Spreading Mental Health:

The Pioneer Spirit Revisited

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Table of Contents

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> How much do we, as a society, do for others? "Save me from being saved!" as Oscar Wilde used to pray, or might have. But he did say that "every country's doormen are dressed like every other country's generals."
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> It is probably impossible for well-intentioned people not to want to do good. Strachey's famous paper on the moderating influences of psychoanalysis speaks of how the analytic perspective will come to replace that of the archaic introjects when the patient identifies himself with the analyst, as he was bound, it was hoped, to do. This beating of swords into ploughshares doesn't quite take account of the possibility of enabling the patient to live, not in the world of introjects, but of people, the one (free association) making possible the other.
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> Although people argue about what good is, they cannot argue whether good is good, which may be the interesting question. Don't ask the peacock about his tail. Time and tide have blessed him with the accursed thing.

The authors of *Mental Health Consultants*—who were the research director and the consulting psychiatrist of the project it describes—write in their preface:

> [This] documents the development of a community mental health program in New Mexico. It is the log of a pioneering venture by lone mental health workers who developed coordinated, comprehensive, locally based mental health services in communities far removed from centers of professional practice. In four years of dedicated effort, a variety of new or substantially revised community-based mental health programs were enacted, reflecting in their variety the dynamic and responsive relationship each consultant was able to establish with his many and diverse communities. [Griffith and Libo 1968, p. iii]

And, indeed, the story is in its way a splendid one. The scene in New Mexico was specifically the rural areas of the long desert reaches surrounding the state's central core of cities. These rural communities are barren of mental health services and facilities, though not, of course, of the need for them. At the time the story opens, previous efforts to inaugurate and provide services had been tried and had failed: Travelers from the core of cities had come to the rural areas and gone without leaving their stamp. In the meantime local people, including physicians and, for example, one school guidance counselor, had established a kind of hegemony of service, but a service that was, at least in the authors' view, not quite so useful to the community recipients as to the profferers themselves. Then the project began—and in the end, after many vicissitudes, it succeeded in developing a strong foundation for, and in some areas even the structure of, mental health services. If the book reads like a story of the conquest and colonization of the West, it is not by accident. The people involved, the consultants, had to have a missionary zeal

strong enough, first, to wish to move (from the urban areas that were their own natural habitat) into these distant parts; then, to offer themselves to an unasking and indeed often antagonistic public; and finally, to face and sustain the retaliation of those who feared and resented them. Progress was inevitably slow, and they had to pay out a good deal of trust and hope before they could see any return. At the end of the four years, however, these consultants—a nurse, a social worker, and two clinical psychologists—could claim substantial achievements.

Although written as if it were a final report to the National Institute of Mental Health, the book aspires to serve as a handbook for other projects. And it is as a model for future projects that I propose to consider it.

Along with the superabundance of facts and figures the book presents, feelings are also expressed. One of these would seem to account for the fact that this project, like others of its sort, did not enjoy greater success than it did. It occurs, significantly enough, in the first sentence of the first paragraph on page 1:

> Short of the nightmare we might envision as the aftermath of a nuclear holocaust, it is inconceivable for most of us to imagine a world without professional mental health facilities.

The anxiety inherent in this statement cannot help but have significance for the project. Although the authors themselves, in Chapter 3, closely examine the consultants' motivations, personalities, and value systems, the matter of anxiety also bears analysis. Anxiety of the sort expressed above, for instance, is often precisely what engenders the very sense of mission without which such a project may be impossible.

Put plainly, however, the quoted sentence says this: We feel unsafe when help is not available—for ourselves or for others, as the case may be—and must do what we can to persuade you to create such help. It must follow that those who do not comply with this condition for safety become intolerable in proportion to the anxiety they don't allay. Naturally, such an unallayed feeling is only partially evident in the report. And, of course, everyone has hang-ups that represent important motivations for the work he does. However, one seeks and gains distance from these unresolved needs or anxieties in order to avoid acting them out, for it is their acting out that may impede the success of one's work. Mental health professionals have by now been schooled in the theory of dynamics, derived primarily (though not exclusively) from psychoanalysis, that views behavior as a consequence of forces—drives, needs, feelings, or motives—in conflict with one another. In this framework behavior is seen as the best compromise formation that people can make out of their conflicts. When that compromise formation, however workable it may be for certain purposes, fails of other purposes—as in the case of a symptom like compulsive handwashing, for example

—the individual involved may come to see it as a poor compromise and thus seek help in discovering the elements of the conflict in order to effect a more workable solution. Psychotherapists have learned, however, that the conflicting motives usually are not wholly conscious, and that considerable time and skill are often required to enable them to become so. They have also learned that even more fundamental than time and skill is their willingness to keep a neutral attitude about the conflicting forces. The successful therapist is as interested in, and sympathetic to, the compulsive's urge toward filth and sadism as he is concerned with the countering motives for cleanliness and scrupulousness. And, indeed, only when he is do both motives reveal themselves to him and to his patient.

Somehow, this neutrality too often flees the mental health professional upon his entry into the community. Perhaps the very pressure of his own motives has increased to the point where, no longer content with the impassivity of office or clinic practice, he is seized by a righteousness or anger or anxiety or guilt that will not be stayed. And thus he forays, neutrality abandoned, to rescue the sufferers and do battle with the vanquishers.

We have, then, a situation in which, on the one hand, an intensity of concern seems to have provided the sense of apostolic mission without which the project's accomplishments might have remained unachieved, and, on the other hand, the indifference to outcome that is necessary for the indication and resolution of conflict seems by its absence to have impeded achievement. Is there a way out of this bind?

Suppose a project were undertaken in which the mental health consultant begins with a curious act of faith: He assumes that there is reason for the community he encounters to be as it is. If the situation seems catastrophic to him, he will take that as the measure of the reason. Having made such an act of faith, he can then express this to the people: "I can't help feeling frightened by the lack of mental health resources in your community, and yet you yourselves don't feel that way. Or maybe you do, but something else weighs even more heavily with you. I wonder what it's all about? Maybe I'm too alarmed, and what you can tell me would help. Or maybe I'm alarmed because I can't see that you too are alarmed, and I end up feeling that I have to do the worrying because no one else is. Can we discuss it?"

I don't insist on the set of words I've used, but however one phrases it, the alternative would, I think, have to include a clear profession of the consultant's own motive, a statement that he knows his own motive and has enough distance from it to realize that it is his own burden and needn't become the responsibility of those he is addressing.

These ingredients express the neutrality necessary to enable the conflict response to emerge safely, after which consultant and townspeople can jointly consider whether the existing solution of no, or inadequate, or problematic mental health resources is the best compromise for the diverse motivations of the people, and then whether the solution represented by these questionable mental health resources is worth the maintenance of the conflict.

Let's see how this might work. Mental health resources, as Talcott Parsons among others has pointed out, are generally for those who, it is believed, cannot help themselves. Most people believe that those who can should, and when they themselves experience difficulty in doing as they should, they increase the "should" component proportionately. They do not want to be led into temptation—into passivity, dependency, and the like. Perhaps they envy those others who can let themselves be passive and dependent, and are as little interested in smoothing the path for such people as they are to have the path for backsliding, as they would see it, smoothed for them. Since basically they don't wish temptation to be available, they are pleased not to have too many resources around. Where resources are deemed necessary, they prefer them to be staffed by professionals who are not sympathetic to the patient —who won't "spoil" the patient. And quite naturally, when people who feel this way are in the majority, they create resources like the many existing state hospitals, resources that are hells on hills, and thus stigmatize or otherwise deter those who might wish to avail themselves of help.

Given the urgency of the need not to backslide, the solution of having few and bad resources makes sense. However, for the people holding it this formulation isn't likely to be conscious, no doubt because its explicit acknowledgment of self-need might border on being intolerable. Yet it can emerge, given the sympathetic neutrality of the consultant, and then be there for those of the community who have this attitude to inspect it also. Their inspection will pose to them the question: Are they in fact so temptable as all that? And if they are, is it really so bad to get themselves a little help?

It is unlikely, however, that their conflict will emerge without any attempt by the people to use projection. The wish for mental health resources and its implied interest in the people's passivity and dependency will be attributed to the consultant. Then, feeling filled with righteousness and good conscience, the people of the community will attack the consultant: "You, not we, are the bad wisher for these regressive temptations!"

If the consultant is in fact what the projection has him being, the conflict now takes place between community and consultant. Since, fortunately, the natives no longer eat the missionary, their perception of him as a powerful and

dangerous person is not likely to result in direct harm to the consultant. But it advances nothing, at the least, and it may set things back simply by helping the people indigenous to the area to feel even less conflict about their solutions of no, few, or bad mental health resources than they felt before the consultant's arrival on the scene. On the other hand, neutrality on the part of the consultant would, precisely at this point, supply to the intractable conflict a leavening necessary to avert the hardening of attitudes. For in his neutrality he is not selling anything. He is asking. He is even offering. But he doesn't need anything. The people will have no cause to fear that the consultant's need to deal with his own anxieties will take precedence over his attention to their own. Instead, the consultant will appear as someone able to tolerate his own conflicts, and therefore he will inspire the hope that he can further tolerate theirs. This, in turn, will help the projected aspect of the conflict to be taken back inside. It is better to have a good consultant and a bad conflict than the reverse, and the neutral consultant has at least the promise of being a good one. He is not, at any rate, a person with a cure, trying hard to persuade people to develop the prerequisite illness.

Since, as *Mental Health Consultants* shows, much can be achieved through "gentle persuasion," there is clearly room for sensitive missionary efforts. Moreover, this is true throughout the indoor practice of mental health as represented in the clinic, hospital, and consulting office. However, just as the limitations of gentle persuasion in the one-to-one treatment situation argued for a dynamic psychotherapy (this as long ago as the nineteenth century, when Freud abandoned hypnosis and the laying on of hands), so what cannot be thus achieved in the community would seem to argue for dynamic consultation.

Dynamic consultation, however, like dynamic psychotherapy, is difficult—not methodologically, but personally. The neutrality it requires means that its practitioners have to renounce the luxury of getting people to change in ways that make them, the practitioners, feel better. Its objective is not This or That, but the freedom compounded of outer possibility and inner option to elect either. The consultant's client may make a choice other than that which the consultant needs, likes, or deems wise, leaving the consultant with what may feel like the poor satisfaction of having helped create an option only to see its potential frittered away. But the alternative may really prove to be worse. The spirit that pioneered the West, for all its achievements, was, after all, a bit hard on the Indians.

REFERENCE

Griffith, C., and Libo, L. (1968). *Mental Health Consultants: Agents of Community Change*. San Francisco: Jossey-Bass.