On the Stresses of Community Psychiatry, and Helping Residents To Survive Them

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The authors underscore the major themes that challenge the resident who moves into community work from his initial experience as an individual therapist. The resident must be able to change, especially in terms of his own role expectations, to expand his repertoire of professional techniques, and to move from his former relatively passive stance to a new role in which he becomes more active. The supervisor should be ready to guide the resident in his work and be sensitive to his anxieties.

WITH THE COMMUNITY psychiatry movement of the 1960s, the relationship between service commitment and training orientation in psychiatric centers has come under scrutiny. If community psychiatry is to offer a major new theoretical model, with the community mental health center as its instrument, how can psychiatric training centers with a traditional viewpoint adapt to the demands of this movement and train potential leaders in the techniques required by community work? Early there developed schisms between the community psychiatrist and the psychoanalyst, and between intrapsychically and socially oriented factions (among other competing groups). More recently, however, several departments have moved toward integrating community concepts and experiences into general psychiatric training in an attempt to break down the barriers between community mental health and the rest of psychiatry (1–5).

The program from which the present observations were made is still evolving within a department that aims at reducing the polarization between community-oriented and psychoanalytically oriented psychiatry. The Tufts Mental Health Center is part of the Massachusetts system of community mental health centers; it consists of an affiliation of 17 agencies already existing in the South Boston-North Dorchester communities. At the same time it is an integral part of the training activities of the Tufts Department of Psychiatry, a dynamically oriented training center of Tufts Medical School and the New England Medical Center.

Some of the problems that psychiatric residents encounter as they move from the protection and status of the consulting room into the activity-oriented marketplace of the community will be considered here.

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THE NEED FOR TRAINING IN COMMUNITY PSYCHIATRY

From an institutional point of view, ideological values and funding necessities both support a shift toward delivery of mental health services at the neighborhood level. In order to prepare staff to work in these new programs, training in community mental health is becoming a significant part of residency training across the country; thus there is increasing emphasis upon crisis intervention, brief psychotherapy, outreach programs, aftercare, home visits, and even community organization and political action.

Also, the demands and needs of students entering residency training are shifting. In general, medical students during the late 60s and early 70s grew up in an atmosphere of activism, social commitment, and idealism that was not experienced by those of us who came before. A major shift in the professional goals of residents across the country has occurred, moving from an emphasis on exclusively psychotherapeutic private practice to the inclusion of more active, community-oriented roles. Part of this shift has led to demands by individual residents for more autonomy in determining the course of their training. Struggles between residents and their therapy supervisors reflect in part a desire to move out from under the thumb of their teachers and to become more actively involved in the community surrounding the training center. This shift, then, is part of a greater interest in and demand for training in the techniques of community psychiatry from some residents. Other residents, however, are anxious and resist deep community involvement.

PROBLEMS ENCOUNTERED IN COMMUNITY INVOLVEMENT WITHIN A GENERAL RESIDENCY PROGRAM

The problems enumerated in the following sections refer specifically to psychiatric residents, but obviously the same stresses may also apply to other mental health professionals and workers. These problems will be formulated in terms of specific anxiety-provoking stimuli and occasional responses to them that may be determined by the character styles of the residents themselves. The "culture shock" encountered from working in a community setting leads not infrequently to regressive trends, while

at other times it merely reinforces the disinclination of some residents to participate in community mental health. Other residents, of course, readily accept the challenges of community psychiatry.

1. From the Safety of the Office to the Dangers of the Community

In most training programs the resident is introduced to the central task of individual psychotherapy in a quiet office. In general, this office is his "turf," a haven for him alone to explore the intricacies of a patient's inner life. Here is seclusion, a place in which to conceptualize and feel, a potential retreat from the demands of patients, supervisors, and administrators.

Upon entering the community, the resident is stripped of this haven and must see people in busy, public, uncomfortable surroundings—the open marketplace. The setting is no longer of his choosing but is "theirs"—the alien turf of the community, where he is a guest. No longer can the resident sit back and wait for his patient to knock at his office door. Instead, he must initiate contact with people, in their domain, and with unclear goals. This change is, we believe, one of the important and underrecognized anxieties and sources of alienation in beginning community work (6).

These settings may include the large state hospital with its barren wards and disturbing inmates, the living room in home visits made to the families of patients, street consultations with adolescents and gangs, discussions with community leaders in cars while driving to a meeting, etc. This experience, it seems to us, leads not infrequently to a projection of the resident's own hostility at being ejected from his safe office. In this projection the responsibility is shifted from the resident's feelings on finding himself in an alien setting to questions of "treatability" of the patient. It is not the fact that the resident is frightened to be in the living room of a lower-class home that makes it difficult for him to treat patients, but rather that the patient is too sick or "too primitive."

2. From Receptivity to Activity

There are several facets to this particular point. Not only is the resident stripped of the protection of the office, but the comfort of having a patient request help is also gone. Much of community psychiatry is involved not with patients but with populations at risk, consumers, and ordinary citizens. To a certain degree, beginning residents learn to define themselves in terms of their role as "not patient" or helper, and for this self-definition the presence of a patient is essential. When this role does not apply, as is the case in much community work, psychiatric residents are confronted with a role diffusion of their own. Also, patients whom the resident is asked to see may differ sharply from those seen in clinics or on inpatient services. He may be confronted with a wildly aggressive family; the whole unit may be defined as the patient. The "patient" may be a dissatisfied group of community residents demonstrating for better health care.

These are situations with which the supervisor, to whom the resident turns in fright, may himself be unfamiliar. The supervisor can provide support, but the resident himself must frequently muddle through the situation as best he can, relying on his own judgment and developing expertise as he goes along. The need for self-reliance provokes considerable anxiety in the beginning resident, but it may also help him free himself from the infantilizing quality of supervisory relationships. The resident may choose to respond to the patient in a way other than as therapist. He may find a conflict between the role of clinician and consultant and may choose to help other workers serve as primary care givers. This role of consultant is new to the beginning psychotherapist.

Related to the switch in orientations necessitated by community psychiatric work is the matter of professional identity. There is frequently a conflict between seeing oneself as a screen reflecting the patient's projections and using oneself as a reactive person interacting with other real people in the community. As a function of supervision that necessarily teaches beginning residents to be more objective, scientific, and not quite so "giving" to their patients as they would ordinarily be, they learn a professional persona that is detached and aloof from patients. The neophyte resident may become like the familiar caricature of a psychiatrist, who responds to questions with more questions rather than with appropriate answers.

In contrast, the resident entering the community must learn to use his psychiatric skills with a persona that is more like ordinary social behavior. He is called upon to be a "regular guy" who meets agency staff and consumers openly and with respect. Can he be a real person and at the same time maintain his identity as a psychiatrist? The community experience can enhance a maturing process in which the resident learns to be real, available, and open in the formation of working alliances with community staff and patients alike.

However, this challenge can also cause turmoil in the beginning therapist. Not only is he confronted with the absence of the "patient" role, but his role definition as physician is undermined. He is demoted from the leadership position familiar in the hospital team, inherent in the primacy of the medical model. As psychiatric therapist, he determined the course of treatment and medication for his patients. In the community, however, he must interact as a peer with people from various professional backgrounds and frequently must take directions from a superior who lacks medical training—the agency director or community leader. This new set of role relationships is a blow to the resident's hard-earned status and self-esteem; residents' reactions to this loss vary widely, but it is a challenge to them all.

3. Role Conflicts in the Community

In this context we refer to the tendency, implied earlier, toward "either-or" thinking with regard to professional commitments. Because of the difficulty in learning intensive individual psychotherapy, many residents view psychoanalytic training as the pinnacle of their professional career. Others perceive the commitment to dy-

namic psychiatry of analytically oriented teachers and adopt what they consider to be an opposite, action-oriented community approach. These orientations tend to become polarized, with residents feeling that they have to choose between them. Thus if the resident sees himself heading toward an analytic career, he is sometimes anxious about feeling an interest in participating in community events. This problem can be minimized if a department's attitude is respectful of both orientations, emphasizing that they are not mutually exclusive. In the Tufts program, for instance, the fact that many of the psychiatrists working in community mental health are also psychoanalysts or analytic candidates demonstrates that one can at the same time be psychoanalytically oriented and work in the community.

However, related to the role conflicts that residents feel with regard to these orientations is the ever-present subtle devaluation of a community psychiatric orientation by therapists who are not at the same time involved in community work. Thus supervisors of individual therapy may ask, "What does the community psychiatrist really do?" or they may state, "I guess if one is uncomfortable sitting with patients and sharing their feelings, one can always do community work." This devaluation by people esteemed for their clinical abilities establishes professional priorities for the resident and makes it difficult for him to view community work with the same commitment as his more traditional therapeutic endeavors.

4. The Lack of Structure

With regard to time to be spent in the community, the work task to be established, and the identity of consumers with whom to interact, the resident is confronted with a lack of structure and defined expectations very different from his experience in doing psychotherapy. In contrast to the office appointments at a set hour, the resident may be asked to enter a neighborhood, contact agencies and find useful ways to interact with them, and meet people at unspecified times. The consumers do not have set expectations of the resident, and relationships must develop out of mutual exploration and discussion to establish shared goals. The resident cannot turn to his supervisor to be told what he should do, for frequently it is not clear which intervention or approach is the most effective for a given community situation. As an example of this turmoil and lack of structure, one resident entered a tumultuous situation in an agency just at the time that a generalized staff rebellion against the agency leader was in process. There was tremendous anger and confusion among the staff of the agency, and the resident was pulled in all directions to take a stand on his loyalties. In supervision, he confided that he did not even know what his task in the agency was supposed to be, let alone which groups he was to align himself with.

This chaos offers the opportunity for a real mastering experience, in which the resident can attempt to structure and understand both his task and his role within the agency. Intellectualization and other organizing defenses can be used in the mastery of an unstructured situation. On the other hand, some residents respond to the lack of structure by withdrawal and avoidance, retreating to a setting in which they feel more comfortable. Residents tend to reestablish well-integrated activities in alien surroundings in an attempt to bring familiarity to their task. An example of this tendency is a resident who elects to evaluate and treat patients at the new setting or agency. He might alter the therapeutic modalities that he offers (e.g., beginning to do brief psychotherapy), but it is psychotherapy nonetheless.

5. Community Rejection and Apathy

A major source of anxiety is the not infrequent response of disinterest and/or open hostility of community groups when the resident comes to offer his services. Used to gratitude, deference, or at least respect from his patients, the resident frequently is faced with angry, demanding citizens who criticize him or his profession for ignoring their needs or shun him for representing a discipline that frightens or alarms them. Such a response strikes a blow at professional pride and is the source of the anger and withdrawal of many residents in the community. An example of this response occurred when one resident, with the selfless feeling that he was offering his services to the poor, was interviewed by a citizens' committee on professional hiring for a ghetto health project where he wished to work for one day a week. The resident's motivations were challenged, he was called a racist and a do-gooder, and the committee finally rejected him for work in its center.

In our experience, some residents respond to such hostility in the community by recoiling with the shock of injured pride—the feeling of "Don't they realize that I am here to help them?" The resident may become angry and resentful in turn, either intellectualizing his experience (sometimes in a condescending manner) or withdrawing to avoid repetition of the situation. This anger is frequently a response to his being deposed from a position of control and relegated to being just another team member.

One example of the response to apathy is that of a resident who attempted to establish mental health consultation with the faculty and staff of a local high school, but who was perpetually confronted with excuses, unreturned telephone calls, failure of some faculty and staff to show up for scheduled meetings, etc. Certainly this experience is common to any worker actively engaged in trying to establish a mental health program. The response pattern includes that of injured self-esteem. However, rather than the anger with which many residents respond to community hostility, in the case of apathy one frequent response is that of depression and withdrawal. The resident wonders what he is doing wrong, why he is not being accepted for what he has to offer. He experiences considerable self-doubt and, occasionally, the depression that can accompany such a drop in self-esteem.

6. Excessive Expectations

In this last source of anxiety, residents initially place an excessively high demand on themselves to produce meaningful change. They may hope to restructure an

agency, overhaul society, or even change educational systems, as well as providing mental health aid to citizens. One resident, for instance, began to meet with a group of teachers in a local parochial school. Not only did he hope to teach them techniques of helping their students, but he also wanted to impart concepts of family dynamics and progressive teaching methods. Obviously his goals were unrealistic; it did not take long for the teachers to set him straight, since attendance quickly dwindled.

In attempting to meet these excessive expectations, the resident is frequently shocked by the limited change he can effect. He may intellectualize his distress at falling short of his own expectations, but he usually becomes anxious, and having failed to meet his own goals, he withdraws from the field.

HELPFUL HINTS FOR EFFECTIVE SURVIVAL

Recognizing that these stresses are inevitable and can never be totally eliminated, but must be weathered and gone through as part of professional development, we turn now to considerations of what can be helpful to the residents in mastering them. These suggestions will not be dramatically new to supervisors of psychiatric residents, and it will be seen that in many ways the supervisory task is similar to that of clinical supervision for new therapists. In fact, it is the familiarity of this supervisory relationship that gives the instructor a toehold in helping the resident to master his anxiety in this new professional endeavor.

Structuring

The supervisor must realize that the resident has very few guidelines or preconceptions of what his task in the community should be. He should thus be encouraged and assisted in defining one or more specific tasks with regard to agencies or a segment of the community with which he is going to interact. In order to assist the resident in doing this, of course, the supervisor must be familiar with the scope and tasks of community psychiatry and the range of possibilities open to the resident. The supervisor must know the community in order to be realistic in this task.

The process of structuring should be a mutually thoughtful exploration of possibilities, and the resident's own preference, fears, and feelings about his limitations should be fully considered in arriving at a project for his community work. Also, the need of the community or agency and the service commitments of the mental health program must be accounted for in helping the resident to define and structure his own task. At the Tufts Mental Health Center we have found that an important ingredient of the community experience, after the resident has had time to explore the range of options open to him, has been his own participation in structuring his work.

Conceptualizing

This relates very closely to the structuring factor just discussed. Here, we help the residents to step back from their immediate community experience, to look at the various issues in the task being required of them, and to formulate their plans, much as a supervisor helps a therapist to formulate his patient's needs and treatment goals. Basically, we refer here to utilization of mature intellectual skills to master a potentially chaotic experience. For the past two years at the Tufts Mental Health Center we have offered an introductory seminar for residents prior to their community experience, covering such areas as crisis intervention, brief psychotherapy, mental health consultation, and home visiting.

Support

The instructor of the beginning resident in community mental health must be aware of the stresses that the work involves (enumerated earlier) and willing to intervene supportively to share his trainee's anxieties. Of course, this is also true of clinical supervision, but the diffuseness of the task and the fact that the supervisor will not always have dealt with similar community situations himself makes the emphasis somewhat different. On the other hand, as in the experience from psychotherapy, some anxiety is necessary in order to motivate growth and change.

This inherent dilemma requires sensitivity to the resident's potential for being overwhelmed by anxiety and the supervisor's attention to cues that this may be occurring. Supervisors should make themselves available for night consultations to their residents, since emergencies may arise in the community at any hour. The instructor must also empathize with the resident's anxiety in situations that might normally seem trivial, e.g., meeting with a group of angry adolescents, approaching a meeting with a school principal to set up consultation with teachers, etc. The supervisor must be willing to switch into a clinical framework when emergency cases arise in the community and be able to share his own confusion or lack of knowledge when this is indicated.

The supportive function, then, represents a willingness to accept the resident's confusion in his new task, to provide a model of open humanness that he can emulate, and to share responsibility appropriately. This may help the resident to decrease his excessive expectations and hence to modify his guilt.

Psychiatric Commitment to Principles of Community Mental Health

In order to help the resident master his stresses in community work, the staff supervisor *must* be respectful of the community experience. Very often, as noted earlier, there is an unwritten message in analytically oriented departments of psychiatry relegating the community psychiatric work to second- or third-order importance. If the supervisor is unable to oppose such downgrading, how can the resident do otherwise? Thus a department committed to training in community mental health must also value community activities. The supervisor in community psychiatry must be able to help the resident to place in perspective some of the professional negativism to which he will be exposed, and ultimately—if community training is to be effective—there must be a cadre of flexible

staff members who serve as role models of equal status to teachers committed exclusively to intensive individual psychotherapy.

SUMMARY AND CONCLUSIONS

We have not attempted to present the ultimate word on how to help residents survive their community psychiatry experience. Rather, we have tried to underscore the major themes that challenge the resident who moves into community work from his initial experience as an individual therapist. We have presented these problems from the viewpoint of the resident and have related some of the more frequent anxiety-provoking stimuli to typical responses in terms of character styles of the residents.

We have an obligation to supervise and support the resident as he meets the challenge of community mental health, and in the process we are asking that same resident to *grow* as a mental health professional. In fact, we are asking the resident to *change*, especially in terms of his own role expectations. As the therapist requests and stimulates change from his patient, so too must training in community mental health require that the resident expand his repertoire of professional techniques. We ask that he be able to move out of the newly learned, relatively passive stance of the psychotherapist waiting in his office for a patient who requests help to a new role in which he becomes more active, involved in change, reaching out as an advocate of programs, techniques, and activities.

In effect, we are often asking him to add some of the skills of the salesman in presenting helping techniques to the consumer, who may not know of the mental health professional's skills or abilities (7). He must be willing to meet the challenges of lack of interest and resistance that he will find in the community and to take on what may be for him the new role of teacher. We ask him to step out of a role that emphasizes patienthood and the medical model and to interact as colleague, student, teacher, and even adversary. Finally, he must be willing and able not only to use the professional, distancing skills that he has learned in the initial experience with psychotherapy, but to integrate into a comfortable style personal, open skills of human relations that he has practiced in other settings since childhood.

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