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Community Development as a Therapeutic Force: A Case Study with Measurements

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ABSTRACT

A cross-disciplinary study was undertaken to learn what the social sciences had to offer psychiatry in understanding mental illness. The authors hypothesized that human settlements deficient in satisfying basic physical, psychological, and social needs will evidence higher rates of psychiatric disorders than localities where such needs are met more adequately. A case study is presented showing how community development interventions that provided for greater self-esteem and other need satisfaction resulted in a lower rate of mental illness. Methods for measuring mental illness useful for further research are suggested. This piece originally appeared in Sociological Perspectives on Community Health *(1974).*

Recent generations of sociologists have become increasingly reluctant to participate in community development programs; psychiatrists have never participated. Each discipline studies communities or individuals to learn more about human behavior and to derive theories, yet neither has been very willing to put knowledge thus gathered to a practical test in the hurly-burly of the "real" world. There is little interest or feeling of responsibility in either discipline for combining respective areas of expertise in a way that would be useful for planning social change or for the amerlioration of change that is clearly upsetting to the groups most involved. These are seen as jobs for "planners" or the government. Sociologists claim ignorance in detecting clinical evidence of human damage concomitant with intolerable social conditions. It is likewise

common for psychiatrists to be sadly lacking in adequate acquaintance with principles of social organization. While there is now in evidence a slight tendency for some cross-disciplinary activity, the approach by both sides is still very tentative.

The senior author of this paper had the good fortune to interrupt a psychiatric residency for a year spent (with Alexander Leighton) trying to find out what the anthropological way of investigating humanity had to offer psychiatry. Living with Navajos for a winter, we frequently drove past the town dump and noted a small group of Navajo families encamped there. Conversations with other Navajos indicated that this group of tribesmen were regarded as useless, lazy, corrupt, and altogether despicable. Intimate association with non-dump Navajos and comparison of them with the dump group highlighted the fact that poverty was not the differentiating factor; almost all Navajos were extremely poor by white standards. My subsequent encounters with Eskimos, Japanese in a World War II relocation center, Zuni and Hopi Indians, plus previous intimate knowledge of various subgroups within Western culture, started cerebrations and resonances. These eventually developed into an effort to try to pin down what aspects of the social experience affect, for better or worse, human adaptation as reflected in the presence or absence of psychiatric symptoms. This in turn led to conceptualizing and operationalizing the Stirling County Study which, with the help of many others, was tentatively begun in 1948 and which, in a limited way, still continues (2,3).

The Frame of Reference

This paper describes the research and the philosophy of the Stirling County Study of psychiatric disorder and sociocultural environment, in which both authors participated. The study grew out of Adolf Meyer's psychobiology (29), with additions from physiology, psychology, anthropology, sociology, statistics, history, and so on. The frame of reference for the study, as set forth by A. H. Leighton (11), can be outlined very briefly:

Man exists in a state of continual striving to satisfy basic physical, psychological, and social needs. The needs, expressed abstractly, can be listed as:

  I. Biological
       a. Physical security (food, shelter, health)
       b. Sexual satisfaction
 II. Psychological
       a. Opportunity to express hostility (without reprisal)
       b. Opportunity to expresss love
       c. Opportunity to secure love
       d. Opportunity to secure recognition
       e. Opportunity to express spontaneity, creativity, volition, etc.

III. Social
   a. Orientation in terms of one's own place and the terms of others in
      society
   b. Securing and maintaining membership in a definite human group
   c. Sense of belonging to a moral order (a system of values and of being
      right in what one does)

Interference with achievement of these needs, either from within or from
outside the person, may produce a number of results, one of which is the possibility
of developing symptoms that reflect the person's frustration, dissatisfaction, or
actual suffering. The particular result of a given interference to need achievement
is strongly influenced by the person's sentiment system, derived from his culture
and quite similar to what other writers speak of as a "value system."

The Stirling County Study

On the basis of this frame of reference, the Stirling County study was
designed as an investigation of the epidemiology of psychiatric disorder in a
general population. Its basic hypothesis was that in a social setting where
achievement of need satisfaction is most faulty, one will find the most psychiatric
symptoms. An elaboration and specification of this hypothesis was that there
would be many people with symptoms of psychiatric disorder living in local
settlements characterized by "social disintegration" (11,8). Such localities are
deficient in social and cultural patterns that provide for the achievement of signif-
icant needs. It was expected, conversely, that there would be fewer persons with
such symptoms in communities which could be characterized as relatively well
integrated by these same indicators.

Stirling County, located in a Canadian Maritime Province, was selected in
1950 as the study site. One of the first steps taken was to designate five rural focus
areas in the county for intensive studies of both sociocultural patterns and the
prevalence of psychiatric disorder. Two of these were relatively affluent, well-
integrated communities, and three were examples of the most economically
depressed, socially disintegrated settlements to be found in the county. In addi-
tion to detailed studies of the focus areas, a survey of remaining sections of the
county was also conducted to provide estimates of the overall prevalence of psy-
chiatric symptoms and of selected sociocultural patterns.

A great effort was made to keep the study of the social setting separate from
the determination of which people had psychiatric symptoms. Although in the
end a single structured interview, supplemented in various ways (17), provided
material for both sides of the investigation, the major attempt to avoid contamina-
tion and prevent circularity took the form of carefully abstracting and editing the
parts of the schedule to be evaluated by psychiatrists. Consequently, psychiatric
evaluations were blind insofar as any identification of person or sociocultural

setting was concerned, including clues to socioeconomic status, ethnicity, religiosity, etc.

The definition of "psychiatric" symptoms was taken from the first version of the *Diagnostic and Statistical Manual, Mental Disorders* (American Psychiatric Association, 1952). Since most people assume psychiatric symptoms to mean "mental illness" or at least "something serious," the quotation marks indicate that in many of the individuals studied these were mild and only slightly, if at all, impairing. The researchers' interest lay in identifying even slight reflections of inadequate need achievement so as to study as delicately as possible those associations between conditions of living and personal reactions. It seemed desirable to count all such symptoms in each subject rather than to limit the estimate to some clinical level of "illness" or "seriousness" or to a single descriptive "diagnosis." We hoped to relate particular kinds of symptoms to particular kinds of sociocultural situations (such as peptic ulcers in London bus drivers), and it was decided that the chance for this should be preserved.

As has been reported in considerable detail (17), the basic hypothesis was confirmed. Communities at opposite ends of the integration-disintegration continuum stood in strong contrast with regard to the amount and intensity of psychiatric disorder which could be identified in individual residents.

The Focus

In this paper we confine ourselves to discussing certain aspects of the unorganized and socioeconomically depressed communities in which we could find very few people who could be considered free of any signs of psychiatric disorder. It is worth noting that there was no evidence of a high number of psychotics in these communities. Rather, there were increased numbers of symptoms of other psychiatric categories, and these were commonly associated with a significant degree of impairment of functioning. This point is made because of the widely held opinion that poor people have psychoses (especially schizophrenia), while rich people have neuroses, a conclusion derived from the studies of *treated* populations where such a relationship has been clearly demonstrated. In the depressed communities studied in Stirling County, individuals had numbers of psychophysiological and psychoneurotic symptoms, sociopathic behavior, personality disorders, and the usual small percentages of brain syndrome, mental retardation, and psychoses. It seemed to be a circular relationship where unfavorable, unsatisfactory living circumstances led to symptom development, which in turn increased the difficulty of doing anything to improve the living circumstances.

Once it was demonstrated that there was a strong relationship between unfavorable social and economic conditions and a relatively high prevalence of psychiatric symptoms, it was a natural intellectual progression to wonder if the symptoms could be diminished by intentionally improving the living conditions.

The latter, of course, has been the avowed aim of many community development programs, but rarely have such programs held specific expectations of mental health consequences. Improvement of living conditions has usually been seen as a sufficient good in itself. However, with the study's commitment to the interrelationship of life circumstances and psychiatric symptoms, it seemed imperative to further test the hypothesis by seeing if changes in the mental health level might be achieved by stimulating social, educational, and economic changes of a sort that could be expected to enhance individuals' skills, interpersonal competence, and possibilities for choices.

Recent history has seen the rise of community organization and action programs in many parts of the United States and other countries, where much effort has been invested in helping the local people to identify their problems, set their priorities, and then learn how to go about improving their living circumstances. Some of these have been quite successful in ways comparable to the events to be described below which took place in the Stirling County community. To the best of our knowledge, however, no attempt has been made to estimate the mental health level of the people involved in other community-change programs, either before or after the effort. This is not surprising in view of the compelling socioeconomic needs of the people and the slow development of an understanding of the implications of sociocultural change for mental health. This has been further hindered by the impression that the estimation of mental health level can only be done by psychiatrists, who are in short supply and not trained for this kind of research. Alternative means of such measurement are discussed later in this paper.

We first describe the series of events which took place in one of the three depressed communities studied which transformed the settlement from a depressed to an ordinary community in the space of only a few years. Whereas in 1952, at the time of the first survey, this community had all the unfavorable characteristics of a slum, ten years later most of its characteristics, including its mental health rating, had become indistinguishable from those of average communities in the county. There follows, then, an account of "The Road," one of the depressed focus communities, where certain intentional inputs were supplemented by spontaneous and chance events to produce significant social and economic change and a concomitant rise in the level of community mental health.

A Case Study

At the beginning of the 1950s, The Road incorporated a population of 118 persons occupying 29 households scattered along a two-mile dirt road that extended from the coast to the sparsely populated interior of the country. It stood out clearly among neighboring settlements as a rural slum: a string of ramshackle, crudely patched, tarpapered and unkempt homes situated on scrubby and rocky land which was largely untended and overgrown with undersized trees among a general cover

of weeds and bushes. The Road had first been settled in the 1850s, but never in its history had it constituted a highly developed, exclusive, and self-sufficient community. From the beginning, its social life was very much a product of the character of its relations with surrounding populations.

The first settlers were families of French background who had migrated to a predominantly English area of the country, attracted by employment in shipyards at the coast and the opportunity for hauling timber from woodlots further inland. Not being concerned with farming, these early migrants settled on poor, cheap land strategically located for both employment on the shore and the profitable timber trade.

In time, ties between the inhabitants of The Road and their natal French communities weakened. Intermarriage with surrounding English populations began to take place, the French language began to drop out of use, and significant economic bonds to the English Protestants of the area increased. Efforts by local Protestants to establish a Baptist mission on The Road proved generally ill-fated, but some converts were won and some weakening of commitment to the Catholic faith occurred. The failure of missionization, however, coupled with the incomplete assimilation of English cultural characteristics, served to perpetuate cool feelings on the part of the English in the local area toward the French. Prior to the turn of the century, The Road nevertheless remained economically viable, enjoying the fruits of a booming shipbuilding industry at the coast and an active lumber trade between the coast and the interior.

At the beginning of the present century, the shipbuilding industry collapsed, and with it the trade in lumber. This resulted in the precipitous loss of the economic resources upon which people on The Road had depended. Although the change in the economic situation also wrought hardship on surrounding English populations, their greater education, fluency in English, social connections, and capital resources facilitated their adaptation to the economic crisis. The Road, on the other hand, had few resources to fall back on: its inhabitants formed a small population, situated on poor land, with little capital or education, isolated from their French homeland, and socially peripheral to the neighboring English. In difficult circumstances themselves, the neighboring English were ill disposed toward supporting the people of The Road economically or otherwise, and the social boundaries between the two groups became firmer.

In the years that followed, as surrounding communities managed to recover their economic position in some measure, the people of The Road were forced to resort to arduous, low-paying forms of labor which did not afford the margin of surplus that might have permitted them to break out of their economic straits. The settlement thus gradually acquired the appearance of a rural slum, with a distinctive economic position and life style which set it clearly apart from its milieu and rendered its inhabitants easy targets for disparagement as an inferior breed. With no traditional image of themselves as constituents of a cohesive and prideworthy community, the people of The Road appear to have promptly acquired the social

and psychological characteristics which typified the settlement in 1950 when studies of it were begun.

Intergroup Relations

Known pejoratively throughout the country as "monkeys," Road inhabitants were found in 1950 to share a widespread reputation for laziness, drunkenness, fighting, thievery, illicit sexual indulgence, and a variety of other traits deemed indicative of amorality and mental inferiority. These characteristics were attributed, in the popular stereotype, to excessive inbreeding. Repeatedly, "Monkeytown" was singled out by informants elsewhere in Stirling as "the worst place in the county."

For their part, people on The Road did not hold a benign opinion of outsiders. While it was widely recognized that respect should be shown to the faces of people from neighboring communities, particularly those in positions of authority, it was felt that outsiders were not to be trusted, and they were conventionally regarded as hypocritical, hostile, and exploitative in their dealings with people from the settlement. Social contact with outsiders was thus avoided when possible, crude but subtle jokes at their expense were a source of much amusement, and accusations and stories concerning the outsiders' immoral activities were common conversational topics among Road residents.

However, this did not generate ingroup solidarity. Even more striking than the negative stereotype of The Road held by outsiders was the frequency and intensity with which its inhabitants themselves expressed negative conceptions of one another. Field workers' first contacts within the settlement often stimulated remarks about The Road which matched the most extreme disparagement voiced by outsiders. Chronic animosities supported by disparaging stereotypes divided the residents along kin group lines, and even normally friendly or benign relations between close kinsmen and others were often breached by public accusations. Hostilities of this temporary sort tended to erupt with only minor provocation, coming to public view in a fight or, more commonly, in the form of character assassination on one side and response in kind. These conflicts were coupled with accusations of "putting on airs." Taken altogether, these patterns left few individuals safe from being targets of publicly expressed hostile feelings and public avowals of their untrustworthiness.

These sentiments found concrete expression in the limited and transient character of the voluntary, leisure time, social contacts among inhabitants of the settlements (1.) Such contacts were limited to occasional visits between close kin for the women and to gatherings of men at a nearby dance hall, filling station, or the home of one of the local bachelors where there would be drinking, swapping stories, and often, fighting. Aside from these activities and from contacts with one another in the course of work, a pattern of guarded mutual social isolation

was the normal state of interpersonal relations. The pattern here stood in sharp contrast to the relations sustained through a variety of regularly organized community activities among members of most other communities in the county.

Residents of the settlement thus shared an identification by outsiders as being fundamentally amoral and untrustworthy, which they reciprocated with sentiments in kind. These stereotypes appeared to guide behavior in interactions between The Road and surrounding communities. Within the settlement, even if individuals denied that such stereotypes applied to themselves, there was little support for their viewing one another as more trustworthy or deserving of social commitments than the stereotype would justify. The frequent and pervasive allegations to the contrary and the readiness to disparage one another served to continually reinforce a conception of their relations as normally mistrustful and hostile and to further the adoption of this concept as the basis of all their social dealings.

The economic position of the people of The Road in the early 1950s afforded a material standard of living far below the norm for the county as a whole. Occupationally, 74 percent of the household heads either relied on work of the lowest category on the scale of occupational advantage-disadvantage constructed for the county or were drawing only unearned incomes. No household derived income from farms or woodlots of its own nor from fishing on its own account, both of which were typical occupations in most other rural parts of the county.

The bulk of The Road's wage earners made their living by contracting for farm labor in neighboring settlements, by temporarily hiring-on to cut timber with woodlot owners in the vicinity, or by digging clams. In any given year, a man typically engaged in some combination of these activities, since none by itself could provide a steady income. Most men supplemented these earnings by occasional day labor at various odd jobs in surrounding communities.

Farming served as a source of day labor only during the summer months. Lumbering, on the other hand, while less seasonal, was nevertheless an irregular form of employment, being only occasional and for relatively short periods. The men who worked in the woods did so as employees of local lumbermen or farmers who needed extra hands for cutting work on their own lots. The nearest clam flats, located some 25 miles from The Road, were the scene of the mos widely practiced single form of subsistence activity. Diggers were paid by the barrel by companies located in Bristol, the county seat, and clamming offered a year-round opportunity for income. Given the distance to the clamming grounds, however, daily travel back and forth to the flats was impossible. Accordingly, men from The Road established camp on the flats in crud brush or tarpaulin shelters for a week or two at a time, returning home to seek other types of work between trips. These extended sojourns and the high level of activity in clamming were characteristic of the summer months only. In the winter the freezing rain, ice, and snow precluded camping for any extended period, and clamming was generally undertaken only as a last resort.

All these occupations represented the bottom of the county hierarchy of oc-
cupational status, and the resulting negative evaluation of their occupational roles
was fully recognized by people on The Road. To outsiders, their position simply
indicated their inferiority and genetic incompetence; on The Road, the low oc-
cupational position was ascribed to the exploitation and hostility of outsiders.

Social Organization

It is clear, however, that the economic history of The Road as outlined
above was primarily responsible for the plight of its inhabitants. The settlement
had never had the resources-the woodlots, farmland, or other capital-to produce
anything of economic value locally. The one commodity it had ever offered on
the local market was labor, and in this respect alone it differed from most other
settlements in the country. Secondly, from the time of the decline in shipbuild-
ing and the lumber trade, The Road had no marketable skills and no monopoly
on the type of marketable labor it was able to supply. The educational and skill
level of its workers could be matched or surpassed almost anywhere in the
county. The labor force was clearly unsuited to either professional roles or to
other economically rewarding and respectable forms of employment. Among the
opportunities for unskilled work available, the types which could absorb the
greatest numbers were those which brought the least compensation, both in
status and in the amount and steadiness of income.

In 1952, nearly 80 percent of the adults on The Road continued to identify
themselves as Catholic in the French tradition, with the remainder indicating
Baptist affiliation. These religious affiliations were almost entirely nominal,
however. There was no local church, and the people who attended services at all
did so in neighboring communities. Residents attended church two or three
times at most in the course of a year. Participation in church sponsored activities
of a more secular nature was equally rare and peripheral. This contrasted
markedly with church-related activity os a Catholic community in the French
section of the county also studied as a focus area in 1952. In the latter com-
munity, 90 percent of the population reported attending all or most services of
the church in the course of a year (8). On a scale of public religious participa-
tion constructed for the county as a whole, The Road registered very low com-
pared to county norms. Still, this low level was not reflected in private religious
alienation. On the contrary, a scale of private religious participation (including
such items as the personal importance of religion, prayers, and grace at meals)
showed The Road to be substantially closer to county norms than the public
sphere. Thus, a striking discrepancy between the levels of religious involvement
was registered by the settlement on these two measures.

The typical rationale expressed for the minimal participation in public
religious activities was, first, that the clergy took little interest in them and

generally harbored unfriendly attitudes toward them. Secondly, Road residents felt self-conscious and uncomfortable associating with outsiders who looked down on them. Although persons from The Road were permitted to join in the activities of churches outside the settlement, they felt that they were accorded inferior status, and that their presence was tolerated only with obvious distaste and condescension. No alternative was afforded through indigenously organized religious activities, with the result that they completely lacked one of the institutions which served as a major focus for social activities in other communities in the county.

A small one-room school at the inland end of The Road served most families in the settlement and a few other scattered homes. Up to eight grades of formal schooling were offered. In order to go beyond this level, a youngster would be required to board in Bristol, a financial impossibility for virtually every family.

For years, The Road school had been poorly staffed. In all but one of the ten years prior to the study, it had no fully qualified teacher, with the post consequently occupied by a succession of individuals who had been granted temporary "permissive" teaching licenses. Understandably, there was a widespread opinion that there was little use in sending children to the school. In particular, some were encouraged to drop out and work for the family by finding odd jobs or going clamming because the teachers "didn't know anything anyway." Resentment was also expressed toward paying tax money to support teachers who were "no damn good."

There was no formal parents' organization associated with The Road school, while such organizations flourished in other districts in the immediate area. Furthermore, no one from The Road held a position on the locally elected Board of Trustees responsible for the management of school affairs. Little attention was paid to Board elections in the settlement, and the long-standing incumbencies of the outside Board members were never challenged. Similarly, Road adults virtually never made contact with the teacher or trustees concerning such matters as the progress of children in school, the maintenance of school facilities, or the quality and selection of teachers. The local school represented the one formal institution which The Road might have claimed as its own and which afforded a potential focus for community activity. In spite of this, collective involvement related to school matters remained negligible.

Seeds of Change

An immediate outgrowth of the first study of The Road was a program for improvement drawn up by the researcher who had conducted the initial field work there, Allister M. Macmillan. Macmillan succeeded in interesting school author-

ities to give special attention to the settlement, with the result that a man responsible for adult education in the area was encouraged to attempt an experimental program. This educator defined his objective as that of improving the skills of The Road people so as to make them more employable, and he planned to accomplish this long-range goal by establishing regular adult education classes at the settlement's school. His initial tactic, however, was to attract adults to regular evening gatherings at the school by showing free movies. With the collaboration of the schoolteacher, he began by showing movies during school hours to the children, then sending them home with the news that there would be movies again in the evening for anyone who wished to attend. Attendance at the first showings was reasonably good, and the first attempt toward community organization was the suggestion by the educator that The Road people elect a committee to select subsequent programs from the list of available films. He also gradually encouraged the showing of films with educational content, and began suggesting the possibility of adult classes in the school.

Since there was no electricity in the school, the first showings required that the educator bring along a portable generator. He pointed out at a suitable time that the school ought to be electrified if the evening programs were to be carried on properly and, furthermore, that the Department of Education was prepared to meet half the cost if the rest were raised in the neighborhood. This suggestion was made partly because of the immediate practicalities, but was also influenced by his recognition that local organization and involvement in support of the project was a necessary preliminary to success in any more ambitious program. The risk was, of course, that the wiring project might fail from lack of interest. Fortunately, it proved a success: enough money was raised to finance half the wiring and to pay the electrical bill for the succeeding year—the first voluntary contribution of Road residents to any public cause.

At this juncture, however, the project came to an abrupt halt because the adult educator was transferred to a different district. Such a collapse was thoroughly in keeping with The Road's attitudes of suspicion, apathy, and disparagement, and completely matched the predictions of the project's opponents on The Road. Recovery seemed unlikely and the prospects for any further activities of this kind looked bleak.

In the meantime, however, county school officials had managed to secure the services of a fully qualified and interested teacher, and she continued as a catalyst for activity and involvement where the adult-educator had left off. She maintained frequent contacts with the women and encouraged them to seek improved education conditions. (Although the teacher's work with women was doubtless partly motivated by her feeling at home with them, it has usually been found in depressed, disintegrated communities that women can be motivated to move sooner and more easily than men.) Evening bingo games were organized at the school as a means of raising money to purchase new desks,

with prizes provided by the women. However, one of the teacher's most important moves was to stir up (at the suggestion of school authorities) the question of having the local school admitted to the consolidated school district of the region. Such admission meant daily bus transportation to Bristol for the children above the sixth grade. There, educational opportunities were considerably richer and the way would be clear for going on through high school. It also meant increased taxes for the school district of which The Road was a part.

In spite of opposition on and near The Road stemming from the necessity for increased taxes, the women who were in favor of the move (urged on by the teacher), campaigned on its behalf through the whole school district with success. Supporters in sufficient numbers were brought out to a meeting of the district rate-payers to vote the measure through. Among those in opposition were the school trustees, who resigned as a result of the vote. For the first time in history they were replaced by three men elected from The Road. Thus, a partial end to social isolation, along with a need for citizen participation, was achieved.

Another development of major importance, beginning around 1950, was the establishment of a work circuit that linked the settlement to a major city in Ontario. Before this time, many individuals had left The Road to seek their fortune in large cities. Their lack of interpersonal skills and of previous close contact with people different from themselves, however, induced an overwhelming loneliness which soon drove them home, empty handed. Thus, the work circuit's survival might be taken as evidence of some sort of renaissance. It is impossible to trace contributory forces to ascertain whether the early steps in community organization had played any part. Possibly the original investigation by Macmillan had begun a subtle change in self-perception—if that college man would spend time to come and talk to Road inhabitants again and again, perhaps they weren't really so no-account as they had thought. It seems quite clear that the women would never have had the courage to tackle the larger community on the school issue without the practice afforded by the movie program and the bingo games.

The work circuit's initiation had taken place when a family originally from The Road, who had settled in Ontario, wrote home inviting some of their relatives to join them for a time to take advantage of the comparatively lucrative employment opportunities in the city. By 1952, four people had responded and were living close to one another in the city, engaged in the same type of unskilled industrial work. With this start, a pattern developed whereby people form The Road would go to work in Ontario for six months or a year and then return home. The arrangement was such that before leaving The Road they had assurance from those in the city that jobs would be available and that they would be moving in among people they knew. They apparently made a good impression as workers, for when they left the city their employers were glad to accept a friend or a relative as a replacement. The returnees to The Road expended

their accumulated savings on paint, furniture, house construction, cars, and in-
vestment in a variety of new economic enterprises.

It has often been a cause for astonishment to those unfamiliar with the Maritime
Provinces that successful emigrants from such a community would have any wish
to return. An extremely common pattern, however, is for young adults of all stations
in this society to go away to the States or to upper Canada to accumulate enough
money so that they can afford to "retire" to the old homestead. This may take many
years during which taxes are scrupulously paid and occasional visits made to mend
the roof or to ready the home for later occupancy. No doubt the Road people were
familiar with this pattern even though it had not worked well for them previously.
The pattern is probably more widespread than the Maritimes—common, very
likely, in many rural areas. In the States, the pressure is great to move perma-
nently to the city, but it seems there could be many emotional gains in maintain-
ing a foothold somewhere while undertaking new, perhaps dangerous, ventures.

In 1957 the movement reached a peak with 21 people from The Road (about
18 percent of the total population) at the Ontario location. By 1962 some in-
dividuals had made the circuit four or five times. Both men and women—married
couples as well as single people—made the trip. Some newly married couples chose
this adventure as a means of acquiring a sum of money to start a new home. It is clear
that the circuit served as an economic pump, not only temporarily raising the income
level of migrants, but resulting in significant improvement in material living conditions
and capital on The Road itself. Factors important in its success seem to have been the
receiving friends at the Ontario end, the arranged job, and a prepared place to live.
Anxieties about being stranded among strangers in a strange place were thus reduced,
while confidence in finding an acceptable job and getting fair treatment from employers
was established. Far from home, the migrants had escaped the curse of their local
reputation as unreliable workers.

People on The Road (and others in the vicinity who know the neighborhood
well) claimed that the old habits of speech, dress, and deportment that had char-
acterized those who made the circuit had dropped away by the time they returned. The
migrants arrived. back home with confidence in their ability to do more
respected forms of work and a marked unwillingness to take part in the traditional,
low-status occupations of the neighborhood. They also displayed confidence in
their ability to deal with outsiders on an equal footing and a desire for living down
the neighborhood's unsavory reputation. It is worth noting that the same kind of
change took place in the children who began to attend the consolidated school.

Coincident with these developments, a public works project in the county,
employing between 300 and 400 men over a three year period, had afforded a new,
albeit temporary, source of employment for unskilled laborers at wages substan-
tially higher than they could otherwise secure. The Road, of course, provided a
ready supply of labor recruits for the project, and those employed mostly con-
formed to the pattern which had been established with the work circuit to Ontario:

new earnings were invested in various home improvements and applied to the development of new economic enterprises of their own.

The Consequences of Social Change

By 1962, when a re-study of the focus areas of the county was undertaken, changes on The Road were evident to even the most casual observer. The population of the settlement had remained largely stable: only 11 percent of the 1962 adult population had arrived as immigrants since 1952, virtually all of these in-marrying women. The most striking change was in the appearance of the area. Freshly painted and newly constructed or refurbished homes, surrounded by cultivated shrubbery and well tended lawns largely indistinguishable from those in neighboring, more affluent communities, had replaced the tarpaper shacks and dilapidated larger dwellings of a decade before.

Economic measures of the material standard of living of Road families also showed a marked improvement, a change not even remotely approached by the other depressed settlements in the county in the same period. Furthermore, the new economic roles and resources now evident were very similar to what could be found elsewhere in the county. For example, clamming was no longer practiced. Only one man still worked as a farm laborer, but he did so year-round on an annual salary rather than in the earlier pattern of occasional day labor. For those relatively few men who continued to rely on wage work in lumbering, the work had become steady during the season, was for major contractors, and was sufficient to enable workers to draw unemployment compensation during the slack months. Only 36 percent of the families on The Road in 1962 gained their subsistence from traditionally low-status occupations or were dependent on unearned income, as compared to the figure of 74 percent a decade earlier.

Capital accumulated during the decade had led to several new economic ventures and cooperative patterns. Several men, for example, had jointly invested in the operation of a fish weir; another had acquired a lobster boat; a dairy farm and mink ranch had been established and were being operated by a group of closely related families; two men had acquired tractors and other equipment and had gone into business with their sons, hauling lumber in the winter and hiring out their services to local farmers during planting season; woodlots had been purchased and were being cut by men from several families in the settlement. Other new forms of employment included full time jobs at fish-processing firms in the county and a variety of occupations ranging from electrical repair and maintenance work at a local resort to clerking in the department stores in Bristol.

Aside from these changes, participation in the activities of churches increased during the decade, particularly among the women. Church services were now regularly attended by almost half the women on The Road. Sisters from the nearby Catholic church were making frequent visits in a generally successful

effort to encourage Sunday school attendance on the part of the children. They were also holding regular catechism classes at a home in the settlement. Church suppers and church-sponsored bingo games had become a regular activity for many Road couples.

Consolidation of the primary schools in the area had taken place in 1961, when The Road was combined with six small neighboring districts to form a single larger district. The consolidation, however, had not lessened interest and involvement of Road people in local school affairs. Women in the settlement had played an important role in the formation of the new Home and School Association which served all the communities included in the new district, and they represented The Road at its meetings.

Queried about The Road in 1962, people elsewhere in the county were likely to immediately remark on the changes they had noticed, especially their undisguised surprise at its "new look" (27). The familiar stereotypes attributing genetic inferiority and amorality to the inhabitants were no longer voiced. On a workaday level, the change in the self and public image of The Road was clearly evidenced by the greatly improved acceptance of its people by outsiders in various institutional contexts. The decade had also marked a changed outlook on The Road toward residents of neighboring communities, who were no longer warily viewed as hypocritical, hostile, and exploitative. Gone, too, were the allegations and public displays of antipathy that had previously divided both kin groups and individuals. The current image of the settlement and of those within it now accentuated the positive character of intracommunity relations.

These changes were reflected in new forms of leisure-time associations. Many couples gathered regularly for card games, usually on a weekly basis, with nearly half the households in the settlement represented in such activity. The several groups meeting together for entertainment consistently included a cross section of the settlement's major kin groups. On a larger scale, although less often, "rappie pie" parties were being hosted on a rotating basis by a number of families, and attendance at these affairs also drew a substantial proportion of the population.

Perhaps the most notable development was the inauguration of the first genuine community celebrations that the settlement had witnessed in many years. Any birth or wedding had become the occasion for a "shower" held at the home of a close friend or relative of one of the principals, to which every family in the settlement was extended a formal invitation. These gatherings were not only frequent and large, but were festive affairs with both men and women in attendance. Everyone taking part donned their best attire for the event which, in addition to the usual presentation of gifts to the guests of honor, provided the occasion for a night of community singing, dancing, and card games.

Taking into account all the changes evident in 1962, developments during the decade of the 1950s had clearly served to foster increased access to

conventionally recognized relationships of trust and solidarity for Road in-habitants. The same factors had promoted participation in social activities where individuals were accorded a status which provided some measure of self and public respect. This signaled not only a significant transformation of social relationships among inhabitants of the settlement themselves, but an equally striking alteration of the previous state of their relations with other residents of the county.

Better Mental Health

As was noted earlier, the mental health rating of The Road population in 1952 was substantially poorer than that of the county as a whole, the latter figure being based on a survey of a sample of residents throughout the county-at-large in addition to data from the five focus communities. The other two depressed focus areas were also worse than the county norm, but The Road had received the poorest mental health rating of all five focus areas (17).

In the 1962 re-survey (carried out according to previous Stirling County study techniques) (17), psychiatric as well as sociocultural data were again collected for all five focus areas to determine what changes, if any, had occurred in their mental health level during the decade. Analysis of the psychiatric data from The Road revealed a significant change in a positive direction so that its mental health rating had shifted to a position virtually equivalent to the mean for the county as a whole (14).

The re-survey also indicated that no social changes comparable to those which had taken place on The Road had occurred in the remaining two depressed settlements. Some less dramatic improvements in one of these could be noted in the way of lessened inter- and intracommunity social isolation and hostility (27), and better material style of life. In neither of these settlements was there such a positive change in mental health as was found on The Road, although some improvement was registered in the one that had also experienced some social improvement.

Finally, one of the two well-integrated communities that had registered a high level of mental health in 1952 showed decline in its mental health rating in 1962, even sharper than the rise on The Road. The decline in its mental health paralleled evident social change in a direction opposite to that observed on The Road, namely a marked decrease in the level of intracommunity solidarity and organization (14).

These findings clearly suggest the potential significance of community devel-opment programs for improving mental health in psychiatrically impaired, economically and socially depressed local groups. Individuals depend on the support of others for carrying out the activities and winning the recognition necessary to satisfy the needs, values, and goals on which their psychological

well-being and mental health depend. Their capacity to secure such support can suffer significant impairment where prevailing social patterns deny some persons access to interpersonal bonds of solidarity and trust or when access is denied to collectively organized and performed activities which would provide roles accorded social values and respect. Insofar as programs for community development include successful efforts to alter such social consequences of membership in a socioeconomically depressed local group, benefits in the form of improved mental health for the population are likely to result.

Further Research

Beginning in 1964 and presently nearing completion, a program and a series of studies in a second of Stirling's three depressed settlements has been under way, designed both as an experiment to evaluate means for intentionally stimulating change of the types which took place on The Road, and as a further test of the effects of such change on mental health (10). One of the major aims of this research has been to experiment with techniques for achieving change that can be implemented by local people willing to organize and devote time and effort to such an undertaking.

Kern (10) says, "The specific goals of the action program were to foster cooperation, to build a positive self and community image, to promote community power, and to increase ability to plan on a long term basis." To this end, three main activities were undertaken. The first was to make several movies of successful events in the community with much citizen participation. These were shown not only to residents, but also to outside opinion leaders, especially in Bristol, which sets the standard for the area. A second effort was to solicit the participation of two men to join the investigator in a cooperative garden. In spite of doubts and bad weather, a good crop was realized, and the venture stimulated a request by several men for some adult agricultural education. The third undertaking was the organization of a baseball league for men and boys that included a number of teams from other communities. This provided some of the same opportuniites for dispelling stereotypes and promoting communication as have been noted in some school desegregation experiences. The report does not quote figures measuring outcome, but if the major hypothesis of the Stirling county study is supported by measurements, this experiment can provide a model of useful guidelines for similar programs elsewhere which involve members of a local citizenry as the principal agents of change.

The currently widespread efforts to encourage community development noted earlier, both in this country and elsewhere, could obviously provide opportunities for further evaluation and refinement of such a sociotherapeutic approach to the improvement of mental health. The contributions of present and

future development activities will depend a great deal not only on attentiveness to the social consequences and the effectiveness of techniques in terms of socioeconomic program goals, but also on techniques for adequately assessing the consequences of various types of community development activities for mental health.

As stated in the introduction, one reason for the lack of efforts to determine the mental health consequences of development programs has doubtless been the anticipated difficulty of measuring mental health or illness. The investigators planning the Stirling County Study were plagued by this problem and tried several indirect and unsystematic means such as collecting hospital records, interviewing key informants, and setting up an outpatient clinic. Fortunately, it also planned to include a set of psychological screening questions in the structured questionnaire interview, along with a health history. These two sections, supplemented by comments from as many local doctors who knew the subject and by a hospital record where one had been found, eventually provided the material which was carefully edited and given to psychiatrists to evaluate.

In addition to the psychiatric evaluation, which was done from a base of clinical experience by a method developed to achieve reliability between raters, the screening questions could be scored independently and compared with the psychiatrists' ratings. Comparisons of the age/sex distributions of psychiatrists' ratings with the mean score of the screening questions (17) indicated that the two ways of assessing the data give very similar results. At the same time, there is the interesting fact that psychiatrists judged people 70 years of age or over to be "healthier" than the next younger age group, while the screening test score continues to rise with age. Which view of the oldest group is "right" remains to be settled.

The method of making a rating by using psychiatrists' judgments has proved stable, reliable, and teachable (30), and it yields a list of symptom patterns, an estimate of confidence that the person has or has not any psychiatric condition, and an estimate of how much his functioning has been impaired by such a condition. A computer program has been prepared which provides ratings that are as reliable as those of any pair of evaluating psychiatrists (5, 26). The questionnaire has also been shown to discriminate validly between groups of known psychiatric patients (20) and community groups.

The full scale method has, however, two principal drawbacks: it is a time consuming data gathering technique and without a computer it is a psychiatrist consuming analytic technique. Once the 1952 survey had been completed and reported, it appeared highly desirable that some briefer means of achieving an approximate mental health estimate be developed for use in less painstaking and less well-financed research efforts in order to expand understanding of the dimensions of the mental health/sociocultural envirnoment relationships under many diverse circumstances.

A Brief Mental Health Assessment Instrument

Naturally enough, thoughts turned to the psychological screening questions for this purpose. The set that had been used in the questionnaire had been selected and standardized by Allister M. Macmillan, beginning with such sources as the Armed Forces' Neuropsychiatric Screening Adjunct and the Cornell Medical Index and eventually encompassing most of the sets of psychiatric screening questions that had been devised in the post-World War II years up to about 1950. Macmillan tried out seventy-five such questions in an area quite similar to Stirling County, eliminated duplicates in various sets, standardized them against a group of neurotic patients in metropolitan hospitals, and selected the most useful ones by discriminant function analysis. He also tested their reliability in re-interview, and had a psychiatrist examine a sample of his subjects (18). All indications were that the screening questions, labeled the Health Opinion Survey (HOS), did reasonably competent in distinguishing various levels of psychiatric involvement by means of a numerical score. (The HOS is a set of questions, response categories, and scoring weights utilized in Myers and Bean {21} and in Rogler and Hollingshead {22}). The refinements of the psychiatrists' rating described above were not, of course, available.

When the opportunity arose in some Nigerian villages to conduct a study modeled on the Sterling County study, the screening questions were included (13). The necessity to translate the entire questionnaire into the Yoruba language brought to attention some aspects of the screening questions that had not been particularly noticed before. One of these, "Have you ever felt as if you would have a nervous breakdown?" presents obvious problems of imprecision in spite of the fact that it had been used successfully with English speakers and can be translated into Spanish without difficulty (22). A second point was that it seemed inadvisable to add to the complications of interviewing subjects through interpreters a variation in the answer modalities. Macmillan had experimented with several answer choice patterns and answer weights, but it seems imperative to simplify the procedure, and so standard answers ("often," "sometimes," or "never") were used. The need for translation also served to considerably improve the grammatical form of some of the questions.

Once the Nigerian study was completed, statistical members of the research team identified twenty questions from all those that had been used that (1) agreed best with the overall psychiatric ratings, and (2) had been usable in Nigeria. The latter point resulted from the desire to have screening questions that could be used under diverse sociocultural conditions. A final improvement, made a little later, consisted in framing all questions clearly in the present tense and eliminating the word "ever" from them. This change arose from a wish to use the screening questions to measure clinical change in psychiatric patients, where a definite time referent would be required. The present tense version is as follows:

The Health Opinion Survey for Assessing Mental Health Levels

1. Do you have any physical or health problems at the present?
2. Do your hands tremble enough to bother you?
3. Are you troubled by your hands or feet sweating so that they feel damp and clammy?
4. Are you bothered by your heart beating hard?
5. Do you tend to feel tired in the morning?
6. Do you have any trouble getting to sleep or staying asleep?
7. How often are you bothered by having an upset stomach?
8. Are you bothered by nightmares (dreams that frighten or upset you)?
9. Are you troubled by "cold sweats"?
10. Do you feel that you are bothered by all sorts (different kinds) of ailments in different parts of your body?
11. Do you smoke?
12. Do you have loss of appetite?
13. Does ill health affect the amount of work (or housework) that you do?
14. Do you feel weak all over?
15. Do you have spells of dizziness?
16. Do you tend to lose weight when you worry?
17. Are you bothered by shortness of breath when you are not exerting yourself?
18. Do you feel healthy enough to carry out the things that you would like to do?
19. Do you feel in good spirits?
20. Do you sometimes wonder if anything is worthwhile anymore?

Except for the first question, which is answered yes or no, all answers are chosen from "often," "sometimes," or "never." Scoring is accomplished by giving three points to the "sick" answer, one to the "well" answer, and two to the "sometimes" answer. Questions 2, 3, 4, 8, 9, and 17 can be used as a subscore for anxiety, and questions 5, 13, 16, 18, 19, and 20 for depression.

These direct, inoffensive, easily understood questions are frequently regarded as a medical history, having much in common with a brief stand-ardized history. No systematic attempt has yet been made to test wording changes or to scatter the questions throughout a longer interview schedule. The aim of each question is to convey its meaning to the subject, and any slight modification to assist in this is justifiable. All are matters of opinion with regard to symptoms commonly associated with reactions to stress, so that it is of no significance whether the person actually has a demonstrable basis for his opinion: *the degree of his concern is the measure of his mental health status.*

The strength of the instrument lies partly in the variety of organ systems covered, including the possibility of registering overall reactions (fatigue, sleep, mood). The answer categories offer some measure of frequency and intensity, and are generally better received than the yes/no or agree/disagree pattern of some other scales. It seems quite likely that this instrument, the result of largely pragmatic experimentation, may in the end prove to be firmly founded on psycho-physiological interactions involving emotional, hormonal, and neural components. For example, Dr. Richard Udry found, in studying the outcome of pregnancy in a sample of some 2,000 women, that those who had a successful outcome could be differentiated from unsuccessful ones on the basis of whether they chose the "often" or the "never" answer to a set of the HOS querstions. A medical expert felt that the differential choice of response could be clearly associated with differential hormonal factors.

Evidence from a study focused on cardiovascular disease, in which the HOS was given to two random samples of a population who also answered an extensive sociological questionnaire and health history and received a searching physical exam and laboratory tests, will soon advance our knowledge of the relationship of physical symptoms and findings to HOS responses (4).

This screening instrument has now been used in a number of other studies, some of which have been published or will be published in the near future. The populations tested include a sample of the patients of public health nurses in North Carolina (16); a sample of the population of three rural counties in North Carolina and Virginia (6); a cross section of the patient population of four state mental hospitals; an entire university freshman class; university students who had consulted the psychiatrists in the student health service (31); a sample of Makah Indians in Washington (32); several small Indian groups in various subarctic communities; the Pine Ridge Sioux (19); five different types of work organizations in New York state (23,24,25); and 1,280 aged respondents in a sample of New York state communities (28). It was also used in the follow-up of the New Haven Study (21) and in a study of schizophrenic families in Puerto Rico (22). A new application that seems promising is in determining stress points in a school population, in which the version given above is used for grades seven to twelve, while a modification is used for grades three to six (15).

Analysis can be done by comparing mean scores of various subgroups or by scrutinizing the characteristics of individuals found near the ends of the scoring range or both. In addition to the screening questions, data are usually gathered on common demographic variables and on other characteristics in which the investigator is interested or which he believes to have some probable influence on mental health. The score can be thought of as a symptom count, or a stress score or mental health level, the lower levels being "healthy" as compared to the upper levels. Experience has indicated that the 20 to 30 range is within normal limits. A sharp dividing point between "sick" and "well" does not

seem appropriate in most instances. So far the instrument has only been tested for group estimations. It remains to be seen how useful it may be in work with individuals, such as in measuring clinical change.

Generally speaking, correlation of mean group scores with such variables as age, sex, race, socioeconomic status, and so on, serves to indicate which subgroups of the population studied are under some sort of excess stress. More refined examination of the high scoring groups may indicate which characteristics are most strongly related to the score elevation. *Consistency of correlation of any given characteristic (e.g., sex) with high or low score should not be expected,* since score level will depend on the intensity of stressful forces impinging on either sex at a particular point in history and in a particular cultural setting. Rather, the score level tends to point out which groups are currently in trouble and which are adapting satisfactorily in the population studied.

Summary and Discussion

This (article) has set forth a rationale for anticipating that certain kinds of social changes will diminish the amount of psychiatric disorder that a community group shows and has further detailed a case study where this, in fact, happened. It has mentioned a study (which could not be included because of space considerations) where the rationale was intentionally implemented; and it has described and discussed an instrument for measuring mental health which can be readily applied by nonpsychiatrists.

This is obviously only a drop in the seething social bucket, but it is a beginning. Investigation needs to be continued and expanded in order to fill in the outlines suggested here and to refine our understanding of the ways in which the social behavioral sciences can supplement each other and illuminate new pathways to better human functioning. We need to combine Meyer's ideas of the psychobiological integration of each person with the intuitive insights of Freud and the methods of modern social science (not available to either of the masters) in order to forge improved ways of thinking about the maladaptations of mankind and fresh ways of solving its problems.

It is worth emphasizing that, although there was a wealth of psychopathology apparent in residents of The Road, the ten-year improvement took place without the benefit of psychiatry and with comparatively little medical input of any kind beyond symptomatic relief for such conditions as were traeated by the local doctors. No one can say with certainty whether an intense effort by mental health workers to find and treat cases by conventional methods would have resulted in similar improvement. At the same time, the events and interactions described fit into current notions of cause and effect quite compellingly and incline one to say of the outcome, "Why, of course!" There is a great need for further monitored experiments to clarify the forces at work.

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Mental Health Education in
A Canadian Community

John Cumming and Elaine Cumming

ABSTRACT

The experiment described here was aimed at changing negative attitudes of the public toward the mentally ill. An intensive educational campaign about mental health was conducted in a small community in western Canada. Before-after questionnaires were used to determine what effect the campaign had on attitudes toward the mentally ill. The tests showed no appreciable changes in beliefs about mental illness or attitudes toward the mentally ill as a result of the program. The unanticipated hostility that was generated by the project is discussed. This piece originally appeared in 1955 Health, Culture and Community.

The Problem: Unexpected Outcome of an Educational Experiment

In 1951 an experiment in altering popular attitudes toward the mentally ill was launched in Prairie Town, a community in a western Canadian province. The project grew out of a desire on the part of the province's Department of Public Health to extend its usefulness by entering the field of preventive psychiatry. We who were working in the psychiatric division of the Department pondered how to make a beginning in this direction. One possibility considered was that of early case-finding. But, our mental hospitals were already overcrowded and our recently established outpatient clinics had long waiting lists of people eager to be helped.

A more appealing plan, we reasoned, was to develop a program of education that would give people in the community a better understanding of mental illness

and of current knowledge about child development, delinquency, and allied subjects. In the long run such an educational program might possibly decrease the incidence of mental illness. Whether or not this would prove true, it did seem that bringing about a more tolerant popular attitude toward those who had been in mental institutions might well speed the process of psychiatric rehabilitation and lower the high relapse and readmission rate. Discharged mental patients usually encountered a generalized attitude of fear, suspicion, and rejection when they returned to their community. Our public health nurses knew this from their efforts to help former patients readjust to their home surroundings, and we knew it from stories told us by former patients.

Aided by a generous grant from the Commonwealth Fund, we carried out the Prairie Town experiment. We prepared the ground slowly and carefully. Then for six months we utilized all local facilities in a concerted effort to bring about a measurable change in attitudes toward the mentally ill. By means of questionnaires and interviews we tested a sample of townspeople twice, once at the beginning of the intensive campaign and again at the end. After our educational experiment was over, we had time to analyze and compare the two sets of test material. The tests showed that no significant change in attitude had occurred.

We had been unable to effect any evident change in attitudes toward the mentally ill. Attitudes toward us, on the other hand, had undergone a very evident change. The people of Prairie Town, initially friendly and cooperative, had become increasingly aloof as the months went by, despite every effort on our part to be tactful and friendly. From apathy they resorted to withdrawal, and when our interviewers returned to Prairie Town at the end of six months to administer the retest, they were dismayed at the outright antagonism they encountered. Our well-intentioned efforts to alter attitudes had apparently produced side effects that we had not bargained for. What was the connection between the negative outcome of our educational program and the positive hostility that was aroused? What does this connection reveal about the needs served by popular concepts of illness?

The Situation: An Effort to Alter Mental Illness Concepts

The Community of Prairie Town

Prairie Town is located about 50 miles from Prairie City and was chosen mainly for reasons of convenience. It can be reached both by transcontinental railroad and by a good highway which is kept open and free from snow all winter, an important consideration in this part of the world. This area of the province is mainly Anglo-Saxon in origin, and Prairie Town is an old and stable community. Thus, project workers did not have to deal with language difficulties or a shifting population.

Prairie Town is mainly a distributing center. Many residents are farmers who own homes in the town as well as farmsteads in the surrounding area. Most residents have lived in the town for many years; many were born there. It is a wealthy town for this part of the country, proud of its modern facilities, including sewer and water systems, which are unusual for a prairie town of 1,350 persons. People of Prairie Town are essentially conservative and individualistic. When the library board canvassed the town for donations for a small building to house the library, they could not raise the necessary $400, despite the fact that three people in town are reputedly near millionaires. One of these said to the canvasser, "If people want to read books, let them buy them themselves." The town has one movie house and a weekly newspaper. Community recreational facilities are poor. Both the grade school and the high school are old and inadequate, in marked contrast to Prairie Town's many fine homes with well-kept grounds. Many streets are lined with stately trees, carefully planted and cared for, something seldom found in other prairie towns. Most of the better homes have large flower gardens, and local pride in the appearance of the town is reflected in the commonly used slogan, "Prairie Town, the beautiful."

However, when Prairie Town citizens use this slogan, they do not mean to include that part of town known as Germantown. Germantown contains no Germans but was so named, according to a local story, during World War I, when the term "German" was applied to any unpopular group. Germantown is a collection of tiny wooden and tar-paper-covered houses on the east side of Prairie Town. It is inhabited mainly by Metis, a French-Indian cross comprising about 5 percent of the population, and by a few other economically depressed minority groups. Germantown families are not served by the sewer and water facilities of which Prairie Town is so proud. Prairie Town is a wealthy town, but it is also a town of contrasts.

In Prairie Town there are a large number of organizations, social clubs, church groups, choirs, sports clubs, service clubs, and fraternal organizations. A local agricultural agent who proposed building a community center surveyed these groups and counted more than 70 organizations. The groups show a high degree of overlap in membership and direction, but there are also many people in town who belong to only a few organizations or to none. The town is set off from others around it by two government agricultural and experimental stations. Personnel from these installations contribute a small group of highly educated persons in Prairie Town's population. These people have a social life largely confined to their own numbers and, while respected by the townsfolk, they are not included in the informal groupings of the town.

Our survey revealed two main types of people in Prairie Town. One segment of the town places a high value on the puritan virtues: honesty, hard work, thrift, good housekeeping, and a God-fearing religious life. The values of the other segment, more educated and better housed, center on community service; men of

this group want to be known as good mixers and proficient businessmen and prefer that their wives be active in community affairs as well as proficient in housekeeping.

A Mental Health Educational Campaign

In planning the educational campaign before coming to Prairie Town, we had postulated that people tend to reject the mentally ill because of fear, ignorance, and guilt. Experience has shown that the average layman thinks that most persons who become mentally ill are violent; this is believed not only by those who have had no direct contact with the mentally ill but also by many who have. The latter seem to accept the general belief rather than trust their personal experience.

In addition to this explicit fear, we thought, people may have a less conscious fear of becoming mentally ill themselves, since causative factors are so general and so imperfectly understood. This fear may be created by a little knowledge. We found, for example, when teaching student nurses in the psychiatric department of a general hospital that they had a great deal of anxiety because in some respects they could see little difference between the mentally ill and themselves, and because they could find in themselves many of the psychological mechanisms used to explain mental illness.

Many people who have placed friends or relatives in an institution feel relieved at being absolved of their responsibility. To acknowledge that such institutions are socially undesirable or physically inadequate would provoke a sense of guilt; the easier course is to remain blind to the facts. Relatives of mentally ill persons often keep reassuring themselves that institutional care is "the best thing" for their relatives, and that the institution in question is at least "better than most others." Another way to redirect guilt is to attribute to minority groups traits about which the "projecting" individual feels ambivalent. This mechanism is well known in racial prejudice, and we assumed it to be partly responsible for some of the distorted concepts about the mentally ill. We reasoned that some of the violent impulses attributed to the mentally ill might in fact be projections of a normal person's unconscious urges.

On the assumption that misconceptions about the mentally ill were tied in with deeper emotions such as fear and guilt, we regarded the task of community education as a delicate undertaking. We would have to avoid assuaging some fears at the cost of arousing others. For example, if we were to stress the point that mental hospitals, contrary to widespread sentiment, are not an ideal setting for inducing recovery, we might thereby increase the amount of guilt felt by those with hospitalized relatives.

We knew that we would often be questioned on the nature of mental illness, the characteristics of the mentally ill, conditions in mental hospitals, and treatments for these disorders. To evade these questions would in itself produce

suspicion and anxiety; therefore, we decided that when they did arise they should be answered honestly, sympathetically, and with a minimum of sensationalism.

We undertook to teach three basic concepts: first, that there is a very wide range of human conduct that can be considered "normal"; second, that behavior does not "just happen" but has determinate causes and can therefore be understood if one knows the factors involved; and third, that the borderline between "abnormal" and "normal" is vague and arbitrary.

Although our primary backing came from the provincial government, it was decided that we would align the program with the Canadian Mental Health Association, a voluntary nonprofit organization, so that we would not be considered an agency of government. We expected Prairie Town to be a conservative town where there would be a great deal of opposition to the liberal ideas of the current government. We used as a rationale for entering the community the idea that we were trying to establish what the term "mental illness" meant to a group of typical citizens. The project team included a psychiatrist and a sociologist as senior workers, and six trained interviewers. Some of these personnel stayed in Prairie Town for extended periods of time, and others came to the community from their base in Prairie City when their special services were required.

Initial contacts in the community were established without too much difficulty. On a bright day in late August we drove the 50 miles from our Prairie City base to Prairie Town. Our first stop was at a local store, whose owner we already knew. We explained to him that we were interested in learning what the townspeople thought about the mentally ill. During our discussion, he posed a question which we were to hear many times: "Why do you want to know what we think? Why not go to the experts?" To this question we developed a standard reply: We countered with the question, "Who sends people to mental hospitals?" In answer, people usually placed the responsibility on the local doctor, but when we then asked why the mentally ill person had been taken to the doctor in the first place, they usually recognized that the ultimate responsibility rested with the family and neighbors of the ill person. We told the storekeeper that many experts felt that some of the patients in mental hospitals might not be as ill as those who remained harmlessly in the community, and pointed out the role of community beliefs and attitudes in bringing about the situation.

From the storekeeper we got a list of people who were influential in the community. The list included not only town officials but many executive officers of local clubs and organizations. Over a period of about a week we called on each of them. We talked about our survey, asked for permission to attend their club meetings from time to time, and volunteered to help plan their programs for the coming winter. Their response, in general, was polite and friendly, but they seemed a little puzzled. They accepted our purposes intellectually but had difficulty

understanding why we wanted to collect information without any immediate practical use in mind. We did not yet realize that very few people consider this type of research to be a normal occupation.

When our initial rounds were completed, we had a chat with the proprietor of the local weekly newspaper and gave him a release concerning our program. He promised to cooperate and in the months that followed gave us wholehearted assistance. News stories and articles we furnished appeared in his paper almost every week, in addition to paid notices advertising various facets of our educational program. The proprietor also gave us editorial support on several occasions.

We tried to reach as many people as possible. We used all means and resources usually called into play in such campaigns: motion pictures, pamphlets, special books placed in the local library, notices in the local newspaper, radio broadcasts, speakers, and small group discussions with competent discussion leaders. Not wishing to make this an impractical experiment, we included no items in our program that could not be obtained by an interested and informed citizenry at a cost within their local means. While we promoted a great deal more mental health activity than has ever before been induced in a community of comparable size to our knowledge, a similar educational campaign could be produced again without calling for special outside funds.

The first group to become interested in our program was the local Parent-Teacher Association. The president of the group invited us to its first executive meeting, during which the forthcoming winter's program was to be planned. We attended two executive sessions and were disappointed to find that the quorum necessary for decisions was not present at either meeting. We felt that this was partly due to the fact that the P.T.A. was a new and relatively weak organization, but we were soon to find this pattern of reaction recurring as we met with other groups and executives. We began to believe that the whole town was suffering from some sort of apathy. Only later when we saw the energy and enthusiasm devoted to other town projects did we realize that this "apathy" was in some way connected with what we were trying to do.

Later on, however, the P.T.A. became a source of strength to us. It accepted our help in planning the winter program and joined us to co-sponsor a three-day festival of educational films on child care. It also did a good deal of work in helping us produce a series of 12 half-hour radio programs in which local children and adults held panel discussions on children's problems. These programs were popular and had a good listening audience.

Community "apathy" was evidenced in other situations. Some local citizens felt it might be useful to form a group to discuss the development and mechanisms of human personality. We were quite eager to help with this. First, we discussed the idea informally with a few people and then called a meeting to discuss the formation of such a group. It was decided that the theme of the discussions would be "Why I am as I am" and that the group should meet every second week

throughout the winter. Several came to the organizational meeting without specific invitation; fourteen persons were present. Enthusiasm seemed to be high and almost everyone claimed to know of others who would be interested. Expecting a large turnout, we arranged for two other specialists from Prairie City to attend the first meeting so that the participants could divide into small discussion groups with one informed person in each group. When we arrived at the rather large meeting room, we found a total attendance of five persons. Although this group eventually grew larger, the small initial turnout typified community response to our educational efforts.

Another form of "apathy" was evidenced during the history of this discussion group. Peak attendance at meetings grew to about 35, but with the exception of a few faithful participants, the composition of this group was constantly changing. Thus, five or six newcomers would be present at each meeting, and five or six who had attended previously would be absent. This same pattern occurred at meetings of other groups, although it was more pronounced in this group that continued to meet throughout the winter.

It became apparent that our use of written material was not very successful. The local newspaper, as noted, was especially cooperative and printed whatever material we furnished. However, there was little evidence that these stories were widely read. Similarly, the demand for the pamphlets we offered at meetings and advertised in the newspaper or on the radio proved to be very slight. It seemed that the citizens of Prairie Town were not a pamphlet-reading people. On the other hand, about a dozen popular books on mental health topics we placed in the local library had a very good circulation as compared with the usual rate for new books. The library board, incidentally, felt that any more books on mental health would have caused an imbalance in this direction. Perhaps with some justice, the board has classed these books with those donated by various religious organizations setting forth their doctrines.

Apathy, Anxiety and Hostility

The sparse attendance at meetings, the rapid turnover of discussion groups, and the apparent neglect of our printed educational materials—all these we at first attributed to apathy. As the program progressed, however, we began to realize that what we had interpreted as a general lack of interest in our message and as indifference to our program was actually something very different and far more active. The educational program itself was creating unrest and anxiety. When we first came to Prairie Town, the people were polite and friendly. These attitudes changed slowly and subtly; only in retrospect were we able to put together certain incidents and events as evidence of mounting anxiety.

As already indicated, on entering the town we had told people that our object was to learn what an average community thought about mental disease.

In retrospect, we believe that few of them were completely satisfied with this explanation. One way of expressing their puzzlement was to joke about our stated purpose. One man said, "Well I guess you're here because you found out we're all crazy."

The next evidence of the community's discomfort at our presence was a series of rumors that swept the town. One was that "the government" had sent our research team to investigate attitudes toward mental illness because "they" were thinking of building a new mental hospital in Prairie Town. This rumor, while quite unfounded, was not unreasonable in light of the avowed purpose of our program and the content of the questionnaires. The next rumor was less logical: the survey was said to be a "plot" of the Roman Catholic Church. The grounds for this rumor were difficult to find; the local Catholic clergy was definitely, if not actively, opposed to our program. The only possible basis we could see was the fact that a member of the Parent Teacher Association, which was working with us, was a Roman Catholic. About 15 percent of Prairie Town is Roman Catholic.

The faltering attendance at the citizens' study group and the lack of enthusiasm for other aspects of our work have already been cited. As the months went by, people increasingly claimed that "other interests" took precedence over those of our program. One man, asked why he ceased attending an activity sponsored by the project, said, "People say there's nothing to do in Prairie Town, but you could keep going morning, noon, and night if you belonged to everything." During the latter part of the program, we helped a local organization sponsor two very good commercial films, one of which dealt with a mental health topic. Ordinarily Prairie Town attends its local theater faithfully. Since the proceeds of the showing were to go to the local sponsoring organization, representatives sold tickets from house to house. There was no competing event in the town, but despite this the theater was less than half full, an attendance smaller than would be expected from an ordinary poor film on a bad night.

During the early part of the program, the Civil Servants' Association requested us to provide a speaker for one of its meetings. We decided to show the group an educational film on mental health called "Breakdown," made by the National Film Board of Canada. The main incident of the film is the sudden schizophrenic breakdown of a young woman of twenty-three. Knowing from previous experience that the film disturbs some viewers because the heroine's breakdown seems to be "uncaused," we decided to counteract the anxiety thus aroused by conducting a discussion immediately afterward to explain the cause of the breakdown. Although these discussions were held, the Association voted at its next meeting not to have any more mental health films or speakers, despite a previous commitment to present a series of mental health programs.

The most dramatic evidence that our educational program was generating anxiety came from a local citizen who had been closely associated with the project. June was an intelligent, alert woman of about thirty-five. She was very active in

civic affairs and had been instrumental in forming the P.T.A. in Prairie Town. Form the start of our project she welcomed our aid in planning P.T.A. programs, and as time went on became more involved with the activities and materials of our campaign. She had done a great deal of voluntary work, and when the pace of our program was accelerated in midwinter, we decided to employ her as a paid part-time worker. In late winter she became upset. She began to warn us that it would be better if we stopped certain educational activities, saying that they had "run their course" and that "everyone is so busy at other things." Shortly afterward, our staff headquarters in Prairie City received several urgent long distance calls from June. She became so highly agitated that it was necessary to admit her to a psychiatric unit where she was given intensive treatment for a state of acute anxiety. In retrospect, we feel that her association with our anxiety-producing program had caused tension between her and her friends, which had led to her temporary instability.

Not until the program reached its end did the increasing anxiousness of the people of Prairie Town manifest itself in overt hostility to our project. When the interviewers returned to Prairie Town at the end of six months to conduct the second interview of our before-and-after series, they were disconcerted by the coldness of their reception. Those interviewed were guarded and cautious. They asked questions such as this: "What happens if I give the wrong answer?" Some kept threatening to break off the interview. One man of considerable influence in Prairie Town, who was scarcely involved with any phase of our program but who had noted its general effects, said to us, "You've sure got this town by its ear." He added that he was amazed at the intensity of the excitement and anger in the community. There is little doubt that the people felt our project was directly responsible for June's temporary breakdown.

Not only did the interviewers meet with reluctance to cooperate, but with active and angry refusal as well. They had been in Prairie Town only a few hours when the wife of one of the original members of the study group telephoned and declared curtly that she did not wish to be interviewed, refusing to give any reason. Shortly afterward her husband, an agricultural scientist who had been an early and active member of the study group, telephoned us and similarly refused to be interviewed. We told him that he had no reason to assume he would be interviewed again since our reinterview sample was different from the original sample. This assurance had little effect. In ten minutes he burst into the hotel room occupied by the project staff and said angrily, "Withdraw my name from anything you have it on." We again declared we would not involve him in any way and asked why he felt as he did. "There's no reason," he said. "I'm just not interested, let's put it that way—I'm just not interested," and left abruptly.

Finally, as if representing the feelings and wishes of the community as a whole, the mayor of Prairie Town approached one of our interviewers and

inquired what he was doing there. He proceeded to question him at length as to his credentials and his right to conduct the interviews. Then he said, "We have had too much of this sort of thing. We are not interested in it in this town any more. The sooner you leave the better." Although the mayor was finally mollified, it was evident that we had worn out our welcome in Prairie Town! It is significant that it was not the education team who felt this hostility but the interviewers, who were virtually unknown in the town. Thus, there appears to have been hostility to the material rather than to the people who carried it.

At the end of our educational program, when both the attitude questionnaire and the intensive interview were administered a second time, there was some falling off in the number of people returning the questionnaire, but it was not enough to bias the results to any appreciable extent. Similarly, fewer people were willing to submit to the interview on this second occasion, but our sample was not significantly affected by this difference. Results were surprisingly clear-cut. After an intensive educational campaign of six months, virtually no change had occurred in attitudes toward or beliefs about the mentally ill.

It could not possibly be argued that we had not touched our community, that our message had simply failed to reach the 900 adults in Prairie Town. The intensity of response to our program was amply evidenced by the man who commented, "You've sure got this town by its ear." The widespread and openly manifested hostility that greeted our returning interviewers could scarcely betoken indifference or ignorance. The people of Prairie Town knew we were there, knew that we were trying to change their ideas, and refused stubbornly and actively to accept that change. It was evident that we had been trying to change ideas that were very deeply and firmly held and that the more energetically we tried to dislodge them, the more tightly people held onto them and the angrier they became at us for trying to take them away.

The results of the attitude questionnaires and interviews, systematically analyzed after we had left Prairie Town, revealed that some of our efforts had been misdirected. The primary purpose of giving tests before and after the educational campaign was to ascertain whether and in what respects our experiment had succeeded in changing popular attitudes concerning mental illness. As it turned out, the interview material also served another purpose: it supplied clues that enabled us to understand why our attempts had incurred hostility. What did the test show?

Attitudes Toward Mental Illness

After we had become well accepted within Prairie Town and before beginning our educational program, we persuaded several local groups to help us distribute a two-page mimeographed paper-and-pencil questionnaire. One Monday afternoon a copy of this questionnaire for each adult was distributed to

every house in town. The volunteers also distributed a reprint of an editorial from the local paper urging cooperation with our project. Later that evening the same group picked up the filled-in questionnaires.

At about the same time, a group of six psychologists and social workers trained as interviewers administered a long interview schedule to a carefully randomized sample of 100 adults. The interview schedule was much more intensive than the questionnaire and sought information on a wide variety of topics relating to mental illness. The interview schedule was developed by the National Opinion Research Center of the University of Chicago under the direction of Dr. Shirley Star and has been administered in the United States. The interview reached fewer people but at a deeper level than the questionnaire. The two research instruments, when the data were later analyzed, produced a fairly detailed picture of how the people of Prairie Town felt about the mentally ill.

The questionnaire was answered and returned by 540 people, or about 60 percent of the adult population. It consisted of a number of yes-or-no questions on two topics: whether people were willing to associate with those who had been mentally ill and under what circumstances; and whether they felt in any way responsible for causing mental illness or caring for the mentally ill.

Answers to the questions on willingness to associate with former patients revealed wide variation in attitudes, roughly corresponding to the different social and economic positions of community members. In general, the community-minded people-who tended also to be younger and better educated-appeared more willing to associate with those who had been mentally ill than did the "puritan" group, who tended to be in lower economic brackets and less well educated. Willingness to associate with former patients depended on the intimacy of the association. For example, 78 percent replied they would not object to having a discharged mental patient in their club but only 32 percent said they felt it would be possible to fall in love with someone who had been mentally ill. Thus, data from Prairie Town supported our assumption that people tend to fear and avoid the mentally ill. The questionnaire further indicated that degrees of proximity varied with the type of respondent and the type of situation in which the association occurred. Of course, it is likely that in an effort to appear enlightened and tolerant, some respondents expressed greater willingness to associate with the mentally ill than they really felt.

Answers to the questions on responsibility also showed wide variation, but this was not related to social and economic differences. Rather, it depended on one's notions as to the cause of mental illness. Those who believed that the causes of mental illness were primarily biological did not feel so responsible for the mentally ill as, for example, those who believed mental illness was mainly due to social and economic factors.

The interview schedule was administered to a sample of 100 adults, as already mentioned. Most of the questions were "open-ended," permitting people to express their opinions quite freely. The interview material was typed in detail and stored

in Prairie City until it could be analyzed at leisure after the educational campaign ended in Prairie Town. When the results of the interviews were finally processed, this paramount impression emerged: popular thinking about mental illness appeared confused and inconsistent. Conceptions of the nature, cause, and treatment of mental illness seemed hazy and frequently contradictory. In general, the people tended to regard as "normal" a much wider range of behavior than psychiatrists would. Behavior that would seem clearly pathological to a psychiatrist would be dismissed by many respondents as "just a quirk" or by saying "he'll get over it" or "it takes all kinds to make a world."

As part of the interview, six "cases" were briefly described, each typifying a different form of mental illness according to psychiatry. These were presented as specific individuals. Only their behavior was given; no psychiatric labels were attached. Most of those interviewed agreed that the description intended to exemplify a paranoid schizophrenic was indeed that of a person who was "mentally ill." But for each of the other five cases, a majority of the people denied that the person described was mentally ill. Between 65 and 76 percent rendered the judgment "not mentally ill" in the cases representing respectively a chronic alcoholic, a woman with simple schizophrenia, and a man diagnosed clinically as "a depressive with underlying suicidal tendencies," although more than half the respondents agreed there was "something wrong" in each of these three instances. Only 4 percent thought the case of a delinquent boy reflected "mental illness," and many found the behavior of a compulsive girl with phobic features praiseworthy because of her excessive care concerning details.

The question "What is mental illness?" drew a wide variety of answers. Most respondents tended to make a sharp distinction between insanity or mental illness (considered serious and virtually incurable) on the one hand, and "nervous" disorders (less serious and amenable to treatment) on the other. However, in citing symptoms, they tended to attribute the same symptoms to both types. Asked to characterize mental illness, they cited a wide range of attributes: unpredictability, violence, irrational behavior, anxiety states, withdrawal, depression, and others. Of these, "unpredictability" was most frequently cited.

However, it appeared that the single most important criterion for adjudging a person sane or insane was whether or not he had been institutionalized. A mentally ill person was someone whom doctors had acclaimed mentally ill by placing him in a mental hospital. Thus, it can be inferred that the same behavior that was judged "normal" in a nonhospitalized person was judged "abnormal" in one who had been hospitalized.

Notions of the cause of mental illness appeared to by unsystematic and often mutually contradictory. Many factors were cited as capable of causing mental illness, ranging from purely biological factors to bad social conditions. In general, the human organism was visualized as a machine in very delicate balance, easily upset or put out of order. A small number of people attributed mental illness to moral dereliction, a punishment for failure to live a clean and moral life.

Conceptions of cure of mental illness were related to ideas of its cause. Those who saw biological factors as causing mental illness tended to believe that it could be readily cured by a doctor or a nerve specialist, who would fix up the "nerves" that had gone wrong. Those espousing moral causality felt that mental illness could be cured by returning to correct moral behavior and seeking salvation.

Almost everyone expressed great confidence in the effectiveness of mental hospitals as agencies of cure. If the machinery of the body was easily thrown out of kilter, it could as easily be righted. This picture of mental illness as something readily cured by doctors and hospitals appeared to contradict the conception of mental illness as essentially incurable. Similarly, the picture of mental hospitals as highly effective agencies of cure appeared inconsistent with the tendency to class as "mentally ill" only those who had been hospitalized.

Attitudes toward the mentally ill expressed during the interview were similar to those revealed by the paper-and-pencil questionnaire. Half of those interviewed felt that insane people were dangerous to be near. More than two-thirds claimed that while they personally would not feel differently toward someone who had been mentally ill, others would; it is likely that the attitude attributed to others was really their own.

Why the Hostility?

It will be recalled that an important motive for trying to change popular attitudes toward mental disease was our conviction that misconceptions about the cause and nature of mental illness were harmful to discharged patients, tending to drive them back to the hospital. It will be recalled that our educational program aimed to replace erroneous conceptions with three basic ideas: the range of "normal" behavior is wider than is generally realized; abnormal behavior does not just happen but is caused and therefore subject to change; abnormality and normality are not two separate and unrelated states, but rather differing manifestations of the same kinds of behavior.

The results of our attitude questionnaires and interviews showed us that some of our educational efforts were misdirected. The "fit" between their set of ideas and ours appeared haphazard and unsystematic. Apparently the people of Prairie Town not only already believed that a wide range of behavior was "normal," but were willing to accept as normal an even wider range of behavior than were most psychiatrists. As to our next point, that disturbed behavior is "caused," the people of Prairie Town already knew this. They differed from medical personnel in that they imputed a different set of causes-a set more ramified and inclusive and yet less logically consistent than medical notions of etiology. It was our third idea-that there is a gradation rather than a sharp division between normality and abnormality-that diverged most strikingly from popular conceptions.

It was our hope that the net results of our program would be to make people more accepting of the mentally ill and more willing to act toward them as they did toward "normal" people. It was precisely this result that the people of Prairie Town seemed determined to prevent. Their ideas about mental illness and the mentally ill appeared inconsistent and often illogical when judged in terms of our ideas, but looked at in their own terms they were consistent, even reasonable and necessary. The whole set of ideas, beliefs, and attitudes about mental illness held by the people of Prairie Town was a response not to considerations of empirical truth, but rather to the needs of the community. For the community of Prairie Town, it was far less important to know the detached "truth" about mental illness than to have some workable way to handle the difficult problem of mental illness. A crucial element in their method of handling this problem was belief in a black-and-white difference between the sane and the insane, and the concomitant conviction that the mentally ill must be removed from the community. These popular ideas were diametrically opposed to those our educational program sought to teach. As we worked to determine the popular ideas and replace them with "correct" ideas, people became increasingly upset and angry. Why should this be so?

From the point of view of the people of Prairie Town rather than from a scientific or clinical standpoint, their ideas concerning the nature, cause, and treatment of mental illness formed a consistent pattern, one we can call the "pattern of denial and isolation." Many aspects of the behavior of the community became meaningful once we began to view them in the context of this pattern. Briefly, the pattern is as follows: People tend to deny the existence of abnormal behavior for as long a time as they possibly can. When behavior becomes so deviant that it can no longer be tolerated or construed as normal, people act to isolate the mentally ill person, both physically and conceptually.

The attitudes expressed in the questionnaires and interviews, as well as the observed behavior of the people of Prairie Town, testify to this pattern. Responses to the psychiatric cases in the interviews showed that the people tended to deny the existence of disturbed behavior, to "normalize" what was clinically mental illness. A very wide range of behavior was accepted as "normal." Having a wide and heterogeneous conception of the cause and nature of mental illness helps to maintain this acceptance. However, once a person is definitely categorized as "mentally ill," usually because he has been hospitalized, people's attitudes sharply reverse themselves. Instead of saying in effect, "He's just about like everyone else," people say, "He's very different from everyone else and must be separated from normal people." The attitude questionnaire showed that people wished to avoid close contact with the mentally ill. It also showed a considerable fear of disturbed persons, as we had anticipated, along with a tendency to be ashamed of that fear.

The feeling that mental hospitals are good places and will cure the mentally ill is connected with the desire to put out of one's mind all thoughts of a

mentally disturbed friend or relative. Once a person is placed in a mental hospital, he is "put away" both physically and from one's thoughts, and the picture of the mental hospital as a desirable place helps to assuage the guilt a person might feel at so isolating a friend or relative. Once a person is admitted to a hospital, he is virtually deserted by friends and relatives, as if contact were somehow contaminating and dangerous.

It is evident that this whole complex of beliefs and attitudes is a product of the community's attempt to solve a perplexing problem. At the core of this solution is the need of the community to separate itself from deviant people. The people themselves indicate that "unpredictability" of behavior is the basic reason they fear the mentally ill, but since most of the mentally ill are scarcely less predictable than anyone else, it is likely that people equate deviation from behavioral norms with unpredictability. The pattern of denial and isolation arises from the attempt on the part of the community to maintain its code of conduct and hence its own integrity by protecting itself from deviant behavior.

The reasoning runs like this: There are two main kinds of people-people like you and me, and the mentally ill-and there is a sharp line between them. When a person's quirks, odd habits, "different" behavior, funny actions are still reasonably close to those of most people, he belongs in the ranks of the sane. The community tries to keep him there by "denying" as long as possible that such behavior constitutes mental illness. But if the behavior of the disturbed person produces some conspicuous results-a breakdown, commitment to a psychiatric ward, an undeniable breach of the laws of society-the community then mobilizes to protect itself and its rules of conduct. It does so by suddenly branding the disturbing person "insane," a verdict carrying the sentence of banishment. He is now in a completely different category from "normal" people and must be treated differently. The community, in order to maintain the sanity and balance of its members, must dissociate itself from the now dangerous deviant.

It may now be understood why our educational efforts caused so much disturbance in Prairie Town. In our attempt to produce a more permissive climate for former mental patients, we conveyed the idea that they were pretty much like everyone else, and that there was no sharp line dividing the sane from the insane, but rather a continuous range of behavior. In stressing this idea we were hammering directly at the core of the community's own solution to the problem of the mentally ill. Our problem was not theirs. We were concerned with the cure of the mentally ill; the people of Prairie Town were concerned with the stability and solidarity of their own community. In striving to achieve our purpose, we violated theirs.

From our therapy-centered viewpoint it was evident that mental hospitals are not the best means for curing the mentally ill; the hospitalized patient is maintained in an artificial situation isolated from the beneficial influence of normal social intercourse. In trying to educate the community to this point of view we challenged a basic part of their solution to the problem of mental illness. The community

"solves" this problem by putting the mentally ill in a class apart and keeping them in isolation, but underneath it is uncomfortable about the solution. Doubts as to whether this is really the right way come to the surface from time to time. People cope with these doubts by reassuring themselves and one another that the mental hospital really is the best place for anyone mentally ill, that people are cured there, and that their hospitalized friend or relative is really being helped much more than if he remained in the community. We have noted the almost pathetic eagerness of the relatives of the hospitalized mental patients to assure themselves that this was a good hospital, or at least better than most others.

By informing the people that many mental hospitals were in fact overcrowded, inadequately staffed, and maltherapeutic, we were destroying the device people used to assuage their guilt over having exiled their relatives. If people accept our assertion that mental hospitals were undesirable or even harmful, they would have to face their own inner feelings of guilt and shame, feelings that had been kept in check by their motivated evaluation of the mental hospital as a "good" place.

In short, Prairie Town's pattern of beliefs and attitudes toward mental illness was not merely a patchwork of half-truths, fallacies, and inconsistencies, as appeared from a first inspection of the interview data; it played an important part in preserving the well-being of the community and the peace of mind and self-esteem of the average individual. When they sensed that our educational program was a concerted attempt to weaken and dislodge these protective beliefs, the people of Prairie Town became disturbed and anxious and warned us indirectly to soften our message and relax our efforts. When we persisted, their anxiety went over into active hostility. To protect itself, the community mobilized to eject the disturbing forces.

Implications

We all base our lives on certain cultural assumptions about the nature of disease, the proper way to raise crops, what are wholesome and unwholesome foods, and a myriad of other attitudes and beliefs. It is reasonable to suppose that these are organized into a workable interrelated pattern. Thus, any sudden onslaught on a particular set of beliefs, whether they concern diet or mental illness, may cause considerable dislocation in this whole system. However, attempts to change beliefs and attitudes will probably go on and we can only hope that this will be done more and more skillfully so that the process will become less uncomfortable both for the educator and for the public. What can our experiences in Prairie Town teach us about planning and carrying out similar programs in the future?

The Program in Retrospect

Reviewing the total program, there are a few things we are glad that we did as we did. Among these was our gradual and unobtrusive entry into the

community. We feel sure that this town could not be taken by a frontal assault. The fact that we offered to aid the various organizations in planning their programs facilitated cooperation. Establishing contact with and explaining our program to key figures in these organizations before our publicity campaign began helped in gaining their cooperation. We were wise to have dissociated ourselves from the government and any specific organization already in the town and to have avoided identification with any particular group or person until we could gauge how well they were accepted by their fellow citizens.

There are several factors which we might have anticipated, but did not. For one thing, we had no moral purpose in our stated aims. If we had had such a purpose, greater cooperation would probably have been forthcoming from the various religious groups. In addition, we had no real program of action. That is, we did not, for instance, realize until too late that there was a considerable force in the community that favored building a common recreation center. To have allied ourselves with such a cause early would perhaps would have given more meaning to our campaign. Furthermore, although we had anticipated some anxiety, we were perhaps not sufficiently zealous enough in reading those signals presented to us. Further, we had no suitable program, if such is possible, for dealing with this anxiety as it arose.

Other conditions could have been made evident only by more thorough advance investigation of the community. Had such a study been made we would have been aware, for instance, that the town was divided rather sharply into a low-educational group, which included the Metis minority, and a middle- and upper-educational group. We would have learned in advance that there were two segments within the educated group-"joiners," who made up the membership of most of the town's 70 organizations, and those who admired the puritan virtues and stood apart from most organizations other than the Protestant churches. This knowledge would have alerted us to the difficulty of trying to reach the whole population through these 70 organizations.

Moreover, we would have become aware of the sharp Protestant-Catholic schism in the town, which had been made more intense by the militant activity of a recently appointed priest. We would have found that the dominant Protestant minister had accepted a call to a city church and would probably not be much interested in innovations, and we would have been dubious of the possibility of working simultaneously with Catholics and Protestants. We might have concentrated on working through the Catholic Church to reach the low-education group while attempting to reach the other educational groups through secular organizations.

An advance community survey would have revealed that the technically educated workers in the government agricultural stations were a group separated from the rest of the community. The town regarded them with mixed feelings,

and while they could have damaged the program if they felt slighted, close identification with them could alienate other sectors of the community.

Other factors could not have been anticipated, although better knowledge of the community might have made them easier to cope with. One such unforeseen event involved the local priest. A very cordial relationship was initially established, and there was every likelihood of getting his cooperation in working with the Catholic portion of the community. However, just about the time our program began, a psychiatrist in Montreal made a radio speech in which he implied that religion was detrimental to mental health, and about the same time a West Coast mental health group brought out a pamphlet on masturbation, describing it as a normal and natural part of childhood. These two claims drew a sharp official rebuke to mental health organizations by a high church official, and the cooperation of the local priest disappeared almost overnight.

Similarly, one cannot anticipate the weather. An unusually wet autumn delayed harvesting operations and kept many resident farmers out of town almost a month later than was usual, while a warm dry spring had a similar detrimental effect on the terminal part of our program.

Limits for Health Education

Our experience in Prairie Town may be summarized under four general points. Each of these poses questions for the health educator. First, we found, as others have, that mass media were less effective than group contacts. But in working with groups, we faced the problem that organized groups in Prairie Town were composed of and controlled by a relatively small portion of the total community. What are the techniques by which we can reach the less-educated groups in these communities? How does one present complicated ideas to people who are relatively unable to integrate them into their own experience?

Second, it became evident that people were motivated toward learning only when they felt that the material applied to them personally. How are people to be motivated toward learning without "scare" techniques ("one person in 20 will spend time in a mental hospital"), since scare techniques inevitably produce undesirable side effects? This point would seem obvious from the upsurge of phobias and anxiety states centering around cancer and syphilis after educational programs of this type have been attempted.

Third, we can speculate as to whether a tangible action program or a treatment clinic introduced in the program might have produced more motivation to learn new attitudes and helped to reduce anxiety. If such extension of a project is sometimes advantageous and sometimes detrimental, are there criteria for judging when such extension is advisable and when it is not? When does extension of a program make it more vulnerable by providing more areas in which to make mistakes?

Finally, our experiences in Prairie Town made it abundantly clear that any energetic attempt to change attitudes and beliefs will produce anxiety. To some extent this is true even for areas of apparently minor importance, such as attitudes toward the use of powdered eggs or a new kind of seed corn. But this phenomenon becomes increasingly evident as one begins to deal with beliefs and attitudes closer to the core of a people's culture. The pattern of beliefs surrounding mental illness is certainly close to this core because it touches the very network of interpersonal relations that binds a community together. Any attempts to change existing attitudes in so vital an area must be approached with caution. There seems to be little doubt that anxiety will be aroused no matter how carefully one plans or how cautiously he proceeds. Would virtually the same results have occurred had we based our program in Prairie Town on better knowledge of the community and more sophisticated assumptions, avoiding the various practical and organizational pitfalls just cited and spreading our educational program over years rather than months?

This poses questions for the worker attempting mental health education. Can the anxiety associated with efforts to touch this area be lessened by moving more slowly, working less intensively, using different techniques, or confining such education to optimally receptive communities? Can a set of techniques be developed for handling this anxiety? Can it be controlled and made to facilitate rather than disrupt the learning process? Is it wise to attempt such a program at all? If "erroneous" beliefs about mental illness in fact fill a critical social need, should the effort be made to change them? Will the benefits accruing to the mentally ill outweigh the possible "cost" to the community in augmented insecurity about its own sanity and standards? If misconceptions about the mentally ill serve to reaffirm the solidarity of the sane, how can health workers best avert the risk of disrupting this solidarity? The case of Prairie Town has not answered these questions nor could it answer them, but it has shown clearly that they must be asked.

Summary

A six-month educational program designed to alter popular attitudes toward the mentally ill was carried out in a small Canadian prairie town. Questionnaires and standard interviews were administered before and after the educational program to measure its effects. The tests showed no appreciable change in beliefs about mental illness or attitudes toward the mentally ill as a result of the program. Interviews and other data pointed to the existence of a community "pattern of denial and isolation" as a method for dealing with the threat of mental illness: the existence of abnormal behavior is denied as long as possible; when denial is no longer feasible, the degree of abnormality is exaggerated and the ill person is isolated socially and conceptually, as well as physically. Although malfunctional in reference to the rehabilitation of the mentally ill, this pattern

appeared functional in reference to the maintenance of community solidarity. Efforts to change parts of this pattern by education produced anxiety and hostility. The Prairie Town experience indicates that mental health educators must carefully take into account the social function of beliefs about mental illness, anticipate the occurrence of anxiety, and prepare themselves for difficulty and slow success.

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Hamilton, Missouri: A Community Development Process Case Study

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ABSTRACT

A Classical community development process approach was applied in a northwestern Missouri community. The article provides a case study of how the community revitalized itself to meet citizen needs. The development stages—policy formulation, recognition, intelligence, commitment and accomplishments—are discussed.

Community development, as exemplified in Hamilton, Missouri, is a self-help, democratic process. Leadership training and development, involvement of persons representing a broad spectrum of background, capabilities and interests, and promotion of an informed public are integral components of this process (Littrell, 1980:64-71).

Local community development efforts are often carried on with the assistance of area extension community development specialists who live in the area they serve. The specialists are active facilitators whose work with citizens extends beyond the scope of economic issues. They respond to citizens' needs with their own expertise and the resources they can bring from the land grant university and other institutions. Their contacts with citizens in several communities are frequent and often entail intense involvement over an extended period. These area specialists are given technical support by state specialists in community development and other specializations.

This case study portrays a continuous process of investigation, planning, and action-a process at work in many rural communities throughout the United States.

Local citizens are working to improve their abilities to make decisions, work with others, and to make the best use of available resources.

The study was first developed around a policy formulation process described by Lovan (1986) for use by a rural revitalization effort sponsored by the Organization for Economic Cooperation and Development. The policy model in its simplest form presents three basic stages of development: (1) recognition, (2) intelligence, and (3) commitment. The following narrative report of the process in Hamilton attempts to show those three stages and then adds an accomplishment stage.

The Situation

Hamilton, Missouri, in Caldwell County, was slowly deteriorating as a community. A combination of a depressed agriculture, a changing production economy, a shift of retail business to other larger centers, and the gradual migration of young people to other areas had eroded both local employment and retail sales. Many buildings in downtown Hamilton were empty and many of those still occupied were showing signs of age, lacking adequate maintenance. The railroad that had been part of the first line across Missouri was closing down. Pride was low in this small rural community of 1,600 people.

By 1983 Hamilton appeared to have lost its spark. Many of the changes that had taken place had crept up on the people of the town. The spark that kindles pride in community and hope for the future was nearly extinguished when the railroad announced it would abandon the line through town. The railroad's decision startled Hamilton's residents into open recognition that their town was dying.

There had been sporadic revitalization efforts prior to 1983. An industrial development corporation (a branch of the Chamber of Commerce) had existed for several years, but competition for the small number of new industrial plants was stiff. The corporation's sole success had been attracting a bowling alley to improve recreation services. Some members hoped there might be additional ways to improve Hamilton and its economy other than through "smokestack chasing."

The University of Missouri extension community development specialist serving north central Missouri had responded in the past when different community groups had sought help or information related to specific community problems. The community development specialist also had suggested exploring a variety of development opportunities.

Other university-sponsored activities had occurred over several years that helped develop the awareness of community potentials which eventually resulted in an active development program. A 1976 presentation was made by a state specialist in community development that identified the architectural potential of nineteenth century downtown commercial buildings and suggested

ways to renovate them that would improve the appearance and preserve cultural heritage.

In 1980 a rural youth leadership development workshop was conducted by university faculty in which adults who assisted learned about developing human and natural resources. In 1981 an extension rural sociologist made a presentation concerning trends that affect community growth and decline.

Recognition of the Situation

The response to these presentations and other activities prior to 1983 was positive, but ideas often take a while to germinate. The closing of the railroad was the catalyst that prompted action in Hamilton.

Motivated local leaders requested help from the extension community development specialist. The specialist told them of the university's model for conducting economic base studies and suggested they begin their exploration by using this model to analyze Hamilton's economy.

The economic base study revealed some surprises. It was found that income from agricultural production for Caldwell County was a relatively small and declining percentage of total income, and that bad years in agriculture only marginally affected the local economy, although there were serious social impacts. Transfer payments to senior citizens proved to be the largest single source of local income.

Several local retailers acted immediately. They modified marketing strategies and merchandise lines to target more of their goods and services toward senior citizens. Businesses reported sales were good on the new items.

Several meetings were held to discuss a variety of strategies to improve economic activity. No single strategy emerged as a panacea to all the problems, but collectively they showed greater potential than concentrating only on industrial recruitment.

Community members filled out a one page "Rate Your Community" scale at a public meeting. The results highlighted Hamilton's shortcomings as perceived by this group of citizens. The community leaders were pleasantly surprised to find that over 75 percent of those responding indicated they were willing to help bring about change if someone would assume leadership in proposing projects.

The Intelligence Gathering Phase

Encouraged, the study group decided to conduct an in-depth survey of community attitudes toward Hamilton's public and private services. The Junior Chamber of Commerce led in developing and distributing the survey in early 1984. The results were analyzed by the community development specialist and a state

extension specialist in the Office of Socio-Economic Data Analysis. Opportunities for specific action emerged.

The survey revealed that people were generally positive about local businesses and thought the sales people were pleasant and courteous (83 percent). Respondents indicated a need for restroom facilities downtown (72 percent) and felt that improving the appearance of downtown would attract more business (69 percent).

Community members expressed a strong need for recreation and entertainment for young adults (55 percent) and nearly all (87 percent) said that Hamilton needed more employment opportunities. More than 70 percent felt efforts to gain new industry were inadequate.

Citizens also identified enterprises missing from Hamilton's business district. As one outcome, a local individual has equipped and now operates a laundromat. In addition, grocery stores have extended their hours to accommodate people who work out of town.

There were a number of assets in the community that people thought could be bases for growth. It was proposed that the nearby J.C. Penney birthplace be purchased and moved into town near the existing J.C. Penney museum to encourage tourism.

Several people recalled the downtown architecture presentation that occurred in 1976. A local young man majoring in architecture accepted the challenge to develop drawings of feasible changes in the commercial buildings. He and his classmates also completed and presented a downtown park and landscaping plan in 1985.

During 1984 and 1985, several public meetings were sponsored by the development group and by local officials to hear and benefit from resource people with experience in problem solving on issues affecting Hamilton. Acting as a broker, the community development specialist made important contributions by identifying and obtaining the services of these resource specialists.

Citizens discussed problems and possibilities with experts from the university, state agencies and national non-profit organizations. An awareness of purpose and a sense of self-reliance emerged in Hamilton.

Several members of the loosely knit development group attended a "Main Street" conference in St. Joseph, Missouri, in April 1985. "Main Street" is a national program that provides a strategy and technical assistance to rebuild the commercial sector in communities with a population of less than 40,000. The Hamilton participants came home from the conference with renewed enthusiasm.

By mid-1988 there were over twenty task forces, short- and long-term, studying different issues and developing plans. Their concerns included quality of life community issues as well as the exploration of economic potential. For example, one task force began exploring the establishment of a business incubator. Another began to look at ways to help people who had lost their farms.

The Commitment Phase

The combination of the community development process advocated and practiced by the area extension community development specialist and the "Main Street" strategy proved to be the springboard that launched the community into concerted efforts to develop its own program. The development group formally organized itself as "Hamilton Second Century" and initially formed six task forces: (1) Merchant Support; (2) Tourism; (3) Landscaping; (4) Promotion; (5) Rural Crisis; and (6) Organization. Goals were selected, data bases for each task force were established, plans were developed and activities initiated.

"Hamilton Second Century" has assumed an informal governing role. It is an organization outside the existing formal government structure and, as such, provides leadership for the development process with an inherent flexibility that is difficult to achieve through the formal system. The organization is in a position to experiment, undertake tasks that the city government is not legally empowered to address, and take risks that government cannot. For example, the development organization has purchased land for special development, helped businesses get started with a small venture capital fund, and sponsored special workshops and meetings that would have been politically risky.

"Hamilton Second Century" coordinates idea generation, discussion and planning. Other organizations (which function independently) often assume the responsibility for implementation. The high level of commitment among Hamilton's citizenry is underscored by the broad spectrum of individuals and organizations that have accepted the coordination role of "Hamilton Second Century". These include, for instance, retail business people, bankers, a publisher, a locker plant operator, farmers, service providers, manufacturers, housewives, a garden club, the Chamber of Commerce, the Junior Chamber of Commerce, schools, a nursing home, and developers.

Throughout the citizens' efforts, excellent coverage by the local newspaper and radio station has informed the general public of their activities, shared intelligence, and provided well-deserved recognition. Dissemination of information through reports to various organizations and by word of mouth was also very effective.

The Results

The six original task forces are proud of their efforts. They have been joined by others to make a body of more than twenty task forces working on various ideas and opportunities.

Successes include:

- Thirty new businesses have opened in four years, ranging from a laundromat to a mall remodeling firm. Although a few businesses have closed, they all have been purchased and reopened by someone else.

- Design packages prepared for business people who wish to renovate buildings. (Three have been used so far.)

- Financial assistance provided for a new light industrial plant. (Six new jobs have been created.)

- Expansion of a private nursing home (40 new jobs) "because the attitude in Hamilton is positive."

- The J.C. Penney home has been acquired. (It was moved to a downtown park and renovated.)

- Approval of railroad land purchase for a downtown park and tourist center. (Some land already has been purchased.)

- Organization of a bus tour by a regional tourism organization.

- Purchase and operation of a rail line by a regional consortium.

- A reactivated garden club which is taking responsibility for downtown plantings, including trees.

- North Missouri steam and gas engine show adopted as a major promotion.

- Logo designed for T-shirts and caps sold to raise funds.

- Several fund-raising events sponsored (including softball tournaments and dances).

- Sponsorship of a seminar on effects of bankruptcies and farm foreclosures.

- Opportunity Day instituted to provide a positive focus on career change and training opportunities available to farmers.

- Receipt of a demonstration grant to establish an emergency assistance center to aid rural families. (The center is staffed and functioning).

- Creation of an independent board of directors to work with the city of Hamilton.

- VISTA (Volunteers in Service to America—often called the "domestic Peace Corps") proposal accepted and funded twice.

- A second VISTA worker recruited to assist with the local VISTA project. (This was undertaken at the suggestion of the regional VISTA office.)

- Fifth place award for community efforts the first year Hamilton entered the Missouri Community Betterment Program, a statewide competition. Subsequently, the community received the third place award.

- Established J.C. Penney Days to annually recognize local efforts and bring in speakers who have special skills in development.

Members of the community have been involved with a number of regional and state conferences during the last three years. They have presented the Hamilton story and, in return, have learned from other communities who are working to cope with the changing world economy.

The Community Development Process in Hamilton

The citizens of Hamilton engaged in deliberate discussion to identify, explore and take action on issues affecting their community. They learned how to create a community environment compatible with the larger world and still meet their local needs and wants.

The period prior to 1983 was a slowly developing recognition phase for the community of Hamilton. Local leaders tried to improve the economic and social environment through several projects, but community energy had not been activated.

Several educational programs had been conducted, but still were being digested. The elements were present for the beginning of a concerted development process, but the spark had not yet ignited the fires.

The loss of the railroad and the deepening agricultural economic crisis stimulated local leadership to a commitment for constructive action. This does not mean that community development can only be done in a crisis; it appears, however, that the process is more condensed and intense when there is a strong element of immediacy.

The recognition that something needed to be done to prevent Hamilton from continuing to decline in business, population, and vitality prompted leaders to study the community and find out how it operates. The economic base study, the survey, and the public meetings provided the intelligence for doing this.

Concern and commitment to action were evidenced by the regular attendance at meetings and participation in the study. Local leadership contributed to the success of all stages of the development process.

As people learned about their own community and listened to the ideas of outside resource people, they began to develop strategies to deal with their situation. The more involved they became, the more their commitment grew.

The formation of a new, independent organization—"Hamilton Second Century"—promoted participation of people who were not involved in the formal government of Hamilton and further increased commitment within the community. Each of the task forces developed new leadership, expanded the base of participation, and implemented projects important to the overall effort. When "Hamilton Second Century" was organized, it was with the knowledge that the members were embarking on a comprehensive community development program.

City government was not in the forefront of the development effort, but provided assistance upon request. The city's commitment to the program has included legal support, equipment for various activities, office and clerical support, and encouragement.

The Hamilton experience is an example of the community development approach to local policy decisions and program implementation. The community, with the help of the area extension community development specialist, looked at itself, drew on outside information, defined gaps between what it was becoming and what it hoped to become, began exploring ways to move toward its preferred future, and initiated action to bring about that future.

This is essentially a refinement of the situation described by de Tocqueville a century and a half ago. Raise a problem with people in an American community and they will call a meeting to discuss it, propose solutions, select a course of action, and carry it out.

Today, Hamilton is a proud community on the way back to economic and social viability. As of August 1989, every business front on Main Street was occupied except the hotel (which has been purchased and donated to the city) and a recently closed beauty shop that is for sale. Plans are being formulated to obtain a historical site designation for the hotel which will then guide its future use. Most communities would consider themselves well-off if forty-four of their forty-five Main Street business fronts were occupied.

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Community Health and Development: Applying Sociological Concepts to Practice

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ABSTRACT

Health for all is a priority social goal set by the World Health Organization. In an international agreement, the world community has agreed to address global health needs through primary health care. Key to primary health care is community health development, a social systems approach to health care based on sociological concepts. This article defines community health, discusses primary health care, and examines the application of selected sociological principles to community health development practice.

"Health for all by the Year 2000" was the challenge issued by the World Health Organization (WHO) in 1978. Declaring health to be the most important social goal in the twentieth century, WHO (1978) proceeded to describe a framework for the achievement of global community health. The approach to be used was called primary health care, a community-based, intersectoral approach which places health within the context of community development. Although the desired outcome-a state of complete physical, mental, and social well-being-may seem like an impossible dream, member nations of WHO (including the United States) have signed an agreement titled the Declaration of Alma Ata, pledging to promote global health within the guidelines for primary health care. Although the goal of health for all is still distant, the efforts to implement primary health care are worthy of note. Setting health in a social rather than a medical context, community health developers have applied a variety of sociological concepts and methods to the

pursuit of community well-being. This article will define community health, discuss primary health care as the framework for promoting health, and examine selected sociological concepts used by community health developers.

Community Health

Twaddle and Hessler (1977) referred to community health as a normatively described social label. Norms define what a community accepts as adequate health, how community members feel about health and the lack of health, and what level of functioning is expected by the community. WHO (1978) has defined health as a state of complete physical, mental and social well-being, with wellness being described normatively by each community. Jazairi (1976) observed that a major problem of defining community health in terms of a positive degree of wellness is that community health is a set of interacting and intersecting characteristics, rather than a single observable entity. Blum (1974) identified the health components of the community system as being the physical, social, cultural, political, educational, and economic environment, group behavior, health care services, and hereditary characteristics of community members. Acknowledging the complex nature of community health, Blum included both process and outcome components in defining health as the capacity of an organism (e.g., community) to maintain a balance appropriate to its level of development and social needs, with relative freedom from gross dissatisfaction, discomfort, disease, or disability, and to behave in ways which promote collective survival as well as individual self-fulfillment and enjoyment.

Cottrell's (1976) concept of community competence has formed the basis for several contemporary definitions of community health. Goeppinger and Shuster (1988) defined community health as the process of effective community functioning or problem solving. Goeppinger, Lassiter, and Wilcox (1982) use Cottrell's concepts in defining community health as an outcome measured by the indicators of commitment, self-other awareness and clarity of situational definitions, articulateness, conflict containment and accommodation, effective communication, participation, management of relations with larger society, and machinery for facilitating participant interaction and decision making. Lackey, Burke, and Peterson (1987) combine Cottrell's concepts with those of Kauffman (1959), Sanders (1953), and Warren (1983) to define community health as a sociological and developmental concept possessing the attributes of attitudes and values, capacities, organization, and leadership.

Primary Health Care

Recognizing the importance of community ownership of a normatively defined goal, WHO has set health within the framework of primary health care. Primary health care refers to the provision of essential health services which are

acceptable and accessible to the entire community. Although societal definitions of "essential" health services vary greatly, international health organizations use the term to mean health promotion and disease prevention services such as provision of clean air, safe water, adequate food, maternal and child health care, immunizations, and health education, as well as basic curative services focused on prevailing health problems. The measures for acceptability and accessibility are socio-cultural, economic, political, technological, and geographic in nature. Community participation in planning and implementation of services is emphasized. The World Health Organization further states that community based primary health care must be a part of overall community development and fit within the context of national health policy and system(s).

WHO (1981a) urges each country to establish national health goals. Traditional public health indicators such as infant mortality are combined with social, economic, and political indicators to measure progress toward community health. Although such indicators often are used comparatively to rank the health status of various countries, WHO (1981b) reiterates that the desired outcomes are to be normatively determined within each country. In the United States, a normative approach to defining and measuring health is found in the "Model Standards" concept developed collaboratively by the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the DHHS Centers For Disease Control (Model Standards Project Wrok Group 1985). Within the Model Standards concept, community-specific objectives for reduction of levels of preventable disease and death were established, and services required to achieve the objectives were designated through a process of community participation and negotiation.

Within the framework of primary health care, WHO (1978) indicated that community health should be promoted through community development. Although the definitions of community development are as varied as the definitions of community health, the Community Development Society, an international organization of community development professionals, has identified six practice guidelines titled "Principles of Good Practice" (Cary, Anderson, Gibson, and Houde, 1989). Good community development practice promotes informed citizen participation in community planning and problem solving, expands community leadership capacity, and avoids actions which might adversely affect disadvantaged segments of a community. Hereafter, the term community health development will be used to denote the promotion of community health within the guidelines and principles of community development. Lackey, et al. (1987) have attempted to operationalize community health development by describing full citizen partnership in a problem solving process which includes assessment of community health needs, analysis and prioritization of problems, and planning, implementing, and evaluating solutions.

Community Health Development: Sociological Practice

To be effective, a community-focused profession must apply sociological concepts to intervention and research. Collaborative planning for the promotion of normatively defined community health through development of a contextually relevant health care system requires an understanding of community norms, values, sentiments, knowledge, beliefs, history, resources, technology, and power structure. To facilitate analysis of community health development as sociological practice, selected concepts will be grouped into two categories for discussion-focus of practice and approaches to practice.

Focus of Practice

The general focus of community health development is social systems. Community health development uses the concept of social systems as an analytical model as well as a practice model. The social systems stance, as noted by Anderson and Carter (1984) and Bertalanffy (1967:93) may be described as "contextual, interactional, transactional, pluralistic, or perspective." Primary health care, as defined by the World Health Organization (1978) is both contextual and interactional in content and process. The primary health care system must be developed through an interactional process and fit within the context of the community's social, cultural, political, economic, environmental, and technological realities as a part of total community development.

A social systems model useful to community health development research and practice is "holon," a term coined by Koestler (1979) and expanded by Anderson and Carter (1984). Holon is used to express the idea that an entity is simultaneously a part and a whole. Each entity or system is made up of parts or subsystems, of which it is the whole or suprasystem. At the same time, the entity or system is a component or subsystem of a larger whole or suprasystem. Anderson and Carter (1984) suggest the designation of a focal system to identify the social system chosen to receive primary attention within the concept of "holon." Focal systems may include communities, organizations, groups, families, and individuals. When analyzing a social concern such as health, the practitioner or researcher must understand the sociological context of the concern at a variety of system levels and analyze the impact of change in the focal system on the suprasystem and subsystems. The primary focal system of the community health developer is the community.

Classic sociological definitions of community are used extensively in community health development. Articles by Hillery (1955) and Moe (1977), in which the authors discuss the multiple definitions of community, are frequently cited in texts and assigned as required reading for students of community health and development. To provide workable models upon which to base practice, some analysts in community health and development have grouped the multiple

constructs and characteristics identified by sociologists into community typologies (Blum, 1974; Turner, 1982). Although the resulting conceptual models are as varied as their sociological forerunners, the community as a social system remains the focus of community health development practice and research.

Approaches To Practice

Social systems as the focus of practice require a comprehensive approach to community needs assessment. An example of a comprehensive sociological model frequently used in community health development is Connor's (1969) "Social Compass." Connor identifies twelve elements of the community social system and eleven patterns of social relationships within the community. The elements are norms, positions and roles, power, leadership, and influence, social rank, sanctions, history, space relations, resources, technology, knowledge and beliefs, values and sentiments, and goals and felt needs. The patterns of social relationships include family, education, economy, government, religion, recreation, social class, communication networks, health, agriculture, and groups. The patterns of social relationships identified by Connor correspond to the sectors of the community identified by the World Health Organization (1978) as essential partners in the process of community health development for primary health care. Ideally, a community health developer would analyze each of the eleven patterns of social relationships using the twelve elements of the social compass for a comprehensive community health assessment.

Planning and implementation are conceptually based on a variety of theories of social change and organizational behavior. Although modified practice models are being developed, the conceptual basis is the same as described in texts about social change and will not be reiterated in this article. The following example drawn from a practice situation is used to illustrate the application of sociological concepts to community health development within the framework of primary health care.

A community health developer was requested by a rural midwestern county health department to assist in the capacity of consultant with the development of a program to prevent the epidemiologically identified problem of teenage pregnancies. The general approach to practice selected by the community health developer as philosophically keeping within the principles of community development was Rothman's (1974) "locality development" model of community organization practice. Within the locality development model, the community was viewed as an equal partner in the change process.

The focal community in the example under discussion was the entire county. Based on an awareness that the initial needs assessment had been based on health statistics, the community health developer recommended a second assessment focused on determining the characteristics and felt needs of the county as related to

health. Using a combination of participant observation and key informant inter-
views, the community health developer guided the staff of the county health
department through a needs assessment and analysis of the health and welfare
pattern of social relationships, using the elements of Connor's (1969) Social Com-
pass. Because of time constraints, the other patterns were addressed in a cursory
manner.

Key information from the re-assessment included the following: Spatially the
county population was scattered. Public transportation was not available. County
demographics indicated a shift from a youthful population to an aging population.
Health ranked low on the hierarchy of community values. Resources were allo-
cated accordingly, with resources for the promotion of health and the prevention
and treatment of disease being minimal.

Health, itself, was defined in two ways. The majority of the county defined
health as being able to work, or, in the case of youth, to attend school. Refusal or
inability to work or attend school was viewed as "unhealthy" or deviant behavior.
A significant minority within the county defined health and illness in a punitive
context, with health being a reward for morally good behavior and illness being a
punishment for sin or misbehavior. Within the majority group, early childbearing
was an accepted norm. Teenage pregnancy was considered a reality of community
life, but not a problem. The norm for the minority group was deferred childbirth,
with marriage prior to initiation of sexual activity being valued.

For both groups, the locus of control for personal and community health was
generally ascribed to the physician. Community health planning was reactive
rather than proactive, with goals being imposed by state and federal health and
social service agencies. Major influence over health decisions belonged to the
physicians practicing in the county, with the county health officer being
gatekeeper for public health issues. Formal power belonged to the county council
responsible for approving and funding municipal programs.

Ranking of community health concerns indicated felt needs of general health
services for working "medically indigent" families and support services for frail or
ill elderly wishing to live at home. The role of the community health developer
during the planning process was that of facilitator and skills builder. Outcomes of
the community health developer's consultation included the decision to reallocate
personnel and financial resources to programs addressing the identified felt needs.

Historically, the health department had attempted to bring about change by
attempting to persuade the medical society to take action. In a Lewinian approach
to change, the medical society as an entity was identified during reassessment of
the power structure as a restraining force, rather than a driving force, in regard to
community health promotion. Driving forces included other health and social
service organizations and agencies in the county, churches, and the potential
recipients of the county health department's services. Staff of the health depart-
ment used a variety of community organization approaches to mobilize pressure

on the county council to redirect the community's limited health resources into priority felt needs. Evaluation of the resulting programs one year after initiation revealed client satisfaction and utilization of the services and an improvement in the county's morbidity and mortality rates. Ongoing evaluation was planned to determine whether the improvement in health data was a trend or a coincidental statistical fluctuation.

Recommendations

Recommendations arising from this analysis are twofold. First, community health development is strengthened by the application of sociological concepts to practice and research. Although introductory courses in sociology are part of most community health and development curricula, practice trends would indicate the need for inclusion of advanced sociological concepts, models, theories, and methods. Second, WHO's definition of primary health care emphasizes interdisciplinary collaboration. If WHO's goal of "Health for All by the Year 2000" is to reached, sociologists must continue to be active members of the community health development team.

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Community Cooperation and Development

Robert C. Anderson

ABSTRACT

The paper describes a phenomenological approach to the understanding and explanation of how people and organizations make the decision to become involved in community action. Three sufficient conditions to induce cooperation are presented. Community action is presented as the result of a cooperative system of people and organizations that choose to become involved independently, based on their absolute and dynamic values. A model for community involvement is described that includes a problem, the social structure, convergence of interest, and goal formation. Formation of effective initiating, recruitment, and execution sets is presented as an important consideration for all community action.

This article is an essay on community-wide efforts at change as seen by the author in more than 30 years of direct experience in the business of community development education. It is written to present core ideas designed to give a clearer understanding of the communities in which we live. We know, to begin with, that each community has a history of successful and not-so-successful "community development" efforts. As a result of these efforts, over time the relationships among people and between their systems tend to become fragmented and highly polarized. Positions are taken; sides are drawn as problems arise and are resolved. Conflicting relationships tend to develop among social systems and the people in these systems when their attention is turned to community development problems. The solutions of these problems generally call for significant commitment and cooperation on the part of units (social systems) and people directly affected by the problem.

A Phenomenological Start

A starting point from which to study the process is to keep in mind that the community, our community, is what we think it is, what we believe it to be or not to be. If we view our community as good, then that is the way we are going to keep it. If we view it as bad, then we are either going to try to alter it or leave it. How we view our community is related to our belief system. It is phenomenological. It has something to do with perceptions, identity, loyalty, and structure. (Boulding, 1961)

The proposition is made that the community—in terms of its people, social systems, and structure—is a cooperative system, not because cooperation is a "good thing," but because it is absolutely necessary in order to achieve community goals (Kanter, 1983; Kelman and Warwick, 1973; Loomis, 1960; Louman and Pappi, 1976; Parsons, 1937, 1960; Weber, 1943).

Despite an almost universal impression of national selfishness and narcissism, Americans are basically cooperative. In fact, there is a widely held cultural belief that it is good to be cooperative and bad to be noncooperative. As a society we tend to shy away from or avoid noncooperative people. But Americans are also pragmatic and discriminate carefully in their patterns of cooperation or involvement. So the basic question is, "Why—that is, in what circumstances and under what conditions—do we cooperate or not cooperate?"

From my scholarship, research, and observation of human behavior, I have worked out this explanation. The general philosophical principle is: *I will not cooperate with anybody, for any reason, on any task that I can do myself* (Anderson, 1963; 1970; 1976; 1986).

I believe that this individualistic, self-centered do-it-myself position characterizes the American people more accurately than participatory democracy, cooperation, altruism, or concern for the well-being of others. When I say this, I am not making a value judgment. I am simply saying analytically that if there is any one principle that seems to govern the behavior of most people, it is the principle that they do not cooperate with anybody on any task they can do themselves.

We all deal with, and are responsible for, very limited resources, the resources of our own time, talent, money, and values. Therefore, it is logical that we ask, "Why should I cooperate?" before making a cooperative commitment.

Clearly, we cannot always remain independent because we haven't the resources to do everything alone. We organize and cooperate to achieve tasks that we perceive are worth doing and that we cannot achieve by ourselves. If any one of us could do these tasks individually we probably would, because then the benefits derived from them would be ours—social recognition, monetary reward, self-satisfaction, or whatever—benefits based on values of importance to us. If I cooperate with somebody on a task, then it is no longer

my project, it is *our* project. I must share the gains or losses associated with it with somebody else.

Once we identify a project worth doing and assess what is needed to get the job done, the relevant principle of involvement is that the only time we should seek *the involvement of someone else is when he or she has a resource that, combined* with our resource, will accomplish the task that could not be independently achieved. Then we tend to share or exchange our loosely held or surplus resources, but not our closely held values.

All acts of involvement have a price tag, a cost, an investment, a responsibility. This cost is reflected in terms of the allocation of our own limited resources and our identification with the resulting product. So when we set up cooperative arrangements, these are not to be entered into lightly. None of us can afford to be so cooperative as to say, "Sure, count me in," every time we are asked to become involved in an activity. That may be why there appears to be some public apathy in most communities. It may well be that many of our community projects are really not worth the cost of commitment called for or necessary to complete the project. Maybe the costs, or the potential losses, are too high. Or it simply may be a project of little or no importance to us at that time. In other words, cooperation may be good and rewarding, not so good and not rewarding, or irrelevant and unnecessary. In fact, it may be harmful (Etzioni, 1975; Kimberly et al., 1980; March, 1965; March and Simon, 1959; Merton, 1959).

We do not really involve ourselves in any meaningful decision making, development, or cooperative act without committing ourselves and our resources to that action. To simply say, "It is a good idea," or "I wish you luck," or "Let me know how it turns out," is not meaningful interaction. It is not sufficient cooperation and does not generally lead to development. Only when we are willing to invest ourselves and our resources are we likely to become a part of community decision making and community development. When we do this, we place our life's values on the line and they cannot be retracted. That is what it takes to get into the decision-making structures of communities and to become a community decision maker for community development. Our personal and organizational resources—name, reputation, what we stand for—are involved.

The Cooperative Process

Community involvement is a very obvious part of community development. Community involvement, by definition, calls for community cooperation, but what is "cooperation?" (Barnard, 1938). Cooperation is a very widely used and generally misunderstood concept in most communities of America. It is appropriate, at this point, to state my ideas about community cooperation in a more precise form:

1. Cooperation is not *good* or *bad*; it may be either or both.
2. Community action is organizational in character, whether it is the informal organization of two people or large-scale formal organizations of 500 people. Community action is an organizational activity and, as such, some common "principles of organization" govern the action.
3. Community actions are interorganizational and therefore cooperative activities. This is true not because of choice or because of the goodness or appropriateness of cooperation, but because of a *necessity* for multi-person/multiunit involvement and commitment for successful community problem resolution.
4. Cooperation is the ordinary business of life in a human society.
5. Cooperation comes into being when: (1) there are persons or organizations able to communicate with each other (2) who are willing to contribute their own limited resources to a cooperative action (3) to accomplish a specific goal.
6. Cooperation occurs only when individual or organizational limitations become significant factors in goal achievement and when the application of the resource energy of two or more persons or organizations has the potential to overcome this limitation.

People must be induced to cooperation or there can be no cooperation. *The net satisfactions that induce people to contribute their efforts to an organization result from their perception of positive advantages as against the disadvantages that are entailed.*

Sufficient conditions for involvement in cooperative community action programs involve at least three elements or postulates:

Postulate 1:

An individual or organization will become involved in, and contribute resources to, cooperative activities that will directly enhance the interest of that specific individual or organization.

Postulate 2:

An individual or organization will become involved in, and contribute resources to, cooperative activities that will directly enhance the interest of a broader community of interests of which that specific individual or organization is a member or part.

When these two conditions are met, it is possible to postulate that:

Postulate 3:

An individual or organization will insist on becoming involved in and contributing resources to cooperative activities that are perceived as serving the actual or potential good of the whole community of interest as well as of each individual or organization holding membership in that community.

The Involvement Process

Given this image of the cooperative process, I now want to describe briefly a model for community involvement. To do so, I have drawn heavily on the work of a number of sociologists at Michigan State University. I believe their work provides a base for understanding community involvement as it really is (Sower et al., 1957; Miller, 1953).

There are three major parts to the model:

1. *Problem recognition, convergence of interest,* and *goal formation*
    (1) Identification of a problem
    (2) Identification of the individual units and groups directly affected, positively as well as negatively
    (3) Development of alternative solutions

2. Establishment of an *initiating set*
    (1) Justifying the membership of the initiating set
    (2) Justifying the goals proposed by the initiating set
    (3) Securing legitimation, support, and sponsorship of these goals

3. Recruitment and establishment of an *execution set*
    (1) Justifying the membership of the execution set
    (2) Securing organizational as well as individual commitment to a program of action
    (3) Planning the detailed course of action to follow
    (4) Implementing or carrying out the action program

Briefly let us follow the path through this model for community involvement (Figure 1) and see if it has any relevance to the understanding of community action programs. I believe it does account for and explain essential aspects of most community action projects. Note that all of the "action" in this model takes place before the implementation of the community action. (Figure 1, Model for Community Involvement, is derived and adapted from Model for Community Action in Sower et al., 1957:317.)
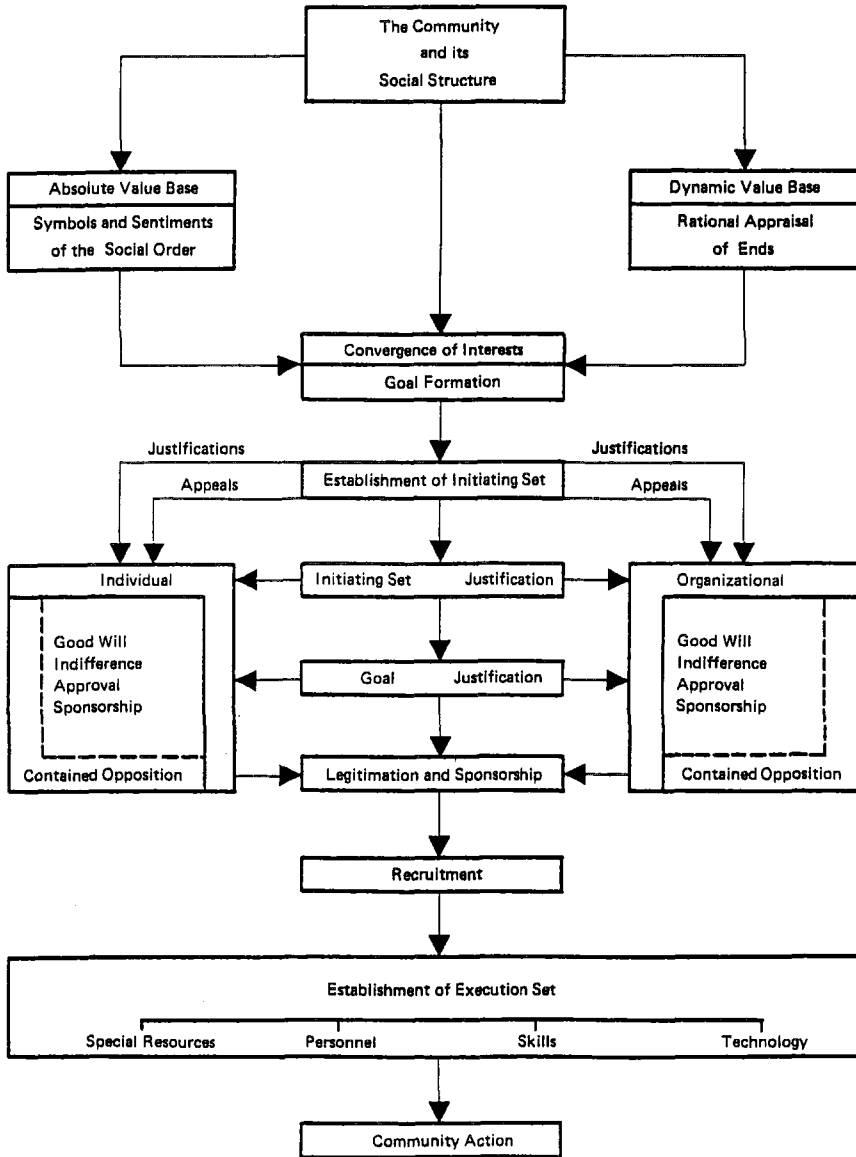
Figure 1 - Model for Community Involvement

Let us assume a community problem has been recognized and alternative courses of action have been contemplated. Starting at the top of the model, our first task is to identify the specific social units (the social structures) that in one way or another are directly affected by the community action to be taken. Make a list of all individuals, groups or organizations that have a socially defined right to become involved in the action. At this point it is not important how or if they will get involved or what position (for or against) they are likely to take. The only test to be met is: do they have the socially defined right to be involved in the action?

If so, they make up the *legitimate order* affected by that particular problem. The legitimate order is defined as including all individuals or groups who see themselves and are seen by others as having the socially defined right to be involved in the action. One test of such membership is whether the unit in question will go into opposition if it is ignored, not consulted, or not involved.

Next we need to consider the basis for securing cooperation of members of the legitimate order for the community action proposed. Support for such action must logically evolve from *value bases* appropriate to each unit in the legitimate order of the social structure within which it is being proposed. By this I mean that each organization in the legitimate order will independently test—approve or reject—the proposed action using its own organizational values as involvement criteria.

The value bases for cooperative involvement of these units are derived from two sources. The first I call the *absolute value base,* such as "symbols and sentiment;" the second may be referred to as the *dynamic value base*, such as "appraisal and allocative standards."

Symbols and sentiments are considered to be absolute in character. They are the time-tested, traditional, generally unchallengeable foundations of an individual's or an organization's behavior. They are belief systems. Every individual and every organization has a belief system, an absolute value base that is not challengeable. To debate it is nonsense. If, for example, I am bigoted and a racist, you are not going to change my mind or my heart with logical reasoning and arguments that assert that I shouldn't be. You may be able to do it with some other kinds of strategy, but probably not with rational debate or systematic evidence. This value base may govern whether and how I do or do not become involved in cooperative activity.

Dynamic values, or appraisal and allocative standards, on the other hand, are rationally derived, tentative in nature, and subject to periodic evaluation and change. They are best illustrated by our use of new knowledge. As technology develops, we drop old technologies and old ways of doing things and adopt new ways, employing the new technology. Such value changes are ever-present and occur in all facets of life. We see evidence of this in the market place, in the food we eat and the fashions we wear. We see it in modes of travel, in offices

and industry. We even see changes in education, religion, and community affairs.

After the assessment of value bases likely to govern the behavior of the social structure to be involved, the next step in the model is the *convergence of interest*. This takes on a special meaning here in that it implies a convergence upon the acceptance of a specific group goal. Different individual organizations can accept the same goal for quite different reasons. The important point is that convergence does take place *regardless of the individual or independent motive backing this social convergence*. When social convergence takes place, then, and only then, does meaningful goal formation occur.

In many community development efforts, however, the tendency is to deal with the people who have the same values we have, those who have to contribute essentially the same resources that we possess. We hesitate to talk to those who have a different set of values; we find it uncomfortable and difficult to associate with them. We have difficulty understanding their positions. In essence, we tend to talk to ourselves, never really recognizing that there are other views in the world. If we really want to solve community problems, we must involve people with different viewpoints; and on their terms, not ours.

In so doing, we will modify our goal a little bit to accommodate their vested interests. To the extent that points of common interest can be enhanced or solved by a community action proposal, we can expect to secure a positive commitment of cooperation from the relevant units. If, on the other hand, we push for action and such a move is perceived as detrimental or upsetting to these vested interests, we would predict that organized opposition to the plan would be forthcoming. It also is entirely possible to propose a project that affects relevant units but, in their view of the situation, the potential impact seems inconsequential so they are indifferent to the project and take no action.

The decision to cooperate or not cooperate made by each unit involved is determined by some combination of absolute values and dynamic values. There is not much room to argue or debate the first. It is generally not advisable to tamper with symbols and sentiments or belief systems. If our proposal fits, it will generate support. If not, we cannot do much to change the situation. Isolation of such units in the legitimate order may be called for. The use of reason or debate, when the proposal is counter to the organization's symbols and sentiments, could well result in the generation of dedicated opposition rather than cooperation. On the other hand, appraisal and allocative standards or dynamic values can be changed with the proper presentation of sound rational and factual information.

When we attempt to induce an organization to cooperate in community action programs, the main points to remember are:

    1. Select symbols and sentiments *common* to each organization for use in the appeal for cooperation.

2. Select symbols and sentiments *independently* held that are not in conflict with other organizations' interests.
3. Do not directly alter or attempt to change organizational symbols and sentiments that run counter to the proposed plan of action. Try to avoid them; it is generally better to "go it alone" than stir up dedicated opposition.
4. Select common appraisal and allocation standards when possible.
5. Aggressively counter conflicting appraisal and allocation standards with hard factual evidence and you will establish a new base for cooperative efforts.

I want to underscore again the point that the decision to become involved, to cooperate, is made by each unit of the legitimate order on its own value terms, not ours. After we have accounted for vested interests, then we can move to the next step, the establishment of an *initiating set*. This is a group of individuals or organizations who are held in high enough regard to have the social right to initiate a plan of action. They also must be able to legitimize the plan and secure the obligation of others in the sponsorship of action. The right of an individual or an organization to initiate, to introduce something in a community, has to be earned. It is not granted automatically. Here is where many community development efforts run into program difficulties. What kinds of activities does that group have the right to initiate with the community? What activities are strictly not their right to become involved in? For example, presidents of universities have the right to raise money for teaching and research, but they are not the right people to initiate changes in the curriculum. That is a faculty responsibility. Preplanning the correct strategy to use is essential at this stage of the process.

The initiating set also has to justify its goal in terms of value bases. As mentioned above, findings on community action show clearly that different individuals and organizations justify group goals for quite different or even opposing reasons. The important test is not *how* each group justifies the goal, but whether or not it *does*, and whether it then decides to join in the sponsorship of the action.

An important function of the initiating set in the involvement process is to conduct negotiations to determine how to alter and redefine the goal so as to involve the critical proportion of the legitimate order that can justify, legitimize, and, hence, sponsor and support the proposed action.

Moving to the lefthand block of the model, we see that individuals will either offer good will, support, be indifferent to, or oppose the proposed action. Likewise, we see on the righthand block of the model that organizations have the same alternatives. How access to different individuals or organizations in the legitimate order is to be gained—i.e., whether by overlapping or multimembership in different organizations, personal channels, justification based on logical

reasoning, or by some other kind of general appeal—must be determined and carried out by the initiating set at this stage of the involvement process.

To begin with, they need to account for major organized interests that potentially have something at stake in such a goal effort. These may be classified into at least three groups: approving, indifferent, and opposed. The point here is to actually identify and specifically account for the kind of involvement that can be expected from the individual and organized interests directly affected by the action proposal.

Early strategy to follow would be the neutralization or containment of potential opposition and the moving of indifferent individuals and organizations into a position of supportive involvement in goal formation and program sponsorship. This can be accomplished by carefully justifying the proposed plan using the independent value bases governing the behavior of each individual or organization. It may be that one of the best sources of assistance in goal formation, sponsorship, and execution leadership can be obtained from what are initially indifferent individuals and organizations. If the opposition is not contained or neutralized at this point in the process, common sense would say the plan should be brought to a halt and a reappraisal made.

Community action programs traditionally are perceived as being carried out by community leaders, community-minded individuals. I would argue, however, that most action programs call for commitments of resources far beyond those held by individuals. If we are trying to achieve anything that has an impact, not only do we have personal commitments of individuals, but we also have to secure corporate or organizational commitment, large and small, public and private, and vertical as well as horizontal. Many projects call for commitment of the scarce resources of the city, churches, utilities, associations, industrial and business firms, schools, colleges, and universities. Unless we obtain such commitment, we are not likely to activate a meaningful program. Rather, we will probably engage in a lot of talk, have a lot of dialogue, but have no action program.

It is individuals who in the end must represent their organization and commit its resources for or against the proposed action. It should not be too difficult to identify the individuals who, as responsible organizational representatives, can justify and sponsor an action program within their own organization. They must not only be *personally* committed, but must be able to justify the program to their representative organization and secure an *organizational commitment* of support.

After the decision is made to carry out or execute the action, it is important to obtain the necessary facilities for carrying it out. This is accomplished through what can be called the *recruitment process*. This is the point at which firm commitments for cooperative action are made, and *execution set* is formed and carries out the details of the action plan.

Winding It Up

As we attempt to mobilize resources for our program, I would like to suggest that we secure only the resources sufficient to get the job done. I question the advisability of always attempting to maximize involvement. I do so on several grounds:

1. We are always dealing with limited resources of people's time, talent, and economic possessions. We must be discriminating in our allocation of these resources.
2. There are many good alternative community development projects that call for citizen and corporate or organizational involvement. To expect extensive, continuous commitment of people for all "good causes" is to expect the impossible.
3. For some projects, widespread involvement may, in fact, prevent rather than facilitate community goal achievement. When the task becomes everybody's responsibility, in all too many cases it becomes nobody's responsibility.
4. There is a social cost associated with involvement. You can go to the social bank and withdraw people's commitment and involvement only for a limited period without making some new deposits.

Finally, I wish to restate the basic questions which must be answered if you are to secure cooperative involvement of people and their organizations in community development programs:

- What specific tasks are you attempting to achieve?

- What kind of involvement is really necessary to get the job done?

- What contribution will each involved person or organization be expected to make and can they afford to make such a contribution?

- What is in it for them?

- What is in it for you?

- What is in it for your community?

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