THE TECHNIQUE OF PSYCHOTHERAPY

THE
PSYCHOTHERAPIST
IN COMMUNITY
MENTAL HEALTH

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The Psychotherapist in Community Mental Health

There is a story about a unique way of diagnosing mental illness developed in a small community in Scotland. The "suspected" person is placed in a basement room that has a water tap. The faucet is turned on to flood the floor, the person is handed a mop and asked to dry the floor. If he or she continues to dry the floor without turning off the faucet, the diagnosis of "madness" is confirmed. This droll story is sometimes used to illustrate the situation of mental disturbances in the community. By concentrating efforts on managing the pressing disorders of the mentally and emotionally ill, therapists often lose sight of the fact that they coordinately fail to turn off the faucet in the polluted social system that is pouring out more patients than can be treated.

Such a statement assumes that enough is known about what causes emotional illness and that there are means to remedy the causes to turn off the faucet. Such assumptions are only partially true, but there certainly is sufficient knowledge at the present time, if not to dry the floor, to keep the basement from being flooded. The point is that such knowledge is not being used, nor does our society yet support with adequate economic and other means its implementation.

On the debit side it must be admitted that what was posited 20 years ago as "community mental health" is still a relatively unchartered field that embodies a variety of theoretical systems and methodological approaches. Designs for essential services vary with the characteristics and problems of the community being accommodated, with the needs of the individuals and agencies who constitute the consumers or the client systems, and with the philosophies and training of the personnel staffing the center or clinic that is executing the program. The problem areas for reform potentially are limitless, and, obviously, a rigid selection of zones of involvement will be in order. These range from clinical services for severe emotional problems, to counseling or casework for circumscribed personal and environmental difficulties, to

educational projects for the public geared to preventive objectives, to training programs for allied professionals and paraprofessionals, to hospitalization and day care facilities for the mentally ill, to rehabilitative and work adjustment programs for the handicapped, to consultation aids to organizations or groups in the community.

There are many existing models in community mental health that deal with how these services may be integrated, and many more will undoubtedly be developed with changing politico-socioeconomic conditions. Caplan (1974) in explicating some of these models states that "since we are grappling with a highly complex multifactorial field, no single model can be expected to do more than focus our attention and pattern our expectations about one aspect of the field." What would be applicable in one community does not necessarily conform with the special problems and conditions of another community. Mental health workers must consequently maintain flexibility and use whatever models seem pertinent, always altering these as new accommodations become necessary. At the Postgraduate Center for Mental Health in New York City we have worked in different communities and with almost 500 different agencies, institutions, and community groups in cities and counties in New York, New Jersey, and Connecticut. We have found that rigid adherence to any one model of operation can cripple a program and that a great deal more innovative flexibility is required than in working with individual and group psychotherapy.

There are times in the career of most psychotherapists when they are called on to apply their mental health skills to the social system. For example, a local school is experiencing an extraordinary increase in dropouts. A community is being plagued with an epidemic of misdemeanors and crimes perpetrated by juvenile delinquents. A center is being organized to provide recreational and rehabilitative services for older people, and the founders insist that it be oriented around sound mental health principles. A social agency wants to know how to start a mental health clinic. A group of ministers needs help in doing more effective pastoral counseling. Vocational rehabilitative workers request a course in the psychiatric and psychological aspects of work readjustment. A parent-teacher's association desires a lecture on child

development illustrated by a good film. A fraternal society is setting up a series of discussion groups dealing with family life education and needs a discussion leader. The roles that psychotherapists will be expected to play in servicing any of these requests go beyond those they conventionally assume in the clinic or their office. They must take on among other responsibilities those of educator, public health expert and mental health consultant. If they have had the traditional residency and post-residency training, they will not be equipped to do this, the focus of their education being more on clinical than on community functions.

It is beyond the scope of this book to explicate the details of community mental health or the full operations of the mental health specialist. Ample literature exists on these subjects. Mannino, MacLennan, and Shore (1975) have compiled an excellent reference guide to the consultation literature as well as a serviceable list of films and tapes. A full bibliography may be found in *Community Mental Health and Social Psychiatry*, prepared by Harvard Medical School and the Psychiatric Service of the Massachusetts General Hospital (Cambridge, Harvard University Press, 1962), and *Community Mental Health, Selected Reading List 1961-1965* (Canada's Mental Health Supplement No. 50; November-December, 1965), as well as Bellak et al. (1969, 1972, 1975) Bindman (1966), Braceland et al. (1975), Hume (1966), and NIMH (1967-1970). Nevertheless, some guidelines will be indicated in this chapter that therapists may find of practical value.

Assume for illustration that a therapist receives a letter requesting a consultation from the director of a boys' club that has been organized around activities, such as carpentry and other handicrafts, for adolescents from deprived economic areas. The presenting problem is poor staff morale, which the director credits to the fact that the staff members feel themselves to be ineffectual in dealing with psychiatric problems. Delinquency and drug addiction among many of the boys, for example, continue unabated. The director believes that a course on psychopathology would be good for the staff and may

help them to function more efficiently. The therapist replies affirmatively to the letter and sets up an appointment with the director. Prior to the conference, the therapist may make several assumptions:

1. The director's diagnosis of what is needed, namely a course on psychopathology, may or may not be what is required to resolve the problem.

2. In entering into the picture, the consultant (therapist) most likely will find among different levels of the administration, supervisory group, and staff workers, as well as among the recipients of the service (the adolescents) a hotbed of interlocking psychopathological constellations. The consultant will, with full justification, be tempted to prescribe psychotherapy for the most disturbed individuals. To do this would probably prove fatal. Limited finances, absent motivation, and the dearth of treatment facilities render psychotherapy impractical. Solutions other than therapy will be required.

3. A series of conferences will be needed with the director, the supervisors, and the staff individually and collectively to determine what they believe is wrong and to observe the way that they interact with one another in the work situation.

4. A series of conferences with the adolescents, particularly the leaders, may be desirable at some time once the picture has crystallized.

5. The entry of the consultant into the organization will probably stir up initial anxiety and resistance on all levels of the organization that will require handling.

6. Being involved in the dynamics of a social system, the consultant will have to keep communication channels open between the administrative, supervisory, and staff levels of the organization. The boundaries of the consultant's operations will require explicit definition; i.e., the director may need to be informed about what is going on but may not have to be involved in the project itself; written communications will have to be sent by the consultant to the director outlining what decisions are reached and what the consultant proposes to do; written agreement to proposals must be received by the consultant; a liaison person must be appointed by the director to represent the administration; and a decision must be made in joint conference who the consultant will work with in the project.

With these assumptions in mind, the consultant and director set up an appointment to meet in the consultants office. The director appears to be an intelligent, interested, and knowledgeable person, a social worker who has had considerable experience in the field of group work. The director is very active in community affairs and has affiliations with many community organizations. The director is sociable and relates well. The consultant, inquiring about the program, discovers that 1000 boys are being worked with who live in the area of the club. During the summer the club runs a camp outside of the city. The activity program is managed by a staff of expert crafts people who have had no mental health orientation. The initial impression of the consultant is that if the staff had some mental health information, they may be able to use this in their work with the adolescents. For instance, many of the boys are expressing the usual defiant gestures of adolescents, and some of the staff, the consultant believes, are responding with feelings of not being appreciated. Moreover, a good number of the adolescents have severe character disturbances and are engaging in antisocial activities that may be upsetting the staff. Clarification about the dynamics would, therefore, seem indicated.

The consultant makes an appointment to visit the club and arranges to meet with the staff and supervisory groups individually. Several meetings are also held jointly with the staff supervisors and director. It soon becomes obvious to the consultant that the relationship of the staff and supervisors with the director leaves much to be desired. They consider the director an autocrat who overrides their decisions and who does not allow them freedom in their work. They respond to this by sullen withdrawal and disinterest in their duties. Most of the staff believe that they might learn something constructive from a course in mental health principles and practices. The consultant, however, is convinced that little will be accomplished until better relationships are established among the personnel. The director is not at all aware of personal shortcomings in managing the staff or of their hostile reactions to this management. From the way the director had communicated in the initial conference, the consultant could not diagnose what was wrong until the work situation and the ongoing interactions had been observed.

In discussion with the staff, the following plan is elaborated: (1) a group process to enable the staff to verbalize feelings and to become aware of self-sabotaging reactions that paralyze their functions and interfere with their relationships with the adolescents, (2) conferences with the director to give the director an opportunity to express feelings and to test the director's flexibility, (3) group meetings with the staff, supervisors, and director, during which they are encouraged to discuss how they feel about one another in their work roles. Such sessions help the director play a more cooperative role with the staff and encourage them to talk to the director about their "gripes."

The consultant does not consider the staff participants as "patients" for very good reasons. First, they do not regard themselves as patients; second, the consultant is principally concerned with their work problems and not their neuroses; and third, group process, employing principles of group dynamics, is the instrumentality that will be used, not probing techniques into defenses and unconscious conflicts. The upshot may be therapeutic for all participants, but this is a byproduct. The focus is on conscious feelings in relation to the staffs ongoing interactions. Improved morale results in the staff taking greater interest in the boys, even taking them on outings. The effects are registered in dramatic improvements in behavior both within and outside the club.

Another example of how a therapist-consultant may respond to a community need is contained in the request of a suburban psychiatric clinic for staff training in psychotherapy. Upon visiting the clinic, the consultant finds that the problem confronting the clinic is that all of the available time of the staff members is occupied in treating a stationary caseload that does not seem to be going anywhere. The waiting lists are long; intake has more or less been frozen for months due to the absence of available therapeutic hours.

Examining the records of the kinds of patients being treated, the consultant finds that most of them are chronic cases: borderlines, or dependent-personality patients who have fastened themselves onto their therapists and have settled into what is turning out to be a permanent niche. The director of the clinic believes that what is required is more sophisticated training of the staff in depth approaches so that the

basic inner problems of their patients may be influenced, in this way "curing the patients" and resolving the stalemate. An interview with the staff reveals frustration and demoralization because of disappointment that they are unable to effectuate cures and because of pressures on them to open up more time for new patients.

The consultant sets up conferences with the staff members, and what is finally decided is the following: (1) establishment of a special clinic for sicker patients organized around drug therapy and no more than 15-minute supportive interview sessions once weekly or bimonthly, (2) transfer of the bulk of patients to this clinic, (3) development of a social rehabilitative unit in a neighboring church recreational center to which the patients may be referred for adjunctive social programs, (4) organization of a group therapy clinic and training of the staff in group therapeutic techniques, (5) concentration on short-term therapy as standard for the clinic and staff training in brief psychotherapy, (6) since this plan is long-term, requiring a period of years for its full development, a training program in group therapy and short-term therapy, for which the consultant will help recruit appropriately qualified trainers, (7) work by the consultant, if possible, with this group over the 3 or 4 years of transition, since there will be much staff anxiety that will require handling.

A third example will illustrate how psychotherapists engage in community work. A therapist-consultant is called into a school to determine why so large a percentage of the students are failing their college entrance examinations. Upon studying the school program, and after conferences with the principal, the teachers, and some of the students, the consultant comes to the conclusion that what is needed in the school is a school psychologist who can help students with problems in school and personal adjustment. An expanded budget is presented by the principal to the school board, some of whose members accuse the principal of being lax in running the school. They then oppose the recommendations. A group of irate taxpayers organizes itself into a political-action body and argue that a psychologist in the school will "make the students crazy" or give them "new-fangled foolish ideas about sex." The principal

of the school is greatly disturbed and realizes that the community will not accept a psychologist to serve the high school population. The consultant and the principal discuss the problem with the teachers, and it is decided that an educational program is needed for the community. The help of the PTA is enlisted, and an educational program is planned. A series of community lectures is organized employing mental health films, with discussion groups following the lectures around problems of child development and family life. There results a change in attitude, and the psychologist is accepted into the school system.

It will be seen from these illustrations that the operations of community mental health specialists go beyond those of mere psychotherapist. If they are to live up to community responsibility, psychotherapists will need skills not now developed in the traditional residency and post-residency programs. It so happens that by the nature of education and background, psychotherapists may not know as much about the community and their proper role in it as do certain professionals, such as community organizers, public health officers, and other social scientists. Yet the knowledge of human dynamics and of the irrational forces that prompt people and groups qualifies psychotherapists to understand the disorganizing emotional cross-currents that operate in society. What therapists need, as has been mentioned before, is the acquisition of a completely new set of professional talents in addition to psychotherapy, since psychotherapy as such may not be suited to the client group or will require reinforcement with other techniques.

The lines along which this supplementation may be organized is perhaps best conceptualized in an ecological model of community mental health that draws upon theories and techniques from clinical psychiatry, social science, and public health. Since one objective is the control en masse of emotional disturbance, it is essential to bring into the orbit of techniques methods that not only influence individuals but also families and other groups. A network of coordinated services is consequently employed that acts independent of psychotherapy. By the very nature of the work, psychotherapists who work in the community must collaborate with other professionals in the fields of education, medicine, nursing,

welfare, correction, law, religion, and other disciplines. This does not mean a watering down of psychotherapy when it is indicated in individual cases; however, the limitations of psychotherapy in dealing with community problems must be acknowledged. Essential is a broadening of the base of operations to include every measure—psychological and sociotherapeutic—that can help people relate better and function better.

Actually, present knowledge of dynamics and psychopathology has widened the horizons of illness to include deviant behavior in addition to the traditional neurotic and psychotic syndromes. With this insight has come the need to provide services for disorders up to recently not considered within the province of psychotherapeutic concern. As a consequence, it has been necessary to blend therapeutic methodologies with educational, social, and rehabilitative approaches and to modify ideas and methods within the context of the communities' medical and social organizations.

Alterations in line with community need inevitably includes psychotherapy. In extending the benefits of psychotherapy to the masses, however, it becomes necessary to adapt psychotherapeutic tactics to abbreviated objectives. Short-term psychotherapy devoid of ambiguous abstractions and amorphous theoretical concepts that applies itself to the immediate problems of patients becomes essential. The effect of these modified treatment techniques can be both reparative and reconstructive, although goal compromise may be necessary to meet the practical needs of the millions who require aid. Attention to the populations that are now being unserved or underserved, such as the chronically mentally ill, the aged, children, minorities, alcoholics, and substance abusers, is particularly urgent.

In addition to psychotherapy, the total involvement of the community and its resources in a comprehensive program is unavoidable. One form particularly suited for sicker patients is the "therapeutic community" (Edelson, 1964; Kraft, AM, 1966). The therapeutic community is actually an old concept, dating far back in history. But the ways in which therapeutic communities have operated have varied with the level of our understanding of group and interpersonal processes. Mental health specialists will need to

know how to help each member of the community achieve as maximal a development as is within the individual's potential.

Because emergencies in the lives of people most commonly motivate them to seek help, some mental health centers have largely devoted their efforts to working with crises. According to Caplan and Grunebaum (1972), the following points are essential crisis intervention:

1. Timing: Intensive and frequent visits during the first 4 to 6 weeks are mandatory, rather than spacing interviews at weekly intervals over a long-term period.

2. Family orientation: The integrity of the family should be preserved to help support the member in crisis. Interviews with the family at its home may be required.

3. Avoiding dependency: Undue dependency is avoided by dealing with the current situation rather than focusing on past problems.

4. Fostering mastery: All efforts are made to encourage understanding of a problem and modes of coping with it effectively. This may require intensive short-term education.

5. Outside support: Enlisting the help of available outside support (friends, clergy, and other agencies) facilitates treatment.

6. Goals: The objective is to improve adjustment and immediate coping with the current situation rather than "cure." Trained non-professionals may be useful in carrying out the therapeutic plan.

Helping people to deal constructively with crises necessitates less a focus on etiology than on encouraging exiting health-promoting forces of an interpersonal and social nature that are present or latent. Caplan (1974) points out appropriately that capacities for adaptation of individuals are bolstered by help from their social networks, "which provide them with consistent communications of what is expected of them, supports and assistance with tasks, evaluations of their performance, and appropriate rewards." Although the intensity of stress and the existing ego strength of individuals is important, the quality of the support that the individuals get from their group is even more important in adjusting to the noxious effects of an environment or in coping with crises. Supportive groups are many, the individuals involving

themselves consistently with some of these such as in work, church, and political or recreational associations; or groups may be selected and utilized only in times of need, such as self-help groups, physicians, social workers, ministers, lawyers, non-professionals, mental health aides, and concerned friends who have had and perhaps conquered problems similar to those of the individuals. These helping aids may be exploited spontaneously by the individuals or, if a community is lacking in them, organized and stimulated by a knowledgeable professional. Where they exist and the individuals isolate themselves from them, the task of community mental-health workers may be to motivate the clients to make use of them or to deal with the resistances against their use. Adequate support programs are vital in any comprehensive program of community mental health (Caplan and Killilea, 1976).

COMMUNITY PSYCHIATRY

The reduction of psychiatric morbidity through preventive, rehabilitative, and therapeutic measures is the objective of "community psychiatry" or "social psychiatry." Elaboration of community-based treatment and aftercare services draws upon principles of public health and incorporates epidemiological and biostatistical precepts even though psychiatric techniques are ultimately employed. An ample body of literature has accumulated on community psychiatry: Beliak (1964, 1974); Bernard (1954, 1960); Carstairs (1962); Clausen and Kohn (1954); J. V. Coleman (1953); Columbia University School of Public Health (1961); Dax (1961); Dohrenwend et al. (1962); Duhl (1963); Dunhan and Weinberg (1960); Faris and Dunham (1939); Felix (1957, 1961); Forstenzer (1961); L. K. Frank (1957); H. Freeman and Farndale (1963); GAP (Reports 1949, 1956b; Symposium, 1965); Goldston (1965); Greenblatt et al. (1957); Gruenberg (1957); Hanlon (1957); Harvard Medical School (1962); Hume (1964, 1965, 1966); M. Jones (1952); I. Kaufman (1956); Kupers (1981); Lager and Zwerling (1983); Lamb (1984); Lebensohn (1964); Leighton (1960); Leighton et al. (1957, 1963); Lemkau (1955); Lin and Standley (1962); Milbank Memorial Fund (1956, 1957, 1959); Mintz and Schwartz (1964); NIMH (1961); Pepper et al. (1965);

Plunkett and Gordon (1960); Redlich and Pepper (1963, 1964); Rennie and Woodward (1948); Ruesch (1965); Stainbrook (1955); Talbot (1984); Weston (1975); and WHO (1960).

PREVENTIVE PSYCHIATRY

Originally, therapy was focused on caring for seriously impaired mental patients. The emphasis on prevention, however, has shifted attention to patients with less severe emotional ailments, i.e., the psychoneuroses, the character disorders, the minor addictions, and even the milder adjustment problems. Caplan (1965) stressed that it was essential to accept responsibility "for helping those of all ages and classes who are suffering from disorders of all types, wherever they occur in the community." His statement makes clear why therapeutic services shifted away from the desperately mentally ill: there just was not enough money to go around.

A public health model of prevention divides such a program into primary, secondary, and tertiary categories (Caplan, 1964; Zusman, 1975). In *primary prevention*, attempts are made both to modify the environment and to reinforce constructive elements within individuals to aid in their coping capacities and to reduce the incidence of mental disorder. In *secondary prevention*, the aim is to diagnose and to treat patients with existing mental disorders to lower the severity and duration of morbidity. In *tertiary prevention*, the object is to rehabilitate people with emotional difficulties so that they may make some kind of adaptation to their environment.

Efforts at prevention require knowledge of community organization and planning as well as cooperation with other productive community programs that are operative within the community. There are relatively few psychotherapists who have gone beyond their clinical training to acquire required skills to work at prevention. But even if mental health workers have had adequate knowledge and training, there are regressive forces within the community that will resist change and will even attempt to restore the prior pathogenic elements once change is effectuated. Indeed, there are professionals who insist that the

present-day community mental health movement is geared predominantly toward social control and toward preserving the politico-economic system and that change will be possible only by the assumption of a radical position, with mental health centers becoming politically involved while using methods that reach large masses of people (Kunnes, 1972). Advocated is turning over the control of policies and priorities of services to the citizenry of the community, the "consumers." On the other hand, it is pointed out by oppositionists that where such a radical position has been taken, the results have been sadly wanting and that, therefore, a more conservative stance is to be preferred. Therapists can only do for a community what it is willing to accept. This should not dampen enthusiasm about what can be accomplished or discourage efforts at public education that can reduce the resistance threshold.

Primary prevention, though "the most desirable and potentially most effective approach to a solution of the problem of mental disorder in our communities, is clearly more a hope than a reality" (Caplan and Grunebaum, 1972). "In regard to preventive programs there seems to be no empirical evidence that any program is capable of preventing abnormal behavior." The provision of adequate health, housing, police, sanitation, educational, welfare, social, and recreational facilities requires outlays of public funds so vast that any effective provision would threaten other priorities. Increasing taxation and the issuing of bonds to bolster flagging budgets have acted like time bombs that threaten fiscal solvency. Accepting the fact that primary prevention is still a dream, some community mental-health operations have served quite successfully to supply services for secondary and tertiary prevention.

THE COMMUNITY MENTAL HEALTH CENTER

Broadening the base of services to the mentally ill and emotionally disturbed and focusing on early treatment and ambulatory services result in a minimal disruption of personal, family, work, and social life. Essentially, therapists function most effectively as consultants both for the management of individual

cases and for the development and implementation of programs. Therapists' major areas of competence, diagnosis and treatment, is of great value here.

Two patterns of community psychiatry appear to be emerging. The first is organized around the community mental-health center, which aims at decentralization, regionalization and local service and is not too intimately related to other health services. The second is the integration of psychiatric services centered around the general hospital, which has consultative, outpatient, inpatient, round-the-clock care facilities but which is relatively isolated from community welfare and educational services.

The assembly under one umbrella of *all* services for the mentally ill was one of the recommendations of the National Congress of Mental Illness and Health, held by the American Medical Association Council on Mental Health in 1962 (NIMH: *The Comprehensive Community Mental Health Center*, Public Health Service Pamphlet No. 1137, 1964; see also *Community Mental Health Advances*, Public Health Services Publication No. 1141). The Joint Commission on Mental Illness and Health, in its report to Congress in 1961, also emphasized the need for community services as a way of prevention and treatment to avert the debilitating effects of long hospitalization. The Joint Commission recommended expanded services in the community, a shift of focus from mental hospital institutionalization to smaller inpatient units as well as increased community care, a concentration on prevention and rehabilitation, greater cooperation among the different professions toward improving mental health research and treatment, and a more intimate coordination of hospital and community resources (*Action for Mental Health: Joint Commission on Mental Illness and Health.* New York, Basic Books, 1961). These recommendations fostered the organization of community mental health centers that promised the following:

1. Inpatient services, including a 24-hour emergency service

2. A day hospital

3. Outpatient clinic services for adults, children, and families without a waiting period

4. Partial hospitalization for day care and night care

5. Consultation services

6. Diagnostic services

7. Rehabilitative services of an educational, vocational, and social nature

8. Precare and aftercare services, such as placement in foster homes and halfway houses

9. Training of all types of mental health personnel

10. Research and evaluation

These instrumentalities were not to be under one roof or one sponsorship but were to be administered so that a continuity of care was achieved (Downing et al., 1966; Dorsett and Jones, 1967; McKinley et al., 1966; NIMH, 1963a & b).

The concentration of services around a general hospital was recommended by some authorities, and a selected annotated bibliography was prepared by the National Institute for Mental Health detailing how a hospital may function as a psychiatric resource (*The Community General Hospital as a Psychiatric Resource*, Public Health Service Publication No. 1484, Public Health Bibliography Series No. 66).

The experience of implementing the community mental health center program has not been an entirely happy one. Glasscote et al. (1969) believed that the flaw was in the timetable: "Lack of experience, lack of staff, and lack of definition have all played a role, but they have been less of a problem than bad timing." The urgency to spend allocated funds for construction of community mental health centers over a two-year period encouraged the building of centers prior to planning how they would be used in comprehensive statewide designs. Problems also developed in providing for adequate staffing, a prime key to the adequate operation of a center. Psychiatrists, who were in preponderance, now find themselves in the minority in comparison to psychologists, social workers, and nurses. Much of the fault in fulfilling the original purpose of Congress in creating the program lay in the fact that providing for the mental health needs of all

people in all parts of each state with adequate preventive, screening, diagnostic, therapeutic, rehabilitative, consultative, educational, research, and training services was a too ambitious, and perhaps unrealistic, goal that awaited a good deal of experiment over many years before it could be even minimally fulfilled. This is perhaps why unfavorable publicity and reports of failure of the community mental health programs have appeared in the literature. For instance, Ralph Nader (*Medical Tribune*, 1972) has claimed that the programs in action have perpetuated a two-class system of care that is sterile in ideas and operations. An overcommitment to broad social problems at the expense of the immediate needs of clients "wastes professional staff and is both expensive and unfruitful, thus causing public disillusionment and endangering the whole community psychiatry program" (Wachpress, 1972). Under the circumstances it is remarkable that many community mental health centers have functioned as well as they have (*New York Times*, 1972). It is hoped that profiting from what has happened in the past, with adequate governmental funding and more sophisticated staffing, the centers may ultimately bring to fruition some of Congress's original goals. It is hoped, too, that aftercare programs for patients discharged from mental hospitals will become better financed and organized so that readmissions to hospitals are less necessary. Some of the statistics are presented as impressive. The number of hospital beds for mental patients has been more than halved, and the average stay has been reduced from 8 years to 17 months. Without adequate support systems in the community, however, the benefits of deinstitutionalization are questionable.

EXPANDED FUNCTIONS OF THE PSYCHOTHERAPIST

Since diagnostic and treatment resources cannot be deployed for relatively large groups of patients, and patient-therapist contact being limited, other modes of contact are necessary. Preventive methods entail the detection and remedying of *social forces* and *environmental pressures* that have a potentially pathogenic effect. Consequently it is advisable to include in the treatment plan "the active manipulation of the organizational aspect" of patients' lives (Caplan, 1965). This often requires the offering of individual or group consultation to administrators and others in an organization. Advice may be given affecting any

phase of organizational functioning, including policy making. In expanding operations, therapists will, as has been mentioned before, have to go beyond habitual clinical theoretical models.

Community work foists onto therapists responsibilities that differ from those of traditional psychotherapy and are in line with the new tools being used (i.e., consultation, in-service training, and general public education). Guiding people in the organization (executives, foremen, staff workers) with problems is complicated. Exploiting the theory and practice of community psychiatry, the practical implementation of community research methodology, the planning of services in line with the most efficient use of resources, and the development and administration of community programs are functions that will require specialized training beyond that of the psychiatric residency. Such training will undoubtedly be organized in the future as part of a career program and may be as eagerly sought after as psychoanalytic training had been for the past generations of psychotherapists. One design of training was a model offered at the Columbia Presbyterian Medical Center, which was organized and carried out jointly by the Department of Psychiatry and the School of Public Health and Administrative Medicine through an interdepartmental Division of Community Psychiatry (Columbia University, 1961; Bernard, 1960, 1965). Other training programs have been at the Johns Hopkins School of Hygiene and Public Health (Lemkau, 1955), at Harvard (Caplan, 1959), and at Berkeley (Beliak, 1964). There are some who believe that it is possible to teach community psychiatry in a traditional residency training program (Daniels and Margolis, 1965). Some favor the Community Mental Health Center (Sabshin, 1965). Others have developed programs in relationship to state and local health departments and university, state, and private training centers (Kern, 1965).

Comprehensive Training in Community Mental Health

There is disparity in ideas of who should be trained in community psychiatry and community mental health. Some authorities believe that psychiatrists should have the priority; others believe that psychiatric nurses, clinical psychologists, and clinical social workers are fully capable, with training, of learning skills

in community psychiatry (Hume, 1966). Community mental health is, according to Lemhkau (1965), of medical concern, but it is not identical or coincident with psychiatry. It is much broader: it is a community-wide responsibility that sponsors the concept that "the program is to be under professional and lay auspices, and that mental health is promoted and fostered not solely through medical treatment, but also through a variety of institutions and agencies with numerous disciplines joining in the effort."

The multidisciplinary accent on community mental health has exacerbated rivalries and hostilities among the disciplines involved whenever adequate financing for services has become available. With expanded funding, arguments of who can practice—and under what auspices and supervision—will perhaps be as vehement as in the practice of psychotherapy. With added information about epidemiology and biostatistics, and with a greater public health orientation, trained psychotherapists in any of the professions can very well adapt to a community-based design for the mentally ill and, if creative and experienced, may be able to organize, direct, and execute projects of public education in mental health. To do consultation, however, and the in-service staff training and education of allied professionals (ministers, nurses, social workers, physicians, rehabilitation workers, speech therapists, and teachers) in therapeutic techniques (counseling, group process, and so on), even experienced therapists will need to fulfill certain requirements. They will preferably, following their residencies, have completed postgraduate work in a psychoanalytic or psychotherapeutic training center. They will ideally also have completed a structured course in community mental health that draws upon the public health and behavioral science fields. Work in community projects under supervision will have taught them the fundamentals of mental health consultation and how to gear teaching methods to the needs of the different professionals who handle people experiencing problems. It is hardly conceivable that a mental health consultant and professional trainer can be on a level below that of supervising psychotherapist.

One of the chief difficulties for most psychotherapists launching into the field of mental health is that, with the possible exception of social workers, their training, experience, and hence conceptual framework

is largely clinical. Although this framework may operate effectively in psychotherapy, it does not apply to many, perhaps most, of the problems encountered in the community. An ideal community mental health worker should in part be a sociologist, anthropologist, psychologist, educator, political scientist, community organizer and planner, psychoanalyst, psychiatrist, physiologist, social worker, historian, pubic health specialist, biologist, social philosopher, researcher, and administrator. Since no therapist has or will ever have a complete combination of skills relating to the above professions, therapists will have to accommodate existing talents to a complex, difficult, and constantly changing community atmosphere, utilizing themselves as constructively as possible while preserving the open mind of a student and scholar who is in constant search for new information and knowledge. Training is helpful within a community mental health center to equip therapists with the specialized abilities required to work in the community. When therapists have the motivation and are fortunate enough to live in an area where there is a training course in community mental health, the experience may be very profitable.

The kind of training that is most suited for community mental health specialists is, in addition to psychotherapy, experience with group processes and group dynamics, research design and methods, community organization and planning, communication techniques, teaching, various rehabilitation procedures, administration, and legal and legislative processes. A knowledge of public health objectives and measures is also helpful. It is rare that an individual can be interested in all of these fields. Generally therapists concentrate on a special area, such as mental health education, but comprehensive knowledge will enhance functioning even though greatest weight is given one kind of activity. Work in such fields as rehabilitation, law enforcement, industry, recreation, and religion, requires an extensive repertoire of techniques. The broader the education of therapists, the more effective they will be as consultants.

Since substantial therapeutic impact may be made during periods of crisis, contact with individuals in trouble may be of incalculable help if therapists have fundamental information about how to recognize an emotional problem, how to interview, how to conduct themselves constructively in therapeutic

relationships, and how to make referrals. Educating such individuals presupposes an understanding of teaching method.

TECHNIQUES IN COMMUNITY MENTAL HEALTH

Mental Health Consultation

Consultation is a basic tool of mental health specialists. It consists of an interaction between a specialist or consultant and one or more consultees (usually agency professionals) aimed at the mental health components of their work, including program and practices of the consultee organization. In the course of such consultation the consultee is also, according to Gerald Caplan, "being educated in order that he will be able in the future to handle similar problems in the same or other clients in a more effective manner than in the past" (U.S. Public Health Service, 1962).

Mental health consultation must be differentiated from psychotherapy, supervision, professional education, in-service training, and collaboration (Haylett and Rapaport, 1964). In psychotherapy, the interaction is with patients toward resolving symptoms and strengthening personality assets; in consultation, the relationship is with consultees and is geared toward enhancing their knowledge and skills. In supervision, supervisors assume an administrative in addition to an educative role; in consultation, consultants do not play an administrative authority role. In professional education, students are schooled in a skill that equips them to enter a certain profession; in consultation the consultees have already fulfilled the minimum requirements for their profession. In in-service training, the focus is on improving competence in the tasks for which therapists have been hired; in consultation new tasks are envisioned to expand the consultees' functions in mental health areas.

Consultation is usually offered to individuals in key administrative and supervisory positions to maximize the effect and reach the greatest numbers of people, i.e., the working staffs. It is generally done at the consultees' place of work unless consultants possess or arrange for special facilities.

Stages of consultation may be divided into a beginning or "entry" phase, a problem-solving phase, and a termination phase. It is assumed that the consultee is acquainted with the consultant or the consultant's work and is oriented regarding the nature of consultation services. If not, a preparatory interpretive meeting or group of meetings may have to be arranged. A contract is drawn up either verbally or, preferably, in the form of an exchange of letters. The consultant and consultee agree on details about participating personnel, the extent of time of the project, and physical arrangements. It may be necessary to clarify the consultant's role—for instance, that services are not given directly to the consultee's clients. The next phase is that of problem solving, which is the core of the consultation process. Here the consultee's motivations and readiness for change mingle with the consultant's skill, experience, and capacity to handle emotional aspects of the relationship. This interaction will determine the rapidity with which movement and change are registered. The final phase is that of a mutually agreed upon termination.

The methods employed by the mental health consultant will have to be adapted to the special needs and problems of the agency, group, or individual who is seeking help. Generally, methods derived from the clinical model, i.e., therapeutic work with individuals, are not too applicable to consultation. As an example, suppose that the specialist is engaged by a social agency as a consultant in making their functions more effective. The first step is the "entry process" into the agency—"consultee system," or "client-system" as R. Lippitt et al. (1958) call it. This entails a proper diagnosis of the problem determined by setting up a series of meetings with key personnel. The objective is to help the consultee arrive at an understanding of what is needed and which aspects of the problem to approach immediately and which later on. A problem-solving plan is evolved, and the consultant then focuses on facilitating and enhancing the problem-solving skills of the individuals who will execute the plan. Communication channels are opened up between the various levels of the agency (executive, supervisor, and staff) to handle the effects of feedback, and resistances to change and to learning. The consultant then continues to work with the agency until the plan is proceeding satisfactorily. If the agency is large, the consultant may restrict efforts

just to training the supervisory staff, expanding their information and skills so that they may by themselves manage and continue the program that has been instituted. The consultant may have to use some research techniques and engage in 9 or 10 group conference services, getting details of work habits, studying records, and becoming familiar with the functions of the organization. Then attention may be directed to training. If the consultant cannot personally enter into the problem-solving process, help may be obtained from the proper outside resources for this task. Finally, the consultant withdraws from the agency or "consultee system" (Wolberg A and Padilla-Lawson, 1965).

Considerable numbers of writings have accumulated detailing theory and method in mental health consultation. Recommended readings are the following: Argyris (1961); Berlin (1956, 1960, 1964); Bindman (1959, 1960, 1966); Boehme (1956); Brashear et al. (1954); Caplan (1961b, 1963, 1964, 1970); L. D. Cohen (1966); J. V. Coleman (1947); Cooper and Hodges (1983); Covner (1947); Croley (1961); Davies (1960); W. E. Davis (1957); GAP (1956a); Garrett (1956); Gibb (1959); Gibb and Lippitt (1959); Gilbert (1960); Gilbertson (1952); Glidewell (1959); Gordon DE (1953); Greenblatt (1975); Halleck and Miller (1963); Kazanjian et al. (1962); Lamb and Peterson (1983); Leader (1957); Lifschutz et al. (1958); G. Lippitt (1959); R. Lippitt et al. (1958); Maddux (1953); Malamud (1959); Mannino et al. (1975); Mental Hygiene Committee (1950); Nunnally (1957); K. B. Oettinger (1950); Parker (1958, 1962); L. Rapaport (1963); Rogawski (1979); M. J. Rosenthal and Sullivan (1959); San Mateo County (1961); G. S. Stevenson (1956); Valenstein (1955); A. Wolberg and Padilla-Lawson (1965); Zander (1957).

More specifically, the entry phase is characterized by an exploration during conferences of the manifest problems and needs of the consultee. During this phase relationships will be established. If possible, a personal interview is arranged by the consultee for the consultant with the head of the agency to affirm the agency's support for the project. Answers are needed to the following:

1. What is the structure of the agency, including the history, budget, and financing?

2. What is the organizational structure involving the personnel in the agency? What are the authority lines and policy-making bodies?

3. What are the supervisory policies?

4. Are there any apparent personality problems of, and conflicts in relation to, the leadership?

5. Are there any apparent conflicts in policies and aims?

6. What are the existing functions of the agency and are these being fulfilled?

7. What are the proposed future functions, if any, and are these realistic?

8. What is the community setting in which the agency operates? Are there conflicts between policies and functions of the agency and the community? What are the -areas of community support and the areas of opposition? (For example, a school may wish to focus its resources and energies on the most gifted children who are showing learning blocks. The parents' association may be pressing for better tutoring to prepare the students for college boards. Some community organizations, courts, and social agencies, in contrast, may be insistent that juvenile delinquents and retarded children receive special attention, which will conflict with a program for brighter students.)

9. What is the community organization; is there now or will there be a duplication of services? Is there cooperation with other agencies?

10. What are the existing and anticipated conflicts regarding programming and policy changes?

11. What were the previous experiences of the agency with consultants?

During the next (problem-solving) phase of the consultation there is an ordered gathering of information about the consultee system, including needs and difficulties. A true working relationship begins to develop. Diagnostic assessments are made and a plan of action is agreed upon. It will be essential for consultants to educate the consultees in handling anxieties and resistances. A periodic review of services and problems may be required and role limitations defined. It is to be expected that some untoward reactions will crop up among the staff, supervisors, and administration when program changes are proposed or implemented. Great tact must be exercised in dealing with these. It may that the staff's

proposals for change may not be consonant with the personal philosophies of the administrator, in which case exploratory conferences will be necessary.

In the course of problem solving, transference and countertransference will come into evidence. The consultants' own analysis and experience as psychotherapists will help the consultants deal with these contingencies. Obviously, psychotherapy will not be done; however, inimical reactions may tactfully be interpreted on the "here-and-now" level. Temptation to fall back on clinical methods must be resisted. If the consultees recognize an emotional problem in themselves and request help for this, the consultants may offer advice about resources. Plunging in blindly and trying to get consultees to accept personal therapy without their desire for this may destroy the working relationship.

What is discouraging to most consultants is the slowness with which attitude change can be brought about. Personality difficulties among the personnel in an agency are the greatest deterrents to change and constructive action, and consultants will have to work with these obstructions painstakingly. Honest, frank communication in the matrix of a working relationship is the best way of dealing with emerging resistances and problems. Consultants must expect that some of the intrusions proffered will be challenged and that discrimination may be exercised that will not always be in the consultants' favor. Questions consultants ask about the organization and its functions may arouse suspicions of "trespassing" and may mobilize guilt feelings in those who fear that their negligence in duty will be discovered. Some may resent being told how to do their jobs. The consultants during conferences should convey no implication of blame or criticism, no "eyebrow lifting." A casual reassuring manner is best punctuated by occasional approving remarks for praiseworthy tasks the consultees are doing. Attempts should be made to build up confidence and trust, realizing that no matter how meritorious or urgently changes are needed, they are bound to be resisted. Even a poorly functioning organization has achieved a shaky equilibrium, which will be defended.

Among the rules to follow are these:

1. Do not be hasty with advice. Community problems are complex and a thorough exploration will be essential before conclusions are valid.

2. Consider carefully the ideas and opinions of the people with whom you are working.

3. Expect power groups to try to involve you; avoid taking sides.

4. Try to see all aspects of a question if there is conflict. Verbalize how the opponents must feel. Let them offer suggestions regarding proposed courses of action

5. Try to exhibit tact and to retain a sense of humor.

The withdrawal phase of consultation will take place after the problem for which the consultants was retained has been solved, or prior to its solution by mutual consent. An evaluation of the service and plans for future cooperation (e.g., reports, personal contact) are made.

It is apparent that the consultants will need to know something about community organization and planning for mental health, social planning, organizational management, administration, public relations, public health, individual and group dynamics, research, law, teaching, supervision, social psychology, cultural anthropology, sociology, and political action.

At the Postgraduate Center for Mental Health in New York City, an interdisciplinary specialty program trained psychiatrists, psychiatric social workers, and clinical psychologists to function as community mental health consultants only after they had completed a postgraduate psychoanalytic training program (which requires an average of 4 years of didactic courses, personal psychoanalysis, and intensive supervision) and who thereafter spent an additional 2 years, part time, in active consultative work in the community under supervision (Hamburger, 1976; Wolberg A, and Padilla-Lawson, 1962). In practically all cases, students have become so interested in community work that they have participated substantially as community workers after completing their course in addition to operating as therapists in private practice. The model for the consultation process taught has been developed and organized in part around the paradigms of G. Lippitt (1959) and Gibb and R. Lippitt (1959), which emphasize systems

theory and group dynamics, and in part around concepts of a mental health "multilevel planning-activity group (MPAG)" developed by A. Wolberg and Padilla-Lawson (1959), an outline of which is given in Table 67-1 and Table 67-2.

To apply themselves most effectively in the community, therapist-consultants will have to fulfill a number of roles. Ideally, they should be able to plan, develop, and implement programs for prevention of mental illness, for reduction of psychiatric morbidity, for training of mental health personnel, for agency evaluation and reorganization, for education of professionals (e.g., physicians, teachers, ministers, lawyers, correctional workers) who deal with people blocked in learning, work, and interpersonal and social relationships, for upgrading of skills of institutional staffs (e.g., schools, industry, social agencies), and for public education in mental health. Obviously, neither the consultants' backgrounds nor available time will enable consultants to be equally effective as community mental health consultant, professional trainer, and public health educator. Consequently, it will be necessary to restrict efforts to areas within the consultants' competence while acquiring further training that will equip consultants to play an expanded mental health role. Thus if zones of interest and ability are in the field of treatment, administration, research, or teaching, therapist-consultants will most likely seek out and be sought for selective projects in line with this expertise.

In some of these projects the consultants will become involved in organizing, administrating, and supervising a variety of other services, some of which they can do better than others. These include preventive care, home treatment, walk-in clinics, admission procedures, partial hospitalization, work programs, social rehabilitation, planning development of the locus of care, rural program development, metropolitan mental health center development, legal issues in establishment and operation, record keeping and research, and so on (Grunebaum H, 1970).

The Training of Mental Health Personnel

Mental disorders constitute a major public health problem resulting not only in syndromes that totally incapacitate a large section of the population, but also, in their early stages and incipient forms, directly or indirectly influencing the happiness and efficiency of every individual alive. Because of the ubiquity of the problem, psychotherapists are being increasingly drawn into programs of training on federal, state, and local levels. The broadening of vistas of mental health to penetrate into every nook and cranny of the community and diffusion of psychological knowledge into programs of education, correction, health, and welfare have resulted in an enlistment of psychotherapists toward planning programs and participating in their development in accordance with the needs, readiness, and practical limitations existing in a specific area of the country. Psychotherapists are also playing a vital role in the recruitment of mental health personnel.

In view of the great shortage of mental-health workers, training programs are being sponsored with federal and state support, which include not only professional groups such as general practitioners, nurses, social scientists, health officers, health educators, ministers, teachers, social workers, occupational therapists, recreational therapists, speech therapists, and vocational counselors, but also sub-professional and technical personnel such as psychiatric aides and paraprofessionals. While it is difficult to estimate the precise personnel requirements, it is safe to assume that at least twice the number of mental health professionals will be needed to cope even minimally with the existing demand for services. In recognition of these needs, the Surgeon General's Ad Hoc Committee on Mental Health Activities (NIMH, 1962) encouraged the in-service training in mental health of professional personnel in organizations that deal with problems confronting human beings on every level of functioning, the introduction of mental health courses in schools of public health, more intensive exposure of psychiatric residents to social science and public health methods, and support for the training of greater numbers of high-level professional mental health personnel, particularly for work in community mental health programs.

In designing a training program for an agency or organization, the therapist-consultant will need to use some of the processes of consultation. This may be illustrated by a problem presented to the Postgraduate Center by the casework staff of the case study unit of one of the bureaus of a school system (Wolberg A, 1964). The staff was concerned with the need to learn new techniques to approach the hard-to-reach children expressing their emotional problems in poor school attendance. Home visits, referrals to community agencies, supervision of the children, consultation with community agencies, and appearances in court constituted the work done by the social work staff. After a series of conferences of the consultees with the casework staff, it was agreed that some of the children might benefit from group approaches. It was decided to organize a training program to teach the social workers the group-counseling method within casework process.

Four broad phases in this program were planned: (1) Six to eight exploratory sessions with the case study supervisors of the bureau and the consulting supervisory staff of the Postgraduate Center to discuss typical cases handled by the bureau, with the hope (a) of developing a set of criteria for the choice of clients who would participate in the groups and (b) of developing group techniques appropriate to this situation. (2) A regular 15-session seminar in group process for the case-study supervisory staff of the bureau and for the three caseworkers who were to handle the first three trial groups. (3) Three consultants assigned to the first trial groups were to teach the caseworkers how to use group dynamic methods in handling their groups of children, and to teach the supervisors how to supervise this group process. Other supervisors and social workers were to observe the supervision of the worker. This phase was to continue for 2 or 3 years in a progressively diminishing manner as the bureau staff acquired greater skills. (4) In 4 or 5 years the project was to be expanded to train social workers in the bureau to assume responsibility for a citywide group program in the schools. After this the Postgraduate Center was to withdraw and the consultation program was to be terminated. According to the plan, each caseworker (attendance teacher) carried 2 groups of 8 children each, weekly, over a period of 1 semester (15 weeks), in addition to the

caseworker's regular work. The objective was not to make group therapists out of the social workers, but to adapt group methods to casework procedure to enhance the mental health of the children.

The value of this program was proven by the marked improvement by the participant children in actual school attendance (complete cessation of absenteeism in 53 percent, marked reduction in 20 percent), in scholastic achievement, in attitudes toward school, and in general attitudes toward their classmates and adults. The school personnel expressed enthusiasm regarding the results of the program. A total of 25 attendance teachers was trained to manage groups, most of whom became supervisors and in turn began to train others.

Training programs must be tailor-made, designed for the specific needs of the professionals who are seeking further tutelage, taking into consideration their present education and the functions that they intend to fulfill. Generally, a consultation process will be required to assess what the training requirements are and the best means of executing the proposed goals. It is essential that the training equip the individuals to work more effectively within their particular profession and not be geared to making the "trainees" psychotherapists. Didactic lectures are secondary to case discussions and supervised work with clients. A group process is often helpful for the professionals themselves, enabling them to become aware of some of their personal problems and resistances.

Public Education in Mental Health

The great need for public education in mental health was pointed out by Braceland (1955): "public information on what constitutes illness and health is a hodgepodge of folklore, information, and misinformation." He appropriately warned, moreover, that the techniques and particularly the use of mass propaganda methods may present a distorted picture of any public health problem. Data about mental and emotional disease may easily arouse fears and anxieties. The ineffectiveness of intensive educational programs using a wide variety of materials is, unfortunately, not too uncommon an experience, established

attitudes rarely being changed. Braceland affirmed the need to avoid calling attention to the ravages of mental illness; rather it is essential, he noted, to stress hope and the promise of recovery with early diagnosis and treatment "to reassure rather than to threaten or frighten" and "the audience…spared technical language and abstruse, complex material that they are not prepared to handle." What requires emphasis is normal behavior, the fluctuations in emotional wellbeing, the universality of anxiety and some of its common manifestations, the determining (but not necessarily irreversible) influences of past experiences, the impact of social and cultural factors on personality development and functioning, the psychological needs at various developmental phases, the stress situations that create emotional insecurity at different age periods, and a description of how emotions influence humans toward unrealistic goals and immature behavior.

Mass approaches to public education in mental health must await the development of television and radio programs as well as the kinds of press reporting and magazine writing that does not emphasize the destructive, dramatic, and violent aspects of mental illness and emotional disturbance. If the sponsors of programs and the controlling forces in the publication field were to apply the organizational and creative skills they use to sell advertised products, they undoubtedly would be able to adapt mental health materials that would change attitudes. This would necessitate a shift in the content of mass media away from preoccupations with violence and disturbed relationships among people.

In the meantime, mental health workers may have to confine themselves to the influencing of small, motivated groups who need and ask for special kinds of information. Materials pertinent to the topics of interest may be procured, and leads regarding appropriate films, pamphlets, plays, and other audiovisual and graphic aids may be obtained, from such educational organizations as the Mental Health Materials Center, 30 E. 29th St., New York, NY 10016. There is a useful Public Health Service Publication (No. 218, Washington, D. C., 1960) titled *Mental Health Motion Pictures: A selective Guide*. A film guide, *Index to 16 mm Educational Films*, is published by NI-CEM, University of Southern California, National

Information Center for Educational Media, University Park, Los Angeles, CA 90024. The Library of Congress publishes a catalogue of motion pictures and filmstrips on many educational topics. Films may also be obtained from Psychological Cinema Register, Audiovisual Service, Pennsylvania State University, University Park, PA 16802; and New York University Film Library, Washington Square North, New York, NY 10003. If audio materials alone would be sufficient, a catalogue with a full listing may be obtained from The Center for Cassette Studios, 8110 Webb Avenue, North Hollywood, CA 91605; and from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, MI 48106.

In the section on Bibliotherapy, books and pamphlets on different subjects written for the general public will give educators ideas of content and methods of presentation.

A brief outline of suggested methods of working with films and conducting discussion groups follows.

SUGGESTIONS ON METHODS OF INTRODUCING AND DISCUSSING MENTAL HEALTH VIDEOS

1. *General.* Mental health films presented to lay groups are mainly informational in objective. This means that the discussion leaders function as "experts." They must make the largest contributions elaborating on the theme of the film and clarifying the questions brought up by the audience. Nevertheless, audience participation must be encouraged. This can be done by stimulating discussion on several points illustrated by the film.

   Many members of the audience will identify with characters in the film. Consequently, the tone of the discussion must always be sympathetic and reassuring. Never belittle or ridicule any character; *never* say a condition is hopeless or incurable.

2. *Previewing the film.* If possible, preview the film, preferably at least an hour before the actual showing. Make a notation in writing of the following: (a) What is the theme of the film? (b) What three or four points does it illustrate? The discussion that follows the film may be organized around these points.

If a preview of the film is not possible, study the *leader's guide* issued with the film, if there is such a guide, at least an hour before the showing. Make notations in writing of the film theme and of several psychiatric points that are illustrated.

If a preview of the film is not possible and if there is no leader's guide, make a mental note of the theme and points raised while watching the film at the actual showing.

3. *Starting the class or meeting*. The class or meeting must be started sharply on time. Latecomers will probably come on time at the next meeting if this is done.

4. *Introducing the film*. There are two methods of introducing the film: Method 1—Give a brief lecture (10 to 15 minutes) on the general topic illustrated by the film, indicating which points the audience is to observe. Method 2—Describe the film briefly (1 to 5 minutes), indicating the general theme and the points the audience is to watch for especially.

5. *Film showing*. Arrangements will probably have been made with a projector operator so that the film is ready for showing on a signal from you. Since breakdowns in equipment are common, you should determine in advance if the projector is in good working order. Do this also with the videotape recorder if a tape is to be shown.

6. *Discussing the film*. After reviewing the film, you may proceed along several lines:

   a. *Lecture*. If there is to be a lecture, this should last no more than 15 minutes. The points in the film are introduced in the context as illustrative material. Following this, the meeting is opened to discussion.

   b. *Presentation of the salient points of the film*. The chief points illustrated by the film are mentioned, following which there is discussion.

   c. *Asking pertinent questions about the film*. The points illustrated by the film are presented as questions. This is a very good way to get audience participation.

7. *Handling group situations*.

   a. *Group failing to participate*. When the group fails to enter into the discussion, ask one or two provocative questions. If no one responds, call on one member of the group.

   b. *A member arguing too much*. Simply say, "I understand your reaction; perhaps other people here would like to comment on it." The group usually has a way of subduing the

disturbed member. If this does not work, invite the person to discuss matters with you after the meeting.

c. *One member talking too much*. At a pause in his talk, cut the person off with a summarizing statement and direct a question at someone else.

d. *A member persisting on talking off the subject*. Cut the person off with the statement, "That is interesting, and we may come back to that later." Direct a question at someone else.

8. *Terminating meeting*. The meeting should be terminated after about one hour of discussion, or lecture and discussion. A brief summary is sometimes helpful, as is assignment of reading material.

SUGGESTIONS ON CONDUCTING A DISCUSSION GROUP

1. *General*. A discussion group provides the participants with perhaps the best opportunity for learning. Sharing ideas and experiences promotes an exchange of information. Verbalizing attitudes and doubts helps to resolve resistances and learning blocks. Furthermore, the discussion group may serve a therapeutic function, enabling individuals to gain a measure of assuredness in expressing their ideas and opinions and in working through fears, hostilities, and other disabling attitudes in relation to a group.

2. *Physical arrangements*.

a. *Size of group*. The ideal size of the group ranges from 6 to 10 people. This number makes it possible for all members to contribute actively. In exceptional or unavoidable instances, a larger group may be handled, though this will involve some sacrifice in individual activity.

b. *Position of chairs*. Seating arrangement is important to avoid your being placed in too prominent a position, which is apt to stifle discussion. Members may be seated facing you and one another around a table, or, if this is impractical, in chairs placed in a circle or semicircle. It goes without saying that proper ventilation, comfortable lighting and where smoking is permitted ash trays add to the relaxed atmosphere that is most conducive to good discussion.

c. *Length of discussion sessions*. This will vary depending on the circumstances, but a good average is 1 ½ hours.

d. *Starting the session on time.* The session should begin on time. Latecomers will probably come on time at the next session if this is done.

3. *The first session.*

    a. Once members are seated, a good way to start is to ask members to introduce themselves to the group by stating their names, disciplines, (if they have one, and the organization, if any, with which they are associated. This serves to "break the ice" and to introduce an air of informality into the atmosphere.

    b. Next introduce the general subject to be discussed and relate it to the interests of the group members. A distributed outline designating material to be considered is a very helpful adjunct.

    c. If essential information needs to be conveyed to the members before discussion begins, a short talk is in order. If desired, introduce an auxiliary lecturer, or a movie, filmstrip, or other audiovisual aid. Make this preliminary presentation as brief as possible.

    d. Following this, begin the discussion. If there is any doubt in the minds of the members about procedure, inform them that no one will be called on formally, that anyone may speak up whenever desired, and that members should limit their comments to 2 or 3 minutes at most.

    e. Encourage the group to participate by any of the following methods:

        i. Ask a provocative question relating to the outline or to the material under discussion.

        ii. If there are two points of view on a topic germane to the discussion, call for a show of hands of those who share the different viewpoints. Then ask a question as to why one or the other point of view is taken.

        iii. Select a topic related to the general subject and ask if there is anyone in the group who has had experience with this topic.

        iv. Using a blackboard, list the different opinions or ideas of the members about a topic, or possible approaches to the topic. Group these into specific categories, and then ask questions about the various listings.

4. *Subsequent sessions*. At the start of each subsequent session, you may summarize the salient points about the previous session and then bring up the topic for the present session. If new information is to be introduced, this may be done by, for example, assigned readings, written reports from the members, an informative talk by an expert, or films.

5. *Activity of the leader*. Your function as leader in a discussion group is to help the members verbalize their ideas and integrate their thinking about a specific subject. Your role is to participate in the discussion only when the members stop talking, when they deviate from the topic under consideration, or when they are not able to think things through for themselves. Such participation does not mean delivering a lecture, giving advice, or showing off knowledge.

   To fulfill this function, there must be respect for all the members in the group and for their opinions, resistances, and resentments. The fact must be accepted that the learning process requires time and that people must resolve their doubts and suspicions before they can accept ideas, no matter how logical these may seem. This will necessitate great tolerance and the ability to handle aggression that is projected by some members toward the group and toward you. Required is an informal manner and a sense of humor. Essential also is an ability to talk the same down-to-earth language as the group, eschewing complicated formulations and avoiding impressing the members with abstruse talk.

   From time to time, clarify the material presented, particularly conflicting issues, and summarize the contributions that have been made by the members. If certain points are not covered, ask questions about these. Never argue, belittle, or disagree with anyone. If you have a contribution to make yourself, make it briefly, saying, "This is what I have come to believe," or "This is what is generally believed.".

6. *Handling special situations*. This is, on the whole, handled as done in this category under the section on discussing films

   a. *Group fails to participate*. When the group fails to enter into discussion, ask one or two provocative questions. If no one responds, call on one member of the group. If, after this person comments, nobody else volunteers, say, "Perhaps someone has a different slant on this."

   b. *A member arguing too much*. Simply say, "I can understand your reaction; perhaps other people here would like to comment on it." The group usually has a way of subduing the

disturbed member. If this does not work, invite the person to discuss matters with you after the meeting.

c. *One member talking too much*. At a pause in this talk, cut the person off with a summarizing statement and direct a question at the group.

d. *A member persisting on talking off the subject*. Cut the person off with the statement, "That is interesting, and we may come back to that later." Direct a question at the group.

e. *A side argument developing between two or more members*. Rap on the table or chair and say, "May I interrupt please. Perhaps others here would like to comment on this question that is causing controversy." If this does not stop the argument, or if the argument spreads, say, "Obviously there are several points of view; perhaps I can help integrate them." Attempt then to explain why the differences exist and how they can be resolved. If no resolution is possible, say, "Let us think about this matter further, and we may have a chance to come back to it later." Following this, ask another question, directing the discussion into another channel.

f. *One member constantly interrupting the comments of others*. Firmly say to the person at each interruption, "X [the person interrupted] has not finished talking, let us permit X to continue." If this does not stop the person from interrupting, say, "There is something that is bothering you, and it may be helpful for you to see me after the session." Arrange then to have a talk or talks with the person, and if the disruptive activity does not halt, suggest that the person drop out from the group.

g. *Side conversations*. Rap on the table or chair and say, "Please let us all concentrate on what is being said."

h. *The discussion straying too far afield from the subject*. Say, "This is interesting, but how does it apply to the subject we are discussing?"

i. *A member refusing to budge from an opinionated and obviously erroneous point of view*. Do not take issue directly. Merely say, "Perhaps Y would like to bring in source material next time to back up that point of view." Then pass on to another person.

j. *A member refusing to participate*. Respect the person's silence. After a number of sessions, if the person asks to speak, respond positively immediately. Rarely you may say, "Perhaps

Z may want to comment on this subject." If the person indicates no or remains silent, gloss this over with, "Not at this time; well, perhaps later."

    k.   *Lags in the discussion*. Point out the differences in ideas or opinions that have been presented, and ask how these differences may be reconciled.

    l.   *Unnecessary repetition*. Summarize what has been said, point out important aspects and highlights; then introduce a different question.

7. *The recorder and observer*. In some discussion groups it is helpful to appoint a volunteer who will record the salient features of the discussion for purposes of transcription or for summarization at the end of the present or at the beginning of the next session. Another volunteer, an observer, may be appointed to record the activity or passivity of the various members and leaders, the interpersonal reactions, and perhaps the dynamics of the group process, if trained in dynamics, which may also be prepared at the end of the session or at the beginning of the next session.

8. *Summarizing the discussion*. Before the session ends, it may be helpful to summarize the discussion, mentioning the salient points that have been covered, relating the material to what has gone on in previous sessions, restating differences of opinion, tying together topics that have not been coordinated, and adding suggestions about procedure and areas of future exploration. It is essential that the summary contain the conclusions of the group rather than your own conclusions. If the group conclusions are in your opinion inadequate or erroneous, a statement may be made to the effect that further discussion on the subject will open up areas that may yield important data.

9. *Reading assignments and reports*. Assigned readings, and verbal or written presentations by the members, are helpful as teaching aids. They serve also to introduce new material for group consideration. Suggestions regarding readings may be obtained in the Bibliotherapy section in Chapter 56.