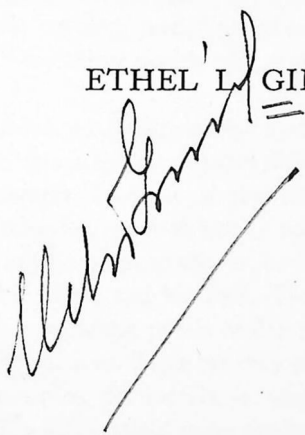
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An institute on mental health in public health held at Berkeley, California, 1948

ETHEL L. GINSBURG



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New York · 1950

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INTRODUCTION

THIS is a report of an institute on mental health in public health, which was held at the Claremont Hotel, Berkeley, California, July 5–17, 1948, under the joint sponsorship of the California State Department of Public Health and the Commonwealth Fund. In this institute eight psychiatrists, three pediatricians with psychiatric training, and five public health leaders served as "faculty" for thirty health officers who comprised the "student body."

In lectures, small daily section meetings, clinic visits, and intersection meetings the participants discussed the application of dynamic concepts of emotional growth and development, motivations of behavior, common human needs, and the nature of interpersonal relationships to the responsibilities and everyday job of the health officer and his staff. The psychiatric "faculty" had much to learn about public health practice and the "students" were good teachers. Together they explored modern mental hygiene principles, not merely as interesting theoretical concepts, but as tools which might make the health department's service to its community more effective.

The student body, as selected by the California State Department of Public Health, was drawn from city and county health officers in all parts of the state. In addition, there were several division chiefs from the State Department of Public Health and three health officers from other states. For the most part, these health officers were selected from those who were interested in the sub-

ject and in a position to share with others what they learned at the institute. In general, the state department attempted to select health officers with formal public health training and sufficient subsequent experience to assure a good working knowledge of the field. Invitations were issued by the state department which arranged for transportation and housing for those who accepted.

In so far as possible, the psychiatric faculty was selected for its familiarity with public health or pediatrics or both, once the basic criteria of sound psychiatric knowledge and teaching skill were met. The five public health faculty members were drawn from those leaders in the field who were especially interested in the development of the mental health component in public health practice. The faculty consisted of:

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The institute program grew out of two preliminary faculty meetings and numerous conferences between the personnel of the California State Department of Public Health and the Common-

wealth Fund. The 1946 Minnesota experiment served as a springboard for the planning discussions and shortened by many months the time that was required for the development of a working schedule.* More than that, it provided tested knowledge about the institute method as a teaching device that enabled the planning group to adapt content and procedure from a course for general physicians in Minnesota to a course for public health officers in California with the assurance that the basic principles were sound.

The working schedule for the two-week period was designed to provide a balanced program of lectures, group discussion, and supervised clinical experience but with ample opportunity for modification as indicated. Special sessions were arranged whenever the students requested them and on several occasions during the second week, inter-section discussion groups were substituted for clinic visits. For the most part, however, the general pattern remained unchanged throughout the institute. Each week-day morning began with a lecture from 8:30 to 9:30, followed by section discussion. The entire group assembled for the lecture each morning and then dispersed to section meeting rooms. There were five sections, each with six students, two psychiatrists, and one public health instructor. Each section also had one observer. These observers were representatives of the central or regional offices of the Public Health Service and the Children's Bureau of the Federal Security Agency. The section groups met from 9:45 to 11:15 A.M. for informal discussion of anything that seemed pertinent at the time, such as the lecture they had just heard or a clinic situation from the afternoon before or a continuation of the preceding

* *Teaching Psychotherapeutic Medicine: An Experimental Course for General Physicians.* Helen L. Witmer, Editor. New York, Commonwealth Fund, 1947.

day's discussion or, as frequently happened, a question that had been the subject of extracurricular discussion late the night before.

The morning section meeting frequently continued during lunch and the drive to the afternoon clinical assignment. For reasons of space and in order to disturb health department clinics as little as possible, the five sections of six students each were subdivided still further. Each group of six was split into two subsections consisting of three students and one psychiatrist with the public health instructor alternating between the two. These ten sub-sections spent weekday afternoons from 1:00 to 5:00 in health department clinics in the East Bay region of San Francisco—Richmond, Berkeley, and Oakland. In the course of the two weeks, each sub-section visited all the different types of health department clinics available in the region and had an opportunity to schedule a return visit to at least one of them.

The clinics included: Prenatal and Postpartum, Child Health Conferences, Crippled Children's Physiotherapy, Crippled Children's Diagnostic, Rheumatic Fever, Tuberculosis, and Venereal Disease. Depending on space limitations or other circumstances, the health officers interviewed patients either individually or as a group. Every effort was made to avoid disruption of normal clinic routine and it was understood by clinic personnel that these doctors would neither advise nor prescribe; they were seeing the patients for the purpose of talking with them in terms of how they felt about coming to clinic, how they felt about the illness or situation which brought them to the health department and about any problems which might be troubling them. Occasionally the patients who were seen had been selected by the public health nurses because of emotional difficulties about which the nurses wanted psychiatric consultation, but in general these were routine clinic patients reporting on schedule. The patients were informed that

these visiting doctors would like to talk with them if they were willing, and with only one exception they expressed interest and readiness. The exception was a young woman whose hesitancy about the interview was clarified by the arrival of her highly-suspicious husband who would not permit her to talk to another man, "doctor or no doctor."

From 4:00 to 5:00 P.M., when the clinic had closed and the nurses and clinicians were free, the institute sub-section and the personnel of the clinic met in the health center conference room for informal discussion of the patients who had been interviewed. These were fruitful sessions for all concerned; the nurses in particular were eager for discussion and help with difficult situations and were in turn able to throw light on obscure points from their intimate knowledge of the patients. Interviewing techniques, the meaning of some of the interview content, the public health implications of emotionally-charged material which had been elicited in interviews—all this was discussed freely in relation to the needs of the patients who had been seen that afternoon.

Evening sessions, though unscheduled, were frequent, and soon after the institute got under way they became almost routine. By the middle of the first week the rooms in which these "bull sessions" could be expected to occur became generally known and shortly after dinner each evening the institute members made their way to the rooms of their choice. These extracurricular discussion groups ranged in size from two to as many as the room could hold and in subject matter, from what to do about a recalcitrant employee to some of the more esoteric aspects of modern psychiatry. "Free-wheeling" was the term most often used to describe these discussions. The sessions served to clarify for the participants many issues and questions that were then brought back to the regularly scheduled section meetings.

The complete program for the two-week period is given below:

FIRST WEEK

Monday, July 5

3:00 to 5:00 P.M. *Entire group:* Introductions. Discussion of purpose of institute and its relation to public health needs. Dr. Dyar, Dr. Kaufman.

Tuesday, July 6

8:30 to 11:15 A.M. *Section discussions:* Interviewing, history-taking, and patient-physician relationship.

1:00 to 5:00 P.M. *Clinics:* Supervised clinical experience and group discussion.

Wednesday, July 7

8:30 to 9:30 A.M. *Lecture:* Parent-Child Relationships. Dr. Spock.

9:45 to 11:15 A.M. *Section discussions*

1:00 to 5:00 P.M. *Clinics*

Thursday, July 8

8:30 to 9:30 A.M. *Lecture:* Emotional Growth and Development. Dr. Sylvester.

9:45 to 11:15 A.M. *Section discussions*

1:00 to 5:00 P.M. *Clinics*

Friday, July 9

8:30 to 9:30 A.M. *Lecture:* Anxiety and Defenses. Dr. Coleman.

9:45 to 11:15 A.M. *Section Discussions*

1:00 to 5:00 P.M. *Clinics*

Saturday, July 10

9:00 A.M. to 12 M. *Panel discussion:* Recapitulation of the three preceding lectures.

SECOND WEEK

Monday, July 12

8:30 to 9:30 A.M. *Lecture:* Emotional Factors in Community and Family Living. Dr. MacDonald.

9:45 to 11:15 A.M. *Section discussions*

1:00 to 5:00 P.M. *Clinics*

Tuesday, July 13

8:30 to 9:30 A.M. *Lecture:* Emotional Factors in Illness and Disability. Dr. Hastings.

9:45 to 11:15 A.M. *Section discussions*

1:30 to 4:30 P.M. *Panel discussion:* Health Education.

Wednesday, July 14

8:30 to 9:30 A.M. *Lecture:* Epidemiology of Mental Illness: Community Factors in Mental Health. Dr. Lemkau.

9:45 A.M. to 12:15 P.M. *Panel discussion:* Community Mental Health Needs and Planning: Community Organization.

1:30 to 4:30 P.M. *Section discussions:* Mental Health Planning within Health Agencies.

Thursday, July 15

8:30 to 9:30 A.M. *Lecture:* Emotional Factors in the Utilization of Authority. Dr. Szurek.

9:45 to 11:15 A.M. *Section discussions*

1:00 to 5:00 P.M. *Clinics*

Friday, July 16

8:30 to 9:30 A.M. *Lecture:* Emotional Factors in Administration. Dr. Zimmerman.

9:45 to 11:15 A.M. *Section discussions*

1:30 to 4:30 P.M. *Section discussions*

Saturday, July 17

9:00 A.M. to 12 M. *Recapitulation and summation.* Dr. Warner.

The time, the place, and the student group for this institute were determined by the sequence of developments in public health practice in California. Since 1946 the California State Department of Public Health has had a mental health consultant under a grant from the Commonwealth Fund. This pediatrician with psychiatric training has served the state department and local health departments in a variety of ways: in-service training for health department personnel; consultation on the mental health implications of public health practice; and interpretation of emotional components in the clinical problems which come to the health depart-

ment. By the end of the first year, the work of the mental health consultant had revealed widespread interest on the part of California health officers in expanding their working knowledge of mental hygiene.*

The institute was offered to health officers rather than to clinicians or nurses for a number of reasons. As the course was being planned, it was recognized that the health officer frequently carries administrative rather than clinical responsibilities. The nurses, clinicians, and sanitarians have more day-to-day contact with patients and clients of the department and could therefore be expected to translate mental health concepts into personal service more directly than is true of the health officer. However, when one seeks to obtain the greatest return on an initial investment, it becomes clear that in a student body limited to thirty it is essential that each student be so situated as to be able to influence a maximum number of co-workers.

Health officers are in a position of leadership in their departments. They make the policy of the department and are responsible for carrying it out. They provide the atmosphere in which the staff operates and can influence individual service to patients by the degree of understanding and interest which they bring to their administrative and supervisory responsibilities.

The health officer is the key person in public health practice. That his heightened awareness will permeate an entire department has been increasingly demonstrated in California by the demands for in-service training for staff members that have come in from all sections of the state. The mental health consultant and his associate in the bureau of nursing have been deluged with requests for institutes, and in several communities the health officers

* Kent A. Zimmerman: "Beginnings of a Mental Health Program in a State and Local Department of Health," *American Journal of Public Health*, 38:811–816, June, 1948.

have enlisted the aid of local psychiatrists in their staff development programs. A representative of the Mississippi State Board of Health who had attended the Berkeley institute went even further. As a result of his enthusiasm and his ability to interpret what he had learned, the Commonwealth Fund cooperated with the Board of Health of Mississippi in another mental health institute in April, 1949, for the health officers of a group of southern states.*

With the exception of the informal evening sessions and the clinic interviews and case conferences, all sessions at the institute were mechanically recorded. This record of the course provides a 5,000 page reservoir of illustrative material from which verbatim quotations are used freely in this report. Editing has been minimal, as required by recording or transcription difficulties.

In compliance with the recommendations of both students and faculty, this report is concerned with the mental health implications of public health practice, with the "broader, more comprehensive concept of public health" which they believed they had acquired from the institute. The report has a threefold purpose as defined by institute members: to help public health workers understand that the local health department is potentially one of the most significant agencies in the community for the promotion of mental health; to offer leads and suggestions to those who may wish to incorporate mental health concepts in staff development programs; and to reaffirm the conviction that training of this kind should be available to students in all professional schools concerned with the preparation of practitioners in health and welfare.

* Mississippi Institute, Edgewater Beach Hotel, Edgewater Park, Mississippi.

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A LEARNING EXPERIENCE

"We are gathered together here for very informal and exploratory conversations in which we hope all of you will take part. You will notice that the psychiatrists have been listed as faculty, but I'd suggest that you not take the title too literally. They are faculty to the extent that they can probably teach you something about mental health and psychiatry, but to my way of thinking, that is only half the purpose of this get-together. From the other side of the picture, you California health officers and visitors from outside the state are likewise faculty: our visiting firemen know a great deal about psychiatry, but they don't know nearly as much as you do about public health. It is your job to give them something about public health. I'd say that each of you will be 50 per cent student and 50 per cent teacher."

These remarks by a public health faculty member opened the first session of the Berkeley institute on mental health in public health. Subsequently the "student" health officers and the "faculty" members were introduced to the group and each was asked to tell briefly why he had come and what it was that he wanted or expected of the institute. The health officers talked freely about their increasing awareness of psychiatric problems and of the need for public health participation in mental hygiene programs. The range of interests as well as the level of psychiatric orientation and, to some degree, the personality differences in the student group began to emerge as they talked.

Some, who were seriously concerned about the need for better

mental health practices in the day-to-day public health job, demonstrated their interest and general orientation by such comments as:

"A health department has a diversified staff with diversified training—physicians, nurses, sanitarians, clerks—and they're all doing some kind of mental hygiene, good or bad. One thing I'd like you to tell me is how to get all these people who are doing this work to do a better mental hygiene job in relation to the public."

"I think I had in mind the problems that the health officer meets in specific situations, such as the impact of tuberculosis on the patient and his family; to a lesser degree, the impact of venereal disease on the patients who come to v.d. clinics; and in a different sense, the problems of families with severely handicapped children."

"I'm interested in the problems of administration, human problems in relationship within the local health department, in the state department, and in the relationships of the state department to the personnel in local health departments and to other professional groups."

"I'm interested in some of the problems associated with the use of authority in the field of public health. We have legal authority in many situations but a lot of us seem to have trouble using it constructively. We also have the problem of administrative responsibility for the use that health department personnel makes of its authority in the community."

"We have a well developed psychiatric treatment program. What I'm interested in now is the development of a mental hygiene program that will draw in not only the medical personnel but all the other staff members of the health department."

"I'm from a rural state but what I want is pretty much the same as what the gentleman from the big city has just described. We

have a specialized mental hygiene program which is largely treatment. I want to learn how to help health department personnel do a better job in its everyday work with people."

"One of our basic problems is the attitude of most people toward mental hygiene. It's a very popular subject. In our state everybody wants to do something about mental hygiene. A couple of local groups have taken leadership but they have little sense of direction. Somebody has to come up with sound advice about the program and how it should go. That's what I'm here for—to get some ideas on how to guide that force. The attitude of the public health people themselves is not too good. You talk to the average health officer about a mental hygiene program and he gets scared, yet when I talk to the nurses I'm sure they're practicing preventive mental hygiene every day."

Others in the group wanted advice on how to set up clinics, how to meet the public demand for treatment services, or how to sell a program to their appropriating bodies. For example:

"We've recently added a full-time psychiatrist to our staff and have given considerable thought to the matter of a formal program of mental hygiene on a local level. I hope that this meeting will answer my questions about the scope of such a program."

"I think my idea was to see if we could get together on some place where we could begin a mental hygiene program in a health department of average size and average financial support. Right now we're rather vague as to where the program begins, and if we don't know where it begins, then we don't know where we're going or how to sell it to our board of supervisors."

"I'd like help in developing a positive community attitude toward a mental health program in public health. All the community seems to want is psychotherapy."

"We've been under pressure to start a child guidance clinic in the health department and we've managed to hold off so far. But

when I get home, our local mental hygiene society will expect me to have the blueprint for a clinic all drawn up and ready to go. I need a lot of help on this."

"I've been waiting for somebody to bring up the kind of problem we have in our county. Not very long ago I had an opportunity to look in on what was going on in the mental hygiene program down there. Four different organizations are offering limited treatment programs for specific groups and if they go along the way they're planning, there will be seven of them in the county, each going off on its own tangent except in the more fortunate places that have official agencies to help develop their programs around a coordinated plan. I don't believe these local mental hygiene societies are too well guided. Generally they're a group of lay individuals who decide that it would be a good idea to develop a mental hygiene program and off they go. They need help and I need help to help them."

Speaking for the psychiatric faculty, one member commented: "From the things you've said it's clear that many of you are under pressure at home to start child guidance or mental hygiene clinics and that some of you are hoping to get advice from us on how to set them up and run them. That's not what we're here for. Psychiatric clinics are extremely important health services but they're only a fraction of the total mental health job. You are in a position to do much more fundamental promotion of mental health in your regularly established public health programs, and from what some of you have said this afternoon you're well aware of your opportunity and responsibility to improve the mental health aspects of your service to your communities.

"That's what we're interested in too, and that's what we're here for: to see if and how psychiatrists can be useful in broadening the scope of public health practice to include mental health concepts. Most of us have been boning up on public health in preparation

for this institute, but our real orientation will have to come from you as we talk about your questions and problems and how to deal with them. We'll contribute what we can from psychiatry, but the application of what we have to offer must be made by you to the job of the public health officer as you see it, not as we see it. We'll learn from you as you apply psychiatric principles to public health and as we learn, we may see new ways of being helpful that we can't visualize now."

Other psychiatrists spoke of the relatively recent emergence of psychiatry from its preoccupation with the hospitalized psychotic patient into the more dynamic treatment of the neuroses, and now into a still more socially-oriented phase in which "we are attempting to apply what we know to keeping people well." Some commented on their own growing awareness of the interdependence of the professional disciplines that are concerned with health and welfare. They pointed out that the promotion of mental health is the job of all professional groups who serve people and that psychiatry can best contribute by sharing its specialized knowledge about people with the doctor, the nurse, the teacher, and others who must carry the major responsibility. In general, the emphasis was as much on what they hoped to learn as on the contribution which they would try to make to public health practice.

Two weeks later the institute members attempted to evaluate this learning experience. Verbally and in writing they outlined the changes in thinking, in approach, and in awareness which they believed they saw in themselves and others. For example:

"Public health is people. That's what we've been talking about these two weeks. We're people, our staff is people, the community is made up of people, and we all have feelings and ways of reacting to and looking at people and things. There are cross-relationships in our administrative activities just as there are in our personal relationships. These are the things we've learned: a new con-

cept of interpersonal relationships; a little insight into things we've known but didn't know we knew; we've learned a little bit about ourselves and a little bit about the other fellow. And, as a result of our exposure to the psychiatrists, we have developed here a concept of public health, not a new concept of what public health is but a much broader, more comprehensive concept than you find in so much of the literature."

And from a psychiatrist: "What we've had here these last two weeks has been an experiment in two-way communication. That's the distinguishing characteristic of this experience. You've applied the psychiatric concepts that we gave you and you've come out with a more comprehensive and therefore more useful approach to public health. We, the psychiatrists, have worked with you in these discussion groups and in your clinics and have acquired a deep respect for the strategic place of public health in the promotion of mental health. And we've learned how to make ourselves more useful to our own health departments back home as well as to the members of other medical and related groups with whom we may be called on to share our knowledge of mental health concepts. I'd say we have just concluded a unique exercise in communication."

There has been considerable speculation about the steps by which the group arrived at the simple but fundamental concept that "public health is people." Usually, these discussions begin with the acknowledged fact that "something" happened during the institute; and that this "something" resulted in changes in attitude and approach to people which could be expected to affect the future professional and personal relationships of the student group. Beyond this point in the discussion most of the comments are usually prefaced by "I really don't know" or "I can't put my finger on it, but. . . ." Some tentative generalizations have materialized from these discussions of this and other mental health

institutes—they will be found in the concluding chapter of this report. As a prelude to the report itself, an attempt is made here to describe the sequence of this learning experience in terms of its emotional as well as educational implications for students and faculty.

There was considerable tension that first afternoon and evening. Even the more enthusiastic members of the student group were obviously ill at ease and their speech was more flippant that day than at any time thereafter. At the opening session otherwise pertinent comments were prefaced by such remarks as: "I came because I understood there was going to be an array of very impressive talent—that's one reason. I thought I might learn something. What I hoped to learn, I'm not sure. Another reason is that the Hotel Claremont is a very beautiful place and has a very nice view, particularly from the bar, and it's much cooler here than it is in my valley."

"My reasons for coming—my motives—were various. I'm somewhat isolated, so I came, first of all, because I received an invitation and then, too, it was an opportunity to come here to the cultural center of the state for a couple of weeks and visit. Last but not least, I hoped something worthwhile might come out of the meeting and I was afraid if I didn't come, I might miss something."

"One of the reasons I'm here is because of the repeated urgings of my chief, but one thing uppermost in my mind was the fear that there would be something worth while and I'd miss it. Whether that will happen at all remains to be seen."

"I don't have very much to add to this confessional. About half an hour ago I had a fairly clear idea of why I was here. Each time I've heard something different and now I don't know why the hell I'm here."

The students were not alone in this; faculty members, too,

tended to be somewhat flippant about what lay ahead. As one observer commented, "Wisecracks were a dime a dozen and they weren't worth that much except as safety valves for the tension." It was in the small section meetings the next morning that this tension and anxiety began to take shape. It was expressed by the students in various ways: in direct or veiled hostility toward psychiatry and psychiatrists; marked resistance to simple preliminary statements which in themselves did not warrant such reactions; fear of interviewing patients after years of being out of the clinic; fear that they might not measure up to what would be expected of them.

The psychiatrists, too, were uneasy in this new situation. They made light of it but the tension in preliminary faculty meetings was clear. Over all their friendly and sometimes unfriendly bickering lay the anxiety of a group that was "on the spot"; that had a body of knowledge to share with another professional group but insufficient familiarity with the students' field of specialization to make for security. Added to this was the ever-present apprehension about the judgment of one's colleagues and the need to do as well if not better than the next fellow. In general, the members of the faculty were somewhat defensive about the vulnerability of their position with thirty public health officers, most of whom knew one another well, thereby representing a kind of united front, and about their exposed position with their psychiatric colleagues.

When the section assignments were announced, the generalized anxiety became focused. The fact that the sections would meet separately was a source of comfort to some but to others it meant that they would be exposed to the idiosyncrasies of a few individuals at close range. Students hastened to check up on the background of the psychiatrists to whom they had been assigned, and

psychiatrists, more discreetly perhaps, asked to have their prospective section-mates pointed out to them.

All sections devoted some part of the first morning meeting to a discussion of the principles of interviewing and how these would relate to clinic visits that afternoon. In each section, anxiety and hostility were revealed soon after the preliminary amenities had been observed. In one group, what started as a discussion of the meaning of asking for help was deflected by, "We have trouble sending people for help. After all, you must admit that there is an innate fear on the part of the general public of the term psychiatrist." Subsequently another health officer suggested that it might be better if psychiatrists called themselves something else and saw patients the first time or two without telling them that they were psychiatrists. Another health officer pointed out the inadequacy of the psychiatrist as a helping person compared with others whose counsel and guidance were accepted and understood, as, for example, the priest.

The psychiatrist leading this section recognized the meaning of the onslaught and handled it indirectly by helping those who hesitated to complete their negative statements and by discussing each of the points realistically. He related them all to the subject of interviewing and its basic premise of acceptance of the other person, of individual difference, and of the depth and character of the average human being who usually has greater strength and potentialities for growth than might appear at the first casual glance. He accepted their negative statements in an easy, unperturbed fashion that made it possible for the group as a whole to examine them and determine with some beginning objectivity whether or not they were valid. He also dealt with their hesitancy about interviewing clinic patients by assuming that this was one of the things they were there for and that while he and his colleague would be

available to give them every support, the health officers would be expected to interview patients rather than to watch the psychiatrists.

In another section that morning the offensive began with: "I understand that for each section there's a kind of order of clinics which has been arranged so that shifting from one section to another might cheat you of some particular type of clinic that's been arranged for each section. The smart thing to do would be to have a system of shifting instructors." The section had not yet been called to order before this health officer was suggesting a shift in instructors. That he was not alone in this was clear in subsequent discussion. The idea had been worked out the night before by the health officers in the section, almost as a kind of anticipatory defense against what might lie ahead.

There was also some expression of resentment at the fact that the students had not received specific information about just what was to happen and in what sequence. "We don't know what's going to happen next. They keep us in the dark, you know." There followed an interesting bit of by-play between this health officer and a colleague, in which they tried to demonstrate for the benefit of the psychiatrists, why the faculty rather than the students should do the interviewing in the clinics. "I've been in public health administration for a good many years, so what do I know about the practice of medicine or about feeding a baby? If the mother doesn't know more about it than I do, she's just out of luck." Or, "I don't think I'd gain very much by being put in a clinic and just told to go ahead and then have somebody criticize me because I don't know how to do it. We ought to have a background of observation first and then perhaps in the second week we could be put on our own."

Another health officer in this section took the discussion from the theoretical to the concrete with the presentation of three prob-

lem cases about which he wanted psychiatric consultation. When these had been discussed and the contents used to point up health department function and interviewing principles, the session went on to develop the concept of relationships between people; doctor-patient, administrator-staff member, public employee-community.

A third section was launched by: "My roommate is in another section and he said that last night they had considerable discussion as to who would do the interviewing—the instructors or the students—and they finally came to the conclusion that the instructors should do the interviewing." After some mild discussion of this point, one of the health officers added, "We want to see how you psychiatrists would go about it." This was followed by, "The folks back home want me to bring back suggestions as to how to do their interviewing better. What I came here for, I don't know. It won't do them any good to have me tell them about my interviews, but if I watch the experts, I might learn." After a reasonable lapse of time and sober consideration of these arguments, the psychiatrists, with the help of the public health faculty member, turned the discussion to the clinics, the administrative arrangements for their visits, how the interviews might be worked into clinic routine, and then, eventually, into the principles of interviewing.

In still another section, resistance took a rather different form. This group had met the evening before and had spent about two hours discussing the principles of interviewing. A trend that was noticeable in this group throughout the two weeks became evident at that time and was pursued vehemently the next morning. Group resistance in this section was frequently channeled by one articulate member into philosophical byways that tended to obscure the main point under discussion at a given time. For example, during the preliminary evening session the discussion of interviewing was sidetracked by the introduction of a somewhat aca-

demic consideration of the "purposeful" versus the "open-end" interview. The morning session began with some of the basic concepts of observation and relationship in the interview and found itself within the first ten minutes at a temporary halt because of the introduction of a philosophical question as to group participation versus lectures by faculty members. And again, when the session had moved on to interviewing principles and their application, there came a question which led the discussion into still another philosophical blind alley, "What do we want to get out of these two weeks? Do we want to get the ultimate in streamlined practicalities, or do we want to indulge in more serious and fundamental considerations?" A little later there was a comment to the effect that it would be necessary for the psychiatrist to become more sensitive to the public health situation in order to know how to adapt psychiatric principles to the needs of the student group. "The basic problem is that the psychiatrist thinks in terms of thirty days and we think in terms of thirty minutes."

Soon thereafter the group launched into a detailed discussion of the difference between the psychologist and the psychiatrist. What they were saying, as they discussed the training, function, and overlapping responsibilities of the two professions, was quite clear: Psychologists can do everything psychiatrists can do and, besides, they give tests. Why, then, refer anyone to a psychiatrist, especially when they are so often confused about their own area of function and can add little to the situation beyond that which is already known to the referring source?

After this conversational ball had been tossed around the room to the point where it was becoming repetitious, one of the psychiatrists brought the situation to a head with this gentle comment: "I wonder whether you aren't telling us in a not very devious fashion, 'You psychiatrists go home and clean out your house before you come and tell us anything.' " He was assured that if this were

the implication it was certainly not intentional. He indicated his understanding of the situation, assured the group that psychiatry, in common with other professional groups, might well clean house, but that the purpose of this institute was the sharing of knowledge and attitudes that might be useful to health officers. He then pulled the discussion back to interviewing and the clinic visits scheduled for the afternoon. This cleared the air and enabled the group to move forward on a much more comfortable plane.

In the fifth group there was little tangible evidence of anxiety or resistance, perhaps because much of the session was carried by the two psychiatrists on an alternating basis. Interviewing, the meaning of behavior, the validity of observations, the use of recording were covered in semi-lecture form with little participation by the students. On only one occasion—when the need for privacy during interviews was being stressed—did one of the students point out that the idea was fine in principle but that his health department was not built to provide such luxury.

It would have been difficult, perhaps impossible, for the students to see that they were expressing anxiety and resistance in some of these delaying actions or in the skeptical, sarcastic comments that were heard during the first day or two. Had they been told that they were resisting the people from whom they had come to learn and the concepts which they were being asked to consider, they would have denied it vehemently and honestly. Yet to the dynamically-oriented faculty and observers the evidence was clear. And it was equally clear that the psychiatrically-sophisticated faculty was also anxious. Faculty members tended, as do all human beings, to fall back on their individual ways of dealing with anxiety in new situations: some talked too much, others too little; some turned for protection to elaborate psychoanalytic terminology; some gave the typical psychiatric lectures

with which they were most familiar; and some became involved personally in arguments which had little rational basis.

This initial anxiety is inevitable in such situations and the employment of defensive tactics is likely to be its unconscious corollary. Seldom, if ever, does the individual involved have such complete objectivity that he sees himself as others see him. The psychiatrists saw clearly the evidence of anxiety in the students and in their colleagues but each was less prone to see it in himself. Fortunately, experience has demonstrated that under favorable circumstances the anxiety phase is temporary. Also, it would appear reasonable to think that it is a necessary prelude to the kind of relationship that must be developed if the experience is to have any fundamental meaning to students and faculty alike.

If the faculty member sees the institute as just another routine situation in which he tells a group of students what he thinks they should know about psychiatric concepts, he will have no anxiety but neither will he make a basic contribution to the group. If the student comes, as if to a lecture, to listen attentively or otherwise to information which he may or may not understand or accept, he has no more anxiety than he would have when attending a mildly educational film. The result would be just as minimal: a new idea or two, but no meaningful participation in an experience that should involve him personally if he is to learn and accept concepts that may be as painful as they are fundamental to his understanding of himself and others.

The clinic visits the first afternoon served to relieve much of the faculty's anxiety, while it dramatized for the students the skill of their instructors and the validity of what they had been saying that morning. The sections came back from the clinics vying with one another, each group describing the exploits of its instructors and the skill with which they had been able to elicit fascinating emotionally-charged information from people who had seemed to

the students to be run-of-the-mill public health clinic cases. In one or two groups the material coincided so neatly with the subject of the morning discussion that the only term that seemed to do the experience full justice was "miracle." This was equally true of the groups in which the instructor interviewed patients on a demonstration basis; those in which he asked the patient a few questions after the health officer had completed his interview; and those in which the instructor pointed out the implications of the material which had been elicited by the student.

In child health conferences, venereal disease clinics, tuberculosis clinics, and crippled children's services that afternoon, ten groups working separately and in different ways began to see demonstrated the fact that all behavior is motivated; that even seemingly commonplace situations have emotional connotations which are related to the participant's earlier experiences; that the way in which one listens to people and reacts to them can influence a relationship positively or negatively; and that in a few minutes a skilled interviewer can elicit more pertinent information about an individual than the average person might learn in months, if at all.

This was the beginning of the next phase, also inevitable and necessary in this kind of teaching relationship—the identification of the student with his teacher. Soon the students were not only accepting the specialized knowledge of the psychiatrists but found themselves, sometimes unconsciously, trying to imitate them. They began using their words or phrases, aping some of their opening techniques in the interview and indulging in serious discussions about psychotherapy and who might practice it. Without this identification little can be anticipated in a two-week institute. There is some degree of identification between student and teacher in any sound educational experience but it is especially important in an institute of this kind for at least two reasons: The material

under discussion is fraught with emotional significance to the student and is bound to arouse resistance and anxiety as he attempts to assimilate and make it his own. And the need for speed, if essential material is to be well covered in a two-week period, makes it necessary to avoid the handicaps that are imposed by negative or only mildly positive relationships. The value of this identification with the instructors has been stressed repeatedly in post-institute discussions. It has been variously described as the "spark that sets the whole thing off," the "pump-primer without which you're just talking and nothing clicks," and the "emotional groundwork that is absolutely necessary if you're going to get your ideas across."

In retrospect, however, it is possible to see some of the dangers in this identification. While a reasonable degree of objectivity is assumed to be part of the equipment of a dynamically-oriented psychiatrist, he is nevertheless prone to reactions which are common to most of us. Therefore, when students are obviously awed by his exploits, he is understandably tempted to prolong them in order to merit the continued admiration of the student. This was demonstrated during the institute in a number of different but essentially similar ways. The students' expressions of admiration for their interviewing skills led some psychiatrists to continue to interview for the group somewhat longer than was necessary to prove their point. Others made it a practice to come in on interviews after the students had gone as far as they could and in each case their superior skill brought forth emotionally-charged material that the student had not known was there. Up to a point, demonstration and repetition are sound pedagogical techniques. When they are carried beyond that point, however, they may serve to enhance the instructor's position, but they do not contribute materially to the students' growth.

There is a more basic fallacy in this approach than that involved

in the instructor's personal need to belabor a point. The real danger lies in the tendency to delve more deeply into the patient's personality than the situation warrants. In some instances this resulted in the collection of considerable dynamic information which demonstrated how much one could learn if one knew how to seek it but did not indicate to the students what use was to be made of the information within public health limits and responsibilities. The problem for the psychiatrists who had not taught in similar situations and who were primarily oriented to psychotherapy was that of somehow realigning their goals in the interview.

This is a problem for all psychiatrists who try to share their technical knowledge with members of other professions, who must in turn adapt this knowledge to their own needs. The psychiatrist whose entire professional training and experience have been oriented to the treatment of patients with emotional difficulties usually gears his interviews to diagnosis and the evaluation of treatment potentialities. In order to teach a group of health officers, it is essential that the psychiatrist think of the interview not primarily as a diagnostic situation in which the physician is attempting to determine the advisability of psychotherapy or the patient's availability for it, but rather as the beginning of a relationship between a representative of the public health department and a patient who comes or is brought for one or another kind of medical service. In order to serve a patient who is thought to have tuberculosis the doctor needs to know something about the patient's feelings, how he customarily deals with serious, anxiety-producing experiences, and as much as the doctor can learn about the patient's physical, emotional, and social resources. He is interested in this information for a purpose, namely, to be of help to the patient in the latter's struggle to deal with the problems of his disease and of the altered life pattern resulting from a chronic illness. To go beyond this is to delve into material which

is not pertinent to the situation and which in most instances the doctor is not equipped to handle. To uncover and make the patient aware of painful emotions with which the interviewer is not qualified to deal and which do not fall within the scope of the agency's function is to do the patient a disservice.

This is a dilemma which faces all psychiatrists who teach members of other professions. It is a serious dilemma because it is only by revealing the underlying feelings and motivations that one can drive home to the student the validity of dynamic concepts. But to do this is sometimes to uncover unnecessarily painful material which cannot be handled in the teaching situation. In the institute this dilemma was solved with varying degrees of success by the eleven psychiatric members of the faculty. Those who had more than a passing knowledge of public health seemed to have less difficulty in keeping the interview material within the scope of a health department's function. Some of the others tended to demonstrate the depths to which one could go in a single interview with the average health department patient. This difference was more evident in the early days of the institute when each instructor was trying to establish himself with his students and demonstrate the validity of psychiatric concepts.

A useful corrective device was the bull session. These informal get-togethers began at dinner and frequently continued long after midnight. The students' bull sessions sometimes lasted until dawn and occasionally they "went out and corralled a psychiatrist." There was a continuous interchange of ideas, experiences, and questions among faculty and students, with the result that each participant had the benefit, informally, of a running account of what was going on in all sections and sub-sections. The recorded sessions give only a partial picture of the range of discussion. The regularly scheduled sessions were time-limited and even though discussion was lively and only minimally controlled, they did not

have the free-wheeling characteristics of the bull sessions. It was in the latter that many fundamental psychoanalytic concepts and other ideas less pertinent to public health practice were explored. One of the more frequent opening comments of the morning sessions was "In our bull session last night we got into. . . ." Often what they had got into was found to be rather esoteric in the cold light of morning and the subject was not pursued further. It did, however, serve to keep the group on its toes emotionally as well as intellectually and to make the members much more receptive to concepts that might have taken somewhat longer to present in a situation which brought students and faculty together only during daylight hours. Actually these two weeks were the equivalent of a much longer period, since the group thought and talked about very little else on almost a twenty-four-hour schedule. The heightened awareness and receptivity of this kind of intensive experience can be recognized, if not evaluated.

One of the assets of the California institute was the fact that the student group was composed of individuals who knew one another, in some instances very well. This might make for rivalry, but in this institute the fact that most of the students were on first-name terms with each other and with some members of the public health faculty was of distinct advantage in getting things under way early. Also, one of the two psychiatrists in each section had had at least a working knowledge of public health practice, three of them in the state of California. It took only a day for the others to begin to realize the extent of their ignorance about public health and the importance of learning from their students about the scope and responsibilities of a health department. The readiness with which they admitted their ignorance and asked for orientation from the students was the measure of their own security and the extent to which they could enter into a two-way learning experience.

Even those who needed to cling longest to the psychiatrist's orientation to patients found that the core of the learning experience for the students rested in the problems, experiences, and questions which the health officers introduced into the discussion. If a concept could not be related to the functions of a health officer, such as administration, health promotion, or disease control, it remained a meaningless theory and, as such, essentially useless. In some sections the psychiatrists continued to give examples from their own experience longer than was true of others, but before the institute was half over, generalization gave way to specificity and the health department was drawn on almost uniformly for illustration and application of all concepts. This was especially true as soon as there had been sufficient experience in the daily clinic visits to which to relate points under discussion.

In planning the institute, much thought had been given to the integration of lectures into the sequence of the course. How many lectures, at what time of day, in what order, and for what purpose are some of the questions to be considered by any group organizing an institute of this kind. It had been determined in the course of the Minnesota experiment that lectures must keep pace with group progress; that two lecture periods a day were too much; that the early morning lecture, when the group was fresh, was the most satisfactory, while an evening lecture found the audience too exhausted to be attentive; and that the content of the lectures was useful only in so far as it provided a coordinating framework for the smaller section discussions.*

On this premise, the first lecture, by Dr. Spock, was given the second morning. At this point the group had already begun to

* *Teaching Psychotherapeutic Medicine: An Experimental Course for General Physicians.* Helen L. Witmer, Editor. New York, Commonwealth Fund, 1947.

discuss interpersonal relationships in the interview situation and had spent an afternoon seeing clinic patients, followed by a section discussion of their interviews. In his informal lecture, Dr. Spock talked about the mother-child relationship as seen by the pediatrician or child health conference clinician and indicated some of the feelings and experiences which might give rise to the behavior which the doctor observes.

The following morning Dr. Sylvester discussed the principles of emotional growth and development in infancy, childhood, and adolescence, pointing out the relationship between the biological progress of the infant and his gradually evolving personality structure. Dr. Sylvester sketched for the group the interplay between the emotional needs of the child and the environmental forces which aid or impede the ultimate achievement of emotional maturity. The next day Dr. Coleman talked on anxiety and the defenses which we tend to build up in order to deal with anxiety. He related his material to the stages of growth and development which Dr. Sylvester had introduced the day before, pointing up the inevitable anxiety-producing characteristics of the major crossroads of growing up. On Saturday of that week these three lecturers served as a panel to lead group discussion of points which they had made and to amplify those which appeared to require it.

Observation of section meetings during the week reinforced the general impression that the lectures were keeping pace with group progress and that they served to focus the general development of dynamic orientation. Frequently one heard opening remarks in the sections such as: "When Dr. X was talking this morning about how we handle anxiety, I thought of that t.b. patient we saw yesterday"; or, "You know, it was interesting to hear him say that the emotional tone of a mother's feeling for her child gets transmitted to a baby regardless of words or deeds. That's just

what we were talking about yesterday, that you don't have to put on an act for a baby—if you love him, he feels it and if you don't, he knows it no matter how you try to cover up."

At the beginning of the second week, Dr. MacDonald discussed the emotional factors in family and community living, with special attention to anxiety-producing situations which arise in the lives of many people, such as the broken home, sibling rivalry, physical defects, unhappy school experiences, minority group handicaps, inadequate housing, inadequate recreational or employment opportunities, and marital problems. She discussed these briefly in terms of the impact on the total human being of such additional obstacles to the already hazardous task of growing up. This material was clearly in line with the situations which the sections were seeing in the clinics and discussing in their daily sessions.

The following day Dr. Hastings, in a lecture on the emotional factors in illness and disability, discussed the so-called psychosomatic aspects of illness with less emphasis on the commonly accepted psychosomatic conditions than on the emotional components in all illness, with special reference to those frequently encountered by the health officer. The group was intrigued by Dr. Hastings' presentation of the "ladder" concept of personality development. He pointed out that the gradual climb toward maturity is very much like climbing a ladder, not steadily upward but fluctuating, moving forward and then regressing a little as the individual loses ground for one or another reason. Illness is known to influence this fluctuation in a downward direction, with the result that a serious illness is certain to produce regression to a point far below the individual's normal level on the ladder. In several of the sections later that morning the health officers commented on the simplicity of the concept and the ease with which they were

able to apply it in thinking about situations with which they were familiar.

That afternoon, in response to numerous requests, a session on health education was arranged for the entire group led by the public health members of the faculty. Everyone participated in this session, which was limited only by the clock and the necessity for relinquishing the room. Discussion spilled over into smaller groups and continued throughout the evening. This session had its frustrations for those who had hoped that it would result in a precise definition of health education and how to go about it. But it was an extremely useful experience for all who participated, because it pointed up the confusion as to purpose, method, and emphasis in health education today, even among well-trained and experienced public health personnel.

Whether a health department undertakes health education to enlist public financial support of the department's program or to teach people good health habits or to arouse citizen interest in public improvements or a combination of all of them was not clear when the session started and only slightly less confused when it ended. On the other hand, a good deal of clarity was achieved on the question of method. Here the effectiveness of the institute was revealed at every point in the discussion. The students' comments on the mental health implications of health education were indicative of their assimilation of psychological concepts to the point where they were able to apply them spontaneously at appropriate stages in the discussion. There was general agreement on the importance of timeliness and the readiness of individuals or groups to be educated, together with acceptance of the premise that an individual's availability for education is a variable that is seldom given enough weight in most educational programs. And there was unanimous agreement on the anxiety-producing dan-

gers of the fear motif of some health campaigns which have fund raising as the immediate goal.

The next lecture, by Dr. Lemkau, on the epidemiology of mental illness was well timed. The students were now familiar with many of the basic psychiatric concepts and they had sorted out and were using correctly the psychiatric terms which are frequently confusing to persons unacquainted with the field. They were ready at that point for Dr. Lemkau's discussion of the common misconceptions about the epidemiology of mental illness and for his well-documented presentation of the scope and limitations of the application of epidemiological methods to mental disease.

The remainder of the day was devoted to the subject of community organization, with a panel discussion in the morning and the sections meeting in two large groups during the afternoon. This, too, proved to have been well timed, coming as it did after ten days of section discussion in which the health department's responsibility to the community came in for frequent mention. Members of the faculty who had had the widest community experience formed the panel, each giving briefly a portion of the total picture of the interrelated services to be found or sought in any community. Prior to this panel discussion, the stage was set informally by asking the students to list, from their own experience, the services which were available to them in their communities for the kinds of social and health needs that might arise among people anywhere.

The goal of this day's discussion was a comprehensive picture of the interdependence of community services, the place of a public health agency in the total network of services, and the responsibility of the health officer for spearheading community action when unmet needs are revealed. The health department's specific responsibility in a local mental health program was given consid-

erable attention in response to numerous questions which the health officers had brought to the institute, about whether and how to set up mental hygiene clinics. That these questions were answered to their satisfaction was demonstrated by their clearly expressed understanding of the broad scope of a mental hygiene program in which psychiatric clinics represent only one facet. Further evidence of this understanding has been forthcoming since the health officers returned to their jobs. A recurrent note in all reports from these men has been concerned with the comparative ease with which they now enter into community organization activities and the difference in the orientation which they are able to give local groups interested in mental health, as a result of their institute experience.

The next lecture by Dr. Szurek on the emotional factors in the utilization of authority was for many of the students the high point of the institute. It is included in this report because of the great interest which it aroused and the use which health officers have made of it since then. This lecture seemed to tie together for the group all that they had heard during the institute about motivating factors in behavior and relationships. It was especially pertinent to the experience and interests of health officers, to their administrative responsibilities, and to the legal authority which they represent. There was much discussion, largely academic, about the timing of this lecture and whether the impact would have been as great had it come at the beginning rather than near the end of the institute. Another moot question had to do with the prepared paper—which this was—versus the informal talk, and again the pros and cons were discussed at length. The eventual resolution of this pedagogical conflict will depend on subsequent experience in institutes of this kind; however, majority opinion in this instance held that the students would not have been ready for

the lecture earlier in the course and that the informality of the delivery counteracted any of the disadvantages that might ordinarily have accrued from a formal paper.

The last scheduled lecture of the course, by Dr. Zimmerman, was an informal discussion of emotional factors in administration, in which he applied Dr. Szurek's material to the everyday administrative problems and relationships in a health department. This was familiar ground to the health officers and they readily agreed with Dr. Zimmerman as he related mental health concepts to these important aspects of their work. The ease with which they followed his points about the impact of administrative procedures and routines on the individuals who are enmeshed in them was still another indication of the development of insight in this group.

The institute was brought to a close the next day by Dr. Warner, whose summary of what she thought it had accomplished was dramatic in its simplicity. It is reproduced here as the most fitting commentary that could be devised on the nature and meaning of this experience:

"To review what has happened seems a monumental, if not impossible, task. But there are a few highlights that we, as administrators in public health, need to note because they are applicable throughout all public health organizations—federal, state, or local.

"The first thing worthy of comment, I think, is that for two weeks we've been together daily from 8:30 in the morning until all hours of the night, discussing varied public health problems and related matters. However, contrary to our usual assemblies of public health officers, there has been no mention of budgets, standards, or regulations. Nor have we mentioned organization or administration as reflected in the kind of chart-form we so love to devise and talk about. Such items have been singularly absent. They may have been referred to in section groups on an occasion

or two. In our section, for instance, the use of an organization chart was referred to, but we soon discovered that it didn't mean too much, other than as a diagram of activities to meet areas of need and to indicate lines of responsibility from health officer to staff. We soon dispensed with the picture, having determined that it merely illustrated a framework upon which a developing program could be planned and projected and was a means to an end, not an end in itself. Our real organization, our real activities, programs, and functions were concerned with people—a patient, a staff member, a county commissioner, a PTA group, or the aggregate of them all, the community. The tools or techniques of administration that we use have little purpose unless the approach, the planning, the administration, and the services rendered are geared to and tempered by an understanding and appreciation of people, individually or collectively. That, I think, has been brought into high focus throughout our discussions, and provides a concept of 'administration' which we shall well remember and utilize.

"Now, at the end of two weeks, we've all been brought to the realization that out of this experience 'something' has happened —an intangible something. It may be an experience that will not be fully realized immediately and each of us will have his own interpretation of it. But we are agreed that concepts have changed; concepts of our jobs have undergone a change that would be hard to define. It may be that the crux of this change has been our increasing awareness that the structure of administration is based upon the interrelationships of people—doctor-patient, administrator-staff, staff member-staff member, the whole health department to the community. If we keep that in mind as we return to our administrative jobs, as we look at our activities programs, as we look at the content of our services, then we will begin interpreting the 'something' we have experienced into actual function.

"How did this happen? Well, these are some of the things that contributed: here were lectures to present background material on growth and development. We've had such material before, but this time it was presented from a different focus. Major emphasis was upon the emotional development of the infant and the growing child, but in lectures and discussions we did not neglect the mature individual, the adult and the aging. We saw the emotional pattern as a continuous process; we saw that no matter where one might come in contact with an individual—the child, the adult, or the aged—it is possible to influence emotional or mental health for good or ill.

"Too, we discussed the interview and began to understand some of its implications. We have all done interviewing in the past, but out of this experience we have arrived at new concepts of the interview which on Monday morning when we get back to our jobs can go straight into practice. Patience is a part of the technique—listening with understanding and not becoming irritable, listening with a background of awareness of what may have brought the person to you—whether it be patient, staff member, a 'griped' citizen of the community or a pressure group; listening with some appreciation of human and individual behavior, with understanding and respect for the person's point of view; sifting out what is of value; applying judgment and taking whatever action seems indicated or possible. Of course, all this is not new but it is striking here because we have seen its use in a new relation to our daily tasks. From morning till night we interview people for one reason or another; the new concept we have obtained gives more meaning to this important instrument which is used throughout our health department activities.

"We discussed authority and its use, the line of authority from administrator to staff. The expression we often used was 'sharing of responsibility.' By direct statement, by implication, it was

brought out that the strength of the administrator was not in his doing the job alone, but in how well the members of his staff could share in responsibility and help carry the total load of health department activities. Dr. Szurek, in his paper on authority and its use, brought out quite clearly that the strongest administrator is the one who is willing and able to delegate authority and responsibility, who is not too eager to retain all the praise and the glory, who is willing to share honors as well as responsibility. After all, the strength of a health department lies in the total group, not in any one individual; in the organization and utilization of the total staff; in the relationships within the staff; and in the community.

"It is so easy to think and speak of our activities as being departmentalized, to be possessive of duties assigned to others, or for staff members to be possessive of their assigned duties or programs, with the result that jealousies and personality conflicts begin to develop. The administrator has a job to perform in the development of relationship—his own to the staff and that between staff members. I think each of us, as we listened to Dr. Szurek's lecture and as we have gone through these two weeks, has done a little 'research' of his own and found that perhaps some of the happenings and situations in our own organizations might be traceable to the fact that these relationships had failed to produce a unity of purpose: a group service to a community and not the pursuit of any single section or phase of a total program which one might possessively claim as 'my job.'

"We discussed the community itself. What motivation lies behind community action? Out of that came interesting ideas—again not new to us, but ideas which, as we exposed and aired them, seemed to have different meaning. What does community organization mean? Well, it means something different to each of us, but throughout the discussion, community organization seemed to relate to three things which seemed important. One was the knowl-

edge on the part of the administrator of the different activities within the community: what groups or organizations were doing; how their interests might relate to the health program; cataloging those interests in his mind for future use and as situations arose, seeking assistance, technical advice, and general counsel, and correlating action as the occasion indicated.

"The second point in organization was that too often we go to a group or agency with a superimposed plan of action. After all, community groups do have interests of their own, and it is our job to utilize that interest, find where that interest is focused and develop from that point the program that suits them. The interchange of ideas, the sharing of responsibility, the planning and understanding that ensues—these lead to action.

"The third point concerned recognition. We mentioned it several times in relation to individuals, staff associates, and groups. It is equally important in our working relationships with community groups. Recognition and respect both require our serious attention and help us arrive at our common goals.

"Leadership was a word we often used. We've learned that leadership is a matter of understanding and evaluation, judgment and willingness to accept other points of view. It just does not grow independently. It is based on relationship to the individual, the group, the community. Our techniques may vary, we mentioned different ways to develop leadership. We realized that in a health department, the total personnel, not only the health officer, is responsible for providing 'leadership' in its relationships as it carries out the activities of the health department.

"Of course, the purpose of our being here was to arrive at a better understanding of what a health department might do in the field of mental hygiene. We came here, all of us, from more or less common occupations, but with several different interests as our reasons for coming and many questions in our minds. We have

an appropriation for mental hygiene; how are we going to use it? What kind of a program should we be planning, what activities can we carry out? Should we have a mental hygiene clinic? Well, I think we are going home with a very different understanding of mental hygiene from that which we brought with us. We've found that we have been doing mental hygiene all along, whether it was done well or poorly. One cannot come in contact with an individual or a group without utilizing or practicing some of the principles of mental hygiene. The concept of what interpersonal relationship means has been interpreted for us as a part of a mental hygiene program. Certainly one cannot say that an interview with a patient or a staff conference is worth $2,000 or $10,000, but they are one phase of your mental health program.

"Another thing we have learned is that in a mental hygiene program, we do not have to do the whole job ourselves; that the many resources of the community—some of which we have never thought of as being related—can be explored and utilized in a mental hygiene program. The strength of the program depends on how far a community can reach to share responsibility and develop resources. As has been said, it doesn't make much difference where you begin, whether you begin with a clinic and go back into the community to strengthen resources or begin with the development of community resources and go forward to a clinic. If you begin with the community and go forward to the clinic, you will find at every step the need for professional technical services in mental hygiene. If you begin with the clinic, you go back and find the need for supporting agencies. Whichever way you begin, you arrive at the same awareness of needs.

"Throughout, the health department role is one of interrelationship with other community resources in studying needs of the community, assisting in providing professional and technical resources and some leadership in the planning and conduct of train-

ing and service. Personnel—we hear that day after day—the lack of preparation and training of personnel for services in mental hygiene programs! I believe, however, that we are more aware now of what we can do in mental hygiene in our departments and communities despite the lack of professional psychiatric personnel.

"We are going home in sort of a maze—I am and I'm sure you are. But there is one thing that is going home with each of us and that is a very clear understanding that the health department has a terrific responsibility. It seems almost superhuman for one individual—the health officer—to carry out all the responsibility that is thrown to him. However, if we think of the health department as a unit, the staff working side by side, sharing with the community the interests, the action programs, the responsibilities, but offering leadership, creating awareness, pointing the way to action, then it becomes a little less of a burden on the shoulders of Atlas.

"No matter how we look at the health department—my job, your job, our job—we depart from and come back to the fact that whatever we may develop, use, or project as a program or service must be translated into the effectiveness of the interpersonal relationships of the administrator to the staff, the staff members to staff members, the total staff to the total community."

WHAT THEY LEARNED ABOUT PEOPLE

"MENTAL hygiene begins at home and I think I understand more about my own motivations and reactions to individuals and situations than I did before. Also, I really believe I'll get twice as much understanding out of talking to, or rather listening to, people as I did before, whether they are my staff, patients, or bosses."

The increased understanding of motivations and behavior which this health officer believed that he had acquired was an outgrowth of his acceptance and application of dynamic psychiatric concepts to personal as well as professional relationships. Others were less articulate but indicated in one way or another that they were approaching their relationships with people in a different frame of mind. There was general agreement that the job of the health worker was of much deeper emotional significance to both the worker and the recipient of his services than they had ever realized. Many of the health officers were heard to comment that they were seeing the child health conference mothers and babies in a different light and that they were beginning to understand the potential mental hygiene value of a positive relationship between a health worker and the mother of a young infant.

As the institute progressed, the health officers speculated about the basis for this new attitude and attempted to summarize for themselves what they had learned. As they did so, they saw that it was in the realm of their feelings about people that the greatest change had occurred. Even those who had been familiar with the literature on emotional growth and development realized that

without the intensive experience in clinical demonstration and group discussion the concepts would have remained largely theoretical.

Out of the students' attempts to summarize what they had learned about people, it is possible to define a basic theme and to present in broad outlines some of the concepts about behavior and its motivations that they took away with them.

The theme is that of dynamic psychiatry which is predicated on the assumption that the development of personality is a continuous process which begins with the beginning of life and ends at its termination; that from cradle to grave, therefore, the human being is changing, growing or regressing but always in flux, as there continues the largely unconscious effort to reconcile inner strivings and outer forces in the search for the emotional balance which is essential to effective adjustment.

As this theme was developed in relation to specific case situations and problems, with lectures to focus and amplify some of the basic concepts, the health officers were able to synthesize for their own use a simple running picture of emotional growth and development. The summary which follows was compiled from recorded material and notes on extracurricular discussions. It is not the complete story of emotional growth and development; it was not possible, nor was it desirable in these two weeks, to attempt a detailed discussion of the theory of the unconscious or of all the ramifications of psychosexual development. It was enough that the students accepted and were able to apply in practice the concepts that all behavior is purposeful and that much of it is unconsciously motivated; that life is a cumulative experience; that the adult carries within his person some residue of every thing that has happened to him from infancy; and hence, that both positive and negative experiences are reflected in the individual's later life adjustment.

Very few technical psychiatric terms were used either in lectures or discussions and even those were paraphrased by the health officers as they began to understand their meaning and application. This, then, is an approximation of what the majority of the health officers could be said to have acquired in the way of a working philosophy about people:

"The personalities of all of us are built out of similar bricks, similar units of need and behavior." The composition of the bricks may vary and the vulnerability to wear and tear may differ in degree. But while it is recognized that each human being is a separate and unique entity, it is nevertheless true that all human beings are subjected to certain common experiences. How successfully the individual makes his way through the inevitable crises of growing up will depend in part on what he brings to each stage of development and in part on the special circumstances which he encounters.

These stages may be defined as the chronological periods when major biological and emotional readjustments are demanded of the individual. They are the periods—infancy, childhood, adolescence, adulthood, and old age—when changes occur in body structure and organ systems which affect the functioning and adjustment of the total individual and which in turn are affected by environmental forces. Within these broad time periods, which are not subject to precise definition in terms of months or years but which flow into one another almost unnoticed, each of us encounters minor crises that are characteristic of that stage of development.

Not all of us have exactly the same sequence of minor crises but all of us have generally similar experiences. The infant reaches the point eventually when he is no longer fed by an adult in the manner to which he has become accustomed but is expected to drink his milk from a glass and to take solid food. In early child-

hood most youngsters in our culture start school, their first major separation from home. In adolescence young people are faced with a bewildering array of new or reactivated physical and emotional crises. As mature men and women we meet and adjust to the crosscurrents of adult life involving work, marriage, parenthood, and responsibility for ourselves and others. In old age we are faced with the opposite side of the coin, dwindling physical resources and a general retrenchment that may be markedly at variance with the tempo and productivity of middle age.

The process of individual emotional as well as physical development begins, of course, at the time that the infant is separated from the body of the mother at birth. Before that time they are interdependent in a way that cannot be duplicated once the process of delivery cuts the cord and requires the baby to begin using his own respiratory apparatus in order to live.

It is entirely reasonable to assume that the infant will only slowly relinquish the physiological-psychological advantages of fetal security. The mother, too, must be expected to need a period of reorganization, emotional as well as physical. Objectivity about this new creature who has only recently ceased to be part of her own body does not come with the separation of the birth process.

The infant is helpless, entirely dependent on the mother for food, warmth, and comfort, and the mother finds happiness in giving these services together with lavish affection and much physical contact. It has been demonstrated in numerous studies and in the experience of those who have worked with infants that the child who is deprived of the emotional warmth and comfort of personalized love is handicapped so seriously as to be vulnerable for the rest of his life. The movement away from institutions toward foster home care for dependent infants and small children is based on the demonstrated fact that while proper diet and

fine physical care are essential, there is another ingredient that must also be included for the well-being of the developing infant. This ingredient—the consistent and continuous love of a mother person—is less tangible than a carefully balanced formula or the asepsis of a nursery cubicle, but without it the personality of the child may be stunted. In this connection several pediatricians and psychiatrists pointed out the growing tendency to prescribe T.L.C. for small children on pediatric wards and in nurseries. T.L.C. means Tender Loving Care, a prescription which nurses are happy to fill now that the taboos against such contacts are being lifted.

The gradual renunciation of rigidly scheduled feedings and of the spartan regime that prohibited picking the child up when he cried can be attributed in part to the obvious fact that such practices were contrary to the needs and best interests of the participants in that highly personal drama, the care and feeding of the infant. The "rooming-in" plan is another manifestation of this changing philosophy. In this plan the newborn infant remains in the mother's room throughout the hospital stay rather than in the nursery. A small crib on wheels is placed close to the mother's bed so that she can reach out and pick the baby up at any time to feed or change him or otherwise meet his needs. The emphasis in rooming-in is on the family unit—mother, father, and child—and with few exceptions, the father is the only one who is encouraged to visit. He may come at any time and help in the care of the infant rather than having to become acquainted with his offspring through the nursery window. Not only does rooming-in give the mother with a first baby an opportunity to get acquainted with her child and learn how to handle him from the beginning, but it encourages the development of a comfortable, easy relationship at a time when the mother need not be concerned with household and other responsibilities.

Mothers have been exposed to innumerable volumes of ad-

vice—often contradictory—by experts on child care. Depending on what she reads in the press, periodicals, or books on the subject, the mother may be admonished to avoid too much fondling for fear of spoiling the baby; to keep other adults at arm's length to avoid infection; to discourage grandmother's attentions because she is so unscientific; and to build the baby's character by instilling early habits of cleanliness and by guarding against what is said to be his congenital tendency to take advantage of his elders. Then more recently comes the pronouncement that it's quite all right for the mother to love her baby, openly and unashamedly. Furthermore, she is encouraged to feed him when he is hungry and to accommodate feeding time to the baby's own biological rhythm. She is also advised that character and emotional strength are built on a firm foundation of love and the natural manifestations of this love in early infancy, such as fondling, cuddling, and even baby-talk, which is no longer considered a threat to perfect diction in later life.

Any experienced health worker knows that the mother who loves her baby comfortably and without conflict is not seriously handicapped by what the experts have to say. She may worry a little; she may feel less secure about what she is doing to her child; but with the basic ingredient—love—intact, the way in which she does anything for her child is likely to be beneficial. Conversely, the mother who did not want the baby, who is insecure in her marital relationship and feels further threatened by this new responsibility that represents either a burden or a further obstacle in her search for protection and dependency, is likely to be uncomfortable and rejecting.

But rejection of one's offspring is neither socially nor personally acceptable in our culture. Child guidance clinics have long been familiar with the two most frequent manifestations of rejection. Unable to recognize and accept such "unnatural" feelings, the

mother unconsciously represses them and may overcompensate, still unconsciously, by lavish overindulgence which can deny the child nothing but gives him little that is sound or realistic on which to grow and mature. It has been likened to trying to develop one's muscles by punching a feather bed.

The other kind of overcompensation is seen in the mother "who lives for her child," who in return is expected to live within the rigid confines of the pattern which his mother has laid down. Restrictions, admonitions, rigid health and food prescriptions, and intolerant and antisocial ethical codes are imposed by this righteous individual who "sacrifices" everything for her child and may do him irreparable harm "for his own good."

These mothers may follow to the letter all the approved pamphlets on child care, but the end result reflects their own personality difficulties and their failure to give their children that all-important sense of complete acceptance coupled with the reasonable controls which is essential to healthy emotional growth.

Perhaps because they are more pliable and less complicated, infants and young children respond much more readily than adults to unspoken and presumably hidden feelings on the part of people in their environment. Neither words nor gestures are required to transmit love and acceptance; nor are they necessary to communicate to the young child impatience, dislike, tension, or other unfriendly feelings. Similarly, inconsistencies or confusion in the family situation find a way of being communicated to the infant.

These earliest days of living as a separate human being also see the beginning of anxiety and the development of methods for dealing with it. "Anxiety is a very general, basic problem in living. It is a normal, natural reaction to danger; whenever there is danger the normal person experiences anxiety." Whenever a situation presents problems that are unpleasant, apparently insurmountable, or overpowering, the individual will become anxious

if he is unable to deal with it directly and successfully. Individual tolerance varies, as does vulnerability to certain kinds of situations.

Much of this difference may stem from early anxiety-producing experiences in the life of the individual. For example, the infant whose mother does not respond to his instinctive cry for food and physical contact becomes frightened and anxious. He may cry harder and longer or he may whimper fretfully, or, as in child-care institutions, he may make no sound because he has learned that it is futile to ask for what is not available. But he has already begun to find a way of dealing with anxiety and for him the absence of a loved one will always be colored by this early experience; he will be vulnerable to a repetition of it.

There are other potential sources of anxiety in the developmental process. Many of them are associated with the interaction of social pressures and the biological rhythm and biological readiness of the infant. Not so long ago, when all children were expected to be weaned from the bottle at a fixed number of months from the date of birth and to have bowel and bladder control well established at an equally arbitrary moment, we saw this phenomenon at its height. The four-hour feeding schedule with its prescribed number of ounces per feeding frequently violated the biological rhythm of the infant and the tussle that followed was for many a source of anxiety and discomfort. The "quart of milk a day" fetish, the stipulated number of ounces to be gained weekly, the standard height and weight chart to which thousands of infants and children were molded by anxious mothers, and the approved age for walking, talking, and the like—all tended to disregard the individual's own normal biological rate of development and threatened his status as a unique human being.

This earlier tendency to fit each new member of society into a preconceived pattern was not only artificial and harmful to many; it was indicative of a fundamental lack of respect for the indi-

vidual, an attitude that was both undemocratic and unsound from the point of view of dynamic psychiatry. It would be reasonably accurate, though somewhat oversimplified, to say that the basic principles of the mental hygiene approach to people are synonymous with the democratic approach in its best sense. Each individual is an individual in his own right as well as a member of society. He has rights, privileges, and responsibilities both as an individual and as a member of his group. He is like his fellow citizens in many fundamental ways and unlike any other human being in equally basic ways. He is privileged to be as different as need be from his neighbors so long as this difference does not conflict with the needs and prerogatives of other members of society or with his own adjustment. Homeostasis for the individual and the group is the goal; imbalance in either is the trouble signal.

In their simplest form the ingredients of dynamic understanding and relationship can be reduced to the words respect and affection. If you like an individual for himself, you can disapprove of something he does while continuing to like *him;* if you respect him as a human being, you assume his right to think and feel as he does and to be the kind of person he is, even though you may believe that he is not realizing his full potentialities or contributing to social progress in accordance with your standards. You may try to help him change or improve his level of functioning but you will not do so by inflicting your standards on him or expecting him to move at a pace that is not consistent with his personality structure. You will provide in your relationship with him or in the setting in which he finds himself an atmosphere that is conducive to growth, that accepts him as he is, while making it possible for him to grow as rapidly as his needs and ability permit. This concept is as fundamental to the modern approach to emotional growth and development from infancy as it is to interpersonal relationships throughout life.

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Specifically, in relation to child care, this concept jumps the intervening years and takes us back, this time with theory to bolster practice, to the time when "doing what comes naturally" was the prevailing philosophy. It is natural for a newborn infant to sleep when he is satisfied and wake when he is hungry or otherwise uncomfortable. It is natural for him to look to his environment for warmth and comfort and the reassurance of the mother person. It is natural for his mother to fondle and smile at him and to anticipate his needs as his rhythm becomes familiar to her.

It is also natural for him to develop skills in accordance with his biological readiness and to want to explore and perfect these skills by persistent practice. First he lifts his head, then he pushes himself up, then he sits alone, eventually pulls himself up to standing position, and on a given day comes the culmination of this process—he walks. It is natural for the mother to feel a qualm at the passing of helpless infancy. When he begins to toddle from room to room, the infant is no longer the extension of the mother person; he is a self-motivated dynamo. Many mothers say that this is the point at which they begin to realize that the baby can't stay a baby forever.

It is natural for the average mother to take pride in the development of her child's independence and to encourage all his efforts to do things for himself, even when the first attempts are clumsy and imperfect. It is also natural for the mother who is comfortable with her child to recognize and accept her own needs and rights. The anxious, overindulgent mother who never goes out, who would not trust a baby-sitter, who looks in on the baby at frequent intervals for fear he might smother, this mother does not allow her baby to do things for himself because he's "too young, too delicate, too sensitive." And her martyrdom must also include the sacrifice of her own rights and privileges as a human being.

The emotionally healthy young woman realizes instinctively that a change of scene will refresh her and break the monotony of close association with the baby and her household responsibilities. She also recognizes that her husband has need of her time and attention, perhaps even more than before the baby came. It is natural for her to maintain some extra-nursery interests and to reactivate them when the first few months of intense preoccupation with the newborn are over. As the baby begins to develop skills, it is natural for the mother not only to encourage them but also to direct them into channels that will be satisfying to the child and will eventually lead to their integration in his daily life in a way that will contribute to his evolution as a social being.

For example: The toddler inevitably reaches for everything that catches his fancy and explores it to see what it is made of, whether it moves, makes noise, comes apart, or otherwise responds to his investigation. The fastidious housekeeper who cherishes her porcelain vase or crackleware bowl may try to impress upon the toddler the value of beautiful things or shout "No!" whenever he sidles up to this doubly attractive, because forbidden, object. The comfortable mother who instinctively realizes that this period of exploration will run its course, removes valuable or fragile objects for the duration and knows that the baby can easily be distracted if his carpentry experiments become too drastic. This mother, too, learns that the child enjoys having simple, shiny, noisy objects that are his own and that with patience and repetition he can learn and take pride in the fact that there is one spot in the whole house where his toys are always available, provided, of course, that they are returned to that spot when play is over.

In this way the child learns the first principles of citizenship, of give and take, literally of live and let live, and he learns it positively in his immediate family setting where all basic social behavior is learned. He learns slowly that there is a sequence in

living, a cause and effect relationship in the events that occur around him, and gradually, as he emerges from infancy into childhood, he develops an awareness of his own place in the total scheme of things.

He has been weaned, he walks and talks a little, he has developed some measure of bowel and bladder control when the infancy period begins to wane. "This has been a period of the greatest biological change in the entire life span. At no other time does the individual grow as rapidly or learn as many fundamentally new skills. He spends the remainder of his life tapering off from this precipitous start and perfecting or refining these basic skills." He may learn to walk a tight-rope or become a fine pianist, but he learned the basic art of walking in infancy and the manipulation of his fingers even earlier.

"Childhood is the period of adaptation of basic skills and the socialization of the personality." We bring with us into childhood the security or insecurity, the readiness to move forward, or the fears and fixations that were established in infancy. If an anxious mother made a fetish of feeding schedules and the full complement of milk, iron, protein, and the like, we may move into childhood with well-established food fads. If toilet training was rigidly applied, there may be a highly disproportionate preoccupation with biological functions. If there has been marital discord, with an atmosphere of inconsistency and rivalry, we are already adept at playing one parent off against the other to the confusion of all concerned. And more basically, if there have been love and warmth and encouragement and reasonable boundaries in infancy, childhood becomes a period of expanding horizons physically and socially, with innumerable opportunities for new experiences, new independence, and new orientation to oneself and others.

The child who has never been separated from his mother even for an afternoon finds the first day of school a nightmare, while

the youngster who has played with friends and relatives and who has visited Aunt Hattie or grandma unattended, or whose mother has encouraged new experiences will find something positive in this adventure even though he is reasonably apprehensive. It is safe to assume that the first mother will have prepared her overprotected youngster for his first day of school by weeping either overtly or figuratively and making clear to the already frightened child that this separation is the beginning of the end; that he is about to experience the hazards of a hostile world without the protection of his devoted mother. The second mother will also have prepared her youngster with a cheerful description of high adventure ahead and her great interest in his report at the end of the day.

It is during early childhood that the individual's pattern of interpersonal relationships is laid down. There are superficial changes and fluctuations throughout life in response to environmental factors, but the individual's basic attitude toward and response to persons of the same and opposite sex is largely a product of the interplay of personalities during these formative years. In early infancy the mother is the pivotal person and the mother-child relationship leaves little room for others, except incidentally. The father usually remains on the periphery of this relationship, carrying many new responsibilities and experiencing many disruptions in his everyday habits but without the direct emotional satisfactions which the mother derives from the infant. The father takes on a heavier financial burden, both current and future; he loses the companionship of his wife, who now gives most of her attention to the infant—in the case of the first baby this represents a marked change in family relationships; he may be asked to help with household chores for the first time since his marriage; and his sleep and other habits are usually disturbed. There are, of course, personal and social satisfactions of deep emo-

tional significance for the father, and if he is a mature individual, he accepts this temporary inconvenience and loss of status as secondary to the ultimate values in parenthood. The mature adult takes pride in the support—financial, physical, and emotional—which he can provide his wife and baby, even though for the time being his direct emotional satisfactions from the infant are limited. Then as the baby becomes more perceptive, the father evolves into a recognizable figure who visits the child at regular or irregular intervals and who is friendly and even helpful at times. Later the baby differentiates and calls the parents by name, and fairly soon the toddler learns daddy's schedule of departure and return. It is soon thereafter that the father begins to play a major role in the emotional growth of his child. The presence of a father in the home during these formative years is essential to healthy character development.

As the infant moves into childhood and becomes a social being, his relationships with his parents take on new dimensions and meaning. The process of identification, the means by which patterns of behavior are formed, can be seen in any family constellation. Girls become women and boys men, not only because they have primary and secondary sex characteristics but because life experiences mold and shape them into feminine women and masculine men, or, as sometimes happens, masculine women and feminine men. Identification with an adult of the same sex is the process by which much of this happens, as well as the formation of the social conscience by which we function as members of society in good standing.

As the young child begins to relate himself more consciously to his parents and their relationship to one another, he attempts, usually by trial and error, to find a place for himself in the constellation. Fairly early we see the phase of intense love for the

parent of the opposite sex and its attendant rivalry with the parent of the same sex. The little boy who loves his mother so much that he wants to eat her up is a well-known phenomenon, as is the little girl who primps for her daddy and uses all her feminine wiles to obtain and hold his attention. Along with this passing attachment comes a concomitant feeling of hostility and guilt toward the parent of the same sex. It is a confusing and, for parents, often an embarrassing experience, and unless they are secure within themselves and with one another, unfortunate results may ensue. In the beginning this behavior is frequently considered cute, but as it continues, the parent who is left out of the "romance" may begin to retaliate by expressions of resentment at this rejection, or by punishment or deprivation that is motivated less by adult objectivity than by immature jealousy. This confuses the child, who is of two minds about the parent of the same sex and unconsciously guilty about his equally unconscious hostility.

The parent on whom this early attachment is fixed has a dual responsibility: first, to accept and respond to this natural phase of development, and later to help the child grow through it and move on to other ways of relating himself to people. A nice balance of reciprocal affection and recognition of its temporary intensity helps the attachment to run its course without undue trauma. This, of course, requires a degree of maturity in the parent that is not always present. It is, perhaps, the rare parent who can take this onslaught of affection without falling victim to some of the natural feelings that such a demonstration invites: "He loves me better than anybody else, better than his father; I am the most important person in the world to him." This is so obviously satisfying that it is often difficult to realize or remember that an excessive response is useful to neither party. The mother may find herself stranded with her unrequited love when her son

moves on to the next phase of intense preoccupation with persons of his own age and sex and becomes an active member of the local gang that is so important to later childhood.

If the attachment remains fixed, however, we find the boy who is too confused by his unresolved love, hate, and guilt to be able to move on to the next step. The seeds of later effeminate attitudes and behavior are sown, and we see the young man who is so devoted to his mother that he has no interest in girl friends, would not think of marrying while his mother needs him—in other words, the "perfect" son and inadequate man. Usually in this, as in all situations, there have been multiple factors at work: The father has not been strong enough to meet the mother's dependency and other needs; or the marital relationship has not provided the security which would have helped the mother withstand her son's demands; or the mother's own difficulties have prevented her from entering into a mature marital relationship, with the result that she is more comfortable and satisfied with her son than with her husband; or it may be that there is no strong father person in the home to provide for the son the kind of masculine pattern that is essential to the normal development of male children.

It is during this period, too, that a new baby is likely to enter the family picture. In recent years there has been a steadily growing awareness of the fact that children are jealous of younger brothers or sisters whose arrival inevitably disturbs the existing family relationships and threatens their status and security. It would, however, be highly optimistic to assume that the acceptance of this fact is nearly so widespread as we should like. There are still many parents who, despite exposure to all the modern popular literature and lectures on the subject, will state emphatically that there is no truth in it. "Why, my Johnny loves his little brother. He helps take care of him and can't seem to leave him alone, he's so devoted." That this devoted attendance also brings

Johnny in close touch with mother and keeps her from giving her undivided attention to the interloper, or that his hostility is so great that he must expiate some of it in socially acceptable ways would not occur to this parent. It is in the families that permit children free expression of feelings that one sees the clearest manifestations of sibling rivalry. In these families, the older child is not afraid to say what he thinks and feels and in so doing some of the intensity of his feeling is lessened and he is able eventually to see some good in this new creature who was originally all bad.

The early school and pre-adolescent years are predictably a period of relative emotional quiescence, steady physical growth, and expanding social exploration. Talents, special interests or aptitudes, and ways of reacting to a variety of situations begin to appear. The need for being like one's fellows; for spending twenty-four hours a day with the gang; for shutting out adults who could not be expected to understand the intricacies of thought and experiment that are the framework of important club activities; for speculating with one's buddies about the present and the future and the mysteries inherent in both—these are the characteristics of this stage of development.

Equally characteristic are the tangible and intangible ways in which the child builds on his identification with the parent of the same sex. The little girl who dresses up in her mother's clothes, uses her cosmetics, and plays house with dolls and with toy cooking, cleaning, or other household equipment is beginning to shape herself in her mother's image. Other women also play a role—teachers, film stars, older sisters. The little boy who plays that he is coming home to his pipe, newspaper, and slippers, or begs for long pants and a real necktie, or practices shaving, or helps daddy wash the car on Sunday, or is delighted when his father will toss a baseball with him after work—this typical boy is grooming himself for his masculine place in society by using the pattern that is

available to him. As his horizon expands, other men help round out the picture—the neighborhood policeman or fireman, the outstanding aviator of the moment, cowboys, parachute troopers, G-Men, and, of course, Superman.

Thus the child becomes the rough draft of the future adult during this period: habits and rhythms become crystalized. Sleep habits, work habits, ways of reacting to new stimuli are more clearly defined; relationships to parents and siblings reach extreme limits and then become stabilized; a social conscience begins to develop; and a pattern for getting along with people gradually becomes integrated into the personality of the youngster.

All this is a gradual, positive growth experience for the child who has in his environment the warmth and security that permit learning by trial and error, that set examples and limits which point the way toward maturity, and that are always available when the world that the child knows gets out of alignment and presents stumbling blocks to progress.

At about the time when childhood has fallen into familiar patterns, there is another crisis. The condition known as adolescence is somewhat ludicrous to all except the adolescent, his parents, his teachers, and others who are responsible for him, his behavior, and its results.

The youngster approaching adolescence brings to it all the strengths and weaknesses he has accumulated during infancy and childhood, his special fears, his special talents, and his own particular pattern of behavior under stress. He also brings to it his biological stage of development and his physical attributes, which may be positive or negative. He may be tall, well-built, and handsome or he may be undersized and plagued with acne; she may be a dainty, blue-eyed, blonde charmer or a square-rigged Amazon who has to wear glasses. We know that whatever his initial equipment, the young person encounters in adolescence major

physical changes and serious emotional upheaval. It will leave its mark on him, however well equipped he may be to withstand its stresses, but obviously the more security he has known in his life to date and the better his pattern for dealing with traumatic situations, the more chance there is that he will weather this storm without excessive residual insecurity. Similarly, the more favorable the environment in which he lives through adolescence, the greater is his chance for successful emergence into adulthood. By favorable we do not mean perfect, or yielding, or indulgent. Adolescents, like all developing human beings, need security and consistency in their environment, and indulgence without limits does not make for security. No human being wants or should have so soft and yielding an environment that he has no boundaries within which to shape his personality and to learn to relate to people and things around him.

For the adolescent it is of the utmost importance that he have in his environment at least one adult who represents consistency and strength and acceptance of him as a person who is temporarily serving as the battleground for opposing forces of great power and unpredictable, frequently contradictory, spurts in one direction or another. If the adult can at the same time demonstrate that he loves this human being who is in the throes of renouncing childhood and desiring yet fearing maturity, the struggling youngster has a constant source of strength always at hand when he needs and wants to make use of it.

If the adult can use his love not only to provide encouragement toward independence as it emerges but also to set reasonable limits around the evolving personality, the strength of the adolescent is less likely to be expended in unnecessary and frequently harmful testing out of just how far he can go before he runs into trouble, personal or social.

This magnanimous tolerance of the vagaries of adolescence

may be too much to expect of the average adult who brings to such a relationship all of his own needs and anxieties in addition to whatever degree of understanding and acceptance he may possess. The tribal customs of the most remote aborigines are no more fantastic than the group idiosyncrasies of adolescent boys and girls. The concentrated weekly doses of radio adolescents are exaggerated only in the frequency of major escapades and the telescoping of all phases of behavior in the person of a Henry Aldrich or a Judy Graves. But the parent who has survived his child's emergence into adulthood can testify that nothing is too fantastic to expect: the violent mood swings from ecstasy to misery and back; the deathless love and the monumental loathing; the ultrafashionable phase and the return to little girl clothes; and the sophistication and infantile regression that follow one another around the clock, frequently with no rhyme or reason that the distraught parent can discern.

Patience and fortitude are essential parental attributes during this most trying phase in the evolution of an adult. It is assumed, however, that parents too have rights, not only to the family car and telephone but also to the privilege and even the obligation to express exasperation or disapproval of an act, or, on occasion, refusal to continue to accept certain kinds of behavior. When such self-expression by the adult does not imply rejection of the young person himself, there is a healthy give-and-take and the establishment of reasonable adult standards which the adolescent will gradually accept as his own.

Basic to all this is the confidence in the strategic adult that the youngster has developed during earlier, less crucial experiences. If his parental relationships have been predominantly good, he can transfer this confidence to others. If he has been less fortunate in his familial contacts, he has even greater need at every major

step along the way for positive, friendly relationships with strategic adults who enter his life.

The period between adolescence and old age can be described rather loosely as maturity. Chronologically and biologically the members of this age group are adults, but the degree of emotional and social maturity that each individual brings to his adult life is again dependent on his cumulative experiences to date and the interaction between what he brings to the situation and what he finds in it. A dependent, immature man may make a satisfactory adjustment in a job that does not demand more initiative or aggression than he has to give, and his marital relations may be adequate for his needs if his wife is a strong, rather dominating woman who does not need or want to depend on her husband. But if this man is thrust by external circumstances into a job where he must make decisions and be responsible for others, he will be frustrated by failure and become even less competent as a result. We all know people who know themselves well enough to refuse promotion to positions of responsibility—a decision considered strange in our competitive culture, but a wise decision in terms of the emotional capacity of the individual. Conversely, there are many individuals whose dependency and immaturity are much less fundamental. They have been bruised, and somewhere in their experience they have developed a feeling of inadequacy. But the capacity is there waiting to be tapped and the demands of work or social situations will draw out the strength that has been dormant.

As mentioned earlier, since we subscribe to the premise that life is a cumulative experience, we must believe that the adult carries within his person some residue of everything that has happened to him from infancy. He has been scarred by frustrating experiences and has suffered anxiety because of them. To protect him-

self he will have established defenses against anxiety which meet his needs. Usually these defenses will have been unconscious so that he will not be aware of their original motivation. But they are essential to the maintenance of his emotional equilibrium and in a sense are as automatic as the mobilization of white blood cells when infection threatens.

Severe emotional deprivation may leave the victim permanently incapable of meeting or dealing with situations which reactivate the feelings and tensions that are associated with the painful experience. Or in dealing with such situations he may express feelings and attitudes that are not logically commensurate with the situation itself. It is only when we realize that it is never the situation alone to which we react but rather to what it means to us, that we begin to understand the complicated nature of man and the depth of the personality which lies behind the façade.

Too often this theory of emotional growth and development is used to bolster the belief that by the time an individual reaches chronological adulthood his personality is fixed for all time and cannot be modified. This is taken to mean that he cannot change his way of life either for better or for worse and that he is henceforth immune to environmental forces. If this were true, there would be little value in any activity designed to effect change or improvement in adjustment.

Actually, we know that the human being is always changing and that the environment can and frequently does modify his adjustment, depending on the nature of the situation. When we say that the personality structure is solidified by the time adulthood is reached we mean only that the individual brings with him a way of looking at and reacting to people and things that has been built up out of his experiences to date. At each stage of development his character structure becomes more complex and less malleable.

As a young child, while his personality structure is still in the process of formation, he is affected by environmental forces in deep and basic ways that would not be true later on.

For example, a warm, friendly nursery school teacher can, by her interest in and affection for a frightened little girl, compensate for the lack of such affection at home to the extent that some of the personality distortions which might otherwise have developed are actually prevented. This is a major influence on the total human being. Twenty years later such a warm, friendly interest on the part of a teacher or employer, while desirable and helpful in the social adjustment of the recipient, could, however, not be expected to effect a basic change in personality. Its value lies in the fact that it enables the recipient to do his best with the equipment which he brings to the situation and to experience a positive relationship with a person in authority. A useful, productive, satisfying existence is built on a succession of such positive relationships which help us to realize our potentialities, to build on our strengths, and to counteract the negative effects of anxiety-producing experiences.

The strengths that are in all of us must always be weighed in any evaluation of potentialities. Since no human being is ever a finished product from birth to death, the capacity for change and growth must be assumed. If proof is needed, we might look at some of the experiences of World War II. The world over, people were exposed to horror so devastating as to be described most often by the word "intolerable." But it was not intolerable; millions of people tolerated it and continued to function. Out of reservoirs that we cannot measure but must respect, they drew dignity and strength that enabled them to withstand the bombings, the torture, the exhaustion of war. Individual tolerance varied, but for the people as a whole the level was high enough to war-

rant the assumption that the man on the street has "got what it takes" somewhere in his personality structure. Those who deal with people would be wise to operate on that premise.

This potential is equally present in childhood, during maturity, and after middle age. Unfortunately, in our society persons who have passed middle age are too often considered to have passed social usefulness at the same time. In our competitive society adults are expected to function at top speed and top capacity until they are no longer able to maintain the pace. At that point they are expected to cease functioning altogether and begin subsisting, pending eventual extinction. Paradoxically medicine works feverishly to devise ways in which life may be prolonged still further, quite apart from the question of social usefulness or emotional needs. This is the climate in which the adult contemplates old age and in which the aging person lives out his lengthening span.

There is a gradual lessening of physical stamina and an increasing tendency to regress emotionally to the time when the individual had acceptance and status. The patterns of a lifetime are clearly in evidence in the ways in which old people attempt to adjust to present situations. The range is as wide as the differences in human beings and their personalities. But it should be noted that the aging person who continues to work to the limit of his capacity and to carry responsibilities for himself and others is seldom the one who becomes a crotchety old soul, demanding attention from his children and complaining that he is forgotten. And the experiences during the last war proved that these two are not different kinds of people. They are the same people in different circumstances. Old men who had not worked throughout the long depression of the 1930's and who seemed much too deteriorated ever to work again entered the shipyards and the airplane factories by the thousands and rolled up a record of attendance and production that amazed even those who had hoped for the best.

At this point it is reasonable to expect that someone will ask, as did several of the health officers: "O.K., suppose all this is true and I guess it is, what do we do about it? It's like a conveyor belt that keeps going 'round and 'round. Where do we fit in? How far do we go and when does the psychiatrist come into the picture?" Briefly, the answer would be that public health fits in wherever and whenever public health personnel has contact with people.

It is not the psychiatrist who has the opportunity to provide guidance and counsel at strategic points in the development of the average child in the average home. It is the doctor, the nurse, the teacher, the clergyman, the recreation worker—the professional person who comes in contact with the family in the normal course of events and has it within his power to make that contact a constructive experience for the entire family. As each of these disciplines recognizes and accepts this responsibility, the basic training of its members will be enriched with a new orientation to people, their motivations, and their needs. Teachers will realize that educational content is only a fraction of what the child should take away from his school experience. The doctor will understand that the importance of his role in the lives of his patients goes far beyond the treatment of specific ailments.

These changes will come about slowly. They are inevitable, but they are so laden with concepts and implications that have personal significance to each of us that the resistance to their acceptance has been great. They can be said to have arrived when people who have a helping relationship with other people see them not as entities suspended in time and space but as human beings with cultural, socio-economic, and interpersonal antecedents; current capacities, responsibilities, and interdependencies; and future potentialities for growth and development. When this perspective is achieved, it will be accompanied by recognition of the potential usefulness of professional contacts in the promotion of positive

mental health. If we see the sequence of emotional growth and development as a circle or "conveyor belt" in which the infant gradually moves around the arc to adulthood, when he becomes a parent and starts another human being on his way, we realize that a positive contribution to a number of human beings can result from a constructive contact with one human being wherever we happen to encounter him.

PUBLIC HEALTH AND PEOPLE

"One of the main things I hope we will get here is some help in knowing how to work better with people. I'm convinced that we have to get a whole lot deeper than most of us do working with people. We have to get down to the place where we find out what people want and why they want it and build on that rather than on something we may have in our minds to put across."

As the health officers discussed this and other reasons for participating in the sessions, it became clear that they were not so much concerned with getting deeper as with getting closer to the people whom they served, understanding them better in order to help them better. There is no finer motivation for learning about people than the desire to be of more adequate service to them. The tempo of the institute was in large measure the result of this motivation on the part of the health officers.

The daily clinic visits and their own extensive clinical experience provided the institute members with abundant material for discussion of the health department's relationships with its patients. Out of this discussion there came the realization that there are basic mental health concepts which are common to all situations in which one undertakes to help individuals. We are culling these concepts out of the stream of discussion and presenting them here in summary form in order to point up their universality. The way in which the concepts apply to specific health department services will be discussed in subsequent chapters.

We are concerned here with the impact on people of the man-

ner in which they are received by those to whom they come for help. These are simple concepts when one sets them down in sequence. They are psychiatrically sound and could be documented with many references to the literature, but fundamentally they are also based on the simple, almost naïve concepts of the dignity of man and the Golden Rule.

Let us take, for example, the individual who comes to the health department because he has a health problem, or wishes to avoid a health problem, or because he has been ordered to report. He is not quite sure that he is eligible for help or that he has come to the right place, and in most instances is of two minds about seeking help. This indecision, especially in relation to health matters, is so frequent as to be almost universal. Questions of health stir up in most of us deep-seated anxieties which we seldom understand, but which have a profound influence on our reactions and behavior.

It is safe to say that the patient is usually apprehensive and that when he has been ordered to report, he is likely to be resentful as well as anxious. He brings to this relationship his own well-established way of reacting to new situations. He may stride into the building demanding service or he may sidle past the partially opened door in a most humble fashion; he may toss off an account of symptoms with little apparent concern or he may fearfully enumerate his difficulties with more anxiety than seems appropriate to the situation; he may accept diagnoses and recommendations with apparent ease or he may become panic-stricken. These are some of the extremes; most people fall somewhere within them. The continuing responsibility of the service agency is to see each person as an individual and to understand that the façade which meets the eye is important only as it reflects the needs and motivations which it covers.

"Because we believe that the human being is constantly reacting

to his environment, both consciously and unconsciously, we know that he is influenced favorably or otherwise by everything that happens to him." The patient who is listening to a doctor's discussion of symptomatology may seem to be merely listening in a kind of suspended animation. Actually, he is doing nothing of the sort. He is listening hard, trying to understand, trying to relate what he hears to whatever there might be in his experience that would help him clarify it for himself, and trying to see what it means for him, his job, his family, his financial resources, while unconsciously his earlier feelings and fears about illness are being reactivated. As the medical information or recommendation is screened through this film of confusion, it tends to become distorted and we frequently hear the tired doctor exclaim: "I talk and talk and he doesn't hear a word I say, and when he does he gets it all wrong!" Unfortunately, this failure to communicate is inevitable so long as the doctor talks to the outside of the patient and not to that part of the total human being that is concerned with absorbing and integrating the information in the highly personal fashion that is true for all of us.

We have, then, an individual—apparently typical, actually unique—who comes to his health department for service. Depending on the scope of the local department, he finds a variety of services which may or may not meet his needs. How the health department provides these services will be our concern in this report as it was during the institute. In all the discussions of health work the chief emphasis was not on the structure or the specific techniques but on the people who come for service and the people who give it and the interpersonal relationships which determine the quantity and quality of effective service.

The patient's relationship to the clinic starts when he telephones or comes in to ask about service. It might be well to emphasize here something that was brought up independently in

each section of the institute as the groups recognized the importance of the total public health team in the lives of their patients. As one health officer said, "I sent my telephone operator to the telephone company to take a course and you'd never guess the difference that made in some of our community relations." This basic principle of good business management is too often overlooked in social and health services, especially in public agencies. If we assume a certain degree of resistance in everyone who seeks help, as well as a fair amount of apprehension, it is clear that an individual who may be otherwise ready and willing to enter into treatment can be put off by a brusque telephone voice which indicates that its owner is not at all interested in whether the individual comes or goes. It is this initial experience that frequently discourages clients and patients who might have benefited by service. It can be said, of course, that if the individual is sufficiently eager for help, he will overcome any number of hurdles. But if we believe that negative as well as positive feelings toward seeking help are present in most of us, we must accept the fact that the patient's tentative approach should be our signal to meet him halfway. This is especially true in public health where much of the time the health department is concerned with making available services that people may need but may not understand.

The receptionist is frequently the next hurdle and a very important member of the team. In a follow-up seminar arranged by one of the health officers who had participated in the institute, there was some question as to which staff members should take part in the discussion. After it had been agreed that doctors, nurses, and sanitarians were to be included, the clerks and receptionists entered a complaint. They pointed out that, "You said you were going to have this for all the staff members who work with people. What do you think we do? We see everybody who comes to our center and to the clinics, and if you're going to talk

about improving the approach to people, we certainly ought to be in on it." They were.

Receptionists and admitting clerks in large public agencies and even in private agencies the country over usually have a form of some kind to fill out about each individual whom they see. Unfortunately, it is the rare receptionist who looks at the speaker long enough or with sufficient interest to recognize him the next time around. The receptionist may be sitting at a desk, but unless he has difficulty hearing the person he is interviewing, he may not ask him to be seated. Certainly the amenities, such as a greeting, a smile, a comment that might put the other person at ease, are usually lost in the procedure which most of us will recognize. It goes something like this: "Next. Name? Address? Baby's name? Birth date? Age? O.K. Next."

This violation of the individual's right to be recognized and treated as a human being is seldom deliberate. It would be an exaggeration to deduce from it a crass disregard for the human race or conscious contempt for those who must make use of public services. It is largely the result of routine concentration on the task at hand, a component of the mass approach which often governs practice in our public services. Frequently one hears: "We can't expect more of these people. They've got a job to do. They haven't had any special training. Besides, this is a public, not a private, service and it's being rendered with the taxpayers' money." The recipients of this service are taxpayers too, though often they and those who serve them forget this basic fact.

There is another basic fact that might be taken into account here. Efficiency of performance and quantity of output by workers of all kinds go up in direct proportion to the amount of satisfaction and status which they find in their jobs. If the health officer really believes that each person's contribution is of vital importance to the total service, if he shares that belief with his

staff, and if he uses his ingenuity and skill to help each staff member do the best he can with the greatest personal satisfaction, wherever he may be located on the team, there will be no member of his staff who performs his function in a routine manner. The clerk who is helped to understand the potential value of his contact with patients will soon begin to see the patients as people and will derive satisfactions from doing so that will more than compensate for the time that is spent in in-service training.

The setting in which patients wait for service came in for considerable discussion in all sections. It is perhaps best summarized in this excerpt:

One of the psychiatrists was explaining to his section the principles underlying the construction of the psychiatric section of a general hospital. He emphasized the importance of the setting, of individual chairs rather than benches, and of simple, inexpensive pictures and other decorations to make the waiting room habitable so that the patients would have the feeling, as they waited for their appointments, that the clinic considered them worthy of the small, decent attentions that one pays to people whom one respects. He pointed out that from this experience it was possible to turn the thinking of the hospital authorities to the provision of something approaching it for other clinic patients in the hospital.

There followed a lively discussion of the implications of the long rows of benches in most clinics and the tradition of reporting at nine in the morning, though everyone knows that the doctor does not come before eleven and there is no assurance that all the people who are waiting will be seen before the doctor leaves. Another psychiatrist added, "I want to comment on this point about the individual chair as opposed to benches. It's not the fact that these benches are hard, that they are made of wood and

uncomfortable, but the fact that the individual chair means that I am an individual and I can sit down as near or as far from the next fellow as I want to. It also means that I am a separate unit and am not going to be treated exactly like the guy sitting next to me or the one who just went in to see the doctor."

The first psychiatrist continued with, "I'd take the benches if I had to have my choice and I'd take all the other inadequacies of a clinic, if I could get one little cubicle where I could give the patient the privacy in which to sit down and tell his story. The minute we get off the treadmill and begin to treat the patient like a human being, we begin to deal with the things that people usually keep to themselves. And unless you can begin to deal with the things that are of importance to the person, you won't get very far.

"Granted that in public health you are doing a kind of mass medicine, it is still especially important, if your work is to be productive, that you see the individuals who are part of the mass. No matter how many people you treat, the principal thing is to give the individual the dignity of being treated as an individual. Certainly a friendly interest beginning at the front door and including a chair to wait in and a place to talk privately is the least you can do. In many ways they also add up to the beginnings of a helping relationship. You may say it's expensive but it's not. You can put up a cubicle in any kind of room, anything that will give the feeling of privacy."

Several of the health officers felt that their health departments did not lend themselves even to a cubicle, but after further discussion it developed that most of them could find some corner that might be set apart. Chairs and a can of paint or two that could be used by the staff or the fathers of child health conference patients after work or Sundays to make the place more livable were

discussed. A joint undertaking among mothers to run up some curtains and collect some bright pictures from magazines also seemed within reason to many of the health officers.

In the beginning, when the health officers were still somewhat apprehensive about the implied criticism of their way of doing things, the question of numbers and lack of time was raised rather frequently: "But when you've got so many people to see, you can't give them appointments, you can't sit down and take time with each of them. You've got to do the best you can for all of them." Gradually, however, they came to see that the "best you can do for all of them" might well become the worst for many of them, when that "best" is a mere routine processing of numbers of people.

"Routine is the enemy of personalized service. It weakens relationships and obscures the individuality of people." This was not to say that routine administrative measures are not useful in promoting the smooth functioning of an agency. But it was emphasized that too often routine procedures become substitutes for the imaginative flexibility that is essential in a service agency where each client or patient should be approached as the unique individual that he is. On numerous occasions during the institute this point was underscored, not only in discussion but even more in the clinics where the health officers saw demonstrated the value of a single thoughtful interview in contrast to a half-dozen perfunctory contacts.

When the matter of appointment systems was raised, one health officer reported: "I tried an appointment system after many years of telling myself that it wouldn't work. It does work and it works well. Instead of having twenty mothers sitting around for hours wondering what's going on at home and if they'll have time to do their shopping before supper, and the kids getting cranky and hard to handle, we have a surprisingly quiet waiting room. The

mothers feel that their convenience is being considered and they're less likely to have a chip on their shoulders. The kids are less hard to handle too." He might have added that the nurses and clinicians are under less strain and better able to give their undivided attention to each patient in turn.

On the question of time, one of the psychiatrists in the group had this to say: "Do you remember last night when we were talking about time, we said that five minutes or ten minutes is valuable time both for the patient and for the physician and can be constructive if we know what to do with it and use is properly? Let's say that you are going to run forty or fifty patients through a clinic. You have little enough time to give to each patient, but if he gets all of that time and has your undivided attention during it, you have the makings of a helpful interview. You'll find that the success of some of your interviews in the clinic this afternoon will depend on your attitude, on what you say to the patient when you invite him in, and how you focus your attention on him and nothing else while you are with him. You will be looking at the patient, you will be listening to him, and forming a judgment about him, and the patient will be doing the same thing about you. Some of his judgment will be based on what he has gone through before he gets to you. In the beginning you will be part of what the clinic means to the patient. And then as you are able to reach him, to establish yourself as an individual, he will judge you by your attitude and manner and what you do and say."

Some of the details of establishing contact with the patient were discussed—the matter of shaking hands with him, of introducing oneself to him, of calling a mother by her name and not by the more common generic term "mother," of referring to the baby by name. These were recognized as techniques of relatively little significance in themselves but of extreme importance as an indication of the attitude of the person giving service. In most instances

the group felt that the nurses were much more attuned to the nuances of relationship than other members of the staff, including the doctors. And it was agreed that frequently the nurse acts as a buffer, interpreting the patient to the doctor and interpreting the doctor's orders to the patient.

INTERVIEWING

Throughout the two weeks there was continuing emphasis on the interview as the means by which the health department serves the individual. Psychiatry and its allied disciplines have long recognized the prime importance of the interview and the techniques which produce therapeutic results. This is a specialized skill requiring years of intensive work under supervision. It is not this kind of psychotherapeutic interviewing that psychiatry is now trying to share with other professional groups, however. What psychiatry stresses is an approach to people that can be modified and adapted to the functions of a service organization and the needs of its clients. Therefore, in this institute care was taken to differentiate between the psychotherapeutic interview, in which the therapist attempts to help the patient to deal directly with emotional conflict, and the interview which other professions use to serve people who come to them for help.

It is difficult at first for most people to accept the fact that the interview is a major tool of all service professions. One's first thought might well be, "But I've been talking to people all my life and when I talk to patients and members of my staff or to people in the community, how does that differ from just talking with people?" One of the major problems in an institute of this kind is to establish the difference between casual, friendly, or even purposeful conversation with friends or acquaintances and the interview as a professional instrument with which we serve those who come to us. It is always difficult at first to understand how just

by looking, listening, and responding we can help another person deal with his problems, even though no other steps are taken, no treatment, no medication, no manipulation of the environment.

In most professional schools where students are taught the techniques of interviewing, there is this initial phase of disbelief. Then, as students observe skilled professional interviewing, as they read records in which such interviews are reported in detail, and as they begin to interview under skilled supervision, it becomes clear that a great deal can happen between two people in such a relationship when one of them comes asking for help and the other has the skills with which to give it. Usually the reaction to this discovery is an initial tendency to magnify the interview as an end in itself. The techniques of this interesting new procedure become all-important and the students look to their instructors for specific prescriptions as to what to say first, next, and subsequently during an interview. The participants in the institute went through these phases at a lively tempo with much discussion of techniques of interviewing at the beginning of the sessions and none at the end.

It was not expected that the health officers would be skilled psychotherapeutic interviewers nor was it expected that they would undertake interviews designed to resolve deep emotional conflicts. What was attempted, and in some measure accomplished, during the institute was the development of a different attitude toward people and an awareness of the part which a member of a service profession plays in the lives of those who come to him for help. The principles of interviewing are the principles of relationship, which are predicated on respect for and acceptance of our fellow human beings. A professional interview presumes competence on the part of the interviewer to deal with, or at any rate to understand, the implications of what the patient brings. The word "patient" will be used here to designate the per-

son interviewed but, as was demonstrated frequently during the institute, most of what is said about interviewing a patient can be transposed to interviews with staff members, persons in the community, and others with whom one deals as a professional person.

It might be well to repeat here that the setting of the interview is important in so far as a favorable setting predisposes the patient to a good relationship with the interviewer. The manner in which one greets the patient; whether one goes out to the waiting room to get him or has the nurse bring him in; whether one shakes hands with the patient and asks him to be seated or merely greets him and assumes he will take the chair that is at the desk; whether one offers him a cigaret or doesn't—these are mechanics which are useful or not, depending on how comfortable the interviewer is in using them and how much they truly represent his attitude toward the patient. If he performs these acts artificially, because they have been prescribed, it would be safe to say that he might as well omit them entirely. If the interviewer is genuinely fond of people and is able to like the patient as a person, it makes very little difference whether he rises when the patient comes into the room, or merely waves and says "Hi." The essential ingredient is his acceptance of the other human being. How he demonstrates that acceptance will depend on what is comfortable and natural for him. There is no approved pattern; there need be none, so long as the interviewer makes known to the patient this positive feeling and acceptance.

We are assuming here that in their interviews health department personnel are recognized as representatives of the department, not as independent specialists who happen to be housed there. In one session there was considerable discussion about the role of the doctor in the community and the authority which people are accustomed to confer upon him. The role of the doctor in our culture and the ignorance of the public have combined to

place the physician in a unique position. "The doctor knows, and because he knows what's wrong with you, you are on the road to getting better. It's a kind of magical laying on of hands as if by investing him with these magic powers we can protect our own security."

"There certainly is something in this God concept about doctors. All doctors are asked questions on economics and politics and things about which we know damn well we are not informed enough to speak with authority, but patients will quote the doctor on political or economic matters as though it were out of the great oracle itself." This investment of the physician with extraordinary qualities has made it possible for him to influence the lives of patients much more basically than he frequently realizes. If it is well used, it is a valuable asset. If not, it may become an extension of the physician's own need for power or protection and may not be directed toward helping the patient.

When the physician is a member of a health department, he has a dual responsibility in that he represents not only his own best medical judgment but the policies and standards of the agency as well. It is therefore incumbent on him to acquaint himself with the institution which he represents, even though he may be only a part-time clinician and not a full-time paid staff member. It is also incumbent on the health officer to orient and supervise his part-time clinicians so that health department philosophy and policy may be interpreted to the community with a maximum of uniformity.

There are many other individuals who serve the public as representatives of the health department, though usually without the "magic" attributes of the physician or, in lesser measure, the nurse. These staff members, too, share an important asset that should be recognized and used. Each member of the staff is invested with the authority of the social institution which he represents. This identi-

fication with an institution is basic to much of professional interviewing. The institution is the ultimate authority and by virtue of its role in the community it sets the scope and the limits of the relationships which its representative may have with its patients or clients. Recognition of this fact, if carried into practice, will ensure that the staff member makes full use of the strength and resources of his agency without exceeding its authority.

It has often been said that a good interviewer is a good listener, but in the course of the discussion at the institute it was made clear that listening as such can be quite unproductive if the listener does not participate beyond that point. Again, it is a matter of attitude and purpose. One of the major difficulties in developing skills in interviewing lies in the ease with which the purpose of an interview can become obscured. The purpose is in part dependent on what the patient presumably comes for and in large measure on the services which the agency has to offer.

For example, the mother of five small children, who came to a child health conference on what appeared to be a routine visit, became disturbed by the clinician's apparent implication that she was not taking care of her small children in a satisfactory manner. Later, when she talked with one of the health officers, she expressed resentment and hostility toward the clinician and began to pour out some of her own frustration. She was quite young, the children were small and needed a great deal of attention, living accommodations were poor, and her husband was too tired to give her much help when he came home from work. She was very near the breaking point as she summarized her difficulties and added, "And he tells me I don't take proper care of my children." She felt the friendly acceptance of the health officer who was interviewing her and was able to separate him from her unpleasant experience with the clinician. To her the health officer was a benevolent representative of the clinic and the health department, one who

could understand what she was going through and who listened and responded sympathetically.

The purpose of this mother's visit to the clinic—a scheduled conference check-up for her youngest child—was still her reason for being there. The health department was in a position to offer guidance and counsel in relation to rearing the baby. In the course of doing so, the health officer learned that there were many real problems in this home which were affecting the mother's physical and emotional health and thereby influencing the progress of the baby who was the health department's patient. It was not within the scope of the health department's function to relieve this mother of the heavy work load she was carrying, but it was entirely appropriate for the department's representative to listen and try to understand what she was facing. Further, it was incumbent on him to help her to see what she might be able to do about it within the realistic limitations of her situation.

The health officer and the mother discussed day-care placement for one or two of the older children, the possibility of temporary housekeeping help if it could be arranged through a family agency, and in general what the community had to offer that might make her lot a little easier. When she expressed interest in seeking help, she was referred to the appropriate community resources. In this case the health officer provided excellent service based on two fundamental premises in professional interviewing: the total family situation affects the individual who is being served by the agency, hence it is incumbent on the agency representative to help the patient to see the situation a little more clearly; and when further help is needed outside the scope of the agency's function, to assist the individual in obtaining service from the proper source.

In some cases, however, there appeared to be a tendency to go beyond the appropriate scope of the health department, that is, to take action over and above that which was reasonably the function

of a health agency. In one situation, for example, the clinician became so interested in the marital difficulties of one of the mothers that he would have sent for the father and gone even further into a complex family problem, had the psychiatrist not suggested that such activity might lie outside the scope of the health department. The marital situation had been precarious for some time, and the mother attributed all the child's difficulties to the father's attitude. There was little likelihood that the doctor's telling the father how to treat his wife and child would be the most constructive step at that time and in those circumstances. However, it was entirely within the function of the health department to evaluate the needs of the child as the staff saw them and to determine the extent of the agency's responsibility to its patient—the child.

In this case it was felt by the nurse who knew the family and by the group that discussed the situation later that the emotional health of the infant was being seriously affected by the marital conflict. As in most such situations, it was a two-way conflict in which it would have been unwise and even harmful to have taken sides. The difficulty was of such intensity and duration as to require skilled professional service for both parents if a way could be found to interpret the need and effect a referral to the appropriate community agency. Meanwhile, the well-being of the child remained the focus for health department activity, which included the recognition of other pertinent needs and the most effective use of community resources to meet them.

There were also situations in which the more restrictive aspects of health department function came in for consideration. In these interviews the patient does not come for service but is forced into a relationship with the health department because of his illness or that of a relative or neighbor, or because he is conducting himself or his business in a way that impinges on the health of the community. In such settings the interviewer has a more difficult role,

but here, too, he can be greatly aided by the function, scope, and limitations of the institution which he represents. The tendency to personalize authority and responsibility is always present in the patient and in the interviewer. The patient sees the interviewer as the one who has made the law which he is now about to enforce and assumes that the interviewer also has the power to modify or abrogate the law if he so desires.

If the interviewer himself is not clear about the impersonal nature of his authority, he too succumbs to misapprehension on this score. He tends to say, as did a number of health officers in discussing this point, "But I told him a hundred times that I wasn't going to let him go home. Why couldn't he see reason?" Eventually the health officers were able to see that it was not "I" who would not let him go home but a state or county law which had been passed for reasons of public health and which provided the setting in which these two people, the health officer and the patient, were talking.

Actually, the individual against whom a law is invoked is as much a part of the society that promulgated it as the individual who is carrying out its regulations. The health department employee who really believes this and acts accordingly is well along the way toward the effective implementation of the law. It is not an easy task, and most people who are involved need frequent reorientation to the basic philosophy. This is equally true in situations in which the health department can do little to modify circumstances that are obviously difficult or even painful. The interviewer may have no authority in a given situation or there may be so many realistic handicaps that no one can be of basic assistance to the individual who is caught up in it.

In describing the difficulties that were inherent in a particularly complicated wartime setting, one of the public health faculty members said, "There were many things that happened which

people complained to us about, but we had no authority. We made a frank statement: 'I have no authority to act in this situation at all. I'm terribly interested in it. Now let's see just where we go from here. Let's see what can be done, if there is anything to be done. Let's look at it together.' I think that this is something we sometimes lose sight of in an interview. We can't do anything about something, therefore it's not our problem, and we pass the buck to somebody else. But if they do go to somebody else what are they going there for and why?"

A psychiatrist then suggested, "At least they are coming to you with the problem, and even if it isn't a problem that you have authority over, you assume the responsibility of trying to understand it with them. What you have been describing is the process of listening actively and trying to understand. You are not just a receptacle into which words flow and are lost; you are trying to understand what this person's problem is. I think people with problems in general have a tendency not to state them clearly. Chiefly, this is because they don't see them clearly themselves. If they saw the problem clearly, they might be able to do something about it. Very often the difficulty lies in not being able to see it clearly at the beginning. One has to sift, allow certain things to drop away and other aspects to emerge in their proper relationship. As the problem emerges, the person who is telling the story begins to see it more clearly himself."

As one of the health officers summarized it, "I guess what you're doing, then, is helping the patient feel that you and he together are going to work this out, not that you as the physician will work it out alone from what the patient tells you. In other words, let's get together on this thing and hash it over." Later the psychiatrist added, "You're not assuming that *you* know the answer. You're assuming that he knows the answer. One of the important functions of the interviewer is to help a person try to find his own answers.

Then he comes out feeling that he has dealt with his own problem. The answer that he arrives at will be more acceptable to him than if you had told him what you thought he ought to do."

This active listening, trying to understand, helping the patient to find his own answers, using one's medical knowledge and authority in a positive sense, all revolve around the feeling that one has toward the individual being interviewed. We hear frequently such words as "non-critical, free from prejudice, non-judgmental," all of them valid terms, to describe the approach of the interviewer. We also hear the words "identification, sympathy, and empathy." As the institute progressed there was gradual recognition of the necessity for acceptance of the individual as well as awareness of the fact that complete freedom from preconceptions and prejudices is rare. The point that was emphasized and eventually accepted was that every effort should be made in so far as possible to recognize one's own blind spots, prejudices, loyalties, and patterns of behavior. Since these are often unconsciously motivated, one rarely comes upon them without considerable thought and introspection, if then. The responsibility remains, however, to observe oneself in the interview situation and to learn from one's experiences. For example, if an interviewer finds that he does less well as a rule with persons of one sex or of a given age group or cultural background or type of problem, this should be the signal for an earnest search for some of the reasons. It may be that persons of this kind or with this sort of problem arouse latent anxieties or hostility in the interviewer, so that he must be more aggressive with them or overly sympathetic and therefore less useful. With such recognition it is possible to control these feelings to some extent and to recognize danger signals when they appear.

This is not to say that the underlying unconscious motivation will ever be brought to light or that it need be. In the course of discussions at the institute, the atmosphere was such that the par-

ticipants could look at themselves and their job relationships with a degree of objectivity that few of them had achieved before. They found it possible to relate the concepts of motivation and behavior to themselves in ways that were startling at first but quite commonplace before the sessions were finished. For example: "I go overboard every time I see what some of our minority groups have to contend with in just scratching a living out of this wealthy country of ours. I think, 'What's the use of talking to them about the broader goals when they have to run like hell just to keep alive.' But I've been thinking here that I'm not helping these people by just sympathizing with them and not giving them a chance to move forward with the rest of the community. I guess really I'm treating them like third-class citizens by assuming that all they want to worry about is three squares a day."

It was unnecessary for this health officer to understand his unconsciously motivated anxieties and insecurities in order to see that he tended to overidentify with the underprivileged to the point where he believed them to be as frustrated and incapable of forward movement as he might have been had he found himself in their place. By figuratively weeping over their plight and resigning them to their fate, he had failed to take into account not only the fluidity of our social structure but the essential strengths in people, which should have been the basis for his working relationships with them.

The ability to identify with the other person and his problem is an essential component in good interviewing. The interviewer who has no basis for understanding how the patient feels in the situation in which he finds himself is seriously handicapped in trying to help him. And the interviewer who does not understand the basic motivations in human behavior and the complexity that underlies the so-called simple problems that are brought to a clinic will have great difficulty in managing his own reactions to patients' atti-

tudes. Without training, supervised experience, and the continued application and development of one's interviewing skills, it is difficult for the most well-intentioned person to accept and deal with the range of attitudes and feelings expressed by patients.

"The patient may be hostile, disrespectful, or resentful, and if you are inclined to personalize these attitudes you may either feel guilty about having aroused them or resentful of their being directed toward you. The successful interviewer is the one who knows that attitudes of this kind are frequently the end-products of a series of experiences that have been reactivated by the present situation and that the interviewer merely happens to be the one who is in the situation when they emerge." And again, "The patient may be hostile because of reasons which he hasn't yet confided. He is probably reacting to a lot of things in his background that have nothing to do with you. Your interest should be in trying to understand why he feels this way, so that you may be better able to help him." But though it is difficult for the average interviewer to accept and deal with these reactions, a willingness to try can be a source of strength for him and the patient.

The good interviewer has an endless curiosity about people. It is not a morbid curiosity, but a desire to know more about people and their milieu because of genuine interest. He is interested in where they live, not because there is a line on the face-sheet which calls for an address, but because the neighborhood tells him something about the people and their circumstances. He is interested in knowing where they have lived in the past. In California, for example, he is interested in migrants and the special problems which they face and which they present to a community agency.

The cultural background which has helped to shape the human being is of great importance to a health worker because in a very real sense it may limit or support what the patient is able to do with the information and guidance which he receives. The rather uni-

versal tendency to think in terms of stereotypes is a distortion of the more constructive approach which uses that which is common to a cultural group as the basis for enhancing one's understanding of an individual member of the group. The members of the institute came away with a greatly heightened awareness both of the uniqueness of the individual and the value of seeing him in his social context, if one is truly interested in understanding and helping him.

RECORDING

There was also considerable discussion about recording, its use and its limitations. The need for re-evaluating the record as a tool in order to use it effectively was emphasized in all sections. There was general agreement that records in many institutions tend to become an end in themselves, with steadily decreasing usefulness to the individual patient. When it is used for training and supervision, detailed recording can play a useful role; but when it is used by physicians and others just to make a showing, it is of less than minimal value. When the record is needed for statistical purposes only, a minimum of concrete information is desirable. Too often it becomes a habit and one tends merely to continue a procedure which has little meaning to anyone involved, as a study of records frequently reveals. Often we find so little use made of the record that full-length histories are repeated on all readmissions, while treatment or other services are prescribed with little or no reference to what has gone before.

"No one questions the value of medical data in a medical agency. It's the history-taking approach that I quarrel with," said one psychiatrist. And another described the typical training of medical students in an outpatient setting with which he had been affiliated: "Our students rotated between pediatrics and the children's mental hygiene clinic. In taking a history in the morning on

the pediatric side, the student would ask his series of routine questions, and if the mother should happen to mention some emotional problem with the child, he would cut her short because it was outside of the measles, mumps, whooping-cough sequence and, besides, that belonged in the mental hygiene clinic. He might see the same mother in the mental hygiene clinic that afternoon, at which point he would ask a standard set of questions about the emotional problem. The child was neatly bisected down the middle, the mother was frustrated and confused, and the medical student learned very little about helping people."

In still another session the difference between history-taking and interviewing was developed by the psychiatrist: "Just go back to your own medical school days. Did anybody ever talk to you about how to interview a patient? They told you how to get a history on him, but getting that kind of a history and interviewing a patient are two completely different things. And how did they teach you to get a history? They gave you a form—a long one—and the longer it was, the better it was; and you were supposed to start out at the top and work your way down to the bottom, covering all questions. In any emotional problems—and if you're dealing with people, you're dealing with emotional problems—the question-and-answer technique is the equivalent of having a hostile witness on the stand. When you ask him a direct question, he knows what to avoid. This is absolutely so, whether it's v.d., t.b., or the well-baby clinic, whether it's a psychiatric problem as such or not, because you've got a hostile witness, although not a consciously hostile witness. I'm not talking about somebody who deliberately wants not to help you, but, after all, if we are theoretically correct in our concepts of emotional problems and the conflicts which people carry with them, there's always a part of the personality that tries to repress and push these things aside. Therefore, no matter how honest or sincere he is, part of him wants to keep things out.

He is almost incapable of answering deliberately and consciously and giving you a true picture.

"Now when do you get a true picture of the situation? When you allow the patient to talk and let him follow his own tempo and association of ideas. That is the art of interviewing. The social worker, for instance, is taught that as part and parcel of his training, and the doctor is not. The doctor is taught how to ask questions which usually call for a "yes" or "no" answer. At one of the Boston hospitals they did an interesting study of case records some years back. These cases involved readmissions to the hospital and they checked on factual data such as, at what age did the patient have measles, if he did have measles. They found on three admissions three different histories. Sometimes they had measles on one admission and didn't have it on the second; or they had it at the age of two on one admission and at the age of seven on the next.

"It depends on so many things: on the kind of illness, on the mother's feelings about it, on what unconsciously she is trying to create as an illusion for herself and for you. Or in cases where there might be said to be a causative relationship between the mother's handling and the child's illness, for her own peace of mind she has to kid herself and you; and if you ask her point-blank something about the events leading up to the illness, she will give you what she thinks you want to hear or what she needs to tell you. But if you take the time to get to know her as a person —and it doesn't take long—so that she can feel comfortable with you, she can talk about these things with much more validity and a lot less pain, and you have a history that means a great deal more than the kind of true-or-false exam that usually takes place in medicine."

As another psychiatrist summed it up, "You are seeing the patient because he needs help and because you believe that you are in

a position to help him. In order to help him you must get to know him. You are interested in the patient not as a detached, isolated individual but as a part of the social order. The questions you ask should come to him as an expression of your interest in him, never merely because you have a form to fill out."

HEALTH DEPARTMENT CLINICAL SERVICES

"Do you know what I was thinking after clinic yesterday? We didn't really need to go around to all these different clinics in order to see a variety of problems. We could have sat in any one of them and the whole range of human problems would have come through sooner or later, no matter what the clinic specialized in."

"That's what I've been thinking too, but I couldn't put my finger on it until you said that. I'd have expected that the people and their problems in a t.b. clinic would be very different from a v.d. or a well-baby clinic and in a way they are, but the thing that's the same is this business of listening and paying attention and giving them a chance to feel that you're really interested. Then they're able to tell you what being sick or needing help really means to them and you get a better idea of how to help them."

"You've hit it," a psychiatrist commented. "That's what the institute is all about. That's what we mean when we say that there are common human problems and needs but that within them each individual is the composite result of his own peculiar life history. He's like everybody else in many ways and like nobody else in some highly important ways. Your job is to see him as an individual who has come to you for help. One of the greatest obstacles to this is the mass approach that your work requires. In a t.b. clinic you see hundreds of patients with t.b. The disease loses its impact for you after a time. You see patients come and go in all stages and with all kinds of reactions to the knowledge that they have t.b. It's very difficult to bear in mind that each time it happens to an indi-

vidual, it is a catastrophe that threatens to wreck his life and the lives of his loved ones. How he can be helped to mobilize his emotional as well as his physical strength is the question you must try to answer in each case. And to answer it you must try to understand the particular individual. It is equally true for other major upheavals, regardless of classification—that's why there's a similarity from clinic to clinic but a tremendous difference from person to person in the same clinic!"

Another psychiatrist emphasized the same point to his group with the suggestion that the day a doctor finds himself looking at a waiting-room full of patients without wondering who they are, where they come from, why one is sitting as he is, or what another is thinking about so unhappily, or what the relationship might be between those two frightened, apprehensive young people in the corner—that's the day when he should pull himself up short and try to discover what has happened to his curiosity about life, his interest in people, his ability to observe and sift observations. "That's the day," he added, "when you've stopped seeing people as people, and you'd better get busy having your emotional vision refracted. When they all look alike to you, you've stopped seeing them at all."

During the institute the health officers saw and listened to many people in health department clinics. They experimented with and came to accept the application of mental health concepts to the daily job of the health department in a variety of clinical settings. With the exception of community relations and administration, clinical services came in for more intensive scrutiny and discussion than any other public health functions. But the ease with which the health officers translated basic principles of mental hygiene into their personal and professional relationships would seem to warrant the assumption that what they learned at the institute will carry over into all aspects of public health practice.

CHILD HEALTH CONFERENCE

"It seems to me that a community mental hygiene program ought to begin in the well-baby clinic. We don't see all the babies in our communities, but those we do see could get a better start in life if we applied what we've learned here to our child health services."

Throughout the institute special attention was given to the child health conference (well-baby clinic) and its potentialities as a positive mental health resource. It was emphasized and re-emphasized that the doctor and the nurse in the child health conference are uniquely privileged to contribute to the mental and emotional well-being of the community by the service which they provide for infants at the earliest and therefore the most strategic point in the entire life span. In these clinics babies are being shaped into people emotionally as well as physically, through the advice and guidance that is dispensed and through the quality of the relationships which are established between the mothers and the clinic personnel.

Clinic visits and subsequent discussion provided much dynamic content about emotional growth and development and the needs of infants and young children. But the application of this knowledge was seen to be dependent in part at least on the administrative structure into which it must be integrated. The health officers were interested in the operation of the clinics which they visited and as they compared notes they discovered that there was as much variation in practice among well-baby clinics in the San Francisco Bay region as there was among the health departments from which the students came. It was agreed, however, that the homogeneity of the patient group and the similarity of health department responsibility from clinic to clinic were so basic as to outweigh any differences in procedure. The problems were also found to be almost identical in the small traveling clinic and the large, well-staffed, urban child health conference.

The recruitment problem that is presented by pediatricians who are too busy and general practitioners who are not oriented to modern child care was of great concern to all the health officers: "One of the biggest problems we have in our county is that there are no pediatricians. Our physicians are mostly general practitioners and most of them aren't interested. They don't feel that they have the time, and the one or two or three who are interested can't be depended on to be on hand at a certain hour, because they have their own practices to take care of. As often as not, when you arrange a conference to help them understand the program, there's no clinician, or the clinician is there for ten minutes and then he's gone. You lose a great deal of time, and it certainly doesn't help the mental hygiene of the nurses who are trying to keep the clinic tied together."

"How would you handle this problem? We all have it. Some of us have just a few clinicians to worry about, some have hundreds. But how do you reach the point where you can feel that all the clinicians in the health department are working toward the same ends in approximately the same way? Get two or more health officers together anywhere and the same problem comes up. We know that our nurses are much more aware of and skilled in personal relationships and that for a long time now they have fretted and stewed about the problems they recognize, whereas the private practitioner in the clinic doesn't seem to care. What's the answer?"

"There are various devices. In some states, for instance, if the physician is going to participate in health department work, he must take some training first and he's paid for this training just as if he were working. They just don't let the physicians loose until they've had some preparation."

"In one place I heard about recently new clinicians are assigned to the well-baby clinic conducted by the health department pedia-

trician. They work in that clinic under supervision for at least four or five sessions before being sent out on their own."

"That's fine if you have two or more physicians to choose from. Some of us have the problem of finding just anybody with a medical degree who will give us some time."

The faculty members joined the discussion at this point, a psychiatrist commenting: "Obviously, so long as the present wave of financial security continues for American medicine, the fee alone is not sufficient inducement for pediatricians or even most general practitioners. What can you offer them that will make it worth their while to become oriented to what the health department stands for and is trying to do for the children of the community? Is there some prestige value in a health department connection for men who don't have hospital appointments? Or can you ride the crest of the newer developments in pediatrics and offer to provide refresher courses or orientation sessions as a service to the local medical men, perhaps in cooperation with the local medical society, thereby doing two things—making the job in the health department more appealing to them and helping them give more comprehensive medical care to the patients whom they see anyway?"

And from the public health instructor: "Several of the men asked me the other night how we did it in our department back home. We've largely operated on the trial-and-error principle but we've emphasized the prestige factor that you talked about. Also we've tried to give it a scientific slant so that the clinician gets the feeling that he is pursuing his own postgraduate medical training for himself as much as for the health department. One of the things we learned very early was not to call it a teaching session. We do maintain a continuous teaching relationship, but we never call the man a trainee. We always call him a research associate. It's not as funny as it sounds and it's extremely important to point up that difference. We call the training center where all this goes on

the research center and we make it a little tough to get in, so that there's some satisfaction in having been admitted. We call our sessions staff meetings or clinical conferences and usually have nurses, doctors, and social workers in attendance, all focusing on a given case. This does two things: it gives the session the professional flavor of a hospital, which most of them can accept more easily and, more fundamentally, it helps the doctors to see themselves as part of a professional team. Out of the case discussions they seem to get a pretty good idea of their role in a clinic as well as a real understanding of modern pediatrics. But I don't think that you'll ever sell the idea by letting it be known that the doctor is coming to a training session to learn how to take care of a baby."

The psychiatrist also emphasized the importance of the prestige factor in such training sessions but added that one must not lose sight of the basic purpose, which is the implementation of health department policy and philosophy. He endorsed the validity of including other health department personnel in these training sessions and added, "If this is a conference where you don't just lecture, where you talk and let them talk too, where you let them ask questions freely, they begin to bring their own problems in as illustrations, and at that point you have a really useful structure. Then too, I've found, and I understand others have too, that where you divide the groups and have just a doctor group and just a nurse group, the groups move at different rates and you've got rivalry to deal with, usually with the nurses way out in front."

The public health instructor concluded the discussion of training programs with: "I'd like to emphasize just as strongly as I can that one of the important things we learned out of our research center activities is that we had more real potential strength in our own staff than we had ever imagined. And one happy result of our continued sessions is that our clinicians really came to believe that their relations with the department involved much more than get-

ting paid x dollars to see x number of babies; that there was something over and above that in working for the health department."

The importance of a coordinated approach to patients and the dangers that are inherent in its absence were summarized by one of the health officers: "I think we've gotten some good leads about how to strengthen our teams so that we really are presenting a united front to our patients. Our big problem, as you say, is to be quite sure that the mother isn't getting one brand of advice from the nurse and another brand from the doctor. At the clinic yesterday I listened to the child psychiatrist attached to the department. It was one of the most beautiful interviews I have ever heard. The mother finally spilled all of her difficulties about feeding the child and worked out for herself everything that she was going to do about this baby, which involved some permissiveness and some changes. Then the nurse talked with her for a few minutes and reinforced what the psychiatrist had said. Then she went in to the clinician, who asked, 'How many times do you feed the baby? How much does the baby get? Wrong! Here's what you're to give it and how.' And as the mother left, the clinician re-emphasized 'Now remember, you feed that baby every four hours.' "

This precipitated further discussion and exploration of the meaning of the clinic to the mother and, through her, to the child: "Why does a mother bring her baby to the child health conference? Why does she go regularly to a private pediatrician when she can afford to?"

The answers to the psychiatrist's questions began with the traditional concepts of weight, diet, and immunization and progressed in easy stages through the entire range of needs that a child health conference must try to meet. The group agreed that the success of child health conference work seems to depend on intangible factors which influence the use that the mother makes of the advice and guidance which is provided. They came to the conclusion that

while the mother comes ostensibly for advice about child care, she is really asking for something more than factual information and recommendations; she needs and wants support and reassurance for herself as a mother. "If anything, the need for reassurance today is greater than ever. One has to remember that these mothers have an intuitive feeling about their children and their relationships to them, but unfortunately some of it is knocked out of them by what they read and hear. Often the young mother who tends to be somewhat insecure is unable to accept her own intuition. She can't believe that she is able to cope with this developing human being and so she hesitates and while hesitating she may do nothing; or she may go to the other extreme and do too much."

"There's been a lot of talk here about reassurance," said one health officer. "But sometimes they do things wrong and we certainly don't want to reassure them about that. How liberal should the dose of reassurance be?"

"That depends on many factors, not the least of which is your knowledge of the mother, of her as a person and of her relationship to her child in particular. Certainly wholesale reassurance is not your job, but the kind of anticipatory guidance that we were talking about earlier is what I think I mean by reassurance. You'll see what I mean as we go along.

"Let's start with one simple premise. *The child belongs to the mother.* He is not the property of the doctor. Don't laugh. This is a lot more serious than you think. I've seen too many pediatricians and health department clinicians, too, who assumed that the baby was their property temporarily loaned to the mother, who was under orders and expected to obey, or else. This is the extreme kind of medical authoritarianism, extreme in quality, that is, but not, unfortunately, in incidence. A change in attitude on the part of the doctor or of clinic personnel can have tremendous value to a great many mothers and babies.

"For example, suppose we were to say that beginning next week we will assume that all the children who come to our clinics belong to their mothers, that the mothers are basically responsible for bringing up their children and that we and our services are available to assist them. You'd be surprised at the difference that would make in the atmosphere of many well-baby clinics. We'd begin to look at the baby through the mother's eyes, we'd ask her how the baby is and really listen to what she says. We'd tell her what to expect and how she might approach the important developmental changes as they come along. We'd emphasize for her the uniqueness of her child and help her relax about taking care of him. We'd assume that she has to take care of him twenty-four hours a day, seven days a week, and that our relationship is only incidental to her enduring relationship.

"We'd assume, too, that mothers bring to the maternal experience their strengths and weaknesses, their fears and hopes, and that, for the most part unconsciously, each becomes the only kind of mother she can possibly be as a result of her life experience to date. We'd no longer say to all mothers, 'You must do so and so for your baby in such and such a way,' and then proceed to sit in judgment on their performance. We would say to the mother: 'This is your baby. He's a fine youngster. These are some of the things he will be doing sooner or later, depending on his rate of development. If you watch him, you'll see him begin to make progress and you'll recognize when he's ready for the next steps. Take it easy. He's yours to enjoy and take care of. Don't worry too much about rules and regulations. Advice is always available when you need it, but don't let anything the experts say keep you from being comfortable with your baby.' "

One of the common stumbling blocks in all work with children —the tendency to identify with the child—was discussed by all sections at one time or another and emphasized by one psychiatrist

as follows: "Most mothers who come to the well-baby clinic have the same underlying question, 'Am I doing a good job as a mother?' I'm very anxious to stress this point because it is fundamental to what we have been saying about reassurance. In my experience I've sensed that most of us who are primarily interested in the welfare of the child more or less identify ourselves with him and tend to inflict our concepts of what constitutes a good parent on the mother and father. This is true in child psychiatry among the psychiatrists, psychologists, and social workers, and from my observation of health departments I believe it's just as true of nurses and clinicians. It is not a conscious determination to exclude the parents, but a perfectly natural tendency to identify with the young child, to want to protect it, to carry responsibility for it, and to take advantage of our professional position to sit in judgment on the parents. I believe that to have this tendency is natural and human and shows the kind of warm personality that we like to see in work with children. But to let it get in the way of the mother's comfortable relationship with her child is a serious misapplication of one's authority and should be conscientiously controlled."

The extent of the need for help was raised by a health officer: "I think we've all seen enough in these interviews in the clinics to go along with you a hundred per cent on the value to people of the kind of approach we've been talking about. But what'll we do about that eternal question of how to find the time to give to these people? You said that even if the time you have to give is very short, the important thing is to concentrate on the person you're giving it to. I know what you mean by that. I think all of us do. But there is another question. From these interviews we get the impression that there isn't anybody without problems. Isn't there anybody who can bring up a child without help?"

To this expression of frustration the psychiatrist replied, "I'm afraid I'd have to say that every mother needs some help and tries

to get it in one way or another. If a mother doesn't come to a doctor for it, she gets it somewhere else, from her mother-in-law or an older sister or the corner grocer or the neighbors. Nobody raises a child in a vacuum, and depending on the quality of the advice and guidance which the mother seeks and gets, she is either helped or not helped, but she certainly gets advice and she just as certainly needs it.

"Actually you know, it might be much better to let the mothers ask for clinic visits when they need them than to put the interviews on a regular schedule in which the clinic takes the initiative. If the mothers came in when they wanted help, there would be little danger of overdoing it. As a matter of fact, the clinics wouldn't be so crowded, the mothers who really needed and wanted help would get it in terms of what they were asking for rather than in terms of standard procedures of weighing, measuring, and the like, and the whole thing would be much more purposeful. On this basis, too, you would be able to expand the service to include the preschool years and have more continuity of service."

Later in this session the talk turned to the special difficulties which health officers encounter in the case of children with physical or mental defects: "I don't know if the rest of you have this as much as we have, but it seems to me that one of the worst problems—certainly one of the most difficult—that we have is how to talk with the parent of the defective child, who brings the child in in the hope that something may be done in the crippled children's clinic or in some other special children's service. You remember I mentioned last night at dinner the child whose mother thinks he is tongue-tied because he can't talk. He isn't tongue-tied at all. There's nothing anatomically wrong with the tongue.

"When I'm faced with a situation like this, I have a serious problem. I've always been concerned, perhaps too much so, about the

problem of being completely honest with parents. I always try to make sure that they get the whole truth, hoping that in this way I'll save them the experience of going around from doctor to doctor, or eventually from quack to quack, spending money which might better be spent on other children in the family, if it's not possible to correct this child's condition. Now, I don't know. In thinking back over it, there may have been times when I've been a little too brutal in talking to them and in saying that nothing could be expected from pursuing their present course of more and more examinations. What do you think?"

All were agreed that it is the physician's responsibility to confirm the diagnosis and then to use the facts to safeguard the parents from "shopping around and getting into the hands of quacks who may bleed them financially." This rational approach, however, frequently meets with defeat when it is pitted against the emotional need to deny such painful facts. Most professional persons find it extremely difficult to deal with the parents of defective children because they, in common with others, are so distressed by the situation that they tend either to make light of it and thereby avoid the whole truth, or to emphasize the complete hopelessness of the condition so as to convince the parent by sheer weight of evidence.

"Even though your intentions are good, an abrupt or dogmatic statement can be very painful. It gives the mother no outlet for her guilt. She feels that in some way she is responsible for this child's abnormality and to ignore her feeling is to intensify it. The guilt is always there. No one who has worked with mothers and babies can have failed to see the obvious fact that all mothers unconsciously feel wholly responsible for the babies they produce. If the baby is beautiful and bright, they have a sense of accomplishment. Their product is good. If the baby has a defect of one kind or another, the producer is guilty. Usually she tries to hide it even from herself

and goes on for as long as possible assuming that he'll outgrow whatever it is, even though she really knows that he won't. It's pretty hard to strike a mid-point in dealing with these situations."

"Well then," said the health officer who had raised the question, "I guess the key to the situation may be this—that I as an interviewer and the rest of us, if we're inclined to look at these things as a tragedy or something we're frightened about ourselves, had better take a second look at what our own feelings are doing to people. I think I probably have had a hypersensitive attitude toward defective children, whether physical or mental, and maybe because of the fact that I'm sort of nervous or concerned about it, I tend to make it all the worse for the mother."

"We can't stop being disturbed by these situations, but we can try to make the interview a positive experience for the parent. These parents have so few positive experiences that it may mean a great deal to them to find someone who understands or tries to. As a psychiatrist I've seen many such parents and their children. It might help if I try to tell you what my attitude is and how I approach them. I try to go along with what it really means to the mother to have a child like this. I try to put myself in her place, because I've found that when she knows that somebody else realizes what it means to her, she doesn't have to go on fighting it. Often when you approach a mother in this way you find that she is able to talk about the problem for the first time and can stop covering up. Frequently mothers will say, 'I've never been able to say this to anyone before, but I can see that you understand and know what a great disappointment it has been to us.' Once this happens, the mother is able to go on and find whatever is positive in the situation: things that the mother can do that will be useful, helpful things from which she can get satisfaction and which she feels have real meaning for her and for the youngster."

It was noted that the slowly increasing use of rooming-in, the

growing interest in breast-feeding on the part of many mothers and some pediatricians, and the increasing acceptance of on-demand feeding are all trends toward the kind of natural relationship between mother and child that existed long before the rigid schedules which were considered scientifically valid during the 1920's and early 1930's. As one of the psychiatrists put it, "We had become so scientific about all of this that most people felt insecure in dealing with their children. We have a civilization that believes in science and experts, and we tend to assume that all cultures are like ours. But they aren't. In many places even in our own highly scientific country we have mothers who are much closer to the traditions of their mothers and grandmothers than to the latest word from the expert. Any well-baby clinic doctor who is honest with himself can tell you a story about a situation in which the doctor talks his head off about what the best procedure is in child care, only to have the mother go home and do what seems natural to her, what her mother had taught her or what she had seen her older sister doing with her baby. She had the feeling of confidence in tradition that made her quite comfortable about being old-fashioned. These mothers are usually very polite to the doctor. If the doctor asks, 'Are you giving him the cod-liver oil?,' the mother replies, 'Yes,' with a relatively free conscience. She's just being polite in guessing that if that's what the doctor wants, she'll say that she's been doing it. They were the despair of the pediatricians in earlier days—the mothers who would not take seriously what the doctor was telling them. But now we recognize that the kind of self-assurance that those mothers had was probably infinitely better for the child than the kind of awesome respect for somebody else's opinion that our educated mothers had."

Some pediatrically-trained members of the group objected to the apparent implication in all this, that warmth and affection

alone make for health and happiness. They pointed out that scientific developments in medicine have not only cut the infant mortality rate, but have provided greater protection for growing children than was true in the early days of the century. They asked whether some of the statements made by psychiatrists did not seem to negate the importance of life-saving, disease-controlling practices in pediatrics. They were assured that this was not the intent, that the opposite was true. Psychiatrists are doctors first and specialists second; they respect scientific progress and seek only to supplement and render more effective the use of medical knowledge by adding to it the human ingredient that will make it more acceptable and therefore more useful to people.

At the end of this session one of the health officers was heard to remark, "After all this discussion I've become very skeptical about our civilization. We've just kind of milked the human-kindness out of it. Our difficulties all pretty much come down to neglect of the personal element in our everyday situations."

In another section there was discussion of the human element in immunization and other mass techniques. In discussing anxiety, which had been the subject of the lecture that morning, one of the health officers raised a question about the apparently disproportionate amount of anxiety that is precipitated by some of the current immunization methods. One of the health officers repeated what he had heard about a clinic in England which was making a conscious effort to cut down this anxiety.

A psychiatrist who had visited that clinic said, "One of the first things they did was to switch from bringing in a whole batch of children for immunization to bringing them in one at a time, so that they weren't all standing around watching others being immunized. They also tried to keep the waiting time down to a minimum so that there wasn't a long line outside the door, and they also arranged for separate entrances and exits. Then, too, they

covered the needles so that the child did not see a whole array of dangerous-looking objects when he came into the room. Their attitude toward immunization was that it hurt and the child was encouraged to talk about it and to cry if he wanted to. The parent was told that the child might be upset about it and that he might want to get rid of some of his feeling about it in the play situation afterwards, so that they would understand when the child pretended to stick needles in a doll or stuffed animal. They learned that it is preferable to let the child know what's going to happen and to help him get rid of as much of his feeling about it as possible, because often the child who is stoical about the shot when it happens may cry in his sleep that night and may have continuing fears about it if he has to bottle up his feelings at the time when a spontaneous reaction would be reasonable. The result of this approach in the London clinic is that it's as noiseless as any clinic could be; they no longer have a roomful of howling, screaming youngsters."

The psychiatrist went on to say, "I've been interested to see the change in techniques in one of the clinics out here that I knew rather well about three years ago. At that time they used to bring in the youngster, tell him that he is a big boy and that big boys don't cry, and then give him a piece of colored paper with a figure on it with instructions to look at the figure, which he could take home with him to color. While he looked, he got the shot and was removed from the room at once. They've changed their methods. Now they tell him that it's going to hurt but not too much; he can cry if he wants to and he gets his piece of colored paper on the way out."

"There's another point about all this that might be stressed and that sometimes increases the difficulty," said another psychiatrist. "If crying or showing fear or some resentment is met by the nurse or doctor with admonitions or with criticism, it may actually lead

to even greater fear of doctors later on; whereas if one can empathize enough with the child—because after all it does hurt, and he probably is more afraid than the occasion warrants, also justifiably—the doctor can permit the child to react naturally. He can permit the child to be afraid and to be angry. Of course, on occasion, the anxious child is more afraid or more angry than need be and here firmness, not anger or impatience, but healthy firmness actually helps and supports the child. I am sure you have had this kind of experience. You'll get a screaming child who is in a panic and if you say gently, 'Yes, it is pretty bad, isn't it? It's awful,' the kid may look back at you and stop crying and be much better able to take it. For the average relatively well-adjusted child, your recognition that he's scared and that it will hurt, but not as much as he thinks it will, and that you think he can take it, is usually enough. But you must remember that it won't cut out all those who have already been conditioned to exaggerated fear by their earlier experiences."

"I am interested in some of the administrative angles in immunization," commented the public health instructor. "I remember one clinic I used to work in where it was the rule for the doctors and nurses to gang up outside and wait until six mothers got their babies all set on the six tables in the room that we used. All we'd say to them was, 'All right, take your kids in and pull down their pants,' and we'd wait outside until they did. Then, when all six youngsters were uncomfortable as hell, with all their buttocks up and waiting, we'd come along and administer the shots down the line. Actually the time we took waiting outside could have been spent much more profitably for everybody concerned if we had taken the trouble to see each child individually and to say a few kind words. The tension we must have created makes me shudder."

One of the health officers added, "It seems to me that most of

the children need to feel that they have some control over the situation. Now I've done this for years. I don't know whether anyone else does it or not, but I've never gotten into difficulty. I just say to the child, 'Now this is going to hurt a little bit, but if it hurts too much, you tell me and I'll take it out.' They're so busy trying to decide whether it hurts too much that it's all over before they say anything. Of course I do it very quickly and if they do beat me to it, I do take it out, but that's only happened once or twice."

The psychiatrist pointed out that a method of this kind means to the child that he is not helpless in a situation controlled by grown-ups. He is participating in something over which he has some control.

There was also some discussion of the attitude of the doctor and the nurse and recognition of the fact that an uneasy, unskillful person who is tense always has a tendency to create tension in children. In the words of one health officer, "Leadership and morale are pretty important. When you have a class that has a good teacher, you find that the whole group goes through without any trouble. Another thing is that the children who have trouble at the immunization clinic are the children who have problems at home. They're the ones that throw a terrific wingding."

In still another section the talk flowed along pretty much the same lines and eventually turned to the doctor-patient relationship in pediatrics. Several health officers indicated that they had been thinking about the validity of separating immunization and other traumatic experiences from the regular contacts with the child in the well-baby clinic. It was their feeling that it might be advisable to try to keep the clinic relationship a relatively happy one, while tests and shots of one kind or another were given in another clinic by another doctor who did not have a continuing relationship with the child. There was a difference of opinion on this question. Some members of the group felt that it might be

valid for the child to have this separation between the pleasant contact and the painful one, but by and large, the group felt that it was somewhat unrealistic.

One of the proponents of immunizing children in the well-baby clinic explained that his reason for doing so was concerned with the convenience of the mothers, especially those with small children who would find it difficult to arrange additional visits. He felt that it was also more practical from the point of view of the clinic. Others felt that a separation of this kind would tend to negate the validity of the pediatrician's continuing relationship with a child in private practice. After further discussion there was general agreement when one of the psychiatrists summed up the situation as follows: "Certainly in private practice we have found that one can be both the regular doctor and the immunizer or the giver of painful medications. There will be crying on occasion, it's true, but, as some of you have indicated in talking about this, the basic determinant is the doctor's previous relationship with the child, whether it has been good or bad, and also what the child's general life experiences have been with people."

The other psychiatrist picked this up to point out that the trend in the discussion had been toward protecting the child from all kinds of experiences which might potentially be anxiety-producing. He reminded the group that at each step in development the infant, the young child, and later the adolescent encounter situations which inevitably produce anxiety and that if an individual is to live in a world of reality he must be exposed to such situations. He said further, "You will remember in this morning's lecture about anxiety it was made clear that while anxiety may at times be devastating and may be followed by terrible consequences, a certain amount of anxiety is unavoidable and our problem is to manage it and its results, to minimize them rather than to try to avoid them. For example, those children who will react with the most

intense anxiety to these procedures that we have been discussing, whether in school or in the health department, are in large measure doing so because of their earlier experiences in the home. A healthy teacher-pupil relationship or nurse-patient relationship will tend to counteract the results of the home experiences and we should try to provide it wherever possible. We can also think in terms of reducing the number of procedures which we know to be potentially harmful to emotional or mental health. In doing so, however, one must always remember that there will be severe anxiety in some cases and that you can try, but will not necessarily succeed, in reducing pathological anxiety. Nor is it possible to act in such a way that some anxiety does not occur. That's the heart of what I'm trying to get across."

SERVICES FOR CRIPPLED CHILDREN

Several visits were made to convalescent wards and physiotherapy departments where interviews were held with children and adults under treatment. Emotional identification with persons suffering from crippling diseases was evident in the discussion in all sections. Most members of the faculty in their discussions of these patients attempted to point out some of the pitfalls in this overidentification and some of the common fallacies in treatment.

In several sections there was brief discussion of the dangers of the long-term physiotherapy which is ordered during or immediately after the acute phase of an illness and sometimes continued far too long without appropriate review. This was in part related to the administrative set-up in which diagnosis and early treatment occur in one institution while continuing physiotherapy is carried on elsewhere. It was also felt to be the result of the rather widespread tendency to look upon a concrete physical symptom of the kind one finds in polio as something which requires many months of treatment without need for re-evaluation.

As one psychiatrist put it, "This is a dread disease. We don't know when it will strike and whom, and we have no way of protecting ourselves from it. Therefore, our fear and anxiety are diffuse and our behavior when it strikes isn't always rational. Those who suffer from it have our warm sympathy, sometimes beyond the point that is useful for their full physical and emotional recovery. The point that I want to make is not that we should stop sympathizing or that we should become very objective toward something that holds such personal terror for everyone, but that we should understand what we are doing to people when we go on giving treatments to a limb that has long since regained as much strength and flexibility as possible, thereby postponing for the patient the day when he must come to grips with his handicap, or even with the fact that he is no longer handicapped and should not expect to go on being the recipient of special attentions which set him apart."

A number of factors in the understanding and treatment of post-polio patients, as well as some basic interviewing principles, will be found in this account of an interview between one of the health officers and a fourteen-year-old boy at the physiotherapy clinic. The health officer had chosen to interview the boy because he was attracted to him and thought he would like to get to know him a little better. The following is largely in the health officer's own words:

"I looked at his chart and talked with him for about five minutes and I found myself wishing for a conference with you, Doctor. My question is this. If you have advance information about a patient before you see him, how does that affect the interview? I found that I directed all my questions toward getting information about a certain point and I'm afraid it made me awkward." (He referred here to information that had been given him by the nurse to the effect that the mother of this boy had deserted

the family soon after the patient was released from the hospital following the acute onset of polio. At the psychiatrist's suggestion he then gave a running account of how the interview had gone.)

"I got into the interview by telling him that I had seen him having a treatment, that it looked like a good rubdown, and that after driving through the desert I felt that I would enjoy one too. I then said, 'Tell me about it. How did it start? And he did. He said that as he figured it, if you're in a rundown condition, germs have a chance to get going. He was run down. He had been very active, swimming and all that, and this gave the polio germ a chance to take hold. He described his acute symptoms and hospitalization. He had spent the evening baby-sitting and had come home rather late with a terrific headache. He felt restless and sick and complained to his mother. They couldn't get a doctor that night and his mother gave him some headache medicine, but it didn't help. She slept with him that night and tried to comfort him. The next morning he was taken to the hospital. In talking about this he mentioned his mother several times and her attentions to him. He was given hot packs at the hospital and remembers that he was burned by one of them. Then after sixteen days in the hospital he came home and his mother took care of him, giving him hot packs four times a day.

"At this point he began to get a little nervous. I felt that maybe it was because it was along about then that his mother deserted him and I did not press him or show that I noticed he was nervous. He then said that his father took good care of him, built a stand for the back wheels of his bike so that he could exercise, took him to the hospital whenever he needed to go, took him swimming, and the like. He's now doing a lot of swimming and feels better. I asked about his brothers and sisters and he said that he has two sisters, one older and one younger. The older sister helps him when he needs assistance but most of the time he manages O.K.

He seems to take quite a bit of responsibility for his younger sister.

"I asked him whether he spends much time reading and he said that he doesn't read much; never seems to be able to finish a book. I asked about the funnies and he said he doesn't read them because 'they aren't good for you and the print is poor.' We talked some more about how he feels about things and he said, 'Sometimes I have a feeling that everything is going to explode. When I feel like that I go into my room, close the door, and have a good cry.' I asked him how he feels after that and he said he feels fine; he could go out and lick a half a dozen kids. Sometimes he feels nervous about nothing in particular and then he said 'Sometimes I wish I could go to sleep and wake up in the morning and everything would be O.K.—like a miracle.' But he said he knows that that can't be, that there will be no miracle, that it has to be the slow way. He also believes that everything will be O.K. eventually. His muscles are getting bigger and he's feeling better.

"I asked about his father and he said that he now has temporary work but that he's talking about going to Canada. I said, 'That might make for complications,' and he said, 'Yes,' but that his father would be able to save money and buy a house for the family. I asked where the family had come from and how long ago and he said that they had lived in Arkansas, but the river had washed away their farm so his father came here, got a job in the shipyards, and brought the family here six years ago. About his schooling, he said that he has a home teacher now and is managing to keep up to grade. He'll go back to school in the fall. He has no favorite subjects but does fairly well in all of them.

"When I asked what he would like to be when he grows up, he said he would like to be a doctor in a clinic like this one. When I asked what else he had thought of being, he asked me whether I thought he was underweight or undersize for his age. I said I didn't think so and why did he ask that? He has often thought

that he would like to be a jockey because he loves horses. When I asked whether he had ever gone to races, he said, 'No,' but that they had had a good horse on the farm, not only a good work-horse but a good saddle-horse, and he had been very fond of riding.

"When we talked about living conditions, he told me that the family lives in one of the housing projects. His father is now trying to redecorate the flat. They used to be crowded but they have plenty of room now because his two older brothers are out of the home. They're in the Army and stationed overseas. An older sister who is married lives nearby and comes to visit. When I asked if there was any other illness in the family, he said his mother had been sick at times. She was in the hospital several times with stomach trouble but is home now. I never did get to ask about the mother's leaving the family. I couldn't bring myself to do it and I was disappointed because I wanted to know." (A nurse who knows the family and was present at this session said that when she had visited the home the week before, the mother had been there.)

Psychiatrist: "How did the interview end?"

Health officer: "I asked 'Why do you think I have been talking with you?' and he said 'You're all out here to see how we're getting along.' "

Psychiatrist: "You did a wonderful job. Adolescents are the most difficult to interview and I was a little worried when you said you wanted to talk with this boy. How did you feel about this interview?"

Health officer: "I was very tense about the mother."

Psychiatrist: "Let's talk about your question. Does information you get beforehand help or hinder in an interview?"

Health officer: "This information worried me, because if it was true, it meant that he was hit hard when he needed his mother most. It might have been bad not to have this information because

I might have gone right ahead and asked a natural question that might have upset him."

Psychiatrist: "You can't give a hard-and-fast rule about what kinds of information you should or shouldn't have before you see a patient. By and large, the more useful, factual data you have, the better, because you can save time and you have many leads for getting into your interview. But in this case you were identified with the boy, perhaps overly afraid of hurting him and that made you uncomfortable. It wouldn't have been so bad if you had asked the natural question. If you had been natural and had asked a question that hurt, he would have blocked on it and you would have been warned. You were afraid of the impact of your feelings on him. You were afraid of hurting him.

"Let's take up some of the points you might have picked up and also the meaning of some of the things he said. One of the general principles in interviewing might be to look for what the patient does not talk about. Also, in relation to these gaps, identifying data is helpful before an interview so that you can spot gaps. For example, if he has some sisters in the home that he doesn't talk about, why doesn't he? Or you would be interested in any expression of the ways in which a patient handles his anxiety. He had a good relationship with you and could bring up freely the fact that he sometimes goes in his room and cries. We know that is considered an unmanly thing for an adolescent boy to do. I wondered if you might not have picked up on his wanting to be a doctor and what it means to him."

Health officer: "Maybe if doctors had done more, he wouldn't have had polio."

Psychiatrist: "That's a possibility, and also he may be saying 'I want to be a doctor to help others and myself.' It is common to find patients with chronic illness identifying with the doctor who helps them. And his notion about being a jockey might be called pro-

jection; he wants to become part of something that can run fast, with him in control. He told you about his daydream about the miracle. What do you think his dreams are like?

Health officer: "Probably running and winning. I guess that's what you call wishing through dreams."

Psychiatrist: "And a very normal mechanism for handling anxieties."

Health officer: "He said that he doesn't read the funnies because they are bad for the eyes. I wonder what that means."

Psychiatrist: "That is an interesting defense. As you know, in the comics there is a lot of aggression and destruction which can be very disturbing to a boy who is caged and frustrated, who has the drives of a normal adolescent and no release. In a sense I would think that this is his way of protecting himself against stirring up feelings that he can't handle. Some patients say they wish they were dead. What they're saying is that they wish that they could escape from the frustration."

Health officer: "When we talked about how tough it was to be sick in this way, he said that there were two other boys in the neighborhood, both of whom were having a harder struggle than he was with their post-polio convalescence, and I told him he was a swell fellow and was going to be all right."

Psychiatrist: "Let me warn you against a common error; that is, falling in with the patient's wish by saying, 'You're going to be all right.' We really say that to reassure ourselves. True, it helps protect the patient's defenses, but there is danger of overbalancing reality and giving false assurance. The doctor represents authority and the patient needs to grasp at this symbol for security. Too often the doctor needs to give this assurance to handle his own anxiety."

Health officer: "I guess it's not honest. Even when our own anxiety isn't involved, we tend to do it because it's easier. It's a

little like that patient yesterday who had a bad language difficulty. We told her she spoke beautiful English, when she knew she didn't and also knew that we didn't really think so."

Nurse: "I'm sorry that I put the doctor off with the information about the mother, but I knew what Malcolm had gone through and wanted to protect him. In many ways Malcolm is older than his chronological age. In his mother's absence he carried a tremendous responsibility for the family because he was home much of the time and his father was away working."

Psychiatrist: "Even though the mother may have deserted the family recently for whatever combination of reasons, she must have given this boy love and security at some time so that he had something on which to draw when he needed strength most. Instead of retiring into his illness, he was able to take on responsibilities and think of the family as a whole when he could easily have thought only of his own troubles, with the result that he has made better than average progress, physically as well as emotionally, and has grown up, perhaps too much but certainly enough, to meet the demands that the world has placed on him."

Nurse: "As a matter of fact, the other two boys that Malcolm mentioned didn't take it the way he did at all. They went downgrade and have been in the institution pretty regularly since the acute illness."

Psychiatrist: "We are all vulnerable about crippling. It stirs up our fears and sympathies. We want to protect the patients and in doing so may succeed only in incapacitating them."

This discussion was terminated officially because of lack of time; but on the trip back from the clinic and in bull sessions later that evening, other points were made, such as the rationalizations which mothers use to handle their guilt when crippling diseases strike their children. The health officers were able to produce from their experience many examples of this kind of thing which they had

not previously understood but which fell into line as they discussed them. The need to attribute polio to a tonsillectomy during the polio season was fairly common, or blaming the child who insisted on going swimming when his mother had warned him that polio might be the result, or the father's insistence on going to baseball games or other sports during the polio season, thereby exposing the child whom the mother would have protected. Of course the other extreme was also represented plentifully in the health officers' experience, that of the excessively anxious mother who accepts—in fact, seeks—the full blame for what has happened to her child.

The group came to the conclusion that parental feelings of guilt probably are present to some degree in all such situations and should be taken into account in prescribing treatment. It was also felt that health department personnel should be helped to an awareness of the ever-present danger of overprotection of the physically handicapped, with the resultant aggravation of dependency.

TUBERCULOSIS CLINIC

"Rehabilitation of a tuberculosis patient starts at the moment the diagnosis is made. Or maybe I should say that it should start then, but often doesn't."

This comment by a health officer led to discussion of rehabilitation in general and tuberculosis in particular. It was recognized that it is still common practice in medicine to observe a rather artificial demarkation between diagnosis, treatment, and rehabilitation. Newer concepts of the total human being, of the interdependence of the psyche and the soma, of the individual and his environment are now accepted in theory; but medical education generally does not yet prepare the physician to apply this theory in his everyday relationships with patients.

This was found to be equally true in health department organization where lines are drawn between diagnostic and treatment services, while rehabilitation is usually seen as still another separate function either within or outside of the department. The fallacy of this dichotomy was clear to all as the nature and impact of tuberculosis was discussed.

"Sure, we can tell the patient with some degree of assurance that he'll probably recover within a couple of years if he does as he's told, but I never added up for myself all the other things that are involved. If you put them all on the scale, they'd far outweigh the mere fact that the patient will probably not die of the disease. As a matter of fact, they're so serious that death might be simpler to contemplate."

As the group enumerated the dislocations that come with the knowledge that one has tuberculosis, it expressed some wonder at the resilience of the human being who can deal with them in the face of the profound anxiety which the diagnosis precipitates. The moment that the diagnosis is made, the individual's way of life terminates abruptly: his work or his schooling ceases; his responsibility for his own livelihood and the welfare of his family must be relinquished; his personal relationships with family and friends are affected, first by the danger of contagion and subsequently by his removal from the home; his goals for himself and his family must be revamped at a time when thought processes are seriously handicapped by confusion and anxiety; he must stop thinking of himself as an independent, self-determining human being who knows where he is going and by what stages he expects to reach his goal and begin thinking about the future in terms of years of dependent existence away from his loved ones, with death or partial recovery as the end point.

"All this is really part of diagnosis and certainly the crux of

treatment. Are we really helping these people when we say, 'Too bad, old man, this is it, but it's only for a year or so and if you cooperate it may be less.' "

As one of the psychiatrists pointed out, "You can set the whole tone of the patient's course by the way in which you break the news to him and the help you're able to give him in reaching the point where he really believes that it has happened to *him*. Coming to grips with the fact that he has it is often a long process even though verbal acceptance seems to be fairly rapid."

The manner in which diagnosis is confirmed came in for considerable critical evaluation. Mass x-ray techniques were considered by some to be anything but conducive to anxiety-alleviating relationships. The plates used in mass x-rays can only pick up the doubtful cases. These persons are then asked by post-card to come in for another x-ray. Their questions and fears are seldom discussed with them when they come. If the x-ray is positive, the patient is again summoned for the next step and may subsequently learn, again by post-card, that he has positive sputum and is suffering from pulmonary tuberculosis.

Several health officers expressed vehement and colorful disapproval of such methods, adding that they too had been guilty of this practice because public pressure for mass x-ray campaigns had been stronger than their power to resist. It was the consensus of the group that the time has come when to consider the individual in mass health programs is not only good mental health but good public health practice as well. They were agreed that community-wide programs are highly desirable, but that care must be taken to gear such programs to the needs of the individuals who make up the community.

It was further agreed that from the most pragmatic of all considerations, that of the taxpayer's dollar, a more personalized ap-

proach to diagnosis and treatment in tuberculosis would net a far greater return in health and productivity than the current segmented practice.

"I think I could even sell this to my board of supervisors as a money-saving program. Let's talk about it some more. Let's say this young fellow comes in and you have to tell him, or somebody in the department has to tell him, that he has pulmonary tuberculosis and he'll have to go to the sanatorium. Now the way most of us do it is just to tell him, follow that up with a word or two about the sanatorium, and inform him that the nurse will let him know when to report. Then what happens? He goes out on a binge, or he leaves town, or he refuses to go to the sanatorium and has to be forced, or he goes to bed and stays there and his family has to shift for itself."

The psychiatrists picked up the several illustrative reactions and discussed their meaning in terms of personality structure and social adjustment. "He goes out on a binge because that's his way of escaping an intolerable reality. While he's drunk he doesn't have to face the facts, but they'll still be there waiting for him when he sobers up. He may therefore prolong the binge to prolong the escape. That he's injuring his health still further by this episode may not occur to him consciously. There may also be an unconscious desire to achieve the ultimate escape in death. To leave town is another attempt to escape from something that has not yet been fully grasped as being within himself and therefore inescapable. The individual who refuses to go to the sanatorium is reacting to authority in a way that is compatible with his pattern of behavior. He's insecure, anxious about status, and needs to behave in a way that'll demonstrate to the world which he fears that he's really not afraid of anything and can't be pushed around. In this way he can continue to deny to himself and others the fact that he really does have t.b. And the man who retires to his sickbed

and throws himself on the mercy of the doctors and nurses, the perfect patient who does everything he's told to do, except get well, is unconsciously seizing upon the diagnosis as his escape from the burdens and responsibilities of life."

The range of possible kinds of reaction was by no means exhausted during these discussions, but the health officers recognized the fundamental aspects of the problem as they related to health department responsibility to the individual and to the community. The individual needs to be helped to understand the nature and meaning of the illness, its implications for him and his family now and in the future, and must be helped to make the best possible use of the resources which the community provides. The community, in turn, must be helped to understand its responsibility to the patient and to the larger group and must also be helped to discharge that responsibility so that complete rehabilitation is seen as a corollary to every positive diagnosis.

"Let me say quite dogmatically that nobody can comprehend fully the fact that he has t.b. merely by being told that he has it. He must be helped to understand what it means to him and to his way of life and must further be helped to take action to modify his environment before the reality actually begins to seep in. The situation is further complicated by the fact that an individual who normally made decisions easily now finds it difficult to make up his mind about anything or jumps to hasty conclusions that may be unwise."

It was clear as the discussion proceeded that the patient's approach to treatment is predicated on his understanding of the disease and his acceptance of its place in his life. Time spent in helping him look at his situation and take steps to deal with it may seem to be mere postponement of essential therapy; actually it is a prelude to more effective therapy. If at the same time the health worker considers with the patient shifts in occupational

goals or long-range objectives, there is less likelihood that the patient will enter the hospital as though he were entering another world from which there is no return or as though it were a penal institution from which he hopes to escape at the earliest possible moment.

An opportunity to express his fears to someone who tries to understand, someone who will enlist the community's resources to help him and his family is every citizen's right when disaster strikes. To ignore this right and need is to increase the suffering of the individual and to deny to the community the contribution of one of its potentially productive citizens.

Again the question of time came up for consideration and there were some who wondered how one could give each tuberculosis patient all that he needed. But after a brief review of the alternatives, it became clear that time could not be measured in terms of the number of minutes available per patient on a given day. "If you think of time in terms of the years during which this patient and his family will be known to public health and welfare agencies as a result of his illness, the three or four hours you might spend with him in the beginning are microscopic. And if they're well spent, they may save months of public expenditures and services later on."

The situation of one tuberculosis patient who was interviewed at the clinic by a psychiatrist on the first day of the institute so graphically illustrated this point that the health officers who were present at the interview talked about it throughout the course and even referred to it when they were visited six months later. In the section discussion that morning the psychiatrists had outlined the essentials of interviewing and had emphasized for the health officers the importance of trying to understand the meaning of the illness to the patient and his personal and social resources for dealing with it. They had stressed the value of listen-

ing and observing and trying to see the patient as a unique human being who moves in a familial and cultural constellation which inevitably affects his ability to deal with life experiences.

The health officers were interested, but not impressed, and on several occasions they commented that they "just didn't see how all that could come out of an interview." At the tuberculosis clinic that first afternoon the psychiatrist asked to see a patient who had just learned that he had the disease and perhaps several others who had been under treatment for some time. Since this selection was not readily available, the psychiatrist interviewed the first patient to arrive.

Dick F. was a young man of about twenty-three who had had tuberculosis for a little over a year. He was on pneumothorax treatment and had come in for an air refill. The record stated that he was rather uncooperative, that he frequently missed appointments at the clinic and seemed to have a devil-may-care attitude toward his illness and life in general. The nurses were annoyed with him because his approach to them was flippant and flirtatious. The general impression at the clinic was that Dick was an irresponsible young man who tended to ignore the serious nature of his illness.

After the psychiatrist had introduced the group to the patient as doctors who were interested in his condition and in knowing how he was getting along, Dick talked freely but superficially in response to an initial question. A description of the interview follows in the words of an observer:

"Dick was pretty cocky and self-assured when he started talking. In the first fifteen or twenty minutes, as he outlined his history and present situation, it seemed like a rather simple, straightforward story. He had left home a couple of years before because he had wanted to be on his own. He moved to another city and obtained work in an automobile factory. While there he became

ill and learned from the company doctor that he had pulmonary tuberculosis.

"Dick said that he knew tuberculosis was a terrible thing and just couldn't believe it had happened to him. He made it quite clear that he had always thought that his body was very nearly perfect and that the idea of a thing like this eating away at his lungs was too fantastic to believe. To disprove this unacceptable diagnosis, Dick returned home to see his family physician, who he felt would certainly be able to assure him that it was all a mistake. The diagnosis was confirmed by the family doctor, but Dick still found it difficult to believe. Since the family could not afford private care, Dick became a patient of the public agency. He was hospitalized for several months, during which time he made good progress and was able to return home. For the past six months he had been under treatment at the clinic.

"Up to this point the observers saw Dick as just another tuberculosis patient who was pretty independent and not too cooperative about coming in for treatment. It seemed to be the general feeling that this young man needed to be impressed with the seriousness of his condition so that he would become more cooperative. But as the interview progressed, the situation took a decidedly different turn. In a friendly, interested manner the psychiatrist followed up on earlier leads with a question or two where they seemed indicated: questions about treatment, about how he happened to miss appointments so frequently, about what he did to keep busy if he were not working, and about the effect of his illness on his family relationships.

"In response to this interest and the skillful use of leads which he had given earlier, Dick lost most of his devil-may-care attitude and began talking about a very painful family situation. Some years before, his father had left home and his mother had subsequently obtained a divorce. Dick occasionally sees his father on

the street but avoids any contact with him because he is ashamed of the father's alcoholic deterioration. About three years ago the mother remarried. Dick had disliked his step-father from the beginning and had gone to great lengths to avoid him because they quarreled whenever they were together.

"He evolved a routine which made it possible for him to have only minimal contact with his step-father. He would sleep late in the morning and not leave his room until after his step-father had left for work; then he might work for a few hours at odd jobs or just sit around at home. In any event, he would leave the house in the late afternoon and usually not return until after midnight. He played basketball on a local team and considered himself an excellent athlete. Eventually, however, the friction between Dick and his step-father became so great that the boy left home.

"Following his return home after hospitalization, Dick reverted to his earlier regime. He slept late in the morning and again in the early afternoon. He would leave before his step-father was due home from work and remain out until after midnight. Since he was no longer able to pursue his athletic interests, he spent his evenings in pool halls and similar establishments. Not only were his hours irregular, but his diet of hot dogs and beer was certainly not conducive to good health. He was also worried about his mother, who seemed to be unhappy with her husband and was apparently saving her small private income against the day when she could divorce him.

"It was perfectly clear to all of us as the interview ended and we began discussing what we had heard that this boy's family situation would be the deciding factor in his illness. From what he said and the way he said it we could see that he would have liked to cooperate with the clinic physician and follow the regime that had been outlined for him. This would restore his health and mend the body of which he had been so proud. But his family situ-

ation was too painful and his pattern of running away from it into a do-nothing, flippant kind of passive resistance was too well established. Consciously or unconsciously he was following a regime that would eventually cause a relapse and require his removal from the home to a sanatorium where he would be looked after and protected from his intolerable family situation.

"The psychiatrist also mentioned, but did not pursue, some of the other implications, such as the boy's unconcious hostility and guilt about the father who had deserted the family; his hostility toward the step-father and the way in which he tried to displace him by remaining at home with his mother while his step-father was out; and the self-punishing aspects of his failure to follow a regime designed to improve his health. All of these factors and others were probably present in this boy's reactions and behavior and could have been discussed further; but even without them we had enough to warrant serious reconsideration of public health responsibility in this case.

"As the discussion developed, it became apparent that this boy's fate—whether he recovered and became a useful citizen or deteriorated and eventually became a permanent charge on the community with chronic tuberculosis—would probably be determined within the next few months. And it was equally apparent that the crucial factor here was the family problem and not how much air and good advice he was given each week or two at the clinic. As the psychiatrist summed it up: 'This could be a turning point in Dick's life. It should have happened earlier, but it's not too late. He presents a public health problem which in this single instance might run into thousands of dollars over a period of years. On the other hand, at a moderate expense this young man might be helped toward a satisfactory solution of his problem in a relatively short time with the result that he would be restored to good health and a more effective personal and social adjustment.'

"It was recognized that this boy's situation was pretty serious and that he might need psychotherapy in order to handle it effectively, but the point which Dick's problem emphasized was the futility of symptomatic treatment unrelated to the fundamental influences in his past and present life. The other point that was demonstrated here was neatly described by one of the health officers as follows: 'I'm not from Missouri, but I had to be shown and, boy, did he show me! I was one of those who said that you can't get all that out of an interview. Now I see that you can get all that and more, if you know how.' "

VENEREAL DISEASE CLINIC

"But in v.d., for instance, can you just listen, don't you have to be a little more inquisitive? In other words, you're going to the patient, the patient is not coming to you, and you've got to get information about contacts." This pertinent observation about the relationship between the doctor and the venereal disease patient pointed up the difference between giving service in response to request and entering the lives of people, frequently against their will and often in situations which are highly charged emotionally. The health officers were seriously concerned about the problem of rendering service in an authoritative setting and by their comments revealed considerable understanding of the difficulties inherent in such a situation.

To the venereal disease patient the health officer may represent the police arm of the community. He therefore becomes someone to be feared and obeyed or not, depending on the personality structure of the individual. The meaning of the disease and the circumstances in which it was acquired are obscured by the social implications and the authority vested in the health department. Frequently this confusion is equally great for the doctor and the patient.

In a sense the individual becomes, not a patient who is ill and needs treatment, but a person who has sinned and is required by law to inform on his accomplices. Usually the doctor's approach, which has been dictated by the society of which he and the patient are members, is confined to treatment of the immediate disease process and follow-up of contacts in order to control the possible further spread of the disease. With few exceptions the term "v.d. control" has been taken literally to mean that one exercises control over the patient who has an active lesion and other persons who might be similarly affected. Though a patient may come back innumerable times, he is considered to have been successfully treated each time the danger of his infecting someone else has been cleared up. From the point of view of mental health and the well-being of society, this approach to venereal disease control might be considered short-sighted, to say the least.

That many health officers have been thinking about this and wondering what their basic responsibility might be was evident in the discussion in all sections of the institute. As one thoughtful health officer put it, "What is our true function in v.d. work, which takes up so much of the average health officer's time? Under the law we have a responsibility to get information on the source and contacts and to treat those with active conditions. But doesn't the public health man have a more basic responsibility to try to determine why the patient acquired his infection in the way he did, so that he can be helped not to repeat his exposure? More than ever—with our new treatment which does more for v.d. than we can do for the common cold and in less time—we are faced with the problem of re-exposure. Do we have a responsibility to find out why he did what he did? Where does our responsibility end? We have a legal responsibility; but do we have a medical or social responsibility to do more than that?"

It was agreed that the legal responsibility in most cases was

clearly and very narrowly defined. How far beyond those limits the health officer might go is often influenced by his own attitude and that of the community in which he works. There was some discussion of the cultural differences in patients and communities and the degree of anxiety which venereal disease produces in different people. The social taboo, which until recent years forbade the mention of the venereal diseases in public, was indicative of a fundamental attitude in our culture. The fact that this taboo has been lifted to some extent represents progress, but does not mean that all of us have by any means freed ourselves from our own unconscious reactions to the individual who has contracted venereal disease. The situation in which we find ourselves when dealing with these persons is still too fraught, for most of us, with deep-seated conflict and anxiety to permit the kind of objective thinking and approach that we would like to see in ourselves and others.

However, the group came to the conclusion that it is possible to recognize some of the implications of this situation and to plan programs in the light of an awareness of our own limitations. "Of course the attitude of most of us in public health is the typical social reaction that men are promiscuous and that sooner or later the percentages catch up with them, but that women should not be promiscuous. There's a kind of man-to-man relationship in the v.d. clinic between the doctor and the male patient, a kind of 'Too bad, bub, it caught up with you.' But when we come to the female patient, it's as if we were assuming that she is a fallen woman and that we are treating her in order to protect our fellowmen, and ourselves. This business about empathy that you were talking about, of understanding how the other fellow feels about his problem, isn't too hard for us with the male patient. It's a kind of 'There but for the grace of God go I' sort of thing. You don't talk much about it or ask any more questions than you have to. Give him his treatment and send him out with the tacit understanding

that you hope he'll have better luck next time. With the female patient your curiosity is aroused and there might be some underlying anxiety on your part. Sometimes you take it out in kidding the patient in a fairly earthy fashion and let it go at that, and sometimes you get pretty moralistic."

It was the general feeling that male patients, because of this fairly prevalent attitude, are less traumatized by the venereal disease clinic experience than women. The attitude of the nurses was also discussed, with general agreement that there was a greater tendency toward a moralistic approach on the part of the nurses toward women patients than toward men. It was agreed that this was a natural situation unless the nurses were adequately trained and had a fairly sound basic preparation for dealing with situations that present potential emotional hazards.

It was also considered of prime importance to indoctrinate all members of the health department staff with some of the implications of their work with venereal disease patients; their social responsibility and the need to understand that the rights of the human being to respect and to thoughtful service are not abrogated by the fact that the patient has contracted a "social" disease. Several of the health officers indicated their awareness of this as they talked about the care with which they selected receptionists for their venereal disease clinics and the training which they tried to give the staff on the question of the possibility of infection. The common misconceptions about the ease with which venereal diseases can be transmitted were recognized as serious stumbling blocks to friendly objective relationships, and many of the health officers indicated that they had not done as much as they might have about correcting these misconceptions among the staff members.

It was not anticipated by even the most optimistic that the legalistic approach to the venereal disease patient, as though he were a

criminal and not an individual who is suffering from a potentially serious disease, will be eradicated in this generation or perhaps even in the next. It was believed fair to assume, however, that responsible authorities in the health field, as represented by the local health officer, will have to take leadership in this movement. The education of the community must admittedly proceed at a pace that is compatible with the nature and potentialities of its members. It was agreed that where cultural, racial, or religious taboos are strong, the health officer must move ahead of the local tempo, but not so rapidly that he defeats his purpose by antagonizing responsible groups in the community.

The most important contribution that he can make would seem to lie in the attitude and approach within the health department itself toward the people who are served in the venereal disease clinics. Actually, the concept of service rather than control would be a rather large step forward for many departments. Within this concept would fall the flexible application of rules and regulations in terms of the individual patient. A number of the health officers reported successful experiments in which they had refrained from applying the full force of their legal authority in situations which seemed to them to warrant less stringent measures. In all instances the results were excellent and the people involved not only received treatment but were helped immeasurably in their general social adjustment.

Group thinking and discussion were definitely in favor of trying, in so far as possible, to make the patient's contact with the health department a constructive experience that might lessen the possibility of re-exposure and contribute to the individual's overall adjustment. How to do this was discussed around the clock, and though no blueprint could be worked out, there were several general conclusions.

The health department must attempt somehow to see and treat

promptly all persons who come with venereal disease. It must also follow up on contacts and on patients who do not return for treatment. Within that setting it must render the most effective service of which it is capable, both to the individual and to the community. The service to the individual should include not only good physical treatment but an enlightened, interested approach that makes it possible for the patient to derive the strength and emotional support that he needs in order to make a more positive social adjustment. Similarly, the service to the community should include not only the control of the current infection but also the discriminating use of any techniques which will prevent reinfection and contribute to the future social adjustment of the patient.

How this twofold purpose might best be implemented was discussed at considerable length. The following example is typical: One of the clinics that was used during the institute averaged 5,000 visits a month. This is perhaps fairly representative of urban communities. In that clinic the so-called post-treatment education is done by two public health nurses. The doctors, working rapidly, give the treatments but have little personal relationship with the patient. One of the health officers commented, "Ten or even five years ago, the average clinic that had 5,000 visits a month might carry a patient in continuous therapy for as long as eighteen months, so that the number of new patients in those 5,000 visits was relatively small. Today when we're treating syphilis with penicillin on a ten-day or five-day basis there is obviously a higher proportion of new patients being seen in the 5,000 visits."

Several members of the group felt that there had been some value in the old eighteen-month treatment, because there were so many more opportunities to work with the patients than there are today. "You had that patient coming in for seventy or eighty weeks. You took time with him just from the point of view of preparation of the material, the needle, and the syringe, and a few

questions like 'How are you getting along? Did you have any reaction last week?' Now add up those eighty weeks of contact with that patient. It may have amounted to a total of twenty-five hours for the one individual. We're now getting down to the point where we may spend fifteen or twenty minutes on an interview, a half hour on a physical examination, ten minutes on treatment, and maybe another fifteen minutes on one follow-up. There's one hour per patient instead of the twenty-five to thirty hours. Why can't we figure on spending a little bit, maybe only twenty minutes, more on each patient and doing a better job?"

To the psychiatrist's comment that, "Actually, the improvement of the treatment method has resulted in a loss to the patient of what may have been a valuable relationship with the doctor," the health officer replied, "That's right. I don't think it happened often enough, but the possibility was there and we've got to recognize that we've lost something, though I think we can find a substitute for it without losing our efficiency. I believe that the substitute is in this change of attitude, in our assumption of responsibility for something more than just treatment."

In somewhat oversimplified form, this "something more than" quality was agreed to reside in individualization of the patients as people. This came out rather graphically in a discussion of the ways in which people respond to the request for names of contacts and the health officer's own growing concern about how to approach patients so as to get this information reliably but without recourse to legal sanctions. The individual differences which were described can be duplicated in any health department clinic across the country. From the anxious, frightened young person to the defiant, "hardened" repeater, they were enumerated and discussed, as were the differences in reaction to a request for the names of contacts. These ranged from the guilt-ridden individual who needs to suffer and carry responsibility for disease and wrong-doing in

general and who does not give information about contacts because he prefers to believe that it is all his fault, to the patient who is eager to name contacts because of his hostility toward the person who infected him. Obviously these are the extremes, but it was agreed that from one end of the scale to the other, there are personal, social, cultural, and other differences which must be reckoned with, if one is to serve the people involved and the community of which they are a part.

In one of the clinics the health officers interviewed two venereal disease patients selected at random. One was a young adult who had had repeated exposures and was back for what seemed to him to be a routine course of treatments in an apparently continuous chain of re-exposures. In the course of the interview it was the psychiatrist's impression that this was only one symptom of a rather profound personal and social maladjustment. The patient had little or no guilt, gave names of contacts readily, and went on his way with no apparent concern. He was a transient with no visible means of support, no ties, emotional or otherwise, that could be determined in the course of the single interview. That his life pattern was set early by a series of profound frustrations and emotional deprivations was clear even from this brief interview, as was the fact that the young man was a liability that society had helped mold and for which it would now have to carry responsibility. It seemed highly unlikely that anything sufficiently basic could be done at this point to rehabilitate such a person as a useful member of society. Control in this case might be the only approach.

On the same afternoon one of the group interviewed an eighteen-year-old boy who was ashamed, frightened, and apprehensive about what this might mean for his future health and relationships. He had contracted gonorrhea on the occasion of his first sexual experience with an older woman, and was shocked at the very idea of what had happened to him. It was the psychiatrist's

feeling that the boy was in a seriously disturbed emotional state and that he was ready, in fact eager, to talk about it with someone who might understand and help him through this experience. A brusque, offhand approach to this boy, while it might have been friendly and not likely to increase his shame or disturbance, would not have relieved it as did this opportunity to talk about the disease and what it meant to him. It was the psychiatrist's opinion, too, that to have approached the boy in a way that would not have permitted him to talk about it might have led to unfortunate results.

For example, the man-to-man approach of a doctor who is seeing some fraction of the 5,000 patients a month and finds it difficult to differentiate among them might have given the boy the impression, "Oh well, it's all in a day's work. Thousands of other people come and get their shots and go on about their business, so I guess it can't be so bad." Or he might have been given to feel that in some way this was evidence of his manliness, of coming of age, and he might have felt encouraged to seek additional proof. Or it might have increased his anxiety and feeling of difference because he might have been given to understand that he was much more disturbed than the situation warranted. He might also have been exposed to the moralistic, "And you so young," attitude, which would only have served to intensify his shame and anxiety.

In this instance, however, he was given an opportunity to tell how he felt, what it meant to him to have contracted gonorrhea and what he feared as a result of the infection. With the psychiatrist's help he was able to see that it was entirely reasonable for him to feel disturbed, but that his life was not ruined, that he need have no fear for his health or future relations with women if he were treated, that promiscuity has its price and that this was one aspect of it. It was the psychiatrist's feeling, however, that the brief interview with other persons present was not truly psycho-

therapeutic and that the boy would have benefited by a somewhat more intensive service.

During another clinic session, a health officer saw two women also selected at random, who presented equally divergent pictures. The first was a self-assured young woman who told her story smoothly and without any obvious feeling. Her early history was that of serious economic and emotional deprivation. She was orphaned early, brought up by a grandmother in whose home there were several uncles who drank heavily. She began drinking as a young adolescent and apparently was an incorrigible youngster. She had had a checkered career with several marriages and considerably fewer divorces, and had come to California to divorce her most recent husband who, she said, beat her. She said she had never had what she wanted out of life. She wanted a home and family and hoped sometime to get them, though at present she was "pretty sour on men." Her story was quite contradictory. It came out rather casually later in an interview with the psychiatrist that her bruises, which she said her husband had inflicted, had been received when she had been arrested and served thirty days in jail because, again according to her own story, she and her husband had been involved in a drinking bout and attempted robbery in a clip joint. She admitted that drinking was really more of a problem for her than gonorrhea and, quite obviously, more than promiscuity. She thought it was no sin to have gonorrhea. It was just a sin to keep it. Her latest infection dated from a situation which she could not describe because she had been too drunk to remember the man involved.

The psychiatrist pointed up the implications of this patient's personality, life history, and way of living for the health department and its responsibility to the community. Obviously this woman is more than likely to be a fairly steady repeater at the clinic. The fact that gonorrhea can now be cured by a single injec-

tion will certainly contribute to her already strong predisposition to reinfection. The best that the clinic can hope to do for this patient and for the community is to render service in a way that ensures her willingness to come back for treatment, no matter how often, so that she may be rendered non-infectious. Another point in this regard is the matter of attitude and approach, because there is danger of alienating this patient if one becomes too moralistic. If the clinic doctor or some member of the personnel can set up enough of a relationship with her to ensure her repeated return, her infection can be kept within limits. If, on the other hand, she feels resentful toward the clinic because of the way she is treated, she might take out this resentment in avoiding treatment, thereby spreading the infection among the men with whom she has contact.

The second young woman had sought treatment for syphilis, first in the health department clinic in the area in which she lived and later in the area in which she was interviewed. In the first clinic the nurse who talked with her had indicated by her attitude that, as the girl said, "she was sleeping with every Tom, Dick, and Harry." This attitude was so disturbing that the girl could not return to the clinic. She was even more disturbed by the fact that her four-year-old child had been with her at the time. This young woman was sensitive, apprehensive, and lonely. She had been brought up alternately by her two grandmothers who were of quite different cultural backgrounds and though devoted to her were very hostile toward one another.

While still in her teens she had responded to the apparent interest of an older man, who, according to her story, had spent one night with her and then disappeared, leaving her pregnant. Her relatives would have nothing to do with her when her condition was discovered and she left home to make her own way. She apparently had taken good care of her child and was trying in so far as possible to maintain standards for the child's sake. But her lone-

liness, the feeling of being rejected, and her need for love and attention drove her into a relationship with a man which was rather fleeting and which resulted in syphilis. Whether it was true that she had been raped by this man, as she said, or whether she needed to believe that this was the case was relatively unimportant in view of the girl's obvious anxiety and tension which resulted from the information that her condition was not clearing up as rapidly as she had hoped.

In this case there might have been question about the validity of her story and some members of the group were inclined to doubt much of it. As the psychiatrist pointed out, however, there might well be some room for question; but the girl was not on trial, evidence did not need to be collected, and the facts that were clear had little to do with the precise sequence of events. The facts that stood out were that this was an anxious, frightened girl who had standards for herself which apparently required of her that she surround her situation with a story acceptable to her; that she had attended clinic faithfully and was anxious to cooperate; and that her social adjustment and that of her child were dependent on an understanding, helpful attitude on the part of some responsible member of the community. Certainly it lay within the scope of the health department to continue her treatment in as constructive a manner as possible, while enlisting the help of an appropriate social agency to work with the girl toward a more adequate adjustment for herself and her child.

The twofold responsibility of the health department—to the individual and to the community—in venereal disease control as in all other situations with public health implications remains a challenge to the practitioners in the field. It was made abundantly clear during the institute that while psychiatry might help clarify issues and provide concepts that would assist public health personnel in improving attitudes and techniques, the major re-

sponsibility for their application would continue to be lodged in public health itself. Basic to the discussion was acceptance of the fact that the community implications of venereal disease control are so fundamental that they must be taken into consideration in each case and at every stage of treatment.

With this premise in mind it was still possible for a number of the health officers to comment that the psychiatrists seemed to be all for coddling the patients and for pretending to accept as true some obviously far-fetched stories. They added that this preoccupation with establishing a relationship with the patient tended to negate the health department's responsibility to society. Eventually, they came to see that their goal and that of the psychiatrists are the same: well-adjusted human beings functioning constructively as members of society. They were also able to see that the application of mental health concepts did not mean "making it easy for everybody to do just as he pleases." And they understood that duties and responsibilities are as much a part of sound mental health as rights and privileges.

As these questions were discussed, it became clear that the individual approach is a diagnostic device without which treatment of the patient can only proceed in the most haphazard fashion. Hence it is essential that the health officer determine in each case the potential strength of the patient, the amount of anxiety he brings to the situation, and the positive factors in his social setting which might be brought to bear on his physical and emotional recovery. An individualized evaluation is necessary not only for the patient but for the community as well.

The treatment approach will then be based on the diagnostic evaluation of the situation and will vary as widely as do the situations themselves. In the venereal disease clinic there are the young people, still in the process of adolescent revolt, who need a firm, dispassionate approach that will accept them without condoning

what they have done and will not drive them still further into rebellion against adults to the point where they may ruin their opportunity for a socially-acceptable adjustment later on. There are the horrified first-timers who need reassurance and support in order to face themselves and others if this episode is not to affect their social relationships in the future. There are the repeaters who are driven by an unconscious need for punishment and self-depreciation and who might be helped by psychotherapy to achieve a more healthy and satisfactory life adjustment. There are the repeaters who because of low intelligence do not have the judgment which is required for discriminating living in our society. Control must be exercised by society in the case of these persons who are not able to control their own behavior.

And then there are the most difficult repeaters, commonly known as psychopaths. These are the men and women who, by reason of earlier emotional deprivation, have never learned the first principles of human relationships. They are the end products of unloved infancy, of pathological family patterns, of deprivation so profound that there was no opportunity during their early emotional growth and development for them to learn to love and rely on persons in their environment. Now as adults there is something missing in their character structure which cannot be replaced. They have learned to live by taking what they want from life and giving as little as possible in return, either materially or emotionally. These patients must be controlled for the sake of society and a firm hand is essential. They are adept at avoiding responsibility and concocting apparently credible stories. As every psychiatrist and social worker learns sooner or later, psychopaths are the most intriguing and frustrating patients in any clinic or agency and much more numerous than most people think. They comprise a large proportion of the patients in venereal disease clinics and it would be well for clinic

personnel to pay serious attention to diagnostic criteria and treatment techniques for this group.

These are only some of the differences which appear when the case-load of a venereal disease clinic is studied individually. But they are indicative of the selective approach that should be applied in order to find those who might benefit by individualized service and identify those for whom the health department must exercise the control which society requires of its members.

PUBLIC HEALTH IN THE COMMUNITY

"It's been my experience that when the people want something, they pretty nearly always get it." This is a health officer's comment on a rather lengthy discussion at the institute of the dilemma of the health department, which is a tax-supported institution responsible to and for all the people in a community and at the same time buffeted by special interest pressure groups with conflicting programs. In this simple statement lies much of the motivation and philosophy of public health and other public services.

The people, in this health officer's concept, are all the people who live in a given community and have group needs and group rights as citizens of that community. In an earlier chapter we were concerned with the emotional growth and development of the individual. In that chapter we saw that the individual first learns social behavior in the home, and later modifies and expands it as he emerges from the home and enters into successive levels of social responsibility. As he joins other individuals in common pursuits and interests, he becomes a member of progressively complicated and far-flung communities within the larger community. As he moves toward adulthood, the individual acquires rights and privileges and also duties and responsibilities to himself, to other individuals, and to the group as a whole. The community is, therefore, a group of individuals who impinge on one another, compete with one another, help one another, and affect

one another in individual and group ways, unorganized and unplanned, as well as organized and planned. It is much more than the sum of its parts; it is a complex social machine which grows in complexity through the cumulative interaction of its parts.

The adult member of society is concerned with many needs and goals. He must earn a living, provide shelter and sustenance for himself and his family, and must make changes in his way of life to accommodate to changes in the family picture as it grows. He must try to satisfy his basic needs and those of the persons for whom he is responsible and must also participate in the lives of his neighbors through institutions which they have erected together to meet common needs.

Government is an increasingly complex and important instrument which the individual, in company with his neighbors, has devised to perform common services. Unfortunately, in our society agencies of government are so many layers removed from the daily life of the average citizen that his responsibility to it and for it becomes somewhat attenuated. Periodic participation in local, state, or national elections and a somewhat grudging payment of taxes are, for the most part, the extent of the individual citizen's participation in government. What measures might be taken to effect a more intimate relationship between the individual and the institutions to which he has delegated responsibility for service are not within the scope of this report. That the growth and development of the public health movement is dependent on this cooperative relationship, however, was clear throughout the discussion at the institute. It was recognized that public health practice is a development of community living and interdependence, and that its growth is a direct reflection of demonstrated need in the community. It was also seen that many of the frustrations inherent in public health work are the result of the common

human tendency to see a need, to set up machinery for meeting it, and then to look at it from that time on as something outside oneself.

The health and welfare field as a whole suffers from the handicap of bigness and complexity. In large urban areas there may be as many as seven or eight hundred separate health and welfare agencies, both public and private, many of them tradition-ridden, others newly established to meet new needs. Duplication is inevitable in a system that does not sort out and eliminate unnecessary resources before new ones are added. In addition to the complexity of private philanthropy and the local chapters of national voluntary agencies, there may be confusion in the integration of the regional and local activities of the Federal Security Agency, which is responsible for much of the public health and welfare activities from coast to coast.

In order to carry out its multiple functions, it is essential that an attempt be made to coordinate activities at several levels below the national. Thus we may have regional, state, district, county, or city coordination of health and welfare programs. The effectiveness of such coordination is dependent on many factors, personal and political, which may influence the development of social and health services in large sections of the country. But it is at the local level, where the health department functions, that the individual citizen feels the impact of the total national program. It is here that public health and welfare agencies meet the ultimate consumer and attempt to provide the service which he needs. It is here, too, that coordination of related programs and resources meets the final test. Coordination at this level goes beyond blueprints, organization charts, and interlocking directorates: the measure of its success lies in the degree to which people are served efficiently and effectively with a minimum of duplication and a maximum of service per tax dollar.

In the visits to clinics during the California institute there were many instances in which it was clear that the health department could serve only one member of a family or only one aspect of an individual's need, while recognizing other needs that could only be met by other specialized agencies. As the group discussed the relationship of the health department to other community resources, it became clear that one of the more important functions of the health department was the clarification of individual and collective responsibilities to the end that the citizens of the community might be better served.

In response to the expressed interest of the student group, a meeting was arranged on the subject of community organization. The session was led by a panel which included persons with experience in public health, community organization, psychiatric clinics, pediatrics, and social work. With the life cycle of the individual as a framework, the group discussed and listed the social and health needs which may arise in the lives of people and the services which are necessary to meet them. Within a few minutes the range of common human needs and the appropriate services covered two large blackboards.

It was determined in discussion that each of the essential community services that were listed was available in at least one of the cities or counties represented at the institute. No community provided all the services and none could be said to offer completely adequate service, quantitatively or qualitatively. In some instances health officers were uncertain about the existence of a particular resource in their counties; in others, they mentioned that there was an agency whose name might indicate a given function but that they were unfamilar with the scope of the agency's potential service.

This uncertainty about existing resources highlighted one of the major problems in community organization. It was empha-

sized by panel members that organized community effort must be predicated on full knowledge of existing needs and resources if we are to avoid the wasteful duplication that has developed in many urban areas where we often find two or more agencies struggling with projects that might be handled more effectively if they were to pool their resources. It was agreed that when a need is demonstrated and the resource is found not to be available, it then becomes the responsibility of existing community resources to promote the establishment of the appropriate service. The group also recognized the potential confusion, for clients and agencies alike, in the rather common tendency of an agency to attempt to meet needs which are outside its legal or professional scope. It was understood that occasionally assistance with problems outside the logical concern or competence of the agency might be undertaken temporarily in the absence of an appropriate resource, but it was agreed that the community would ultimately benefit most from the continuing development of specific services for which needs have been demonstrated.

Briefly, these are some of the common human needs that were discussed and listed. The entire range will not be reproduced—any health or welfare worker can enlarge upon this sample from his own experience. The concern of the group was not with specific items but rather with the mobilization of community interest and support for services that will help us avoid or ameliorate many of the actual or potential problems that are common to our society. For example, young couples contemplating marriage need, and many of them want, premarital counselling to help them over the hurdles of adjustment which they may be unable to understand and meet. The church, the family doctor, the local family service agency have something to contribute and though their special interests may differ, each might add to the sum total of the young couple's understanding of and preparation for this important step.

Problems of housing, to some degree, fall within the province of the health department in so far as substandard housing is concerned; but by and large they are the responsibility of the appropriate housing agency. Questions of management, budgeting, nutrition, and the like may lie within the recognized function of the family service agency, the local representative of the Farm Security Administration, the extension service of the local university or the nutritionist of the local health department. Which agency does which part of the job and with how much recognized responsibility must be determined by the agencies as a group. This becomes a community organization responsibility.

The family doctor, the local visiting nurse association, the local hospital, and the health department are all concerned with the provision of prenatal care, and if community organization has taken place, they are clear as to which one takes responsibility for which group of expectant mothers. The anxious, insecure young woman who may need help with her feelings about maternity and her relationships to her husband or others occasionally presents a problem which cannot ordinarily be met by the prenatal service and which may require the help of the family agency or a mental hygiene clinic. How such an individual will find her way to the appropriate service is also a problem of community organization, as is the case of the unmarried mother who will need help before and after childbirth if she is to be guided toward a socially-useful resolution of her problem and a wise plan for her baby.

In the case of the postnatal period medical supervision of the mother and baby are indicated, whether by the private physician, the hospital outpatient department, the local health department, or some other medical service. And here, too, the special problems which arise may require specialized help. The unmarried mother, for example, may need psychiatric or social case work help to the

point where she is able to plan for herself and her child, whether it be adoption, foster care, or some other arrangement.

In the infant and preschool period there is a variety of normal services for the average situation and there should be a variety of specialized services for the difficult situations which may arise. For the well baby there are potential services through the family doctor or pediatrician or the health department, but for the deviant situations many more services will be required, as in the case of the physically-handicapped child. The community should have all the necessary treatment and rehabilitation services available for such children; it should also offer guidance and support to the parents of children with long-term conditions which may affect the emotional tone of the whole family. In the case of the family with social pathology, special services are needed which will compensate the child for the deprivation which the family situation has inflicted. It may be foster home care, day care, housekeeping service, case work, or psychiatric service for the parents or the child, depending on the individual needs.

As the group noted the kinds of services that are required to provide a school child with a positive range of healthy recreational and guidance services and the adult and aging person with services which each requires for maximum adjustment, it became clear that the health department is only one of a network of community resources which are essential to the effective functioning of all the people. But it was also noted that more than any other single agency, the health department touches the individual either directly or indirectly at nearly every strategic point in his life cycle and is therefore a vital force in the health and welfare of the community.

Many communities were reported by their health officers to have undertaken the establishment of local health councils through which agencies with health functions can meet, share their ex-

periences, and pool their resources. This is a rapidly developing aspect of community organization for which there has been a demonstrated need. Frequently these local health councils are sub-sections of larger health and welfare councils which include social agencies as well. Of prime importance in the effective functioning of these professional agencies is the degree of lay support which they can develop and maintain. Social and health services are dependent first for their existence and then for their improvement and expansion on the understanding and active interest of the lay community. Unfortunately, many professional workers, busy with the details and responsibilities of their jobs, are disinclined to take the time to interpret the work of their agencies or to cooperate imaginatively with lay groups. In the health field there are groups already organized and eager for action, who seek out the health officer and in their enthusiasm attempt to influence programs in the direction of their major interest. The health officers at the institute had much to say about these groups—pressure groups, as they called them—and much of what they said was tinged with exasperation.

In the face of this generally negative attitude, the public health faculty members, aided by the psychiatrists, took advantage of every opportunity to point up the strategic importance of lay support for health services and to throw light on the meaning of group motivations and action in the health field. During the panel discussion this point was emphasized by one of the public health faculty members who discussed voluntary service organizations, such as Rotary, Kiwanis, and Lions, and the local chapters or committees of national voluntary health agencies, as well as the women's clubs which are active in most communities.

"Let's go back to what motivates these organizations. They've been called pressure groups and maybe they are. The pressure may be put on by one or two individuals or the whole organiza-

tion. But what do they want? Some may be on a personal level; some may be working out a personal gripe but is that really true for most of them? Several of you have mentioned the P.T.A. as a pressure group. Why? The Tuberculosis Association has been mentioned specifically. Why? In the first place, it has a motivation. The Tuberculosis Association raises funds to combat tuberculosis and it wants to use that money wisely for that specific purpose. The program that it wants to support may or may not be appropriate to the specific community setting. It may be putting pressure on the health officer to do something, to get out a unit. The health officer's job is to recognize the motivation of such organizations and to help them see how their proposal fits in with the community's needs. Often we lose a real opportunity when we put them off. They have something to give, and we can use them if we make them our partners and let them work along with us. Take them into your confidence on the community situation. Work with them and let them work with you. It isn't done in a day or in a month. It takes time and meanwhile if you give them the feeling that they are participating, they will go along with you and feel that they are working constructively toward a goal.

"I've been asked to mention some of my own early experiences in a rural community. We had groups of all sorts in that county. In a way they were pressure groups; they represented different organizations with different interests, each of them wanting to do something. We went into that community assuming that all the people really wanted to work, not only for themselves and their own projects but for the community as a whole. We went to them with our problems, talked freely and frankly about the need, and gradually they were able to merge their separate interests into the total and to work for one improvement after another in terms of priorities that they could recognize.

"I was in that county for six years. The first two years I worked

like a dog getting those groups together. It took all that time. But this is what happened: I never personally appeared before a budget bureau. That was done by the executive committee or representatives of the various organizations. They appeared before the budget bureau and our budget increased from somewhere around $7,500, the first year we went in, to an annual county appropriation of about $50,000 in six years. And I didn't do it, the community group did. Now they were a pressure group, but they were a pressure group with an objective and they were a pressure group that was representative of the community and the services which were for the welfare of the community and not for themselves. Most of us in public health look on these groups as pressure groups and they become a headache to us because they come in with a special slant and it takes time and thought and effort to help them see their place in the total program."

One of the state health department people pointed out that groups with purely local interests are much less difficult to deal with than those which are the local arms of state and national organizations. It was his belief that in the health field real progress could be made with local chapters if they were given sufficient autonomy to permit their functioning much more in relation to the needs of the community than to the national or state directives which might be at variance with the local situation. He added: "Perhaps we'd better focus our attention on the national and state organizations so that their policies and philosophy and their manuals can be brought more into line with what we see to be the need. Then the health officer wouldn't always be bumping up against national and state philosophy."

But this, too, was recognized as a local responsibility, since it is at that level that national voluntary agencies serve the individual citizen. It was pointed out that national and state policy is usually the result of pooled thinking by the executive and the field staff,

who in turn must derive their knowledge of needs and programs from the experiences of their local representatives. A cooperative undertaking at the local level will inevitably affect national policy if it is soundly conceived and successfully executed. To be able to interpret its activities to the regional or national office, the local chapter must understand the community in which it functions and must feel itself to be an integral part of the health services of that community. It was suggested that when one finds a local chapter convinced that the only effective operating premise must be to put pressure on the health department if its mission is to be accomplished, it might be well to look to the health department's attitude toward its community relations for some of the contributing factors.

A group of people interested in a particular health problem is frequently motivated by personal experience. A member of the family, a close friend, or the individual himself may have suffered from the disease, or in the course of social or professional contacts the person may have witnessed the devastating effect of such conditions as tuberculosis or cancer or mental illness. For whatever combination of reasons, the individual is emotionally motivated to do something about the disease and he proceeds to join others with a similar motivation. As a first step, they turn to the official health agency in their community for help in combating the disease.

Sometimes their dedication to their cause can be disturbing. As one of the health officers commented, "Each of these groups thinks their special disease is the only one that the flesh is heir to and they want us to drop everything and wipe it out tomorrow." In the discussion which followed, however, it became clear that this preoccupation with one phase of health could be a major asset if it were understood and used. The results of group deliberation on this subject might be summarized as follows: The health offi-

cer should be eager to have these groups turn to him for help and should seek them out if he hears of their existence before they approach him. He should accept the validity of their motivation and should try to understand that it may sometimes seem unreasonably narrow when viewed from his broad perspective of the total health field. He should assume that if they are helped to understand the health resources of the community and the range of needs which must be met, they will see how their particular interest can be reconciled with all the others.

The health officer who is alert to the meaning of interpersonal relationships and feelings will know that a special interest group will be more easily integrated into a broader program if it is given an opportunity to continue with its major interest even on a less than all-out basis. The group will cooperate so long as it knows that its major interest is not being neglected or ignored but is being fitted into a priority system which the group itself has helped to devise. In the meantime the local group can be helped to become better informed in its field of special health interest, to gather and analyze data as to the incidence, distribution, and treatment of the disease. The group can also investigate existing resources to see if they can be helped to provide more adequate service.

As the institute progressed, a more positive approach to community organization became evident among the health officers, and the term "pressure groups" was heard less frequently. There was interest in trying out the concepts that had been discussed as soon as the health officers returned home and began taking up their community responsibilities again. Follow-up reports six months later revealed a marked change in approach to community relations. This was one of the areas in which the health officers' new awareness of the implications of mental health concepts was most clearly evident. The majority of them reported that they

were much more at ease with local groups; much more inclined to listen and to try to understand what the groups wanted; more interested in finding ways in which to work with the other groups; and much more patient in the face of the slower tempo which is essential if one is to carry a group along toward a common goal. The result, according to their reports, was uniformly good and many were already beginning to benefit from increased community understanding and support of health department programs.

Throughout the institute there was recurrent mention of another community group with which the health officer is eager to establish and maintain good working relationships: the local medical society and its individual members. This question was brought up for discussion frequently in all sections and it was clear that the relationships between public health personnel and the private physician were a source of concern to all members of the student group. They shared their experiences and problems and gained considerable insight into the situation by applying to it some basic principles of interpersonal relationships and motivations of behavior, their own and others.

They realized that as doctors, they have much in common with their medical colleagues by way of training and earlier orientation to the practice of medicine. But as health officers, they have acquired another perspective, and as public officials, they have responsibilities toward the community as a whole that are different from those of the doctor who treats individual patients. The well-trained and experienced health officer respects the contribution of the public health movement to the well-being of the community and endeavors to promote its development to the best of his ability. At least once in each section some health officer quoted Dr. C.-E. A. Winslow's definition of public health to demonstrate the difference in approach between public service and private practice. According to Dr. Winslow, public health administration is the

"art and science of preventing disease, prolonging life, and promoting physical and mental efficiency, *through organized community effort.*"

In organizing community effort the health officer needs and wants the cooperation of the private physician, who has the ultimate responsibility for treatment of the individual patient and the continuing doctor-patient relationship on which sound medical practice is based. When he finds that his colleagues in private practice tend to think that he negates the value of the private physician's contribution to medical care or that he would like to take over their treatment function, the health officer is disturbed by what he knows to be an unwarranted assumption. It seems to him that his colleagues are willfully misinterpreting his function and his attitude, and as a result he is hurt and resentful. It is difficult for him to see this situation in context, to see that he and his colleagues in private practice may be reacting not so much to each other in the local setting, as to repercussions of national developments in the health and welfare field. Labels that originate at one level of organization or legislation are attached to people and groups across the country with little thought as to whether or not they apply. Rivalries that exist at national, regional, or even state levels are taken over by local counterparts even though the potential for cooperation and a smooth working relationship is waiting to be tapped.

The health officers then attempted to look at the situation from the point of view of the private practitioner. In some instances their discussion began with consideration of what it means to be a physician. The symbolic significance of the physician in our society and the satisfactions which he derives from it were seen as important underlying motivations for the tenacity with which medicine holds to its place in our culture. To the physician are ascribed certain special—in some instances almost superhuman—attributes

which are a source of great satisfaction and personal aggrandizement. "Because a patient wants us to play that role in his life, we sometimes automatically assume the role and become dictatorial, a judge, a god who can pass judgment on others." There are other secondary gains in our society for the physician, not so much in terms of financial remuneration as in special status, rights, and privileges which he does not share with others.

Of course the physician is also concerned with his own needs, financial and otherwise, and his own striving for security, emotional and social. He is no more immune than his fellow citizens to the basic anxieties of people and, as a physician, he is a member of a profession which is in a state of flux. He may be doing well today but he is as worried as his neighbor about another depression. He may not be able to take care of all the patients who come to him today, but he foresees the time when there may be empty chairs in his waiting-room during office hours.

In his anxiety about the future, it is perhaps inevitable that the private physician will look upon the development of public health in this country as a threat to his status and livelihood. This was true when the growth of the public health movement was much less accelerated than it is today and when it was less difficult to define mutually exclusive areas of operation. As one of the health officers said, "I defy anybody to draw a straight line and say, 'On this side of the fence is public health and on that side of the fence is clinical practice.' " It was agreed that the usual definitions of public health function sometimes fail to hold up in practice, and that considerable flexibility and imagination are necessary whenever one attempts to draw even a dotted line between public health and clinical practice.

Actually, it is quite obvious that almost anything one does medically for or with another human being may be called preventive, or may be said to have preventive aspects. It is therefore

somewhat difficult to draw a line that will differentiate between public health and preventive medicine on one side and private practice and remedial medicine on the other. Public health workers recognize the dilemma and exercise great care in confining their clinical efforts to the prevention and control of communicable disease and to the promotion of good health through mass educational techniques and health supervision services such as prenatal clinics, child health conferences, school health services, and the like.

Unfortunately, this philosophy and practice is relatively unknown to the average general practitioner who seldom knows his local health department as something other than a government agency which supplies certain drugs and vaccines and requires reports for its vital statistics. He does not know that the health department's preventive services function as case-finding agents and that the correction of defects discovered in this way is considered the function of the private physician if the family can afford it, or of the local hospital clinic when private medical care is beyond the family's means. Instead, organized medicine sees a threat to private practice and the danger of socialized medicine in the expanding public health program. And the average general practitioner sees it as a threat to his income rather than as a community agency which can enhance and support his service to patients.

It was agreed that medical education might do much to help the physician understand public health philosophy and practice, but that few medical schools today are providing this orientation adequately. As one member of the public health faculty put it: "When a man goes to medical school he knows that at the end of his training he will be more or less prepared to deal with people. In medical school he studies anatomy and works with cadavers. He studies biology, physiology, and things of that sort. In the

first two years he is not yet dealing with people, but he can see the connection between this study and the people he is going to meet later on. Then suddenly, along about his second or third year, public health comes into the picture. It is at this point that I think the teachers of public health make their mistake, because the first things that they introduce to the medical students are the non-people side of public health—maybe the sewage system, the public water supply, or statistics—and if the medical student is there because he is interested in people, he has every reason to develop the belief that public health hasn't anything to do with people. It's just a collection of things and facts. Then he gets out in practice and finds that public health is serving individual patients and he thinks they're poaching on his territory."

The group was agreed that on the basis of what they had learned about the motivations of behavior, it was perfectly reasonable that private physicians should dislike and distrust that which is potentially threatening to them because they do not understand it and that it is a responsibility of the health officer to work away steadily at the job of interpreting and attempting to achieve acceptance of what he is trying to do. The group was unanimous in its belief that people should seek private medical care if they can afford it and if the medical care which is given meets their needs. "The health department's responsibility is to see that it is done, not necessarily to do it. The obstetrician, the pediatrician, the good general practitioner who takes the time to know and understand his patient is doing a good public health job and more power to him."

As they discussed this, the health officers saw that they must carry the major responsibility for establishing and maintaining positive working relationships with private physicians and local medical societies in their communities. They cannot assume knowledge or acceptance of their work on the part of their colleagues in private practice, nor can they expect the latter to meet them

more than half way. The public health agency needs and wants the cooperation of the private physician. The latter has no reason to reciprocate unless and until the health department provides the reason in a manner that is acceptable to him. In reaching this conclusion several of the health officers commented: "We've been defensive about this in the past. We've been so sure they were agin' us that we haven't given them a chance to find out why they might want to be for us." And one added, "I think I know how to go about it now. I should make more progress with the medical society than I did before because I see the situation much more clearly."

This new conviction was corroborated by the health officers' experiences after they returned home from the institute. Several health officers reported that they had attended medical society meetings in a different frame of mind than before and had succeeded in interesting some of their fellow-members in health department activities for the first time. Said one health officer, "Without the old chip on my shoulder I found it a lot easier to sell something I believe in very much. In the old days I used to build up sales resistance by the way I went at it. Now that I can see the other fellow's point of view a little more clearly, I find that they're willing to listen."

A most important segment of the community for the health officer is, of course, the local board of supervisors which controls the allocation of tax funds for public health purposes. There was considerable discussion of ways and means, in the hope that specific suggestions about methods of approach might be forthcoming. But as the institute proceeded, it became clear that no prescriptions were possible or even desirable. Each local situation has much in common with all others, but it is unique in that it has its own constellation of personalities and circumstances. The interpersonal relationships between a health officer and his board of

supervisors are dependent on the motivations and reaction patterns of all concerned, and it is especially important for the health officer to see himself as the client who turns to the board for service. In pleading his case he runs the danger of moving at a pace that is not consistent with the board's tempo or of emphasizing points that may meet with indifference or even hostility.

No governing body is eager to appropriate funds merely because an official asks for them. Traditionally it is assumed that operating officials have a vested interest in their departments and that they gain in stature as their allocations increase. It is also assumed by appropriating bodies that departments will ask for more than they need, on the premise that the original budget request will be pared down. This is the socio-economic framework within which the health officer meets his board and attempts to interpret his program. Blustering has worked for some in the past and political maneuvering for others. But these are temporary measures that depend much more on external pressures than on the soundness of the program to be financed. The health officer who has the support of responsible local citizens is in a much more strategic position and on a much sounder footing. Legislators and local boards respond to the intelligent, well-timed expression of citizen interest in good health services, especially when they are given an opportunity to see for themselves what they are being asked to support. When and how this is done depends in large measure on the sensitivity and skill of the health officer in evaluating the numerous ramifications of the situation.

The community as a whole is the ultimate judge of the local health service. The citizens have set up a health department. Now they must use it and help it expand to meet the needs of the community. Here, too, the health officers felt that they had much to learn about how to improve the quality of their community rela-

tions. In this connection they talked about the attitude of the average citizen toward the question of health versus illness.

"I have often wondered what the average American thinks are his medical rights as a citizen. It's like no other thing that I know of, perhaps more like education than anything else. Should it be a purchasable commodity or a right? What per cent of an individual's income should he be expected to pay to stay well?

"When a man gets sick, he is least able to help himself. It's like kicking a guy when he's down. He certainly gets kicked financially when he's sick. People who would never think of buying a ten-thousand-dollar yacht get sick and buy the equivalent of a ten-thousand-dollar medical cure, if you include hospital care, x-rays, special services, and so on. Is it fair to have one group of people plan and budget and set aside ten per cent of their annual income for medical care while another group is only able to live from month to month and never has anything laid by for an emergency?

"They're all willing to pay when they're sick, and usually people are willing to pay more than they can afford because they're frightened. But there is something pretty basic about this attitude toward illness versus prevention. A pediatrician I know told me of a mother who said she could not afford to pay two and a half dollars for a urinalysis. The next day the pediatrician met the woman in town as she was leaving a beauty parlor where she had had a permanent wave costing five dollars. I'm not criticizing her, but what is the basis for this choice of how to spend your money? I rather think it's just human nature to assume that you're going to be healthy until something happens. Perhaps that's why prevention is so hard to sell. You can't demonstrate it. It's such a negative thing, or rather it's the absence of something positive."

It was agreed that we still know relatively little about community organization on this level, but that it is vitally important

to experiment with group techniques in the hope that effective methods may be devised. It was the consensus of the group that the most effective community relations are found where the responsible official works with those interested members of the lay community who are in a position to arouse and channel wide interest and participation. Large meetings may stimulate momentary enthusiasm for a special project, but they will never provide the continuing understanding and action that is essential to sound program development. "A small group of community leaders who can in turn stimulate other groups, that is our most valuable community asset. It takes time, but the return on the investment certainly warrants it. It can be frustrating, but what isn't that's worth doing?"

These are some of the frustrations which beset the health officer in the pursuit of his goals. There are others which arise, not so much from the external forces in the community as from the nature of public health responsibility. The people have delegated to public health certain functions which inevitably affect the public in ways which they may not have anticipated when these functions were defined. For example, the protection of the public health carries with it responsibility for the manner in which some citizens go about their business, the places in which other citizens live, and the rights of still others to move about the community at will.

"You must remember that you are in a restrictive profession and that it may occasionally be your duty to create very practical problems for members of your community. You are in a position to close a man's factory or his restaurant, or condemn a building which he owns, or hospitalize him as a carrier. These activities of yours, while necessary and even though carried out with the utmost tact, discretion, and consideration for the feelings of others, are nevertheless so serious and have such wide ramifications for so many people that you must accept the fact that in certain of your

functions you are a threat to the happiness, comfort, or security of a segment of the population that you serve."

The fact that persons other than the health officer himself are concerned with these restrictive functions makes it incumbent on the health officer to be certain that they are all well aware of the need to lessen the impact of these activities on the citizens of the community. It was agreed that there can be, and all too frequently are, occasions when restrictions are unnecessarily imposed in following the letter rather than the spirit of the law; when opportunities for modifying the harshness of necessary regulations are not taken, either through ignorance or lack of interest in building up good community relations. The gradual evolution of the sanitarian from an inspector in uniform with a police badge to a trained, courteous, sensitive individual who tries to establish a helpful relationship between the health department and the citizen, using his police power only as a last resort, is one of the more hopeful developments in the field.

Of equal importance is the necessity for mature acceptance of his legal responsibility by the health officer. In one very lively session the members of the group drew on their own experiences in the field to caricature the health officer who does not have this mature acceptance of the responsibilities of his position. In summary: He is a little man who relies on authority rather than competence and uses his legal powers to hide from himself and others the fact that he has relatively little that is positive to contribute to the community. Because he needs the feeling of power that it gives him, he may crack down excessively and needlessly on business people in the community and take advantage of the potential news value of such a campaign, even though it causes undue hardship to people whom he was appointed to serve and does not advance the public health to an appreciable degree. He may close swimming and recreational facilities in the summer long before an epidemic

threatens, because it is a dramatic gesture and shows that "the health department is on the job." He may make demands on private practitioners for reports in a manner that is certain to arouse their hostility and keep it at high pitch, or he may adhere rigidly to rules and regulations about tuberculosis, venereal disease, or the quarantine of communicable diseases, even when, in the judgment of those best qualified in the field, intelligent flexibility in the interpretation of regulations will bring the greatest good to the greatest number. He will obviously get satisfactions from all this that will compensate him for the absence of more positive services which he may be incapable of rendering. In the opinion of the group, it is the responsibility of public health personnel to work toward the eventual disappearance of these characteristics in health officers.

The more positive aspects of the discussion might be summarized as follows: The health officer who has accepted and assimilated his legal responsibility and is able to see it in the total perspective of his job finds it possible to move slowly in many of these areas. He will encourage his sanitarians to get to know the people with whom they work and to provide educational opportunities for them in the way of visual aids, discussion groups, and the like on subjects of common interest. He will take action that affects the public morale as well as the public health cautiously and only as indicated, and then with full use of the public press for interpretation. In general, he will see his role as that of a helping person responsible for the kind and quality of his staff's relationships with the citizens of the community. In all his activities he will see the promotion of health—its interpretation and public cooperation in the program—as his goal. He will avoid precipitous action and will consider the ultimate result of his program in terms of people, their needs and their feelings. He will hesitate to use force and will use it only when necessary. He knows that

even then he will incur some hostility but will recognize it for what it is and accept the fact that some measure of hostility is inevitable, while having the satisfaction of knowing that he has kept it to a minimum through his own thoughtful efforts. He will endeavor to serve and lead the community in matters pertaining to health, never forgetting that "the community is people and people have feelings."

HEALTH EDUCATION

"What people do with the facts that we give them depends less on the validity of the fact than on how they feel about it. Now that I've learned this fundamental truth, I know that I'll be able to do a better job of health education than I did before. I won't get so impatient and angry when the people I'm trying to educate don't start changing their lives immediately just because I tell them they should."

One of the more frequently mentioned areas of concern at the institute was that of health education. It cropped up repeatedly in each small section and was the subject of frequent informal conversations. The members of the group knew that their service to their communities depended in large measure on their ability to make health information available in a way that would stimulate citizen awareness and action. In response to their expressed interest in the subject, a general meeting on health education was arranged headed by a panel consisting of all five members of the public health faculty.

Since this meeting represented, and to some extent clarified, discussions of health education which had occurred in the small section meetings, it is summarized here. Considerable time was spent in an initial discussion of the meaning of education, its purpose and method. This was followed by an attempt to relate educational principles to the dissemination of health information.

"Wouldn't you say that many of us in the past have thought about health education as the acquisition of a series of facts, such as the incubation period of diphtheria, the number of shots that are needed for immunization, how you get venereal disease, and how to prevent it, and the like? Now, we're coming to think that health education is an active process by which we experience something. The experience may make us act positively or negatively, depending on factors which we haven't yet defined."

"There seems to be confusion in the use of the terms health education and public health education. How does public health education differ from health education?" An attempt to define the difference led to clarification of the fact that they are not different. Some were thinking of *public* health education as that which is directed at groups rather than individuals. Others had thought that it should be used to designate educational activities when they are carried on by health department personnel. In the course of discussion it was agreed that health education may be done by anyone who is in a position to impart sound health information in a way that will make it acceptable and useful to other persons; that health education of groups or individuals may contribute to the general health of the public; and that the designation public health education is redundant and likely to be confusing.

It was recognized that the educational activities of the health department might range in purpose from the development of financial support for the department's program to adult education, school health education, and the broad dissemination of information through the usual media of mass communication. Obviously, such diverse activities under the same label might, and frequently do, lead to confusion and misunderstanding of function. However, the group realized that this was largely a matter of semantics and that there were basic principles which must be defined before the superstructure of terminology could be erected. Several

health officers commented that they had been involved in philosophical discussions of education in the past and usually got no further than the matter of terminology.

It was then suggested that some one lead off with what seemed to be a basic principle in health education. The following example of free association was characteristic of the group:

"Try to find out what the guy is interested in before you sell him anything."

"Sure. If he's not interested in what you're interested in, then you have to develop his interest before you can put over what you're trying to sell."

"These people talk as if they could educate somebody. You can't educate anybody. They have to educate themselves."

"Maybe I've got a one-track mind, but I know that you don't have a health department to carry on health education if you don't have the money. Did anybody ever try to get money out of a government body? The first principle is the urgency, the need, the interpretation of responsibility, and the presentation of a plan that has some chance of being approved. To do this effectively you've got to have the community with you. You've got to capitalize on the feelings of people in regard to specific problems that interest them, for example, the P.T.A. in matters pertaining to children. Many health departments have been developed as a result of someone's having the good sense to capitalize on local problems."

"Here is an example of that kind of thing. When I worked in a rural community, one of the problems was the need for help in the home care of the sick. This need was expressed, and we were able to get the group together in the small country schoolhouse and talk about it. As a result, a home nursing program was organized. That was what they wanted and that was what they got, because we were able to use their group interest to develop a needed

service. The group went on from there to the problem of school lunches, and eventually, about two years later, we had a good public health program." There was discussion of other experiences of a similar nature, all emphasizing the potential interest of a community group, its readiness for new steps and the need for skill in mobilizing this interest and readiness. Actually, public relations (interpretation of the agency's program) and community organization rather than health education were under discussion at this time, but the members of the group were thinking in a way that was fundamental to their orientation: the use of health information to promote program development. As the discussion proceeded, they moved from interpretation and community organization to educational method and content, and here another principle began to emerge—the nature and acceptability of information. The individual has to want this particular kind of information. He may be enthusiastic or just mildly ready, but the soil must have some degree of fertility.

"In other words, we seem to be saying that here we have a person who can do certain things which will have a favorable or unfavorable effect on his own health and that of his family. You may want him to do the favorable things, but *unless* you find out what that person wants and *until* you find that out, you're just wasting your breath."

These two principles of an actual or potential interest on the part of the individual and his readiness to receive and make use of information were finally agreed to be the basic ingredients of any successful educational activity in the health field, whether it be the promotion of a health department program, the mobilization of citizen responsibility and action in the face of a threatened epidemic or any other health hazard, or the dissemination of facts about health, its restoration or maintenance. It was further

agreed that interest and readiness could sometimes be stimulated where they did not exist originally.

"There was a time when the period of adolescence involved an antipathy to cleanliness that drove parents mad. You know the kind of revolt against bathing and the like that was pretty true for most youngsters. I think it's still pretty true for the boys, but identification with movie heroines and the persuasive powers of the advertisers have combined to make the adolescent girl of today a most thoroughly scrubbed creature. If you look around at a group of high school girls these days, you'll see an intelligent use of makeup, shining hair, and well-groomed clothing, which may be extreme if the fashion calls for it, but which meets the highest standards of cleanliness."

"That's right, and there's another thing. I guess we could call it health habits. They result from constant repetition in school health programs, reinforced by toothpaste ads and other kinds of institutional advertising, so that you get people from earliest childhood automatically doing certain things that are good health habits, though they couldn't tell you exactly when they started or why they do it."

"We've been talking a lot about the use of fear in health education. What the advertisers use is not so much fear, as snob appeal or keeping-up-with-the-Joneses sort of thing. And, of course, we shouldn't underestimate the value in emphasizing dental hygiene before a date, or the sexual attraction of a clean scalp, or any of the other tricks that are used to make people buy products which do, in the long run, tend to improve personal hygiene."

The problem of interest and readiness in relation to health problems that are not of an epidemic nature or cannot be dramatized readily was seen as a continuing responsibility. How to make the average citizen aware of the early symptoms of diabetes

or the non-acute heart conditions, for example, was a matter of serious concern. It was felt that the introduction of such general health information into the community might be expected to have one of two alternative results. The average recipient of the information would be uninterested and quite unlikely to believe that it might refer to him. The hypochondriac who needed to believe that he was suffering from a variety of ailments would have one more reason for anxiety added to his already sizable array. Emphasis on early symptomatology and diagnosis in almost any situation might have the same alternative results unless some way could be devised to make the information available in relation to a recognized interest and readiness.

The health conditions that call forth the most widespread response are those which threaten to cripple or to kill. These conditions carry with them an anxiety that invariably induces interest and usually provokes a readiness to do something. Unfortunately, and here the group was unanimous, the use of fear in promoting action is highly questionable if one also considers the mental health of the persons involved. Except for an occasional mention of the fact that many health departments owed their creation to epidemics and a community's need to fight them, there seemed to be no question in the mind of anyone present at the institute that the "one out of three will die" technique was bad. Admittedly this approach raises money, but whether fund-raising and the welfare of the public can be considered synonymous remained a question. This matter had been raised so often in the smaller sections that there was little specific discussion at the panel meeting. A few examples from the sections might be useful:

"Playing on fear in order to produce money is shortsighted propaganda of the worst kind. One of the primary functions of health education should be to give reassurance and to build people's confidence in being able to help themselves."

"My approach has always been that had it not been for good medical care, good hospital surgery, and pediatric care, we wouldn't be where we are today. I remind people to take a look at some of the old cemeteries where you can still see the lineup of tombstones over the graves of infants who died in that first precarious year. I've tried to point out that the group of people who never got to be adults just didn't live long enough to die of the diseases of old age which we are now so exercised about. It wasn't the fear technique that produced advances in medicine. It's true that by scaring people out of their wits you can get them to give money to speed up research, but what is the cost to them in anxiety and confusion?"

Still another kind of mass anxiety is seen in the public attitude toward poliomyelitis. This phenomenon was given a great deal of attention because at the time of the institute the state of California was faced with a beginning epidemic. As one of the health officers commented: "We've got an epidemic in our county, and at this point I wish I could give everybody in the county a mild dose of phenobarbital to get their hysteria under control."

The universal fear of this crippling disease and the uncertainty as to whom it will strike next were recognized as basic to the spontaneous anxiety which it seems to arouse. In its anxiety the community turns to any suggestion, however farfetched, that seems in any way designed to check the dreaded epidemic. Action, ill-suited or unfounded, is preferable to no action at all in the opinion of a panic-stricken community, and the local health department is frequently the instrument which the public chooses to implement such action.

Many health officers reported that they were faced with a difficult decision in dealing with this problem locally. They could go along with public demand and close schools, swimming pools, movies, and other places where children might congregate, or

they could try to point out to the public that there is no proof that these gathering places are the source of infection. Several have tried to reason with the public, only to find that newspaper campaigns against the laxity of the health department finally forced them into such measures. One health officer mentioned that he had had his community sprayed from the air with a disinfectant because public demand for it was whipped up by the local press and radio.

Conversely, it was reported by several of the health officers that educational material, such as radio transcriptions or leaflets designed to help people look at this illness reasonably, had the opposite result if they were made available to the public when no epidemic threatened. Though the leaflets specifically stated that there was no epidemic and that the information was provided to acquaint people with what is now known about polio so that they would be less anxious and better able to manage the situation should something happen, the people read what they wanted to read and the health department was swamped with telephone calls and demands for service. Certainly in this connection interest and readiness were present, but so was anxiety, and the readiness was not of the positive kind that could be expected to make use of rational facts.

Positive education for healthier living was ultimately agreed upon as the sound, basic, continuing responsibility of the health department, with full recognition of the fact that emergencies could always be expected to arise and would have to be met as they came up. It was further seen that such positive long-range education must be dependent not only on the development of interest and readiness, but also on techniques for reaching the public that would have more personal meaning than the media of mass communication. Included in this positive education are the basic mental health principles that are essential to emotional

as well as physical well-being. While it was recognized that one could not measure in dollars and cents or in tangible behavior the results of such educational activities, it was agreed that no so-called preventive work was complete without it.

One of the psychiatrists took pains to point out that, in relation to emotional problems, one cannot have the same kind of certainty about prevention that one has about physical conditions, because there is not the same kind of predictability: "We know very well that given exposure to measles in childhood, youngsters often develop measles if they haven't had it before. We don't know with the same degree of certainty that given exposure to noxious psychological elements, this individual will develop psychological disturbances. We can't predict, we can only assume from experience that something of the sort may happen."

To this, one of the health officers replied, "That's perfectly true, but while, on the one hand, we know that everyone who drinks water out of a canal may not get typhoid fever, on the other hand, we know that a certain proportion of people will; because of that we set up a protective water system. Isn't it possible to do the same sort of thing in the psychological field to prevent some of the difficulties which may develop?"

The psychiatrist agreed with this idea but pointed out that the complexity of psychological problems makes it more difficult to outline a preventive program: "For example, when a person drinks canal water, if conditions are right he's probably going to get typhoid, unless a certain degree of immunity has been built up in his system. We know that the control of typhoid is not particularly complex. The factors that produce emotional disturbances, however, are infinitely more complex, and it's difficult to evaluate from a given situation or constellation of factors what may happen to these individuals ten years from now as a result of having been exposed to the factors."

He then referred to a case which had been under discussion in this section, that of a young woman who had had polio when she was an adolescent girl and was now the mother of a one-year-old child, with another baby expected in about six months. Her husband was in the Army, stationed away from San Francisco, and while she seemed quite self-sufficient and able to manage, the health officer who had interviewed her was concerned about the fact that she had her year-old infant sleeping with her and would have to begin to make other arrangements before long.

The psychiatrist went on: "This mother of yours with the one-year-old child has already gone through a particularly trying situation in her own lifetime. Now that her husband is away, she wants, perhaps needs, the comfort of sleeping close to someone and this youngster of hers provides some of the reassurance she needs after coping with her problems all day long. We tend, I think, to assume that she will continue to need that kind of reassurance. She may, but we don't know. We can't predict what this young woman, who has already surmounted a whole series of obstacles, will do six months from now or next year. We can't jump to the conclusion that if we do thus and so today, we are inevitably going to wind up with such and such a problem later on. We really don't know what factors we can control with reference to emotional disturbances. At this stage in our knowledge there certainly is a great deal of room for humility in relation to predictability."

Several of the health officers pointed out that this case seemed to furnish grounds for the prediction of problems in the immediate future. "Here is one baby in the bed and another baby coming, which means that the first baby is going to have to be weaned from sleeping with the mother. If that isn't done, there's going to be a crisis. We can't predict that this child will have a behavior problem afterward, but we should be able to predict that the child will

go through a period of emotional crisis if he sleeps in bed with the mother until the other baby comes and then is put out at that moment."

The psychiatrist took it up again with: "You see, we don't really know what the mother's attitude is. We don't know just what she will do when the second baby comes. We have here a young woman who has impressed all of us with her rather good adjustment in spite of her handicap, a handicap which many people would not have had the courage to face so well psychologically. There are great extremes in people's capacity to compensate and adjust in spite of handicaps. The process of compensation is in itself a major psychological process. We certainly can't say to her: 'If you don't start getting that youngster used to sleeping alone right away, you'll have a problem in six months.' What we can do here is to anticipate some of the developments which might arise from a given situation and try to help the individual look at them in the light of what he can do or wants to do about them."

Throughout the institute this caution about the label "preventive" when applied to psychological matters was emphasized. It was pointed out that our experience to date is still largely related to retrospective information about childhood as it has been gained from persons with emotional problems. While it can be said with assurance that emotionally-disturbed patients, as they work through their difficulties under psychiatric treatment, reveal traumatic experiences in childhood which are related to their current problems; it cannot be assumed with equal certainty that the absence of these traumatic experiences will result in emotional well-being. It can be deduced, however, that if certain painful experiences are minimized, a child might have a better chance of growing into healthy and happy adulthood. The group agreed, therefore, that while the term "preventive" cannot be applied in emotional matters as it can in certain physical conditions, it might

be used loosely to describe activities designed to promote mental health.

It was recognized that effective health education of a positive nature must influence attitudes and lead to action if it is to succeed. It was further recognized that mass communication seldom influences basic attitudes. It was also agreed that a person-to-person relationship, whether it is one-to-one or one-to-several in a group, is ultimately the most effective means of health education.

"I guess the place to attack this is with the youngsters. Get 'em young and start them out right. With high school groups, for instance, you'd be hitting two generations at once. You'd be able to help them and through them the children that they'll be having. Maybe there's an even better spot, in the child health conference where you'd also be affecting two generations and getting the child earlier, but at that point the pattern of the mother has already been established."

To this the psychiatrist replied: "Yes, the pattern of the mother has been established, but I don't think that this needs to discourage us from the effort to change attitudes. It's true that there will be mothers whose attitudes are so fixed that they're not subject to change, but the majority of them are flexible and can be helped if we know how to help them."

"But look at it from our point of view, the administrator in public health, let's say, who has a limited amount of money to spend. Now, if you're going to see only twelve children in a three-hour child health conference, and I agree that that's all you should see, then with our limited staff and limited finances, what can we do to make these limited resources serve a greater number of people?"

"You can do much more with the group discussion method than has been done to date. I know you've done some of it in nutrition, but I don't think the child health conference has made as

much use of group discussion as it might. As a matter of fact, in psychiatry and other medical disciplines we haven't begun to make full use of the group method or even to explore it adequately. It is an extremely valuable method, not only as a substitute for individual contacts—that is, a question of saving time by seeing several people together instead of individually; it has values quite apart from that. In a group discussion you get social support and release of social anxiety and guilt which you don't get as readily in an individual conference."

It was pointed out, too, that no one professional group in the community has the ultimate responsibility for health education. It is the combined responsibility of all professional groups that work with people in a helping relationship. Teachers were seen as strong potential allies in the campaign for the promotion of better physical and emotional health, if they could be given the kind of knowledge they should have about people. The responsibility of the medical and teaching professions for sharing knowledge and using the results was recognized. One of the health officers summarized it by saying: "There are too many nurses and doctors teaching who know the material but don't know how to teach, and too many teachers who have the techniques but don't have the information."

In this connection the chairman of the meeting asked: "I wonder if we might talk about the people we are afraid of as health officers. They are the health educators." A panel member said: "I wonder if some of our fear of health educators isn't the result of our anxiety about the power and authority we delegate to them and their ability to reach people to propagandize and to influence public relations."

Several health officers who had health educators in their departments said that while they understood that some of their colleagues were apprehensive about health educators, they saw no

reason for it. One said: "I don't see any reason for you to fear a health educator on your staff any more than you fear a public health nurse or a sanitarian. I use mine in a variety of ways—educational campaigns, working relationships with newspapers, representation on health committees, and a whole range of projects—and I always make a practice of clearing with my health educator on matters that she knows more about, just as she would never think of assuming responsibility for action of a major sort without getting my O.K."

A member of the panel indicated that there might be two aspects to the question: one, the position of health educator, and the other, the individual who fills it. Several health officers pointed out that the health educator does not have the background in medical education and health matters that the health officer has and should therefore always be required to clear written material with medical content. There were other such expressions of anxiety and fear on the part of the health officers that their authority might be usurped. However, some felt that this was an administrative matter which could be ironed out if one really wished to establish and fill such a position.

One panel member suggested: "Too often we decide that we need a health educator. What for? We don't know, but everybody else is getting one, so we do too. But we don't think through how we want to use the health educator. So much of the current confusion is a result of the fact that this is a new position and we're not clear as to its potentialities. That's always true whenever we try to use personnel for unclarified responsibilities."

Added to this confusion was the fact that the health educator, as he was described at one stage in the discussion, was expected to possess an almost impossible range of skills. As someone pointed out, "The person you are describing has to be a kind of jack of all trades who is a writer, who is a journalistic expert, who is

skilled in the use of visual aids, community organization, and teaching in general. And he should also know all about people and how to help an individual integrate new knowledge." It was agreed that there were few such paragons available.

Another added: "I was just wondering if this doesn't go back to our training as doctors. We know all the answers. We work with nurses and they're not supposed to question us. They do what they're told. Here you bring in a whole new breed. We never saw this health educator before. While we know something of the health education field, this guy knows more; we know he knows more and it makes us a little uncertain."

At this point, when the chairman asked: "Do you think we hand them all the things we don't like to do?" there was fairly general agreement. To this a panel member added: "It's interesting that there's a sharp division within this group. Some of you have said that the health educator serves a very useful purpose; others have serious question. The problems that have been raised here are real. What we've got to do is to realize that we all believe that health education is a desirable and vital function of the health department. Our next problem is how to overcome potential misunderstanding and confusion. I'd like to point out something. Suppose we have a health officer who's been more concerned with introducing programs in environmental control and not so much with developing community relations. Then he gets on his staff a person who is rather highly trained in community organization. A great deal of the curriculum in health education is concerned with understanding the community, its psychology and operation. This means that the health officer has on his staff a person who has a higher skill than he in this particular thing. There's nothing wrong in this and the health officer has to get used to it. But it is potentially difficult because community organization is one of his most vital frontiers. Unless he is loyal

to the health educator and the health educator to him, the whole program fails.

"In our training of these people we're putting a great deal of stress on community organization and relationships and are trying to bring the two groups together in their post-graduate work so that future generations of health officers and educators will have learned teamwork from the start. The job at the moment seems to me to be introducing them into established health departments. Perhaps if you see him as an expert consultant serving the staff of the health department and representing it in certain areas of special competence, you'll be able to work things out."

In the words of one of the health officers: "The way I see it, most of the beefs about health educators come from health officers who never had a health educator."

Another member of the group then summarized the afternoon's discussion with: "I guess health education, like any other activity, ought to be oriented to time, place, and person, as it says on the history blank. *Time* seems to me to refer to the timeliness of the information in relation to the people involved; *place* means where people are and where you can reach them or cause them to congregate as a group or even individually; and *person* would refer to who they are, what they want, and what they can take."

And a psychiatrist added: "I think you've got a good concept there. Let's carry it a little further. As someone said today, 'Telling people what to do never educated anybody.' Helping them want to do something about health is our goal. In the ordinary course of community life there are innumerable opportunities to come in contact with people who have a common interest at a given point and who would be receptive to information which is skillfully transmitted. Starting—and you have to start somewhere in the life cycle—with young married couples or couples contemplating marriage, you can take your educational work through all

the stages: prenatal, postnatal, child health conference, school health education, sex education for adolescents, and so on around the circle, anticipating interests and needs and giving them help in groups of their peers. Mass educational techniques may serve a supportive purpose, but without the opportunity to learn personally at strategic points along the way I doubt very much whether health education has more than a peripheral effect on the recipient."

MENTAL HYGIENE SERVICES

"I have a better understanding of the term 'mental hygiene.' I've been somewhat surprised and pleased to discover that I have been conducting a mental hygiene program of a sort for years. More important, however, is the fact that now I think I know how to improve on the mental hygiene aspect of the general public health program."

This was typical of the health officers' comments at the close of the institute. Two weeks earlier most of them had thought of the term "mental hygiene program" as a synonym for psychiatric treatment. They were well aware of the need for such treatment and frustrated by the dearth of resources in their own communities. And they shared the common misconceptions about case-finding and referral of patients with emotional problems that prevail among professional persons in the fields of education, health, and welfare: "O.K. Suppose I learn more about emotional disturbance and its symptoms? That just means that I recognize them more quickly and find more cases. Then what do I do? If we don't have a mental hygiene clinic, I'm stuck, and if we do, it just means another name added to the waiting list."

Public health personnel, even more than members of other service professions, have good reason for this approach to mental health problems. Their training and experience in case-finding

has given them a clear-cut pattern which works well in other situations such as tuberculosis or cancer programs. Finding a case of cancer is the first step in a clearly defined chain of events which terminates in recovery or death. But finding a case of emotional disturbance has many intangible implications which do not lend themselves to the same precise sequence.

Emotional maladjustment may range from a beginning feeding problem in infancy, which can be corrected by simple reassurance and advice, to a psychotic state which requires hospitalization. The "case" may be a kindergarten youngster who is too shy and withdrawn to play well with the group and needs a little special understanding and help from his teacher or, at the other end of the scale, it may be a schizophrenic who requires the combined skills of psychiatry and its related disciplines in a specialized hospital setting if he is to regain a reasonable level of emotional adjustment. Evidence of emotional imbalance may be found at every level of human growth and development and often appropriate help can best be given at the point where this evidence first comes to light. The opportunity to see the need for help and to give it prevails throughout the entire range of public health services.

Clarification of the mental hygiene potential in day-to-day public health practice was the basic, and for many of the health officers, the most difficult lesson which the institute had to offer. Not only did this concept violate the health officer's case-finding habits, it also asked him to understand and accept the difference between psychiatry as a medical specialty and those psychiatric concepts about human behavior and needs which pervade all interpersonal relationships and are no longer the unique province of the specialty which originally formulated them.

Early in the discussion, the health officers' confusion was demonstrated by such comments as, "If I see a patient with a sur-

gical condition, I send him to a surgeon. I don't open him up and start poking around in an abdomen when I haven't seen the inside of one since I left medical school. And if it's an orthopedic condition and there's a specialist around, you won't find me treating the case. So I don't see why I should try to practice psychiatry when I don't know anything about it."

Eventually, however, the health officers began to see the extent of the variations in emotional deviation and need and to realize that mental hygiene services may encompass almost the entire range. They saw that the nurse who helped a young woman in the prenatal clinic to feel less apprehensive about planning for her baby was providing a mental hygiene service for the mother, the father, and the baby even though her service could not be measured in precise units. If the nurse were sufficiently trained and experienced in mental hygiene to be able to attach a diagnostic label to the patient's behavior and attitude, she might then technically have been said to have "found a case" of emotional disturbance. But even without the label, the nurse sensed that this young woman was as tense and nervous about her pregnancy as the average prenatal patient, or perhaps a little more so, and with or without diagnostic label, the nurse gave the patient what she needed: a chance to talk about her fears; a chance to see that she was not alone or unusual in her apprehension; some practical advice and guidance about things to do which helped her to take hold of the situation and to deal with it more realistically; and above all, the reassurance and emotional support which grew out of her relationship with this friendly, interested, and experienced professional person.

Every clinic visit, every discussion of public health practice furnished additional evidence of the mental hygiene implications in the everyday job of the health department. The evidence went even further to include the mental health implications in the work

of all other educational, health, and welfare services in the community. The health officers saw that they are not alone in their responsibility for the promotion and protection of mental health. They saw that doctors and nurses wherever they may practice have a continuing responsibility and opportunity to give, not psychiatric treatment, but the kind of professional service that incorporates an intelligent concern for the individual and his feelings and needs as an integral part of the practitioner's working equipment. They saw too that the teacher, the recreation worker, the social worker, the clergyman, and others are also strategically situated to promote the mental health of those whom they serve.

As their orientation proceeded, the health officers began to see case-finding and screening as a continuous process which involves not merely diagnosis and referral, but a developing sensitivity to the needs of persons with whom they come into contact professionally. This sensitivity, they realized, will enable them to approach their clients and patients with an eye to seeing how much help they can give within the public health setting rather than how many patients they can find who need psychiatric referral. Likewise, a mental hygiene program was seen to include much more than a treatment service for clearly defined psychiatric problems.

After considerable discussion it was agreed that a mental hygiene program is the concern of the entire community and depends for its success on the combined efforts of its citizens. The factors which make for emotional well-being are numerous and interdependent. Since the personality structure of the individual is influenced for good or ill by the entire range of environmental factors, there are mental hygiene implications in each of them. Adequate housing; reasonable satisfactions and security on the job; adequate recreational and cultural facilities; schools in which the individual child is recognized as an individual and helped to

realize his potentialities; health services which provide socially-oriented, rather than sharply delimited medical care and attention; remedial social services to which the individual who is temporarily unable to cope with his environment or relationships can turn for help in gaining a new perspective and the strength he needs to deal with his problems; a continuous educational program for the citizens of the community to the end that they may learn and incorporate mental health concepts in their daily lives and interpersonal relationships—these are all essential to a sound mental hygiene program.

The place of psychiatric clinics—adult, child guidance, or those serving both adults and children—in a community mental hygiene program was the subject of many formal and informal discussions. Several of the psychiatrists who had had experience in child guidance and other community clinics summarized current thinking about psychiatric clinical services, pointing out that there is difference of opinion on the subject. There is general agreement in the field that the success of a community clinic is dependent on the presence in that community of a reasonably adequate network of essential health and welfare services. The difference of opinion is concerned with the function of the clinic itself. One group believes that psychiatric clinics should be concerned with the treatment of patients and not with the educational or community aspects of a mental hygiene program. The other opinion, to which a majority of the psychiatrists at the institute subscribed, holds that a community clinic must be "something more than just a treatment service for patients." By "something more" is meant the clinic's assumption and discharge of responsibility for leadership in studying and attacking the sources of emotional disturbances and improving the ability of the local educational, health, and welfare agencies to promote the mental health of their students, patients, or clients. All are agreed that every community

needs and should have a psychiatric clinic as soon as it is ready for it and qualified personnel is available.

"The kind of pressure you've been under to set up clinics is perfectly understandable from the point of view of the interested citizens who are putting on the pressure. They see emotionally-disturbed children and they want help for them. Psychiatry has been well publicized in recent years—perhaps too much—and they're sure that once there's a clinic in the community all the psychiatric ills will be eradicated. Now that there are National Mental Health Act funds for states to use in the establishment of services, it's very hard for the interested citizens to understand why they can't have a clinic right away. Let's take a look at some of the problems so that you can help your pressure groups to see how they add up."

The problems, as they were enumerated and discussed, were found not to be insurmountable but were seen as sufficiently serious to warrant careful consideration and planning at every step. Personnel shortages in the psychiatric clinical field have been well publicized, with the result that some communities have either postponed plans for clinics indefinitely or have set up services staffed with untrained or partially trained personnel in the "mistaken notion that once you open something called a clinic, you've licked the problem. Actually you've created a problem. Patients don't get the treatment they need, and when word of the poor service gets around in the community, the responsible people turn against it. It takes a long time to counteract the effects of a poor clinic, sometimes years after it's been closed but not forgotten."

The recent experiences of a number of communities were cited as examples of how some personnel problems can be met. Once the planning group accepts the premise that a specialized clinical service must be staffed by persons professionally equipped to give

the service, recruitment is the next step. Housing, salary, and the opportunity for professional and cultural growth are basic considerations in recruitment and some communities have shown remarkable imagination and judgment in providing attractive inducements. Usually, however, clinic jobs go unfilled for months, even years. "This is where long-range planning pays off. Clinic committees usually have funds available or they wouldn't be ready to hire a staff. What they can do, and more of them are doing it every year, is to take on personnel and send them for training, with the proviso that they give a certain period of service in return. That's how quite a few good clinics have been started in fairly remote parts of the country."

It was emphasized repeatedly that the extent and kind of service which a clinic can give must be clearly understood by the responsible persons in the community before it is launched: "Take your average city of 100,000. It's been estimated that a city that size can support one small clinic. But we know that a small clinic or even a large one will never be able to handle all the psychiatric problems in that city. You've got to make clear just what kinds of cases you're equipped to handle and why. And you've got to be prepared to deal with the resentment you'll get if you don't take everything that comes along. Otherwise you'll have what usually happens when clinics are started without enough preparation: As soon as the doors are opened the demand for service swamps the resources of the clinic. Schools, social agencies, courts, hospitals, and other agencies promptly deposit their problem cases on the clinic's doorstep."

The psychiatrists were agreed that unless the way has been paved for the clinic and its services and limitations clearly defined in advance, the future of a mental hygiene clinic can be undermined before it begins. They pointed out that clinics do not perform miracles and cannot work alone. If the relationships in the

home or other environmental factors are too pathological, a child guidance clinic can do little. If the neighborhood provides none of the supportive services that help children grow into well-integrated citizens, the clinic cannot compensate for this lack. If the school, or a teacher in the school, is turning out problem children on a mass production basis, the clinic's treatment of one or a half-dozen of the problem children is just a drop in the bucket.

One psychiatrist with considerable experience in child guidance added another problem that has long concerned experts in the field: "When you talk about interpretation of clinic service, you're talking about a day-in-day-out job that never ends. You start interpreting before the clinic opens and you keep right on through every new referral and every report to the people who are supporting you. One of the biggest headaches is your statistics. You're asked, 'How many children have you cured this year?' Cured of what? Cured for what length of time? Cured by what standards? It isn't a broken leg that you've set and cured. Maybe it was the mother who was relieved of her tension about her child who had been misbehaving; maybe it was the teacher who was relieved and now doesn't find Johnny so thoublesome; maybe something else happened in the teacher's life to make her more comfortable at about this time; or maybe joining the Boy Scout troop had a lot to do with the observable fact that Johnny was much less difficult than before. You see, child guidance clinic people are humble folk. They should be, but often they're put in the position of claiming credit for things they know they didn't do. When you're dealing with growing things like children, it's hard to put your finger on the exact curative agent."

Another problem, the solution of which also depends on interpretation and demonstration, has to do with the per capita cost of clinic service. As the psychiatrists pointed out, if one divides the total operating cost by the number of patients treated, it runs

high. But the people of the community must be helped to understand that clinic service involves much more than treating a few hundred patients a year. The patient in a child guidance clinic is not treated in a vacuum. At least one of his parents must be seen regularly; his teachers are important parts of his environment and must be included in treatment plans; recreational and other opportunities must be explored; and the referral source must be kept in touch with developments. Then, too, the well-trained clinic staff is in a position to give consultation to other agencies and has an obligation to do so. But unless responsible members of the community can be helped to see this, their support of the clinic may falter.

In summary, the psychiatrists expressed their conviction that no psychiatric clinic can ever be expected to provide treatment for all the potential patients in a community. Nor can the clinic alone embark on an educational program aimed at the extermination of all the psychological evils in the community. To aspire to either would lead only to frustration and certain defeat. The community clinic is a treatment resource and as such must strive constantly to improve the quality and quantity of the psychiatric treatment which it was established to render. Treatment is the core of the clinic's existence but in order to strengthen itself as a treatment resource, the clinic must be concerned with the community of which it is a part: it must be concerned with parent education and with the education of the professional people in the community so that the number of potential patients may be reduced and the referrals that are made to the clinic become more discriminating. It must stimulate the establishment of adequate health and welfare services for the community as a whole. And it must work constantly for the day when a mental hygiene approach is so much a part of all service agencies that it is practiced automatically.

There was general agreement that most communities expect

too much and too little from psychiatric clinical services: too much in the way of cures of impossible situations that have long since passed the remediable stage and too little in the way of consultation with other agencies as a service to the community as a whole. When a clinic is visualized as a community agency with a role to play in the improvement of general social and health services, it can be used successfully much earlier in a community's development than the clinic which is seen only as a specialized treatment service. Similarly, a clinic which is supported by adequate health and welfare services is much nearer its goal of providing treatment for those who require it than one which is artificially introduced into a community that is not equipped to meet the basic health and welfare needs of people. The need to interpret this to the community was recognized by the group, and several of the health officers remarked that they were now ready to meet with their local mental hygiene societies and to try to help them work out more realistic plans for the future.

"There are lots of things they can do in my county while we wait for the personnel shortage to ease off. They've got some money and they can use it for an institute like this one for teachers, or they can take a look at the courts to see what happens to kids who get in trouble, or they can plump for better playground facilities. And I'm going to tell them about sending personnel for training so we can have them back for a clinic later on when we'll be readier for it. That should give them something to get their teeth into and it'll help our county a lot."

PUBLIC HEALTH ADMINISTRATION

"THE lecture on emotional factors in the use of authority hit pretty close to home because of the character of my job as an administrator.* I got to thinking about some of my difficulties and the defense reactions which I am aware that I manufacture in other people; and there must be a good many others that I'm not aware of. I wonder if anyone else would be interested in a little fuller discussion of the ways we use defense mechanisms in our administrative relationships. It might be interesting."

This comment at the start of one of the small section meetings brought the following response from another health officer: "Yes, it would be interesting. I think we're thinking about the same thing. What are the signs that a person can recognize within himself or within his relationships that demonstrate his own immaturity or inadequacy? It certainly would be very helpful to be able to recognize them."

After some discussion of the fact that our own immaturity is less likely to be clear to us than that of others, one of the psychiatrists noted that "usually these are the things we defend ourselves against acknowledging," while a health officer suggested "and a defense mechanism is the way we protect ourselves, isn't it?"

Since the group obviously wished to pursue the subject further, the psychiatrist commented, "I wonder if you'd like to talk a little further about some of the things you've noticed in yourself or

* Dr. Szurek's paper on "Emotional Factors in the Use of Authority" appears in the next section.

others, the type of defense mechanisms that you've used, that you think you've come to rely on?"

The public health administrator, whose comment had started this discussion, went on with: "There are a number of things that I do. You psychiatrists probably have a classification for them or a term that describes them. For instance, in trying to reach a decision on some matter of policy with a subordinate or superior, I may be sure in my own mind and I may feel quite deeply about it. But occasionally, after I've reached a decision, I fail to sell my opinion either up or down the hierarchical scale in the department. When that happens I usually assure myself that 'Well, after all, it doesn't make so much difference; it wasn't as important as I thought it was, just a minor matter.' But that really doesn't satisfy me. I know that I'm covering up my concern over my failure.

"Another type of thing which I'm aware that I do sometimes is this: An argument or dispute will go along to the point where I really get stirred up about it—really emotional—and if I don't explode openly, I'm just raging inside. The very next person who comes in to see me, no matter how reasonable his proposition may be, gets a good strong 'No' to anything he asks. That's my 'No' day.

"These are just examples that I'm aware of: some have been pointed out to me; some I've discovered myself; and some I can see in retrospect here. There are probably others which seriously affect my efficiency and there may be some which have improved my efficiency but I don't recognize them. I presume everyone in this group has got some little stunts of his own which he uses to modify situations."

Entering into the spirit of the occasion, a health officer responded to his colleague with: "Boy, have I got a lulu! Do you remember about a year ago when we were arguing about whether

one of my men was to go to school or not? The sequel to that argument is the point that's interesting. We had an honest argument about whether this man, assigned to my health department, should be sent to school this year or should wait until next year. I argued that I couldn't spare him this year and I argued very vehemently, didn't I?"

The administrator to whom this was addressed remembered the incident vividly and joined his colleague in a very thoughtful exploration of some of their motivations in that situation. They discussed the amount of pressure each had exerted to gain his own way and the "righteous" anger each had felt toward the other because of behavior which he had considered unreasonable. The staff member did not go to school that year and the matter was ostensibly forgotten. But according to the health officer, "I thought I had forgotten about it. But I realize now that I didn't really forget about it underneath, unconsciously. Do you remember with what glee I pounced on a little thing not long ago and wrote you a very hot, sarcastic letter about it? It was something about the exchange of record information which assumed far greater proportions than it would have ordinarily. The issue was silly and unimportant, but I remember the pleasure I took in that letter. It was a masterpiece of sarcastic extremism, or at least I thought so. Looking back at the thing, I'm pretty sure those two events were connected."

"It might well be," suggested the psychiatrist, "that the feeling that was aroused by the first set-to was carried over for quite a while and you found outlets for it in various unrelated situations that gave you an opportunity to express it. Perhaps with this clarification and insight there won't be so much need for carrying it over."

"That's it, yes," answered the health officer. "You know I just hadn't thought about it before, but I really think that the

letter that I wrote was largely colored by our argument about whether my staff person was going to school this year or next. I wouldn't have believed you if you'd told me that when I was composing my masterpiece, but I see it now."

To this his colleague replied, "And in my case the reaction to that argument was very interesting. The individual we were arguing about was of no great personal concern to either one of us. I told myself that it was a matter of principle and was unwilling to make any concession as to a postponement of this man's educational leave. I was being vindictive and taking out my rage at you while the poor victim was torn between us." And the health officer added, "I was just as determined, come hell or high water, that he was going to school next year and not this."

The psychiatrist then summarized the meaning of this contretemps: "While it started as a routine administrative decision, it became a matter of principle and policy, and I wonder, too, how much it became a personal issue: who's boss here? Not so much do I get what I want or not, but rather who's going to be the dominant person in this show?" The public health administrator added another pertinent point here, "It was a question of saving face, after we got into the thing. Frankly, I think that's frequently the issue in staff relationships. You get yourself out on a limb and to save face you're unwilling to retreat."

This exchange represented more organized insight than was true for the student group as a whole, but was typical of the freedom with which they brought their own experiences and feelings into the section discussion. As health officers of large city and county units, they were concerned about their administrative relationships and eager to understand motivations. Administration was discussed frequently in all sections of the institute. It was not the administration of the textbooks, not the art or science of

budget construction, not the topography of the organization chart, nor the precision of the operating manual. The machinery of administration was seen as the framework within which people can work effectively to achieve the purpose of the organization.

Too often, they agreed, machinery becomes an end in itself. There is apparent safety in directives and memos in triplicate, in the assumption of omnipotence, in the system of channels that frequently vitiates the force of ideas and impulses before they reach their destination, in all the devices that administrators erect to protect themselves against the impact of the true administrative process which is concerned with interpersonal relationships.

This is to be expected because administrators are people and people have needs, chief among them the need for security. Security has many facets: financial, cultural, physical, social, and emotional. Emotional security or maturity is compounded of many ingredients: the basic personality structure of the individual which is the product of his initial equipment and his experience to date; the liabilities or assets of his present situation; and the potentialities that are inherent in the interplay between the two.

As one psychiatrist put it, "We all know people of whom it is said, 'He was all right until he got in a position where he could take it out on the other fellow. Power went to his head.' What do we mean by 'Power went to his head'? Do we mean that he became a different person, or that latent needs to exert his will over others came to the fore, or that in a situation in which he felt himself to be at a loss he turned to a very common way of dealing with his essential insecurity—he surrounded himself with the cloak of omnipotence? We mean that he became the 'Boss' with a capital B, because he didn't know how else to enter into working relationships with those who were subordinate to him. It takes a

tremendous supply of basic maturity to be able to enter into the give-and-take relationship that is administration, and too few people reach adulthood with that degree of maturity."

Administration involves responsibility for oneself and for others, and the mature administrator should be able to derive as much satisfaction from the professional and personal achievements of his staff as he does from his own advancement. This might be said to be the ideal toward which the administrator may strive, even while one expects that enlightened self-interest, which is common to all human beings, would make his major concern his own professional and personal achievements. The same enlightened self-interest, however, would indicate to the administrator that in the last analysis he stands or falls by the performance of his department. There are few settings in which the administrator has as many different but vitally interdependent subdivisions of activity to administer as one finds in a health department.

It was clear to all who had had even peripheral contact with the public health field that it is at best an amalgamation of several specialties, each with its own training program, techniques, and literature. Today's public health agency is a collection of departments, divisions, or bureaus, some new, some old, all of them carrying functions which have been evolved to meet needs in the community.

That these specialties should now be in varying stages of evolution and integration into the total program is inevitable. That each specialty should be preoccupied with its responsibilities, its prerogatives, and the relative value of its contribution to the total program is also inevitable. Within the confines of a specialty in any field the practitioner seeks and often finds the security that stems from specialization. If he can continue to do what he was trained to do according to methods that were laid down by his predecessors, he achieves the security which comes from the repe-

a task with which he is familiar. It is essential to his con-
and sense of importance to believe that what he is doing
as important as what his neighbor is doing, if not more so.
blic health there can be no question that each part of the
is important. What is frequently lost sight of, however,
t that no one part of the total job meets all public health
can even continue to meet a portion of the need unless
as a whole is working at full capacity and with the full
ion of all its component parts. The health officers ex-
serious concern over the extent of their responsibility in
ection. They felt that much was expected of them in the
leadership and many were eager to meet the challenge.
ealth officers had much to say on the matter of team-
ne team concept in medicine has long been recognized in
but it would be most optimistic to believe that it actually
practice. There has been much talk about the team that
e patient in the hospital or in the out-patient clinic or in
ealth, but there is little in the training of the disciplines
mprise the team that prepares their members to work co-
ely with others in the accomplishment of a common goal.
y in medicine and its allied disciplines the age of speciali-
very much with us, so that paradoxically we are training
s who "know more and more about less and less," and
me time are asking them to work in intimate, daily, co-
e endeavor with other specialists who know just as little
hat the other fellow is doing. In this atmosphere it is not
ng that one of the chief obstacles to realistic teamwork in
ealth is the precise and rather rigidly defined training
n of the component specialties.

ave, then, the picture of the typical health department in
he administrator is basically a physician who has been
to practice medicine with individual patients. He is ex-

pected in his public health job to carry executive, community relations, educational, financial, and other responsibilities for which his medical training did not prepare him. This is a problem which the physician-administrator shares with all other administrators whose basic training was professional. The public health officer is more fortunate than most, in that his formal public health training supplies the administrative orientation which other professionally-trained persons are expected to acquire by experience alone. But he is still a physician whose basic training was concerned with the practice of medicine.

Then, as a result of tenure or performance, this doctor eventually reaches the point where he no longer has any contact with patients and is thereby denied the opportunity to derive satisfaction from doing the thing for which his medical training presumably fitted him. He has no way to renew his professional enthusiasm, to derive job satisfaction, or to experience a sense of personal growth unless he can see in his administrative responsibilities an opportunity for the exercise of the highest level of skill in interpersonal relationships—the successful development of a health department which will be characterized by constructive, satisfying relationships with the community, within the staff, and between staff and patients.

If one were to enumerate the component parts of administrative responsibility, the list would be so long and so contradictory in the kinds of qualities, characteristics, and skills that are required that no single human being could be expected to encompass all of them. This list would include a high level of salesmanship in interpreting and selling the work of the agency to the potential sponsors and supporters; skill in financial planning, budgeting, cost accounting, and other aspects of sound financial practice; broad vision in planning today for the future and in coordinating the work of the agency with that of other organi-

zations in the community; sufficient interest and skill in handling details of operation so that the machinery of the agency works smoothly; the ability to understand, evaluate, and use each member of the staff most effectively; and the imagination to see the implications of individual and collective activities, not only the immediate implications but the broader effects of action as well.

Obviously each human being who undertakes administrative responsibilities brings to the task a different constellation of personal and professional qualifications. Granted that all individuals will seek in the job some measure of personal and professional security and prestige and satisfactions of a rather generally accepted kind, it is also true that each will seek a somewhat different proportion and combination of these ingredients, depending upon his own needs, and will bring to the responsibilities of the job his own particular strengths and weaknesses.

As the group discussed variations in administrative skill, it was assumed that one could not expect all administrators to have the same degree of tolerance for individual differences in a staff or for the pressures that are inevitable in such a position. It was further assumed that some will tend to delegate more responsibility than others, while some will be more adept at community relations and others at planning operational details. These individual variations were accepted as inevitable, but the group sought to determine what ingredients were essential to the effective functioning of an administrator. They approached these basic ingredients or common denominators through discussion of their own administrative problems. There was complete readiness to use themselves as guinea pigs and to toss into the discussion examples of good and bad administrative procedures as they came to mind.

In a score of different ways the problem of the administrator's own insecurity was brought up for consideration, and as the health officers saw the relationship between his attitude and the staff's

response, they became aware of a curious resemblance between their situation and that of the parent-child relationship. They saw that the administrator as the parent figure carries responsibilities which are inherent in his position, responsibilities which demand maturity, consistency, and the friendly firmness of the good parent.

Said a health officer, "There is one trouble that the administrator has that his staff does not understand. He's supposed to be a good father, the all-wise, all-seeing parent who's always around when he's needed and doesn't ever need to have reassurance himself or a pat on the back once in a while."

And another added, "If he acts promptly and makes quick decisions, he may step on somebody's toes and if he tries to think about something and puts it off for a while, then the staff feels he's not giving them proper recognition and attention. That's not all. Just because he's a doctor, he's supposed to know all the most up-to-date answers, even though he may be months behind in the medical literature and hasn't even heard about some new drug that was reported in the morning newspapers."

One of the psychiatrists commented, "You bring up one of the most important aspects of administrative responsibility and that is the feeling of inadequacy within the adminstrator who, like the father in the parent-child relationship, is supposed to know all the answers. It seems to me that if one grants that people in general have feelings of inadequacy and that an administrator is 'people,' then it follows that he, too, has feelings of inadequacy. What he does is going to be largely determined by how threatened he is by these feelings of inadequacy. For example, if the administrator feels so insecure within himself that he must overcompensate and act as if he's an all-knowing, all-seeing figure, he'll obviously get himself out on a limb and become dictatorial or authoritarian."

league added, "This is so typical of parent-child relation-
often the parent gets himself into a similarly impos-
ation by making a decision for the child, frequently
ngs that are not clear and about which the parent has
ke the conviction that he seems to have. I'm sure you've
. The child then begins to put up arguments and to push
modification of the parental edict, with the parent be-
ore and more rigid until the youngster finally says, 'But
t I do this?' and the parent falls back on the good old,
I say so,' as if the child doesn't have a right to a more
t reason than that. How much better it would be for
t to say honestly, 'Well, now I'm not sure, but I think
k this would be the better way to do it. Maybe it isn't
: for the time being we'll have to do it this way and then
and talk about it again.' The parent has the ultimate re-
ty, as does the administrator."

st psychiatrist elaborated the point further with, "And
the other approach to that kind of situation, parental as
dministrative. For example, 'O.K. This isn't a situation
harm will come to anyone if you follow through on
n. I don't see that it's the most effective way, but let's try
, or think about it and let's talk about it some more.' That
another factor, if we're drawing on the parent-child
hip for examples as we certainly can in thinking about
ration, and that is the question of security. To say that the
eds security is to come up with a truism. Among other
e needs security in the feeling that there are certain broad
or principles for behavior in our society and that he, like
e else, is expected to learn to abide by them. Absence of
other words, wishy-washiness on the part of parents, can
reat difficulties in the child's formation within himself of
r socially-accepted lines of conduct. The same thing is di-

rectly true in administration. If the administrator always leaves everything up to the group, say in staff meetings, always lets the group decide and has no opinions of his own, he can create a great deal of insecurity within the group and in their feelings toward him. They feel that there is nobody to whom they can turn for final authority."

"That's a good point," said one of the health officers. "That means that there is no real direction, no support that the staff can depend upon. If they get into a tight pinch and don't know the answers, there's no one they can go to for help and direction."

And the psychiatrist replied, "That's right. You've seen it, I'm sure, with youngsters when they sense indecision on the part of the parent. They get more and more anxious and more wound up and then proceed to test the limits of how far they can go. You see them pushing farther and farther until they sense what the limits are in a situation, and when they find them they settle down; the relief and satisfaction that come with it is quite tangible. You know the story that is often told about the very early ultra-progressive school where one of the youngsters was heard to comment, 'Oh dear, do we always have to do just what *we* want to do?' From the administrative point of view, somebody has to take authority and responsibility for final decisions and has to feel secure enough to be able to revise them tomorrow if necessary."

Individual differences among staff members in personality, capacity, and needs popped up at frequent intervals. The necessity for understanding and making the most of each person's potentialities was a running theme throughout the institute. This represents a twofold problem, affecting as it does the relationships within the agency and the service which the agency renders to the community. The staff member who has been trained to do a job in a certain way and who is by personality make-up inclined to be comfortable only when adhering to rigidly defined schedules,

manuals, and procedures is not an easy person to work with in the agency, nor is he well fitted to interpret a flexible, evolving program. Since health officers work most closely with nurses, they tended to draw from this group many of the examples which were discussed.

Said one public health instructor, "Some of our nurses who were trained in the days when feeding schedules, habit training, and the like were pretty rigidly laid down now face a real problem when they take over or try to take over this so-called newer method. It robs them of the things they have leaned on for a great many years. It's just as true of pediatricians when they first begin to pick up a more flexible approach to infant care. After all, it was so simple to write out those exact formulas and all those precise hours for doing this, that, and the other thing; and then suddenly you're faced with a series of questions that you can't answer with a direct yes or no. You have to have more ingenuity, more imagination, and a pretty flexible personality yourself to put it across convincingly."

A psychiatrist suggested: "The nurse is in a dilemma on two counts: first, because she's a member of a profession that's in a period of transition and, second, because even when she's able to make the grade herself, she is met by doctors who are still molded in the old rigid pattern. It's also hard for nurses to see tangible value in some of the things that newer training courses have emphasized. Like doctors, they've been trained to give something to patients, something tangible that can pass from one to the other in the way of medication or a prescription or something. It's hard for them to see that some of the things we've been talking about —the giving of help, the giving of psychological support by listening—that some of these things that are involved in good interviewing can be an important contribution to the patient. It's hard for them to accept these things just because they are so intangible."

To which a public health instructor added, "We know that the nurses will take this a lot more easily than most of our doctors, but I think that because of the nurse's relationship to medicine—always turning to the great medical expert for the last word—she'll always be in a state of transition as long as we keep changing our minds about what is right. I'll never forget a nice old nurse who came in one day when I was in the office of our director of nurses and said, 'Now don't bother to tell me why you asked me to come in. I know you want to tell me it's time to retire.' And then she looked at me just as grim and weary as could be and said, 'It's all right for me to retire, but I wish you doctors had made up your minds.' I waited a minute and she said, 'That tomato juice!' You could feel the weariness of the thousands of hours of tramping up and down tenement stairs as she added, 'When I think of all the families I told tomatoes were bad for babies, and now you doctors say tomato juice is good for them.' It was as if her whole life's work had been wasted because we doctors hadn't made up our minds."

There seemed to be a general acceptance of the fact that more recent training for nurses has emphasized flexibility and that group-for-group in the public health field today the nurses are far in advance of other disciplines and much more ready to accept newer methods and philosophy. Nevertheless, there is still and will continue to be for some time a somewhat excessive dependency on the physician. This dependency tends to invest the doctor with a degree of omniscience that he could not possibly have, while at the same time it tends to be critical of normal vacillation or change. In several different ways the health officers were saying that their security is threatened by the dependency of the nursing group. "They expect you to make up your mind at once and then not deviate, because unless you act exactly the same in every instance, they think you just simply don't know your own mind. I

complaints from supervising nurses to their superior
administrative ability because I don't always act the
under what seems to them to be the same circumstances.
at this is the fault of nursing training somewhere along

iatrist asked, "Isn't it failure of education all along the
make a fetish of our pioneer, progressive thinking in
y, but our educational system stresses that the powers
e authorities or experts, always know the right answer.
's the way that new ideas are sold to the public as well
rofessional people. We all go to such extremes on a new
we're completely let down when a still newer idea comes
wipes out the old one. There is also the more general
that with increasing specialization and the narrowing
pecialties, the specialist has to be the final authority and
ays know the right answer in order to keep up his pres-

the personnel problems with individuals which seemed
ather widespread incidence were those involving the im-
r dependent staff members. These persons were vari-
cribed: those who are bright and skillful enough in the
oncept of the job, but not grown-up enough to carry on
ently; or those who become so involved in the problems
patients that they do not see either the patient or them-
arly so far as responsibilities are concerned; or those who
ll enough if decisions are made for them, but tend to
he supervisor with details that should be within the scope
actitioner.

examples led naturally to the role of the administrator
es of his subordinates. There was considerable discussion
con before this concept became clear to the group. It was
ummarized by a psychiatrist as follows: "In somewhat

oversimplified form you can say that during childhood there develops a two-sided relationship to authority, which for the child is represented by the parent. This warm, loving individual, on whom the child depends, is also the strong, much larger individual who wields authority in the life of the child. It's perfectly natural, therefore, that the child will feel both love and fear toward the parent figure. All of this tends to get transferred to authorities later on in life, first to his school teacher, then to his boss, and so on.

Whenever you are in authority yourself, you've got to recognize that all the people under you have this two-sided relationship and expectation and that if, for example, you merely fail to show the friendly side of your authority, they almost automatically assume that it isn't there. The awe-inspiring and fear-inspiring side of authority is all they see. In the individual to whom authority represents much more fear than love, the tendency will be to look for that aspect of it in his boss; he will have to be shown that the friendly side is there too. It's something that we tend to forget when we get into positions of responsibility ourselves. Most of us, especially during the school period and early professional period, are quite aware of the people who are over us as authorities and we're aware of how intense these feelings are. But the tendency is to forget that the people over whom you have authority are looking at you in the same two-sided way and are making their own evaluations from the little, almost unconcious things you do. It's inevitable that they'll exaggerate and use, as they need to, evidences of friendliness, disapproval, or neglect that may not have been intended as such. The administrator must constantly look at what he does, listen to what he says, and try to feel their implications to the members of his staff."

Another section meeting covered similar ground with a somewhat different emphasis. It grew out of a discussion of public

health education and the problems in developing self-motivation on the part of citizens so that they would take active responsibility for the community's health needs. In the natural progression of the discussion the group arrived at the importance of leadership and, as happened in every session at some point, this led to the question of administration. The responsibilities and potential dangers inherent in authority were the concern of this group and within that framework they recognized that the administrator must accept his role in the lives of those over whom he has authority.

"When you first talked about the administrator as a father figure I didn't get it, but now I realize that you mean 'father' in the sense of the responsible authoritative person in the working or social lives of other people. I used to think it was enough if I tried to get my staff decent working conditions and a living wage and let them know that I thought they were doing O.K. Now a lot of things I didn't understand are perfectly clear when I look at myself through their eyes and accept the fact that I'm a pretty important guy to them. I affect their lives in good and bad ways all the time, even when I don't know it."

"I'm just thinking of the kind of administrator who is a father figure in the bad sense," said another health officer. "He's so strong, or shall we say, needs to feel that he's so strong that he doesn't need anybody's help. He doesn't invite support, and though he gets lip-service from his staff, he develops no initiative in them, no imagination, or desire to do better."

The psychiatrist underscored this with, "The kind of father figure you're talking about is seen much too often in administrative settings. He's the one who's an autocrat, not a democrat. He stifles independence. He doesn't make it possible for the child to grow into participating activity. He has to do the whole job. He has to tell them what to do, how to do it, and when to do it. He

doesn't develop self-discipline or the desire for self-correction."

In all sections, the talk sooner or later turned to ambivalence, or being of two minds or two kinds of feeling toward others. In each section it developed out of a discussion of parent-child relationships and their carry-over into adult life. The strength of the negative aspect of one's mixed feelings was recognized. There were numerous examples from medical practice and administrative settings in which negative feelings were seen as basic to much of our everyday behavior. Their strength is due in large part to the fact that they are seldom recognized or accepted. Since we tend to repress socially unacceptable hostility, it must find its way through the subterranean passages in the personality until it emerges in behavior which is usually rationalized. For example:

"So much of the negative feelings we have for the people we love must be repressed and denied because the recognition of it is something that creates terrific anxiety. It's the hardest thing one has to do, to face the fact that along with love goes hate, that no feeling is entirely pure. We see this in the child who must repress the hostility which he feels toward a parent. You can't express negative feelings during childhood. You have learned that it's too dangerous. You've got to cover it up. But with patients in psychiatric practice the mechanism becomes very clear. The psychiatrist feels that when a patient is able to accept the fact that he has mixed feelings and can see how his hostility has come out in his behavior, he's well on the road to recovery."

A public health instructor commented, "I can see that very clearly in relation to administration. Wouldn't you say that it's important and desirable that some opportunity be provided for the expression of negative feelings so that staff members and the administrator too, for that matter, needn't go on bottling them up?"

"I'd suggest," said a psychiatrist, "that we take a look at our

Army or Navy for just this kind of thing. I, for one, think that one of the most beneficial techniques in the armed services for the expression of negative feeling was the gripe session that was developed to give enlisted personnel a chance really to crack back at an officer without fear of punishment."

A public health instructor corroborated this with, "I've been trying to do that kind of thing in my office. Most of my department heads know that our staff meetings are their golden opportunity to pour it out on the senior administrative staff."

But one of the health officers raised a question: "Well now, there's a difference between a gripe session and a staff meeting. I found that in staff meetings in which department heads are present as well as the lower echelons of staff, the rank and file is pretty much inhibited by the presence of their bosses; whereas if it's just staff without the brass, they can really go to town and have their say."

After further discussion of this point it was agreed that if the atmosphere in the agency and the attitude of the supervisory person are sufficiently mature and positive, much can happen in a staff meeting that has definite value for all. If the administrator can accept and handle negative feelings on the part of his staff without needing to hit back, he has one of the finest safety valves and administrative tools at his disposal.

However, another question was injected at this point: "Lets assume that the top administrative officer can take it. There's another problem in a health department, and that is the second layer of administrative personnel—the supervisory or department heads. Suppose you do say that you're going to be the kind of administrator who has an open door and that you're always ready to listen to any staff member with an idea or suggestion. Doesn't that threaten the in-between staff, the supervisors? " It was agreed that there was a potential threat involved, that this

was one of the more delicate areas of administration, but that the same kind of sensitive, positive approach was essential to its solution.

As one of the health officers summarized it, "The staff—and I mean everybody on the staff—reflects the personality of the health officer. If his door is always open, then his department heads will develop the open-door policy. If he takes the time to get to know everybody and to be interested in what's happening to them, this, too, will be reflected in the department. They may be on the third level of an organization chart or even the fourth or fifth level, but they represent the agency and stand for public health policy and practice just as much as the fellow in the first box on the chart."

There was much more discussion of all phases of staff relations, with unanimous agreement that staff meetings, department head meetings, gripe sessions, and social functions may be constructive or destructive or entirely negative, depending upon the relationships within the staff and between administrator and staff; and that the tone of the relationships will inevitably stem from the maturity of the administrator. There was also some interesting speculation on buck-passing as it is seen in any organizational structure and in individual personal relationships such as those between physician and patient. There appeared to be two kinds of buck-passing: one which stems from insecurity and lack of forcefulness on the part of the responsible individual who sends the problem along to someone else because he cannot handle it, and the other which grows out of hostility, unrecognized and unchanneled.

The group was agreed that basically each administrator has a choice as to the course he wishes to pursue. True, the demands of the job and the existing pattern which he inherits from his predecessor will color what he is able to do immediately or in any given instance. Equally true is the fact that his own degree of maturity

will influence how effectively he will be able to put theory and intentions into practice. But it was agreed that if he sees human relationships as the foundation of administration, he will bring to the task a heightened awareness of his own feelings and those of others and will see as his first, major, and continuing responsibility the development of the highest level of sensitivity and respect for the dignity of the individual of which he is capable. The fundamental point of this discussion was concerned with the difference between the lonesome administrator, the king who stands alone and makes all decisions, and the leader who mobilizes the best that is in each individual for the good of all and for the successful accomplishment of the job to be done.

The health officers were deeply impressed and many of them were a little awed by their new awareness of the role which they played in the lives of their subordinates. Some looked forward eagerly to the opportunity for trying out a different approach at their next staff meetings, while others expressed the fear that some of their staff problems might be too firmly established to respond to their changed attitudes. The majority, however, were neither as optimistic as the first group, nor as pessimistic as the second—their attitude was expressed by this typical comment: "It's not that I'm going to change items 3, 10, or 25 in the procedure manual when I get back, but that I'm going to look at things differently, at people and things, and at myself in relation to them." That they did look at things differently was demonstrated by their reports and in follow-up visits which indicated an increasingly successful and satisfying recognition of the human values in administration.

EMOTIONAL FACTORS IN THE USE OF AUTHORITY

"This really ties it up for me," said a health officer at the end of Dr. Szurek's lecture. "How I use my authority with my staff or with patients and how I feel about the man who has authority over me are just part of the whole chain of living and getting along with people. This emotional maturity that Dr. Szurek was talking about today is something we all keep aiming for and the closer we come to it the better we are as administrators and, I guess, as people."

Coming as it did toward the close of the institute, Dr. Szurek's lecture served to "tie it up" for many of the health officers. They had already begun to recognize the pervasive influence of emotional factors in all human relations and to understand some of the reasons for the uneven, often erratic progress which all of us make toward emotional maturity. In his talk Dr. Szurek took the students a step further in the application of these psychiatric concepts to interpersonal relations and to their own motivations and needs. He succeeded so well in sharpening their insight and acceptance of basic concepts that there was general agreement on the advisability of including his lecture in this report of the institute.

Dr. Szurek's lecture on the emotional factors in the use of authority follows:

"There is perhaps no more troublesome problem than that of

authority, not only in all kinds of interpersonal situations where two or a few more persons have relations with one other, but also in those where larger groups of people—especially nations—interact. It is not necessary here to say much to substantiate this statement. Such words and phrases as 'civil rights,' 'dictatorship,' 'democracy,' 'totalitarianism,' 'police state,' 'the sovereignty of a nation,' 'freedom'—to name only a few—will recall to your mind the manifold problems of authority which acutely beset us now in the world, and which probably beset every generation in human history.

"Some might object that such problems are far removed from the purpose of our meetings here in these two weeks. These are political problems, one might say, or problems in philosophy or in political science or in law, or at best they are the phenomena of human historical processes. Certainly, such an objector could maintain, the problem of authority has only a tangential relation to science, to medicine, or to one of its specialities, psychiatry. Nevertheless, if our discussions together have succeeded in suggesting to you that psychiatry has something to do with the problems of people living together, with their influence upon one another, with even their effect upon one another's health and bodily functions, then it will be quite obvious to you all that no medical man can be unconcerned about the problem of authority. Whether the doctor is clearly aware of the problem or not, he is constantly involved in its implications. This is true simply because he himself is vested with a certain authority. He is vested with this authority not only by virtue of his medical license and degree, but also by virtue of the feelings of his patients toward him. And in public health work special, legally-established responsibilities of the medical officer invest him with an authority in certain situations which differs in its nature and problems from those of the

physician in private practice. How he exercises this authority is of tremendous importance for the effectiveness of his work and for his own satisfaction in it.

"I shall probably never forget a bit of autobiography one of my teachers in medical school shared with us. He said it took him ten years in private practice to unlearn what he had acquired in his work with charity patients during his internship in a county hospital. During those first ten years of practice he examined conscientiously, studied thoroughly, and prescribed sometimes minutely for his patients. If a patient returned some months later no better for his ministrations and occasionally even worse off, and if he learned that the patient had taken one of his prescriptions but failed even to have another prescription filled, he became angry and offended. He ordered the patient to leave and seek another physician's help. Gradually it dawned on him that the motto of the salesman, 'The customer is always right,' was equally applicable to the practice of medicine. If the patient had asked, received, and paid for a doctor's advice, he really had the right to do with it what he wished, which, of course, included the right to disregard it. After he had learned the lesson it took him a decade of medical practice to acquire, my teacher thereafter, with regretful but more sympathetic patience, tried to unravel the again-tangled threads of his patient's illness.

"This story illustrates very dramatically for me many of the frequent problems with regard to authority involved in the physician-patient relationship. It suggests some sources of our later difficulties with effective medical practice. It describes a too frequent attitude which complicates work with patients and generally diminishes therapeutic influence. An older colleague of mine, himself a psychiatrist, once humorously described a psychiatrist as a doctor who could rarely, if ever, be insulted. The wisecrack has an important half-truth in it.

"Another illustration of the same kind of difficulty, a personal experience from my own early efforts at psychotherapy, comes to mind. It was in the days when I hoped that I had learned enough of psychotherapy from reading and lectures to be able to seem useful, and certainly informed, to patients. One patient in particular continued to come to see me for a much longer time than the circumstances seemed to warrant. I listened for many sessions with a studied, and to me quite frequently strained, silence until an explanation of his behavior, a mechanism—as we were then prone to call it—dawned on me. With insufficiently restrained enthusiasm, if not glee, I pronounced an interpretation to the patient. He listened politely and again effectively reduced me to strained silence by the brief reply, 'So what!' Although I was not clear about it then, I later realized that my patient and I were struggling about authority. The interpretation meant nothing to him subjectively and yet I expected him to accept it wholeheartedly on my say-so.

"Many years later, after I had undergone considerable discipline during training for psychoanalytic therapy, a patient of Central European origin listened with obvious uneasiness to the note of annoyance and impatience in my voice as I commented on what he was saying for the twentieth or more time. He interposed with anxious amazement that I sounded very angry. After I promptly acknowledged that I *was* annoyed and told him why, he said with evident relief, but persistent astonishment, that he had the impression from previous European experience that *Analytikers* did not have, much less did they display, any feelings toward their patients. This patient had had problems of authority and was still struggling vainly with them, but at this time I felt much less uneasy about mine.

"I would like to add one more illustrative anecdote. This was a personal experience during my first month as an intern with a

ward patient who gave me my first, startlingly unexpected experience and minor success in psychotherapy. After a gynecological laparotomy this woman was placed in a quiet room. Her own surgery was uncomplicated, her course post-operatively was expected to be smooth. As junior intern it was my duty to make daily urinalyses until the post-operative acidosis disappeared. On a busy service it became a bit troublesome as well as a matter of considerable concern when the acetone and diacetic acid tests remained four plus on the third and fourth days. I investigated and learned from the nurses that the patient was afraid to drink and eat because her roommate, who had eviscerated following her first intake of fluids by mouth about a week before, lay distended in the other bed still in acute discomfort with a stomach tube protruding from her lips. I tried more or less gently to reassure the first patient that nothing like that threatened her, that her wound was healing well, that her general condition was excellent and would improve if only she would begin to take fluids. On the fifth and sixth days the acidosis was practically undiminished; the patient continued to be uneasy about fluid intake. The pressure of my work increased, as did my concern for the patient. I spoke again to the patient, this time with more annoyance than I wished, telling her I saw no need for her attitude and behavior, that there were reasons for her roommate's condition other than the intake of fluids post-operatively. On the following day the acidosis had completely disappeared.

"For my part, I was a bit ashamed of my assumption of a paternal tone toward a woman a decade or more my senior. I avoided her somewhat for my remaining few days on the service and on the last day was quite uneasy about saying good-bye to her, as I did to all the other patients on the ward. However, in spite of my discomfort, I did say good-bye and tried to turn away quickly. I was amazed to find that one of my hands was suddenly grasped by both of hers and kissed. With tears in her eyes and with quite

obviously genuine gratitude, the woman thanked me and said that I had done more for her than anyone else in the hospital! This was my first clinical lesson in the therapeutic power of authority. Apparently the patient was more impressed with my interest and concern for her welfare than resentful of the impatience of which I had been so ashamed.

"What are some of the elements common to all these situations? Is there more than one kind of authority? Are all situations involving authority equally unpleasant and likely to cause difficulty for both the person in authority and the subordinate? Are these difficulties inevitable? Or are there tendencies on both sides which may spell the difference between a mutually happy and effective relation and one which is full of trouble and discomfort?

"Merely to ask these questions is to suggest some of the answers from our experience. We all know that despite the frequency of trouble in the relations between a superior and a subordinate there are instances in which all kinds of authority are effectively exercised with willing and happy cooperation on the part of subordinates. Now and then we also see some peculiar relationships. We ask ourselves then how a person can take such attitudes from the so-and-so. Or we wonder how someone can be so mean. Yet both parties may not only appear content, but each may actually defend or even extol the situation or the other person. It is easy for most of us to understand why the dominant one might be satisfied in such peculiar relationships. It is more difficult for us to comprehend what the apparent underdog, who seems happy, gets out of it, or how he got that way.

"Suggestions have been made and explanations have been given regarding these same problems in other contexts, so that some of what I say now will be repetitious. But perhaps this repetition may not be altogether useless.

"It is possible—according to Erich Fromm*—to distinguish two general types of interpersonal situations in which authority plays a role. Only rarely do we meet either type in pure culture, especially in this country with its traditions and ethics. These two types are polar opposites. They may be the limits along a scale of variation never actually reached, like the asymptotes of a hyperbola. In other words, we may be making a distinction between the absolute good and the absolute bad, the angel and the devil, and hence may not be describing reality, actually occurring interpersonal integrations. Nevertheless, I have found the conceptions of these two types of authority situations useful in my thinking and practice, provided I also remember to define *how much* of each type is present in any actual instance.

"These two types of authority-subordinate relationships can be distinguished by several criteria: the mode of operation, the basic purpose, and the predominant results or usual outcome.

"In one type of relationship—which might be called *authoritarian*—coercive power, whatever its nature, is exercised by the dominant person primarily for his own rather than the subordinate's immediate gain. The power is exercised to the end that the status quo of the relation in these terms be continued forever, or for as long as possible. In simpler terms it is an enslavement, an effort by the dominant person to maintain control of the slave's services, deference, admiration, or whatever is demanded. Only such care is given, only such concessions or attention to the inferior person's welfare and needs are made by the dominant one as will enhance or assure the continuation of the benefits and profit to the latter. Certainly there is no concern or interest in the development of the inferior's potential abilities or strength, for this might endanger the relationship or lead to freedom for the inferior. On the contrary, there is positive hostility and fear of

* *Escape from Freedom*, New York, Rinehart, 1941.

such a possibility, often on the part of both persons. What is little realized is that personal stultification is inevitable for both persons. As one writer puts it, every dictator is slavish and every slave dictatorial. There are other describable results of this type of relationship, such as ruthless cruelty, mutual suspicions, hostilities, rebelliousness, with retaliatory anxieties and general chronic tensions which produce great anxiety about prestige, brittle rigidity of attitudes, and a narrow pessimistic outlook.

"In the other type of authority-subordinate relation, the polar opposite, which might be called democratic, or more truly, and from our point of view, legitimately *authoritative,* the converse is observed in all these characteristics. Coercion is absent. The authority derives from superior competence and skill. As in the best teacher-student or ideal parent-child relations, the purpose of both persons in the situation is to promote and foster the acquisition by the subordinate of the competence and skill of the authority. Their common effort is to grow more alike in respect to the power which the competence brings and eventually to achieve equality and genuine freedom of each other. Admiration and deep respect is mutual. Confidence, optimism, a benign expansiveness of outlook, readiness for experimentation and risk, and a tolerance for thwarting, frustrating obstacles as well as a capacity for more enthusiastically productive work are characteristic qualities generated in such relations. Rather than envy, the good teacher or ideal parent manifests genuine delight if the student or child approaches or even begins to surpass his own competence. Sympathy without any trace of contemptuous pity and mutually affectionate warmth without anxious oversolicitude permeate the relationship. Flexibility of attitudes coupled with firm consistency is gradually transmitted from the authority to the subordinate.

"There are many other contrasts between these two extremes of authority relations. What has been called spiritual anthropoph-

agia of the first or authoritarian type is replaced by anthropophilia of the second or authoritative type. This is, of course, a polysyllabic way of saying that destructive, emotional swallowing of man by man is supplanted by genuine love of man. This brings one to make some very necessary distinctions between varieties of 'love.' Many relations essentially of the dictator-slave variety are called 'love' even, perhaps especially, by the participants. When sexual activities occur in these situations, one may be certain that they will belong to the sado-masochistic category, regardless of what bodily zones or orifices are stimulated and regardless of the sex of both persons. The fact that jealousy and exclusive possessiveness, as well as depressions, panics, or impulses to murder or suicide on threatened separations are so widely accepted as natural concomitants of 'love' is no justification to perpetuate the unconscious self-deception that mutual enslavement has anything in common with a mature, genuine love. Mature love, it has been said, has no need to be blind. When one loves maturely one loves the other person in spite of the qualities one dislikes in him. Emotional maturity capable of such love is an expression of a self-love which is clear-eyed and tolerant of the limitations within oneself, the while it is contendedly and securely proud of one's assets. Such self-love cannot be mistaken for the deeply anxious concern about the self which must disguise its self-destructive sense of terrible inferiority and weakness either with a brittle and aloof conceit and an exaggerated appearance of superiority or with an ingratiatingly submissive self-abnegation and an assumed false modesty.

"Incidentally, it is probably this very great feeling of inferiority and weakness, however hidden from others or unconscious to the self, which is the source of, and chief motivational energy behind, the compensatory drive for power over others which leads to the dictatorial enslaving types of relationships. A genuine and

solid self-love cannot be depleted by love of another. On the contrary, it is enhanced, and sacrifices or services to the other flow from relatively inexhaustible reserves of strength and plenty. Such self-respect neither countenances domination nor requires submission from another. In other words, there is neither masochism nor sadism, neither slavishness nor tyranny. By its nature it fosters the growth of the potentialities of the other and revels in the give *and* take between equals. By its very nature and its needs it cannot behave otherwise. Hence, without strain or effort on the part of such a person, all others who come in contact with such qualities of personality are attracted and so affected as to make even some tiny steps toward maturity and freedom themselves.

"Maturity is not at all immune to a tragic sense of life. It is not, for instance, immune to genuine and deep grief and mourning for the loss of a friend or a beloved person through death. It is not, however, subject to the likelihood of the severe depressions or agitatedly depressive reactions of the authoritarian-dependent character in the event of the death of, or temporary separation from, the person with whom it is enmeshed. In these depressive reactions, of course, exaggerated fears about one's future, fears of loneliness, and guilt about one's hostilities toward the other person are prominent. In both types of character there is an identification with the other and an incorporation of the other into one's own ego or self. But the treatment of this incorporated object, and in turn, the effect of the incorporated object upon the self are quite opposite and the resultant feelings differ markedly. Instead of panic or anxiety or the repression and splitting off of these emotions, there is ready expression of sadness, grief, and longing. Instead of the schizoid absence of feeling in consciousness resulting from a repression of panic and anxiety, with its attendant sense of impoverishment of the self and unbearable

loneliness, helplessness, and futility, there is a fullness of feeling, however painful, and with its full expression there comes a calm enrichment within the self with positively toned memories of the other.

"Thus, in the case of the mature person there is no panicky sense of loss or abandonment when the other is temporarily absent. He still has contact with the other through pleasant memories and through continuing affectionate feelings despite great geographical separation and despite infrequent communication. In other words, the mature person has a feeling of wholeness and no sense of diminution of his power or strength. With the immature person, however, the opposite is the case. There is a kind of fragmentation of the self with an inevitable increase in the inability to deal with the reality of his own actual assets and potentialities and with the reality of the friendliness of other persons remaining about him.

"The mature person has no Pollyanna quality in his recovering optimism. He has, instead, a capacity for realistic discrimination of the possibilities in the actual situation after his loss. The bereaved, genuinely loving person carries on. The slavish-dictatorial person tends to collapse, to reduce his activities in the real world of remaining persons. At least his hedonism or enjoyment is reduced. He senses within himself a futility and a gloom. An uncanny world of terrors and unnamed threats frequently obscures the actual world of other persons and the possibilities for personal satisfaction. One retains or rapidly regains possession of himself; the other tends to 'lose his grip on himself,' 'goes to pieces,' feels a progressive sense of unreality, and sometimes progresses to a state of depersonalization. In such circumstances the mature person actually requires solitude; but even at other times he serenely enjoys his own companionship. The immature, the authoritarian person, on the other hand, carries within him a deep sense of es-

trangement from himself—the result, if you please, in psychoanalytic terms of the hateful tension between the superego and the ego—such a sense of constant loneliness and bereavement that solitude is intolerable.

"Another difference between these extremely opposite personalities is that the genuinely friendly, mature person, unlike the other, has no need for exclusiveness in his affectionate ties with people. Feeling a good deal of warmth and tenderness for several persons in no way diminishes the intensity of his feeling for a few intimate friends or for the especially beloved person of the opposite sex. The immature personality, however, compulsively attaches himself to one other person with such tremendous, all-consuming force that relations with others are rarely as intense and are generally incompatible with it. Automatically and rather helplessly, he puts all his eggs in one basket, hence any slight threat to this basket tends to precipitate feelings of impending cosmic disaster.

"One could go on and on through the whole gamut of variations in human psychopathology to show that the personality traits of the participants—that is, the emotional factors in the relationship—determine the quality of any authority exercised. Perhaps, however, I have indicated enough of the background to bring into focus the problems suggested by the title of this lecture.

"Conflict between persons generally occurs whenever any egocentric impulse of one person meets opposition to its gratification from another person in authority. The impulse may be for some necessary bodily satisfaction or for some more psychological (emotional) need for security, prestige, affection, approval, or the like. The opposition to gratification may be motivated by various factors, perhaps most often by an inability to supply the need; anxiety about being deprived or hurt by the demand; or ideally, as in the case of a parent in regard to a child's impulse, by genuine

interest in the person's immediate safety or future welfare. This latter problem—the concern of the person in authority for the immediate and future welfare of the subordinate—is, of course, part of a much wider problem, the satisfactory adjustment of the quite individual needs of each person and his welfare to the welfare and needs of the group of which he is a part. In guiding individual persons toward ways of gratifying their egocentric impulses that will be either least destructive or more in consonance with the welfare of the entire group, one has something of the parent's problem of inculcating durable personality traits in the child that will fit him to live happily and responsibly within his culture.

"In any case, whenever such opposition to egocentric impulses is encountered and for whatever reasons, anger is generally the inevitable and biologically adequate reaction. Under such circumstances a healthy organism, human or not, reacts not only with rage but also with efforts to circumvent or remove the obstacles to its satisfactions. If this is impossible, there is a revengeful attack upon the opposing organism. Whether this rage or attack is direct or indirect, frank or disguised, and whether or not it is persistent depends, of course, on many factors, not the least of which is the relative strength and power of the two persons involved. Another factor of great importance to the eventual issue of such a conflict is the firmness of the person in authority. This firmness is very frequently a crucial factor in the manner in which the conflict is solved. It frequently determines whether the subordinate learns how to get satisfactions in ways which are non-destructive to himself and others, or whether he remains rebelliously set in seeking his own satisfactions quite egocentrically, disregarding the welfare of others. In the latter case he may also remain distrustful of all authority, with a suspicious, hostile readiness to react defensively and often self-destructively to any suggestions from others. He then remains unintegrated with the group, in effect isolated from

it, perhaps maintaining an exaggerated self-assertiveness which further estranges him from others and which estranges others still further from him.

"For these reasons the quality of firmness in the authoritative person is very important and requires more detailed examination. In the first place, firmness needs to be distinguished from dictatorial or sadistic suppression, deprivation, or complete denial of any gratification to the subordinate. In brief, the authority does not assert himself in the conflict situation merely for the sake of an egocentric satisfaction in his own power and prestige. His primary purpose is not to deny all satisfaction to the subordinate's impulse, but to guide him in obtaining it in ways which are non-destructive to the interests of others and to his own other self-interests. His purpose is to indicate ways which will ultimately gain for the subordinate deeper satisfaction, since they will tend to integrate him with the social group whose approval enhances his self-esteem. Such firmness on the part of the authority, then, is possible when, and only when, the authoritative person's conscience is clear as to his motives in regard to the welfare of the subordinate. If he has no need to deprive the subordinate, if he has no egocentric (compensatory) power drives or exaggerated prestige needs of his own, if he has no wish to enslave the other or hurt him revengefully, he will be free of retaliatory anxieties. He can then remain calmly and quietly firm in opposition, not to the impulse of the subordinate, but to the manner or circumstances of its satisfaction.

"There are other describable and essential elements which contribute to the quality of firmness on the part of an authority. Perhaps the chief one of these is that the authoritative person himself is integrated, is wholehearted in his own attitude with regard to the impulse active in the subordinate. In other words, it appears to me necessary that the authority, himself, has actually learned

and acquired ways of gratifying such an impulse in accordance with his self-esteem and the mores and ethics of the social group. This again presupposes what one might call emotional maturity, a mastery of exactly similar impulses within himself. By mastery of impulses I do not imply simply a constantly uncertain, although sometimes fanatically rigid, self-restraint, a compensatory reaction formation. Such compensatory attitudes, opposite in direction to the given impulse, generally signify that the conflict is active and persistent. In situations affording temptation or the possibility of gratification, the balance of forces within the self remains precarious. Under these circumstances of unresolved conflict—even though the conflict is largely or wholly unconscious—within the personality of the authoritative person, the pressure or the demand of the impulse of the subordinate often increases the conflict. The authority is usually uneasy and tends to vacillate within himself about prohibiting another from doing what he is either tempted or actually permits himself to do.

"Such anxiety tends to cloud the issue with the subordinate and often leads the authority to irrational behavior in order to deal with his own anxiety: he is either doubtful and hesitant or defensively authoritarian and suppressive. Neither type of reaction can be called firmness. If the authority vacillates, the tendency of the subordinate is to gratify his impulse even though surreptitiously. If the authority is defensively suppressive and dictatorial, defiant self-assertiveness is likely to be aroused in the subordinate. Whether the subordinate responds to either attitude in these ways or in some other manner depends, of course, on *his* character, on his previous experience with authority and the patterns of behavior he has previously acquired in these experiences, as well as on other possibilities in the actual current situation. In any case, the subordinate is likely to experience anxiety in reaction to the anxiety of the authority. Anxiety in a serious degree in any person

tends to fog his perception of the realities of the situation and of his own self-interest.

"Another element in the quality of firmness is patience. The person who has matured emotionally, who has genuinely resolved the conflicts of his earlier life, is not only convinced through his own experience that it is quite often possible to gratify one's selfish impulses non-destructively, but is also convinced through such personal experience that it takes time to achieve such solutions. He has learned among other things that emergencies are relatively rare in peacetime, that most problems are capable of solution, that even though he may not see how to meet a threat to his satisfactions at a given moment, a solution may appear later. He has learned that no miracles are necessary in such instances but that a 'miraculous' clarification of the situation and of his own feelings can occur if only he grants himself time first to see how he feels about the dilemma and to examine more closely what real possibilities exist. He realizes that his own rage at the threatened thwarting need not be destructive to anyone, since he has learned solidly that he can control the form of its expression. He has learned finally that his whole happiness never depends upon the loss of any one satisfaction and that he can survive it. To him the whole world of other persons rarely appears as totally hostile, unjust, or oppressive. At the same time, having lived through such anxieties, impatience, greediness, and subjective cosmic calamities in his own progress toward maturing, he appreciates sympathetically what the subordinate is experiencing. This sympathetic appreciation permits him to wait patiently, but none the less firmly, for the subordinate to make alternative choices of action. His quiet confidence, reflecting his own achievement, is then a positive, constructive aid to the subordinate, who psychologically and often unconsciously imbibes of it.

"I have been discussing the problems and difficulties of the

person in authority. This is in many respects the converse of the 'what is wrong with the patient' type of discussion which is more usual in discourses on psychopathology. This discussion does not mean that I feel that all the difficulty in authority-subordinate relationships resides on one side of such relationships, nor that if the person in authority were only more thoroughly integrated emotionally and more mature, all problems would end. The role of the patient or subordinate in these relationship difficulties is considerable; it has been implied and touched upon here and in other lectures. The entire range of immature tendencies—the regressive attitudes of helplessness; the demand for protection, for care, for relief from all responsibilities; the slavish ingratiation used to obtain gratification; and many other attitudes—are here involved. But I have been interested in making two points, first, that immaturity does not by itself progress to maturity but requires mature help, guidance, and firmness from another, and second, that the difficulties between two people rarely stem from the immaturities of only one of them.

"This latter point brings me to the final topic of this lecture. I have already suggested that the critically important factor is how much immaturity remains and how much maturity has been achieved by any one of us at a given period of his life. The dynamic balance between these two constitutes our total self-organization or personality. Whether we are aware of our immature tendencies or not, whether we are concious either of the regressive trends or of our defenses against them makes little difference. If they constitute an important fraction of our total attitudes toward ourselves, they will be evident in certain interpersonal situations. They will be stirred up or intensified to disturb us and the other person. Our tendencies to irrational behavior, our anxieties and underlying conflicts are particularly apt to be aroused in situations involving authority and in love relationships. In the case of those

relations where authority is involved, our conflicts may be equally heightened in either the position of authority or that of subordinate.

"From this point of view it is obvious that periods of neurotic illness and disorder may be precipitated in our patients, and in ourselves, by situations involving persons in authority, with persons with whom the patient is currently 'in love,' or with both types of persons. It is then that people become our patients whether we are psychiatrists or not.

"This is not the place to review in any detail what the therapy consists of, whether it be in a psychiatrist's office or in the office of the non-psychiatric medical practitioner. However, one may mention a few of the steps which one hopes will occur.

"The first phase of such interaction is the establishment of working rapport—the transference—a relationship between patient and doctor with therapeutic potentialities. This has many rather technical problems. One is the time such a transference may require and another is the basic attitude of the doctor, leaving out of consideration the character of the patient. Both of these are variable from patient to patient and from physician to physician. That is, the time required generally varies inversely with the skill, experience, the basic attitude of the doctor. The greater his skill, experience, and maturity, the shorter the time required, other things being equal, namely, such things as the frequency of visits, age, and the character problem of the patients.

"There follows with no sharp line of demarcation from the first phase, the phase of 'working through.' This in reality is a repetition of the inevitable struggles of the patient both to re-establish and maintain a relationship characteristic of his degree of immaturity, and to resolve the conflict between the immature and mature portions of his total self. The result or outcome of this phase varies, of course, and depends on many factors. Certainly,

even in the most intensive efforts at psychotherapy, namely, in psychoanalytic treatment, no perfectionistically ideal goals are attainable or necessary. Although in this form of therapy the hope is that the character of the patient, the total self or personality, may undergo a rather basic reorganization, a great deal has been accomplished if at least some firm steps are taken in this direction. If only a few limitations to growth are removed or even just loosened, much has been achieved. The only factor I wish to emphasize again is the attitude, the actual maturity, the competence of the doctor. If his authority is based on such competence and if it is infused with at least a measure of the parental desire to help and to allow the patient to grow, then movement toward the common goal of doctor and patient may occur.

"We do not have much time left to examine the specific problem of the utilization of authority in the situation of an executive or director and his staff. There is perhaps time to make only one or two comments. Although some of the same processes may occur, although some of the same dynamics may be present in this situation as in the therapeutic relationship, there are a few obvious differences. For one thing, the complexity in executive-staff relations is obviously greater. One enters the sphere of larger social integrations, of group psychology, and of leadership. The interrelations and the problems between the subordinates either as equals or between levels of a hierarchy of authority are present. Mutual envies and competitions, as well as sibling types of collaboration, are present. In this collaboration, interidentifications, which in effect are identification with the leader for the purpose of the organization's work, occur. Nevertheless interidentifications for mutual support in rebellion against the leader may at times be predominant or coexist with the whole collaborative attitude. Problems of delegation of responsibility and authority always exist. The degree of freedom of choice granted the subordinate

and the encouragement of his independent decisions within the limits of the delegated authority are obviously important.

"The problem frequently arises of how to avoid making punitive changes in general policy that affect all members of the staff when only one member fails to act responsibly. Questions of group morale occur. These are frequently if not generally questions of the nature of the leadership and the type of authority exercised by the director. His attention to reward by approval, appreciation, or promotion is as important as his promptness of censure and disapproval. Perhaps of even greater importance are the leader's actual competence in all phases of the organization's work and his willingness to risk being wrong. The latter quality frequently relieves much anxiety in the subordinates about their inadequacies, inexperience, and incompetence. It may release whatever growth potential exists in them.

"Finally, the leader's readiness to accept specific competences of a subordinate which may be superior to his own is of great importance. For the leader to accept a subordinate who has grown and matured in skill as an equal and as a colleague and for the leader always deeply and spontaneously to respect the subordinate's personality remain the most effective incentives for each individual subordinate and provide the integrating power for the entire staff as a unit. Such authority so exercised is likely to be utilized with a minimum of interference from complicating or obstructing emotional factors."

THE INSTITUTE AS A TEACHING METHOD

THIS has been a report of another experiment in a series which may some day lead to a definitive statement on the selection and teaching of basic psychiatric concepts to members of the related professions in order that they may become mental health resources for those whom they are called upon to serve. The decade which is drawing to a close has seen remarkable advances in public awareness of the role that is played by emotional factors in the everyday lives of people. There is today general agreement that a working knowledge of the motivations of human behavior, of the principles of emotional growth and development, of the ways in which people commonly deal with other people and life situations—that this working knowledge is essential for truly effective performance in all the service professions, certainly in those concerned with the health and welfare of people.

Medicine and its related professions have shown a growing awareness of the need for this orientation. Medical schools and schools of nursing and social work have undertaken to include in the basic training of their students the fundamental dynamic concepts which modern psychiatry has defined. Schools of social work have long since passed the experimental stage. There is no accredited school of social work in the country that does not give at least one basic course in emotional growth and development, and the majority of them provide additional related classroom and field work opportunities. University schools of nursing have made

excellent progress in the introduction of dynamic concepts into the basic training of their students. In medical schools progress has been less rapid, but the trend is clearly in the direction of basic changes in curricula so as to permit the introduction of this orientation to people at the earliest possible point in the student's medical education.

It is a slow process and cannot be expected to achieve universal acceptance or implementation in the immediate future. One may hope that all well-trained physicians, nurses, social workers, and teachers will one day approach the individuals whom they serve with a comparable base of dynamic understanding of the human being. In the meantime, however, practitioners in these fields want and should be given the kind of knowledge that will make their everyday jobs more productive and satisfying. Approaching this task from the two extremes—improved basic professional training on the one hand, and refresher or in-service training for practitioners on the other—the Commonwealth Fund and others have endeavored to devise ways to make the essential minimum of psychiatric information available to physicians in practice, while continuing to stimulate and assist medical schools in the reorganization of basic curricula.

This 1948 Berkeley, California, institute for public health officers followed the Minnesota Course, an institute for general practitioners given in 1946 in cooperation with the University of Minnesota. There have been other institutes: repeat courses at the University of Minnesota in 1948 and 1949; three institutes for Regular Army medical officers in three army training centers in 1948 and another series in 1949; and another institute for public health officers in the spring of 1949.

Each time an institute is given, the original pattern is modified to meet the needs of the local situation and the students in the group. For example, in April 1949 the State Health Department

of Mississippi and the Commonwealth Fund sponsored an institute for twenty-seven public health officers and four supervising nurses at the Edgewater Gulf Hotel, Edgewater Park, Mississippi. These city and county health officers and state health department personnel were drawn from Alabama, Florida, Mississippi, Oklahoma, and Tennessee. The basic plan of the California institute was used with a number of experimental modifications, all of which proved effective: The sections were fewer in number and larger. Nurses were included as students and two mental health nurse consultants were added to the faculty. One of the two psychiatrists in each of the four sections was drawn from a southern state and was therefore available to the students and the local health departments for later consultation. Responsibility for the lectures was carried by two psychiatrists instead of being divided among all of them. The lectures had continuity of subject matter as well as personnel—the first week was devoted to a discussion of growth and development and anxiety-producing experiences, the second to social adaptability. The faculty met in Mississippi for two days prior to the arrival of the students. The instruction covered ten days as compared with twelve in California.

Instead of five sections of six students each, there were four sections, each with eight students. It was generally agreed that this number was adequately served by the teaching staff of two psychiatrists and one public health instructor. The two nurses on the faculty alternated between the sections and were considered to have made an excellent contribution to the institute. At the conclusion of the course several students and instructors expressed the hope that in future institutes there be one nurse instructor to each section.

The inclusion of one public health nurse as a student in each section was undertaken experimentally with considerable question as to the possible effect on the health officers. It proved to be a suc-

cessful innovation. These four supervising nurses were intelligent, experienced professional women with better than average mental hygiene orientation and enough personal security to enable them to pace their participation in the institute to the tempo of their sections. They did not need to demonstrate their more comprehensive knowledge of psychiatric concepts but contributed appropriately when the occasion arose.

The post-institute comments of these students were very much like those of the California group and the experience was apparently equally meaningful. There was one major difference between the two institutes that had not been anticipated. The majority of the California health officers had been concerned primarily with administrative responsibilities in the state health department or in large city and county departments. The health officers in the Mississippi institute for the most part came from smaller communities and many of them carried clinical as well as administrative functions. Then, too, they were closer to the people whom they served and felt less need for discussion of community organization or health education as it is used in larger urban areas. As a result of the California experience, it was considered necessary to stress administration and community organization. But before the first week was over, it was clear that the students in Mississippi were much less concerned with these matters and much more interested in the clinical aspects of their jobs.

This difference not only served to point up the variations in health officers' responsibilities and functions; it underscored for teachers in mental health institutes the necessity for flexible adaptation of basic content to the major interests of their students and the special circumstances of each new situation.

In the fall of 1948 faculty members of the first six institutes met to discuss their experiences. There was enthusiastic agreement on the benefits to be derived by students and faculty from

participation in these institutes. Psychiatrists who had lectured and taught extensively were agreed that this intensive experience, in which the personal investment of teacher and student was magnified by the setting, the material, and the relationships which developed, was one of the most exhausting and rewarding they had ever known.

Reports of all six institutes revealed the same sequence of developing orientation, the same early apprehension, the same resistance to dynamic concepts, the same overenthusiasm for concepts newly grasped, and the same gradual integration of hard-won ideas into the personal and professional equipment of the student. From the Minnesota experiment one could have prophesied the over-all sequence in the California institute, and from the latter it would have been possible to anticipate the sequence in the army institutes. They differed from one another neither in basic content nor in general methodology. The difference lay in emphasis, in the fact that one group of students was composed of general practitioners with a wide range of medical problems to draw on and return to; another group (health officers) was primarily engaged in administration and community organization with little opportunity for clinical practice; and still another (Regular Army medical officers) was concerned with specialized medical practice within the more formal structure of the military.

What are the essential ingredients of a mental health institute? At the 1948 meeting of some twenty members of institute faculties this question was asked and answered by the participants with remarkable unanimity. It was agreed that one of the outstanding factors in the success of an institute is the selection of faculty. Emphasis here was placed not so much on erudition as on the ability of the instructors to catch and hold the students' interest in the shortest possible time. The psychiatrist who can dramatize

himself and what he has to teach will speed the process of identification which is fundamental to the learning process.

Another equally important consideration in faculty selection was stressed, namely, that there must be group cohesion in the faculty so that the student sees a united psychiatric front. For example: "I agree with the stress on the importance of faculty, but not only in terms of showmanship and flexibility. The faculty must think alike. Unless the group thinks alike, the course will flop. If it doesn't go, it's the faculty's fault, not the students'. The faculty must be going in the same direction. The students don't know—some are skeptical, others not, but for them, as you've said, it must be a process of identification. If the faculty is divided, the student group is pulled apart."

Several psychiatrists who had had recent teaching experiences in more formal institutes pointed out the difference between those educational efforts and the kind of institute under discussion here. One said,"I see one essential—the course must be patient-oriented. I'm convinced of this after my recent experience with a course that wasn't." And another added, "I've just been to an institute where I had an experience in what not to do. That course had an excellent agenda covering psychiatry, neurology, and even some pharmacology. But there were no patients. There was no individual tutoring. The students didn't get to know each other until the third day. There were many erudite presentations, but nothing happened. It was a five-day course which ended just as the group was beginning to get oriented."

There was unanimous agreement on the need for a wealth of clinical material throughout the institute so that the students can see the practical application of what must otherwise remain pure theory. It was stressed by several and endorsed by all that patients should be unselected and preferably non-psychiatric. In all

six institutes it was found that the most effective clinical material was the run-of-the-mill patient in a setting with which the student was familiar, the patient he would be quite likely to meet the next time he stepped into his office or clinic.

Lectures were considered of secondary importance except as they served to "sum up where the group is and where it's going." Another comment: "The effective lecture in this kind of course must demonstrate the lecturer's identification with the student body and what they're ready for."

When the question of duration came up, the first comment was: "To attempt anything under two weeks would be disastrous." Others were less emphatic, but equally certain that the sequence of reactions and the scope of the material required approximately two weeks. On the sequence of reactions there was equal unanimity. According to one psychiatrist, "We found a kind of resistance curve that began to go down on about the third day, after the introductions were over and we really got going. After that the students began absorbing and integrating the material at an increasing tempo." Others thought that the resistance curve began to drop a little earlier, while some indicated that it came a day or two later. For the group as a whole there appeared to be general agreement that this essential development occurred somewhere between the second or third day and the end of the first week.

Also essential, in the opinion of the group, is the 'round the clock schedule in a protected setting which makes it possible for students and faculty to spend full time—almost literally—on the business at hand. While no one can place a precise evaluation on the dormitory bull-session component of such an institute or on the physical proximity of the faculty and students and their complete removal from everyday responsibilities during the two

weeks, it is generally agreed that these adjuncts to the course are greatly to be desired.

As the group talked it was recognized that the institute method as such has actually passed the experimental stage. There may be variations in the size of sections or the order of events but the essential characteristics of the method are clear: psychoanalytically-oriented psychiatrists and other auxiliary teaching personnel depending on the student group, that is, public health leaders, mental hygiene nurses, psychiatric social workers, clinical psychologists; a ratio of faculty to students that will ensure supervised clinical experience on an individualized basis; a steady flow of clinical material of a kind and in a clinical setting with which the students are familiar; a minimum of lectures; a maximum of informal discussion of case-material and psychiatric concepts at a tempo which is commensurate with the students' developing understanding and readiness; a flexible schedule which permits the introduction of unplanned sessions or topics in response to the expressed interest of the students; a setting and an atmosphere which provide students and faculty with protection from the pressures of their professional responsibilities and encourage full-time attention to the subject of the institute—these are clearly the ingredients which make for a successful mental health institute.

The question of what should be taught by this method has not yet reached the same degree of clarification. Since psychiatric knowledge shifts and grows with the continuing development of the field, it may never be possible to say precisely how much of what kind of psychiatric information should be transmitted to the student in such an institute. But short of that state of perfection, it is incumbent on those who participate as teachers to continue the search for a more definitive concept of the optimal kind and amount of psychiatric information to be taught.

Since content and method must always be related to purpose, it might be well to restate it at this time. The purpose is *not* to make psychiatrists of the students and *not* to prepare them to engage in psychotherapy; the purpose is simply to help the students understand, accept, and integrate knowledge about human behavior and emotional needs that will enable them to function more effectively as physicians, nurses, teachers, or members of other professions engaged in serving people. The negative emphasis in the preceding sentence is related to one of the more common misconceptions about the reasons for sharing psychiatric concepts with members of other professions. This misconception may at times be unexpressed but it is often present among students and faculty alike, causing anxiety in the student and a tendency in the instructor to teach much more about psychopathology and psychotherapy than the student needs or can use.

Clarity about purpose can throw light on content and will eventually help to formulate what should be taught. Because all the service professions deal with people in a person-to-person relationship, whether it is one-to-one or one-to-several, they should know something about the meaning of interpersonal relationships —physician-patient, nurse-patient, teacher-student. They should understand something about the meaning of illness, of asking for help, of the ways in which people use help, of the role of the helping person in the life of the one who is helped. Because so much of this help is given by talking with the patient or client or student, the significance of the professional interview should be demonstrated and emphasized through supervised experience. Because they deal with people at various stages of emotional as well as biological development, they should know something about the principles of emotional growth and development, anxiety and the defenses against it, and social adaptability so that

they may learn to see the individual as a motivated human being influenced by and influencing his social environment.

Because they affect the lives of the people whom they serve, the service professions should be helped to achieve some awareness of their own attitudes and feelings so that they may understand the importance of an intelligent recognition of one's own blind spots and prejudices and their control within reasonable limits. Because they work with many people who have common presenting problems, there is danger of losing the ability or desire to differentiate one from another. It is therefore essential that they be helped to see the unique and complex human being who is waiting to be recognized and understood once the barrier of the case label is overcome.

These categories are large and rather loosely constructed, but they indicate the general nature of the information and the reason for teaching it. Within these categories there may be discrepancies in the material that is selected and the form in which it is presented. To cite only one example: Emotional growth and development may be given in orthodox Freudian terms by one teacher and in terms of progressive social adaptations by another. Both interpretations are technically correct and each teacher may have good reason for his approach. The deciding factor will necessarily be the student's need and how it can best be met. Psychiatrists are finding that they must expand their own professional horizons to include a working knowledge of the functions of the professional people whom they are being asked to teach. As they do this and as they learn more about the day-to-day job of the public health officer or nurse, or the pediatrician, or teacher, they are beginning to look at the body of psychiatric knowledge and select from it the information which will best serve the purposes of their students. And as they share this information, they are

learning to present it in terms related to the student's experience and interest with a minimum of specialized terminology or implications. When enough psychiatrists have had this salutary experience, we can expect that a comprehensive guide for teachers in mental health institutes will be forthcoming. That this may happen sooner than could have been anticipated before the Minnesota Course is indicated by the fact that more and more psychiatrists are experiencing and appreciating the personal and professional satisfactions that are to be derived from participation in these institutes. Certainly those who took part in the California institute can testify to the satisfactions that are experienced by the psychiatrist who helps his public health colleague reach the conclusion that "public health is people."

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Mt D^r. Grossi -

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