An analysis of the malaise of staff members in a Children and Youth Project program is presented. The burden on those who provide service is the gap between promise and fulfillment. The authors discuss various factors involved.

THE ETIOLOGY OF A CHILDREN AND YOUTH PROJECT'S MALAISE

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The legislation which enabled the Children and Youth Projects had as its major objective the provision of “comprehensive health services for children in low-income families through promotion of health as well as medical care, including case finding, preventive health services, diagnosis, treatment, correction of defects, and aftercare, both medical and dental. The emphasis in a project is to be placed upon the comprehensiveness and continuity of services.”* The next quote is from one of the interviews of our project staff on which this report is based: “So maybe I feel we are doing a little bit of good but I can’t see, the way this has been set up and the amount of time and money that has been invested in it is bringing forth the kind of returns we wanted to see. The problems that most people who come to us are facing are the result of the system, and we don’t have any power to affect that system.”

The San Francisco proposal was submitted to the Children’s Bureau in 1967, two years after the legislation was passed, and was the 40th of the eventual 58 projects to be funded. Mount Zion Hospital and Medical Center, our sponsoring institution, is the only general hospital in our target area. While our proposal specified the broad Children’s Bureau charge in terms of its particular community and institutional setting, the project goals remained loosely stated as “coordination of services,” “prevention,” and “continuity of care.”

About a year and a half after the project was fully started, 35, or exactly one-half of the project staff were interviewed by the co-authors. The decision to interview the staff was made in response to a prevailing malaise about the status of the project which expressed itself in lack of unanimity as to project goals, indecisiveness about future direction, doubts about the project’s achievements, feelings of frustration and tension in interpersonal relations. In the initial interviews we asked only three broad questions: What should the goals of the project be? To what extent had the goals been achieved? And how satisfied was the respondent with his own job and how did he see his activities as contributing toward fulfillment of the project’s goals?

The first few sessions indicated that
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contains other than project goals were pressing and troubling to most staff members and subsequent interviews encompassed these major concerns: the structure of the project, the decision-making process, the composition of the health team, and the impact of the racial crisis on the project. The interviews lasted anywhere from one to two hours. Our staff, described by an astute visitor as “exceptionally prone to introspection and agony,” seemed to welcome the opportunity to unburden themselves. For almost everyone, the concerns and uncertainties at the time the interviews were done fell into a few major categories: the number of children we should serve; the breadth of services we should provide; the degree and kind of community involvement; the appropriateness of direct social action; and the perseverative doubt about “what are we really accomplishing.”

It is both the curse and joy of doing applied research in a live setting that one’s subject matter does not stand still. Our interviews were done at the time our project was in a crisis and in response to that crisis. The interviews may have helped to surface the crisis and also may have helped to allay it. Whatever the case, the things we shall be describing proved to be alterable characteristics of our project. Some continue to hold true; for others we have found solutions, although we are clearer about what causes problems than what solves them. We are reporting on this past stage of our developmental history because we feel it has implications for other socially oriented service programs, especially concerning their expectations. Although we did a systematic analysis of all responses, we shall focus here on the qualitative results of the interviews.

Only those who are relatively unencumbered by service obligations—such as supervisory and administrative staff—are comfortable discussing goals in terms of “project” and “community.” Almost without exception, the greater the distance between patient and staff member, the more articulate the goal statement and the greater the willingness to discuss goals in the general terms of the legislation and the project proposal. Those who are in daily contact with patients find the sweeping promise of “comprehensive health services for children in low-income families” bewildering and burdensome. As they deal with the pressure of multiple family problems and few possible solutions, the charge of “comprehensive care” offers no guidelines to daily activities and no gauge of achievement. There is, if anything, stubborn avoidance of all questions and probes with which we tried to direct our respondents to a consideration of over-all project goals and future direction. There is no patience with or interest in the ringing tones of the legislative charge. The health team members’ goals, if they think of goals at all, are pragmatic, defined family by family, sometimes more ambitious than others, but most often circumscribed and short-range.

While the “distance” principle works across all disciplines, there is considerable inter- and intradisciplinary variation: the public health nurse is by training and experience predisposed to a theory of care and, as a result, essentially goal-oriented; the physician, rigidly focused on medical excellence, is less bewildered than the one with a nagging social conscience; the psychiatrist, wedded to analytic orthodoxy and its techniques, feels very out of place on our project but much clearer in the pursuit of his goals, if only he were allowed, than one more receptive to consideration of environmental issues.

The precision with which one’s job is defined has a bearing on how project goals are perceived, on the level of frustration about the project in general, and on one’s specific part in it. For the highly skilled professionals—the physi-
cian, nutritionist, occupational therapist, and psychologist—the goals, to the extent they are able and willing to discuss them, are almost like job descriptions. With an evolved, specialized, and nontransferable skill to hang on to and practice, the tasks are clear. In the murky interdisciplinary realm and in areas in which traditional job definitions are either nonexistent or inappropriate, the frustration is greatest. "I am happy when I am doing my own thing" is another verbatim quote which, in different forms, we heard over and over again. For several community health workers for whom their "own thing" was, at the time of the interviews, still painfully fuzzy—fuzzier for their fellow team members than themselves—the project's direction and their contribution to it are especially confused.

To be a highly trained specialist is not an automatic ticket to goal clarity and job satisfaction. If one's skill is placed in question—in terms of its value or relevance for our particular population—the level of frustration is very high indeed. A few of those we talked to last spring have left us for they saw no chance to do "their thing."

Our project has not stood still and neither has the immediate and larger community of which we are a part. Many of our black staff members, who once felt accountable to the project, the hospital, the Children's Bureau or their profession, now increasingly see themselves accountable to the black community. Being black takes precedence over being a social worker or nurse. The goals often do not coincide. To many black staff members, the project as a whole and what is possible for them to accomplish within it are trivial compared to the needs of the community.

In many interviews—black or white—the dominant theme is disappointment with the project. The disappointed ones are most predictably the early staff members and not the more recent arrivals. For some there is a global disenchantment with the project, its achievements, and its future. For others, restrictions in expectations are more specific—conceived in terms of geographic area, numbers we can serve, kinds of services we can provide. The most disenchanted are those few who preceded the project at Mount Zion Hospital, to whom it once seemed that the vast impending grant monies and additional people could accomplish what an understaffed and underbudgeted clinic had not done. They are also seasoned veterans of the early staff and team meetings, in which goals and patient care procedures were carefully rehearsed as abstractions or dry runs, untempered by the pressures of reality. The later comers to the project, oriented by a chastened staff, expected less and are less disappointed.

A perseverative phrase in the interviews is "we are making dents." The results of time-consuming, skilled, and often successful team interventions are dismissed as "dents"; appreciable improvements in a child's health are "dents"; the securing of a supplement to a welfare check or finding housing for a family displaced by redevelopment are "dents"; arranging an appropriate school placement for a child with a learning disability is a "dent." We have readily available scapegoats to rationalize our impotence: the traditional hospital setting which is viewed as confining; a limited budget; shortages of staff; insufficiency of community resources. Above all, the enormity and complexity of our families' problems make all achievements appear as dents.

Yet the dents we make are the appropriate and only possible tasks of the project. The ill health and poor medical care of our patient population are both symptom and result of social and economic inequities that our comprehensive care program cannot solve. The program is initiated by a government
and sponsored by an institution unlikely to underwrite social revolution.

For the sweeping promises of the legislation and grant proposal—comprehensiveness and continuity of care, prevention, coordination of services—there is ahead of time no gauge of feasibility, no realistic guidelines for implementation, no warning cautions about obstacles or possible failure.

The authors of the legislation and proposals are in the privileged position of making a promise without responsibility for its fulfillment. The burden of fulfillment rests upon the service people. The disparity between the promise and the reality of service was, we think, the chief cause of our malaise.

Our staff, in many instances with deep roots in the community we are serving, is self-belittling of its achievements which, pitted against the promise on the one hand and the need on the other, do indeed seem like dents. We are cured of our malaise to the extent to which we have learned that all we can do is relieve the health problems of the children in our care; to relieve, not solve, for their solution lies in more radical alterations than a comprehensive health care project can offer.

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