Cultures in Conflict:

Mental Health and the Hard-to-reach

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> The idea of conflicting cultures was already with me when I worked as a consultant to corporations and government agencies—and particularly their R&D efforts. I soon began to know that when a director of research quoted Edison about the ratio of perspiration (99 percent) to inspiration, there was a high probability that he was going to have, if perhaps a productive unit, then one of no distinguishing creativity. And I already knew from my anthropologist friends how culture-bound one could be without noticing this—indeed, having no place to stand from which to notice this. Arriving in Vermont and sending myself out into those who dwelt there, I was able to begin to glimpse what my sort looked like—and how they felt their sort would look to my sort. Since they were naturally making manifest the kind of behavior that was apposite to my sort, and how my sort thought of their sort, I was eventually able, by adding, subtracting, and otherwise factoring, to get the drift. Giving the drift was of course another problem.

Available statistics indicate that although some 25 percent of all Americans have at one time or another experienced psychological difficulties of some magnitude (one in five having felt themselves to be on the verge of a "nervous breakdown"), fewer than 4 percent have seen fit to seek or accept care from mental health resources (Joint Commission on Mental Illness and Health 1961). Our work in several rural Vermont communities, however, suggests that both these percentages may require the footnote "under ordinary conditions." For, although figures from Vermont agencies follow the national ratio of one in 25 accepting care, our program over the last several years has been, and is, producing ratios of a substantially different magnitude.

In this program the adult members of every family in which children under 18 are living at home are invited to request participation in groups that will meet once a week with me. The purpose of these groups, they are told, is to discuss anything and everything in which they feel a psychologist could be helpful. Because we approach families, our statistics on those who make use of this mental health resource are based on family units. The national figures given above when extrapolated to such units indicate that yearly 0.56 percent of families can be expected to have one or more members seeking or accepting assistance from a mental health professional. The response to our own program has been close to 40 percent of the number of families invited (on a random basis) each year.

Since the approach we employ (invitation) differs from the ordinary conditions of self-referral or referral by others, any comparison between our results and others can only be an uneasy one. But such a comparison does suggest, perhaps, two points worth noting: first, that the size and make-up of the so-called "hard-to-reach" group are

responses to the mental health system itself; and, second, that by altering some components of that system it may be possible to diminish the size and alter the make-up of this group.

THE MENTAL HEALTH SYSTEM AND THE POPULATION AT LARGE

I am suggesting, in other words, that the relationship between the mental health system and the response of the population to its services is a transactional one in which changes in the one can induce changes in the other. In some respects this transactional relationship has the characteristics of the free market place. Starting with the figure of 25 percent of the population expressing need (my own figures suggest that need is more prevalent even than that), we can define the market potential. Erik Erikson (1950) speaking of the cultural differences among peoples, provides, by analogy to the educational system, a model that appropriately adds the two other factors we require. "Naturally," he writes, "the rewards of one educational system mean little to the members of another, while the costs are only too obvious to them." One can say, then, that our market operates with need, cost, and reward; thus we can describe a dynamic for decisions regarding the use of mental health services as a ratio of need to cost to reward.

The market place, however, is a curious one. At first glance we see that the available services are heavily oversubscribed. One statistic for the 1960 use of outpatient psychiatric care has it that three-quarters of a million people were seeking assistance from but 30,000 professionals (Rioch et al. 1965). In that sense it is a seller's market. But this is deceptive. Most professionals are only too eager to diminish the number of their prospective clients. They seek, therefore, ways of offsetting the degree and consequences of the need they observe all around them. Prevention and earlier intervention are key factors in this effort. And yet we are, or have been, confounded by the reluctance of those we might wish to help to accept our services. Thus, at the same time that it is a seller's market, it is also a buyer's market. Many groups, agencies, and centers are actively seeking ways to bring their services to the hard-to-reach or to make themselves more reachable.

It is difficult, therefore, to avoid the conclusion that buyer and seller aspects exist on both sides and that the mutual confounding that is taking place has to do with the terms of the transaction. My own view is that the resulting confusion is at once reasonable and unnecessary. It is reasonable when viewed as the natural, but not inevitable, discongruity between two cultures, that of the mental health system and that of the unreached or unreaching population. It is unnecessary insofar as many of the transactional terms are gratuitous in functional, though perhaps not in cultural, ways.

To make this plain, let me begin by suggesting that those who currently make use of mental health services do so under three conditions: first, when need is so great as to brook any cost and accept any reward; second, when, under lesser need, the costs are less in proportion to that need; and, third, when—whatever the extent of need and cost—the reward is highly valued.

In the first group are, of course, the desperately afflicted. Often these are people whose sense of inner need is augmented by the compulsion, direct or implicit, of a referring agency, a court, an employer, a parent, or some sort of social pressure.

To describe the second group, I must pause long enough to elaborate on the issue of cost.

Costs can be material and non-material, but seldom immaterial. The material costs of mental health services are clear: time, money, distance, waiting. Clear as they are, they are likely to exist in a context of less obvious non-material costs. These latter can be defined as a person's or, more broadly, a culture's values; but, in a real sense, they are more than that, because to treat them very long as values fragments what is a dynamic and organic experience of self.

Non-material costs, moreover, exist on several levels. As an example, we can take the matter of acknowledging need. For those whose culture considers illness a deviant status, to confess to mental illness means accepting that onus. Negative sanctions, the offshoots of unconscious envy, are leveled against the self-declared ill person; and any exemptions he should require from the usual or non-deviant status come dear. Only when he is clearly at the end of his rope is the envy of others appeased; short of that he must bear the sanctions and the stigma and the interpersonal consequences of his status. In a family that has had difficulties for some time, for one member suddenly to acknowledge that he needs "help" is a serious defeat, sometimes an unendurable loss of face. Few are likely to make such a concession unless there is an overweening superego in conspiracy with the spouse. The victory of the superego brings on a crushing sense of defeat, perhaps a suicide, perhaps the compulsive need for such punishment as the series of surgical procedures people often undergo before going into psychotherapy. But almost always one can expect a deep sense of failure, a depression, a sense of hopelessness, which all mean that therapy has to proceed very slowly before what therapy is all about can really begin.

With such punishments awaiting the members of this culture, either need must be very great and alternatives invisible or the reward we offer must be enormous. But what can mental health as a service or practice offer? Only

one thing, really: assistance in a person's efforts to understand himself and to examine his life. To be sure, we offer an environment for this: courteousness, steadfastness, a benign optimism, and our professional promise not to act out with or exploit those good enough to consult us. But these are scant intermediate and ultimate rewards when weighed against the costs exacted. Yet we will not, as perhaps we should not, offer commensurate rewards.[1] If our job is to offer assisted self-scrutiny, we may not pay, feed, or marry our consultees, nor may we find them jobs (ordinarily), punish their enemies, or endure any more of their punishment of us than we have to.

Still, as I have suggested, there are those who do not experience the necessity of making such sacrifices as I have much too briefly described. The intellectual is sometimes exempt. When he is, it is often because he is already a member of a deviant group, and deviation permits him freedom from certain of the sanctions against which others have no immunity. The wealthy, the Park Avenue matron or the movie star, are examples of those for whom material costs, such as time and money, represent scant sacrifice, while their superordinate social status permits them prerogatives others do not enjoy. Those for whom reward is great include many mental health professionals, whose competence, ethic, or prestige is gratified by their own analysis or psychotherapy.

But when the three conditions are exhausted, we are left with 96 percent of the population whose need is insufficient in proportion to cost and reward. Some of these people are enviably situated; others are in grave trouble. If we are not to await an increase in their need to the point where they seek our help, we must find ways of reducing the cost of our services.

A PROGRAM FOR THE HARD-TO-REACH

The program to which I have alluded was created to do just that. We began with two assumptions. The first I have already made plain. It was that the divergence between the two cultures implied a conflict. And, if we were not to await the initiative of the community, it was we who would have to take the initiative, for otherwise the conflict was not going to be resolved. The second assumption was that conflicts among need, cost, and reward were broader than their specific reference to mental health. They affected other recourses and alternatives as well, especially within a cultural group in transition. Thus, although people did not necessarily want help with conflicts that kept them from seeking mental health assistance, they might well want help with the same order of conflict that, more ubiquitous in nature, was also precisely what kept them from seeking or accepting assistance. It followed from these assumptions that we must proceed in two phases, a pre-resolution or amelioration phase, in which the conflict could

be attenuated enough for help to be requested, and a second or actual phase, in which assistance could then be provided.

We have come to call that first phase the "overture phase," the second, the "group phase." Essentially, however, the process, from the first call upon a family member to the last group session, is continuous and organically unified. It consists of nothing more or less than assisted self-scrutiny. But the initiative varies from the beginning, in which we take the sole initiative, to the point where the individual takes the sole initiative. Preceding each development in this continuum of initiative is a developmental step toward the resolution of the need-cost-reward conflict. The goal we seek is to accompany people through independence, in which the costs of interdependence seem too high, into interdependence, during which period the conflicts are analyzed and alternative ways of being are tried and mastered, to autonomy, in which independence is restored free of the awful threats of interdependence.

To make the overture we have employed local indigenous persons—project associates—now three in number. It is through them that we take the initiative by seeking out our prospective clients where they are—at home—with either specific imagery of the prospect of working with the mental health professional or a basic image into which the dawning of the prospect is all too readily fitted. Whatever the image, the reaction to the prospect tends to be intense. In most respects it resembles the transference reaction; it is an amalgam of transference expectations and the imputation of what Erikson (1958) has called the "negative identity."

The project associates are equipped to deal with these first perceptions and stances of the family members upon whom they are calling by having gone through a series of group sessions themselves. They have come to know in themselves some of the images imputed to the program; they also know it as a reality. Being of the same culture as those upon whom they call, and recognizable as such, they can identify with the householders, as the latter can with them. Continual work on their own remaining ambivalences prevents them from becoming proselytizers of the program, which, together with their own success as active and articulate people in the community, enables them to present themselves and the program openly. Through discussion and role-playing in weekly staff meetings, they have a chance to work on the problems and issues in their job. Still, theirs is not an easy task.

At any one time each associate is responsible for making and following through overtures to about seventy-five families in our nine communities. Traveling over back roads to remote farmhouses or going from one door to the

next in villages, they call on six, eight, or ten families a day. Their task is twofold: to invite the householder to consider whether working with a psychological consultant might be useful—offering the family that option at *their* option—and to demonstrate just what it is that working with a psychologist involves.

The associate begins by calling unannounced, introducing himself (or herself), and telling the householder that he is working for a mental health project. When invited in, his next step is to find a way to engage the householder in a discussion of how life is going for him or her. He does this by picking up on what the householder, from a glance, seems to care most about, whether it be television, sewing, a car, children, or worries and problems themselves. At first, the associate must ask questions or otherwise direct the conversation. From his own group work, he is skilled at looking inward to measure the degree of caring expressed and at directing the householder toward a deepening expression of that caring. Such subject matter begins then to take on its own momentum, with the householder taking over the initiative. This shift in initiative allows the associate to listen, reflect, and, when the time is right, wonder with the person about the person's life and experience. The associate resists calls for advice, asking instead what the person himself does. From time to time, when necessary, he comments on the nature of the present interaction, largely as he did in a group. He does this primarily when he is being cast in a role (made a recipient of a resistance-engendering transference reaction) as critic, enemy, friend, or sympathizer. Aware of the presumptuousness of his conduct, he is aware, too, that resentments, doubts, and suspicions have to find as much expression, recognition, and acceptance as does the pleasure of his caring to call in the first place.

All of this takes more than one visit, so that when the first visit ends or becomes uncomfortable, the associate raises the question of whether he shall stay or leave, come back or not return. This is the second shift of initiative. Here the associate tries to find the narrow line between taking a "no" at face value and treating it as a preliminary statement that invites reflection and, perhaps, a final "yes." He then makes his own plan to return at an interval determined both by what the needs of the individual seem to warrant and by what the logistics of forming groups call for.

The invitation to consider extending the process initiated by the project associate to work with me is made when, after one or more visits, the conflict between need, cost, and reward has begun to weaken. Just how long this takes varies, of course, from person to person; a rough average is three one-hour visits. In coming to the point of accepting the invitation or not, the householder has by this time visualized it against the backdrop of the accomplishments and problems he or she has been discussing; he has inspected what has been taking place between

the associate and himself, found it useful and meaningful without feeling that he has been found sick or unworthy, laughable or depraved, bad or ennobled; he has wondered about the prospect of replicating past relationships within this new context and found this prospect either subject to comment or deprived of mutual role-taking; he has, in all this, decided yes or no. This answer has, in turn, been inspected and wondered about by associate and householder together, with additional hopes, needs, and resistances brought out and viewed. If the answer remains affirmative, an appointment with me is duly made.

The appointment marks still another shift in initiative, for now the householder must come out of the home, be at an office at a certain time, and get there by his or her own means. But the change is not too drastic. My consulting room is in my home and has little of the clinical office about it; it does not appear to be a place where sick people are seen, diagnoses made, tests given, pathological conditions located, or even notes taken. I do not, in fact, give tests, take histories, or undertake any such interview activities. I try, rather, to conduct the session as if it were the fourth or fifth session of therapy, asking for self-observations and commenting on conditions that seem to obstruct the free presentation of the self.

The process started by the associates thus continues without interruption. My intent in these individual sessions is to locate the conflict in the troublesome situation, detach it somewhat from the circumscribed guise it has taken, interpret it to a degree, listen to the recognition that it is wider or broader or more ubiquitous than it seemed, wonder how it might affect the person's feelings about being here with me—and thereby assist the transition from the present meeting to the prospective group sessions. At the end, I ask whether the sort of work we have been doing seems useful enough to be continued, assuring the person meanwhile that his word is good enough for me. Unless I encounter someone simply too agitated for the group sessions, I abide by the person's own inclination—no matter what the absolute diagnosis. Enviably well-functioning and gravely disturbed people, and all in between, may make up the membership of any given group.

Throughout the overture, as we are attempting to demonstrate what we ask of people and what we don't, we are in other ways reducing costs as well. In general, much of what we do and how we do it adds up to a dispensation with the medical model, which is otherwise so much part and parcel of mental health as a cultural system. We go *to* people—to all the people and not identifiable problem groups; and our groups, group *people*, not symptoms or statuses in life. We *forswear* pressing our invitation or declaring that people "need" our services. We give over the initiative as fast as we can, yet not so quickly that people have to ask before they can bear to. We take

sick and well alike. We are as indifferent as we can be to whether or not our invitations are accepted and thus do not imply that we want to change those we call upon. We hold our group meetings in group members' homes, not in a clinic or office. In all these ways we eliminate the usual costs as much as we do the literal cost by not charging for our services.

The group meetings themselves begin with a trial period of several sessions, after which the groups decide on the ultimate termination point. Since these are "consultative" groups, my alliance is made with the goals the individual members set. These may be couched in terms of situations or relationships they wish to understand, problems they wish to solve, or circumstances they wish to alter or improve. It is made clear that my understanding, at least, is that we are individually and collectively embarked on a collaborative working relationship. When, as it inevitably does, the group departs from that collaboration for another designed to afford it certain satisfactions other than those attendant on the working relationship, I must interpret or bring to cognizance the fact and significance of this abrogation of conscious intent.

The history of each group consists of alternations between collaborative pursuits in a working relationship and attempts to circumvent these pursuits for other sorts of realization. But because the nature of groups and the economy of the individual are such as to coalesce over central issues, one's observations can be directed to either developments in the psychodynamics of the group or the manifest contributions of the individual, with the result that the effects of one's comments touch both. Interpretations touching both contribute to the goals of the members of the group and, with luck, achieve the purposes of those who, many weeks back, responded (sometimes uneasily) to our first overtures.

DISCUSSION

Although viewing the aspirations and orientations of the culture of the mental health professional and that of the unreached public as alien and, in some respects, even inimical to one another, I have suggested that it is possible for them to coalesce around the essentials of mental health practice as assisted self-observation and insight. Indeed, the approach and methods I use in my own work are largely psychoanalytic; and if I compromise these in any essentials, I am not aware of it.

It is equally clear, however, that we knowingly violate certain canons of the mental health cultural tradition.

Foremost among these are our invasion of privacy (when we call unsolicited on people) and the seeming solicitation of "business" that we make. I am not unaware of how few of those who are likely to have read this would welcome such initiative with respect to themselves. The mores that a man's house is his castle and that it is improper to intervene, unsolicited, in the internal affairs of others go back at least to the Magna Carta. Moreover, it is the essence of the tradition of professionalism that the professional, as opposed to the businessman, does not solicit custom or even advertise for it. Then, too, there are certain ethical questions that, in traditional practice, are held at bay by the simple fact that the client seeks out the professional. The cultural system of mental health is not an empty conglomerate of historical derivations; it has much to recommend it.

Yet, though it is not difficult to understand why many would find themselves unwilling to violate tradition and feel ashamed or abashed unless they persuaded themselves to a double standard, our view is easily enough presented. Intentional or not, there is such a thing as cultural arrogance, in which the deeply held traditions of one's own culture supersede those of others. In effect, we cherish ourselves over and above others. This cannot make for an optimal therapeutic relationship with others; and we do not reflect this attitude when we are at work with others. But, if the effect of our "pre-working" relationship is such, must we not also consider potential as a part of the kinesis? In the fundamentals of the work itself, we shall want to be ourselves, only because, so far as I know, that is what is functionally necessary; in the preludes to that work we can allow others to be themselves. Have we another choice? The final outcome is the parity of courtesy as Moore (1965) describes it:

> Courtesy implied more than civility or good manners. It meant that while being completely yourself, you were all the time helping the other person to be himself, through your appreciation of his point of view, your respect for his individuality, your sensibility and quiet awareness of how he thought and felt and who he was.

Within this framework, it has become possible to enable many families to receive psychoanalytic group consultation even as they term the groups, "groups," "classes," "discussions," "group therapy sessions," or "mental hygiene parties."

SUMMARY AND CONCLUSIONS

Mental health (viewed as a system of concepts, practices, and customs), no less than any other cultural system with a tradition, has been created and fostered in the image of the men and women who as professionals and as patients have participated in it. Their values, their needs, their identities are reflected in it. Although this is only reasonable and proper, mental health has, nevertheless, come to represent an alien cultural system and tradition to a

broad swath of the American people. Only some 4 percent of all Americans, some 21 percent fewer than those with an acknowledged need for help, make use of mental health resources over a lifetime.

It is, we submit, the obligation to sacrifice precious values that keeps those who seek or are offered assistance from accepting it. These sacrifices are not intrinsic to the basic process of the mental health procedures of therapy, consultation, and education. If, as we suggest, the basic intent of mental health as a practice is to provide assistance to people in their efforts to understand themselves, no one wishing this service need be asked to accept the onus of illness, problem typology, failure in self-sufficiency, the threat of subordination to a seemingly powerful doctor, or, indeed, any of the "hidden" charges we now make.

Rather, as the program here described is intended to illustrate, the same work can be offered and performed in a different cultural framework, with far greater acceptability and less consultee "motivation." Indeed, it appears possible to hope that further changes along the lines of reducing the costs, broadly speaking, of program participation will serve even more to alter the size and make-up of the so-called "hard-to-reach" group than have those we are able to report at present.

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Notes

1 This is not to say that the issue of rewards should remain closed. On the contrary, when in competition with such self-prescriptions as drugs, alcohol, and adolescent sexual engagements, we may have to review our standards. Transference realization may not be enough. The solution will probably have to be sought out of a consideration of the differing significances rewards have for the two cultures. Synanon and other efforts for addicts that replace, actually or symbolically, the "turn-on" of the original drug or behavior may provide leads in this direction.