

Introducing Community Psychology in an Introductory Psychology Course

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My overall goal for my community psychology lecture in Psych 101 is simple. I want to make the point that there is an alternative to the traditional, medical model approach to understanding and intervening with cognitive, emotional and behavioral problems. I want my students to question the assumption that these problems always have an etiology internal to an individual, and therefore must be dealt with on an individual level.

My specific goals for the lecture are as follows:

- To make clear the assumptions underlying the traditional, medical model of mental disorders.
- To introduce the concept of prevention as an alternative to treatment.
- To present the idea that there are environmental and structural factors which are external to the individual but which play a significant role in the development of mental disorders.
- To effectively argue that the concepts of prevention and a focus on environmental and structural forces can actually provide a much more effective approach compared to the traditional treatment model to dealing with mental disorders.

I make a point of giving the community psychology lecture after the lectures on psychopathology and treatment. In my experience, introductory psychology texts present a very traditional approach to understanding these problems. They present a number of models of etiology such as psychodynamic, behavioral, cognitive, and neurobiological. But the models all have an internal focus. Most introductory texts do present the idea of sociocultural contexts, however, they stress the role that cultural norms and traditions play in the manifestation of mental disorders, rather than the general role of environmental/structural factors. The closest they come to discussing the environment is by presenting a diathesis-stress model, but even there the emphasis is on the relative degree of the individual's predisposition to a disorder, and the intensity of the stress the individual experiences, rather than any discussion of structural influences (see, for example, Bernstein and Nash, 2005).

Going Beyond The Internal Perspective: A Historical View

Luckily for us as teachers, I believe our society has made some strides in encouraging our citizens to question whenever they are presented with only one paradigm. Even if they do not explicitly question what they are being told, at some level they know there has to be another way of approaching the issue, and they are interested in knowing what that "other way" might be. I explicitly present community psychology as that "other way".

First, I review the treatment assumptions that arise from the medical model. The most important of these is the idea that if someone is experiencing problems, then there is

something wrong with that person as an individual. If the cause of the problem is individual and internal, then of course the treatment should be focused on “fixing” that individual. And if people are “sick”, then what they need to do is to go see a professional and do what the “doctor” tells them to do. While these are certainly simplistic presentations of the assumptions underlying the medical model, they have had powerful effects on how we, as a society, understand and approach emotional, behavioral, and cognitive problems.

I talk about the problems with those assumptions, particularly as they were understood in the late 1950s. Most introductory psychology texts discuss Hans Eysenck’s 1952 review of the effectiveness of psychotherapy, in which he concluded that individuals who received no treatment improved just as much or even more than those who received psychotherapy. However, these textbooks generally discuss that study in terms of the difficulty of measuring treatment effectiveness, and with the explicit statement that Eysenck’s conclusions have been refuted since his study (see, for example, Bernstein & Nash, 2005, pg. 493). I put Eysenck’s study in the context of the effect it had upon psychotherapists researching and practicing in the 1950s. How did it feel to them to see the first major review of psychotherapy effectiveness conclude that therapy had no effect?

I tell them about George Albee's 1959 study, in which he concluded that, if we continued to rely upon a one-on-one, professional-to-patient method for providing psychotherapy, the US society would never be able to train enough professionals to provide therapy to everyone who needed it. This makes sense to them, since they have already heard about several large-scale surveys which conclude that 30% of the US adult population meets the criteria for a DSM diagnosis in any given year (Andrade, Walters, Gentil, & Laurenti., 2002; Bjil et al., 2003; Liu, Prince, Blizard, & Mann, 2002).

We also talk about the expense of psychotherapy, the limited effectiveness of some approaches with many cultural groups, and the unavailability of therapy in some areas, particularly rural areas like Northern New Mexico.

The summary of this part of the class is, psychotherapists working in the 1950s saw research saying the following: 1) psychotherapy doesn’t work. 2) Even if it does work, we can’t provide it to everyone who needs it 3) Even if we could provide it, it is time-consuming, expensive, and is not culturally appropriate or available for some groups. These people looked at this research and said, “There has to be a better way”.

This is not just an academic discussion about the usefulness of psychotherapy. The psychologists debating this issue in the 1950s had dedicated their professional lives to improving the lives of others through psychotherapy, and the evidence suggested that perhaps their efforts were wasted. Emory Cowen’s (1980) quote about the “frustration and pessimism inherent in trying to undo psychological damage once it had already occurred” emphasizes the emotional nature of this discussion. The example of a young woman who suffered abuse from the ages of six to sixteen is useful here. The students

realize that she can overcome the abuse, and lead a happy, productive life, but she will still never be the person she would have been if the abuse had never occurred.

This leads to the next question posed to the class, "If you don't want to be stuck trying to undo psychological damage that has already occurred, what can you do instead?" Usually fairly quickly someone comes up with the idea of preventing the damage from ever occurring in the first place. I reply that was exactly the question some psychologists were asking in the early 1960s, and, for answers, they started looking at the public health model and the idea of prevention.

A Prevention Perspective

This is actually a very fun part of the lecture. I ask the class where, in the whole world, they could find the virus that causes smallpox? The guesses span every part of the world, but only occasionally does someone get the actual answer, laboratories (specifically the CDC in Atlanta and a lab in Russia). I tell them that smallpox was declared eradicated in 1980, and ask them how this goal was achieved. Was a treatment for smallpox developed? By this time the class is catching on, and they respond that it was done through vaccination. There are always two or three people in the class who have a smallpox vaccination mark (including myself). I emphasize the fact that there is still no treatment for smallpox, a fact that many of the students do not realize. It is a bit of a challenge not to get diverted into discussions of bioterrorism here, but I persevere. (For more information on smallpox, visit the CDC at <http://www.bt.cdc.gov/agent/smallpox/disease/>)

I tell the class that this is the central point of the public health model, that no disease has ever been eradicated through the treatment of its victims. Generally at this point I tell an abbreviated version of the story of Dr. John Snow, the 1854 cholera outbreak in London, and the Broad Street pump. My purpose in telling this story is to have an engaging way of presenting the public health model, and its focus on prevention, as an alternative to the traditional focus on treatment in the medical model. For more information on John Snow, there are several recent books and many good websites (for example, Vinten-Johansen, Brody, Paneth, Rackman, & Rip, 2003; and <http://www.ph.ucla.edu/epi/snow.html>).

It is relatively easy to help the class see the advantages of a preventive rather than a treatment approach. Getting them to recognize the role of structural factors (as opposed to intrapsychic and neurophysiological factors) in the development of disorders is a bit more difficult. To accomplish this, I explicitly contrast the internal focus of the medical model with the external focus of community psychology by asking, "If I gave you a magic wand and told you that you could eliminate just one thing in the world, with the goal of reducing the occurrence of every disorder in the DSM, what one thing would you get rid of?" They all suggest things like child abuse, other types of violence, and substance abuse. I say that I would get rid of poverty, and talk about the research linking poverty to every disorder listed in the DSM.

For the purposes of this column, I want to note that I do not discuss the complicated nature of the debate regarding the causal relationship between economic factors and mental disorders in this lecture. I just point out that from 1939 to now, studies have repeatedly found a correlation between economic factors and measures of mental illness (see Hudson, 2005, and Lorant, Deliege, & Eaton, 2003, for just two recent reviews, and Faris & Dunham, 1939, for the earliest study).

Although I do not have the time in this class to discuss the structural nature of poverty, most of our students seem willing to accept that poverty is, to at least some degree, a structural/environmental factor. Discussing the relationship between poverty and mental disorders is an effective way of illustrating the idea that community psychology, as opposed to the medical model, focuses on issues external to the individual that we know are related to emotional, cognitive, and behavioral distress, and the idea that these issues are largely beyond individual control.

Changing Settings

After presenting this basic dichotomy between the internal focus of the medical model versus the external focus of community psychology, my goal is to draw the link between environmental factors and structural ones. Community psychology, ultimately, is about changing organizations, neighborhoods and societies in order to support healthy development in everyone. It is about developing mechanisms to provide the resources that everyone needs to deal with problems in their lives, rather than trying to "fix" individuals who experience difficulties.

But this idea of changing structures, processes, and organizations, rather than changing individuals, is not always easy to communicate. To help the class make this jump, I give them the example of an inner-city high school with an 80% drop-out rate. I ask how a psychologist working from a medical model would deal with the problem. With some hints from me they come up with the idea that the medical model would suggest supplying individual or family-level treatment for every child at risk for dropping out. We all agree that approach is unrealistic.

Then I ask, "Well, if you don't want to have to treat each individual, what could you do instead?" And generally, right away, someone says, "Change the school." After that they generally do not need any more hints from me and we spend the rest of the class talking about what they would change about high schools to decrease drop-out rates. Well, actually they do need some hints to move beyond the level of just changing the individual school. But with some suggestions, they can generally develop at least some ideas about developing alternative methods of providing a high school education, or radically changing the relationship between the school and the community.

If we have time, I give them a brief introduction to the concepts of empowerment, social support, taking an active rather than a passive approach to intervention, and changing public policy with the specific goal of improving the functioning of individuals. Or, sometimes I discuss current work that I am doing in the community.

I end by emphasizing what I see as the major point of community psychology. If we develop organizations and societies that support healthy development and provide resources, we will not have anywhere near as many individuals who require "treatment".

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