

International Journals

MENTAL HEALTH SERVICES AND HUMAN NEEDS IN AN URBAN COMMUNITY: A PERSPECTIVE

Author(s): ANDREW C. GORDON and ALICIA McCAREINS

Source: *International Journal of Sociology of the Family*, Vol. 12, No. 2, The Family and the Mental Health Problems (Autumn 1982), pp. 241-249

Published by: [International Journals](#)

Stable URL: <http://www.jstor.org/stable/23027688>

Accessed: 09/02/2014 23:32

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <http://www.jstor.org/page/info/about/policies/terms.jsp>

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.



International Journals is collaborating with JSTOR to digitize, preserve and extend access to *International Journal of Sociology of the Family*.

<http://www.jstor.org>

MENTAL HEALTH SERVICES AND HUMAN NEEDS IN AN URBAN COMMUNITY: A PERSPECTIVE*

ANDREW C. GORDON
Northwestern University, Evanston
and
ALICIA McCAREINS
Northwestern University, Evanston

International Journal of Sociology of the Family 1982, Vol. 12 (Autumn): (241-249)

This essay grows out of a survey of mental health service requirements in the catchment area of an urban community mental health center (CMHC). We observed and administered standard intake forms to 50 persons in public places where apparently needy people congregate. Although one can characterize our sample in diagnostic categories by featuring their psychopathologies and demonstrating the extent of their therapeutic needs, we believe it would be misleading to do so. Social isolation, rootlessness, and joblessness were consistent themes in the interviews. Many of our respondents claim that their material and interpersonal needs are not aided by therapeutic intervention. Subsuming these needs into therapeutic categories, we argue, diverts attention and resources from problems which should be dealt with more directly.

The causal relationship between mental problems and social dysfunction remains unresolved. But our data persuade us that it is misguided to characterize the issue solely in therapeutic terms.

In an important study of patients in a large urban psychiatric after-care clinic, Summers (1979) describes a sample of clinic patients with respect to their demographic, psychiatric, and social characteristics. The research upon which this paper is based consists of interviews and observations in several public places—four hotels, a Y.M.C.A., and an emergency housing residence (the Mission) in the catchment area of the same

*Authors wish to thank Margaret T. Gordon and Steven Whitman for their comments on an earlier draft. Special thanks to our respondents for their cooperation in helping us to better understand their situation, and our own.

mental health facility. Each was defined as a site where persons in apparent need of mental health services are thought to congregate. In these settings, we administered the same instruments that Summers reported as effective measures of psychiatric symptomatology and social dysfunctioning in after-care clinic admissions procedures (Summers, 1979).

Our emphasis in the interviews was on allowing persons to describe their situation in their own terms and in sufficient detail so that their stories, as well as the issues which weigh on their minds when they assess their mental and functional state, would be apparent. Our interviewing technique is informed by the work of Bogdan & Taylor (1976) and Stack (1974) who write persuasively about the capacity of apparently mentally handicapped people to provide informative commentaries on their own lives.

Summers' (1979) survey of 125 consecutive new admissions is farsighted in incorporating measures of social and domestic role performance, as well as psychiatric history, symptomatology, and demographic variables. In summary, he characterizes these patients as "largely a group of chronically unemployed, unskilled though not poorly educated, social isolates in the middle range of life" (page 201). This also would be an accurate description of the persons whom we interviewed in the hotels and the Mission in the urban community that were the focus of this study. From his findings, Summers concluded that the problems of social adjustment are so widespread, and that their solution is so crucial to the patients' recovery, that a demonstrated capacity for independent living should be viewed as an adjustment problem to be included in the criteria for discharge. Summers views their patterns of repeated readmissions as further evidence against the wisdom of discharging them in the first place.

A CONTINUUM OF NEED

Our study and the research of others (Baxter and Hopper, 1981; Lewis and Hugi, 1981) suggest that there are sizable numbers of persons in our nation's urban areas who can be characterized as lacking critical life supports. Many are alienated and rootless in a variety of ways: recent or prolonged unemployment and/or divorce, and/or inadequate or non-existent housing are commonplace.

In another report (McCareins *et al.*, 1981), we developed a set of non-therapeutic categories which attempt to take account of the professional services our respondents need to "get back on their feet," and to estimate their likelihood of succeeding in doing so. On a continuum of intensiveness, we call our respondents "Chronically Needy"; "Marginals"; and "Hopefuls." Examples of each follow.

The "Chronically Needy" category consists of persons whom we

consider to be in need of more intensive therapeutic intervention than is now available to them. Most of them have extensive histories of psychiatric treatment and hospitalization. Many were actively delusional. Virginia, for example, felt that Lyndon Johnson had hounded and attacked her all her life. Mary would talk to us briefly, abruptly leaving to stare for long periods at the elevator, and then return to us as if nothing had happened.¹ Joan showed us the cuts and bruises which she regularly inflicted on herself. Their behavior suggests that these persons are victims of de-institutionalization (Scull, 1977), whose regimen of care should include intensive therapy.

The "Marginals" were primarily victims of social dislocations who, with the timely allocation of meaningful material and social supports, are likely to be re-established as productive citizens. In our estimation, they are at a crucial juncture in their lives; without these supports further emotional deterioration can be anticipated. For example, Dave is depressed about his inability to have long-term relationships with people, about living alone, and not having anyone who cares about him. He does have a job which he regards as meaningless, and adds that "when I have to go day after day to a job I don't like, and I am lonely and depressed, the whole world, well my whole existence, seems pointless." Martha has no sought-after job skill. She feels alone in the Mission because no one stays long enough for her to make friends. She desperately wants to find a job, to be independent, and to regain the pride she has lost by having to reside at the Mission.

The "Hopeful" respondents are people with temporary problems, arguably not of their own making, which nevertheless have had traumatic consequences. Sarah attributes her recent firing to her epilepsy, and had to send her daughter to another state to live with her grandmother until Sarah can once again find a way to support herself. Ralph's recent divorce "stripped him of everything." He moved to Chicago in order to try to find a job and to improve his financial and emotional situation, but now feels even more socially isolated at the Y.M.C.A., which further depresses him. Becky recently ran away from the last in a series of unhappy experiences in foster care. She is trying to become self-reliant, and the people at the Mission have high hopes for her future. She is planning to leave Chicago and begin a "normal, stable life" elsewhere. Diana is presently without a steady home or any means of support. "When I work," she insists, "I'm all right. But when I don't, I have problems."

We are in no position to disentangle the causal relationships in what we saw in the lives of these individuals, that is, it was clear to us that

¹The names of all respondents have been changed to protect their anonymity.

some of these people had severe psychological problems which undoubtedly contributed to their present life situations, including their joblessness and their interpersonal difficulties. But it was equally clear that many of these people were victims of circumstances—lacking meaningful employment opportunities, having experienced painful divorces, or, as in Becky's case, from families in disarray for reasons that had nothing to do with them.

In an impressive series of studies, Brenner (1967; 1973; 1976) has demonstrated highly significant inverse correlations between mental health admissions and a variety of national economic indicators, including various employment indices and measures of national economic activity. Likewise, Barling and Handal (1980) show that first admissions in hospitals in a state system are significantly related to short-range economic downturns for low status occupational groups, especially the unemployed. Brenner (1967) also presented evidence that ethnic groups occupying the highest social categories may be the most substantially affected by fluctuations in the employment index. Even with this formidable array of data, one is unable to identify the causal relationships among these variables. But it is to be predicted that as economic conditions become more difficult, more persons such as our respondents will seek material or psychic relief from their worsening circumstances.

RELATIONS WITH THE MENTAL HEALTH SYSTEM

Many of the people with whom we talked had been involved at one time or another in some form of professional therapy. For those who perceived therapeutic insights as valuable in facilitating their recovery, it was clearly an important component of their lives. For others, therapy provided their most regular and intimate contact with another human being; for them, this was its most important feature. They perceived therapy as otherwise very limited in what it could accomplish for them. Vicky, for example, is in an out-patient program and said that she knew she "needs the kind of support (therapy) provides, but I know it's not all I need. (My therapist) doesn't really treat my loneliness, my unemployment . . . I'm shy as it is, so when there is no one who wants to be friends, I get very depressed."

Other respondents admitted to using various health-related facilities quite manipulatively, checking into missions or after-care facilities to secure food and decent housing for a period of time. Others signed themselves into alcoholic treatment programs for the same reason—they did not know where else to turn for basic sustenance. Several were embarrassed and resentful at having to use such facilities in this fashion. Bruce "hates the Mission" because it means he is at the "bottom of the

barrel" and feels that he will not begin his "road back to independence" until he leaves it. Barbara was quite articulate about her desire to "break out of the cycle of living on Public Aid, having no job, no independence, no social life." She did not want to depend on psychotherapy as the only means of resolving her problems, but presently had no other options.

For some, the distinction between mental health care and a "flophouse" was an important demarcation. The negative image any form of therapy carries for a few, and particularly for our Hispanic respondents, is crucial here. Rudolfo considered therapy as a "crutch" which the "gutless" use when they are unable to work things out for themselves. He had no such feeling about temporary reliance on the Mission. In Raul's case, his parents were upset about his having received therapy for his drug-related problems, and have ostracized him until he understands that "God is his only real hope." Others expressed no discomfort about using mental health facilities interchangeably with other "way-stations" (Wiseman, 1970) in their environment, but (as with Vicky) as a *social* resource rather than as a clinical resource. Likewise, one respondent was proud that he "didn't fit in" at the Mission, but felt it was a necessary resource for him until he could "rejoin society." (For numerous examples of the instrumental use of mental health and other community facilities to supplement scarce psychic and material resources, see Lewis and Hugi, 1981). Psychotherapeutic help serves an important social function in the lives of these people, as do the lobbies, laundromats, and cafeterias of the places they frequent. Each provides essential, if often unsatisfactory, opportunities for social interaction.

LIFE CHANCES

The problems of nearly all of our respondents *could* be cast in therapeutic terms, as their responses to our therapeutically-inclined questions indicate. But we believe that it is inappropriate to conclude from this that it is sensible to so characterize these people and their situations. What they seem to lack and to miss is what we all would miss were they not available to us—people with whom to talk, meaningful ways to fill our time, adequate jobs and housing, and networks of friends to assist and comfort us in hard times.

Luckey and Berman (1979) cite the rate of recidivism among patients in mental hospitals as unequivocal evidence of the failure of short-term care, and argue for the development of more effective short-term therapies. Undoubtedly, some of those who are readmitted could not be effectively treated with short-term strategies. And as we have noted, at least some of these repeaters are persons who deliberately utilize mental facilities as

part of their community network to relieve their loneliness or to secure a meal when it is otherwise unavailable.

Family ties and networks of family and friends are supportive of individuals in a variety of ways. Among the most important of these are persons with whom to share one's time and one's thoughts—to be with, to relieve isolation, to provide companionship—persons with whom one can exchange ideas, who can appreciate and reaffirm one's worth, and share one's problems.

In a recent essay, Dahrendorf (1980) argues that "life chances are attributes *in society* and not attributes *of individuals*" (Emphasis added). "Their life chances may make or break them; but their lives are a response to these chances. Life chances are a mould." Dahrendorf reasons that life chances are distinguished from opportunities, and discusses the importance of "ligatures," the bonds and linkages that tie an individual to the social structure, and, hence, to other people. They are the connections to family, to friends, and to the community which give meaning to the choices one makes. And, importantly, options and ligatures can vary independently of one another. The impoverished Brazilian factory worker lacks both options due to his poverty and the absence of ligatures due to his migration from his extended family. The Chinese farmer has few options but many ligatures and, thus, has relatively better life chances.

Dahrendorf sees the modern Western world as rich in options but poor in ligatures. The respondents in this study are, in our judgement, among the most impoverished of our citizens with respect to life chances. Although it is indeed possible to conceive of our respondents in psychological terms, their lack of life chances and the erosion of ligatures seems a far more accurate way of viewing their life situations. Many are victimized by worsening economic circumstances. Others face difficult interpersonal problems, often rooted in family tension and discord. Most lack meaningful ways to spend their time. They are without the connections which give meaning to their lives and to ours.

CONCLUSION

The question we must ask in examining our data is if it was ever appropriate to characterize groups such as ours—and, we suspect, those in many out-patient and after-care clinics—largely in terms of their psychological symptoms. Summers (1979) did a great service by focusing on the social and vocational difficulties of after-care patients; the complex of rootlessness, social isolation, and job difficulties is similarly important in our neighborhood study. It seems to compound the problem to conceive of these issues primarily as mental health problems requiring therapy.

Tischler, *et al* (1975) found that large segments of the population which utilize community mental health centers were drawn from groups in the community which were isolated or lacked social supports. Recent research demonstrates some positive effects on instrumental functioning of working with clients in their natural environment (Stein and Test, 1980), and of assisting them in developing problem solving and community survival skills (Hogarty, 1977).

In New York, an official in the State Department of Mental Hygiene admitted that "many of the problems of (ex-patients) are due to housing, not mental health" and added that "we don't want to get involved in the housing business" (Health/PAC, 1981). Baxter and Hopper's (1981) position is consistent with ours; they say that "services themselves, however energetic and sophisticated, cannot compensate for deficiencies in living circumstances." In the present era of budget cuts, of shifting financial burdens from one public bureaucracy to another, or away from the government altogether, one might suspect the New York official's motives. But we tend to agree with his assessment, and to think that the remedy for a housing problem should not be to cast it as a therapeutic issue requiring professional intervention by mental health workers. Baxter and Hopper's (1981) insistence that mental health professionals "be willing to take on the role of advocates for essential goods and services" is appropriate only insofar as these problems cannot be effectively dealt with directly, without the involvement of the mental health system.

The Community Mental Health Amendment of 1975 includes the requirement that officials in each area be "in consultation with residents of the catchment area, review its program of services and statistics to assure that services are responsive to the needs of residents of the area" (P.L. 94-63). While this was rarely attempted, Zinober and Dinkel (1981) indicate that in Florida the recommendations of citizens (including former clients) were frequently implemented by Centers. The community residents with whom we talked focused more on problems of social functioning and less on their need for therapy. Their priorities were straightforward: meaningful employment, housing, and relief from social isolation.

Caplan and Nelson (1973) have argued that the focus of psychologists and psychiatrists on person-centered variables, rather than on situation-centered ones, allows policy makers to avoid difficult choices which require systemic change. Strategies for responding effectively to the plights of persons such as our interviewees can take many forms. When the need to respond effectively is cast as an obligation to meet essential human needs, the essence of the response is political—how will funds be distributed, and to whom. When it is cast as a service delivery question, the issue is seen as merely technical—one requiring community

residents to be clients, who are to be serviced by professionals (Gordon, *et al.*, 1976). Clearly and accurately identifying the issue allows one to recognize that the non-therapeutic needs may be equally well or better met by non-professionals, by networks of friends, for example, and by meaningful jobs and adequate housing.

There are at least three separable needs here: (1) the need for therapy, where skilled professional help is required and should be provided; (2) the need for material resources to provide jobs, housing, or other essential goods; (3) the need for sustained personal involvements, often without professional assistance.

An unfair burden is placed on the mental health system by expecting it to provide services for non-therapeutic needs. Moreover, consistently to conceive of joblessness, homelessness, and loneliness as symptoms of mental illness, and then to respond to the perceived therapeutic need rather than to the social and material plight is inappropriate. It is crucial to keep the various areas of evident need as conceptually distinct as one can, and to develop strategies which respond to each as directly as possible.

REFERENCES

- Barling, P. and P. Handal
 1980 "Incidence of Utilization of Public Health Facilities as a Function of Short-Term Economic Decline." *American Journal of Community Psychology* 9(1): 31-39.
- Baxter, E. and K. Hopper
 1981 "The New Mendicancy—Homeless in New York City." Unpublished paper. Community Service Society.
- Bogdan, R. and S. Taylor
 1976 "The Judged, Not the Judges." *American Psychologist* 31: 47-52.
- Brenner, M.H.
 1967 "Economic Changes and Mental Hospitalization in New York State, 1910-1960." *Social Psychiatry* 2: 180-188.
 1969 "Patterns of Psychiatric Hospitalization Among Different Socioeconomic Groups in Response to Economic Stress." *Journal of Nervous and Mental Disease* 148(1): 31-38.
 1973 *Mental Illness and the Economy*. Cambridge: Harvard University Press.
 1976 "Estimating the Social Costs of National Economic Policy." Washington: Joint Economic Committee, Congress of the United States (October).
- Caplan, N. and S. Nelson
 1973 "On Being Useful: The Nature and Consequences of Psychological Research on Social Problems." *American Psychologist* 28: 199-211.
- Dabrendorf, R.
 1980 *Life Chances: Approaches to Social and Political Theory*. London: Weidenfeld and Nicolson.
- Gordon, A., M. Bush, M. Gordon and R. LeBailly
 1976 "Beyond Need: Examples in Dependency and Neglect." Presented at the Annual Meetings of the American Sociological Association.

Health/PAC Bulletin

- 1981 "Disorders in Mental Health Policy." New York: Health/PAC Bulletin 12(6): 20-30.
- Hogarty, G.
1977 "Treatment and Course of Schizophrenia." Schizophrenia Bulletin 3: 587-599.
- Hopper, K., E. Baxter and S. Cox
1981 "Not Making It Crazy: Some Remarks on the Homeless Patient in New York City." Unpublished paper. Community Service Society (November).
- Lewis, D. and R. Hugi
1981 "Therapeutic Stations and the Chronically Treated: A Reassessment of the Community Mental Health Movement." Social Service Review 55: 206-220.
- Luckey, J. and J. Berman
1979 "Effects of a New Commitment Law on Involuntary Admissions and Service Utilization Patterns." Law and Human Behavior 3: 149-161.
- McCareins, A., A. Gordon, and P. Pomerance
1981 "Mental Health Needs in a Community: An Exploratory Study." Unpublished paper. Northwestern University.
- Scull, A.
1977 Decarceration. Englewood Cliffs, N.J.: Prentice Hall.
- Stack, C.
1974 All Our Kin. New York: Harper.
- Stein, L. and M. Test
1980 "Alternative to Mental Hospital Treatment, I." Archives of General Psychiatry 37: 392-397.
- Summers, F.
1979 "Characteristics of New Patient Admissions to Aftercare." Hospital and Community Psychiatry 30: 199-202.
- Warren, D.
1981 Helping Networks. Notre Dame: Notre Dame Press.
- Windle, C. and E. Flaherty
1981 "Emerging Evaluation Methods in Mental Health Services." In N. Smith (ed.) New Directions for Program Evaluation: Federal Efforts to Develop New Evaluation Methods (12). San Francisco: Jossey-Bass.
- Zinober, J. and C. Wurster
1981 A Trust of Evaluation: A Guide for Involving Citizens in Community Mental Health Program Evaluation. Tampa: Florida Consortium for Research and Evaluation.