The Challenge of Community Child Psychiatry

The Role of Ambivalence

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Central to much of the current reality in which community child psychiatry is practiced is the importance of ambivalence both in the motivations of many people with whom a clinic staff interacts and among clinic staff members themselves. Rexford (1969) emphasized the importance of ambivalence toward children as a factor explaining the limited support, despite the rhetoric, given to programs for them. Interest in mental health and mental retardation is a complex matter compounded of conscious and unconscious forces, conflict-laden as well as relatively autonomous internal factors. Mental disturbance is viewed through the special filter of individual personality and perception. While the conscious desire to help and to cure is in the forefront, negative feelings and ideas are invariably present as well. Both sets of feelings and thoughts about mental disturbance relate ultimately to concepts which individuals have about themselves, particularly about their own inner lives. Projections of anxiety-laden fantasies and underlying beliefs help to determine how disturbed children and adults are viewed. Displacements and other defensive operations influence opinions held about those who are involved with their treatment, a clinic and its staff. Much of what might otherwise seem inexplicable in the behavior of community groups and in the behavior of a community clinic staff can be better understood by appreciation of their strongly ambivalent feelings, thoughts, and underlying wishes. Failure to do so, and reliance instead on rationalistic explanations of

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why people behave as they do, lead inevitably to frustration, suspicion, and to litigious, power-oriented, or "philosophical" confrontations. A description of community child psychiatric theory and practice must rest on appreciation of the role of ambivalence and its pervasive influence on publicly stated conscious opinions, beliefs, and rationalized behavior.

In a previous paper (Newman, 1966), the reality in which community child psychiatry is practiced was divided into five major categories: political/economic, administrative, geographic, professional, and clinical. The characteristics of these categories were described, and their impact on the workings of a specific community child psychiatric clinic was discussed.

The Mystic Valley Mental Health Center, organized through a partnership arrangement between the Massachusetts Department of Mental Health and the local voluntary citizens' mental health association, with a professional staff of 40 full- and part-time workers, serves an area containing 167,000 people that includes four suburban towns and a city. The population contains a wide socioeconomic, ethnic, and cultural spectrum, with a large proportion of middle-income, psychologically sophisticated families who are extremely invested in their children. There has been rapid population growth in the area, and the children comprise a large percentage of the total. The often described tensions and anxieties of middle-income suburbia, with its vertically and horizontally mobile nuclear families, cut off from their antecedents and insecure in their social and economic position, are prevalent in our communities. Recently, these anxieties have become exacerbated by the unemployment crisis among scientists, technicians, and engineers who worked along Route 128.

A special feature of the area is that it is composed of five separate, autonomous municipalities, each of which possesses a unique character and little or no tradition of working together. There is a lack of coordination with, and correspondence to, other social service areas. The clinic staff must work with five school systems, five police departments, five boards of health, three family service agencies, three schools for retarded children, three municipal courts, and two regional offices of the Division of Family and Children's Services. One of the major changes which has occurred during the past few years has been reorganization of the Department of Mental Health, involving regionalization of the Department and expansion of its administrative structure.
The most important aspect of the political/economic reality is that the clinic is a public facility, the financial support for which comes largely from state and local tax funds which are in short supply. The clinic receives no federal funds and little money directly from private sources for operating expenses. Dependence on scarce public tax funds and the requirement to report the amount of service given to each of the five communities in terms of number of cases seen, interviews held, and hours spent make it mandatory to maintain an open intake policy and to emphasize not the intensive treatment of a few but rather the provision of service to all those who apply. The clinic must promote an image of helpfulness and availability. No one seeking help must be turned away. The political/economic reality also tends to put pressure on the clinic staff to produce new programs in order to demonstrate that the taxpayer's money is being well spent. There is a tendency for a community attitude to develop which might be summarized as, "What have you done for me this year?"

The geographic reality is that the main clinic facility is located on a street in a suburban town among the patients it serves, and not within the protected walls of a teaching hospital or on the grounds of a state hospital. The fact that the clinic is located in a particular town has tended to work against the concept of the Mystic Valley Area as a community. People tend to think of a clinic as theirs only when it is physically located in their town. In an attempt to bring services closer to people in all the communities of Mystic Valley, and to build community support in each political subdivision, decentralization of clinic operations and the location of activities in several places have been instituted. Problems in staff communication and coordination have resulted from this decentralization, however.

The geographic reality is that the clinic is so close to the people in its town that they come much earlier than they might to a more distant facility and do not always clearly identify themselves as patients. Consequently, they must be approached with less formality and distance and with more of the relaxed interest that one might show to a neighbor who comes to discuss problems. At the same time, this relaxed attitude must be converted into a professional
relationship and directed toward building a therapeutic alliance, a necessary condition if patients are to accept clarifications and interpretations about themselves in order to change behavior and alleviate symptoms.

The clinic is a part of the Department of Mental Health, but is dependent on the local mental health association which receives and dispenses monies for the clinic, and on those members who serve voluntarily on boards and committees. The administrative reality has become complicated by the creation of an area board also composed of citizens which has a planning function for mental health and retardation services. A feature of the area board membership is that it has been composed of individuals who have very specific, usually very personal vested interests: for example, the parents of retarded children and the parents of severely disturbed children. The presence of multiple boards with overlapping functions and without clearly defined spheres of responsibility and authority has created a highly complex and sometimes explosive administrative reality.

Large-scale citizen involvement in administration and program planning as well as militant advocacy of specific causes have been associated with public frustration and anger, produced in part by the impossibility of finding easy solutions to complex problems, and in part by the lack of responsiveness of the bureaucracy. The public has been invited to participate in planning, but has been denied the means to effect real change. Pent-up hostility finds expression, at times, in irrational attacks on care-giving agencies.

The professional reality is dominated by the fact that the clinic staff is not alone in the business of providing service to emotionally disturbed children. Departments of youth service, school guidance departments, and self-help groups are also involved with patients, although the patients may not be so identified, and the practitioners usually have a very different orientation toward and professional view of problems involved. One of the most important developments during the past few years in the professional reality has been a surge of community interest in volunteer and nonprofessional services in the mental health field. The reasons have to do partly with the high cost of professional services compared to the low cost of nonprofessional services. In addition, there is a feeling in the community that professionals, whether they be in clinics, schools, or other agencies, have failed to realize the expectations and hopes placed in them which led to their sponsorship and support originally. Another aspect of the professional reality is that there has been an increasing tendency to begin quickly conceived and modestly funded programs independent of existing services in
an attempt to solve a particularly pressing community problem. The most recent example of this trend has been the formation of self-help agencies to attempt to deal with drug abuse and alienated youth. The professional aspect of reality includes the impact of this self-help movement and its rampant antiprofessional bias.

The basic and inescapable clinical reality is that enormous numbers of people need and want service from the staff of trained professionals. This clinical reality is complicated by differences in the basic assumptions underlying commonsense thinking about mental illness, in contrast to psychiatric, particularly psychoanalytic, thinking about it (Minuchin, 1969). Whereas the psychoanalytic model ascribes the cause of mental health problems to intrapsychic processes, the commonsense or community model tends to be activistic and behavioristic and finds reasons for difficulties in the environment. The difference in the two ways of thinking is particularly striking when the clinic staff moves out into the community and attempts to deal with community problems. The conflict is especially apparent if the activistic and behavioristic theories of causation have a great deal of community support. The psychoanalytically trained mental health worker must then attempt to deal with what may appear to be a defensive process, based on projections and denials, reinforced by community beliefs. These difficulties arise in relation to such projects as the discharge programs for patients from mental hospitals and youth programs involving planned recreation facilities. In the first instance, members of the community tend to believe that the hospital both fails to help existing illness and also creates even more severe disability; and in the second, that alteration in external, reality factors is all which is needed to change the behavior of troublesome adolescents.

This conflict between the two ways of thinking is not irreconcilable. Both sets of assumptions must be used in community work, and their relative weight must be carefully appraised in each situation. The “truth” about mental hospitals and mental illness is not that the hospital creates the illness, nor is it that the character of the hospital has no effect on the illness. The problems of adolescence will certainly be affected by the type of recreation available, but the fundamental intrapsychic and interpersonal issues in teenagers will determine their behavior. Both internal and external factors are important, and neither environmental change alone, nor understanding of intrapsychic and interpersonal dynamics alone is adequate. There are complex interrelations between the two frames of reference which are as yet incompletely understood.

Clinic personnel are exposed to multiple demands associated with clinic expansion and diversification. A multiplicity of clinical
demands and therapeutic methods characterizes the clinical aspect of reality. The impact of these and other factors makes great demands on clinic personnel, induces stress and role conflict, and has important effects on clinic operations (Berlin, 1969).

**ACTIVITIES OF A COMMUNITY CHILD PSYCHIATRIC CLINIC WITHIN THESE REALITIES**

The basic policies of the Mystic Valley Mental Health Center and the specific activities of its staff have been developed consciously and unconsciously in the context outlined above, influenced both by reality demands and by the ambivalence underlying them. While fundamental change has not occurred during the past years, there has been growing awareness of some of the more complex aspects of the issues identified. The very definite limits of consultation have been more clearly defined by the staff. The milieu in which the consultee works imposes restrictions on his capacity to respond to even the most effective consultation. The structure of an institution has become for us at least a more clearly defined limiting factor. The leaders of an institution in which the consultee works may set a tone which further circumscribes the effectiveness of the consultation experience. Another factor is the amount of training that the consultee has and our experience that simple absence of training and experience may limit the effectiveness of a consultation program. Traditional consultation probably works best when the consultee, the institution, and the consultee’s supervisors have identified a problem area and have specifically requested the services of a consultant. In this respect, the model is similar to the patient/therapist relationship, in which the therapist is most effective when the patient has acknowledged that he has problems from which he wants relief, and has identified for himself a problem area in which he is willing to work.

One of the directions the clinic has taken in recent years has been somewhat away from consultation and more toward inservice training in an effort both to develop the skills of the consultees and to make some changes in the institution itself. Basically, however, in relationship to other groups in the community, the clinic functions as a kind of safety valve, as a place to which individuals can turn in order to have problem cases taken off their hands when an impasse develops and anxiety becomes unmanageable.

The professional reality requires establishing and building good relationships with other caretakers in the community. This issue is far from simple, and in the case of other professional caretakers it
means educating them to learn what they may expect from the clinic staff, and what the psychiatric team is able to provide. The process of education is a reciprocal one, for the clinic staff must learn from others what they are willing to accept. The special skills of other caretakers should provide a learning experience for the clinic staff as well. The clinic staff must support the nonprofessional workers in the community when they discover that what they had hoped to do simply and quickly for others does not often result in easy solutions.

The relationship with other caretakers, both professional and nonprofessional, should ideally be characterized by empathy, sympathy, and mutual respect. Yet it would be naive to assume that others approach the clinic staff openly admitting their limitations and asking for help, or that the staff approaches or responds to community groups only with benignancy. There are, behind the appearances, competition over status and power and intense feelings about asking and being asked for help. There is, on both sides, an understandable reluctance to court exposure and admit lack of knowledge or experience. These emotional concerns are reinforced by the real issues of competition among agencies for public funds and recognition.

We have been fairly successful in developing relationships with nonprofessional caretaking agencies in the community. In some instances, the impetus for clinic involvement may come from other sources in the community putting pressure on the nonprofessional care-giving agency to obtain professional participation. This situation involves a consultation relationship, but of the most informal type, in which neither consultant nor consultee is permitted to define the relationship precisely, lest anxiety over status and the ambivalence underlying the relationship become manifest and unmanageable.

Ambivalence is not the exclusive property of the community, but is to be found among clinic staff members as well. Indeed, the peculiar quality of ambivalence is that its presence in one group reinforces its influence in the other. The breakdown of formal consultation relationships and of the traditional roles of patient and therapist has focused our attention on the degree to which professional staff members have dealt with their own ambivalence by projecting pathology onto the "identified patient." The theory and practice of family therapy have helped to focus our attention on this defensive mechanism. By rejecting the concept of individual pathology, however, we find ourselves tending to support defensive denials and thus provide another method for dealing with am-
bivalence. Thus, while the traditional therapist may be guilty of a “we-they” dichotomy based on projection, the family therapist may fail to recognize individual pathology because of repression and denial.

Clinic expansion, increased community participation (with its underlying ambivalence), changing concepts of consultation, and the introduction of multiple therapeutic modalities increase the anxiety of staff members, intensify their own ambivalences, and, while challenging the traditional defensive mechanisms of professional workers, stimulate others. Therapeutic attitudes and beliefs crystallize around these defensive constellations, and controversy may then take place at the conscious level about what is the “best” treatment method.

Long-term individual psychotherapy and casework are applicable to only a small percentage of the population. Coupled with diagnosis of a family and its problems, there must be accurate assessment of a family’s capabilities for change and of their preferred mode of change which is based on their predominant defenses and other ego functions (Newman and San Martino, 1969). Behavior modification therapy, group work, short-term individual and family therapy have been introduced as attempts on the clinic’s part to expand the range of therapeutic possibilities to deal with a variety of clinical problems of wide-ranging severity in families with very different ego structures. These additional treatment modalities have further pointed to the need for the most sophisticated type of diagnosis and assessment. To state this point concisely, the most informed psychoanalytic diagnosis of pathology and assessment of defensive style must be utilized in the initial evaluation of a family so that proper and effective treatment can be instituted. There is continued pressure on key personnel to promote a stable diagnostic sense.

The clinic staff must concern itself with those institutions and practices which are destructive to mental health and self-esteem. There are significant gaps in service. Professional rivalries and professional inadequacies do exist which have a destructive effect on services and on the people who seek help. The staff must attempt to sort out the true from the fictitious, the real from the irrational, the outside factors which may be ameliorable from the projected internal concerns which cannot be changed.

However, problems identified by the community are often not calmly considered and thoughtfully defined. There are no firm contracts and no therapeutic alliances, the usual guidelines to which we are accustomed when working with people. There is a
demand for action and a reluctance to introspect. What appears to us as “acting out” occurs naturally in a community setting. What we have to offer is not quick solutions to complex problems, but rather a way of understanding community needs which may lead to more effective, but not dramatic and immediate action. The role of the community mental health worker might best be likened to the goal “to talk like a man of action and act like a man of thought.” In this way, the community mental health worker attempts to relate to the community in a meaningful manner.

The administrative reality makes many demands on the clinic professional staff, particularly on those members of the staff in executive positions. The staff must be educators and translators, able to communicate what it knows to a variety of audiences and to convert its knowledge into usable, palatable information. At the same time, the staff must possess the skills of the most successful type of politician, the capacity to navigate in uncertain and at times turbulent administrative channels, yet retain a high professional standard of diagnosis and treatment.

The community mental health worker must be able to recognize the anxiety and guilt behind the demands of various pressure groups and, while not reacting immediately to emotionally laden demands, respond effectively to the underlying issues. Awareness of a group’s concerns and readiness to enter into dialogues with its members is of crucial importance. A community group may strongly advocate a particular program, e.g., establishing a residence for teen-agers who cannot or will not go home, only to raise innumerable questions about the program when it is about to become a reality. Objections to agreed-upon expansion of services to meet clearly identified needs may be raised because of apparently real concerns about cost, manpower, or potential effectiveness. These concerns, it should be emphasized, are valid in themselves and deserve objective, factual consideration. We must understand that the timing of doubts about programs, and the force with which questions about them are raised, point to strong underlying feelings about the help which is to be given and about the helpers and those who are to be helped.

The staff must continue to build alliances with those individuals in the community who support professional services. The staff must fundamentally be able to live with a high degree of administrative ambiguity and uncertainty in an atmosphere of rapid change, and react neither with excessive anxiety nor with defensive hostility. These are obviously ideal goals which can be attained only partially in reality.
In many respects, the clinic’s role is to head off scapegoating; that is, the finding of a single external cause for the problem. Scapegoating may be avoided if the basic factors causing it can be recognized, and careful attention can be given to them. Often, these underlying issues involve competition, anxiety, and guilt, the defenses developed to manage them, and the patterns of attitude and behavior which result. Attitudes and behavior which rest largely on projections and displacements must be recognized in a manner which preserves the self-esteem of the people involved. The task confronting the community mental health worker is a difficult and delicate one. He must be aware of the largely unconscious forces underlying blaming and faultfinding, yet believe in the possibility of mobilizing constructive change.

There are clear parallels between working with parents, children, and families clinically, and working in and with the community. In both spheres ambivalence is a central fact of life. In both, the practitioner must listen for the covert as well as the manifest message. In working with families, a capacity to shift point of view from child to parent, from intrapsychic conflicts in each to interpersonal relationships between them is mandatory. This same capacity to look at matters from different points of view, and to be able to shift perspective from one frame of reference to another, to examine and understand both the actual or objective reality and the psychological or perceived reality is basic to effective community mental health work.

**Summary**

We have emphasized that community child psychiatry is influenced both by the beliefs of its practitioners and by the circumstances in which it is practiced, and that effective clinical and administrative performance requires professional workers to evaluate this situation and to integrate their understanding of its requirements with their beliefs about good professional work. Viable programs and practices which have meaning and value result from successful integration of professional ideas and standards with the realistic demands of the environment in which a community child psychiatric clinic functions. Awareness of underlying ambivalence and of the defenses used to manage it deepens understanding of both the implications of reality demands and the meaning of professional attitudes. Such understanding helps to enhance the ability to manage the possibilities and limitations of community child psychiatric practice.
REFERENCES


