Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE SECOND ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Cultural Factors in Mental Health: A Training Program in Ethnicity and Mental Health

Speaker

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Origins

For today's presentation, I am going to discuss the Training Program in Ethnicity and Mental Health that I have recently established with my colleague, Dr. John Papajohn. However, since this is one of the first Erich Lindemann Memorial Lectures and since it is taking place at the Erich Lindemann Mental HealthCenter, it seems only appropriate that I begin by mentioning the influences that Erich had on my own career development and which eventually led up to the current training program.

My first acquaintance with Erich Lindemann came about through our both being members of the Group for the Advancement of Psychiatry (popularly referred to as GAP) in the late 1940s. He was Chairman of the Committee on Preventive Psychiatry, and I had just finished my chairmanship of the Committee on Cooperation with Lay Groups. There we had conceptualized an early version of a community health program. This was achieved through consultation with national and local service organizations, such as the Rotarians, the Elks, the Lions, Junior Chambers of Commerce, etc., who had sought us out to recommend such programs. These contacts were in some ways similar to the work that Erich was beginning to do in his Wellesley Project in contacting community agents that he later referred to as"Gatekeepers", in order to mobilize support for people in crisis from a wider range of resources than could be provided by mental health personnel, per se.

Thus, during our conversations at GAP we had already established that we had similar interests. But as the Committee on Cooperation with Lay Groups had completed its assigned task and was being "sunsetted," I, as chairperson, was appointed to confer with the GAP leadership as to what new committee might be needed in order to further "advance" psychiatry. Bill Menninger and Erich both gave me the same advice: what was needed was a Committee on the Family. Bill had developed this idea at the Menninger Clinic in Topeka because so many relatives came to visit, and he had written several papers on the subject.

Erich's comments were more specific. He said that both from his studies of the grieving process and from his scrutiny of the wider community impacts on mental health and illness, an understanding of the dynamics of family interaction was desperately needed. It was a neglected area and someone had to embark upon it. When I protested that I knew nothing about the subject, he laughed and said that that was all to the good: I would start with an open mind; I would read the existing social science literature, see

what the psychologists and pastoral counselors were saying, and learn what was known; then I would locate whichever psychiatrists were (as he thought) beginning to work in this area and bring them together. Perhaps jointly we then could develop a concept of how family conflicts were related, on the one hand, to the psychodynamic problems of individuals, and, on the other, to social, economic, and cultural problems in the community or in the nation as a whole.

Erich talked so fast about such complicated matters that it was difficult for me to retain everything he said. However, one thing stayed with me very clearly. He said, "John, be careful to go beyond looking at white, middle-class, Caucasian families." He pointed out that there were many minority and ethnic groups in the community whose culturally-determined life styles varied from the mainstream. In addition, he offered to introduce me to a person who could supply the culturally-sophisticated information that we would need for this purpose. That person was Florence Kluckhohn, the wife of the anthropologist, Clyde Kluckhohn, with whom Erich had been associated in the Department of Social Relations at Harvard. Florence was both an anthropologist and a sociologist, and had worked with Hispanics in the Southwestern United States and in Mexico.

Good as his word, Erich arranged for Florence Kluckhohn to attend the first meeting of our new Committee on the Family as a consultant, and we spent the first few meetings listening to her review the literature on the family and on

cultural variations, particularly her theory of Variations in Cultural Value Orientations. These discussions led to the first published report of our Committee, "Integration and Conflict in Family Dynamics" (GAP Report No. 27, 1954), which helped to publicize and legitimize family therapy as a viable and permanent part of the helping professions. More important to me personally was the fact that my association with Florence Kluckhohn at GAP resulted in my being called from my position in the Department of Psychiatry at Michael Reese Hospital in Chicago to a position in the Department of Social Relations at Harvard and an Associate Professorship in the Harvard Medical School. There I was able to establish a long-range comparative research program, with Florence, funded by NIMH, on the mental health problems of Irish, Italian, and Anglo-Saxon families in the Boston area.

From that point on, due to the push provided by Erich Lindemann, my career pattern of interest in the provision of culturally appropriate mental health services to ethnic and minority groups was firmly established. After my move to Cambridge, Erich maintained his interest in our work and often asked me to make presentations in the Department of Psychiatry at the Massachusetts General Hospital and for the Wellesley Project seminars. He was always encouraging, but on one point his encouragements, which he provided to everyone so freely, failed. After his World Health Organization-

sponsored trip to India to promote the expansion of psychiatric teaching in Indian medical schools and to stimulate cultural exchanges between the two nations, he tried to persuade me to go to India to do some teaching and research in line with his program. He was always a good persuader. His descriptions were fascinating. But I refused. I said that to my mind, India was not one culture, but a whole continent of different religions, nations, and cultures. His mind and understanding worked fast, broadly, and comprehensively. Mine worked more slowly, requiring me to proceed over a long time, in depth, with a smaller or narrower culture before I could comfortably feel that I knew what I was doing. He was disappointed, but, as always, accepting.

The Program

The Training Program in Ethnicity and Mental Health was devised for an interdisciplinary team of non-indigenous "mainstream" mental health professionals in the later stages of their initial clinical training. The choice of "non-indigenous" personnel was based on the assumption that there were already in existence a number of "indigenous" training programs in which Blacks were being trained to deal with Black populations, Hispanics with Latin-American populations, and Asians with Chinese, Japanese, Koreans, and the newcomers from Southeast Asia. Under an affirmative action ideology, the needs of the "official" minorities were being addressed—although perhaps not so perfectly in all instances—while the needs of the so-called "white ethnics" were being overlooked. In addition, we assumed that it would take a long time before there existed a sufficient number of well-trained Blacks, Hispanics, Asians, Native Americans, etc. to meet the needs of the official minorities wherever they happened to be living. In the meantime, such ethnic populations were receiving mental health services from "mainstream" mental health professionals who lacked the cross-cultural perspectives and the skills to provide culturally relevant services. Accordingly, we envisioned our Program as one model of a much-needed corrective in the context of the pluralistic and diverse character of the "unmelted" structure of American society.

The approach governing our design of the Training Program utilized the epistemological and theoretical perspectives that constituted the framework that we intended to teach to the trainees. Transactional systems theory and cultural value orientation theory were the two conceptual mainstays guiding us in considering modes of intervening in the two training sites where our work was to be done. These training sites were both Harvard-affiliated teaching institutions: The Cambridge Hospital and Cambridge-Somerville Community Health Center, and the Erich Lindemann Mental Health Center. We perceived these sites as being systems characterized by discrete cultures, each having a social role structure where relationships among the staff and

other personnel were patterned in a consistent manner that reflected the cultural values of the "system" as well as those of individuals, each with his idiosyncratic personality structure. Thus, culture, social roles, and individual psychological organization constituted the three foci in a transacting system of events that would have to be considered if we were to be effective in organizing a successful program for teaching concepts of disordered behavior related to the ethnic backgrounds of individuals who are receiving mental health services in traditional psychiatric settings.

Our target sample of trainees was to consist of psychiatric residents, clinical psychology interns and psychiatric social work students who were working in the clinical settings of university hospitals, outpatient clinics and community mental health centers. They were selected from the general population of trainees already accepted into these programs because of their high motivation for and interest in cross-cultural work.

We considered it important to introduce these trainees to the cross-cultural and ethnic perspective at a relatively early stage of their professional experiences, before their ideas of how to deliver services had become too fixed in "mainstream" patterns which are constructed, for the most part, for urban, middle-class, acculturated populations.

A formal program of this kind almost always develops out of a background of experience which generates ideas that seem useful for educational purposes. For many years we had been engaged in extensive research with several different ethnic groups on the relationship between subcultural values and perceptions, family interaction styles, and mental illness. Although our interest in research of this sort continued, when we first submitted a grant proposal to NIMH in 1976 we had arrived at the opinion that the time had come to translate our accumulated knowledge base and skills into a training procedure. Because of this opinion we had spent the previous year testing out the feasibility of such a transmission of knowledge and skill by means of a small pilot project conducted at the Cambridge Hospital and the Cambridge-Somerville Community Mental Health and Retardation Center, funded by the Marcus Foundation of Chicago. During this pilot year we made ourselves available for consultation on "difficult" ethnic cases in the various components of the Department of Psychiatry and in the Emergency Service. During the course of the experimental year we managed to prove to ourselves and to members of the staff that we had something of value to offer. Enough support emerged to encourage us to plan a program to be submitted to NIMH for funding.

In addition, the pilot year had made us acutely aware of some hazards and obstacles that would have to be taken into consideration in order that such atraining program would have a reasonable chance of success in the departments of psychiatry of major medical schools. These obstacles were understandable from a systems point of view, and we summarized them as deriving from three sources.

The first of these sources was implicit forms of resistance to a new theoretical approach, i.e. cultural value orientation theory which, in some of its underlying assumptions, could be construed as inconsistent with psychoanalytic theory. Psychoanalysis constitutes the main theoretical basis on which these "traditional" training programs are structured (in a very real way psychoanalysis serves as their ideological or "cultural" foundation. Its tenets are shared by the training directors and have direct patterning effect on the content of the formal teaching inputs and, too, an indirect effect by mediating the epistemological assumptions on which it is based. Psychoanalytic theory assumes a shared genetic (biological) heritage that characterizes human development wherein individuation becomes the goal of therapy. This is a process of continuing differentiation and reintegration through progressive stages of development. Cultural value orientation theory, on the other hand, assumes a shared sociocultural heritage, where individual modes of thinking, feeling, and acting are shaped by common environmental (ecological) experiences and are necessary for effective functioning within that cultural system.

The second obstacle we anticipated required that we accommodate our entrance into these two training institutions to the extant role structure. We needed to be allied with and to be validated by both the senior administrators who could facilitate our entrance into their systems and by the line of clinical workers who provided direct services to clients. The latters' support needed to be earned by our demonstrating that we could be useful to them in alleviating their burden in treating difficult, that is, resistive, ethnic patients.

The third obstacle to be overcome was covert ethnocentricity. That is, the lack of awareness on the part of mental health professionals of their own "learned" tendencies to value patients who shared characteristics common to themselves: white, educated, attractive, middle class. This denial of cultural bias is the factor that allows professionals to see patients as "untreatable" because they are viewed as lacking intelligence, motivation, and other such characteris tics associated with one's own social class background.

Theoretical Concepts

We attach a great deal of importance to theory and conceptualization as aids to appropriate service delivery and to training procedures. Clinicians need to internalize a frame of reference that equips them to order cultural variables in a useful way in diagnosis and treatment.

Transactional Field Theory is the first of two theoretical constructs which are central to our approach to training. Most of us have learned to order events in cause and effect

terms, reflecting the Aristotelian assumptions of linear causality. This position is the essence of the scientific method and it delimits the range of variables that can be examined at one time. A person's neurotic reactions, for example, may be conceptualized as caused by a disturbed relationship to the mother. The cause of the dysfunctional behavior can be understood as the relationship between a "dependent variable" (a symptom or problematic behavior) for which a cause and "independent variable" needs to be found. This search is limited, furthermore, to the psychological aspects of the individual. An exception will be found in cases of schizophrenia, where biological or genetic causes are also presumed to be present and may "interact" with psychological stress. Even then the causal relationships are conceptualized in a linear fashion.

Transactional systems theory is based on a very different conceptual assumption: That is, that events constitute a field of transaction processes in which change in one part is related to change in all the other parts (see Figure I). An individual's neurosis can be understood as reflecting a transactional interplay of psychological, cultural, social and biological events. The disturbedbehavior, for example a symbiotic bond to the mother, is not explained solely as a fixation in psychological development, but rather as a related concomitantly to cultural conflict, social dislocation, biological events, etc. Events in any one of these domains, then, transact with each other domain to produce a neurotic reaction in the individual. Ordinarily, these events are not included in a differential diagnosis. Although they may be noted in the history-taking, they are not viewed as significant data that need to be utilized in the treatment planning. From a transaction system perspective, the treatment objective is to address the disequilibrium in the field of events impinging on the individual to bring about a new and more functional balance. This conceptualization is very close to the Field Theory that Erich Lindemann used in his work.

The second theoretical concept is Value Orientation Theory. In the context of the transactional system approach, culture is the focus with which to begin the inquiry into families undergoing acculturation, since we are dealing with a clash of cultural understandings and norms. The map we have been using is the theory of variation in cultural value orientations developed by Florence Kluckhohn. She defines value orientation as follows:

A value orientation is a generalized and organized conception, influencing behavior, of time, of nature, of man's place in it, of man's relationship to man, and of the desirable and non-desirable aspects of man-evironment and inter-human transactions.

In addition, value orientations have a directional, a cognitive, and an affective function. These three functions constitute the "program" for selecting between more or less favored choices of alternative behaviors for individuals within a particular culture.

Furthermore, communication among individuals in a particular culture is contingent upon the shared value orientations that characterize them.

Kluckhohn postulated five common human problems for which all peoples in all places must find some solution. They are: Time, which is the temporal focus of human life; Activity, the preferred pattern of action in daily living; the Relational orientation, which is the preferred way of relating interpersonally; the Man/Nature orientation, which defines the way man relates to the natural or the supernatural environment, however conceptualized; and the Basic Nature of Man, concerned with conceptions of innate good and evil in human behavior.

The theory assumes three possible solutions for each of these common human problems, and the variation among and within cultures is based on the particular rank ordering of these solutions. In Table I the patterning of preferences for mainstream American lifestyles (American middle class) is compared with profiles characteristic of rural, southern Italian and rural southern Irish families drawn from our work with these migrant groups.

Let us first examine the American middle class value orientation patterns. It becomes readily evident that there is a functional relationship between the value orientation profiles and the adaptational demands of a technologically advanced society like that of the United States. The first-order future orientation of the Time area, for example, is a critical one in our society, where planning for the future is a necessary condition for effectively carrying on the functions required for maintaining a technologically advanced system. In the Activity area, the first-order doing orientation reflects the achievement orientation of this society, which is shared by other Western cultures. The opportunities for upward social mobility place demands on individuals to achieve economicallyand socially. The evaluation of one's individual worth is based on the degree to which one has been able to compete with success. The individualistic preference in the Relational area reflects the lifelong thrust toward "individuation" and independence and is consistent with the doing orientation in the Activity area. The dominion over nature preference in the Man/Nature modality is correlated with our assumption that given enough time, money and technology, most problems between man and nature can be solved in the name of "progress." Child-rearing practices in the United States are geared to preparing children for successful functioning in this society. Developmental stages such as weaning, toilet training, are traversed at earlier ages than is the case in other cultures such as rural Italy and rural Ireland, from which a significant portion of the American population has emigrated.

In rural Ireland and rural Italy the first order orientation in the Time area that makes functional sense is the present. In rural societies individuals are rooted "existentially" in the present since the future cannot be controlled or predicted and little

change is expected. Daily life is modulated by the forces of nature which pattern, also, the economic realities which are encountered. The seasons of the year determine what one does, i.e., planting, harvesting,etc. The planning of activities in accordance with a changing future makes no sense in situations where life goes around in cycles the same way every year.

Irish and Italians are being oriented in the Activity dimension. The being orientation places high value on "being oneself," in the sense of the spontaneous expression of inner feelings in given situations. Satisfactions are derived from experiencing, here and now, each other, food, and as broad a range of sensual satisfactions as possible. While this does not imply an uncontrolled hedonism, it contrasts with the "doing" orientation, where immediate pleasure is forfeited for the satisfaction of achievement in the future.

In the relational area the Italians and Irish differ in the rank ordering of the three value orientation preferences. Italians order their relationships on a horizontal, egalitarian dimension. Reciprocal relationships are characterized by the one-for-all, all-for-one principle. In both cultures the individualistic orientation which is the most preferred in American culture is positioned last in the profiles of these two agrarian societies.

The first order collaterality in the Italian pattern reflects the interdependence among family members that is characteristic of Italian family structure. Individuals in this society are socialized for interdependence since the survival of the family is contingent on everyone collaborating with everyone else in common, often agrarian, pursuits. Italians traditionally have never trusted agencies outside the family to protect or to provide for them.

The first order Lineal preference in the Irish value orientation profile represents the essentially matriarchal character of the Irish family. The dominance of the wife and mother derives from a long history of political oppression and economic hardship in Ireland with chronic unemployment relegating the male to a secondary, almost powerless role within the family, despite the wife's attempts to make her husband look good in the eyes of the public.

The subjugated to nature first order preference in the Man-Nature area in both Irish and Italian culture is consistent with the present, being as well as both the collateral and lineal orientations in the Relational area. Man and woman are controlled either by the forces of nature or by a powerful deity. One cannot expect, as in technologically-advanced societies, to harness the forces of nature to serve man. The farmer feels powerless in confronting physical forces beyond his control. This orientation of course generalizes to other areas of one's life. One is rooted in a present condition with no

avenues available in order to plan for future achievement or upward social mobility. The alternative is emigration.

The above framework makes is possible to conceptualize the strain that is experienced by Italian-Americans and Irish-Americans as they confront the American social system. There is an inconsistency in all five modalities between the internalized value orientations of the subculture in which they were socialized and that of the American social system to which they need to adapt. "Acculturation stress" becomes evident in all domains of adaptation such as occupational,

recreational, and social. The clinician who has internalized our frame of reference can include this cultural understanding in assessing the specific psychological issues that confront his patient. He is not limited to a psychological theory that is designed to conceptualize developmental and characterological variables only.

The Program Objectives

We formulated a rather concise training plan which was approved and accepted by the National Institute of Mental Healthon an experimental basis funded through the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University. The program objectives are summarized as follows:

a) To provide the interdisciplinary staff and students operating clinical services in community mental health centers with insight into the effects of ethnicity on patients and families in treatment.
b) To differentiate these effects for the different ethnic groups to which patients belong.
c) To provide staff and students with more effective tools for delivering services, in respect to:
    - Diagnosis, where distinguishing between subcultural practices and psychopathology is a problem;
    - Establishing a therapeutic alliance where social distance or ethnocentricity is the problem;
    - Assessing psychodynamic formulations where variant or deviant child-rearing customs, marital or parental relations, or extended family transactions are the problem;
    - Reorienting therapeutic goals in line with the particular acculturation conflict which the patient and/or the family is undergoing.

The Training Sites

We settled on two Harvard Medical School affiliated training facilities, the Cambridge-Somerville Community Mental Health Center where the department of psychiatry is based at the Cambridge City Hospital and the Erich Lindemann Mental Health Center, an affiliate of the Massachusetts General Hospital Psychiatry Service, which serves the Harbor Area catchment area.

Our engagement of the Cambridge-Somerville and the Lindemann Centers involved several meetings with the respective directors whom we knew personally as well as a twelve-month period of providing consultation to the staff around ethnic cases. Dr. Racquel Cohen, the Lindemann Mental Health Center director, and Dr. Lee Macht, the Cambridge City Hospital chairperson in the Department of Psychiatry knew of our research work on ethnic families and were committed to a cultural perspective. Dr. Cohen worked with Dr. Gerald Caplan at the Harvard Medical School Laboratory of Community Psychiatry and Dr. Macht's work in community mental health was recognized nationally.

For each community we needed to choose an ethnic group for the intensive part of the trainee's experiences. In the case of the Lindemann Center we decided on Hispanics, most of whom were Puerto Ricans, while for Cambridge-Somerville we chose the Azorean-Portuguese population.

The communities for which the Lindemann Center was responsible included Boston's North End (almost 100 percent Italian-American), East Boston (largely Italian), and the suburbs of Chelsea (30 percent Spanish-speaking, 60 percent old-line Jewish), Revere and Charlestown. At Dr. Cohen's suggestion, our negotiations were confined to the North End and to Chelsea. The decision to concentrate on Hispanics in Chelsea was determined by the fact that they were being served by the Chelsea Community Counseling Center under the direction of Dr. Matthew Dumont, a psychiatrist dedicated to community psychiatry. While Hispanics comprised only 30 percent of the Chelsea population and only 10 percent of the Center's clientele, the numbers in both instances were rapidly rising.

The Cambridge-Somerville Community Mental Health Center comprised a large geographical area that corresponded to the boundaries of these two cities. The neighborhood close to the Cambridge City Hospital has a preponderance of Azorean-POrtuguese people. The Greeks and Azorean-Portuguese populations are composed of relatively newly-arrived immigrants, who left their homelands after 1965 when the immigration law was changed to allow immigrants from parts of Southern Europe to come here in larger numbers. The presence of the Egas Moniz Clinic, a health center for Portuguese people near the Hospital, provided a natural site where our trainees could gain experience with Portuguese patients seen in the mental health division.

The Planning Phase

Two quarter-time Program Coordinators were recruited from the staffs of the two training sites. Both were psychologists who had earned a considerable amount of credibility within their respective organizations and so could serve as mediators for the Training Program. The Cambridge-Somerville Program Coordinator was a Black woman psychologist; her Lindemann counterpart was a male of Hispanic origin who was bilingual. They interpreted and advocated what we intended to do among their colleagues. They also accompanied Dr. Papajohn and myself when we met with the heads of the different clinical services to acquaint them with Program objectives and contemplated procedures.

An advisory committee comprised of senior members of these two training sites was created to monitor the Program, especially in the difficult phase of getting started. The directors of training for psychiatry, psychology and social work at the Mental Health Centers were also members of the advisory committee. We negotiated with them the criteria for the selection of recruits for our Program that would satisfy their own independent training program guidelines. We examined with them the various clinical placements within their Centers where the trainees could get the appropriate experiences to satisfy both the hospital training objectives and those of the Ethnicity Training Program as well. We negotiated for blocks of time when they would be free to attend the formal teaching seminars and clinical conferences we had designed to be part of the specialized training we were providing. Our effort, in summary, was to integrate our training inputs into the traditional training formats for psychiatry, psychology and social work.

The Training Format

(1) A one-semester course, offered by John Spiegel at the Heller School, "Social Aspects of Mental Health and Illness," was required of all trainees. This was designed to provide the trainees with a macroscopic overview of social psychiatry where issues such as epidemiology in cross-cultural perspective, social class and mental illness, labeling theory, etc. were reviewed.

(2) A one-semester course offered at the Heller School by John Spiegel and John Papajohn entitled "Ethnicity and Mental Health" constituted the second major academic offering. It was in this course that transactional systems theory and cultural value orientation theory with special reference to diagnosis and treatment were reviewed.

(3) A weekly "ethnic clinical teaching conference" was held on alternate weeks at each of the two training sites. Cases seen by the trainees in their respective clinical

placements were presented in the traditional mode. John Spiegel and John Papajohn alternated chairing these conferences. Guest consultants with special knowledge of different ethnic groups were invited for special conferences.

(4) Ethnic cases seen by the trainees were supervised individually by John Spiegel and John Papajohn. These were structured in the traditional way with the trainee presenting the case and describing the process of treatment with the supervisor providing suggestions and interpretations where appropriate. It was here the trainees could discuss their ideas, questions and doubts about the differential effect of cultural and psychological factors in the clinical process of his or her own individual patient.

(5) In the second year of the Program we instituted an additional seminar entitled, "Ethnocultural Factors in Diagnosis and Treatment." This was a one-semester, weekly, two-hour conference that focused specifically on the application of cultural theory to the clinical process. Formal presentations on different subcultures including Irish, Puerto Rican, Japanese, Haitian, etc. were made by clinicians with special knowledge of these subcultures.

The Trainees

We employed both formal (advertising in professional publications) and informal methods of locating candidates for the NIMH-funded traineeships who met our criteria and those of the training directors in the three disciplines. We wanted individuals highly motivated to work with poor ethnic populations who at the same time could meet the criteria for acceptance into the mental health centers' training slots. The mental health center training directors, themselves, were motivated in this recruitment effort by the fact that each could expect to acquire two additional trainees who were funded by the Ethnicity Training Program.

In the end two major sources for recruits for our Program evolved. The first was the mental health center training directors themselves. In reviewing candidates for their own traineeships they introduced the availability of a conjoint program to those who met, in their views, criteria for both programs. In the first year, the two psychiatric residents and one of the clinical psychology interns were recruited in this way. The second psychology intern was recruited by word of mouth. The two psychiatric social work trainees were recruited from the Smith College School of Social Work. There already was in existence a liaison between this school and the department of psychiatric social work at the Cambridge City Hospital. In addition, we had personal contacts with the new administration of this institution.

In the second year the recruitment process followed a course similar to the first year with one important exception; we were unable to recruit a psychiatric resident for either

the Cambridge City or the Lindemann Mental Health Center sites. We substituted two psychologists in their places: a Ph.D. from the Department of Social Relations at Harvard University and an Ed.D. who wanted to do a post-doctoral internship in clinical psychology at Cambridge City.

As regards ethnic background over the two years, the twelve trainees were almost evenly divided between those whose backgrounds were representative of mainstream American middle-class culture (WASP) and those with an "ethnic" tradition, whose parents or grandparents had emigrated from another country. The two psychiatric residents, three psychologists, and one of the psychiatric social workers derived from a mainstream tradition. One psychologist and two of the social workers were Jewish American with very weak ties to Judaism. One of the psychologists was of Azorean-Portuguese parentage and one social worker was born and raised in a Slavic country in Eastern Europe. With the exception of the Portuguese-American psychologist, all came from predominantly middle-class and professional backgrounds, with strong liberal ideological traditions.

The ethnicity trainees were rotated through the customary sequence of placements in the mental health center system designed to provide them with a broad range of experience with a variety of different patients. These included the inpatient and outpatient units as well as placements in the satellite clinics where the major portion of patients were ethnic. In Cambridge, this was the Egas Moniz Mental Health Clinic serving the Portuguese and in Chelsea the Community Counseling Center serving predominantly the Puerto Rican, low income population. The experiences of our trainees, however, were not uniform as regards the number of ethnic patients that they saw. This was a function of where they were placed, for how long, and was also dictated by the experiences their supervisors (from the mental health centers) determined they needed to have.

Program Evaluation

1. General Strengths of the Program:

Trainees identified several components of the Program which they considered strong points. Three major strengths were: First, the general opportunity to treat ethnic patients in a systematic fashion; second, the clinical case conference, in which specific trainee cases were discussed; and third, the course held at the Heller School on ethnicity and mental health. These components were considered strengths because they served a consciousness-raising function that sensitized trainees to the problems of cross-cultural psychotherapy and the problems of making mental health systems responsive to the

needs of ethnic patients. Thus a typical trainee comment was that before entering the Program he or she knew that ethnics experienced problems getting appropriate clinical services but now understood just how serious and complicated the problems really were. They now understood the subtleties and complexities of cross-cultural psychotherapy and the difficulties in altering mental health agencies to respond to the needs of ethnics.

These observations are not intended to downplay the acquisition of substantive knowledge on the part of trainees concerning specific ethnic groups and related issues, as this was a significant gain. But in a general sense it seems that the primary impact of the Program was in moving trainees from the position of knowing, in an abstract sense, that ethnic patients present unique problems to the clinician to an understanding in a deeper way why this is the case, and what to do about it.

Trainees felt that the first-hand experience of treating ethnics, with its associated pitfalls, coupled with the critical discussion of their cases in the clinical conferences provided the core of this learning experience. The ethnicity course mentioned above was important for placing their experiences in the context of larger human service delivery systems.

2. General Weaknesses of the Program

One category of weaknesses identified by the trainees had to do with administrative matters. Most of them were concerned with what they saw as a lack of communication among various members of the program staff. They felt that communication among the two Directors and the Field Coordinators was at times confused and strained. Particularly at the beginning of the year, when routines and caseloads were being established, they wanted the Directors and Coordinators to be more aggressive with administrators and supervisors in the placement settings. Certain trainees felt that they did not have enough control over the ethnic makeup of their caseloads and that the Coordinators and Directors could have taken more of an advocacy role in this matter. There were also conflicts around the amount of psychological testing expected of psychology interns. Ongoing problems included the difficulty at times, due to mutually heavy schedules, of contacting the Project Directors, as well as occasional confusion as to the times and places of meetings, abrupt schedule changes, delays in receipt of stipend checks, etc. Trainees were, however, willing to make allowances for the newness of the Program.

The second and major weakness related to the training process itself. Trainees, and this included all of them, felt that opportunities were provided for them to see ethnic patients and to discuss these patients in a variety of settings. However, the training aspect of the Program was not always effectively put forth. Some trainees apparently

wanted a specific, highly delineated model of intervention and were somewhat let down when they learned that such a model was not forthcoming. Others, understanding that one of the intentions of the Program was to experiment with such models, were not clear on what "data" to collect on patients and how to utilize such data.

Related to these concerns was a theme running through trainee responses which could be phrased as, "What exactly do I do with the ethnic patients in the counseling situation itself?" For example, they began to understand how to use the value orientation scale to interpret the patient's situation and to make a general treatment plan that was culturally appropriate. However, apart from asking certain specific questions about ethnic background, they were not sure of other clinically-appropriate topics for the therapeutic dialogue, and how this might fit in with whatever treatment approach they were familiar with.

This proved to be a very difficult issue to resolve, given the vagueness with which the trainees described the problem. Nevertheless, it was a real and important issue that needed further consideration. Of particular importance was the development of a way to conceptually merge culturally-relevant approaches with either specific (e.g., analytic, gestalt, cognitive, social learning) therapeutic methodology or an explicitly eclectic model.

Conclusions

The following additional impressions of special relevance to planning future programs will be reported here. One interesting aspect of the Program, which, in some ways is a major strength and at times a weakness, was the freedom which the Program gave each trainee to carve out his or her own program. Thus, in terms of their placements, trainees had very different responsibilities and requirements and, hence, very different experiences. Most of the trainees attempted to create a learning situation that best fitted their needs and backgrounds. The problem with this was that some trainees lost time at the beginning of the year as they attempted to "work the system" in order to locate themselves where they wanted to be. A typical problem for trainees involved the various rules about placements that had been created in each organization.

However, the advantage was that once they got past the bureaucratic hassles, the trainees were to a great extent able to tailor their placements to their own needs. For example, one trainee was specifically interested in the Portuguese and spent a great deal of time at the Egas Moniz Clinic. Another was interested in family therapy and worked closely with a family therapy training organization. Because trainees actually had a great deal of freedom within the placement aspect of the Program, one cannot say that all of the trainees experienced the "same Program." What they brought with them to

supervision and seminars, then, and what they carried away, was a variety of experiences, not one uniform experience. This gave a richness and diversity to the Ethnicity Program that would have been lost if trainees had not been given a great amount of leeway to design a program that provided the kind of educative and growth opportunities that they desired. All the trainees expressed interest in continuing to work with ethnic groups when they finished their training.

In many ways it is apparent that this Training Program constituted not only a product inspired by Erich Lindemann's original contribution to my own thinking, but also represents a kind of sibling to his work in the Wellesley Project and in the West End Study. One function of a Memorial Lecture is to show how much of the spirit of a departed mentor lives on in the work of those who follow. I hope that I have been able to demonstrate how this has happened in my own case.

References