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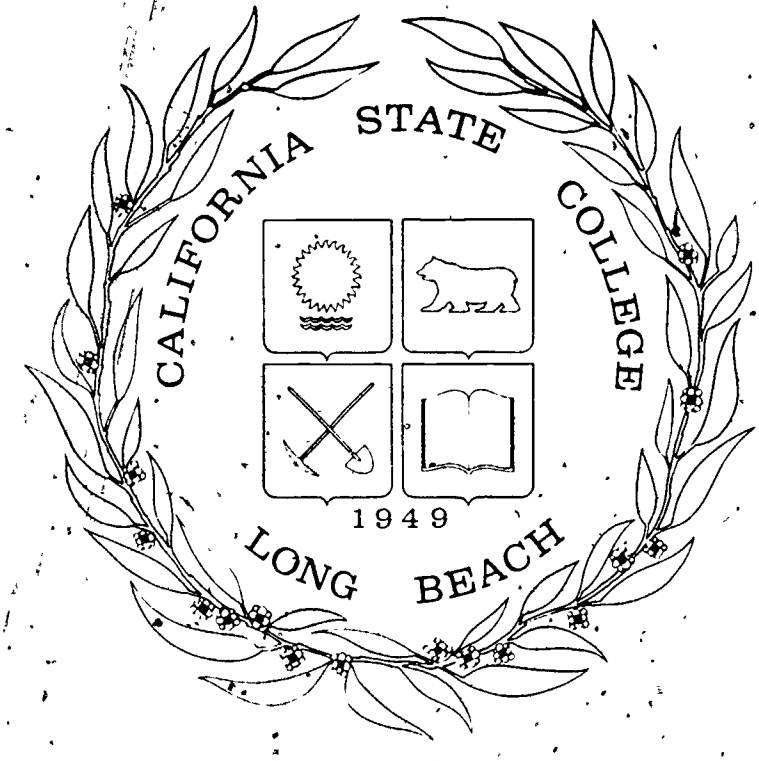
ABSTRACT

In this symposium, six professionals present related papers on community mental health. The first discusses the role of student personnel services in enhancing community mental health. This is followed by a report concerning the role of the college counseling center. Other papers in the symposium include discussions of: (1) the role of the student affairs office in enhancing community mental health, (2) the role of subprofessionals, (3) the educational role of the psychiatrist, and (4) the role of the psychologist. The report concludes with the transcript of a post-symposium discussion by the participants and the audience. The thrust of this discussion deals with the use of subprofessionals in community mental health. Participants cited evidence from research and practice which supports the use of subprofessional mental health workers. (BW)

Leadership in Community Mental Health:

The Role of the College Mental Health Professionals



LEADERSHIP IN COMMUNITY MENTAL HEALTH:
THE ROLE OF THE COLLEGE MENTAL HEALTH PROFESSIONALS

Symposium sponsored by the Long Beach Mental Health Association

Friday, November 5, 1965

Dr. George D. Demos, Chairman
Dean of Students - California State College at Long Beach

"The Role of Student Personnel Services in Enhancing Community Mental Health"

Dr. Lois J. Swanson
Associate Dean - Student Affairs, California State College at Long Beach

"The Role of the Student Affairs Office in Enhancing Community Mental Health"

Dr. Kenneth C. Weisbrod
Associate Dean - Counseling and Testing, California State College at Long Beach

"The Role of the College Counseling Center in Enhancing Community Mental Health"

Dr. Joseph L. White
Assistant Professor - Psychology Department, California State College at Long Beach

"The Role of Sub-professionals in Enhancing Community Mental Health"

Dr. Alex L. Sweet
Consulting Psychiatrist, California State College at Long Beach

"The Educational Role of the Psychiatrist in Enhancing Community Mental Health"

Dr. George R. Hoff
Consulting Psychologist, California State College at Long Beach

"The Role of the Psychologist in Enhancing Community Mental Health"

THE ROLE OF STUDENT PERSONNEL SERVICES IN ENHANCING COMMUNITY MENTAL HEALTH

By

George D. Demos
Dean of Students
California State College at Long Beach

Recently Vice-President Humphrey threw down the gauntlet regarding the college and university role in influencing their respective communities. As a former college professor, he realized from first-hand experience, the necessity of utilizing all of the sources that may be helpful to the society generally. We do need to maximize our impact on the community and become more effective in influencing the larger society.

The community and the college are becoming more and more interdependent rather than independent. We need each other, and we must increasingly work together to continue the dialogue among the mental health professionals of the college and the mental health workers in various segments within the community. Mental health professionals can be found in a variety of settings within the college or university, not only in the traditional mental health field of psychology, but also in the counseling center, departments of sociology, social welfare, educational psychology, health and hygiene, nursing, anthropology, recreation, and the entire student personnel services complex.

We are able to listen, and listening may be our stock and trade. It may very well be our most effective modality in communicating with the community. The art of listening is quickly becoming a lost art. There are very few places in which we can go where an understanding person will actually provide time to listen to our ideas, our complaints, our arguments, etc. Mental health professionals should continue to utilize the listening tool in communicating with the community.

In reducing the plethora of human anxieties that are prevalent in our complex technological society, it is exceedingly important that we utilize all of the professionals at our disposal. Both the college and community at large are in need of innovations to ameliorate the considerable stress and anxiety that seems to be on the rise. Obviously, at the rate we are training professionals, we will not be able to cope with the burgeoning population and their attendant problems. For example, at the present time there are only 16,000 psychiatrists and 25,000 psychologists in the United States. Obviously, they can handle but a small percentage of the human personal problems faced by our populous, particularly in view of the fact that many psychiatrists are psychoanalytically oriented which calls for lengthy and continued individual therapy. Thus, not only should we utilize our existing professionals, but we need to train additional therapists, as well. It may also be necessary to develop a cadre of subprofessionals (lay workers, mental health aids, etc.) who are able to provide an empathetic and understanding environment in which troubled individuals may air their problems (Ala Margaret Rioch, 1961).

It is imperative that we do more work with our college student population, and involve them to a greater degree in community projects. The phenominal success of Project Tutor, Operation Headstart, Operation Right Foot, etc. is a testimony to the success and interest in continuing such programs. These programs are beneficial to the recipients, i.e., the youngsters involved, as well as to the student instructors. Project Weekend is another excellent example of this kind of cooperation between agencies within the community and the college students. It has proved on the whole to be enormously successful for all involved.

What better way is there to enliven a curriculum than to participate in the

natural laboratories of the community. It is difficult to imagine teaching a course in child psychology without visiting cooperative nursery schools or working with deprived youngsters within the community. It is difficult to understand how a course could be taught regarding gifted and exceptional children without actually working with gifted children or mentally retarded youngsters. How much more vivid and alive these classroom experiences become when supplemented by such community projects. How much more meaningful courses in sociology would become if the students were to spend a goodly portion of their time in the Ghetto in Watts, as well as in higher socio-economic areas. It has been said by more than one student, describing a stultifying classroom experience, that the instructor is merely a "textbook wired for sound." It is not only beneficial for students to participate in community projects, but it provides considerable benefits to virtually all of the young people involved. One encouraging sign was the recent hiring of a full-time social worker by Chancellor Hyens at the University of California, Berkeley, to coordinate off and on campus activities of this nature. One study in a large western university indicated that only 10% of the students had any meaningful individual contact with a faculty member. Thus, faculties have not lived up to their possibilities. One faculty member inquired "What do you say to a student when in a room alone with him?"

The time has come for colleges and universities to start a program of self-evaluation. One aspect of this evaluation lies in the area of curriculum. Are we considering the issues in the classroom that are really the important issues of life? Are not the problems posed by race problems, Watts and the "other America" some of the most critical issues facing our society today? Are we coming to grips with the crucial issues involving world peace and international relations? Do we not have the knowledge to predict or at least generally anticipate

the explosions that accompany a minority group struggle for equality? We do. We also have the ability to predict the many problems accompanying automation, the culturally disadvantaged, mass migration, the fleeing of middle class to suburbia, and many other problems.

The colleges and universities, in other words, can serve as a valuable warning system to society. They can help those involved "tool up" for problems before they actually occur. In order to provide the dialogue that is essential for this warning system or preventive action to take place, it is necessary for the college and the community to be open for communication. It is essential then that mental health professionals in the college community avail themselves of as many contacts as possible within the larger community and conversely to bring in mental health leaders from the community into the college. It is imperative that we develop a breed of mental health professionals who are capable of deep analysis and evaluation of our society. We need specialists who will be much more aware of the mental health needs of our people than specialists have been in the past. We live in a dynamic age--a time where there is no room for the "old maids of either sex."

Psychologists have pointed out again and again that there are satisfactions in acting out - participating actively and fighting for one's rights. It is stimulating for young people to engage in controversies. They are quick to note the disparities that exist between the way society should be and the way it is. As a result, many of our more intelligent, creative and well-adjusted young adults need outlets, sublimations for their resentments and hostilities over the inequities that are so apparent within our society. We, in student personnel, are committed to helping them find ways of expressing themselves in constructive, sublimative, socially acceptable ways that drain off excess energy. Many of the athletic, recreational, and intramural contests are utilized for this purpose.

Fortunately, students of today are committed to changing the status quo and fighting for improvements in socially reconstructive ways. For many of these bright young people, the fraternity bash, the big game rally, or the beer bust leave them increasingly cold. The existential identity crisis and search for meaning is occurring much earlier and at a much deeper level than ever before. We must provide avenues for socially approved means for tension reduction.

The times have certainly changed since our college days. It has been said that "college students are now chasing college administrators rather than college girls," which is somewhat indicative of the way in which the values of college students have recently changed. As little as five years ago many college administrators and professors were alarmed by the fact that so few students participated in anything "meaningful." Apathy was prevalent on the campus, and one frequently heard statements like: "When are students going to get involved?" "They seem to lack interest in world affairs, and how we run the university." "They're not participating in college government." What a striking difference exists on most campuses today, and how fortunate we are that so many students are so committed and dedicated to working toward a better community and society. There will be excesses, but it is our task to be understanding of them. An example of the beneficial effects of student participation was reported recently in a study by Beck and others (1963) in which they arranged for Harvard undergraduate students to spend approximately one hour per week with chronic psychotic patients at a state hospital. They report that prior to this experience state hospital discharge of chronic patients was 3%. However, 31% of the 120 chronic patients who interacted with these undergraduate therapists were discharged during the period of the study. Followup of the discharge patients showed that a surprising number were living in the community with seemingly good adjustment.

The fact that there is a need in our community for help of this kind is put forth blatantly in the Midtown Study in Manhattan, New York, reported by Srole and others (1962), which indicated that fewer than 20% of such Americans are free of symptoms of emotional disturbance and that 1/3 are in need of psychiatric treatment. These startling findings were corroborated by Leighton and others (1963) in a study of a small rural county in Canada in which they found that only 17% of the adults were free of psychiatric symptoms. One-third were significantly emotionally disturbed and 20% were in serious need of psychiatric treatment. Other studies have indicated that emotional disturbance occurs anywhere from 5% to 50% in the general population. These data are found to vary significantly due to the fact that a variety of definitions of normality and a myriad of criteria were utilized in defining the term, "emotional disturbance."

There is soberin; evidence, nonetheless, which does, in fact, suggest that the number of individuals in our complex society who are in need of some form of help with their personal problems is indeed on the rise. How are we going to cope with a society so sick, but with so few avenues of help available to it? Obviously, prevention programs must be implemented immediately. Heretofore, emotionally stable individuals in middle class American society felt somewhat smug abbut their status and could not get stimulated in taking preventive steps because they repeatedly said it couldn't happen to us. Let us be repeatedly reminded that it can and does happen to us. Lest we forget our failures - the preventive efforts and therapy needed with the pathological Lee Harvey Oswald and others within our community is legion. The surprise to us working in the field is that more destructive explosions of such magnitude do not happen more frequently, in view of the instability so prevalent in virtually all aspects of societal living. The breakdown of the family, the confusion and proliferation of mixed values within our massed media, the press for social

mobility and materialism, and the lack of effective compensatory and sublimatory outlets for young people is apparent - to mention only a few of the causes. The choice anxieties, the growing impersonality which almost inevitably occurs whenever numbers of individuals in any one place grow increasingly larger, etc., etc.

One promising plan, a new direction or innovation that received much attention was the remarkable results produced by Margaret Rioch (1963), in which eight college-educated, mature, married women with children were trained over a two-year period as psychotherapists. Their didactic and clinical training was focused on psychotherapy. The verdict evidenced that these psychotherapists were as effective with their patients as most broadly trained psychotherapists. Furthermore, they got comparable results in an average of ten interviews.

Another study in San Francisco by Albrondo, et. al., (1964) studied five senior classes of medical students with 384 out-patients covering five socio-economic classes. The results show that even 12 weeks of training in psychotherapy led to an improvement in patients of these students in training. In all probability, what accounted for the success in these individuals was that they provided a warm, sharing relationship with other human beings in need.

The "magic" of interpersonal relationships in which empathic understanding, creative listening, and experiencing in a genuine way, have shown again and again to be the most effective of our helping modalities. We in the helping professions need to explore these relationships in greater depth and breadth. We need not only to train others in their usage, others who have no intent to conduct psychotherapy, but as well to develop a whole host of expert empathic listeners. This includes mothers and fathers, clergymen, Boy Scout leaders, teachers, nurses, and virtually all adults who work in any kind of helping or serving capacity. We now have the knowledge to conduct such training sessions

and to provide dissemination of these simple but yet highly workable concepts. This is one way in which the mental health professionals can serve not only a therapeutic role, but also a preventive role within our communities.

In conclusion, it is apparent to many that the mental health frontier is shifting from the treatment of illness to preventive intervention at the community level. Our usual methods of treating patients are being supplanted by new approaches to interpersonal problems and to the management of debilitating tensions. Most importantly the community itself needs to be taught to collaborate in creating mentally healthy environments.

Hopefully we will be successful at this most important social work!

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THE ROLE OF THE STUDENT AFFAIRS OFFICE IN ENHANCING COMMUNITY MENTAL HEALTH

By

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Until a few years ago, many people I know would have thought that the idea of an office of Student Affairs, or Student Activities as they are often called, didn't have any concern about the mental health of students, or anything to offer in that regard except possibly serving the purpose of letting off steam. There have been a lot of studies, particularly in the last ten years, of college students and how their experience on a campus has effected them. The results of some of these have been a real jolt to a good many of us, because in many respects we haven't been nearly as effective as we had happily assumed we were. Maybe it's just as well. There are lots of contradictions in these studies, but there's one indication that seems to come through on a good many of them. The indication that whether a student is at Michigan State or Antioch or Stanford or wherever, what happens to him during his college years, the changes that take place, depend in very large measure upon the campus climate and the whole atmosphere of the college he attends, the level of expectancy he finds there, the give and take that goes on between students, and between faculty and students. And it is these things that are the focal concern of this office of Student Affairs that I represent.

When I began thinking about this subject, my mind was turning to how many advantages a college student has over people from, say, 17 to 22 who go to work immediately after high school in a service station, or as a clerk. First of all, I think it is true that college personnel departments are staffed largely with people who like the student. I know there are some exceptions. I can think of a couple of very obvious ones that I have known in my time. But in the main, I

really believe most of us like these students we work with, and in liking them we try to understand them. I am convinced too that a good professor knows that whatever may go on in his classroom or the laboratory he conducts, he isn't teaching Joe anything if Joe isn't listening. And so he too is concerned about his mental health, and sometimes he is concerned enough that he'll call our office and say, "Look can't you do something about this boy? He always comes into class alone, he never talks to anybody, he leaves the minute class is over, and he looks unhappy and listless and lonely."

The blight of anonymity without question is one of the foremost evils that we fight on a big impersonal campus like this one. And I really mean evil. People tell me even now that to try to do anything about this in 1965, on a campus the size of our own, is pretty stupid; it is a fact of life that we might just as well face, they tell me. But we do try through the staff that we have, to make it possible for every student who wants it or needs it--and they're not always the same thing--to be part of a primary group on the campus. This might be something as loosely organized as a few students who eat lunch together 3 or 4 times a week. But all the way along the continuum from such a group to a very highly structured group that puts a great deal of emphasis upon group goals and standards and loyalties and all this kind of thing, a youngster can find a home base in this sea of 12,000 strangers. He may get the support and the concern for himself as a human being, for his own problems, that make all the difference. And it really can make all the difference between a student who is healthy enough that he can make the most of today's opportunities and the one who goes to class, and can't wait to get home, or back to his high school friends, or wherever it is that he feels like a person and not a thing. So we try to make these kinds of experiences available to as many students as we can. When we are fortunate, sometimes we can go a step further. Sometimes we find

out that a student can't relate to anybody, and he has tried. He doesn't know how. Sometimes, of course, there are just personal habits that are the factor. Very often we'll find that he is still using ways of relating to his peers that work very well when he was in junior high school, but aren't quite so effective here. And of course lots of times it's true that his evaluation of himself is the thing that gets in the way. Sometimes we are able to help to create a situation, in a student organization or on an Associated Student Committee, in his relation to the other students he works with, that can provide the kind of therapy that he needs. It has been interesting to us to note that every now and then a perceptive, mature student who has good judgment can be brought in on this kind of experiences and he can do a great deal more than we are able to do ourselves.

We are thought of, I know, as an office that is supposed to help students develop a good program--stimulating lectures, good discussions, a gracious reception for a visiting artist on the campus, or whatever. But we focus even more in our office on what's happening to the individual students as the planning goes on. We try, and as Dean Demos knows all to well from a few conversations I've had with him in the past few days, we try with great frustration and very little effectiveness upon occasion, to help these students to confront their own failures and rationalizations for what they are, and to recognize the cause and effect that are part of the picture. But sometimes we can help. When a girl, for example, is so shy that she can't enjoy the ordinary give and take in a group, there are some things we have learned to do. We don't suggest that she go to a lot of college dances; these are too personal. She can feel accepted or rejected in a situation of this kind on extremely broad, unsubtle cues; she's conscious of herself, of how she looks, and all these things. But if we can get her into a ski club, or a bowling group, or a group that's discussing a subject

in which she is vitally concerned, something in which the focus is on an impersonal activity, it does often happpen that some real changes take place.

Of course, we share this kind of attempt with YMCA's and YWCA's and church groups and Girl Scouts and groups of this kind all over the world. And as is true with all these groups, the problem with us is to reach the young people who need it most. The girl who needs to spend long hours around fellows her own age, singing or arguing or skiing or whatever, just in order to feel comfortable around them, just to get over her self consciousness, is just not the girl who is going to have lots of dates. So we work of course on coed intramurals and all kinds of no-date events--and here of course is the genious in the coed residence halls.

There's lots of social mobility going on in a college like ours. We have very many students here who are the first in their family to have the privilege of college experience. So my second point is-we do as much as we can to help some of these students live up to the new image that they are trying to develop for themselves. Some of our male colleagues think it's funny, or pretend they do, but we do try to emphasize acceptable social behavior, and to give these youngsters as many opportunities as we can to practice it. Of course, we don't emphasize empty conformity; of course we don't value a girl any less because she doesn't know how to introduce her father. But we know that the first time this girl goes into a restaurant with a beau, if she knows what to do she may have a fine time, but may be absolutely miserable if she doesn't. And if she is so confident that she knows, but doesn't want to bother, that's all right too.

I think there is one way in which we make some contribution, not so much to individuals but to campus mental health, on another of the efforts we maintain. We try--and here again there's a lot of current frustration, but we try very hard to get the students with whom we work to see the difference between real leadership, in which you learn how to help a number of people arrive at an in-

formed, reasoned consensus, and get something done, and the manipulating and exploitating that they are likely to learn on their own, in their various experiences. We know that right at this very moment there are probably students in the A.S. Offices learning both varieties, but we try.

Of course, when anybody works with groups there are always questions about motivation. We ask ourselves what do we do about this brownie point complex? How much are we wise to use competition? How do you instill group pride, and move from that to personal esteem in those younysters who need it so badly? There are questions about group loyalty and conformity, and how these are related to individual values. We try, at least, to keep these things in perspective and to give to the students some perspective on them too.

In the organized structure of a student program there are relations with another generation that concern us too. There are absolutely amazing differences in students' ability and students' willingness to relate to people of their parents' generation. Sometimes we encounter nothing but resistance and distrust to suggestions that come from any adult. My feeling is that we know a good deal more than we are able to practice in this area. We know, of course, that we may be affecting students' relation to all authority figures. We know a mentally healthy person ought to be able to consider points of view and information from any creditable source when he's making a decision. And we know that it is hard, when you are working with a group and time is limited, not in certain subtle ways to reward the docile and the passive. I find myself avoiding the use of the word cooperative of late when I write a reference for a student.

It is so easy to find yourself maintaining, manipulating those unseen strings, when you really are trying to develop and encourage independence and self-determination. We do, of course, try to avoid this. But at the same time we believe--I can't say that we know, but we believe--that students often gain

the most when there is some spanning of the generation. When students and adults together can help each other understand what's happening to them, or see how inappropriate certain ways they have been conducting their affairs have been, we believe that more can be accomplished.

We know that we have to level with students, especially those who want no truck with adult opinions. We know we can't pretend, for example, that there are sanctions to be invoked when there aren't. We know that it is best to have just a few rigid rules and a large number of mutually arrived at understandings. We know these things, but we're not always able to practice them.

Everybody knows, I suppose, that one of the greatest differences between our colleges and those abroad is in the amount of informal student-faculty contact that goes on on campuses in the United States. This comes up in every discussion I have ever heard in my life about exchange professors and foreign students. It is my feeling that it's almost desperately important that we do everything we can to hold on to this characteristic of American college education, particularly at this time when there are more and more students, more and more professors with publications and off-campus consultations, and all of these things, as important as they are, we must cling to this quality for all we're worth.

When the student and his professor retreat to their own peers, almost immediately after the class is over, I am sure that we have lost one of the truly effective ways in which a college can contribute to the mental health of its students. Let me be specific here. When you think about some of the advantages the college student has over his age peers somewhere else, it occurs to you that there is a built-in hazard for a perceptive college student. All colleges, I suppose, do everything they can to give a student the ability to see his own society as if he belonged to an alien culture. And if he does this, the perceptive

one is going to ask himself not only how well he measures up to the cherished ideals of his own culture, but he's also going to ask just how workable and how desirable these cherished ideals are. This absolutely has to be an unsettling experience. I suppose that a freshman very often becomes aware for the very first time in this critical year of his life of the cynicism and hypocrisy and corruption that exist in some of the institutions that he has known, and has had respect for. He needs help. I am sure he needs help, as he works his way through these new understandings. Either, I think, he separates himself from them altogether, so they don't have any effect upon him, or he thinks them through well enough that he can permit some changes in himself, but at the same time maintain-contact with the people that are important to him. And here he needs endless opportunities for discussion and for continuing the dialogue. So one of the major aims, perhaps the major aim of our office these days is to support, and encourage, and plan all we can to increase these informal student-faculty contacts and help students cope with this problem of integrating their knowledge and their feelings and their behavior.

I read not long ago a note from a student who had spent her first two years at Reed. It may not be true now, but until a year or two ago they had only about 800 students. And she talked about how there they ate dinner together, they talked together and she used a phrase that may sound corny, "We searched for truth together", she said. Then she went on to say that at her present university, which is one of the major universities on the west coast, "Here I have no frame-work for relating what I've learned to the events around me. I want some help in making these connections."

Then to my last point. There's a change, I think, in what is commonly referred to as the service project on a college campus. Fraternities, service groups, and student organizations in general have had such projects as long as

ther have been colleges, I suppose. And some of them have been pretty empty routine performances I believe. I am not talking here about the real activist. These people are with us, and very much part of the campus scene, but at the moment I am not talking about them. My focus here is upon the effect that students' new involvement seems to me to have upon the mental health of our more average student. Dean Demos was talking a few minutes ago about certain projects, Project Weekend, Project Tutor, and of how effective some of the student members of organizations have been in the various areas in which they operated. But there is another value, one that is somewhat in reverse. Students, for example in our A.S. Tutorial Project, have become concerned enough about a deprived youngster that they give several hours a week to tutoring an individual child. They go to his home or to his school, they see him in the places in which he is accustomed to be. And as I have listened to their discussions, sometimes here, and a few times down at the Community Improvement League, I've been struck by something that all of us know very well. As a young person has first hand experience trying to understand and solve the problems of some of these less privileged, there may occur tremendous growth in his own health. Personal attachments do grow; they do demonstrate to him how irrelevant are nationality to warm communication. And he does develop unexpected concerns. A student said to me just a few days ago, "I don't have time to do this, but you just can't walk out and leave a situation like this."

About three weeks ago, I sat for an hour with a group of three girls in one of the service organizations in Rosemary Taylor's office. They were talking about a service project, with Mr. Ernest Preaceley of the Community Improvement League, and they began by asking him some routine, factual questions. What should we do for these youngsters? Should we take them on a picnic, to the beach, on a tour? But before that hour had ended the tenor of the conversation had changed com-

pletely. Before it ended, these girls were gravely and seriously looking at what they might hope to accomplish. They were really excited about a "Project Self" that Mr. Preaceley was telling them about. And as they listened and exchanged views with him about these girls in the area around Olive and Hill in Long Beach, they began to see how important it was for these girls to develop pride in themselves, to believe they could be attractive, and could be liked, and could hold a good job. It is hard for me to think of a more valuable experience for an 18 year old girl who comes from a privileged home.

THE ROLE OF THE COLLEGE COUNSELING CENTER IN ENHANCING COMMUNITY MENTAL HEALTH

By

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Thank you George.

Immediately following this hour, I've been invited to talk at the Physical Education Department on the subject of "Motor Learning". If the things I say now seem to take the slant of motor learning, it is because I am planning ahead.

As we think of the responsibility of the college counseling center, its mental health professionals, and the role of leadership in the college community, I suspect that this responsibility takes the shape of presenting some implications of major factors influencing behavior. It is our responsibility to interpret "the big picture". Ours is a multidiscipline approach to looking at human behavior and human interaction in a community setting. The implication of interaction implies information. The exchange and flow of information on a college campus is the business in which we are engaged. It is our primary responsibility and, if we can think of information in Garner's terms; i. e., as existing on a one-to-one relationship with uncertainty or ignorance, our responsibility to the community as mental health professionals might be thought of as interpreting the big picture in terms of what the community can understand, since without this communication information is not available to the community. We need to understand the interaction aspects of the larger community. We need to look to our own skills and competencies to provide complete and accurate information to the community. All this suggests the need on our part to keep abreast of meaningful research and to actually be involved with laboratory-type experimentation.

We have a composite of skilled, technical, broadly cognitive and able

people. We have an assemblage on the college campus of a representation of many disciplines. It is the responsibility of the mental health professional to draw from all resources of the college community, and to synthesize meaningful implications of research that is being conducted in that setting and in settings like it throughout the country.

A second kind of responsibility in the role of leadership among mental health professions is to interpret to the community the implications of its own behavior. This is in effect the essence of therapy--a one-to-one relationship between the therapist and his patient, which becomes a mutual relationship moving toward a new reality. The patient has little capacity to deal with this new reality therapy; but, in the process of therapy, in the communication of information on a 2 way street between two individuals, a new reality becomes increasingly possible. If we were to hypothesize a role of man-kind as a life in two worlds, one of these is the world which exists around us regardless of what we know, feel or think about it. This is the public world of reality which includes the practical world of physical existance. The other world is the world of intermeaning--the private world of each individual. This other world, the private one, for each individual is precisely what he knows, feels, and thinks and believes to be true about the outer world.

In the process of communicating information we are dealing with both of these worlds, the private world and the outer world, our relationsip with people. We are bringing together the information needed by the individual or the group of individuals relative to the private world. We're bringing from the outer world of experience and practical reality new interpretations of information existing there for the individual that he was incapable of comprehending to the time he received the help of the mental health professionals.

A third kind of responsibility in this role of leadership for the mental

health specialist is a risk taking responsibility. In our society it is dangerous to be different. There is a striving for commonality, there is striving for saneness, there is a striving for pattern-acceptable behavior which falls within the medium of acceptable behavior, a behavior that society prescribes and condones. The college is an intrical part of society, it is a part of society set apart for specialized training that provides short cuts to experiences of many kinds for young people. College is that part of society which must take risks. It must take risks because it deals with some previous known truths that now, through time, have become fallacies. If we can believe what we hear about the explosion of knowledge, knowledge during the decade of 1940 to 1950, and this knowledge from all times during the succeeding decade doubled again. It seems to be in the process of again doubling during this decade. We must look to what happens to previous facts when new information denies their reality for their factual quality.

Part of our responsibility is to serve as a catalist for change. This means involvement. It means that we must become involved with people in the community. In order to promote change, change must be seen in light of the best current knowledge available. Recently I was at the home of the Dean of a graduate school in a nearby university. He was deploring the ignorance and lack of preparation that he was finding among students on his campus. I was questioning his sources of information, (where did he gain this impression that is inconsistent with the impression I have of students), and he said, "I call them in as they near the end of their preparation to receive an advanced degree, and I question them." My reaction was, "Did you ever try listening?" His wife chided me after dinner. She said, "That was a great shock to the Dean, because he hadn't thought of it." She said, "I've been trying to tell him this for a long time. I am so glad you did." Sometimes we need to use a shock technique

to bring society to reality--to a new reality more consistent with the present trend.

Garner suggests that there is a kind of leap frog relationship between the poor culture during adolescence and during college years and the adult society or the adult peer culture. He suggests that there is a conflict of generations and that in this conflict, the impeaching new society challenges and denies the attitudes, values, goals, hopes, and aspirations of the adult society. Within this conflict of generations, we have both product of good and of evil, so far as mental health is concerned, and so far as productive change is concerned. Again our role of leadership in mental health on the college campus and in the college community is to interpret each of these societies and to the other, and to use empathetic understanding coupled with mature judgment in the process of dealing with students who are in rebellion against what they may consider to be social inconsistencies.

Young people may challenge social values dangerously or safely, depending upon the manner in which society is interpreted to them. We have this responsibility on the college campus and within the college community to interpret one society to the other--the peer society of youth to the adult society of the larger community, and the adult society of the larger community conversely to you.

I believe, that many factors which contribute to poor mental health among students could readily be dealt with by reducing some of the tension, and some of the stress placed upon youth by the larger society. I talked with a student recently who told me that both of her parents had, since the time she could remember, required her to receive no grade less than an "A". She said, "I think it started in kindergarten." She has now arrived at the point where she probably will receive F's in the four courses she is taking on campus at the

present time. She had been a straight "A" student, and now she is in the process of failure. We talked about this to some length and she said, "These people, these adults never valued me for me, they valued me for what I knew and what I could learn. Everyone has always told me that I am a bright and gifted student. I am tired of this, and I am going to disprove it." She said, "I'll flunk out th semester." This is a very grave loss. It is a loss of human anguish and suffering which this student has endured. The shock, dismay and disappointment of her parents and other members of the family must be great. This happens all too often, I think, among our student population where students become failure-oriented rather than success oriented. I believe that in the process of interpreting the societies, or these two moduli of society one to the other, there is the practice of tension reduction. I believe that we can relate to students in mature and adult ways, and in groups of classroom size as well as the small group, even the one to one relationship. If we can relate to these individuals feelings of confidence, respect and admiration for them, as individua and without the demands of our own hopes built into the kinds of tension or stress which we place upon them, we'll probably do them a great service, and our succeeding generations as well.

My fourth point and last, the role of the mental health professional in leadership in the college community is one of serving as the super ego as it were. (The super ego for the college community.) This places a rather great responsibility upon mental health professionals because they would be expected then, first of all, to enjoy excellent mental health. This is not necessarily the case. Under the old definition of mental health, which suggests that an individual who is enjoying good mental health is free from the symptoms usually associated with psychosis or psychoneurosis, or other kinds of mental disorders,

an individual performs a maximum of his potential within his social order. He conducts himself at all times creating a minimum of friction and tension and a maximum of satisfaction to himself and to those people with whom he is associated. There is implied in this definition an ideal, an ideal which does not exist, which is an inhuman ideal. It suggests a very cold, sterile kind of relationship between a supreme being and man.

Mental Health professionals are people who are people, they're human individuals who are subject to tensions and stresses and to the changes both in their internal and external environments. They're individuals who of necessity must become skilled in communication, communication of meaning. They must be individuals who omit the flow and maintain in the process something full of information. They're individuals who assume a very large responsibility in society because, in a way, their actions do convey to society what good mental health is. They're individuals who, first of all, I think must admit their own limitations and they must accept these along with their own strengths and capacity. In the process of doing so, I believe that as mental health specialists on the college campus, and as we relate to the community, we need first of all to relate among ourselves. This means building some bridges, both interdepartmental and interprofessional, and bringing the student population into these relationships in the building of these bridges. We do see the prejudice and the ignorance which seems to abound in the dichotomous aspects of many college campuses.

I was talking with a man yesterday who told of his experiences on an eastern campus. He said, "Members of the sociology department, or shall I say psychology and so forth departments, did not speak to each other because each considered the others fools." He said, "In this relationship, productive research was wearing blinders and had some tunneled vision qualities." He also stated that he

believed that on this college or this university campus more poor mental health existed than in any other segment of society due to the lack of communication.

I would like to suggest that the very essence of good mental health is the communication of information without the usual limitations applied. We need an "openness" to sources of information; we need to enhance capacities to modify and to create information, and to convey this information in the process of human interaction. This open communication system makes us capable of interchange, capable of interrelating, capable of developing and producing new ideas and capable of producing thoughts written, verbal and oral. This is a great responsibility. It is our responsibility and we are engaged in it now.

THE ROLE OF SUBPROFESSIONALS IN ENHANCING COMMUNITY MENTAL HEALTH

By

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Thank you George.

When Ken was talking, he mentioned that if you choose to be different you will sometimes find yourself alone and in a position where you will have to fight a system that is bigger than yourself. I recall my first step as a psychologist in being different. When I first went into a mental hospital, the nurse was checking me out on the ward and I was to be on this ward for a year. The first patient came by and she smiled. She said, "You've got to watch schizophrenic people. They sometimes frown and schizophrenics are that way." The next patient came by and didn't say anything, didn't frown or smile. She said, "We've got to watch some of them. They are pretty bland you know." So it struck me as though I'd perceived individual differences with these patients and everything that was different about them was a sign of schizophrenia. So I said to the nurse, "These folks are just like the folks outside the hospital in terms of being different." I said, "There's no such thing as schizophrenia as a sort of concrete entity." "How long have you been saying these patients are schizophrenic?," I asked. "Well that's what we do in medicine and who are you to challenge the concepts of medicine." My response was, "Who are you to tell me not to challenge it?" Whereupon we got into a big argument, whereupon I ended up sitting in front of the chief of service and he asked me what seemed to be the big problem. I said I didn't believe there was any such thing as schizophrenia. He asked me who was I to challenge Dr. Kraeplin and many others that had labeled schizophrenia. I said, "I'm chal-

lenging anything I want. My job as a Ph.D. student is to learn how to think, and I am trying to learn how to think." This went on for about 45 minutes and he couldn't get me to change my mind and I couldn't get him to try and observe the patient for what he was. So we agreed that I was not to announce my belief on the ward, inasmuch as the belief was a private matter. And so I stayed there a year and I wrote my reports and talked about paranoids, schiz, catatonia, and hebephreina and so on. The day I departed he said, "Do you believe now?" I said, "No, I still don't believe." But what I did believe though was that there are many deeply troubled individuals in hospitals.

George referred to the Mid-town Manhattan Study and the Joint Commission on the Mental Hygiene Study which indicated that in some of our urban environments, there are at least 80 people who could use some sort of help in coping with their lives. I guess as one lives this life, we all go through periods of deep personal crises and periods of deep personal unhappiness. For some of us, we are fortunate enough to have the strengths that will see us through these periods in such a way that we don't come out as embittered citizens. For others of us, we need some kind of help outside the immediate family situation to deal with these constructively. Increasingly the social worker, psychologist, and psychiatrist are being turned as helpers with problems in living.

Now the basic ingredient in psychotherapy is what I've come to call "creative listening". And by creative listening, you listen to the patient, or to the client or to the little child in such a way that he can begin to see new solutions for his situation. He can begin to see new ways of viewing himself, new ways in viewing the people that are bugging him and so on. And this listening skill requires things like empathy, the ability to see the other person's frame of references, the ability to be accepting, the ability to care

for other people without trying to engulf them and so on. Now if this is the basic ingredient of psychotherapy, and if there are not enough psychotherapists and mental health workers to go around, clinics will be lacking personnel.

One way of giving more personnel is to find people who already seemed to have developed some kind of creative listening skills, people who seem to be reasonably mature, reasonably able to manage their own lives and who seem to care in a very sensitive and empathic way about the lives of other people. The first attempt to find folks like this and enhance their creative listening skills was something George referred to earlier in the presentation. It was a little project by Margaret Rioch at NIMH, initially reported in the May issue of Harper's Magazine, 1962. As George said, they picked out eight housewives who seemed to be able to bring to the training situation some potential to be creative listeners, some potential to care about other people in a therapeutic manner, and some potential to be warm and empathic. They trained these eight women using group discussion techniques, using tape recordings and letting them listen. They put these women very early into situations with their clients, that is they decided, like Rogers decides with his graduate students, to get the student with the client early in the training relationship so that he begins to get the feel of the actual experience of sitting in the room. When he comes out of the room, the supervisor asks, "What did the client do?" "Well, he told me to go to Hell." "How'd you feel about that?" "I felt pretty bad. Why do you suppose he did it?" and so on. Through these kinds of sensitivity techniques these therapists were able to emerge as competent paraprofessionals or subprofessionals and went on then to work in hospital situations. When we pick these people up in 1965 in the Annual Review of Psychology, as George pointed out, they seemed to be, on all criteria that we can measure, successful psychotherapists. George also pointed out that they scored higher

on the Board Test in Psychiatry than the medical students. Where the medical students scored at the 90 percentile, they scored at the 97 percentile.

Now, if it is the case that we can take people and train them in nontraditional ways to become adequate psychotherapists, then this is one way of fulfilling the vacuum.

Another kind of problem that we have is that in many urban settings throughout the country there is no clinic to service a great many citizens; for example, New York City, in the area that tends to be surrounded by Lincoln Hospital, has 350,000 residents and there were no psychiatrists available until very recently. The hospital applied for a grant through the war on poverty and set up what you might call "satellite stations" around the community. In the satellite stations they had available one trained mental health worker that would have been a social worker, a psychiatrist or a psychologist and a staff of subprofessional workers who had been trained through group discussion techniques, and the subprofessional worker would be the first line of defense. If he felt he could deal with the case under the supervision of the trained worker, then they went on from there, if not the trained worker saw the case. If he felt he could deal with it at the neighborhood level, they did. If not, then they just moved closer in the hospital until some patients finally went on in the hospital and were admitted.

Now a curious thing that we're finding with the paraprofessional or the subprofessional therapist is that they are also teaching us about clients. You see we went off assuming we knew everything, but we are finding, especially in the lower income groups or in nonmiddle class groups, that we have to use a different treatment model. For example, in the middle class we are all brought up under the Protestant ethic, that is, at least you were, I didn't grow up in the middle class. In the Protestant ethic you learned to keep appointments,

to be compulsive and so on. So if you call a clinic and they set you up an appointment for Wednesday morning at 11:00 to see your therapist, well you'll be there for your doctor's appointment and you know you have to be on time because a doctor is busy and his time is valuable and so on, so you show up. However, if you are from a nonmiddle class community, you might call up and schedule an appointment for Wednesday at 11:00 and when Wednesday at 11:00 comes, if you don't feel you have any problems that day, you don't show and you don't feel very badly about it. Now we use to say because we were all middle class that that means the patient has low motivation for treatment. He is resisting and scratch him up as a bad treatment risk and go on to the next case. Well, we're finding in the satellite clinics that the patient won't show up at his scheduled time, but he'll appear the next day and a crisis erupts that morning. He wants to see his therapist right then and so he'll pound on the door. He will be very antagonistic if someone isn't available. He really doesn't care whether it is the same therapist he had last time just so long as someone is there to listen. Also we find that sometimes if the client won't come to you, then you go outside the clinic and inside the client's house and talk to him. For example, a lady might call up the clinic and say, "Well, doctor, I can't come to the clinic because it's two blocks to the bus stop, and it's too hot for me to walk up there." Then you say, Well, gee, you're getting this treatment at a low rate, and again you say a low motivation for treatment. Now you say things like, "I know that it's pretty rough on you. Do you think maybe you could just do it one morning a week?" Or you might make a bargain with the patient and say, "Look, I'll come to your house this one time and you come up here the next time." We're exploring different kinds of treatment models that can be incorporated in the life style of the consumer, and this is something we found usually in

the subprofessionals. Also as we move across the urban arena we have decided in a preventive way that possibly if some things don't get started, they then won't have to be dealt with in later life.

We are very concerned about the Negro child in the inner city. More and more of these children will be going to preschool programs as a way of beginning to enhance the reading readiness skills so they won't fall so far behind in school and be so high on the drop out rate. Now in Project Headstart, for each master teacher, that is credentialed teacher, there will be two subprofessionals or paraprofessionals. For every fifteen children there will be three teachers, one credentialed teacher or one master teacher and two other teachers. Again, I think, you can train a nursery school teacher if she seems to be the sort of a woman that likes children, the sort of woman that doesn't feel at all uneasy with children jumping on her lap and pulling at her---- certainly if she has this basic kind of set for children. I think through group discussion techniques and watered down literature that they can be trained in a course of six months or a year on the job, and then as they are trained they will be incorporated by new headstart centers that are opening up.

I feel that the community, especially the college counseling center, could have some role in training the subprofessional psychotherapist and subprofessional teachers. And we will not, I think, be able to think in bachelor of science, master of science, Ph.D. type of terms. That is, these therapists and these young women who are going to be the teachers do not need the standard kind of a training. If we can empty out the richer aspects of the formal training course and put these in the subprofessional course, I think that this will give us the kind of a model on which to begin to develop this talent within the minority community. Also it provides a source of additional jobs, it provides

a source of recognition and many other things. All this is going to mean some changes in the traditional concept of education. You see the people that educated me, for some reason, seem to think I needed to know such things such as physiology, neurology, anatomy and learning theory. I have subsequently forgotten every bit of it, but they were traditional educators and wanted to train me traditionally. Hence, this will call for some major adjustment on the part of the academic community because we will have to work in conjunction with community agencies in these very different kinds of programs.

THE EDUCATIONAL ROLE OF THE PSYCHIATRIST IN ENHANCING COMMUNITY MENTAL HEALTH

By

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Dr. Demos, Ladies and gentlemen, it is a pleasure and privilege for me to be here with you tonight. I am particularly glad that this is a meeting involving the general public of the community. I am also glad that we have here represented different disciplines such as college counseling, psychology, and educational administration. Mental health is a community concern, just as physical health is also a community concern, and is not confined to physicians' offices. It is especially gratifying that an academic institution such as the California State College at Long Beach is taking the initiative in presenting tonight's meeting. It not only indicates the college's interest and activity in the mental health field, but it also demonstrates its interest in extending itself to participate in the community and not limit its efforts to the campus alone.

I shall speak today as a clinical psychiatrist, from both the vantage of private practice activity and also as a psychiatric consultant at the California State College at Long Beach.

The general topic tonight is Leadership in Community Mental Health. I see as a major aspect of this the education of the public about the meaning of mental health and psychiatric disorder. In this educational approach, the very initial aspect needs to be the view that emotional or mental problems are not something shameful to be kept in secret but instead constitute legitimate problems to obtain help from qualified people. It is of interest, in this regard, that the National Association for Mental Health, of which the Long Beach

Mental Health Association is a constituent part, was established more than fifty years ago by a man named Clifford Beers who had a psychotic episode and who was appalled at the lack of understanding of his condition by the public. He resolved to establish a national society which would attempt to influence the public to view psychiatric disorders as problems to be openly faced and to be constructively dealt with. It is gratifying to realize that this original goal has to a large degree been achieved and that the public does accept the concept of legitimate emotional disorders to be treated by qualified professionals. Though this attitude is not universally accepted and there are still people who are opposed to the concepts of community mental health, a large degree of the battle has already been won. It is now our duty to solidify the ground that has already been won with activities to implement the idea of treatment of emotional and mental disturbances.

I might take this opportunity to describe the educational work that the psychiatrists are doing at the Counseling Center of the California State College at Long Beach. The Couseling Center deals with students who present educational, vocational, or personal problems for counseling. At the same time, among these students are those with definite emotional or psychiatric disorders. The psychiatrists on the staff consult with the counselors about students who are referred for psychiatric evaluation. We hope to share the special skills and knowledge of the psychiatrist with the staff counselors so that they may be in a better position, themselves, to make preliminary evaluations of emotional or psychiatric disorder and to make the proper referrals. At California State College at Long Beach we have a weekly case conference where student cases are discussed in depth and in detail to bring out what is involved in disturbed reactions and the best ways in which they may be treated.

We also have an additional educational function at the Counseling Center in as much as the Center also furnishes clinical training for psychiatrists.

We have physicians in training from Metropolitan State Hospital who spend a day and a half a week or more at the College Counseling Center. These are physicians in training to be psychiatrists. The psychiatric trainees see students on referral. Each of them is supervised by a staff psychiatrist in his diagnostic and therapeutic work. The psychiatrists-in-training also meet with the counselors so that they can learn about the activities and the approaches of the college counseling staff.

The Psychiatrists also play an educational role in the community. Working with the individual patient can be viewed as constituting an educational experience for the patient. In the psychotherapy process, the patient learns what his condition is, how it came to be, and in what ways he is getting better. Psychiatric treatment can be viewed as essentially a reeducational process: unlearning old patterns that get the patient into difficulties, and acquiring new responses that lead to a happier and more effective life. In this educational work with the patient, many aspects that disturb the patient because of their unknown threatening quality become converted to known and understandable factors. This conversion of the unknown to the known which then can be dealt with is one of the main methods of psychotherapy. This education of the patient extends in influence beyond the patient, himself. The patient affects not only himself but his friends, his family, and his associates, so that the educational achievements of the patient reach out to others.

Psychiatric work in the community also involves the education of the family. Very often treatment limited to the patient himself is not adequate, especially if the attitudes of the family are contributing to a continuance of the patient's disturbance rather than toward its relief. We would hope that the family attitudes are parallel to the patient's needs so that the patient and his family can work together in a cooperative effort. In my work with patients, I encourage

the idea of family members coming to see me. Consultation with parents can be particularly helpful in working with adolescents or young adults. Similarly with patients who are married, it is frequently helpful for the therapist to talk with the spouse. The meetings are usually arranged as a conjoint session where all of us meet together and express our views.

Another educational role of the psychiatrist in private practice is his dealings with physicians. Various doctors such as general practitioners, interns, surgeons, and so forth, who refer cases to the psychiatrists are in need of an educational influence with regard to psychiatric problems. This is particularly important since very often the general physician is the one who is first consulted by the patient or by the family with regard to mental or psychiatric reactions. Also, very frequently, somatic complaints such as tiredness or aches or pains in various parts of the body are very often the presenting complaints of neurotic and psychotic reactions. It would greatly advance the welfare of patients to have doctors who have a clear grasp in recognizing psychiatric reactions, and who then can make the appropriate referrals.

In this regard I am reminded of the case of a young woman who complained intensely of lower abdominal pain. Her gynecologist was unable to alleviate this pain and then resorted to an exploratory operation which revealed no physical disorder. After the operation, she continued to complain of lower abdominal pains. In almost a reaction of despair, the gynecologist referred the case to me. It was not difficult to establish the diagnosis of a borderline schizophrenic reaction on the part of the young lady. The treatment, consisting of psychotherapy and the use of drugs appropriate to her condition, alleviated the patient's distress and the removal of her abdominal complaints. I cannot help but think that if the diagnosis were made earlier, the lady would have been

spared an unnecessary operation.

Physicians themselves can very often do mild forms of psychotherapy. In many ways they are preferable therapists because of the strong supporting role they can furnish their own patients. However in their efforts in doing psychotherapy they need support and guidance by psychiatrists to attempt this kind of treatment. A very useful method is for the psychiatrist to make himself available as a consultant to doctors who are attempting psychotherapeutic treatment, so that the physicians can feel that they can get specialized help if they feel the need for it.

Another area of educational influence among doctors is the usefulness of conjoint treatment by both the medical specialist and the psychiatrist in treatment of psychosomatic diseases such as peptic ulcer, high blood pressure, and certain skin diseases. Due to the strong emotional component in either the causation or the aggravation of symptoms in these disorders, it is often effective to have conjoint treatment - that is, the patient sees both the physician and the psychiatrist in an attempt to deal with the problem. Medical treatment is not opposed to psychiatric treatment; both can proceed cooperatively and at the same time. In this type of work, it is important that both the physician and the psychiatrist communicate with one another and have a united approach.

From the few examples discussed here, we can see the numerous and ramified effects on the mental health of the community that the work of the psychiatrist entails. His contributions along with those of other disciplines in mental health and in the general community can help to advance a healthier and happier society.

Thank you very much for your attention.

THE ROLE OF THE COMMUNITY PSYCHOLOGIST IN ENHANCING COMMUNITY MENTAL HEALTH

By

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Thank you very much George.

In thinking over the topic of "The Role of the Psychologist in Community Mental Health," it occurs to me that we expect a great deal from professionals. One way to take care of the unreasonable and impossible expectations, as Joe has pointed out, is perhaps to train subprofessionals and paraprofessionals who can do a good job, because they have something in common with those with whom they're working, and because they are both human beings with all of the problems there-in, and all the rights and privileges there-of. And yet, there are professionals, and there is a middle class, and there are those of us who are in private practice.

I am very happy to have a chance to speak on the problem of community mental health because prior to the time I was asked to present some of my ideas, I knew very little about the problem because I'd been in private practice for about six years. My private practice consists primarily of seeing approximately 35 people a week in individual and group psychotherapy, and I naively go about my business assuming that I am doing something good for mankind. And yet, as many of us who are in private practice very often feel, we're very limited in number, and the people that we see represents such a small segment of the people whom we could influence through one means or another by going out into the community into public practice rather than private practice. In other words, traditionally private practice has had the reputation of being a private club sort of thing.

People who are in private psychotherapy have alliance to their therapist

and they feel that they are in an in-group, which in some respects they are. But perhaps it behooves the private practitioner to look a little more into his role as a public practitioner; to look more toward the community, whether this community be one of low, middle, or even upper-class. You know, there are disturbed people in Beverly Hills just as well as there are in Watts. Furthermore, there is a need for these people to get help on a community level because there can be sick rich communities just as well as there can be sick poor communities.

At any rate, it seems to me that the main essence of the problem was stated a long time ago by Thoreau when he said, "Most men lead lives of quiet desperation." This means that unless we know what's going on we can't help most men because they're quiet about their desperation. Until they hurt enough to seek some type of help on their own, we as professionals don't know what's going on. The mid-town study more or less reinforced the above concept, by finding that persons such as neurotics or character disorders are seldom recognized unless they injure or do something detrimental to someone else; their problems usually remain within their immediate family.

In this regard, then, when a psychologist goes out into a community to seek out areas in which to exert his influence there are four defineable roles he may play. The first would be one of a mental health scientist. He sees the community as a laboratory in which he may study the behavior of man, a place to try out some of the new findings that he has been developing in the university and college, a place where he can try out various novel or unconventional ways of intervening into the life of persons in order to see what he can do to help them. As an example, the mental health scientist can use the community as a place to experiment with some of the small-group techniques which may be applicable in a larger setting. Furthermore, as a mental health scientist, it behooves

the psychologist to use the community as a reservoir from which to develop new theories about both techniques of treatment and the basic nature of man. As you know, very often when a psychologist matures, he becomes a philosopher and when a philosopher matures, he becomes a psychologist. Therefore, there is a correlation between the theoretical and the practical which the mental health scientist, if he's doing his job adequately, should try to bring together in the community. There can be many new innovations the scientist can try out because the government is paying him for his time. If I, as a private practitioner, try out an unconventional method of treatment, I'd have to pay for it and I'd be trying it out on my own time and I'd be trying it out on the person who was paying me. However, in community mental health, ordinarily the tab is picked up by some supra-organization such as the NIMH, or the United States Department of Education, or some other governmental agency. Therefore, the people with whom the scientist is working are not the people who are paying for his time and effort.

A second and very important role that a psychologist can play in community mental health is the role of the mental health educator. At this point I would like to emphasize that there are a lot of "mental illness educators" but there are very few mental health educators. It seems to me that psychologists could put the "health" back into the mental health and emphasize some of the new findings that psychologists have been developing about just what is the meaning of mental health. So far, we have defined mental health as the opposite of mental illness. However, the absence of symptoms doesn't necessarily mean that a person is healthy mentally or physically. Today, there is a lot of work going go in an attempt to find out just what is mental health. Sophisticated mental health educators are needed in order to inform large numbers of lay people about the meaning of being mentally healthy. I am very interested in the use of mass media

techniques for this approach. Commercial and educational TV, radio, newspaper, and other media of mass communication are ideally suited to serve as a platform for mental health educators. These media, however, provide a challenge to us academic people. What we say and write must be in non-technical language. And, unfortunately there are few of us who can translate scientific knowledge into simple language. We can talk together very well because we are all acquainted with the jargon, but it is very difficult for us, sometimes, to say what we can say technically in simple language that anyone without our education can understand.

A community psychologist could wear a third hat -- that of a mental health consultant to groups. For example, a psychologist could conduct sensitivity seminars in homes rather than having them at more formal settings. Such seminars would not only offer technical information, but would also let the participants see how others live. The fringe benefits would probably be as large as the actual therapeutic benefits or the group benefits. We could also conduct discussion groups in which the emphasis would be to try and help the person who has the problem, rather than dealing only on a problem level. So, the psychologist has a responsibility, I think, to be an educator and to innovate new ideas as to how he can best reach the largest number of people. When I was at Compton College, we conducted an experimental program of closed-circuit TV classes. We filmed 52 psychology lectures and the film was used on a closed-circuit basis on the college campus. There's no reason in the world why something comparable to this could not be filmed over the entire southern California area, or the entire country for that matter. There's no reason why people with something worthwhile to say about the behavioral sciences couldn't compete favorably with Hollywood script writers who actually have little to say.

The fourth role of the psychologist, a community psychologist, might be that

of a mental health therapist. We could treat what is known as "sick groups". Both Dr. White and Dr. Sweet mentioned the fact that there can be groups that are sick. Dr. Ackerman in New York is doing a great deal of work in family therapy where the entire family group, not just one individual from the group, receives treatment. Now it makes sense, doesn't it, that if families can get sick so can businesses and industrial concerns. I am reminded of a chap that I was working with for about six months whom I was convinced was suffering from a paranoid-reaction because he believed that management at his particular organization was definitely trying to hold him down and that his peers were also. He believed that the person sitting next to him was watching what he was doing and that his secretary was bugging his phone calls. I was trying to help him deal with his mistaken beliefs. One day I was talking with a friend of mine who was chief engineer of this organization and I mentioned my patient's situation. I said, "You know I've got one of your engineers in therapy and, boy, this guy is paranoid" and he said, "What division does he work in?" When I told him, he said, "No he's not paranoid, that's all true." So, you see, there can be sick organizations whether it's a family, a business, a fraternity, or sorority.

It's tough for a person to remain healthy in an environment which is seriously ill according to our criteria of illness. We know more about treating sick persons than sick communities. For example, the L. A. County Crisis Clinic offers short-term crisis therapy at very low cost. This is an excellent community service. It doesn't take business away from private practitioners, but rather provides a need which hasn't been met before. The Suicide Prevention Center is another example of providing therapy for individuals. However, we have a lot to learn about treating community groups. A phase of this in which I am personally interested is an attempt to create what is called the Therapeutic Community.

Now this doesn't mean that you take a whole city and make it therapeutic. This means that you try to use our knowledge of the helping professions to experiment on a community level in terms of what is an optimum social structure that will best facilitate a person's maximum growth.

"What happens to an individual when certain things go on in a community?" I've had some experience in what is called "sensitivity training" and I have found some of the best sensitivity training is done over the weekend at a retreat where the entire atmosphere for that weekend is psychologically oriented toward improving one's own contact with one's self and with the group with which one is spending the weekend. It is essentially a therapeutic community. An innovation in psychotherapy is what has been called Marathon Psychotherapy, in which people get together for 24 and 36 hours at a time and all of the creature needs are taken care of except sleep. There are shifts of psychologists who provide the leadership of the group. There is a chance, under these circumstances, of really getting into what goes on in a relatively incapsulated community over an intensely short period of time, which might help understand more of what a community, a therapeutic community, can be like.

I realize it's getting late, but just let me briefly summarize. It seems that there may be four roles psychologists could play within a community: (1) a mental health scientist, (2) a mental health educator, (3) a mental health consultant, and (4) a mental health therapist. And, the main purpose of all of this would be to facilitate the optimum development of the human potential through planned community interaction so that, hopefully, we could paraphrase Thoreau's statement so that it reads: To help most men lead lives of lifely inspiration.

Thank you very much.

DISCUSSION

Audience: Something Dr. White said that interested me was the mention of subprofessional helpers. It reminds me a few weeks ago the mental health association sponsored a meeting in which we had a lady who was the editor of the Suicide Prevention Clinic in San Francisco. She told of the wonderful work they're doing solely with nonprofessionals, answering the phone at the time of crises, etc., and how these people without formal education or background are able to handle and deal with these people effectively. This is an excellent resource and I am glad something is being done about it.

Dr. Demos: Dr. White would you like to comment?

Dr. White: I think the idea that training subprofessionals is excellent and I think we can do it and at the same time control quality. This seems to be Dr. Sweet's feeling that while we try to extend roles within the broad field of mental hygiene, if we also be concerned that the people that emerge from these training programs are sufficiently able. I think that we can both expand the supply and at the same time keep the quality at a level that we would feel at home with.

Dr. Demos: Would anyone else like to try a crack at that question? All right, any other question? Yes, George, go ahead.

Dr. Hoff: I think you're very correct in that because one of the deepest of human needs is to believe that there is another person who cares. This caring doesn't necessarily have to come from a highly skilled person so long as it's coming from another human being. This is not to say, however, that the so called housemother approach is adequate in itself. Hopefully we could train people who at least have rudimentary training.

Dr. Weisbrod: I might add that using subprofessionals on a first aid basis is primarily as Dr. Hoff has suggested. The implication is one of caring. When there is another human being listening and caring, the quality of aloneness often experienced by persons undergoing great stress is removed. Primarily an individual who approaches suicide has a way to resolve his problems. He is one who has run out of all alternatives and he has chosen one rather permanent without full recognition of the implications and other alternatives open to him. The fact of another person listening and in the process of listening, responding warmly, helps the individual under stress to find at least one other alternative less fatal. This is adequate first aid. Certainly the follow up with highly skilled professionals is commonly indicated.

Dr. Demos: All right, any other comments? Yes, sir.

Audience: (Question along lines of subprofessionals being very effective.)

Dr. Demos: Yes, this can be the case. In other words, people without academic degrees can be quite empathetic. We have a long way to go to find out really who these people are, but it does seem to be apparent that there are people without any formal education who have these skills to a great degree. Being able to be good listeners is helpful. Perhaps you know friends who can deal with personal problems and you would like to talk problems over with them. These people may not be professionals, but I think the point is that this may only be a first aid approach rather than a permanent long range kind of thing.

Dean Swanson: Only one thing, that in the city of the size of Long Beach this is not true, but in a little town the people who have this are identified by

almost everybody. The three or four helpful people are the people to whom everyone goes.

Dr. Hoff: One further thing on that if I may. I believe that if we think about training subprofessionals we ought to also ask ourselves a question, namely: "What are we asking from the subprofessionals?" Many times we may ask them to do things beyond their level of competency and responsibility. If you have authority, there is also responsibility that goes with it.

Dr. Demos: I might add another experiment that was carried out. Not really an experiment but an experience of Carl Rogers, while at the University of Wisconsin, in which he had an opportunity to teach a class every year in child development, and one of the experiences included work with young college junior and senior girls who happen to be predominately prospective teachers. In his class, Carl Rogers found that most of these young women would go out into a school setting and work with some of the most difficult children in Madison; Wisconsin. Just a couple of years ago I heard him say, "I was just flabbergasted at the progress that these girls made with these troubled youngsters in the school setting." I am not sure what it was, Roger's noted, but I know they brought youth, hope, vitality, interest, concern, caring, love and valuing. They valued these kids, they liked them and they showed it for the short space of time they had to work with these youngsters in the school setting.

Audience: I would like to comment on the subprofessionals and I think that Dr. Sweet and Dr. Hoff and Dr. White hold the feeling that these sub-professionals. . .

Dr. Demos: Yes, we're just beginning to tap the surface here. I've happened to

have had a personal experience similar to this in a school setting. I remember working as a school psychologist in a little sleepy town in the desert and I noticed that virtually all the youngsters in that particular school gravitated, to of all people, the custodian; they would go to this custodian and tell all kinds of things to him, and this was, I think, part of this characteristic we're talking about- - where we're just tapping the surface. But let me turn it over now for Dr. Sweet or Dr. White to respond to this question.

Dr. White: Well, I think certainly their one concern in training the subprofession might be the anxieties of the traditionally trained professionals. However, I feel that the ultimate contribution of the subprofessional may not be to the patient, but as it might create new ways of training the traditional psychologist or psychiatrist. That is, I think in our experiences with the subprofessional, because they will be new unorthodoxed or so on, we might discover new ways of training the college bound type of therapists. After you have been in the field a while, one's vision gets kind of limited. For example, I remember the first time I worked on a closed psychiatric ward I was trying to be a participant individual observer. The first patient walked by and he frowned and the nurse looked at me and she said, "You know schizophrenics do that sometimes, son, and you have to be on watch for them." And so the next patient came by and he smiled and the nurse said now, "Schizophrenics do that you know and you have to be on the watch for them." The next patient came by and he was singing and she said, "They get cheerful sometimes but you kind of have to watch that." So suddenly it dawned on me that everything that was happening on this ward this nurse was assigning a schizophrenia and I said to myself that maybe the guy was smiling,

singing or looking sad because he got a letter that sounded good or a letter that sounded bad. But she had gotten on a fixed track. She would need some new insights to become more flexible. So I think these people coming in with fresh vision can teach her something.

Dr. Demos: That's right. All of us who have done some group therapy realize that certain group members in the group become excellent therapists for other members of the group. Would you care to comment on that, George?

Dr. Hoff: Well, I think, so long as they are members of the group they can. I've tried having people who have allegedly "graduated" from the group, meaning that they have now received the stamp of approval and they're supposedly terminating their therapy, come back into the group and continue to interact. There were so many serious dangers in this that I have subsequently stopped this particular practice, primarily because the "graduates" were neither fish nor fowl; neither did they have the responsibilities of group therapists nor were they bonifide members of the group. They had a problem of role identification.

Dr. Demos: OK, I think we've talked out about it, and I know there are quite a few other questions you would like to discuss.

Audience: (Could not hear question.)

Dr. Demos: Yes, in other words this mother is following her instincts, her intuition or good sense or whatever it is. Yes, anybody -- Dr. Sweet I want you to say something about this. You're noticeably quiet.

Dr. Sweet: I do agree with Dr. White's thesis that mental health needs have to be met, that it cannot be adequately handled by the present professional personnel. In this regard let me also point out that the small towns are at a particular disadvantage. The mental health professional

personnel, the psychiatrist, psychologist, and social workers tend to be located in the cities. There are other instances where accessibility to mental health service is not equal for the nation's population, in addition to the one of social minority status.

The use of subprofessional personnel poses a serious task of training and maintaining standards. In our wish to be maximally helpful, we may tend to welcome people to join our efforts to minimize the idea that a certain degree of knowledgeability is required for this kind of work -- if not to help, at least, not to harm. The use of adequate supervision is thus indicated and I am glad that Dr, White's proposal makes definite provision for this.

Dr. Demos: I think your point is very well taken, particularly when subprofessionals attempt to be psychotherapists or psychoanalysts. I think it is valuable to use subprofessionals in the therapeutic hospital ward but this doesn't mean that every attendant and every nurse should consider themselves to be psychotherapists. In other words, we need to create a therapeutic climate, as we attempt to do in our atmosphere, in a classroom and in this institution. A therapeutic climate is a far cry from the kind of therapy that the psychiatrist does. I think there needs to be a clear distinction, but we're just tapping the surface. Remember that, and we have a lot of research to do, but it seems to be very promising. Some of the results that have come forth seem to indicate some very promising results, but there are some dangers as Dr. Sweet has so well pointed out. We do need more research before we are able to draw any firm conclusions about how effective these people are.

OK, we had better call it off, but let me say one last thing. I feel a little bit like the patient or the doctor who went to Dr. Sweet one

day and said, "Doctor I am losing my memory. I can't remember anything. I loose my keys, I forget my appointments, I can't remember anything." Dr. Sweet said, "How long have you had this difficulty?" and the patient said, "What difficulty Doc?" At any rate, with this kind of staff, with these kinds of professionals, I have the same feeling, "What difficulty Doc?" We are very fortunate indeed to have these kinds of professionals in our community, in our college, and working with our young people. Believe me if I had some college age youth I would like very much for them to be under the direction of every single one of these people. I am sure that you would. We can be very proud of the professionals we have working for our institution, and we are very proud indeed. At this time I hope you will join me in applauding them and then go over to our counseling center for some coffee.