary M. Seguin to social work practice with senior adult volunteers in organizations run by paid personnel. Also, Marie Weil describes the involvement of senior citizens in needs assessment and service planning. Norma Radoll Raiff and Barbara K. Shore address the interfacing mutual-help and mental health delivery systems: implications for policy and administration curricula. Cynthia S. Pincus and Evie Hermann-Kelling assess self-help systems and the professional as volunteer: threat or solution? The professionalization of volunteer administration is represented in the work of Felice Davidson Perlmutter. Sally Y. Orr describes the role of volunteers as advocates. Michael H. Phillips analyzes the motivation and expectation in successful volunteerism. An alternative theoretical perspective on race and voluntary participation is outlined by King E. Davis. Patricia S. and Ronald T. Potter-Efron account for volunteer training for nonbureaucratic agencies: utilizing social work roles to increase volunteer skills. Ralph M. Kramer presents a framework for the analysis of board-executive relationships in voluntary agencies. Charles Guzzetta assesses the voluntary agencies in the welfare state.

A final article looks at the future for volunteer-professional collaboration. Eva Schindler-Rainman examines the implications of trends and changes in the volunteer world: "The 1980's and the 1990's will be challenging periods for volunteers, and staff working with volunteers, and for the systems with volunteer opportunities. The changes that are occurring are rapid and complex. . . . It is a time of transition which makes it possible to be creative, non-traditional, energetic, bound by nothing but human limitations, turfdoms, lack of vision and resistance to change. Indeed transition may be the key concept that characterizes where the volunteer world has been and where it is going."

An attractive feature of this publication is graphic tables and charts displaying data, theoretical concepts, drawings of interrelating systems, and typologies of relevant principles. A clustering of articles into thematic groupings, a glossary of basic defini-

tions and terms, and an index could have added to the utility of this work. It is also to be hoped that future publications will extend and give in-depth treatment to the important topics represented in this fine collection of articles.

In this volume, the editing has yielded a well-rounded selection of material immediately adaptable to the purposes and process of professional social work education. The content is pertinent for students, lay people, researchers, administrators, practitioners of many people-serving disciplines, planners, social activists, concerned community leaders, involved citizens, and especially professional social workers. It would seem to be essential reading for the staff member committed to growth and to enhancing the quality of life within a value set emphasizing pluralism, a holistic approach, and humanistic partnerships.

This publication augers well as a foremost example of the meaningful work of the Association of Voluntary Action Research Scholars. It joins a growing resource file of creative and scholarly studies. Particularly noteworthy in these publications are the selected references cited at the end of each article which anchor it to a growing body of literature on volunteer-professional transactions.

Morris D. Klass
Division of Social Work
Memphis State University
Memphis, Tennessee

Child Welfare. By Erva Zuckerman. New York: Free Press, 1983. 218 pp. $17.95.

Child Welfare: Current Dilemmas • Future Directions. Edited by Brenda McGowan and William Meezan. Itasca, IL: F. E. Peacock Publishers, 1983. 519 pp. $21.95.

Child Welfare by Erva Zuckerman, provides an overview of the child welfare field presented in a readable format. The book uses case examples to demonstrate what child welfare practice is, who provides child welfare services, as well as what is known about preventing breakdown, about restoring families to health, and about finding new families to provide permanent care for children. While the book claims to address a wide range of audiences, including practitioners, students, administrators, and academicians, it is this reviewer's opinion that its level is really appropriate to starting practitioners or students. It does not go beyond describing current practices, including occasional innovative programs, and as such provides nothing new to the more knowledgeable reader. Only the last two chapters on what child welfare professionals still need to learn and on future trends move beyond the descriptive to addressing the many challenges facing child welfare practice. The problem is not so much that issues are ignored but that they are not discussed in detail.

One example of the type of problem is that the book appears to accept, as much child welfare practice does, a sexist role formulation. While the term *family* is used, the author conceives of the family in role terms which see the mothers as primary care givers and fathers as economic providers. This conceptualization leads one to see culturally different styles as deviant. It leads the author to write, "*Even* a single male can adopt successfully in such circumstances" [italics added].

A second example is the degree to which the author avoids the issue that a major cause of child welfare problems is the lack of basic supports for families. The level of income supports provided by the society are too low and, especially in the urban centers of the United States, decent housing is often not available.

These problems must be addressed if prevention is to be possible. It is not that poverty, unemployment, deteriorating neighborhoods, and substandard housing "make it very difficult for parents to give adequate care to their children," it is that such problems lead even the most stable family to provide inadequate care. As noted in the book, James Garbarino has pointed out that economic stress is the best predictor of abuse rates in New York State. A book on child welfare must consider how the child welfare worker can address these systemic problems. While noting that certain programs such as the Lower East Side Family Union have teams addressing housing problems, the author does not discuss how such teams operate. A careful reading of the case vignettes makes clear that finances and housing are often at the base of a family's problem.

While the reviewer supports the book's references to social networking, it is his reaction that the book focuses on structural solutions and spends too little time reviewing what is known on how to go about working with the social network of the family and community in both preventive and restitutive work.

Two other issues need further discussion within the book: (1) How will PL 92-172 impact child welfare practice and (2) What are the dangers inherent in the development of computerized tracking systems in child welfare?

In summary, this book gives a basic overview of child welfare practice as it is. As such, it is good background reading for the beginner, but it does not move us forward either in practice or conceptualization.

Child Welfare: Current Dilemmas and Future Directions, edited by Brenda McGowan and Wil-

Meezan, on the other hand does attempt to with both current practice and the issues con- the attempts to strengthen practice. The suffers from the problem of all books which collection of chapters written by different While each chapter has a clear structure— as if an outline was provided each author the chapters are cross referenced, they tend repetitive and uneven. Despite this relatively flaw, the book is an important child welfare can both help the beginner learn what welfare practice is and provide the experi- child welfare person food for thought.

book has excellent coverage of the child wel- field, with the early chapters setting a con- the later ones by discussing what should boundaries of child welfare practice, how welfare has evolved historically, and what the legislative and policy thrusts has been welfare. Included in the latter is a discus- Title XX legislation and PL 96-272. It is within this larger context that one can under- degree to which ideology rather than the families have determined child welfare

book then covers the major areas of child practice including "preventive services," and adoption, highlighting some of the such as case assessment, decision and the current permanency thrust. In there are many important ideas, challenge to the *best interests of the* of decision making put forth by Theo- Stein and Tina L. Rzepnicki. There is also on staffing and training.

its strengths, two aspects of the book questioned. In the beginning, the position that child welfare practice should be nar- focused on basic child welfare tasks. While acknowledged that it is futile to think that welfare of children in this country can be en- without further efforts to provide adequate supports, housing, health care, and an ade- resource system, the book does not address fact that these do not exist. It is the review- opinion that such a limited framework, while conserving resources, has led to the current situa- where the child welfare system is focused upon itself and sees families as somehow deficient. A family focus will recognize that some fam- are being asked to raise their children without adequate income and housing. What we need to recognize is that adequate social supports must before we can expect families to survive. We need to focus more energy, rather than less, on primary prevention. Our "preventive" work merely been secondary prevention addressed to the "at risk" family. While such thinking is implicit in several of the chapters, it needs to be addressed more directly if there is to be the family centered policy suggested in the chapter by Sheila B. Kamerman and Alfred J. Kahn.

A second problem in the book is that it pays insufficient attention to how intercession might occur through the use of informal networks. Given what is known about the impact of social isolation upon families, a more extensive discussion of how working with indigenous helpers both to avert problems and solve problems would be helpful.

Despite these lacks the McGowan and Meezan book is an important advance on what was available, and it should be used as a basic book in the child welfare field.

Michael H. Phillips
Graduate School of Social Services
Fordham University
New York, New York

Family Therapy in Schizophrenia. Edited by William R. McFarlane. New York: Guilford Press, 1983. 355 pp. $25.00

Family Therapy and Family Medicine: Toward the Primary Care of Families. By William J. Doherty and Macaran A. Baird. New York: Guilford Press, 1983. 302 pp. $22.50.

The Guilford Series, to which these two books belong, is a landmark series dedicated to the task of applying family systems theory to diagnostically diverse, multiethnic families. Alan S. Gurman, the editor of the series, influenced not only the selection of issues to be addressed, but also established the high standard of scholarship. In the two books being reviewed, the relevant research is blended into the presentation in a way that clinicians will find informative and helpful. This reviewer's overall impression of these books is that they demonstrate that it is not only desirable but also possible to present material in a way that thoroughly integrates research and practice. In this area, Gurman has been in the vanguard, quantifying statistically what all family theraists "know": that family therapy works.

Having perhaps overstated his optimism about family therapy, this reviewer shall now address the clinical condition for which family therapy has proved to be overwhelmingly ineffective: schizophrenia. The epistemological breakthrough which led to theorizing about family members as interacting self-governing systems evolved with the exciting discoveries of distorted communication (Bateson and Jackson's double bind theory), schismatic and skewed families (Lidz), conflict avoidance patterns (Wynne's pseudomutuality), and undifferentiated states of ego development (Bowne's ego mass)—

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It was in fact more likely that the
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families. Both approaches failed

ect of family therapy's paralyzation
nia relates to the emerging bio-
ch and the development of psycho-
in the 1950s. Research on the biolog-
of schizophrenia produced such start-
in reducing florid psychotic symptoms
wholesale dispensing of drugs triggered
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tory to meet the needs of an ambulatory
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l health services makes it imperative to
look at the families of schizophrenics
again with this group. The fact is that
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go home. A large proportion of them
e of by families, and, furthermore,
ncipal care givers are "the key in-
patients' ability to function and
the hospital."

Furthermore, family therapy with schizophrenia has been hindered because of a cognitive failure throughout the health field that gives justification to the attack on the medical model. Schizophrenia is not a single-factor condition. Under the best of conditions it cannot be managed, let alone "cured," with drugs or therapy (of any modality) alone. As Lyman Wynne states "family therapy may be a crucial component of treatment but that, alone, it is *never* [italics added] an adequate or sufficient approach to schizophrenic problems. Indeed, therapy of any kind is only one part of the approach that is needed." It is in this context that *Family Therapy with Schizophrenia,* edited by William McFarlane, is such an important addition to the family therapy–community psychiatry literature.

Dedicated to the late Al Scheflen, this book states and restates that "schizophrenia is a multilevel problem, with determinants at the biological, psychological, family, social, and political levels." With this in mind the book describes psychoeducational, behavioral, multiple-family, strategic, paradoxical and multi-faceted approaches, and includes a chapter on working with poor families who have a schizophrenic member. Every chapter is worth careful reading. The following chapters are particularly noteworthy.

Every social worker, regardless of his or her interest in family therapy as a specialty, should be required to read Steven J. Goldstein and Lawrence Dyches' chapter "Family Therapy of the Schizophrenic Poor." In presenting an ecological model for involving and working with the schizophrenic and his or her family, the authors identify "deficits in organization at several levels of the ecosystem, as both the determinant and the result of schizophrenia. By this, we mean (1) deficits in the ability of the patient to organize; (2) underorganization in the family; and (3) disorganization in the network and community." Goldstein and Dyche speak intelligently and knowledgeably as they describe the approach they developed in their eleven years of working at a hospital in the South Bronx.

In a chapter entitled "The Stages and Impact of Crisis-Oriented Family Therapy in the Aftercare of Acute Schizophrenia," Hal S. Kopeikin, Valerie Marshall, and Michael Goldstein describe a six-week program combining medication with crises-oriented family therapy in the aftercare of schizophrenia. Carol M. Anderson describes "A Psychoeducational Program of Families of Patients with Schizophrenia," stressing information about the illness (etiology, onset, treatment, course, and outcome) and management of the illness by the family. Family sessions are held after an initial orientation phase to help the patient and the family reintegrate. In general, the goals of the therapies described are not traditional family therapy objectives of restructuring the family through second

...the resourceful-
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..." the authors say, " the family
... whether to assemble the family
... individual patient's problems in
...al context. Generally, we believe
... should attempt to assemble the
... patient is newly diagnosed with
... chronic illness, is not respond-
...ying with treatment, is suffering
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... such as weight loss."
... that "This orientation suggests
...y safe to assume family involve-
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... the special aspects of the long-term
... that exists between a physician and
... patients, and reflects the wide spectrum
...le interventions from early diagnosis and
...social assessment to direct short- and long-
... family oriented interventions.

This book augurs a coalition between physicians
... family therapists; the authors recognize that
...velopment of family therapy skills requires
...tegration of family therapy training in
... school curriculums and years of supervi-
...graduate training. In fact, the authors'
... reflects this partnership: Doherty is
... therapist and Baird, a physician. As they
... their introduction: "We realized...we
... other."

Sonya L. Rhodes
...ter College School of Social Work
New York, New York

Working with Couples for Marriage Enrichment: A Guide to Developing, Conducting, and Evaluating Programs. By Diana S. Richmond Garland. San Francisco: Jossey-Bass, 1983. 355 pp. $19.95.

This reviewer worked with a couple recently who had been married for 30 years. The husband's opening line was that he and his wife got along just fine "until she started all this talk about relationships." Funny what a little consciousness can do to a pleasant, stable relationship.

Diana Garland seems to believe that couples ought to pay some attention to their relationship before they are on their way to divorce court. She makes a good case for the value of marriage enrichment as a preventative strategy and as a means of revitalizing relationships. Given the terrible anguish stirred by most of the one million divorces in this country annually, it behooves everyone to be thinking about what ails marriage and what remedies can be found for its various diseases.

Garland traces the evolution of marriage enrichment from its roots in the church and in the human potential movement. The interest of the church has to do with values such as the integrity of the family and marital fidelity—in other words, stabilizing forces; the thrust of the human potential movement leads us toward growth, development, or energies focused on change. Some of the negative fall-out from church-based marriage enrichment programs stems from a tendency to overvalue the couple and devalue the individual. Some participants have reported a cultish quality to certain marriage encounter programs. But then, professionals get a little cultish about their particular brand of psychotherapy now and again.

Marriage enrichment programs are focused on improving, developing, and enriching relationships, yet in the reviewer's experience, one of the greatest benefits of getting couples together in groups to talk openly about what it's *really* like to be married is the tremendous relief that ensues when couples discover they are all in very similar boats. The author calls this "normalizing conflict" and helping couples get through developmental stages.

Chapters 3 and 4 describe the design phase of marriage enrichment programs. A strong argument is made for fitting the design to the needs of each group, for clearly articulating goals, and for basing activities and leadership upon a sound theoretical base. General systems theory, Rogerian therapy, and behavioral theory are the three theoretical systems that Garland believes to be most useful.

The dynamics of group composition, recruitment, screening of participants, leadership, and group development phases are well articulated. The point is made that marriage enrichment groups differ from other types of groups in that the various marital subgroups are primary, the group as a

whole is secondary. Discussion is given to the problems and opportunities of working with preformed groups and with groups formed by the leader.

The essence of most marriage enrichment programs is twofold: teaching interpersonal skills and promoting attitudinal change. Listening is a skill that can be taught. Negotiating differences and dealing with conflict and anger are also examples of skills that are teachable. There are technologies that can greatly assist couples in communicating and connecting. The book contains a very comprehensive section on resources for structuring activities. If you are looking for ways to structure your marriage enrichment group, this is the place to look.

Attitudinal change is not as teachable as something like listening skills. Attitudes about sex, about male and female role issues, about power and control tend to become more complex. Attitudes are based on values. Most therapeutic and educational efforts aim for changes in attitudes.

Garland is also concerned with cognitive learning, and she reports on the rather extensive evaluation methods and outcomes of marriage enrichment programs. Most of the research points toward favorable outcomes. It should also be noted that most follow-up studies are short-term, and so the lasting effects of marriage enrichment are in question. Garland stresses the need for evaluative research to find out what works and what doesn't. Chapter 7 is for those with research interests.

Garland writes in a clear, well-focused manner. This book is a state-of-the-art review of the marriage enrichment field. It will be useful to anyone interested in the philosophy, design, implementation, and evaluation of marriage enrichment programs.

Just a few words of caution to those whose zeal to enrich marriage might be near-sighted:

1. Marriage is not for everybody.
2. All of the "right" skills, attitudes, and behaviors do not a soulful relationship make.
3. If you elect to view marriage as a path to individuation, put away your ideas about marital bliss.
4. If you are working to improve marriage—your own or someone else's—just remember the fable of the fisherman's wife who kept wanting more and more from the magic flounder—until she asked for too much and ended up back in the pigsty.

Warren H. Erickson
Family Counseling of Greater New Haven, Inc.
New Haven, Connecticut

Computers in Clinical Practice: Psychotherapy and Mental Health Applications. Edited by Marc D. Schwartz. New York: The Haworth Press, 1984. 510 pp. $34.95.

[illegible] all alike.
[illegible] WAY?
[illegible] always bugging us about something or other.
YOU THINK OF A SPECIFIC EXAMPLE?
[illegible] boyfriend made me come here.
BOYFRIEND MADE YOU COME HERE—
[illegible] INTERESTING.
[illegible] I'm depressed much of the time.
SORRY TO HEAR THAT YOU ARE
[illegible]SSED.
[illegible] I am unhappy.
THINK COMING HERE WILL HELP YOU
[illegible] BE UNHAPPY?

[illegible] not your usual private practitioner interacting with a client in comfortable middle-class surroundings. It is the Eliza computer program [illegible] a psychotherapeutic interview. Although [illegible] represents a fairly exotic use of computers, [illegible] of other tasks that can be performed by microcomputer makes its eventual adaptation by clinicians inevitable. Computers can be [illegible] for word processing, billing and accounts [illegible], document analysis, scheduling, office [illegible], psychological testing, biofeedback, the compilation of progress notes, treatment tracking, financial planning, the generation of clinical case records, access to library and diagnostic data bases, diagnostic assessment, neurobehavioral training, and so forth.

While the future is unlimited, the present leaves a great deal to be desired. Marc D. Schwartz, the editor of this book on the utilization of computers in clinical practice, is properly cautious about the short-term gains.

> . . . the promise of computers can be awesome. [However] the neophyte must guard very carefully against the temptation to confuse this promise with current reality. In general, the more experience people have with computers, the more modest are their expectations of them, and the more willing are they to tolerate the series of frustrating and confusing incidents that may occur in the course of implementing and learning to use them.

Lawrence Lanes illustrates this very clearly in his chapter on applications of the microcomputer when he reports on how difficult it may be to become familiar with new hardware and software:

> By now, my wife is beginning to wonder about the utility of a device that allows me to perform in two hours what used to require one. Inevitably, in my frequent attempts to demonstrate the purpose or usefulness of a program or piece of hardware, I run into some problem that demonstrates clearly my lack of mastery. . . and my position seems to be eroded yet further.

It takes *extra* time, effort, support, money, and training to learn the new technology either in an agency setting or a private practitioner's office. The development of software for clinicians still lags behind the future promise in all tasks associated with clinical practice from accounting to diagnostic assessment.

This book is the best compilation to date of articles relating to all the possible uses of computers in clinical practice. Schwartz has taken some of the best articles from his newsletter *Computers in Psychiatry/Psychology* and added to it a number of articles that discuss such issues as the effects of computers on people, office accounting systems, word processing, psychological testing, psychological reports, clinical assessment by computer, computer based diagnosis, computers in neuropsychology, administrative and clinical management, the computer as therapy adjunct, education as therapy, choosing a computer, and many others. As with any edited book, some chapters are better than others, and, while the book is comprehensive in scope, the chapters often read like articles in a newsletter. Although Schwartz's book is not explicit or thorough enough in treating any one subject, it is an excellent starting point for us all.

Michael J. Smith
Hunter College School of Social Work
New York, New York

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