INTERDISCIPLINARY WORK AND TRAINING IN THE MENTAL HEALTH FIELD

An Approach to the Problem of Manpower

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The general need for manpower, both trained and untrained, in the field of mental health has been recognized for some time. While greatly enlarged funds have been allocated to a good many mental health settings in the last few years, the cry of "not enough" is still heard widely, and even in places where funds are available. At times there are no takers. The common picture of the overworked and understaffed clinic or hospital is still very much with us and in spite of considerable progress the problem of manpower is a day-to-day reality for most professionals, and for many patients. The "helpers" have to restrict intake of patients and most painfully patients find themselves denied treatment, because "there is no one available right now". So-called waiting lists are frequently established even when there is no reasonable expectation that something will be forthcoming soon. The challenge is there to meet, at least partially, the mental health needs of a community or an area. I would like to focus on two particular avenues with which I am familiar from experience in an outpatient clinic setting. They are (1) ability to work in an interdisciplinary setting and (2) wide application of in-service training of semi-trained or untrained people.

Beginning with the first issue, the interdisciplinary nature of mental health work, we may wonder why this particular field, mental health, has not done as most other scientific endeavors have, namely specialized into numerous smaller fields. In other disciplines of medicine and in engineering, for example, a refined division of labor has taken place. Yet in the mental health field a clear-cut definition of boundary lines is missing and therefore confusion as to "who does what" is rather common. While it is perhaps not desirable to have concise boundaries in the field of mental health, interdisciplinary tasks have their problems precisely because people cannot stay only within their own areas of competence. It is, colloquially speaking, impossible for people to "mind their own business", and they must in some way or another, overstep the boundary lines of their professional skills, if not by action, at least by understanding of what the other person is about to do.

But how did mental health work come to be an interdisciplinary task? Does it perhaps lie in the nature of the work that mental health work is different from medicine? If I have a bellyache and a physician decides that my appendix has to come out, the matter is a fairly clear-cut one. I'll go to a hospital and sooner or later a well-qualified doctor or a surgeon will remove my appendix and that will be that. The lines are clearly drawn and the referral process is a simple and by and large, non-controversial one. It may be added that most patients will make allowances for the "master" surgeon to have trainees who will eventually follow the master. Provided the doctor and the hospital inspire confidence, the trust that people put into the professional person or institution can be spread from the expert to a number of staff persons who work under his guidance. It has been accepted for a long time that in teaching institutions, one gets cared for by interns, residents or junior members of the staff and there is

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relatively little objection to extend the necessary trust from the "master" to a large number of people in a teaching or training situation. Manpower in this way is extended, simply along lines of authority by the process of teaching and training.

In psychiatric hospitals and most particularly in psychiatric outpatient facilities, the situation has been somewhat different and seems to become increasingly more different from this relatively simple medical-surgical model. It became repeatedly observable, particularly in institutions where psychotherapy came to take an important place in the treatment of the mentally ill, that very often a young and relatively untrained member of the staff would accomplish great things with a patient where the seniors looked on and felt that they could very likely not have accomplished anything comparable. Continuing in this line of thinking, much research in modern social psychiatry has pointed to the importance precisely of relatively low-status but stable people in an institution, i.e., some of the attendants, the kitchen personnel etc. in the course of certain types of mental illness. Particularly where milieu treatment is intended, it is important to pay attention to many more relationships than the one between doctor and patient which is so important in physical medicine and in office practice. This humiliating fact, that the expert often does not accomplish more than the novice and that sometimes the relationships with low-status personnel is more important than what the doctor may do, calls for an explanation. Why is it that in the mental health field the well trained and recognized expert is not necessarily the one who accomplishes the most?

There must be something else in mental health work which comes into play besides the technical skill or expertise. An example, perhaps, will prove the point. At one point, a 33-year old single lady came to the clinic with complaints of depression. She spoke hardly a word and it was indeed difficult both to assess where her problem was and what could possibly be done to help her. We knew from relatives that she was the youngest of a numerous family, had always lived at home and taken care of the children of her older brothers and sisters. Somehow, something had happened that made her feel worse in the last two or three months. A student was assigned to deal with the case, under supervision. The problems that ensued were considerable. The student was intensely curious and had an obvious commitment to find out what might be the matter; the patient, on the other hand, reacted to him in just as solemn, obtuse and frustrating a manner as she had done before to the clinic social worker, and before that, to her family. Clearly, these two people, the intensely curious student and the solemn, depressed patient, were on a collision course. The collision happened in the third interview and while the student barely contained his anger and frustration, the patient for the first time, was able to shed a few tears and then let the student know what really had been the matter. The story that unfolded in the remaining two or three interviews had to do with a fleeting interest that this female patient had taken in a man who worked in the same factory where she had worked for a while, and this influx of strong feelings on her had not permitted her to keep up her performance, so that she had to leave her job and was once again exposed to being exploited by her numerous family for baby-sitting. After the initial collision with the student had taken place, the patient became more open, and in subsequent interviews with someone else, was able to work out something about her feelings and more importantly, a program of rehabilitation which permitted her to go back to work. I believe in retrospect that it was necessary for this woman to be able to feel the intense interest and curiosity that a young person could bring to her problem and that she, moreover, needed to frustrate someone in retaliation for her frustrations at home before she could accept help. Clearly, something had

happened in this unsatisfactory but useful first encounter, and very likely the intensity of the young professional's involvement had something to do with the ultimate opening up and success of this person's treatment, which at first was considered to have a less than optimal chance.

Experiences such as the one described are not infrequent in teaching programs of clinics and on a rough impression, it is possible to say that easily two thirds of the patients that we have assigned to students for a relatively short period have benefited from that contact and that in very few cases, have there been undue difficulties due to the fact that an untrained person dealt with patients. We were, of course, careful in selecting those problems that would lend themselves for the kind of brief encounter that we were able to provide for the teaching situation, and we were fortunate in the consistently high caliber of trainees. Obviously, such experiences must be closely supervised by a professional, for such encounters as the one described bring about a great deal of anxiety, and anxiety requires understanding. Follow-up treatment with personnel who could be available for a longer time, had to be arranged in many instances. But as the experience with students was by and large encouraging, it became possible not only to use contacts with young professionals, but also to have lay volunteers take a part in the outpatient clinic treatment program.* If indeed it was true that people without training in any of the mental health professions could be worked in to a role in mental health, this was an opportunity to prove it, and to prove it by a proper way of building the untrained worker into the patient's functioning. Clearly, the beginning mental health worker could not fit into the role of the psychotherapist or psychoanalyst; very likely also, she could not replace a caseworker, not having had the necessary training. Therefore, we had to find a new role which an untrained worker could fill and which would lead him or her to further growth and possibly fitting in to other more demanding roles. The first such role we devised was that of the family aide where the most conspicuous function was that of visiting the family of a patient who had applied for help in the clinic. It is perhaps a commonplace to say that in listening to people's many complaints, one finds that a relatively large number are in some ways related to people's interpersonal relations. Many people express their troubles in terms of aching backs, headaches, heart beatings or a multiplicity of other physical symptoms, yet if one listens carefully, the pain most often lies somewhere in a relationship with a spouse, a child or a parent, and clarification of the disturbed relationship often helps. Our volunteer aides were in an outstanding position to look at relationships as they showed themselves in the daily lives of our patients, and by visiting them, they were able to see much more sometimes than a trained psychiatrist or caseworker might in an office setting. We had the gratifying experience that many of our patients told the volunteers that came to visit them at home, more of their secrets than they had been able to tell us in the clinic. In the case of a rather seriously sick woman who was visited by a volunteer, it became apparent just where the husband's rather casual attitude about his wife's needs fitted in and where a rather domineering, although disabled mother came to frustrate the young wife's attempts at asserting herself even more. The volunteer was able to get her into hospital care for a short time and while no great improvement could be made at the time, at least a beginning and a clarification of circumstances had taken place.

We came to see two specific issues very clearly that are related to expansion

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* Human Relations Course given by Dr. James Bryant of Northeastern University, Burlington, Massachusetts

of manpower by way of volunteers; one was that a volunteer, like a professional, needs something of an education. It is not appropriate to have a volunteer simply carry out certain tasks, but we owe him or her an opportunity for learning. We found that a small group discussion is probably the most valuable tool in this regard. It permits not only supervision by a professional, but perhaps more importantly, exchange of views among peers. We as professionals are members of a graduating class, or in some other way relate our experiences to one another and support one another. We furthermore need to discuss particularly the emotional aspects of our professional growth with each other and do the necessary reality testing. The medical people may well remember how as students, they were affected by fears of having heart disease when heart diseases were being lectured about. I am sure in other helping professions, the prospective helper will identify himself at one time or another during his training with the patient or client he is supposed to help and will fear that he may be beset with precisely the kind of illness that he is called upon to remedy. Reality testing during professional education will show the prospective professional the difference between the client's problems and his own, and so of course, it has to be with the volunteer. Our family aides were housewives with families of their own, and they had to learn to see the differences between the problem of the families they visited and the way they themselves ran their own families. This work was done primarily in group discussions with an experienced caseworker. A similar program, of course, would be feasible with college students who might be working primarily with adolescents in the clinic and who in the process will learn to compare what they see in their clients with what they have gone through themselves in their recently past adolescence.

A second and perhaps more obvious issue that came to our attention, is that of the volunteers being included into the work of the clinic. A feeling of belonging to the setting is, I believe, a must and can be attained by attending of staff conferences or similar occasions. From the role of family aide, a volunteer may graduate after a while into a more prolonged contact with clients, participating in group functions perhaps, or undertaking the reporting of a case history, i.e. noting down the patient's complaints and bringing into focus the pertinent problems and eventually become a counsellor.

Perhaps it is possible now to reach some general conclusions about the matter of manpower and training in the mental health field. (1) The relatively simple medical model where the recognized expert is the one who by implication guides or directs all the treatment, is I believe, no longer applicable to the mental health field. It is not correct any more to consider psychologists, caseworkers, educators or counsellors as members of ancillary professions to psychiatry. They have arrived on their own and have their specific contributions to make. Psychiatrists will have to live with that. Vice-versa, the so-called psychiatric outpatient clinic need not limit itself to what seem like purely psychiatric diseases, but may do well to consider problems of disturbed human relations in one form or another, such as marital problems or problems between parents and adolescents as legitimately within their province. More comprehensive outpatient services will be the result. (2) The effectiveness of a given setting is not necessarily commensurate with the technical ability of the staff, but in many instances has to do with the possibility of providing a meaningful and pertinent human relationship, short or long, which will in some way "make a difference" for the patient. It becomes important then, not only to have technical skills, but also to provide a number of possibilities where something significant may happen. The meaningful contact may indeed be with the psychiatrist, it may be in a therapeutic group, it may be in a family setting, on a visit at home, or in

any other contact which may come about through the clinic. A main focus of work in the mental hygiene clinic will then become the correct assessment of the patient's personal or interpersonal needs in the intake situation. (3) Ongoing training, perhaps in-service training of all staff and volunteers, become something of a way of life in a mental health facility. A supportable and livable milieu is created where there is openness to continued adaptation and new learning on the part of the staff who is daily confronted with new and different problems. (4) A common focus appears for the disciplines sharing in mental health work, a focus sometimes evident, sometimes elusive, but available to experts and novices alike given the opportunity: the meaningful human relationship. It is a task for community mental health workers to organize settings where such relationships can come about and where increasing understanding for their meaning can be aimed for.