KEEPING THE COMMUNITY IN COMMUNITY PSYCHOLOGY AND COMMUNITY MENTAL HEALTH

MAINTENIR LA COMMUNAUTE DANS LA PSYCHOLOGIE COMMUNAUTAIRE ET DANS LA SANTE MENTALE COMMUNAUTAIRE

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ABSTRACT

The following address was delivered at the 43rd annual convention of the Canadian Psychological Association, on June 11, 1982, in Montreal, Quebec. Distinctions between community psychology and community mental health were set forth as a focal point for a needed clarification of distinctions between clinical and community psychology, between academics and practitioners. Values underlying the interaction of the community and the professional were highlighted. Attention was drawn to the need for operational definitions of concepts currently used by community psychologists, and for the specific study of the historical antecedents within a Canadian context.

I wish to thank the members of the organizing committee for the invitation to address this section on community psychology. It is both an honor and a challenge and I trust that my thoughts will reflect some of your interests and concerns.

In essence, I would like to cover the following issues: First, a very brief commentary on the distinctions between community psychology and community mental health, which, I believe, are at the basis of some of the tension — hopefully, creative tension — being experienced by those of us who work as clinicians and as community psychologists, a creative tension further complicated for those of us whose base of operations is that of academia. The second issue concerns that of the values underlying the interaction of the community and the professional and

the need for a more operational definition of the word "responsibility," without which, I do not believe the "prise en main" by the community — whomever that may be — can be achieved. Third, I will arrive at the question of the meaning of "community" and how I feel our understanding of that term influences our work as community professionals. Ultimately, I hope to achieve a clarification of the title of this presentation: "Keeping the community in community psychology and community mental health."

One final introductory comment. In view of the bilingual nature of this organization, I will present part in French and part in English, and I trust that this will be agreeable to all of you and reflect an analogous tension for what we are to discuss.

L'approche communautaire n'est pas nouvelle. Sous une forme ou l'autre, elle existe depuis longtemps. Plusieurs disciplines, comme l'épidémiologie, la médecine, la psychologie et le service social s'inspirent de cette approche; et plusieurs pratiques, comme la santé publique et le mouvement de santé mentale communautaire, utilisent cette étiquette. La psychologie communautaire, comme discipline, est née à Boston, en 1965 à la conférence de Swampscott. Cette conférence constituait de la part des psychologues une première manifestation officielle d'un intérêt structuré pour la communauté. Les participants à cette conférence ont fait maintes références à la réalisation optimale du potentiel humain à travers une action sociale planifiée, à la relation de l'homme avec tout son environnement et à la participation du psychologue à l'amélioration de la condition humaine.

Les participants à cette conférence étaient en grande partie des psychologues cliniciens, pour qui il était devenu impérieux de cerner le champ d'action que semblait être le leur, alors que, d'une façon ou d'une autre, ils participaient à des projets communautaires dans le domaine de la santé mentale.

Les points essentiels à retenir sont les suivants: 1) Le psychologue communautaire est un analyste des systèmes sociaux, un consultant en affaires communautaires, et globalement, un spécialiste de l'homme en relation avec tout son environnement. 2) Le psychologue communautaire est engagé explicitement à promouvoir le développement normal de la communauté; les actions du psychologue communautaire n'ont peu ou pas de rapport avec la maladie et ne peuvent se réaliser dans le cadre du modèle médical. 3) Le psychologue communautaire est un participant-conceptualisateur, i.e., qu'il est engagé autant dans la création de connaissances scientifiques que dans la promotion de programmes de développement communautaire. 4) La psychologie communautaire n'est pas qu'un sous-secteur de la psy-

chologie clinique; elle interagit avec tous les secteurs fondamentaux des connaissances psychologiques et elle devient une force intégrante de ces connaissances.

Les principes énoncés à ce moment-là sont les suivants: prévention primaire, développement communautaire, utilisation des ressources de la communauté, consultation, etc. Une distinction importante fut apportée lors de cette conférence; cette distinction constituera le premier point de ma présentation. Pour comprendre la psychologie communautaire il faut être conscient de la distinction qui existe entre elle et la psychologie clinique, et d'autre secteurs de la psychologie qui traitent l'individu et/ou des petits groupes. La psychologie clinique, par exemple, envisage l'application de techniques cliniques aux problèmes de santé mentale des individus dans la communauté, tandis que la psychologie communautaire se tourne vers la communauté sur une grande échelle et tient compte de variables qui débordent le domaine de la clinique. Cette distinction paraît claire quand on considère ce qui sépare la pratique telle qu'on l'exerce dans le domaine de la santé mentale et dans celui de la psychologie communautaire. Premièrement, le modèle médical est à la base des concepts, de la terminologie et de la pratique en santé mentale communautaire, et le but visé est le traitement dans la communauté, alors qu'en psychologie communautaire, c'est à la lumière du modèle écologique que l'on travaille au développement de la communauté. Deuxièmement, en santé mentale communautaire le centre d'intérêt est l'individu malade alors qu'en psychologie communautaire c'est la personne dans son environnement. Troisièmement, la santé mentale communautaire s'attaque aux problèmes de la maladie mentale et cherche à utiliser les ressources de la communauté pour le traitement, alors que la psychologie communautaire cherche à favoriser la prise en charge de la communauté par elle-même en s'intéressant à divers problèmes et situations communautaires et

pas seulement à ceux et celles qui sont reliés à la santé et à la maladie mentale.

It may surprise you that I return to the Swampscott Conference, the Boston Conference, of 1965. I do so to emphasize those principles of a theoretical base other than the medical model set forth for community psychology. This in turn is to stress the concepts of primary prevention, community development, participation-conceptualization, helping the community to assume responsibility for its milieu, etc., the handy tools of the community psychologist. My reason for doing so is to arrive at the end of this presentation with certain conclusions I've reached about the future of the community approach.

To begin with, I would like to return to the distinction that was made at the conference between community mental health and community psychology and the two distinct models underlying these approaches. At that time, the differences seemed quite clear and most logical. These early distinctions, however, have remained more an ideological attitude than an accomplished fact. We have developed theoretical structures about which much has been written, especially concerning the ecological model for community psychology as opposed to the medical model for community mental health. We believe it is not the individual per se but the individual in his environment that is important. We have tried to assist groups to assume responsibility for their endeavors, and most psychologists have seriously tried to avoid taking charge of community groups, thus working towards community autonomy. Nevertheless, we have been, we are, and we will be directly influenced by the economic reality of the market place and governmental policy. It is, I believe, because of these realities that we have come to use the terms "community psychology" and "community mental health" interchangeably. My question is the following: Is it important to reconsider this distinction in

order to clarify the ultimate goals and objectives of a community approach? I strongly suggest that it is, because of the underlying assumptions and conceptual models which are directly reflected in what we do. This is not to propose a rigid dichotomy — far from it — but rather to insist on continuing study of the interaction between theory and practice, the basis of any sound, scientific discipline. In our struggle to attain a certain credibility with others in the mental health field, we have lost some of the drive to establish a sound theoretical model or models for community psychology. Where there has been theory development, little attention has been given to see if it works in actual practice. I wonder how many articles on community programs published in our many journals treat directly the interaction of theory and practice. Has an attempt been made in the reporting of various projects to indicate the conceptual model used, whether directly or indirectly? I do not think so. Yet it is a question we community psychologists should constantly ask ourselves. By not asking it we are avoiding the problem of underlying differences between the theoretical bases of community mental health and community psychology.

Steven Danish, (1982) President of Division 27, of the American Psychological Association, recently wrote: "Community psychology has become the social conscience for psychology." But he adds that the increasing difficulties found in relation to other professionals may be due to the fact that our criticism of existing systems has an arrogant quality to it. I believe that such arrogance and criticism, as well as our defensiveness, and occasional apologies for being community psychologists are due to the fact that we have lessened our struggle for a structural and dynamic theoretical orientation. We have been and perhaps of necessity are so busy working as community psychologists that we do not take the time to define what we are doing as scientists-professionals.

There is another source of tension which is that between community and clinical psychology. As Davidson (1981) pointed out in a recent article, "There is not a large paradigm difference between what clinical and community psychologists do" here in Canada, as opposed to the rather entrenched, dichotomous camps in the United States. According to Davidson, there is the danger that when we change how we practice, underlying conceptions and values remain the same. Perhaps we should pose the question today as has been echoed since the beginning of community psychology: Are we basically clinicians who do community work? Or are we actually social psychologists adhering to a more experimental model? Or are we psychologists for social change? Or are we a mixture of all of the above, none of the above, just different? In view of the fact that many of us are clinicians who work also as community psychologists, I suggest that we must address the problem of roles, a problem I would prefer to avoid, but cannot ignore. Unless you and I do face this issue, we will never confront the underlying conceptions and values of those various roles. Community psychology could easily become an amorphous entity without professional viability.

Of all the tensions facing us, however, possibly the greatest is that between the academics and the practitioners. As Fishman (1982) asked in a recent article: "Can we make the marriage work?"

Although this issue may be less intense here in Canada than in the United States, it remains a source of conflict in view of the basic differences in values, conceptual models, operating strategies, and activities of these two groups. This tension arises, according to Fishman, from the mismatch of high-priority value systems of the two camps. Examples of possible mismatches which he cites are the following: First, the type of problem considered. Whereas the academic deals with intellectual questions with a focus on general theory construction,

the practitioner deals with pragmatic questions, with a focus upon trying to change the behaviour of specific individuals, groups, organizations, and communities. Second, the determination of problems to be addressed. The principle of academic freedom allows the scholar to select problems according to personal predilection, whereas the practitioner selects problems based upon the service needs of clients and funders. Third, the mode of problem solving. The academic approaches intellectual problems primarily by theoretically oriented reading, thinking, and discussion with others in that milieu. In contrast, although practitioners engage in some theoretically oriented conceptual activities, much more of their time is spent in pragmatic interaction with clients and with diverse groups of service planners and service funders. Fourth, the ultimate goal of these problem-solving processes. The academic's ultimate goal is to gain peer recognition and publication of his or her work. The practitioner's ultimate goal is to plan, implement, and evaluate service intervention programs which are viewed positively by the individual, organizational and community clients, and funders, so that the program's continuation is assured.

It is the function of academics to develop basic psychological principles, which are then applied by practitioners. In the application process, new conditions and factors are encountered, which create both the need to revise those basic principles and the need to develop new, additional principles. Feedback from practitioners' work can then guide academics in subsequent theory-building and research efforts. In essence, there is a need for mutuality, mutuality in the eriksonian sense, if a serious split is not to develop between the academics and the practitioners.

I believe our hope here in Canada is that, as noted in the 1979 Canadian Psychological Association conference symposium on community psychology, most representatives of the various provinces recognized

that they had been doing community psychology for years without knowing the label which described their activities. This would suggest an openness for change and development. Now that we have the identifying label, however, and hence a role to play, it is imperative that we sit down and discuss how two divergent high-priority value systems can become a creative, functional coalition. We can no longer ignore the conceptual differences which do exist.

There is another source of tension which exists for those of you, like myself, who work in both areas at the same time. If I act as a consultant to community organizations seeking information on setting up programs, what happens to my academic standing when the pressure exists — and it does indeed exist in varying degrees — to become a noted "scholar"? Which high-priority value system do I follow? Shall I continue to try to do both and hope for the best? I think not. I believe we have a responsibility to confront this value system conflict which is even more acute because in large measure we cope with it alone. The importance of addressing the issue of values was pointed out by Ritchie (1982) in a recent address: "Dans l'approche communautaire, il est essentiel d'effectuer une prise de conscience de nos propres valeurs et celles d'autrui. Il est important parce que nos valeurs sont implicites dans nos choix, autant que dans nos actions."

I would add that if we do not confront the value conflict within our own professional work as clinical and community psychologist, as academic and practitioner, it is obvious that an awareness, a concern for the value systems of the community with whom we work will receive little or no attention whatsoever. It would seem to me that our responsibility in this area of tension and concern is patently clear.

The word "responsibility" brings me to the next point I wish to make. Throughout the literature on community psychology, constant reference is made to the concept of

responsibility. All of the basic principles of community development, the *prise en main*, the belief in human community resources, community autonomy, the role of the participant-conceptualizer, etc., depend upon this concept. I believe that the whole community approach ultimately depends upon the concept of responsibility. The question is how do we operationally define responsibility as a psychological concept? This is a crucial issue, because responsibility is a value; hence, it is inherent in our actions, it influences the projects we undertake, and it plays a major role in our relations with members of the community. This became very clear to me three years ago when we were trying to understand the dynamics of a community program. We realized that the word "responsibility" was constantly used, but never specifically defined except in the sense of "I'll be responsible for this," or "They will be responsible for that." A search of the literature showed that at that time, there was no psychological, operational definition of responsibility. As an initial step, we decided to find out what the word meant to a group of psychology students. We asked one question: "Qu'est-ce que le mot responsabilité évoque en toi?" Of 180 students, 72% responded anonymously. This rate of return at least indicated an interest in the question.

L'analyse suggère un lien étroit entre les concepts de responsabilité et de liberté. Quelqu'un écrit par exemple: "La responsabilité déclenche tout le processus de la liberté." Plusieurs invoquent la notion de choix. Pour d'autres, le concept de responsabilité implique la réflexion, la remise en question de soi. Elle est reliée à la conscience d'être la cause de ses actes. Ce concept est aussi relié à celui de moralité, de conscience morale et de bien-être. Nous avons trouvé que la notion de responsabilité implique aussi les valeurs personnelles. Un exemple: "La responsabilité évoque aussi un problème de valeurs. Le grand problème

inhérent à la responsabilité collective repose sur le fait que certaines valeurs sont plus ou moins partagées à travers la population humaine." Responsabilité est aussi reliée aux notions de devoir, d'obligation et de nécessité. Par exemple, un répondant a écrit: "Etre responsable c'est faire son devoir, mais un devoir consenti, accepté librement. Le devoir perd sa connotation de contrainte et prend le sens d'une tâche à accomplir."

La responsabilité est mentionnée à propos d'autres points d'intérêts, dont l'image de soi et le sentiment de compétence; les domaines de la maturité personnelle, de l'honnêteté, de l'adaptation à la réalité, de la justice, de la nécessité que les parents prennent en charge l'éducation de leurs enfants, etc.

C'est aussi un concept qui se réfère à la société et à la communauté.

Ces réponses suggèrent qu'à la base de la responsabilité se situe la conscience d'un fait, d'un acte, d'un événement et d'un désir. C'est sur la base de cette prise de conscience que s'amorce le processus de "prise en charge," de "prise de responsabilité." La relation entre ces concepts et la psychologie communautaire est très évidente.

Cependant, toutes ces définitions du comportement responsable ne donnent pourtant pas de définition opérationnelle. Je peux dire brièvement que l'analyse de ces descriptions indique que tous les étudiants semblent d'accord pour reconnaître l'importance de la dimension "responsabilité" dans leur vie, mais chacun a sa propre conception de la responsabilité.

The great diversity of responses — descriptive responses — left us with the conviction that we could not assume we were all talking about the same thing; that this concept could range from a purely personal perspective to one which reflected membership in the global village.

Such a mini-study was simply that, a beginning; but it alerted us to the realization that there was a serious need to work towards a more psychological, operational

definition of responsibility, whereby the underlying values could be specified. This need has become more apparent than ever at the present time. If we continue to assume that we are all speaking the same language with similar underlying concepts, we will continue to work more by trial and error than by a logical methodology based on the knowledge of underlying values. It is apparent that we must define our terms of reference in community psychology.

My final point concerns the word "community." The issue is much the same as for responsibility. We all say "community" and we assume that we know what we mean because we can describe a group demographically or by other criteria. In many cases, I am certain that we do have a common understanding of what we are talking about. At least I hope so. But is it possible that some of the confusion, some of our difficulties in community development might be due to the fact that insufficient time and effort are devoted to defining what we mean when we use the word "community"? I believe it has come to assume the position of "client", and rightfully so; but not in its original sense. This is an example of a word which has become so familiar that perhaps we have overlooked the crucial need to be much more accurate as to its veritable meaning. Some may say, "We all know what community means." But do we? Has it not become that place where we work? That group with whom we are consulting?

I was greatly reassured about raising this point when I read Berkowitz's (1982) article on community psychology and the home community. He reflects one aspect of what I am saying as to the lack of meaning the word "community" may have reached.

Ask the naive question: What can I do to make my home community better? Judging from the professional literature, you'd think that community psychologists have no homes — that when night falls, waifs that we are, we pull out office cots. I rarely read

about community psychologists getting involved in hometown affairs. And when we do, somehow that's something separate, something we volunteer to do as private citizens, on our off time.

But some bodies are striving to make their communities better, in their own time. Town employees, for example: also businessmen, media representatives, schoolteachers, elected officials, ministers, youth leaders, others harder to label. Why not us? Do we have any less of a community mandate? These bodies ought to include us, and especially the workday us.

Perhaps it is time for us to apply the journalist's formula to the definition of community: who, what, where, when, and why. Such an application might enable us to study the underlying values at work when we function as academics, or practitioners, or clinicians, or consultants. It would also attune us to the question of how members of a community define themselves as a group.

Let me be more specific. If I were to ask you to define community right now, spontaneously, what would your answer be? Which of the following, if any, of Mr. Webster's definitions would most resemble your own? 1) a body of people having common organization or interest or living in the same place under the same laws; hence, an assemblage of animals or plants living in a common home under similar conditions; 2) society at large; the people in general; restrictedly, the people of a particular region, or the region itself; 3) joint ownership or participation; as, a community of goods; community of interests; 4) common character; likeness; 5) ecology, an aggregate of organisms with mutual relations; applied to any unit of undetermined rank, or as a synonym for a more specific group.

The emphasis on one or other of these definitions could have significant repercussions on how we work in the community, with the community, for the community. I

would suggest that before we begin to identify the needs of a given group, we begin at the beginning and give more thought and time to the definition of that community and ask those members to define it as well. We might be surprised at the possible differentiations to be found not only among ourselves, but among those individuals who have come together as a community. I believe that our work would be far more efficacious were we to do so.

In conclusion, I would suggest that at this point in the development of community psychology — what I refer to as "keeping community in community psychology and community mental health" — there is an urgent need to pause and reflect on those basic principles elucidated early in our history as the discipline of community psychology, when those well-known and greatly appreciated founders worked creatively to provide us with a viable alternative to the traditional scene. Simplistic as those principles may seem, do we really understand those basic concepts? What have we done with them since that time by way of searching out operational definitions which would enable us to solidify our endeavors? Are the terms primary prevention, community development, mental health, program development conceptually clear? Is there a shared understanding of what we mean by them? It is true that there have been many advances in our knowledge of a community approach; efforts have been made towards a conceptual base. But my question to you remains, just what *is* community psychology?

A second point is also a suggestion. I believe that a thorough study of Davidson's succinct study of cultural, political and professional antecedents of community psychology in Canada could serve as an excellent point of reference for a serious consideration and delineation of what is proper to us as distinct from our colleagues South of the border. Let us work on our own unique identity as community psychologists in Canada.

I believe that this dual approach — a return to historical roots and a study of community psychology in Canada — would surely help us towards achieving an honest identity worthy of more respect that we currently receive from our fellow professionals, and certainly from our superiors in academia. As Iscoe noted in his address to the Ontario Psychological Association several months ago, it is important for the psychologist working in the community to know which role he or she is playing in any given setting on any given day. And I would add, that if we know our roles, it would be my assumption that we would understand the underlying concepts and values of that role; that we would tackle the issue of the interac-

tion of theory and practice in every project we undertake; that we would attempt to define and help those involved to define concepts such as responsibility, consultation, development, etc.; and that we would consistently specify what we mean by community in whatever context the word is used.

Those are some of my own objectives and I trust that there are those among you who share the same concerns. With the tension we experience in our society today, I hope that the support we give to one another by sharing these issues will ensure that we remain community psychologists noted for our creative tension — as we run past one another while changing hats to fit our changing roles. Thank you.

RESUME

Le texte qui suit fut présenté à la 43e conférence annuelle de l'Association Canadienne de Psychologie, le 11 juin 1982, à Montréal, Québec. Pour clarifier certaines différences entre la psychologie clinique et la psychologie communautaire, de même qu'entre les théoriciens et les praticiens, l'auteur concentre sa réflexion sur la distinction entre la psychologie communautaire et la santé mentale communautaire. On met de l'avant les valeurs qui sous-tendent l'interaction entre la communauté et le professionnel. On attire l'attention sur le besoin d'opérationnaliser certains concepts couramment utilisés par les psychologues communautaires et d'étudier, de façon spécifique, les antécédents historiques en les situant dans le contexte canadien.

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