Subject	PSYCHOLOGY
Paper No and Title	Paper no.16: Community Psychology
Module No and Title	Module no.2: Disenchantment with clinical pathology- historical perspectives
Module Tag	PSY_P16_M2

Principal Investigator	Co-Principal Investigator	Co- Principal Investigator
Prof N.K.Chadha Head and Professor, Department of Psychology, University of Delhi	**Dr Jaswinder Singh** (Principal) and **Dr H.V.Jhamb,** Associate Professor SGTB Khalsa College University of Delhi	**Dr Vimal Rarh** Assistant Professor, Department of Chemistry, Deputy Director center for e learning, SGTB Khalsa College, University of Delhi *Specialised in : e-Learning and Educational Technologies*
Paper Coordinator	**Author**	**Reviewer**
Dr. Priya Bir Associate Professor Department of Psychology Aditi Mahavidyalaya University of Delhi	**Dr. Priya Bir** Associate Professor Department of Psychology Aditi Mahavidyalaya University of Delhi	**Prof.A.K.Malik** Department of Psychology Jodhpur University
Anchor Institute : SGTB Khalsa College, University of Delhi		

TABLE OF CONTENTS

1. Learning Outcomes
2. Introduction
3. Third Mental Health Revolution
4. Factors Underlying the Emergence of Community Psychology
- 4.1 Discouragement with existing Mental Health Concepts, Activities, and Roles.
  - 4.1.1 Disenchantment with Psychotherapy
  - 4.1.2 Lowered Expectations Concerning Clinical Assessment
  - 4.1.3 Changing concepts of Mental health and Illness
  - 4.1.4 Dissatisfaction with Existing Professional Roles
- 4.2 The Manpower Shortage
- 4.3 Unequal Distribution of Mental health care across Social Class
- 4.4 The Mental Hospital

5. History of Community Movement
6. Comprehensive Community Mental Health Care
7. Summary

1. Learning Outcomes

After studying this module, you shall be able to

- Know about the factors which led to the emergence of the field of Community psychology.
- Learn the history of Community movement.
- Analyze the Comprehensive Community Mental Health Care system.

2. Introduction

Community psychology has developed largely as a response to perceived problems in using other forms of psychological treatment and intervention. The brief history of community psychology is the story of response to needs unmet by traditional practices. The event that is regarded as making the birth of community psychology, the Boston Conference was held in May, 1965. Many have noted that much of the impetus for its development can be attributed to skepticism and discontent over the medical model of mental health care that predominated in the early 1950s (Bernstein & Nietzel, 1980).

3. Third Mental Health Revolution

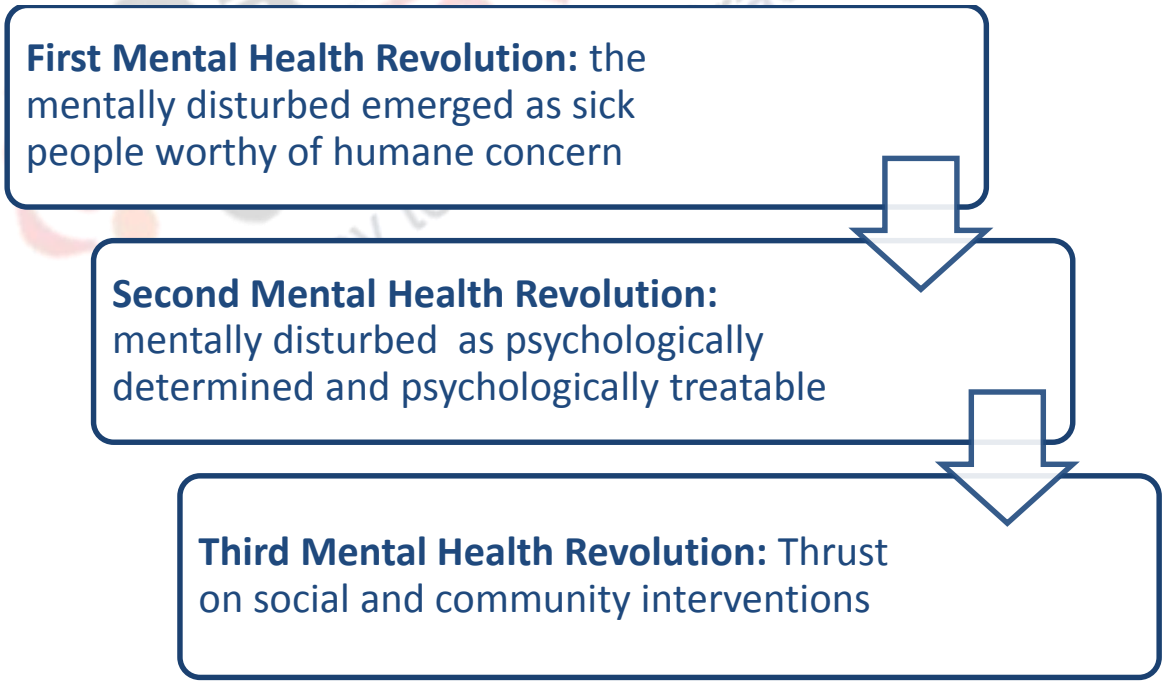

Figure 1: Consequences of the Three revolutions in Mental Health.

Heralded as a "third mental health revolution" (Hobbs, 1965) or a "third psychiatric revolution" (Bellak,1964), the emergent field of community mental health is proclaimed as being as radical a change in perspective on human malfunctioning and its alleviation as was wrought in earlier times by Pinel, when he struck the chains from the insane, and by Freud, when he showed that neuroses are psychologically determined and curable through therapeutic conversations. As consequence of the first revolution, the mentally disturbed emerged as sick people worthy of humane concern; from the second, their conditions were conceived as psychologically determined and psychologically treatable. The thrust of the third mental health revolution lies in the quest for the prevention of emotional disorders through social and community interventions aimed at their social determinants. Even when viewed more modestly, the hope of the community movement is that necessary services can be made effective and available for the total population, including the poor and the alienated who have benefited least from prevailing practices.

Policy makers join with many mental health professionals in the conviction that new models of mental health must evolve if the needs of all the people are to be served. At the same time, thoughtful critics have cautioned against the dangers of overenthusiastic acceptance of the "newest therapeutic bandwagon". Work in the field has been motivated largely by pragmatic and idealistic concerns, with the development of the necessary base of theory, systematic knowledge, and program-relevant research thus far lagging behind.

In 1965, the *Community Mental Health Journal*, exclusively devoted to work in the field, was started; in 1973, two new journals of community psychology were launched. Also in 1965, a conference held near Boston to consider issues in the training of psychologists for work in the community mental health field. At that conference, the term "community psychology" emerged to describe the field which included, but also extended beyond, the community mental health roles of clinical psychologists. A Division of Community Psychology was added to the American Psychological Association, which now has over a thousand members.

4. Factors Underlying the Emergence of Community Psychology

4.1 Discouragement with existing Mental Health Concepts, Activities, and Roles.

Community psychology emerged, out of what Hersch (1968,1969) has termed a "discontent explosion" among clinicians. Established beliefs about the nature of mental disorders and their treatment have been called into question; clinicians have found traditional roles frustrating; they question whether they can contribute significantly to the vast unmet needs of large segments of the population.

4.1.1 Disenchantment with Psychotherapy

Growing criticism from many quarters have shaken the faith of many clinicians in both the effectiveness and efficiency of traditional psychotherapies. Both humanistic and behavioural psychologists, from opposing vantage points, have questioned fundamental premises. More devastating, however, was the claim that psychotherapy ad yet to demonstrate its effectiveness even as against no treatment whatever. This argument, launched by Eysenck in 1952, led to considerable controversy over the interpretation of the limited amount of research data available;

in time, it inspired more sophisticated research studies. In a landmark review of 24 studies that evaluated the effectiveness of psychotherapy, Eyesenck (1952) argued that rates of improvement for neurotic patients following psychotherapy were essentially the same as improvement rates for those who did not receive this form of treatment. Although the presently available evidence shows psychotherapy to be considerably more effective than Eyesenck claimed. However, the same body of research has brought out some genuine issues as to the universal applicability and value of psychotherapy. The ideal patient is someone already on the way to psychological health, with a fair degree of psychosocial competence, intelligence, personality integration, and insight. The more severely disturbed, the mentally retarded, unmotivated and many of those facing the stresses of poverty or race are less well served.

Even if there were no question of the effectiveness of psychotherapy, it is clearly not an efficient procedure. It is costly in time, effort, and money, and hence most available to the motivated and affluent. During a professional lifetime, a clinician practicing intensive psychotherapy can see only a very limited number of people.

4.1.2 Lowered Expectations Concerning Clinical Assessment

Psychologists were also questioning the overall utility of assessment and the ability of clinicians to make complex judgments about human behaviour. In 1954 Paul Meehl published the results of his review of studies comparing the accuracy of predictions made through clinicians' judgments versus those made by the statistical combination of test results. His findings showed that, of the 20 studies he reviewed, only one supported the seniority of clinical inference while all provided clear support for statistical predictions. Meehl's subsequent reviews in 1957 and 1965 provided even stronger support for superiority of some type of statistical combination of assessment information over the evaluations of clinicians. In fact, other research published about this same time also suggested that specialized clinical training can actually lead to an impaired ability to make clinical inferences from assessment information.

4.1.3 Changing concepts of Mental health and Illness

More broadly, there has been widespread dissatisfaction with traditional "medical" concepts, particularly as reflected in the "custodial" but also in the "therapeutic" approaches to mental problems. From various perspectives, it has been argued that conceiving emotional disorders in analogy to physical diseases limits our understanding of human problems and our effectiveness in alleviating them. Of particular concern is the implication, in the medical model, that mental diseases reside in the individual and hence that intervention must involve treatment of the sick person to the end of removing or altering the pathological processes within him. In opposition to such a view, many have argued the need for a "social'" prevention'" "growth-and-development" or in the general term being used here "community psychology" point of view which sees human problems as residing in the interplay between the distressed person and social forces.

4.1.4 Dissatisfaction with Existing Professional Roles

Mental health professionals of all kinds, like their critics, have become concerned with their limited ability to effect important changes in the level of psychological distress in the larger

community. Working in clinics, private offices, and hospitals, waiting rather passively for troubled people to present themselves for help, many have come to realize the need for a greater area of influence and for earlier, quicker, and more effective services. Clinical psychologists face the additional problem of feeling unfulfilled in medical settings where primary decisions are made by physicians. The medical environment, many feel, provides too little opportunity to exert their independence and competence; too often, they see themselves as second-class citizens in a mental health enterprise dominated by medical men. Many see the new roles emerging in community psychology as providing a better route toward professional autonomy and allowing greater freedom to experiment with uniquely psychological interventions.

4.2 The Manpower Shortage

The blatant manpower shortage has been a major impetus to reconceptualize professional roles, to suggest alternate ways of deploying professional time, and to seek new workers in sub-professional roles.

Albee (1959) in one of the major studies of the Joint Commission Mental Illness and Health, surveyed manpower trends in the major mental health professions. His findings led the author and the Joint Commission to conclude with frank pessimism, that sufficient professional personnel to eliminate the glaring deficiencies in our care of mental patients will ever become available if present population trend continues without a commensurate increase in the recruitment and training of mental health manpower."

The emerging community mental health centers of the 1960s have had difficulties in finding sufficient numbers of adequately trained personnel. As the hospitals they sought to complement, they have had to compete with a number of attractive alternatives for the already short number of trained professionals.

4.3 Unequal Distribution of Mental health care across Social Class

Srole, Langner, Michael, Opler, & Rennie (1962) in their survey showed that the highest rate of mental disorder was in the lower socioeconomic groups and that individuals from lower social classes were least likely to receive mental health services. In other words, those with the greatest need for mental health services appeared to be least likely to receive them.

Hollingshed and Redlich (1958) showed in their classic study that the socioeconomic class also affected the type of care received by mental health patients. Among severely disturbed patients, the type of care received by mental health patients. Among severely disturbed patients, those from the higher socioeconomic classes were much more likely to receive psychotherapy than were those from lower socioeconomic classes. Evidence suggested that, compared to patients of higher socioeconomic status, patients in the lower strata were more often treated in public facilities where they were likely to receive drug treatment and other physical interventions (such as psychosurgery and electroconvulsive treatment) or custodial care.

4.4 The Mental Hospital

Another major impetus to the emergence of community psychology was the sorry state of the large state mental hospitals by the end of World War II. When William Tuke founded the Retreat in York, England, in 1972, he believed that the mentally ill if treated humanely and urged to greater responsibility and self-control were capable of resuming normal lives in society; a point of view which has been called "moral treatment." By the mid-nineteenth century, however, American society changed radically, and with it faith in moral treatment declined. Waves of new immigrants were swelling urban populations and straining the resources of psychiatric hospitals. Social historians note (e.g. Grob, 1967), mental illness came to be viewed more pessimistically, and hospitals became more centers for custodial care than for moral treatment. Small asylums grew into vast, overcrowded and understaffed state hospitals, often located far from population centers, and so poorly supported that basic necessities of food, clothing, and shelter were often lacking.

There were considerable gains in reducing the duration and effects of hospitalization. According to NIMH statistics, the state hospital population went from 559,000 in 1955 to 279,955 in 1972, and the trend continues downward, despite U.S. population rise over these years (B. Brown, 1973).

Socially oriented clinicians have contributed to the well being of severely disturbed patients by efforts to (1) make the hospital environment more therapeutic for those already hospitalized (milieu therapy, token economy wards, activity programs); and (2) keep patients out of hospitals through providing community-based alternatives (community mental health program, halfway houses, rehabilitation, self-help organizations).

5. History of Community Movement

The community movement emerged in the 1960s from the professional and social climate we have just reviewed, but its roots run deep in the history of psychiatry and clinical psychology (Rosen, 1968; M. Leine and A. Leine,1970). When Clifford Beers published *A Mind that Found Itself* in 1908, professional and public attention was called sharply to the sorry condition of hospitalized mental patients. Shortly thereafter, a national organization was formed which evolved into the National Association of Mental Hygiene (NAMH), which worked for hospital reform and preventive programs. The term "mental hygiene" itself, was used as early as 1843 by William Sweetser. Adolph Meyer, a leading American psychiatrist early in the century, pressed for socially oriented attacks on mental health problems. He noted that "communities have to learn what they produce in the way of mental problems and waste of human opportunities, and with such knowledge they will rise from mere charity and mending, or hasty propaganda, to well balanced early care, prevention and general gain of health" (quoted by Brand, 1968).

By the end of World War II, mental health professionals and the federal government were ready for more definitive actions toward the improvement of mental health in the general population.

In 1955, Congress passed the Mental Health Study Act which established the Joint Commission on Mental Illness and Health to survey comprehensively the care of the mentally ill in the United States and to recommend future directions and programs. A broad base of professional and citizen

groups were represented in the Joint Commission. Studies were undertaken on positive concepts of mental health, hospital care, social programs, research, manpower, and mental health economics, and among others.

After receiving the Joint Commission's report, President John F. Kennedy called for "bold, new approaches." He proposed "a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill." The traditional neglect of the psychologically disabled was to be replaced by forceful and far-reaching programs. Specifically, these were to be aimed at prevention, wherever possible, early diagnosis and comprehensive care, reducing hospital populations, and developing community-based programs. The many mental health workers who felt that the Joint Commission report was too timid and conservative in its conclusions were heartened by the Kennedy message. The proposed "comprehensive community mental health centers" were seen as a potential vehicle for far-reaching changes.

6. The Comprehensive Community Mental Health Center

Late in 1963, Congress passed the "Community Mental Health Centers Act" which provided up to two-thirds of the funds for the construction of comprehensive mental health centers in communities. Two years later, supplementary legislation provided additional funds for staffing needs. In order to qualify for these funds, states had to draw up long-range plans thoroughly surveying needs and resources, delineating the areas to be served, and the priorities for implementation. It was required that community members participate in the planning. Each center was expected to serve a "catchment area" of not less than 75,000 nor more than 200,000 people.

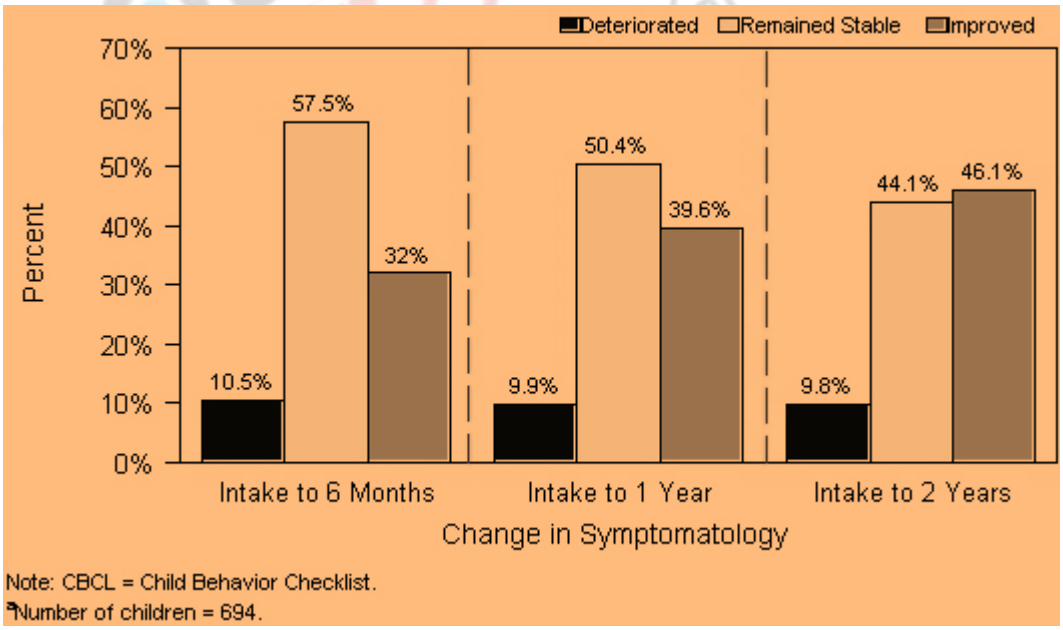

Figure 2: Percentage of Children b y CBCL Reliable Change Category over Time in Grant Communities Funded in 1993–94a
Annual Report to Congress, Executive Summary: 2000

The term "comprehensive" was intended to have a double meaning – *all* mental health services would be available to *all* people. A critical part of the federal legislation is that it requires centers to provide five "essential" services, in order to qualify for federal funds. The essential services are: (1) inpatient care; (2) outpatient treatment; (3) partial hospitalization, i.e., day or night hospitalization, with the patient going home or to work in the other hours; (4) twenty-four-hour emergency services; and (5) consultation and education to community agencies and to professional personnel. The desirable but not essential services were: (6) diagnostic services; (7) rehabilitation and aftercare; (8) training; (9) research; and (10) evaluation.

The concept of the community mental health center in the 1963 act had the desirable consequence of moving psychiatric care from isolated hospitals to community based centers which more usually were located in general hospitals. Moreover, it provided emergency help, readily and locally available, and encouraged consultation, aftercare services, training, and research.

In 1966, the American Psychological Association issued a position paper criticizing current trends and proposing guidelines for the future development of community mental health centers (M. B. Smith and Hobbs, 1966). But during 1960s, the development of new centers was hampered by problems local communities had in raising matching funds and in recruiting qualified professionals.

In contrast, the Westside Community Mental Center of San Francisco weathered and was strengthened in early conflicts between community and professional interests.

The comprehensive community mental health center is by now an established institution, although perhaps less vital in the total mental health picture than was originally intended. A survey of the accomplishments and difficulties of community mental health centers conducted by a Ralph Nader task force paints a fairly dismal picture (Chu and Trotter, 1972). This report alleges that commendable goals are rarely achieved in practice.

7. Summary

- The field of community psychology has experienced considerable growth and continual critical self-examination since its birth.
- It emerged because of the dissatisfaction with traditional mental health efforts.
- The one constant that can be identified in the development of community psychology is change. The field has steadfastly recognized the need to allow itself the latitude to change and develop new techniques to meet these challenges.
- The future development of this dynamic field will undoubtedly see further changes as community psychologists strive to fill society's needs by working through community systems.