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It is estimated that approximately 35 million persons in the United States exist in conditions of want or near want. Even if there were no greater prevalence of psychiatric disorders among the impoverished, the psychiatric issues affecting almost one-fifth of the nation would appear to have substantial claims to a significant portion of American psychiatry's attention and efforts.

The 1958 publication of Hollingshead and Redlich's *Social Class and Mental Illness* confirmed the extent of psychiatry's involvement with the poor but sharply delineated a pattern of highly discriminating distribution of resources. Indeed, it appeared from these studies that the mode of treatment depended as much or more on a patient's socioeconomic status as on the medical or psychological considerations.

Although the specific forms of discrimination vary for different settings, and for different diagnostic entities, the basic pattern is familiar to most practitioners. The psychiatric profession appears to favor patients in the upper social class with the form of treatment it values most highly, namely, psychotherapy. Patients from lower socioeconomic strata are more likely to be assigned to custodial care or some form of organic therapy. Even in the

realm of psychotherapy, private practitioners engage in directive psychotherapy with 85 percent of their class 4 and 5 neurotic patients, whereas 45 percent of class 1 and 2 private patients receive psychoanalysis or analytic psychotherapy.

A report to the Chicago Board of Health on the availability of physicians' services to poverty area residents found that a relatively small number of doctors practiced in the poverty areas, which have 88 percent black residents, and that psychiatry was the specialty least available to black areas. Bahn and others pointed out the way in which such discriminating distribution of psychiatric facilities forces patients into the legal system and then to the state hospital, where they tend to become part of the untreatable chronic population. A similar pattern has been described by Markler for emotionally disturbed poor minority group youngsters in the school system. Whereas white middle-class students are likely to be defined as troubled and placed in a treatment school, lower-class Negroes and Puerto Ricans are likely to be defined as troublesome and placed in custodial institutions.

Some psychiatrists when confronted with this kind of data argue that these contrasting patterns of treatment are not so much a reflection of discrimination against lower socioeconomic or minority-group patients but rather a recognition of the special qualities and limited receptivity to certain forms of treatment associated with the life style of patients from lower

socioeconomic categories.

Hollingshead and Redlich noted that psychiatrists are for the most part drawn from the upper and middle classes and may thus be less accepting and understanding in relation to patients from class 4 and class 5 backgrounds. They suggested that psychiatric training should better prepare psychiatrists to deal with patients from other classes, that new therapeutic approaches should be specifically designed to deal with this type of patient, and that more nonmedical therapists should be trained to work with patients from impoverished areas in those cases where there are no associated medical problems.

Viola Bernard, in a comprehensive review of some of the principles of dynamic psychiatry in relation to poverty, called attention to the need to consider both direct and indirect forms of psychiatric intervention. She pointed out that in addition to modifications in direct clinical contact with patients, psychiatrists can make important contributions through the application of psychiatric principles not only to the administration of mental health agencies but also to all of the nonpsychiatric public programs that have an impact on the life and health of the impoverished population. The need for both direct and indirect approaches in the psychiatrists' intervention with impoverished and disadvantaged populations derives from the complex nature of poverty itself.

Attention must be directed at the actual conditions under which the poor live, as well as the social and psychological attributes associated with those conditions. In 1962, more than 1 million children were being reared in large families with six or more children and incomes of less than $2,000 per year. Families living under such conditions are hard put to provide opportunities for better health or education that might lead to change in their status. Clark pointed out that the poor, living in deteriorated housing, identify with their physical surroundings and incorporate this identification as a part of the view of themselves. Thus, Scherl and English suggested that a strategy of mental health among the poor should address itself to the outer as well as the inner reality and accept the fact that mental health is less valued than money, food, housing, jobs, and general health services.

Leighton, working with a rural population with levels of unemployment and poverty higher than that of neighboring communities, found corresponding higher levels of socioeconomic disintegration and psychiatric disorder. He attempted both to improve social functioning and human relations in the community and to increase economic and educational opportunities. He reported that over a ten-year period the prevalence of mental disorders was reduced in association with improvement in the community's psychological climate and the level of sociocultural integration.

A number of clinicians working within psychiatric settings have

attempted to appraise the deficiencies in traditional approaches developed with reference to middle-class populations and to modify them or offer alternative therapeutic approaches to the poor and to working-class clientele. James McMahon, in a paper on the working-class patient, employed the terms "working class," "lower socioeconomic," and "the poor" interchangeably. He pointed out that mere changes in administrative procedures, such as the elimination of waiting lists, do not lead to any significant improvements in results. He suggested that clinicians and agencies have fostered a number of stereotypes about the poor and erected a host of barriers between themselves and such clients, thus interfering with effective treatment. McMahon felt that clinics that cite the emphasis of the poor on the here and now as a reason for their inability to engage in extended psychotherapy may be ignoring the findings of workers who have found that personal attitudes of the therapist are more likely to be associated with success in treatment than the use of one or another sophisticated therapeutic technique.

Rosen and Frank pointed out that, in addition to lower socioeconomic status, the poor patient may frequently be a member of a minority group and thus have an additional obstacle to face in the attitudes of the therapist, who is most likely to be both white and middle class. Thus, the black patient must also overcome the biases, cultural blind spots, reactive guilt, and unconscious prejudice of the person to whom he comes for help. The attempt to select working-class patients who are good treatment risks leads to the formulation

of lists of criteria for acceptance, including capacity for introspection and psychological thinking, self-control, a desire to relate to people, strong ego, and high motivation. As McMahon pointed out, if a patient met all these demanding qualifications, he might very well not require treatment at all. He suggested that it might be more realistic "to initiate and continue needed psychiatric care if, and only if, the therapist's participation in the treatment is congruent, at least temporarily, with the patient's request, attitude and expectation." The patient who expects active assistance is likely to be discouraged by a passive, detached approach, and McMahon felt this accounts for a number of working-class patients who do not persist after one or two initial psychiatric contacts.

The poor person who is in psychological distress but also in the midst of an overwhelming life situation, and thus looks for specific help and advice, may be able to address himself to his psychological problems only after several initial sessions have been devoted to determining his specific concerns and assisting him to deal with some of his immediate life difficulties. Mendel and Rapport, in dealing with chronic schizophrenics from lower socioeconomic groups, found that immediate and active assistance and encouragement are crucial in overcoming the inertia that is often associated with chronicity.

It may be that because the psychotherapeutic approaches developed in

the United States have been so heavily influenced by psychoanalysis, some of its postures have been automatically applied to situations and populations, such as the poor, where they are not necessarily appropriate. For example, it may be true that recurrent crisis may limit a patient's ability to carry through a successful traditional psychoanalysis. However, this does not mean that the impoverished patients must be eliminated from consideration for other forms of psychotherapy, even though their lives may be characterized by periodic major disruptions in their situations. It is precisely at such times that people from a disadvantaged community are likely to ask for help, and a number of psychiatric agencies serving the poor have incorporated mechanisms for engaging patients in treatment at the point of crisis. These include walk-in clinics, twenty-four-hour staffing of hospital emergency rooms with psychiatric personnel, and provision for emergency phone calls. As Lindemann pointed out, entry into a patient's life at a time of crisis not only relieves suffering and helps avoid a catastrophic outcome but may also provide opportunity to engage the patient at a time in his life when he may be more amenable to establishing a therapeutic relationship which may be maintained after the immediate crisis has been resolved.

Although patients from lower socioeconomic populations may be more accessible at points of crisis, almost all studies indicate considerable difficulty in actually maintaining more extended contact. A review of 499 psychiatric clinics throughout the United States found that 60 percent had fewer than five

sessions. Overall and Aronson reported a dropout rate of 57 percent after the initial interview. Hollingshead and Redlich, in commenting on this pattern, said that 'patients are disappointed in not getting sufficient practical advice about how to solve their problems and how to run their lives. They express in word and action their lack of confidence in a talking treatment. They expect pills and needles . . . and also a gratifying, sympathy and warmth."

A study by Overall and Aronson demonstrated that for a lower socioeconomic population, for the most part, the therapist's behavior was less active, less medically oriented, and less supportive than the patient anticipated and that where such expectations did not correspond with the therapist's behavior, the patient was less likely to return for treatment. The authors suggested "one way of reducing cognitive inaccuracies is to attempt during the initial phase of treatment to re-educate the patient as to both his own and the therapist's role in the treatment." They urged that the patient's expectations be explored during the first interview so that both patient and therapist can more easily view and modify their roles.

A technique that allows both therapist and patient to become more active than in the usual interview situation is that of role playing. Riessman and Guldfob gave several reasons why this technique appears to be particularly viable in working with the disadvantaged.

1. It appears to be more congenial with the low income person's style

which is physical—-concrete, problem directed, externally directed rather than introspective. . . .

2. It allows the practitioner to reduce, in an honest fashion, the role distance between himself and the disadvantaged individual....

3. It changes the setting and tone of what often appears to the low income patient as an office ridden bureaucratic, impersonal foreign world.

4. It appears to be an excellent technique for developing verbal power in the educationally deprived person.

Riessman and Guldfob point out that despite the preference of the poor for informality, they like to have content that is structured and definite, and that role playing lends itself to this need in that it can be used to teach specific types of behavior. In working with the disadvantaged, Riessman discourages use of the more theatrical features often used with the more formal types of psychodrama. Combining role playing with other forms of treatment, such as family therapy or group therapy, seems to work with the poor patient. It is important that the various functions for which role playing is being employed, such as catharsis, self-awareness, or insight, should be explained and made explicit. Of course, this recommendation, directed at the poor, might very well be followed in introducing a new procedure to any patient with whom a therapist wishes to establish some common understanding of what is

hopefully to become a mutual endeavor.

For the most part, psychoanalysis and psychoanalytic therapy have been largely designed for and directed at middle- and upper-class patients. One of the few systematic attempts to explore the application of psychoanalytic therapeutic approaches to a lower socioeconomic population was conducted under the auspices of the William A. White Institute. In a report of this project, Gould explained that though the population was drawn from members of a trade union, he referred to blue collar, the disadvantaged, and lower-class patients, interchangeably. Though some of twenty-three patients treated in the study may have been above the poverty line, many of the approaches suggested appear applicable to the more seriously disadvantaged. Gould believed that resistance to psychotherapy was reduced by several factors built into the study.

1. The service was offered in a simple, direct, open manner.

2. It was voluntary.

3. It was immediately available.

4. The overtures came from the psychiatrists, thus eliminating the fear of rejection.

5. Trade union leaders offered their active support.

Several of the modifications in the treatment approach itself that appeared most productive were:

1. A more directive approach as reflected in specific and concrete questions initiated by the therapist proved productive.

2. Informality was established through an easy give and take manner such as having the therapist open a session with a remark or comment about some subject of mutual interest. Gould found that such exchanges often lead into material of great relevance to the therapy.

3. Role playing proved to be exceedingly productive.

4. Educational and guidance materials proved to be entirely compatible with psychotherapy when the pathology was not too severe.

Gould emphasized that because the lower socioeconomic person has less of a tendency to use intellectualization as a defense, this may make him more accessible to therapy than some of his middle-class neighbors. He also asserted that the usefulness of symptom cure should not be minimized, since it frequently was followed by further changes on a deeper level.

Although it is generally acknowledged that the poor are more likely than others to be exposed to psychological and social stress and hazards to their mental well-being, the treatment of pathology manifested by poor

people has seemed to attract more interest than programs directed at the maintenance of their health or competence. In part, this may be a product of the prevailing treatment. Although manifestations of mental health certainly may be discerned in the one-to-one situation, they are almost inescapable when the patient is studied within the context of some relevant aspect of his social environment. Some workers in the field of mental health have begun to address themselves to the study and intervention into large social institutions as such. However, most clinicians have preferred to deal with the smaller subsystems comprising the patient's more intimate social milieu. In practice this has led to a considerable amount of experimentation with such natural small groups as families or classroom groups and groups comprised of people from some common vocational, religious, social, or agency setting.

Christmas and Richards surveyed agencies employing group psychotherapy with socially disadvantaged adults and found that the group approaches employed tended to be strongly influenced by the overall philosophical orientation of the agency. Institutions with more traditional medical or psychoanalytic orientation tended to be less innovative, made less use of groups, and "the effect of social forces was not generally thought worthy of professional consideration." Agencies with a socio-psychiatric or socioeconomic orientation concerned themselves with the overall functioning of the patient and with such matters as finance and job. The staff reflected values and attitudes of the deprived community in their practice and tended

to minimize intrapsychic and individual determinants of behavior in favor of considerations of social forces. The groups conducted by these agencies frequently focused on contemporary happenings and concentrated on therapeutic group efforts to alter what is, by action, in the present.

The approach of Heacock, in working with groups of young adults, is along these lines. He focused on coping mechanisms to deal with life crises and feelings of powerlessness. A number of other workers have developed groups with comparable approaches to clients on welfare which stress activity, socialization, and social learning.

As noted in a previous report by Peck and Scheidlinger, many of the groups employed with socially disadvantaged populations in contemporary mental health programs are more akin to rehabilitation or socialization than to psychotherapy. Practitioners employed in these programs frequently include nurses, occupational therapists, teachers, and social workers as well as the usual orthopsychiatric team. Scheidlinger categorized these therapeutically oriented group practice models as follows:

1. Activity catharsis and mastery: includes groups for patients with severe ego damage often with occupational therapy, orientation and provision for activity, use of materials and release of tension.

2. Cognitive information: emphasis on teaching new facts and

attitudes as in family life education groups.

3. Interpersonal socialization: includes groups that meet needs for security, belonging and companionship such as leisure time character-building activities, patient government, and hospital activity groups.

4. Relationship experience: includes group programs in halfway houses, rehabilitation programs, and patient social clubs.

When working with disadvantaged populations, therapeutically oriented group programs of the types described above frequently include provisions for work with the patient's family as a unit. Inclusion of pertinent members of the family in therapeutic work lends concreteness to the situation and helps the lower socioeconomic patient specify his concerns. Family treatment is an almost essential element for the psychiatric hospital in maintaining the involvement of such patients in the program.

A number of workers have reported on the advantages of seeing the family in their own home. Levine developed a home family therapy method for the disadvantaged where role playing and manual activities are utilized as the stimulus for eliciting and clarifying family communication patterns.

Although it is generally assumed that there is some relationship between the mental health status of disadvantaged populations and the institutions that form the social context within which the poor live, these have

received relatively little attention from psychiatric workers. S. M. Miller stated that

> services aimed at individual treatment are not enough. Professionals and their organizations have to support and encourage action which will deal with the larger American scene where poverty is being produced and maintained. The professional role cannot end with the limited services that it can provide, but must extend to pressure for the social changes which will make individualized professional services more meaningful and effective. . . .

Although some psychiatric workers accept this position, a number of considerations appear to be responsible for the caution with which the professional approaches the course recommended by Miller.

1. The relationships between poverty, mental illness, and mental health are not well defined or understood.

2. Questions have been raised as to the compatibility of social action or institutional change with the psychiatrist's professional role.

3. Psychiatrists feel ill equipped and without adequate information, knowledge, or the technical skill required to engage in institutional change.

Leighton referred to three major links between psychiatric disorders and poverty.

1. The blocking and frustration of basic needs that living under

conditions of poverty engenders. These include stresses derived from insecurity regarding shelter, food, protection from violence, deprivations of love and recognition, as well as the reinforcement of the effects of debility from chronic organic disease associated with poverty.

2. The absence of remedial resources in the poor environment. Not only are psychiatric resources lacking or in short supply, but there is also a scarcity of those services that might be provided by such gatekeepers as physicians, ministers, and teachers.

3. The malformation of personality owing to the individual's growing up in a deprived environment.

A variety of personal characteristics have been attributed to those who suffer the deprivations associated with poverty. These almost invariably include.

1. Fatalism, which involves a belief in uncontrollable and predetermined external forces.

2. Orientation to the present, with the feeling that it is both useless and wasting of energy to focus on the future.

3. Authoritarianism, which comprises an overrating of the strengths of existing social structures as sources of authority.

Numerous additions to these characteristics have been provided by a

variety of workers. However, a unifying approach is suggested by Haggstrom who pointed out that “over time, the dependency relationships of the poor become institutionalized and habits, traditions and organizations arise in both the affluent community and in the neighborhoods of poverty, maintaining the relationships between them.” Furthermore, he argued that “when social scientists have reported on the psychological consequences of poverty it seems reasonable to believe that they have described the psychological consequences of powerlessness.”

Power is a central component of several of the major criteria of mental health, particularly mastery of the environment and autonomy as delineated by Jahoda in her review of the literature on positive mental health. Jahoda acknowledged that severe deprivations are among the conditions that may preclude the development of autonomy or environmental mastery. For her, adaptation to such environmental conditions means “that a workable arrangement between reality and the individual can be achieved by modifications of either or both through individual initiative.”

However, modification of many of the realities that confront the impoverished individual cannot be achieved through individual initiative. It is for this reason that Haggstrom stated that one way in which the poor can remedy the psychological consequences of their powerlessness, and of the image of the poor as worthless, is for them to undertake social action that

redefines them as potentially worthwhile and individually more powerful. Among the criteria for effective social action cited by Haggstrom are that

1. The poor see themselves as the source of the action.

2. The action affects in major ways, the pre-conceptions, values or interests of institutions and persons defining the poor.

3. The action . . . becomes salient to major areas of the personalities of the poor.

4. The action ends in success.

Programs that fulfill even these minimal criteria are not common on the American scene. For one thing, those institutions that play a prominent part in defining the poor are generally not receptive to programs that would permit the poor to see themselves as the source of the action. However, with the impetus provided by the war on poverty and often with assistance from the Office of Economic Opportunity, a number of different kinds of institutions became the setting for community action-oriented types of mental health endeavors during the 1960s. Because these programs by their very nature were colored by the institutional settings in which they were conducted, their manifest content varied from those that were specifically psychiatric to those that emphasized such matters as education, health, or welfare.

Kellam and Schiff, working in a community mental health center in Chicago's south-side, looked to a community advisory board for the determination of the program's priorities. In response to the community's wishes, they decided to direct the initial thrust of the program around a major attempt to alter the educational environment for a substantial portion of the community's children. Attention to the environment and the institutional structure of the school was dictated by the large percentage (roughly 70 percent) of the first-grade children evaluated by their teachers as manifesting some degree of maladaptation. Because such maladaptation appeared to reflect a complex of social and institutional factors, intervention was directed at the school staff, classroom, and parent meetings in an attempt to influence such elements as (1) the child within the social field of the classroom; (2) the social system of the school; (3) the child's family; and (4) the particular community in which the child lives.

If a mental health program based in a public agency is engaged in social action, it must devise some effective and appropriate means of securing participation of the residents of the community it serves. Such participation requires mechanisms through which the community provides sanction for the agency's activities and through which it can engage in such functions as the determination of policy—the selection of key personnel, the soliciting and disbursement of funds, and the setting of priorities.

Kellam and Schiff preceded the development of their program by the formation of a community advisory board. Peck and his coworkers, at Lincoln Hospital in the South Bronx of New York City, attempted to engage the community through the recruitment of mental health workers drawn from the area. They enlisted them in the development of small storefront neighborhood units with programs designed to be responsive to the particular service needs of the local area, in which the neighborhood center was located. The centers were receptive to any and all types of requests for service, including housing, employment, welfare, health, and family problems. An important contribution of the community health worker was in teaching residents to negotiate the maze of bureaucratic agency procedures. Where needed services could not be secured because of limitations of the agency, residents were encouraged to come together to devise solutions to their common problems. This sometimes gave rise to collaborative programs with school administrators, the local housing authorities, and so on. In other instances, committees of clients and workers from the neighborhood units became involved in organizing tenant councils that worked on code enforcements and participated with the local welfare rights organization in a campaign to improve conditions at Lincoln Hospital itself. These activities led to increasing awareness by the community of the need for a more direct role in hospital policy. Ultimately, these developments, which began in the mental health services, spread to the rest of the hospital and gradually assumed the

form of demands by the community for control of such matters as funding, the selection of key personnel, and determination of hospital priorities.

Similar developments have been reported in quite diverse types of programs in the Woodlawn district of Chicago, Topeka, New Haven, and Washington Heights in New York City. The introduction of such elements into the program as the recruitment of staff from the local areas, the development of a strong community advisory board, decentralization, and participation in community activities provides opportunities for the residents of a community to engage in activities that can reduce the sense of helplessness and powerlessness and reinforce such mental health functions as autonomy and environmental mastery. In addition, it may lead to changes in institutional structures that can help bring about improvements in services. It may also lead to conflicts, crises, and at least temporary disruption in services. However, several developments on the current scene give promise of providing considerable assistance and support for such community action-oriented mental health programs.

One of the problems encountered by neighborhood-based mental health units relates to the difficulty of introducing innovative institutional policies or procedures that may run counter to traditional agency or governmental practices in the area. One approach to this problem is through the growing number of neighborhood health centers with which community mental health

programs are beginning to establish neighborhood units capable of initiating change in a collaborative fashion. Detailed plans for the structural relationship between primary, secondary, and tertiary health and mental health services are outlined in a recent article by Spiro. In a paper on the neighborhood health centers and their relationship to mental health programs, Scherl and English emphasized the central role of community participation and the recruitment of local residents for the staff of the neighborhood center: "the services are made more appropriate, responsive and effective by virtue of their being designed around the needs of people and by virtue of the participation of persons in the neighborhood. This participation is insured through employment of residents as non-professionals and in policy making by neighborhood health councils."

Scherl and English saw the neighborhood health center as sharing the mental health program's orientation so as to "provide one responsive to a reality based sense of hopelessness and anger." They believed that through a neighborhood health center, "the poor can gain a measure of mobility of action and independence and add a measure of power to their voices. . . ."

Neighborhood health and mental health centers that share this type of orientation and consolidate their programs may contribute to their mutual effectiveness in the following ways:

1. Negotiation with mandating and funding institutions may be more

easily accomplished for overall health services rather than for mental health services alone.

2. Relations and negotiation with the community can be more comprehensive and economical when these are centered around overall health and mental health issues.

3. Legal, financial, and organizational problems can best be approached with a comprehensive health program. For example, communities that wish to become the direct recipient of funds should not have to establish separate corporate structures for health and mental health services.

4. Manpower and career programs based on the recruitment of community residents can be more effective if they are designed as health careers programs for all health services rather than being developed for mental health services alone.

Roth neighborhood health and mental health programs in disadvantaged areas are becoming increasingly interested in recruiting manpower from their local communities. The utilization of such indigenous personnel has a number of potential benefits that, from the mental health point of view, may be multiplied if the mental health program is incorporated into an overall health careers program. A health careers program can train local community residents for functions that may assist the health professional, substitute for him, or add new functions and activities to the

center's repertoire. Where mental health personnel participate in the development of a broad health careers program, they may have an opportunity to motivate and prepare personnel working in nonpsychiatric health services. If such personnel become better oriented to mental health principles and priorities, they can help extend the mental health network into the day-to-day operations of the health services. In those programs directed at preparing candidates for careers in health rather than job training for entry level positions, the educational experience may make a major contribution to the individual's growth and interpersonal competence. The participation of mental health personnel in planning and conducting these health career training programs helps focus attention on the psychosocial components involved in such training. This may assist in avoiding or at least reduce some of the inevitable personal strains experienced by the trainee and possibly help contribute to making the training into a meaningful personal growth experience. Thus, under the rubric of training mental health personnel, it is sometimes possible to make a more positive impact on the individual's adaptation than if he were referred for treatment in the role of a patient.

Most of the earlier training programs were primarily in-service training programs designed to prepare the trainee for a specific job in a mental health organization. Though many programs are still conducted at this level, several recent developments tend to greatly improve the quality of such training, and the newer programs embody the following elements.

1. Integration of mental health training with overall preparation for the health field.

2. A career rather than a job orientation, which means horizontal as well as vertical mobility with each step in the training lending itself to progressive escalation toward greater competence, specialization or responsibility.

3. Provision for accreditation through affiliation with the relevant educational institutions.

4. Assurance of job security through association of training programs with civil service certification and continuing promotion opportunities.

The development of career programs, which introduce residents of impoverished communities into the health and mental agencies as colleagues as well as in their role as patients, embodies several of the elements that characterize some of the newer approaches to the poor.

Mental health professionals are beginning to engage themselves with members of the disadvantaged community rather than carrying out procedures on it. As community residents move up ladders of the health and mental health staff hierarchies, they are being increasingly knowledgeable participants not only in the delivery of services but also in the research, planning, and training activities on which such programs are based. Thus, members of a disadvantaged community can look to leadership from

neighbors who, from their vantage point inside the system, can contribute to the development of better informed, more sophisticated community health and mental health boards. If this model becomes generally accepted and applied across the broad range of human services, substantial change may be anticipated in some of the institutions and agencies that have been so ineffective in their delivery of services. If the poor can help transform these institutions, they will not only directly benefit from the resulting improvements in care but will learn new adaptive skills that contribute to the maintenance and preservation of both their physical and psychological well-being.

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