ABSTRACT
        While mental health services can be delivered through
either traditional or community paradigms, most behaviorally oriented
clinicians have implicitly or explicitly opted for the more
traditional approach. This paper examines research which delineates
conceptual limitations in subscribing to a traditional orientation.
The community model represents an alternative conceptual model, one
which prospectively can better meet ever increasing demands and needs
for mental health services. Community interventions embodying the
most potential for salutary change (primary prevention and switching
emphasis from individuals to environments) have been infrequently
implemented. Potent obstacles to mounting such projects are described
and strategies for overcoming such formidable barriers are presented.
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Training in Clinical and Community Psychology for Behavior Analysts:

Community Psychology Issues

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The intention of this presentation is to conceptualize the prospec-
tive range and scope of interventions implemented by behaviorally oriented
community psychologists. Explicit articulation of such activities will
aid appreciably in delineating potential roles and training experiences
for behavioral community psychologists. First, it is critical to elu-
cidate several paradigmatic issues, including differentiating community
from traditional styles of service delivery, discriminating differences
between behavioral practioners operating in traditional and community
modalities, and specifying time and target points of interventions.
The latter sections of this paper are directed towards areas patently
neglected by behavioral community psychologists - primary prevention,
inoculating individuals to prevent onset of dysfunctions; and organi-
zational, community and societal level interventions, engineering
environments to remove irritants predisposing individuals to maldevelopment.

Two explicitly articulated, conceptually divergent styles for
delivering mental health services are known as the traditional (com-
monly called the medical model) and community approaches. The vast
majority of mental health professionals, implicitly or explicitly,
subscribe and operate within the traditional model. Salient character-
istics of a traditional approach include: 1) a one-to-one service
delivery model, patients treated individually by therapists; 2) a late
treatment focus, services extended to those with identifiable, well-
crystallized disorders; 3) a passive-receptive stance, patients are

brought to treatment facilities and 4) an implied authoritarian stance, unquestioning patients accept prescribed treatments. Stark shortcomings inherent in this model include the inability of stretching the paucity of professional manpower to meet the ever increasing demands for service (Albee, 1967).

Several major epidemiological studies suggest staggering unmet mental health needs. Srole, Langer, Michael, Opler & Rennie (1962), for example, adduced only 15-20% of the population completely free from emotional dysfunctions. Based as it is on a one-to-one delivery mode, and a waiting stance, the traditional model can never meet the enormous demand and need for services (Cowen, 1973).

An alternative paradigm for extending mental health services is the community approach, characterized by 1) actively intervening when individuals have relatively better potential for positive change (e. g., crises, early childhood); 2) augmenting the reach of services through utilization of paraprofessionals and consultation, and 3) focusing on eliminating pernicious environmental influences on development.

Crisis interventions are high priority targets for community intervention since failures to resolve crises might lead to more difficult future adjustments, while successful resolutions increase chances for future immunity. The active stance of the community approach is also manifested in an early childhood focus--identifying and formulating interventions to reverse incipient difficulties before such inchoate disorders become more entrenched, pronounced and intractable.

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The community approach is also broadened by extending the reach of services, by training paraprofessionals to perform functions traditionally reserved for professionals. Such developments have been strengthened by several studies (Poser, 1966; Truax & Mitchell, 1971) which indicated the effectiveness of paraprofessionals in carrying out clinical responsibilities. Consultation represents another way of extending the reach of mental health services. Most individuals in distress do not seek out mental health professionals. Gurin, Veroff, and Feld (1960), found most not taking their problems to mental health professionals (42% took their emotional problems to clergymen, 29% to physicians, and 18% to mental health professionals). Such findings point to the need for strengthening the ability of natural caregivers (e. g., physicians, lawyers, clergymen, educators--Caplan, 1964) to deal with mental health related problems.

Undoubtedly, the most distinguishing feature of the community approach is its emphasis on the environment as an appropriate intervention focus. A major impetus behind this development has been the realization that profound social, political and economic factors (e. g., poverty, unemployment, inadequate schools and institutions), exert powerful influences which can militate against the efforts of approaches which focus solely on the individual.

Prior to integrating behavioral conceptual approaches with styles of service delivery, several key terms are in need of explicit articulation. Any intervention subsumed under a traditional or community rubric, can be heuristically located on a rectangular schema, the

vertical axis referring to three time reference points, the horizontal axis specifying targets of interventions (Jason, 1976). Primary, secondary and tertiary interventions refer to time points in the unravelling of a disorder during which ameliorative efforts are implemented.

Primary preventive interventions seek to preclude onset of disturbances; secondary preventive programs detect and reverse incipient manifestations of dysfunction; and tertiary efforts focus on restoring functioning in those evidencing long-standing disorders. Five intervention target points situated on the horizontal axis specify the locus of program thrust; interventions can be targeted towards individuals, groups, organizations, communities or societies. In brief, interventions can be visualized as occupying a cell in the rectangular matrix, aimed at a precise time point in a disorder's evolution, and a carefully defined locus or target.

Generally, those espousing a behavioral orientation have subscribed to two fundamental concepts: a) the reliance of behavioral approaches on a set of experimentally rooted clinical procedures, and b) the validation of procedures using objective, measurable data (Mahoney, Kazden, & Lesswing, 1974). Behaviorally-minded practioners, in delivering mental health services, have traditionally opted to operate out of a traditional as opposed to a community model. Those adhering to traditional modalities have directed treatment efforts towards those with clear-cut, manifest dysfunctions (located at the secondary and tertiary time points), and have exclusively relied on a one-to-one treatment modality (the target focus at the individual level). "Traditional"

behavior therapists frequently conceptualize individual patient problems as resultants of faulty learning; manifested as learning deficits (e. g., mute schizophrenic children), excess response repertoires (e. g., phobia responses to neutral stimuli), and behavioral repertoires at low strength (e. g., dating behaviors in shy students). Following the process of gathering precise and accurate descriptions of problem behaviors and their controlling factors, behavior therapists employ varied behavioral techniques (e. g., counterconditioning, operant conditioning, modelling, cognitive restructuring) to conduce toward salutary changes in identified problem areas. Considerable, noteworthy success has been attained by behavior therapy practioners in treating a myriad of previously recalcitrant clinical disorders. Unfortunately, to date, behaviorally oriented clinicians have primarily adhered to the traditional approach; MacDonald, Hedberg, and Campbell (1974) reviewed fifty articles in four major behavioral journals and found 98% were person-centered. To the extent that behaviorists myopically focus on clinical activities within a traditional purview; alternative potentially more efficacious types of community activities are precluded.

Behaviorists adopting a community model for delivering services are felicitously called behavioral community psychologists. Such practioners conceivably operate at any time and target point. When implementing interventions at the secondary and tertiary time points, in contradistinction to traditional behavior therapists, behavioral community psychologists assume an active stance, entering the community to provide services to those most amenable to change (during

crises or early childhood); or geometrically extend the reach of services through use of paraprofessionals or consultation. Illustrative examples of this community approach include Guralnick's (1972) programs in which undergraduates were trained to teach language skills to handicapped children; and Wasserman, McCarthy & Ferree's (1975) intervention whereby undergraduates provided behavioral supportive companionship services to other university undergraduates in distress. Consultation to teachers, using various behavioral techniques, represents another community intervention which has been successfully employed in multifarious school settings (Jason and Ferone, 1976).

While the above remarks differentiate traditional from community approaches in individual centered, secondary-tertiary interventions; the innovative, exciting possibilities inhering in a behavioral community approach are manifested by broadening the scope of interventions to incorporate time and target domains not compatible with traditional approaches. More concretely, behavioral community psychologists prospectively utilize an expanded network of interventions, ranging from those focusing on primary preventive interventions (immunizing individuals to prevent onset of disorders) to those directed towards modifying organizations, communities or even societies (such target points representing legitimate alternative mechanisms of effecting positive changes in individuals).

Few primary preventive interventions have been implemented by behavioral community psychologists. Broskowsky and Baker (1974) impute the dearth of preventive efforts to problems in arriving at consensually

validated definitions of basic concepts and objectives; difficulties in anticipating and accounting for system complexity; vicissitudes in conclusively demonstrating the efficacy of primary efforts, and inabilities to mobilize powerful constituencies to agitate and demand such services. Albeit such obstacles are formidable, these barriers are not insurmountable. Heretofore, considerable effort has been directed towards eschewing definitional confusion, thereby hopefully avoiding Broskowsky and Baker's first dilemna. Such efforts are, in part, intended to further efforts towards establishing firm conceptual and theoretical foundations for preventive intervention strategies.

Primary preventive interventions can be categorized into three distinct types: 1) classical conditioning strategies aimed at preventing onset of conditioned avoidant responses, 2) operant techniques focusing on immunization to endure stressful situations and 3) tactics directed towards strengthening extant repertoires of problem solving, and health inducing skills. Classical conditioning strategies have been delineated by Poser (1970), who coined the term "antecedent systematic desensitization" to denote pre-exposure to conditioned and unconditioned stimuli to inhibit formation of conditioned avoidance response. High risk individuals susceptible to having potentially fearful stimuli elicit inordinately high levels of arousal (overprotected children about to enter nursery school, pregnant women prior to their first experience of labor, dental and surgical patients), might profit considerably from graduated pre-exposure to anxiety arousing situations, to prevent

establishment of conditioned avoidant responses.

A second strategy has been proposed by Seligman and Maier (1967), based on animal analogue research. In now classic studies, Seligman (1975) found dogs subjected to inescapable shock, manifested symptoms of learned helplessness. If dogs are first exposed to success experiences (escape responses eliminating shock), and then presented with inescapable shock, these immunized dogs do not develop learned helplessness, and later continue to respond normally. Within this preventive variant, Carrol Cradock conducting research at De Paul University, is actively teaching prospectively speech anxious high schoolers behavioral coping strategies, to prevent the students from manifesting overt speech anxiety. The work of Seligman and Poser suggest that operant and classical conditioning principles can be judiciously utilized in preventing establishment of conditioned emotional responses.

Primary prevention, however, must embrace not only procedures which implant armour to withstand pernicious stimuli, but also those which strive to actualize potentials by building competencies, strengths and requisite skills to acquire maximum reinforcements in the environment. Illustrative of such an approach is a project implemented by Larcen, Selinger, Lochman, Chinsky and Allen (1974). Through an elaborate series of behavioral techniques, an entire class of elementary school children were successful taught problem solving skills. Such skills might aid targeted children in becoming more proficient problem solvers in various settings, and concomitantly approach their

potential for gaining pleasurable experiences in life.

At a more general level, the behavioral community interventions, carried out to date have for the most part been based on a pathology orientation--that is, either on improving entrenched and incipient dysfunctions or preventing the occurrence of disorders. It should be stressed that an alternative orientation is available, one founded on positive mental health and the achievement of competencies. Mahoney (1975), in support of such a view, has recently reviewed behavioral applications aimed at encouraging creativity, uniqueness, personal choice, and positive self-validation. Behavioral community psychology would profit considerably from refocusing its orientation from mental disorder to mental health.

While individual or group centered primary preventive interventions have important implications in averting mental health casualties; pervasive, palpable environmental influences have the potential for effecting larger scale salubrious changes. At the organizational level, behavioral community psychologists can actively participate in conceptualizing and constructing new settings to meet identified needs or can become involved via advocacy or consultation in modifications of structural-environmental features in extant settings. Achievement Place provides an example of behavioral community psychologists (Fixsen, Wolf and Phillips, 1973) participating in the creation of a half-way setting for delinquent children based entirely on behavioral principles. Among the diverse ways in which organizations can be structurally altered, include inducing functional changes (e. g., contingencies) throughout

a setting, or modifying ecological units (architecture and physical design), organizational entities (staff-patient ratios), personal characteristics (SES, sex, age) or social-climates of institutions. The wide-scale implementation of behavioral principles in extant settings is well illustrated by Atthowe's (1974) restructuring of a mental hospital using behavioral principles and Reppucci's (1973) successful implementation of token economies throughout an institution for delinquent children. Evaluating effects of planned ecological changes in organizational units on individual functioning represents an intriguing area meriting more attention. An ongoing behavioral-ecological project at De Paul University initially involved rigorously operationally defining structure, routine and social-climate variables in an elementary school classroom. Currently the positive and negative effects on school children of systematically altering each dimension are being monitored. Illustrative of this research was the demonstration of a robust interaction between children's problem status and class size (i. e., problem children manifested significantly more misbehaviors in larger groups having less teacher supervision, no significant changes were observed for nonproblem children, Jason & Nelson, 1976).

Community interventions targeted to environmental influences embody more than an isolated organization (i. e., an intervention aimed at a network of organizations could be construed as operating at a community locus). Baby steps have been taken towards an evolving behavioral technology to attack such intractable community sore-spots as mass transit, energy shortages, littering and unemployment. Everett, Hayward

and Meyers (1974) for example increased bus ridership by dispersing re-
inforcing tokens to riders; Winett and Nietzel (1975) reduced energy
consumption patterns by awarding money bonuses for decreased energy use;
Clark, Burgess and Hendee (1972) lessened littering in state parks by
dispersing economic incentives for appropriate disposal of waste; and
Jones and Azrin (1973) located jobs for the unemployed by paying individ-
uals for job leads. Interventions aimed at establishing balanced eco-
logical settings, enhancing esthetic qualities of environments, remediating
patent pernicious environmental forces (unemployment, dilapidated housing,
inadequate schools), contribute to augmenting positive mental health to
numerous members in a community.

At a societal level, judicial, legislative, and executive decisions
create policies, laws, and regulations which intimately affect com-
munities, organizations and ultimately individuals. At this point, no
systematic efforts have investigated ways of using behavioral principles
to influence such omnipotent decisions, or to help sociopolitical power
blocks (lobbies, special interest groups, various activities) achieve
articulated goals.

More information is required concerning how changes in institution-
al subunits are influenced by other subunits or organizations (Reppucci,
1973). If successful interventions aimed at subunits are vitiated due
to adverse organizational influences not included in the intervention,
then behavioral community programs will have to direct their efforts
towards modifying overall organizational functioning. Relations among
agencies, institutions, and systems are also of critical importance.

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For instance, mental hospitals undergoing organizational changes will fail to reduce readmissions if their changes are not coupled with changes in the environments to which patients are discharged (Atthowe, 1974). Along these lines, more research needs to be directed towards investigating prospective positive and negative second- and third-order consequences of behavioral community interventions (Willems, 1974). Even if behavioral community projects achieve positive short-term effects, deleterious second-order ramifications might invalidate the entire intervention.

Finally, it is appropriate to suggest several caveats which point to limitations in the behavioral base for community psychology. While behavioral technology is often used in fostering salutary goals, it can be used, both wittingly and unwittingly, to instill maladaptive skills or to consolidate power for those engaged in maintaining a status quo antithetical to the well-being of members of a particular setting. Such interventions might well result in feelings of isolation, dependence, alienation, as well as attenuation in the psychological sense of community held by members (Sarason, 1974). Another stark reality behavioral community psychologists must confront concerns the nature of the pluralistic-democratic society in which interventions are mounted. Given the universe of societal problems and prospective alternative interventions, political decisions determine which interventions are to be disseminated and implemented. If behavioral community psychologists are to effect significant societal change, they

need to become more adroit at such "dirty" but crucial activities as influencing, lobbying, and positively presenting their projects to the public and to those possessing the power and responsibility for policy decision.

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