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The Counseling Center as a Healing Community: the Development of a Model

Talitha Day Fair
Andrews University

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THE COUNSELING CENTER AS A HEALING COMMUNITY: THE DEVELOPMENT OF A MODEL

Fair, Talitha Day, Ph.D.
Andrews University, 1987

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Andrews University
School of Education

THE COUNSELING CENTER AS A HEALING COMMUNITY:
THE DEVELOPMENT OF A MODEL

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by

Talitha Day Fair

April 29, 1986
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DEVELOPMENT OF A MODEL

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by
Talitha Day Fair

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ABSTRACT

THE COUNSELING CENTER AS A HEALING COMMUNITY:
THE DEVELOPMENT OF A MODEL

by

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Title: THE COUNSELING CENTER AS A HEALING COMMUNITY:  
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Abstract

In a pluralistic society alternative models for delivery of mental health services are needed to enhance the effectiveness of professional therapy, to provide appropriate care for persons from various subcultures, and to increase job satisfaction and reduce the level of stress for therapists. This study proposes an alternative model based on the concept of a healing community.

Five alternative mental health programs qualifying as healing communities were observed to identify the therapeutic dynamics in such settings. Communities observed were a self-contained village with mentally handicapped and normal adults, a church that functions as a community, a juvenile center, a self-help group, and a private day school for troubled children.
The communities were studied through qualitative, phenomenological methodology utilizing participant-observer techniques. Since there was no way to know what would be found in these communities prior to spending time in them, existing bodies of theory could be tied to the study only after the findings were completed.

In the healing communities observed, the major therapeutic dynamic was found to be warm, close, accepting interpersonal relationships in an egalitarian context in which healing interactions took place in social, peer-oriented as well as in formal counseling.

The resultant model integrated professional therapy with a support system and educational program. The support system provides, for clients, practical assistance, peer counseling, and opportunities to growth through serving others. It also includes features to reduce stress and burnout for counselors.

The findings of this study were related to theories in social psychology, community psychology, and personality theory, particularly to the dynamic of love.
To my beloved Father
# TABLE OF CONTENTS

PREFACE ...................................................... ix

Chapter I. INTRODUCTION AND STATEMENT OF THE PROBLEM .......... 1
  Background .......................................... 1
  Statement of the Problem ........................... 3
  Purpose of the Study ............................... 4
  Concepts ............................................ 5
    Community ....................................... 5
    Conceptual assumptions ........................... 6
  Theory and Process ................................. 7
  Objectives ......................................... 12
  Limitations and Delimitations ..................... 13
  Organization of the Study ........................ 14

II. LITERATURE REVIEW ................................... 15
  Introduction ........................................ 15
  Historical Background ................................ 15
  Alternative Programs ............................... 25
    Therapeutic Community ........................... 26
      Description ................................... 27
      Research ..................................... 32
    Residential Treatment Communities ............... 37
    Positive Peer Culture ........................... 41
    Youth-Oriented Alternative
      Counseling Centers ............................. 45
    Self-help and Support Groups ..................... 50
    Church Community ................................ 57
    Communities with Mentally Handicapped .......... 60
    Call for Change in Model ........................ 64
  Summary of Literature ............................. 69

III. METHODOLOGY ......................................... 71
  Introduction ........................................ 71
  Research Procedures ................................ 73
    Initial Steps ................................... 73
    Finding Observation Sites ........................ 75
    Organization of Information ....................... 76
    Constructing the Model .......................... 80
  Summary ............................................ 81
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Questions and Answers</td>
<td>193</td>
</tr>
<tr>
<td>Contributions of this Observation to the Model of Counseling Center as Community</td>
<td>194</td>
</tr>
<tr>
<td>Benet Learning Center</td>
<td>196</td>
</tr>
<tr>
<td>Introductory Imagery</td>
<td>196</td>
</tr>
<tr>
<td>Facts and History</td>
<td>197</td>
</tr>
<tr>
<td>Roles</td>
<td>200</td>
</tr>
<tr>
<td>Director</td>
<td>200</td>
</tr>
<tr>
<td>Supervisors</td>
<td>201</td>
</tr>
<tr>
<td>Teachers</td>
<td>201</td>
</tr>
<tr>
<td>Aides and volunteers</td>
<td>202</td>
</tr>
<tr>
<td>Students</td>
<td>202</td>
</tr>
<tr>
<td>Activities</td>
<td>203</td>
</tr>
<tr>
<td>Beliefs</td>
<td>205</td>
</tr>
<tr>
<td>Communications</td>
<td>206</td>
</tr>
<tr>
<td>Decision-making Process</td>
<td>207</td>
</tr>
<tr>
<td>Support</td>
<td>210</td>
</tr>
<tr>
<td>Psychological Sense of Community</td>
<td>211</td>
</tr>
<tr>
<td>My Contacts</td>
<td>212</td>
</tr>
<tr>
<td>Persons Interviewed</td>
<td>215</td>
</tr>
<tr>
<td>Research Questions and Answers</td>
<td>218</td>
</tr>
<tr>
<td>Question 1</td>
<td>218</td>
</tr>
<tr>
<td>Question 2</td>
<td>220</td>
</tr>
<tr>
<td>Question 3</td>
<td>224</td>
</tr>
<tr>
<td>Question 4</td>
<td>227</td>
</tr>
<tr>
<td>Summary of Questions and Answers</td>
<td>231</td>
</tr>
<tr>
<td>Contributions of this Observation of the Model of Counseling Center as Community</td>
<td>234</td>
</tr>
<tr>
<td>Summary of Research Findings</td>
<td>236</td>
</tr>
<tr>
<td>V. THE MODEL FOR COUNSELING CENTER AS COMMUNITY</td>
<td>238</td>
</tr>
<tr>
<td>Introduction</td>
<td>238</td>
</tr>
<tr>
<td>Characteristics of a Counseling Center as a Community</td>
<td>239</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>240</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>243</td>
</tr>
<tr>
<td>Professional</td>
<td>244</td>
</tr>
<tr>
<td>Religious</td>
<td>244</td>
</tr>
<tr>
<td>Summary of Characteristics</td>
<td>245</td>
</tr>
<tr>
<td>Organization and Program</td>
<td>246</td>
</tr>
<tr>
<td>Professional Therapy</td>
<td>246</td>
</tr>
<tr>
<td>Support System</td>
<td>246</td>
</tr>
<tr>
<td>Practical assistance</td>
<td>247</td>
</tr>
<tr>
<td>Center-related activities</td>
<td>250</td>
</tr>
<tr>
<td>Peer counseling</td>
<td>251</td>
</tr>
<tr>
<td>Support groups</td>
<td>255</td>
</tr>
<tr>
<td>Educational Component</td>
<td>258</td>
</tr>
<tr>
<td>Classes for children</td>
<td>258</td>
</tr>
<tr>
<td>Classes for adults</td>
<td>261</td>
</tr>
</tbody>
</table>
PREFACE

The principle of the inter-relatedness of all human beings, a basic assumption of this dissertation, has come alive to me through the interaction among the many people who have contributed to this study.

Special recognition should be given to my committee members, Marion Merchant (chairman), Don Gillespie, Thesba Johnston, and Miriam Schultheis for their supportiveness and generous giving of themselves; to Michelle, my typist, for her flexibility; and to my friends and my parents for their encouragement and patience with me during this past year. I also want to express personal appreciation to the women and children of Selah Center, without whom I might never have understood the God-given principle that what affects one of us affects us all.

If I could leave but one impression with the reader, it would be that the principle of inter-relatedness is to be enjoyed, savored, and cultivated. It was shown in the communities and in the model of the Counseling Center As Community; it was expressed by John Donne (Devotions XVII) and later rephrased by Whitney and Kramer (Shawnee Press, 1950), as follows:

No man is an island, no man stands alone.
Each man’s joy is joy to me, each man’s grief is my own.
We need one another, so I will defend,
Each man as my brother, each man as my friend.
CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

Background

Systems for mental health care and development have been a part of all societies, primitive and modern (Cumming, 1966; Erickson & Hyerstay in Gibbs, 1980). Widely varying methods and beliefs have been utilized for the relief of psychological suffering and maintenance of normal psychological and social balance.

In non-Western societies, mental health care has often been given through culturally sanctioned group involvement, rather than through therapist-to-client dyads. The Iroquis Indians prior to 1800 processed disturbing dreams and traumatic life events through tribal meetings. The rituals and ceremonies provided the individual with the therapeutic experience of acceptance and positive regard (Opler, 1959). More recently, the Zuni Indians have treated disruptive behavior through commitment of the individual to a secret medical society, such as the Clown Fraternity (Almond, 1974). In Ethiopia, Amharic women have found relief from symptoms and achieved new social status through participation in the rituals and exotic dances of the Zar cult (Messing, 1957). Almond (1974) studied extensively the treatment of psychosocial disorders through group involvement. He used the term "healing community" to designate primitive and modern groups in which deviance is redefined and channeled and in which the sufferer is a valued member of a mutually supportive network.
Instead of integrating the suffering person, Western society has tended to ostracize, stigmatize, and incarcerate the emotionally disturbed individual. The American Puritans regarded him as tainted, to be isolated lest he contaminate the righteous. In spite of their noble intentions, reformers of the 1800s locked away thousands in psychiatric hospitals, which eventually became national scandals (Wolfenberger, 1975).

After World War II, a movement arose to improve the treatment of the mentally ill, in part as a response to the needs of returning veterans. Deinstitutionalization—returning chronic psychiatric patients from the hospital to the community—and the establishment of Community Mental Health Centers (CMHCs) became national policy. The CMHCs were envisioned as all encompassing programs to treat the chronically mentally ill, minorities, and socially devalued persons, to work with community leaders in correcting the social conditions that foster mental illness, and to provide counseling and education to the general populace.

Unfortunately, neither the "glorious benefits of deinstitutionalization" nor "the unbounded promises of the CMHCs" became social realities. Instead, the chronically mentally ill were dumped onto the streets with almost no provision for their daily living needs or for therapy. The CMHCs treated almost the same population as had been served by private practitioners and public clinics (Donnelly, 1982). Services were still unavailable, out of reach, or inappropriate for a large portion of the American people, including the one-fourth of the nation that lived in rural areas. Professional therapists found the system still fraught with the same frustrating
patients, concerned laymen, and professionals (Chu & Trotter, 1974). The system for delivery of mental health services was still in desperate need of renovation.

**Statement of the Problem**

A pluralistic society such as the United States requires more than one model for the delivery of mental health and human services. Concurrent with the approach advocated by public policy, alternative models for mental health care have been springing up in the private sector. These models often discarded the medical model, traditional hospital organization, and conventional dyadic therapist-to-client relationships. Therapeutic community—a minimally hierarchical, democratic, egalitarian approach to psychiatric ward organization and operation—was proposed by Maxwell Jones, M.D., and was popular during the 1950s, 1960s, and early 1970s in Britain and America. Alternative programs designed to meet the needs of the youth culture, and particularly the "flower children," were established by young professionals who used college students and paraprofessionals as therapists. Simultaneously, the self-help and support group movement was becoming a major force in the mental health field.

Within Christianity during the same time period, the churches were awakening to the need for Christians to grow together in warm, mutually supportive relationships (Miller, 1973). A model to train lay counselors for local congregations was developed by Lawrence Crabb (1977), who continues to instruct counselors at Grace Theological Seminary. As a professional psychologist and researcher, Wolfenberger (198) developed an extensive case for the
church-at-large as the most effective and efficient agency in providing mental health care.

As the enthusiasm of the 1960s settled into the placidity of the late 1970s, many of the alternative programs shifted toward more conventional forms of organization and presentation of themselves to the public. Though the rush to discover a panacea for the nation's problems has subsided and the present system of mental health care has entered a more conservative period, there is still need for alternative models.

This study offers one such possibility. That possibility is to develop small, interdependent groups of lay, paraprofessional, and professional persons who work together in a warm, accepting, open atmosphere to bring about inner healing for sufferers and continued psychosocial learning and maturation for all participants. Such a group is termed in this study a healing community, or simply a community.

Purpose of the Study

The purpose of this study was to do phenomenological and field research into the dynamics of several alternative mental health programs which operate as healing communities, and to identify the effective therapeutic and growth-producing principles in them from the perspective of all participants in these settings. The principles were then applied in developing a model for counseling centers as healing communities. The new model attempts to avoid the anti-therapeutic factors found in the present public and private systems.
Concepts

Community

An understanding of the programs to be observed and the model to be constructed depends on an understanding of community. Although the word community has been given many definitions, it is used in this study to mean a form of organization and a quality of interpersonal relationships. Community as organization is defined in the Literature Review section on therapeutic community and is characterized by interdependence, minimally hierarchal structure, shared decision making, open communications, multiple leadership, and flexible roles. Community as an attitude or quality is more elusive.

Broom and Selznick (1968) defined community as follows:

A community is a comprehensive group with two chief characteristics: (1) within it the individual can have most of the experiences and conduct most of the activities that are important to him; (2) it is bound together by a shared sense of belonging and by the feeling among its members that the group defines for them their distinctive identity. (p. 374)

For the community of the type being proposed as a mental health program, the words "most of the" in the phrase "most of the activities" should be stricken as being too restrictive. Louisa Howe (in Beigel & Levenson, 1972) searched for a definition of community and concluded it consists of a "symbolically expressed sense of common destiny, a common envisioning of situations that are going to arise, a sense of interrelationship in the face of this destiny, and a knowledge of what community members can expect of one another" (p. 377).

Sarason (1974) focused on the inner experience, the psychological sense of community. He stated he had never met anyone with
any great difficulty understanding what was meant by psychological sense of community as:

The sense that one was part of a readily available, mutually supportive network of relationships upon which one could depend and as a result of which one did not experience sustained feelings of loneliness that impel one to actions or to adopting a style of living masking anxiety and setting the stage for later and more destructive anguish. It is not merely a matter of how many people one knows, or how many close friends one has, or even the number of loved ones—if they are scattered all over the country or world, if they are not part of the structure of one’s everyday living, and if they are not available to one in the usual ‘give and get’ way, they can have little effect on one’s immediate or daily sense of community. (p. 1)

Combining these descriptions gives a feel for community as it is used in this paper.

How then may a program that is community become an agent for delivery of mental health services? Each intentionally constructed community centers around certain activities and goals. If the goal is mental health, it is logical to develop a community that is a counseling center or, to reverse the perspective, to develop a counseling center that is a community.

A counseling center that is a community rests on certain assumptions. The following are assumptions of this researcher as foundation for community, assumptions that inevitably shaped the research and the resulting model.

Conceptual Assumptions

Every theory or therapeutic system rests on a particular world view. This paper rests on a view of the nature of man and the universe that the researcher believes is compatible with community, Christianity, psychotherapy, and the American life.
1. Each human being, having been created in the image of God (as described in the Scriptures), has intrinsic value and is worthy of love, respect, and help in meeting his needs, including his psychotherapeutic needs.

2. There is more than one "right" way to do almost anything, including the provision of mental health care. Some ways are "more right" than others for a particular time, circumstance, and person.

3. People need people. Each person, no matter how handicapped or disturbed, contributes to society and enhances the lives of others when provided a proper environment and opportunity. Each person, no matter how talented and mature, has needs for love, belonging, learning, and growth that can be met only through relationships with other people.

4. Individuals may seek psychological help from deficiency motivation or from growth motivation. (Psychological growth should be a lifelong process.)

5. Professional expertise is valuable in helping disturbed persons; however, laymen who are caring, insightful, and empathic can contribute much to the therapeutic endeavor.

6. Successfully helping other people may result in personal growth for the helper.

Theory and Process

The researcher's approach in this paper is rooted in challenges issued in recent years for new research paradigms. The paradigm of research which is commonly known as the scientific method has been effective for studying the inanimate world
and lower animals. Man, however, is a being who is capable of being aware of his own awareness, of thinking reflexively about his own thoughts and emotions. The traditional scientific paradigm of research based on positivism and the experimental method is inadequate for understanding man, according to Diesing (1971) in *Patterns of Discovery in the Social Sciences*.

An entirely new research paradigm is needed, a paradigm that emphasizes description, meaning, and undivided wholeness of human experience. With this intent, Diesing discussed patterns of discovery of knowledge that are phenomenological, that view what is there as what is important and meaningful in itself. These paradigms are descriptive rather than experimental or statistical, are often criticized by traditionalist as atheoretical, and are concerned with experience rather than abstractions.

In a similar vein, Van Leeuwen (1982) challenged psychologists to progress beyond the restrictions imposed by the empirical approach and to develop new patterns of thinking about research that (1) replace positivistic research methods with more descriptive, qualitative, and cooperative methods; (2) set aside causal explanation as the ultimate criterion for judging the adequacy of investigation; and (3) shift allegiance from concerns of powerful institutions to those of ordinary people of every sort.

Echoing these same themes and extending them even further is the volume, *Existential Phenomenological Alternatives for Psychology*, by Valle and King (1978). Repeatedly, in several chapters relevant to this present paper, Valle and King stated that, to understand man, it is imperative to pursue research that results in descriptive
formulations of human experience, that emphasize understanding the life of the common man. An investigator who attempts this perspective "will discover that understanding the investigated phenomenon qualifies exquisitely as a criterion for research knowledge...." (p. 56).

Such research does not begin with a prescribed body of theory, develop and test hypotheses, and then draw conclusions. Instead, it diligently seeks to perceive phenomena just as they are. "The primacy of perception means that we allow what we see to teach us to comprehend the seen as opposed to forcing our comprehension of the seen to determine our seeing" (p. 67).

In this volume (Valle & King, 1978), several possible phenomenological approaches to research are given, the steps of which may be combined in many different patterns, according to the authors. The steps of two patterns of "understanding-descriptive methods" influenced the methodological approach of this paper.

In those patterns of research, Valle and King suggested that the investigator begin by asking himself what he is interested in, why, and what are his experiential assumptions related to the topic. The researcher should then decide what phenomena and what persons he wants to study and how he will gain an understanding of these persons' experience of the phenomena. Through phenomenological methods, which often include participant-observer techniques, the researcher gains as much descriptive data as possible. From this unwieldy bulk of data, he formulates more specific statements and eventually arrives at a description that can be used to communicate an understanding of the phenomena.
It may be noted that in this understanding-descriptive method, which is usually exploratory, there is little reference to information outside of the immediate field of experience. In such a paper, the literature review is usually short and deals only with information immediately pertinent to what is expected to be or has been observed.

Following the same train of advocating new paradigms of research were Reason and Rowan in Human Inquiry: A Sourcebook of New Paradigm Research (1981). Again, an "inductive" approach of gathering data, formulating a description, and then, if appropriate, comparing the finding to existing theory is advocated. Specific techniques, including participant-observer techniques, are discussed.

An interesting imagery was used by Bogdan and Biklen (1982) concerning what they termed "qualitative research." In qualitative research, "you are not putting together a puzzle, whose picture you already know. You are constructing a picture which takes shape as you collect and examine the parts" (p. 29). To put together the "big picture," the object of the research, requires finding the pieces (gathering raw data), assembling groups of pieces (categorizing the data), and finally assembling the whole puzzle. Once the whole description, the picture, is finished, it can be compared, as a whole or in parts, with relevant parts of established bodies of theory.

To summarize, research in psychology has, in recent years, progressed beyond the empirical, quantitative methodology and developed new paradigms for exploration of the world of man. Such research is qualitative, inductive, phenomenological, and descriptive. Rather than seeking correlations or cause and effect, this
research seeks existential understanding of that which is and which has meaning by virtue of its existence.

In the early stages of this study, this researcher encountered the fact that she was breaking new ground in examining alternative programs that affect mental health and viewing them from the perspective of healing communities. There was no way to ascertain what would be found in the actual observations of the communities. Therefore, the researcher could not start with a prescribed body of theory. Only a phenomenological open-ended approach was applicable to the subject.

Following through with Bodgan and Biklen's analogy, as applied to this study, the literature review and the first two observations of communities may be considered as identifying the relevant pieces; the remaining observations with their descriptions correspond to identifying the patterns of pieces; and the model is the whole picture. The concluding chapter brings together the entirety of the research project, including some of the theoretical ideas which support it from social psychology, community psychology, and personality theory.

As a result of the researcher’s training in counseling psychology, the study is heavily influenced by personality theory, particularly theory relating mental health or illness to social environment. The theories of Adler, Sullivan, and Maslow emphasize the effect of the total social environment on the individual’s psychological well-being and the self-enhancing effects of genuine caring about other people. Other aspects of these personality
theories entered into the initial conceptualization of this project but were excluded as the research became more focused.

Carl Rogers' theory that the relationship between the client and therapist is itself healing and growth-producing raised the questions, "What would be the effect of close, accepting, positive relationships with various people for several hours per week in daily life situations, as should occur in healing communities? If such relationships do indeed exist, are they therapeutic or do they become too much of a good thing?"

Another area of theory of obvious importance to the study is community, particularly as expressed in community psychology, in Almond's description and model of healing communities, and in Jones' work on open systems (1976).

In the background, as the study was being formulated, were concepts from anthropology, sociology, and social psychology which found expression in the manner in which the study was conducted.

Thus, while this research is essentially exploratory and descriptive, it does have roots in and relevance to established theory.

The following section details the objectives of this research, which arise in part from the descriptive approach. The last section delineates the limitations inherent in the research process of this study.

Objectives

Since this study is exploratory, descriptive, and model building in nature, there is no testing of hypotheses; however, there are definite research objectives.
1. This researcher intends to observe alternative programs that have a positive effect upon mental health and are based on the concepts of community, to gain information about their therapeutic dynamics and to integrate that information into a new model for counseling centers, particularly for those with a Christian base.

2. In those observations, the researcher will attempt to get inside the experience of both the helper and those seeking help, to understand their subjective perceptions of the therapeutic process. These perceptions will be balanced by the observations of the researcher.

3. The study will formulate the specific perceptions into general patterns of interpersonal relationships and intrapersonal change in a healing community.

4. The new model will seek to increase the effectiveness of therapy and to enhance the level of help given. It will attempt to provide ways of reducing learned helplessness, stigma, and isolation for the client.

5. The model will attempt to provide opportunities and incentives for continued growth within the counseling center for former clients.

6. The model will seek to provide support for and to reduce stress and burnout for therapists.

7. It will attempt to be adaptable to the indigenous population to be served in terms of format, program, and building.

**Limitations and Delimitations**

This study deals with only one of many alternatives for mental health delivery systems. Though it can be generalized beyond
one locality or one social group, it is not a panacea and is not intended for all people of all times. The model will probably be less attractive to people who are concerned with acquisition of status and material goods, and will be more attractive to those concerned with commitment, justice, and social equality, and to those who view themselves as outside the mainstream of American life. The model is expected to appeal to persons in rural areas, to socially devalued persons, and to Christians who are mission or growth oriented.

In the analysis of the observed healing communities, there is no attempt to give a comprehensive description. The intent is to glean the therapeutic elements that can be applied to a counseling center setting.

The observations and analysis will also raise numerous questions which will not be answered in this study but which may suggest further research.

**Organization of the Study**

The remainder of this study will be carried out as follows: Literature Review with one section pertaining to each observation, except the final one; Methodology; Research Findings with descriptions of observations of five communities; Model of a counseling center as community; and Summary, Discussion, and Recommendations, with emphasis on the relationship of certain findings in this paper to aspects of some of the relevant theories and recommendations for further research.
CHAPTER II

LITERATURE REVIEW

Introduction

This section will establish a background for the development of an alternative model for counseling centers through reviewing past and present systems of mental health care and professional literature related to theory and current needs in mental health alternatives.

Historical Background

Mental health care in non-Western societies has often been given through culturally sanctioned group involvement, rather than through therapist-to-client treatment. The Iroquis Indians prior to 1800 dealt with mental health issues through tribal meetings in a warm, accepting atmosphere. They believed that the soul expressed itself through dreams, and that unless the soul was satisfied, it would cause illness of the mind or body. At regular community meetings, each member told his significant dreams. The shamen and other gifted tribe members interpreted the dreams and worked out appropriate prescriptions for the happiness of the soul, prescriptions that often called for change in family or social relationships. In cases of depression, hallucinations, or hysterical conversion, the tribe held special ceremonies or rituals to assist the afflicted person in understanding his plight and changing his life experience. The community involvement and participation
communicated acceptance and positive regard, thus presumably reducing anxiety (Opler, 1959).

Among the Zuni Indians, retardation, epilepsy, or alcoholism have been treated by membership in a medical fraternity in which the deviancy was redefined, channeled, and used to enhance the life of the pueblo. When a pueblo member suffered from a disorder that was chronic and did not respond to simpler treatment, the matrilineal kin group might decide to give the individual to a medical fraternity. Membership in these societies was lifelong, and their rituals for healing were carefully guarded secrets. The Clown societies utilized the bombastic or foolish tendencies of some mentally ill or retarded as part of the drama in ceremonies for the entertainment of the pueblo. When dressed in costumes and masks, the Clowns were applauded for behaving in ways normally considered anti-social or shameful. The ceremonies served as a psychic release and a confirmation of the individual's value, according to Clown tradition (Almond, 1974).

Ethiopian Amharic women have traditionally been treated for hysterical excitation, mania, and fugue through participation in the Zar cult. When the woman persistently exhibited symptoms, often in connection with an abusive marriage, she was taken by friends to a Zar ritual. Through participation in the elaborate, whirling dance and through the interpretation of the cult leader, the woman learned which Zar spirit was causing her misery and how to entice that spirit to aid, rather than torment, her. Often the cult required the husband to pay certain fees or make changes in the home to appease the Zar spirit; such prescribed actions inevitably benefited the
woman. As she became more involved in the Zar cult and her identity was redefined in terms of group membership, the woman gained a lifelong support network, social status, and economic protection (Messing, 1957).

These medical fraternities, tribal meetings, or cults redefined deviancy: the illness became the key to admission to special group membership or status. Group validation of the sufferer's experiences and worth, mutual support among members, and a sense of belonging was not only treatment for acute illness but also probably promoted growth for more experienced participants. Almond has made an in-depth study of these and similar groups and labeled them as "healing communities" (Almond, 1974).

Religion has played a part in healing of the mentally ill in Western society also. After the collapse of the Roman empire, Christian faith and ethics were responsible for the humane treatment of the mentally ill for hundreds of years. Even amidst economic and political turmoil, sanctuary in churches and monasteries and charismatic treatment in centers such as the famous one at Gheel, Belgium was commonplace (Erickson & Hyerstay in Gibbs, 1980, p. 33). Alexander and Selesnick (1966, p. 80) have observed that the physical care of the institutionalized insane during the early Middle Ages was superior to that given in Europe during the seventeenth and eighteenth centuries.

Unfortunately, even when cared for by Christians, the mentally ill were usually segregated, rather than integrated into community life. Foucault (1965) contended that the procedure of segregation and isolation used successfully in Europe to eradicate
leprosy may have formed the model for the treatment of mental illness in the minds of public officials. In the thirteenth century, governments of England and France built large institutions for the insane, and though the original motives may have been commendable, the very names of Bedlam and Bicentre were soon associated with unspeakable horror.

A small bright spot for the mentally ill was the reform of "moral treatment," led by the Quaker Tukes in England and Pinel in France. Moral treatment meant that mental patients were valuable human beings who deserved and would respond to kindly, rational social approaches. Caretakers were to live in quarters like the patients, to eat with them, and to share social and cultural activities. Though moral treatment was temporarily applauded as successful, it was not practical in institutions housing thousands. The public was not willing to supply the necessary funds and personnel to establish and maintain small hospitals necessary to treat fellow human beings as they would want to be treated (Bockover, 1956; Wagenfeld, Lemkau, & Justice, 1982, pp. 16-21; Zax in Gibbs, 1980).

In early America, the mentally ill and retarded fared poorly in New England. Puritans held that handicaps, including overt mental illness, were judgments against individual sin and that those so tainted must be prevented from contaminating the righteous (Wolfenberger, 1975). The mentally deviant were often victims of the witch hunts and brutal practices in the 1600s (Erickson & Hyerstai in Gibbs, 1980, pp. 32-37). Although Benjamin Rush, the first American psychiatrist, held humanitarian views similar to Pinel and the Tukes,
his attempt to change public opinion was unsuccessful. The mentally ill were herded into poor houses and jails, or hidden in closets, in conditions unfit for farm animals.

Seeing the condition of the mentally ill, Dorothea Dix and her followers campaigned for centralized hospitals in which specialists could treat and heal the mentally ill. Though her campaign was successful in persuading state governments to build facilities for these sufferers, the results of her labors were that thousands of persons were locked away under inhumane conditions, rather than integrated into society (Wolfenberger, 1975).

Removal from society and incarceration in a hospital or sanitarium became the expected mode of treatment in the early 1900s, with the possible exception of the class of patients able to pay for private psychoanalysis. However, World War II brought major upheavals in the governmental system of caring for the mentally ill. First, psychiatrists discovered the value of treating combat-related disorders "within the sound of the guns,"—in the situation where the stress occurred—and of utilizing the feelings of responsibility to and support from comrades. Second, because of the demands of the War on national resources, psychiatric hospitals deteriorated in buildings and treatment. Exposes such as those of Albert Deutsch in Shame of the States (1948) depicted "scenes that rivaled the horrors of the Nazi concentration camps—hundreds of naked mental patients herded into huge barn-like, filth-infested wards, in all degrees of deterioration, untended and untreated, stripped of every vestige of human decency, many in stages of semi-starvation" (p. 28). Third, an influx of veterans needing health care raised an outcry from a public
that would not tolerate having its heroes subjected to deplorable hospital conditions (Chu & Trotter, 1974, pp. 3-50; Wagenfeld et al., 1982, pp. 16-29).

The government's response was the addition of more psychiatric facilities in Veteran's Administration hospitals and the passing of new legislation to establish the National Institute of Mental Health (NIMH). The National Mental Health Act of 1946 set up NIMH as the central administrative unit to promote: (1) the financing of education for mental health personnel; (2) the financing of psychiatric research; and (3) the providing of incentive funds to the states for the establishment of mental health clinics. NIMH did not focus on providing direct services but on research, since science was considered the hope of the nation at that time.

During the next twenty years, continued changes in the field of psychiatry and psychology and changes in national public policy and philosophy led to new legislation that attempted to solve the mental health service problems of the country. The development of psychotropic medication aroused professional and popular belief that the mentally ill could be treated medically and in less restrictive environments. Lay organizations, such as the Salvation Army, impacted the mental health of lower class individuals through environmental change. Adolf Meyer's work in aftercare received more attention. Caplan and others caught professional ears with their emphasis on the effects of environment and support on mental health. The ego psychologists began to blend their theories on individual internal dynamics with an understanding of the environment, often
dovetailing with the new discipline of social psychiatry. The philo-
sophy of normalization was pushing into the field of special
education, which impacts the mental health of children. The public,
as a whole, was leaning toward the position that the national
government was responsible for solving problems once left to the
individual, the community, or the state.

Consequently, in 1963, Congress passed the Community Mental
Health Centers Act to provide seed money for the construction of a
mental health center in each catchment area of 75,000-200,000
residents. In 1965, seed money for the staffing of CMHCs was appro-
priated, though that provision had been stricken from the 1963
legislation. The CMHCs were to provide five basic services:
inpatient care, outpatient therapy, emergency care, partial hospi-
talization, and community consultation and education programs. The
bills recommended that services also include specialized diagnostic
services, rehabilitation, pre-admission and post-discharge services
for state hospital patients, research and evaluation programs and
training and education activities for staff. Simultaneously, the
government also espoused plans reducing the population of government
psychiatric hospitals by returning current patients to their home
communities and through accepting fewer new patients. This philo-
sophy of deinstitutionalization seemed reasonable in light of the
research on effects of institutional life and of the criticism of
reformers such as Goffman (1961). The CMHCs were expected to provide
services to discharged hospital patients and to treat acute mental
illnesses in the local psychiatric ward, rather than referring to the
state facilities. In thirty years, deinstitutionalization reduced
the population of public psychiatric hospitals to one-third of its former size (Meyerson & Herman, 1983).

Unfortunately, though government policy reduced the number of incarcerated, it did not necessarily bring about a full or even acceptable solution to the problems of delivery of mental health services. As Chu and Trotter (1974) pointed out, there were basic flaws in the planning of CMHCs. First, the uniqueness of communities was never considered. Catchment areas were too large geographically and cut across normal lines of community allegiance and commerce in both rural and ethnic areas. The federal planners assumed that, if the central government provided seed money for CMHCs, the state and localities would then support the mental health centers. Unfortunately, they never asked the local communities or states how they would continue to fund the CMHCs, or if they even wanted to be responsible for mental health services. Variation in the needs of communities for mental health services was not considered in the awarding of grants for construction or staffing. Consequently, many communities received buildings and services they would not use or did not perceive themselves as needing, while being denied programs they believed would be beneficial.

Second, there have been major changes in public political climate, and the unlimited spending on human services is no longer popular, or tolerated. A bill to extend the funding of CMHCs was defeated under President Carter. During the Reagan administration, funding has been available only for special programs, such as drug and alcohol abuse. Local communities have been unable, or unwilling,
to provide the needed funds for housing, rehabilitation, and employment, for the chronically mentally ill who were dumped into the community (Meyerson & Herman, 1983). Instead of being integrated into the mainstream of society, the mentally ill have been further isolated, stigmatized, and rejected by a fearful public. Few of the deinstitutionalized or the never-institutionalized young adult psychotics receive treatment, and many live in run-down board and care buildings or as street people (Donnelly, 1982). Constantly changing policy and funding has also resulted in instability of services so that clients may suddenly find that their programs are discontinued without satisfactory alternatives.

Besides the problems of mental health care delivery created by public policy, there are problems inherent in the entire mental health profession. First, devalued persons—such as the poor and minorities—have been found to have the greatest needs for mental health care and the least access to appropriate services (Chu & Trotter, 1974). For example, although the economic plight of the farmer has received public attention, little has been done to meet his unique needs in mental health care.

The major models for psychotherapy and delivery of services are based on the outlook and values of the urban middle class which are often incomprehensible, offensive, or inappropriate for persons from other subcultures. The youth culture (Holleb, 1975), ethnic subcultures (Sue & Zane in Gibbs, 1980), rural communities (Bachrach, 1983) and conservative Christian groups shy away from the imposing glass and steel public clinics with their multitude of mysterious, potential entanglements. Private practitioners hidden

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away in their offices are often perceived as equally threatening and aversive and are usually beyond the economic means of lower income persons. For many non-middle class persons, mental health care must be in terms of their own culture and environment, or they will not use the services (Sue, 1978).

For the therapist, the present mental health delivery system can be highly frustrating. Personal and professional burnout rate is high (Wiersma, 1982). The socially conscientious therapist may feel frustrated that, because he can only serve a limited number of clients, his training is not being fully utilized and his ability to impact society is limited (L. A. Becker, personal communication, November 18, 1984). Therapists who want to work with the socially and economically underprivileged are faced with the problem of having an adequate personal income. Either they must work for the government (in which case they are hemmed in by bureaucracy and their jobs are frequently endangered) or they must find a position in a social welfare program that is privately sponsored, such as Catholic Social Services. Only occasionally can a therapist survive in private practice in an economically disadvantaged area or population. The intrusion of insurance companies and governmental examiners is an increasing difficulty for therapists. Aside from economic factors, therapists may feel themselves alone, bearing the heavy burden of responsibility for their clients and their own problems (Edelwich & Brodsky, 1980). The usual rules of confidentiality prohibit the therapist’s discussing his concerns about clients with anyone from whom he might receive support, unless there is a formal arrangement. He can not share with friends or family the deepest concerns of his
work. Social expectations inhibit the therapist from expressing his personal feelings and needs in many subcultures: too often he is expected to have "all the answers" and criticized for any shortcomings in his life. In short, the therapist is too often in the position in which it is difficult for him to meet his own needs; he has difficulty obtaining a dose of his own medicine.

Alternative Programs

Amidst the disappointments with the results of public mental health centers and the problems of the private mental health sector, there has arisen a quiet ground swell of ordinary citizens seeking to solve their own problems and to meet their own needs. Since the early fifties, alternative programs of many varieties have sprung up to bring about improved mental health through group involvement in a social environment that is comfortable and natural for the persons seeking healing and growth.

Six types of alternative mental health programs are discussed in the following sections. The alternatives are therapeutic community, a method of reorganizing psychiatric hospital wards; non-hospital residential treatment programs; Positive Peer Culture for treatment of delinquent adolescents; youth-oriented counseling programs using peers and paraprofessionals as counselors; self-help and support groups; and communities with mentally handicapped. The final section of this chapter discusses the call for a change in the model of service delivery and counseling theory by theorists and practitioners.
Therapeutic Community

In Britain, an alternative solution to the problems of dehumanization and ineffectiveness of psychiatric hospitals was the therapeutic community (TC). During World War II, mature women, accustomed to independence and decision-making, returned to their former careers as nurses, as their contribution to the war effort. Though the hospitals had been authoritarian, doctor-dominated institutions, these nurses gradually assumed more responsibility for decisions concerning patients and ward operation, and the professional team movement emerged. When Maxwell Jones was a psychiatric resident, he participated in the application of the professional team approach to the treatment of prisoners of war in a psychiatric hospital.

In 1947, Jones accepted a post at Henderson Hospital near London treating character disorders and developed the team approach into a new form of ward organization, the therapeutic community. In TC, the patients were no longer passive recipients of treatment administered to them but became active therapeutic agents for themselves and each other. Administrators, psychiatrists, nurses, aides, and patients worked in cooperative relationships to make the ward not only pleasant and helpful to the patients but also educative and growth-enhancing workplaces for the staff. In 1959, Jones tried out the concept of TC in the United States at Oregon State Hospital while he was guest professor at Oregon Medical School. In 1963, when Jones became Physician Superintendent at Dingleton Hospital, a four hundred bed psychiatric facility in Melrose, Scotland, he used his power to initiate a democratic TC in what had been a typical doctor-dominated
system (Jones, 1968a). Later he moved to the United States and established therapeutic communities at Fort Logan Mental Health Center in Denver and numerous other facilities, as well as serving as consultant for school and businesses interested in open systems.

Though Rapoport (1960) and many psychotherapists have made major contributions to the movement, Maxwell Jones is universally considered the father of therapeutic community (Trauer, 1984).

Description

There is no such thing as the therapeutic community, but rather there are many variations on the form and themes as applied to different settings and contexts (Rapoport, 1960). As a model, TC has been continuously evolving, and the language and descriptions have continuously changed. Though Jones had originally used psychoanalytic language, the standard terminology of social psychiatry, in 1976 he shifted toward a systems theory perspective, referring to non-hospital programs using TC principles as "open systems" (Jones, 1976). Instead of a single definition of therapeutic community, what surfaces in the literature is a series of descriptive words or phrases—non-hierarchical, mutually-interactive, egalitarian, democratic, therapeutic environment, flexible roles, shared decision making, open communications, multiple leadership, active patient involvement, permissiveness, and social learning.

Jones' writings about the phenomenon of therapeutic community are more a running narrative than a categorical analysis. He described TC as a non-hierarchical treatment program in which administration, staff, and patients work together in a warm,
accepting, democratic environment to bring about healing and psycho-social growth. Growth-producing activities for the patients were called therapy; for the staff, training.

The conceptual base for therapeutic community is social psychiatry, "the study of the role of social-psychological and sociological factors in the genesis, maintenance, and treatment of mental disorders" (Trauer, 1984, p. 71).

The heart of therapeutic community as an experience is the daily community meeting. Patients, nurses, doctors, and administrators meet daily to discuss the here-and-now events, activities, and problems on the ward. The amount of structure and patient control in meetings varies among TCs. On two days per week small group sessions have been substituted for community meetings in some TCs.

In community meetings, staff encourage patients to become active helpers of each other. For example, if a manic patient who had previously been euphoric and highly sociable became hostile and aggressive the preceding afternoon the staff might explain the problem of manic-depression to the patients and suggest what patients could do to help this man. The patients might bring up their own feelings about the sudden change in their friend or provide information he has given them which may help staff in his treatment. Also, patients could criticize or compliment individual staff members' work in controlling the disturbance the previous day. If the disturbance had triggered suppressed feelings of violence or hostility in another patient, those feelings should be brought up in the meeting by the individual himself or a concerned friend. Such an event would be termed a living-learning situation (Jones, 1968b).
In the staff review meeting that always follows community meeting, staff members discuss their own individual and group experience of the disturbance and of the community meeting. Those who had been criticized by patients have an opportunity to discuss their feelings and receive support from their peers. Better methods of handling or preventing future disturbances might be discussed.

Organizational changes are processed through community meetings. For example, on a long-term ward in a hospital that had been strictly segregated by sexes, the women decided they should be allowed gentleman visitors from other wards during the day. The traditional nurses objected. The pros and cons of male visitors and the feelings of the nurses and patients were discussed in a series of community meetings. A compromise decision to allow male callers with certain restrictions was reached by consensus (Jones, 1968).

In TCs, patient councils are often elected to participate as patient representatives in the decision-making process. In the early TCs, patient councils were only advisory, but during the late 1960s and early 1970s, some wards experimented with patients controlling disciplinary action, passes, releases, and other major therapeutic decisions (Glück, 1977; Mosher & Keith, 1979). The chaotic conditions that often occurred in patient-run wards drew justified criticism (Bouras, Trauer, & Watson, 1982; Islam & Turner, 1982).

Jones clarified the purpose and extent of patient participation and power in ward decisions. Traditionally, in custodial and medical wards, patients were passive victims with no choices, a practice resulting in further breakdown of ego boundaries, increased helplessness, increased loss of identity, lowered
self-esteem, and overdependence, all highly anti-therapeutic experiences (Jones, 1968a, 1976). By contrast in therapeutic community, the patient is an individual who learns to take charge of his life, to be helpful and responsible toward others, and to develop a firm sense of self. Patients ought to be given only as much responsibility as furthers therapeutic objectives. If patient councils assume too much responsibility, such as passes and releases, they acquire the characteristics of authority figures and receive from other patients the hostility that should be directed toward the staff. A "them-us" mentality--patient council and staff versus other patients--develops and is anti-therapeutic (Jones, 1976, p. 93-94). Elevating the role of patient to being helper of other patients does not mean handing over the ultimate responsibility for ward operation or therapy. "In no sense does the staff or doctor in charge relinquish his ultimate authority" (Jones, 1976, p. 102).

Jones also emphasized that the balance between patient and staff power and the balance of leadership between the head psychiatrist and the nursing staff depended upon the condition of the patients in general, the state of ward organization, and the achieved level of communication and cooperation. In times of stress or ward disorganization, the psychiatrist in charge would exert a more active influence, even making unilateral decisions about ward events.

In therapeutic community, roles are flexible and may be changed by the decision of the community or the staff through consensual decision-making. For example, if only social workers had previously made home visits, the staff might decide that the therapist or a nurse would also visit the home of the patient, though...
perhaps with a somewhat different objective (Jones, 1968). For staff, the particular roles are determined more by personal ability than by academic credentials. A nurse is as likely to lead staff review or community meeting as is a psychiatrist, if she has developed skills in communication and group dynamics.

In examining the dynamics of therapeutic community, Jones recommended the research of Robert Rapoport, an anthropologist who systematically studied the TC at Henderson and other therapeutic communities. Jones commented that Rapoport's analysis was more precise, that it filled in the "gaps in our knowledge, of which we were dimly aware" because "the tendency amongst psychiatrists [is] to cover confused thinking with words whose meaning is kept rather vague" (Rapoport, 1960, p. 4).

In examining the beliefs that characterize all therapeutic communities, Rapoport (1960, p. 22) found six assumptions in common. (1) The patient's total social organization—not just the relationship with the therapist—affects therapeutic outcome. (2) The social organization is not just routine background but is a vital therapeutic force that will maximize treatment effects. (3) Democratization, the provision of opportunities for patients to take an active part in the affairs of the ward or institution, is a core element. In some hospitals, democratization is limited to patients meeting to form opinions and make recommendations to the staff, with the staff holding the authority and responsibility to accept or reject those opinions. In other hospitals, democratization implies all decisions being made in a group context by consensus of patients and staff. (4) All relationships within the hospital are potentially
therapeutic, including patient-to-patient relationships. Provisions are made to use the therapeutic potential of relationships other than doctor-patient dyads. The extent and type of relationships that are utilized varies among hospitals. Social workers, nurses, occupational therapists, and patients may or may not be encouraged to be therapeutic agents. (5) The emotional climate of the ward is itself therapeutically important. Warmth and acceptance are valued. The amount of permissiveness and disruptive activity a TC will tolerate varies considerably. (6) Communication per se is valued. Administratively, it is considered valuable for people in one part of the system to know what people in other parts are feeling, thinking, and doing. The act of communicating is expected to have an important effect on the morale and well-being of the staff, as well as patients. The content of communications shared among all persons in the TC provides data that is helpful to the therapist and which would not emerge in direct therapist-patient contacts.

According to Rapoport, the extent and form in which each hospital implements these assumptions varies according to the institutional setting, attitudes of the general population, treatment ideology of the staff, and the type and severity of the disorders of patients. From his observations at Henderson Hospital, Rapoport condensed his description into four themes: (1) democratization; (2) permissiveness; (3) communalism; (4) reality confrontation.

Research

Over the last thirty years, much research literature concerning therapeutic community has been published. One segment of that literature has examined therapeutic communities that are
inpatient wards following Jones' pattern fairly closely and has concluded that therapeutic community is an effective treatment modality (Almond, 1974; Daniels & Rubin, 1968; Denber, Turns, & Seeman, 1968; Jeffrey, Kleban, & Papernik, 1976; Lehman & Ritzler, 1976; Mosher & Keith, 1979; Myers & Clark, 1972; Norris, 1983; Paul, 1969; Paul & Lentz, 1977; Sanders, 1967; Wilmer, 1981; Wing, 1965; Wright & Kogut, 1972).

Other researchers have raised objections to therapeutic community. Bouras, Trauer, and Watson (1982) compared a therapeutic community with a medical model ward and found more disturbed behavior on the therapeutic community ward, though they qualify their findings by stating that the therapeutic ward staff contended that the disruptions were opportunities for patients to learn and grow. Several empirical studies failed to show that therapeutic community is effective or that it is more effective than medical model treatment (Quitkin & Klein, 1967; Raskin, 1971; Reich & Weiss, 1975; Spadoni & Smith, 1969; Steer & Boger, 1975; Van Putten, 1973). Other researchers or therapists have objected to specific features of therapeutic community on theoretical grounds (Islam & Turner, 1982; Johnson & Parker, 1983; Zeitlyn, 1967). Several writers described modifications of therapeutic community to establish optimal environments for specific disorders: Bjork, Steinberg, Lindenmayer, and Pardes (1977) for manics; Jeffrey, Kleban and Papernik (1976), Mosher and Keith (1979), Sullivan (1931), and Wilmer (1981) for acute and chronic schizophrenics; and Levinson and Crabtree (1979) for acting-out adolescents.
Specific issues in operating a therapeutic community have been addressed. Bloor (1981) described the use of inconsistencies within a TC as a teaching process to help patients learn to cope with the real social world. Gunderson (1978) sought to conceptualize the therapeutic processes within the TC environment. Karasu, Plutchik, Conte, and Siegel (1977) investigated staff satisfaction in working in a TC and found that staff generally enjoyed working in a democratic environment; their only complaints were in areas in which the real situation fell short of the therapeutic ideal. The problems of shortened hospital stays on general wards, unionization of nursing staff, the effect of political trends, the problem of role definition and job descriptions, and the practicality of therapeutic community were addressed by Islam and Turner (1982); Herz, Wilensky, and Earle (1966); Trauer (1984); and Zeitlyn (1967).

Therapeutic community has been utilized in day hospitals and transitional residences. Empirical and descriptive studies of such programs generally indicate that the programs are effective for persons currently enrolled in improving psychosocial and adjustment, but may have little or inconclusive effects for patients who have left the program (Bloor, 1980; Dugan, 1981; Koman, 1967; Morrice, 1973; Mosher & Lentz, 1977; Mosher, Menn, & Mathews, 1975; Valesquez, 1979).

Other issues related to therapeutic community have been discussed. The effect of TC on psychiatric residents in training and on normal volunteers working on the ward have been explored (Bell, 1982; Gersten, 1978; Gold, Davenport, Wehr, & Goodwin, 1979). Specht (1976) investigated an outpatient counseling center that claimed to be a
therapeutic community and found that, while it had been highly effective at one time, it was in a state of transition and was about as effective as any other outpatient counseling. Crosson (1976) and Oldham and Russakoff (1982) proposed models for merging the medical model and the therapeutic community to meet the needs of short-term stay general hospital psychiatric wards.

While there was considerable literature on therapeutic community in the 1960s and 1970s, no firm conclusions concerning its efficacy or practicability were reached by professional researchers or psychiatrists. Currently, much less is being written.

Therapeutic community, as described by Maxwell Jones, seems to have been abandoned. In preparing for the observations in this study, the researcher contacted over thirty hospitals in the Midwest looking for an active therapeutic community. Though several hospitals had used TC in the 1960s, not one was currently using the model for inpatient ward organization. Reasons cited were the short stays of patients, the demands of insurance companies and governmental funding agencies, the problems of staffing a TC, and the prominence of psychotropic medication in treatment. Psychiatric wards in general hospitals seemed to take the position that the ward is to stabilize the patient so that he can return to his home as quickly as possible, while the TC position is that the ward is a place for real personality or psychosocial change. The head psychologist at a state hospital which emphasizes treatment explained that their programs integrate social learning principles into treatment but do not use the TC ward organization. The head psychologist for
the state long-term or custodial hospitals stated that TC had been tried and found impractical because the staff was unable to accept the egalitarian philosophy of therapeutic community and because, as a result of governmental policy of deinstitutionalization, the hospital has only patients functioning on very low levels, for whom TC is inappropriate.

In personal communication between Dr. Jones and the researcher (personal communication, November 2 & 10, 1985), Maxwell Jones stated that he was aware of only one therapeutic community in the United States that he considers at all viable. He stated that in Europe there is much interest in open systems (TC) but that in the United States "psychiatrists seem to resist a democratic, egalitarian social structure."

A former head of a therapeutic community in a teaching hospital, Dr. Cornelia Wilbur wrote to this researcher that she was unaware of any active therapeutic community for adults (personal communication, November 22, 1985). She cited the emphasis on psychotropic medication and the profession's attachment to the medical model as part of the demise of therapeutic community.

These findings by the researcher agree with those in Trauer's article on the "Current Status of Therapeutic Community." Trauer (1984) cited as reasons for the waning interest in TC, the retirement of its charismatic leader, Maxwell Jones, the medicalization of psychiatry, shorter in-patient stays, heterogeneity of patient populations, and problems of defining what is therapeutic community.

From the types of articles opposing therapeutic community and from the information gained in the contacts by this researcher, it
appears that the demise of therapeutic community is not on the grounds of lack of effectiveness but on the grounds of shifting public attitudes and policy and the need for status and self-perpetuation of those in control of psychiatric facilities.

To summarize, therapeutic community is a form of in-patient treatment which encourages patients to be active, involved agents for healing in themselves and other patients. TC also emphasizes continuous training for staff through actual situations that occur on the ward. Open communications and social learning are major characteristics of therapeutic community. While TC was experimented with heavily in the 1960s and 1970s, it is today in a state of decline because of societal changes and factors within the profession of psychiatry.

Residential Treatment Communities

While therapeutic community was an alternative approach to deinstitutionalization for solving the problems of psychiatric hospitals, there was a need for alternatives to hospital care for persons who needed or could benefit from some type of twenty-four hour a day sheltering. Sullivan's work in creating a special six-bed unit in which young chronic schizophrenics were treated with the same respect as "normals" is often cited as laying the foundation for residential programs (Sullivan, 1940).

At Kingsley Hall (London), Laing and associates experimented with integrating schizophrenics into normal society in a residential setting. Trained personnel, "ordinary" people, and schizophrenics lived together as a community, with a deliberate blurring of the distinction between staff and patient. The schizophrenics were
allowed to behave as they wished, since Laing believed that the psychotic processes were individualistic means of working through problems of ego integration. The ordinary people were friends and role models to help the schizophrenics to learn new socially adaptive behaviors (Laing & Esterson, 1964; Cooper, 1967).

As deinstitutionalization thrust more seriously ill individuals back into the community, supervised residences for adults and halfway houses sprang up, though not nearly enough to accommodate all those in need. In the U.S. there were over 200 residential programs by 1969. Roy and Rausch (1975) reviewed twenty-seven outcome studies before 1975 on halfway houses or transitional residences. They found that programs emphasizing personal responsibility, decision-making, group support, and close interaction, with as little assistance as possible from professionals, were the most successful.

In an empirical study, Velasquez (1979) evaluated a forty-patient residential program that functioned on principles related to therapeutic community. Begun in 1971, the program accepted persons ages 18-35 with diagnoses of psychosis, neurosis, or personality disorder with at least one hospitalization. All persons entering the residence had difficulties in social interaction and in taking responsibility for their daily needs. Ego psychology was the conceptual framework for the program. Goals included self-concept change, improved problem-solving ability, interactional skills, instrumental skills (like cooking and shopping), social interaction, and responsibility. When compared to a control group on several measures, the community residence was shown to be highly effective in increasing social functioning of mentally ill young adults.
Fairweather (Fairweather, 1964; Fairweather, Sanders, & Maynard, 1969) introduced the concept that a community-based residence, called a lodge, might be a long-term replacement for the hospital for chronic patients. Chronic male patients from a VA hospital were discharged to live in a lodge in which patients were taught progressively to take over administration of the setting, including developing a small patient-run business. Fairweather had no expectation that the lodge would cure the residents, but he correctly expected that while in the lodge, residents would markedly improve in self-concept, employment, social status, and general social functioning. During the later months of the study, the lodge residents had almost complete control of organization and daily activities, with little professional assistance.

For the research, residents were matched with a control group and the progress of the two groups was charted for a span of forty months after the initial discharges, that is from six months after the lodge opened to seven months after it closed. Lodge residents were involved in full-time employment for 40% of the time compared to zero full-time employment for controls. The lodge residents had a 20% rate of re-entry into the hospital, as opposed to 80% for controls. Fairweather and associates concluded that a lodge was a viable replacement for the hospital, more efficacious for the patients and less costly for the public.

The question left unanswered by the Fairweather lodge experiment was "what would happen if the lodge were available as a permanent home, if patients had the opportunity for lifetime self-government in a subculture tailored to fit their needs, within the
context of the larger society? Would the effect of individual responsibility in an accepting environment, combined with change of social status, eventually be enough to cause the disappearance of psychopathology?"

A unique residential program is Atlanta Women's Mission, a program for homeless and disturbed women. Begun in 1969 by Elsie Huck as a division of the Atlanta Union Mission, the Women's Mission soon acquired an identity and therapeutic approach of its own.

Contrary to popular myth, homeless women are not "Skid Row" alcoholics, transients, or only in need of shelter and food. In a study of the 45 residents of Atlanta Women's Mission in 1976, psychiatrist Markham Berry found the following psychiatric disorders: psychosis, 52.5%; personality disorder, 27.5%; neurosis, 12.5%; alcoholism with no other disorder, 7.5%. Almost half (46.3%) had a known history of psychiatric hospitalization. These women obviously need more than temporary housing (Berry, 1977).

In accordance with these needs, Atlanta Women's Mission has provided a strong program of social learning, emphasizing acquiring social competency, self-responsibility, and insight, in an atmosphere of warmth and acceptance. At the time the researcher visited the Mission, in 1982, the residents were responsible for most of the daily instrumental tasks, under the supervision of senior-citizen houseparents who were volunteers. Students from a master's level counseling program were on duty around the clock to work with the women, under the direction of Ms. Huck. Many of the women seemed to regard the mission as their home and the staff as friends. A full range of other services was provided, including social work, some
nursing care, graded employment and assistance with becoming employable, religious services, and medication supervision, with psychiatric consultation.

The residential treatment community seems to be one of the less publicized but more promising approaches to helping the chronically mentally ill.

Positive Peer Culture

At about the same period of time that therapeutic community was becoming a recognized treatment in psychiatric settings, Harry Vorrath was developing a model for treatment of delinquents using many of the same social learning principles as TC. Beginning at Highfields, a mansion given by Charles A. Lindbergh to the state of New Jersey for the rehabilitation of delinquent youth, the new model used group pressure to bring about psychosocial change. The model, Positive Peer Culture, was given its first full trial at a reform school in Red Wing, Minnesota, when a riot prompted the administration to call in Mr. Vorrath to try out his novel ideas. The PPC program not only restored order to the institution, but received national attention (James, 1979). Since that time, PPC has become a standard approach to mental health care for delinquents, with a national organization, a governing body, and a board granting accreditation to correctional programs using the model.

In contrast to therapeutic community, Positive Peer Culture is a tightly defined model contained in one small volume, Positive Peer Culture by Vorrath and Brendtro (1974). In layman's language, the model spells out the problem of "troublesome youth" and specific goals and procedures for assisting these young people in changing
their behavior. Even the language of the staff is defined. The perspective is working with the here-and-now behaviors and is concrete, almost simplistic.

The first principle of Positive Peer Culture is that in modern America "the peer group has the strongest influence over the values, attitudes, and behavior of most youth" (Vorrath & Brendtro, 1974, p. 8). The power of the peer group can be channeled into constructive behavior and goals, developing the potential of young people. The second principle is that "being helpful usually has an enhancing effect on one's self-concept; needing help and being dependent on others often worsens the erosion of what may already be a weak self-concept" (p. 8). Therefore, in PPC a youngster does not have to want to be helped, but he is expected to give help to others in his group. Giving help is "the only route to true strength, autonomy, and positive self-concept" (p. 11).

In contrast to medical approaches to mental health, PPC does not assume that the client is "sick" or disabled. Instead, it assumes the young person is strong, resilient, and able to make an important contribution to society if he can overcome certain specific problems. A "problem" is "anything that damages oneself or another person" (Vorrath & Brendtro, 1974, p. 36). Behavior patterns recognized in PPC are "low self-image" and "inconsiderate of self or others". PPC labels specific problems as follows: authority problem, misleads others, easily misled, aggravates others, easily angered, stealing, alcohol and drugs, lying, and fronting. The PPC text spells out the nature of each problem, the solution, and the criteria for knowing that the problem is solved.
Because the youth are viewed as essentially capable people, their behavior is described in terms of helping or hurting others, rather than in terms of pathology. The specific wording prescribed for staff to use in discussing behavior with the young people is designed to reduce the false bravado and "tough guy" mentality that are intrinsic to delinquent subcultures. If young people are feeling smug or excited about an episode of truancy, the staff may label the behavior as "playing hide and seek." If stealing is seen as slick, then it may be re-labeled as "sneaky and dumb." Violent, threatening behavior becomes "having a childish temper tantrum." On the other hand, gentle, sensitive behaviors that are often scorned by the youth culture, particularly for males, are praised in PPC. Tears shed over a dead pet indicate "he's man enough to care." Helping a senior citizen, rather than accosting her, indicates "he's strong enough to protect another person." Positive helpful behaviors are labeled as great, intelligent, independent, improving or winning. Young people are constantly told by staff that they are expected to be great, to rise above circumstances, to be in control of themselves. Vorrath referred to this type of language as "making caring fashionable" (Vorrath & Brendtro, 1974, p. 29).

In practice, PPC is centered in the activities of the group. The PPC group meets daily to discuss events and personal actions, to give and receive help. In a residential setting, the PPC group live together constantly. The group is responsible for helping the individual, and the individual for helping the group. Responsibility for personal action and change lies with the young people. The adults
are guides, facilitators, and advisors but do not take responsibility for decisions made by the young people. The operation of a PPC group is depicted in the Observation section.

In PPC, adults maintain a definite distance from the young people, keeping firm boundaries and limits, modeling mature, responsible behavior. Control is said to lie within the group, but in actuality the ultimate control and authority lies in the staff and administration, particularly in a residential correctional program.

The Positive Peer Culture model has been primarily used and evaluated in residential correctional programs for delinquents. Wasmund (1980) studied the effect of PPC on self concept in 161 residents of a Minnesota treatment program. Utilizing the Tennessee Self Concept Scale and statistical procedures, Wasmund found that PPC is effective in improving self concept and that the improvement continues after the resident returns to the community.

Sura (1983) examined the applicability of PPC with low intelligence or learning disability offenders and found that it was as effective with those youth as with normals.

One of the most impressive studies on Positive Peer Culture was an evaluation of a program involving 2,000 Chicago high school students sponsored by the Chicago public schools and the Law Enforcement Assistance Administration of the U.S. Department of Justice (M. & E. Associates, 1981). The program was set up by a private consulting corporation and evaluated by a professional research team under the direction of a professor from John Hopkins University. Peer culture groups were established in four secondary schools in troubled areas of the city. Groups met one period of each
school day. Students with exemplary behavior were included in the groups along with troublesome students. Groups were led by teachers, guidance counselors, and psychologists. Control groups were established for statistical purposes. After one year, the study showed that among peer culture adolescents there were a significant decrease in absences from school and in the number of police contacts and a moderate increase in grades. Even with the costs of outside consultants and researchers, the program was economically feasible and, in fact, saved money for the taxpayer.

A full examination of literature on Positive Peer Culture is beyond the interests of this paper. The important aspect of PPC for this research is that it is a viable, current alternative to traditional mental health practices and perspective. It is a method of helping people to help each other and thereby grow themselves.

Youth-Oriented Alternative Counseling Centers

In the late 1960s, alternatives to hospital-type mental health care arose to aid counterculture youth who were afraid that going to a hospital or conventional mental health program would result in a "bust" for drugs or afraid that authorities would try to re-socialize them into conventional molds. Psychiatrists, psychologists, and social workers in various major cities with colonies of these flower children perceived the need to reach the young adults on their own terms. The founders of the programs were usually young themselves and held values at variance with traditional professional views. Through their unconventional dress and mannerisms and through the type of mental health programs they developed, these professionals communicated to the youth, "We are like you. We understand."
Holleb (1975) identified nine characteristics of these alternative centers. First, there was conviction that "established mental health practices reinforced an unnecessary split between therapist and patient. This split left the patient in a one-down position and therefore increased the sufferer's feelings of weakness, passivity, and confusion" (p. 4). The solution was to eliminate the distinction between staff and client. Clients could become helpers, and helpers could become clients. Second, it was felt that "professionals were secretive about their knowledge and deified their role in order to maintain their high status" (p. 4). Therefore, these alternative centers set about to offer help from sensitive, open people with a minimum of training. Usually a psychologist or social worker headed the program, but the actual counseling was done by undergraduate students or persons with a bachelor's degree, trained in the particular methods of that center. Since professionals were perceived as over-charging, services at the alternative centers were free or had a minimal charge. To avoid the waste of time and energy and the rigid hierarchy of bureaucracy, these centers were democratic organizations using a consensual process in decision-making. Personal growth for the staff and an open community between staff and client were seen as ways of eliminating the problem of professionals being cold, isolated, and out of touch with their clients. These centers often focused on the political and social roots of the client's problems and attempted to work within his own value system, rather than re-socialize him into middle-class lifestyle. The physical setting of the traditional mental health clinic was seen as "cold and sterile and often frightening to patients"
Therefore, these centers were informal, with brightly painted walls, and often messy. Founders of these centers usually felt that traditional methods of therapy were overly long and produced dependency; therefore, they emphasized short-term, time-limited counseling that focused on a specific problem. Since individual therapy could reinforce feelings of isolation with one's suffering in an already alienating society, group counseling was preferred.

One example of an alternative center was Fort Help, begun by psychologist Dr. Fort, in a redecorated warehouse on Mission Street, San Francisco. In 1970, Fort Help had a staff of fifty non-professionals and graduate students who were paid fifty dollars per week for being on call twenty-four hours a day. Many of the staff originally lived at the center. A wide variety of people and problems were treated, from street junkies to middle class young adults with the most common problems being drugs, sexual abuse or dysfunction, and overweight.

A similar center, In-Touch, in Oakland originally focused on drug-related problems. Project Place in Boston provided a variety of services in a black and Hispanic neighborhood. Pequod, also in Boston, was an experiment in personal growth through communal living and helping the socially disadvantaged.

At the time of Holleb's writings, all of the alternative centers he had investigated were still functioning; however, they had become more conventional in their financial and professional presentation of themselves. Holleb felt that, in general, these centers were working out a compromise between the demands of society and the ideals on which they were founded.
It was not only counterculture young people who were experimenting with new formats for counseling and personal growth in the 1960s and 1970s. Christians were awakening to the need for increased sharing, openness, and commitment to each other. Older adolescents and young adults within the organized church and in para-church groups such as Campus Crusade set up coffeehouses and crisis centers that were often predicated on many of the same beliefs that Holleb describes.

The WAY INN in Fort Wayne, Indiana, was an example of a counseling and growth center that emphasized sharing, open communications, the use of non-professionals as counselors, and working within the value system and lifestyle of those seeking help. The WAY INN was begun by a group of young adults in a suburban church, who persuaded several church leaders to purchase a dilapidated house nearby as a place for fellowship and prayer. The young people then remodeled the house into what might be called "comfortable shabby." Two rooms were reserved for prayer. The rest of the house was open for lounging and talking, and a great deal of informal counseling and interpersonal development went on in the house during the first year.

As the young people matured as individuals and as a group, they were ready to reach out to the decaying neighborhood and to young people in other churches. Several churches formed a corporation and recruited a minister with a master's degree in counseling psychology to work full time at the WAY INN. The young people continued to assume responsibility for peer counseling, clerical work, and maintenance. There were no clear roles. Each person did what he could, when he could. The researcher, then a master's student,
served as therapist and teacher for children, took her turn as receptionist, and received help from the counselor and other young people. Though the counselor reported that local professionals with whom he conferred found the program confusing, the internal experience was that the WAY INN was like an extended family, or community, and was to be taken on its own merits, not compared with services outside.

As with most alternative centers, the WAY INN was in a constant state of change, according to the needs of persons coming for help and the resources of the group committed to the program. The professional counselor, who had become a charismatic figure to the group, left in 1975. Church members struggled to keep the program open, but it closed in 1980, having completed the task for which it was originally established (Charter and Annual Reports of the WAY INN, INC.).

The WAY INN was only one of many similar programs in the 1960s and 1970s. The researcher was personally in contact with four such programs. Unfortunately, because the programs focused on the immediate needs of those involved with no expectation that the centers would have long-range effects, there is very little written or published about these programs. When Sandbek (1979) surveyed 129 church-related counseling programs, the 39 centers that replied were essentially conventional counseling programs in organization and professional orientation. A search of related literature found no descriptions of this type of Christian alternative counseling center, other than short articles or notes in church publications. What has been learned, from both counterculture and Christian alternative
programs, is that such centers are usually established to meet a specific need at a specific place and time, and that once that need has been fulfilled, the centers either become more conventional or close.

Self-help and Support Groups

Self-help and support groups are one of the major alternative sources for mental health care and growth. Katz (1970) estimated that over a million people are active in self-help or support groups that influence psychological well-being. Levy (1982) described a steady growth in the number of persons in support groups since 1940. He suggested that the self-help movement is furnishing a viable response to social developments, such as progressive weakening of traditional support institutions, growth of governmental bureaucracy, and rapid technological change that promote in people a weakened sense of control over their own destinies.

Nationally, self-help groups deal with a wide range of topics, such as emotional control (Recovery, Inc., Emotions Anonymous), death and dying (Omega), death of one's child (Compassionate Friends), parenting (Parent's Anonymous, Mothers of Twins), weight loss (TOPS), alcohol abuse (Alcoholics Anonymous, Al-Teens), and companionship (COMPEER). Local support groups exist for almost any human problem imaginable.

The terms self-help, support, or mutual-aid are often used interchangeably. Levy (1976) defined self-help groups or support groups as having the following characteristics: (1) the purpose of the group is to provide support for the members, to assist them with problems and to improve psychological functioning; (2) the origin of
and sanction for the group rests with the group itself, not with an outside authority; (3) help comes from the efforts, skills, knowledge and experience of the group members; (4) the group is relatively homogeneous, with members sharing common life experiences; and (5) control of the group is internal, although it may use professionals as consultants. Jerston (1975, p. 144) provided a short definition of self-help groups: "small groups of persons with common problems who work together to achieve specific behavioral, attitudinal, and cognitive goals." Taken together, the definitions adequately distinguish self-help groups from traditional psychotherapy or from traditional organizational groups.

Though self-help groups have gained increasing attention in the helping professions during the last ten years, the concept of people helping people is hardly new. Katz and Bender (1976a) traced such aid through the extended family helping systems, mutual aid groups of the Middle Ages, the societies of the British Industrial Revolution, the pattern of neighborly interactions in Colonial America, and the consumer cooperative and labor union movements. Groups of parents with handicapped or chronically ill children are identified as the immediate forerunners of the self-help movement.

Drakeford (1978) traced one strain of the self-help movement to Christian influences. The early church in Jerusalem shared all important aspects of life, including a common sharing of property. Wesley tried to revive that special quality of sharing, known as Koinonia, through the class meeting, a weekly assembly of small, fairly homogeneous groups of persons who related their experiences for corporate consideration and correction. A similar organization
was the Oxford Group which espoused high standards for Christian living. At a mission sponsored by the Oxford Group, Bill W., an alcoholic, achieved a degree of sobriety and an understanding of the impact of group support. Bill W., along with Dr. Bob, founded Alcoholics Anonymous. In recent years, groups such as Emotions Anonymous have adapted the principles of Alcoholics Anonymous to deal with other concerns.

The best known authority in the development of self help, mutual aid, and support systems is Gerald Caplan, who headed the Laboratory of Community Psychiatry, 1964-1977. Among the dozens of interesting projects originated by Caplan and associates is what is known as the Bishop-to-Bishop program. Begun as a weekly consultation by Caplan with the national House of Bishops of the Episcopal Church to help them develop ways of supporting bishops in their diocesan work, it resulted in a program that taught senior bishops techniques for offering collegial consultation to assist new bishops with human relations problems in the dioceses during their first years in office. Later, the senior bishops who had been trained in counseling transformed part of the regular meetings of the House of Bishops into organized peer support groups. As Caplan studied these spontaneous developments, he began to understand the attractiveness and the power of support systems and to build a description of their effect.

Another program pioneered by Caplan was the widow-to-widow project, in which Caplan attempted to organize nonprofessional caregivers to act as a mechanism for prevention. This work led him
to discover the extent of mutual help groups operating on a widespread scale in most communities (Caplan, 1974; Caplan and Killilea, 1976).

About the same time period, local churches were forming internal small groups for support and emotional growth. The writings of Bruce Larson and Keith Miller frequently allude to such groups (Larson, 1971; Miller, 1973; Miller & Larson, 1974). People to People Therapy is Drakeford's (1978) description of self-help groups in the church.

Self-help and support groups are significant enough in religious contexts that the New Jersey Self-Help Clearinghouse established the Congregational Support Programs in Mental Health (What is CSP/MH, 1985). This project, funded by the New Jersey Division of Mental Health and Hospitals, is a consultation and training service to help churches in developing support systems for mental health clients, particularly for the deinstitutionalized. Church-sponsored projects include social clubs, drop-in centers, and housing opportunities, and are usually operated in coordination with a local mental health agency.

An interesting sidelight of the self-help movement is the development of support groups for persons in the helping professions. Since Freudenberger's work (1975 a & b), there has been increasing awareness of the problem of burnout among mental health professionals themselves. Perpetual helping without adequate feedback, rewards, and support can be draining and eventually produce burnout (Edelwich & Brodsky, 1980; Keith-Lucas, 1972). Self-help groups are being used to combat burnout because they reduce the sense of isolation and
alienation, provide group identification, provide catharsis in a non-stigmatizing setting, and allow sharing of relevant, experiential information that is mutually beneficial (Cherniss, 1980; Kahn, 1978; Karger, 1981; Moeller, 1982; Spicuzza & Devoe, 1982). For the therapist, support groups may simply be a good taste of taking one's own medicine.

The processes of the functioning of these self-help groups have been studied and delineated by Katz (1970). First, self-help groups share the general properties of small groups. Classed as "ideological primary groups" by Marx and Holzmer (1975), the self-help movement is generally characterized by diverse autonomous small groups which form along the lines of friendship networks and are extremely diverse and heterogenous ideologically. Cartwright and Zander (1960) pointed out that individuals belong to these groups because they offer certain satisfactions not elsewhere available. Second, self-help groups are organized around a specific problem. Third, members of a group relate as peers. Professionals are accepted if they share in the group problem, but not as experts or leaders. Fourth, these groups hold common goals formulated within the group, rather than set by a bureaucratic or funding agency. Fifth, the group is a dynamic whole, greater than the sum of its parts.

Sixth, the expressed norm of the group is to help others. Reissman (1976) suggested that people achieve special benefits from being helpers because: (1) the helper is less dependent; (2) in struggling with another person's problem similar to his own, the
helper observes his own difficulty at a distance; (3) the helper obtains a feeling of social usefulness.

Seventh, in self-help groups, the role of the professional is not clear-cut, if it exists at all. Lieberman and Borman (1979), Toseland and Hacker (1982), and Klass and Skinner (1983) asserted that professionals do serve useful roles for self-help groups as consultants and referral sources. Todres (1982) found that in Toronto professionals have a positive attitude toward self-help programs. Hess (1980) discussed the establishment of self-help groups by professionals, who then withdraw, leaving the group on its own. On the other hand, Borkman (1976) and Steinman and Traunstein (1976) contended that professionals are not currently welcome in the self-help movement and do not have a positive attitude toward such programs. The question of professional involvement in self-help groups seems to really be a question of the specific group, the profession, and the norms of the geographic locality.

Katz's eighth characteristic of processes of these groups is that power and leadership are on a peer or horizontal basis. Leadership is earned and justified over a period of time on the basis of personal charisma rather than societal prestige. The role of the leader is to clarify the group's goals and create confidence among the members, clearly not the traditional leadership roles of the mental health professional (McClelland, 1979).

Self-help groups differ in degrees of flexibility and democracy. Recovery, Inc. is highly programmatic, following exactly the teachings of psychiatrist Abraham Low, with no deviations
allowed. Another group, also concerned with psychiatric and emotional disorders, is closer to the democratic therapeutic community in its style of meeting and ideology. Emotions Anonymous (EA) is a loose association of chapters utilizing the Twelve Step Method, slogans, and sayings of Alcoholics Anonymous, to assist people with finding a new way of life for gaining control over their emotions. According to correspondence from the International Service Center (A. S. Linder, personal communication, December 8, 1985), each EA chapter makes its own decisions within the general guidelines of the organization; there is no monitoring of chapters from the central headquarters. The EA groups are supportive and accepting, rather than confrontive.

The issue of the therapeutic efficacy of self-help groups is a difficult area. Sieg (1980) researched COMPEER, a companion program matching persons with psychological difficulties with people who want to be needed. Thirty-one psychiatric outpatients who had COMPEER peer counselors were matched with controls and at the end of six months compared in the areas of self-care, pleasure activities, self-concept and concept of others. Patients with COMPEER companions improved significantly more in all measures. Videka-Sherman (1982) researched the effect of Compassionate Friends and found that though there was no difference in the immediate symptoms of bereaved parents in Compassionate Friends and in the control group, parents in the self-help group reported more personal growth at the end of one year. Raiff (1982) found that participation in Recovery, Inc. groups was associated with positive mental status, according to self reports. Levy (1976) and Lieberman and Bond (1978) pointed out that...
most evaluations of self-help groups have methodological difficulties and that it may never be possible to rigorously evaluate the effectiveness of presently functioning organizations. There is too wide a variation and diversity among self-help groups in ideology, purpose, organization, and functioning style to make general statements or to do empirical research on the movement as a whole. Some organizations, such as those mentioned above, invite research. Others, such as Emotions Anonymous, refuse to allow observers or research, feeling that outside influences will disturb the group's free emotional expression and may entangle the organization in unwanted controversy.

What is certain is that multitudes of Americans indicate by their continued attendance that they feel they are deriving benefit from self-help and support programs.

Church Community

Among alternative programs that influence mental health and psycho-social development, one of the least recognized is the church that functions as a community in which members play out the important aspects of their lives. These church communities vary widely in doctrinal beliefs, formal organization, location, and living conditions, but all focus on intense sharing and life-long growth psychologically, socially, and spiritually for the individual and the group. Though in some church communities, several adults who are not biologically related live under one roof, they are distinct from the communes of the sixties in that they have an ordered life-style, lack of sexual permissiveness, respect for the nuclear family, and most
seek to perform some service for the general society, rather than to be isolated from the world.

Psychiatrist Leigh Bishop (1985) studied the dynamics of church communities in general, and the Church of the Redeemer, in Houston, particularly. Using Almond’s (1974) framework on healing communities, Bishop found that re-definition of deviancy, the inclusion of the devalued person in a group of fellow sufferers, the quality of communities, the concept of widespread healing charisma among the members, and the flexibility of roles characteristic of secular healing communities also exist in church communities. Bishop concluded that the church community is an effective approach for healing and growth.

Church of the Redeemer adopted a community life-style in the sixties as a means by which its wealthy, but diminishing, congregation could reach out with Christ’s love to an impoverished and decaying neighborhood. (For the history of Redeemer, see Harper, 1973.) The primary social unit for healing interaction is the household. Most households are headed by the married couple who owns the house and are composed of that nuclear family plus one or two other families or several single adults. Included in the community’s healing outreach have been individuals with alcohol and drug abuse histories, personality disorders, marital problems, histories of criminal behavior, and thought disorders. The community is not equipped to deal with active psychotics but does assist them in finding professional help. Healing activities include regular household meetings for sharing, discussion, study, and prayer; pastoral counseling; sharing groups which approximate group therapy; and daily work activities.
Several church communities with healing or psycho-social growth emphases were described by the Jacksons in a popular level book (Jackson & Jackson, 1974). Koinonia Partners was begun in 1942 on a 400-acre farm in Americus, Georgia, by two couples who intended to share life, hope and peace, and scientific farming techniques with the local poor. They sought to practice equal rights for all persons regardless of color, in a day when segregation was the established order. Koinonia Partners still exists, in spite of a difficult time during the 1960s. About seventy adults are working together for their own development and for the social welfare of the poor in their area. Healing at Koinonia takes the form of encouraging persons with long family histories of poverty and degradation to respect themselves, to become educated, and to become leaders of their people.

The Society of Brothers in Farmington, Pennsylvania, is a German-originated society in which families share all things in common (except conjugal rights). Their outreach is a retreat center which is open without charge to persons in need of quiet, comfort, and a serene environment in which they may recover their physical or emotional health.

Reba Place, Chicago, is located in several inner-city apartment buildings. About one hundred fifty adults and their children attempt to live as examples of human dignity and possibility. The group operates a day care center for the neighborhood and has worked to upgrade the neighborhood housing and social conditions. Some members work in the community-run industries. Others are teachers, social workers, blue collar workers, or psychologists who work in the general society and help to finance the Reba outreach programs. Reba
Place has accepted persons with a wide variety of disturbances and needs into the living facilities since their beginning in 1957.

Notable in the church community phenomenon is an entire denomination whose churches are communal in life-style. The Evangelical Orthodox Church, begun in the mid-1970s as a result of the work of para-church groups such as Campus Crusade, attempts to recreate the shared life-style of the first century church at Jerusalem in its fifty parishes spread across the United States (Evangelical Orthodoxy, 1979). Christian Century reviewer, Bruce Wollenberg, (1980) wrote positively about the social and mission work of this church.

Though the community life-style is certainly not the answer for every person seeking healing or enhancement of personal growth in a Christian context, it is definitely one alternative which seems to be here to stay.

Communities with Mentally Handicapped

Intentional communities are mental health alternatives based on the self-evident principles that all persons are created equal and have certain rights, including the right to an environment that makes possible the pursuit of life, liberty, and happiness. These rights also include the right to continued life-long learning and psychological and social growth. These principles apply as much to the chronically mentally ill and the retarded as to the middle-class business man. The difference is the specific characteristics of environments that are favorable to particular individuals. Intentional communities are deliberately designed to provide a nourishing
and appropriately stimulating environment for persons with specific needs, which may include a high need to be of service to others.

One of the best known intentional communities is L'Arche. L'Arche (The Ark) began in August, 1964 when Jean Vanier opened his home in Oise, France, to two mentally handicapped men from a nearby psychiatric hospital (International Federation of L'Arche, 1981). In his home, Vanier believed that these men could live in human dignity and grow in every spiritual and human dimension. Vanier has stated that his motives were not only for the good of these men but were also to meet his own need, "the desire to live the Gospel and to follow Jesus Christ more closely, "which is perceived as being done through living for the poor (Vanier, 1979, p. XI). Since that beginning, L'Arche has grown so that currently there are two thousand normal and mentally handicapped persons living in fifty-seven L'Arche communities throughout the world.

In L'Arche communities, the handicapped are considered to be equal in rights and responsibilities with the non-handicapped assistants. The handicapped (retarded and chronically mentally ill) work, earn paychecks, participate in the regular community meetings, vote on issues affecting the community, make independent decisions, carry out household responsibilities, and are in every way adult citizens. They are able to experience this degree of normal living because the environment is simplified, slowed down, and structured to be comprehensible and manageable for them.

Coppersmith (1983), a family therapist, studied the L'Arche community in Calgary, Canada. He observed that during a lengthy decision-making process, handicapped persons were paired with
assistants to discuss the issues. The assistants went slowly, carefully, step-by-step to be certain that the handicapped understood the issue and could vote on it. Coppersmith noted that, while the discussion entailed a complementary relationship between assistants and handicapped, it led to a symmetrical act of voting. As a family therapist, Coppersmith emphasized the frequent interchange between symmetrical relationships and complementary relationships, noting that in a traditional program, complementary relationship—staff to patient—are locked in and prevent the residents from achieving power or self-determination. In a family, there is flexibility between complementary and symmetrical relationships.

At L'Arche there is blurring of the distinction between caregiver and care-receiver. Assistants said that they "receive as much care as they give and that they are taught by the handicapped as much as they teach " (Coppersmith, 1983, p.154).

Coppersmith (1983) concluded the L'Arche is much like a family and that Vanier correctly described the basic community attitude when he wrote, "L'Arche is special, in the sense that we are trying to live in community with people who are mentally handicapped. Certainly we want to help them grow and reach the greatest independence possible. Instead of doing to them, we want to be with them" (Vanier, 1979, p. XI).

A similar intentional community is the Camphill Village system. In 1939, Dr. Karl Koenig, a Viennese pediatrician, opened a program for mentally retarded children at Camphill, Scotland, based on the philosophy of Rudolf Steiner. When the children became adults, the school was transformed into a Village in which volunteer
workers and retarded adults lived for their entire lives. The first Camphill Village in America was begun on a four hundred acre farm in Copake, New York. There are currently three Camphill Villages for adult retarded and one for retarded children and adolescents.

The Camphill Village system is like L'Arche in terms of egalitarianism, sharing, decision-making, and citizenship for the handicapped. Camphill, however, uses houseparents who are long-term volunteers and single young adults who are short termers. The houseparents and their own children share a large dwelling with eight to ten retarded adults, whom they regard as family and for whom they are ultimately responsible. Camphill also emphasizes continued intellectual and cultural experiences for both the handicapped and the workers (Camphill movement, 1983).

Innisfree Village, a program similar to Camphill but newer and with a secular philosophy, was reviewed favorably by Schulman (1980) in Focus on the Retarded Adult.

Schulman (1980) reviewed the field of forming small group living arrangements for retarded and chronically mentally impaired. She termed the process "communitization—the process of coordinating and reinforcing social benefits by means of pursuit of self-interest goals and activities plus the recognition of individual obligations in the social scheme with other people" (p. 273). She emphasized that communitization meets the need for belongingness and being a part of a reference group. The handicapped become a social unit, a subculture of their own. Schulman favored this residential structure for the retarded but cautioned that is not appropriate for all individuals.
In summary, one approach to providing for the long-term mental health needs of persons with life-long impairments, particularly in the cognitive-affective areas, is to create intentional communities designed to enable the handicapped to function as citizens with rights, privileges, and responsibilities in a semi-protected setting. In these communities, there is mutual sharing of experience and feeling between the handicapped and the non-handicapped who are their assistants. In light of the purpose of this study, it is interesting to consider the possibility of such communities for persons with deep-seated psychological disorders which are potentially remediable. Would the same type of environment assist such persons to find health more quickly and with less pain?

Call for Change in Model

Practitioners--professional and lay--who have developed non-traditional modalities for improving mental health are not the only persons calling for alternatives. Numerous theorists have pointed out problems in the present system and have called for new models to meet the current challenges and to utilize present knowledge concerning psychological and social well-being.

Best known may be the works of the three reformers Laing (1964), Goffman (1963), and Szasz (1970) in protesting the inapplicability of the medical model to the overall continuing development of the whole person in a whole society. The medical model focuses on illness, on finding something wrong with the individual, rather than appreciating his unique worth and capitalizing on his assets. The concept of illness is stigmatizing, causing persons to be shut away.
Valuable experiences for the individual and for society are lost. Rosenhan (1973) enhances the case by pointing out that the psychiatric system finds illness even when it is not present and, because of its focus and presuppositions, refuses to allow patients to become well. The medical model increases dependency and learned helplessness, even for outpatients with problems within the normal range (Sue and Zane in Gibbs, 1980).

Too often the present system blames the victim and allows society to escape from making humanitarian changes that would benefit citizens in general. A holistic model that deals with problems of living and societal reform is needed. Albee (in Gibbs, 1980) proposes that a competency model is needed to replace the defect model.

For assisting people with chronic disabilities, Wolfenberger (1975) insists that a management and educational model should replace the medical model which, when cure is not forthcoming, tends to discard the individual as hopeless and useless.

Since the entire professional-to-client office system and the doctor-to-patient hospital dyad seems to be rooted in the medical model, then replacing the medical model will require new forms of therapeutic relationships and activities.

Wagenfeld and Ozarin (1982) emphasize the idea that "effective service delivery must be culturally syntonic--consonant with the needs, perceptions, and values of those served" (p. 473). However, values and relational styles of persons in rural areas and in a diversity of subcultural groups based on regional, racial, ethnic, age, occupational, or social class distinctives are often at
considerable variance with the tenets of the white urban middle class on which the mental health system is based. To the extent that these cultural factors are in conflict, the care-giver will be ineffective and the care-receiver uncomfortable and frustrated (Bachrach, 1981; Eisenhart & Ruff, 1983).

Bachrach (1983) pointed out that according to the 1980 census, over one-fourth of the population lives in rural or non-urban areas and is underserved in total human services. Flaskerud and Kvig (1983) contended, from their survey, that persons in rural areas are aware of their mental health needs and would use services if they were available and perceived as appropriate in accordance with local norms. A model appropriate for rural areas would respect the "folk society" living arrangements with a strong emphasis on tradition, homogeneity of interests and expectations, and religious beliefs and practices. Relationships are expected to be of a long, enduring, though possibly stormy, nature, and family and kin are still central to life. Dependency on the physical environment and the need to survive weather-related hardships often leads to a self-reliance, a deterministic outlook, and an interest in solving only the at-the-moment psychosocial problem that is puzzling to urbanites (Bachrach, 1981; Cassidy, Gordon, & Heller, 1981; Martinez-Brawley, 1980; Youmans, 1977). Other subcultures, particularly blue collar ethnic groups, share many of the same characteristics. Therefore, it would seem that a mental health system for these groups would include the use of self-help, indigenous non-professionals, and natural care-givers.
Non-professionals have already been assuming such major roles in mental health services that many thinkers are looking toward non-professional experimental projects to provide models for humanizing the mental health system (Gartner & Riessman, 1977; Levy, 1976; President's Commission on Mental Health, 1978). Rappaport (1977) listed well over a hundred types of programs in which non-professionals have been employed as primary therapeutic care-givers. Rioch and associates (1966) set a new pattern at National Institute of Mental Health by demonstrating that women given specific training could achieve as great a success in counseling as traditionally-trained psychotherapists. Reiff and Reissman (1965) and Reissman (1976) demonstrated the effective use of indigenous non-professionals from the ranks of the poor. Homemakers have been shown to be effective therapists for disturbed elementary school children (Cowen, Gardner, & Zax, 1975) and for released psychiatric hospital patients (Katkin, Ginsburg, Rifkin, & Scott, 1971). Silverman (in Schulberg & Killilea, 1982) reviewed relevant literature and constructed a model for mutual help and peer counseling. Rappaport (1977) points out that non-professionals have advantages of naive enthusiasm; a special understanding of the viewpoints, life-style, language, and problems of their own people; and being accessible and acceptable role models.

Helpers in non-professional programs often gain as much as those they help. Reissman (1965) termed this the "helper therapy principle." As helpers, indigenous workers may enhance their own mental health by increasing their sense of control over their lives, particularly in socially devalued populations (Peck, Kaplan, & Roman,
Zurcher (1970) has provided some empirical evidence for this claim.

In light of this information, it seems logical that several models for delivery of mental health services that are culturally syntonic may be constructed using primarily indigenous personnel, the majority of whom have minimal academic training. Such a system may also utilize the act of helping as itself therapeutic and growth-enhancing for the helper.

Theory related to non-professionals and self-help programs needs to be addressed at this point. The major theoretical underpinning of self-help or mutual help is from studies of social support systems and stress. When Selye (1946) developed the general adaptation syndrome theory, he recognized that situations or events that caused stress and eventual breakdown in one person did not necessarily so effect another. He looked primarily at intra-individual differences in background and coping style for the explanation. Cassel (1974), a social epidemiologist, postulated that while psychosocial processes may be stressors, they may also be buffers against the effects of stress and, therefore, may be protective and beneficial. Subgroups become important communicators of information that buffers the individual from ill effects of stress generated in strange, complex, and often hostile situations. Since 1974, research findings have led to the conclusion that social support plays a major role in modifying the deleterious effects of stress on physical and psychological health (Levy, 1982).

Social support was defined by Caplan (1974) as attachments between individuals and between individuals and groups that promote
mastery; offer guidance about the field of relevant forces, expec-
able problems, and methods of dealing with them; and provide feedback
about behavior that validates identity and fosters improved
competence. Cobb (1976) looked at social support as information that
tells a person he is loved, valued, and a part of a network of com-
munication and mutual obligation.

Though there have been several approaches to classifying
social support, House (1981) described categories that seem appropri-
ate to use in a mental health care model. Support can be emotional,
that is, the provision of empathy, trust, love, and caring. Support
can be instrumental, direct help in daily life activities. Support
can be informational, the provision of information usable in coping
with personal and environmental problems. It may be appraisal, the
transmission of information relevant to self-evaluation.

Support, then, is obviously a process that should be included
in the development of any alternative model for mental health care.

**Summary of Literature**

Historically, though primitive societies have successfully
integrated the psychologically suffering individual into community
life, Western society has tended to isolate and stigmatize persons
with noticeable psychological needs. The medical model on which most
service has been based, equates psychosocial neediness with intra-
individual illness and attempts to apply the same concepts,
reasoning, and dyadic relationships in dealing with mental health
issues as in treating physical disease.

Since World War II, reformers and researchers have realized
that this model and conventional services are not the only approach
and with some populations may be grossly ineffective. Innovators have developed alternative forms of care—from reorganized hospitals to non-professional and self-help programs. Churches have become active in developing new approaches that encourage healing and continued psychological growth. The literature reviewed gives some hope that at last, society is beginning to integrate care for the psychologically disturbed and provisions for continuing psycho-social growth into the normal mainstream of American life.
CHAPTER III

METHODOLOGY

Introduction

The basic thrust of this study is to develop an alternative model for counseling centers, based on qualitative data gained from observation of existing healing communities. The selection of methodology is related to two assumptions: (1) methodology for research should be selected on the basis of the demands of the topic; and (2) qualitative research is a preferable means of obtaining a holistic understanding of persons and of the systems in which they live and interact.

The nature of this topic calls for qualitative methodology with a general phenomenological approach, utilizing concepts, procedures, and techniques from sociology and social psychology, as well as from counseling psychology.

Qualitative research is the method of choice for this study for several reasons. First, qualitative research uses the natural setting of a phenomenon as the place of study and the direct source of data. To study a healing community, it is logical to spend time in that community, to understand the context in which healing interactions occur. Second, qualitative research is descriptive, approaching the world with the assumption that "nothing is trivial, that everything has the potential of being a clue which might unlock a more comprehensive understanding of what is being studied" (Bogdan
The search for therapeutic principles in a non-traditional setting requires alertness to multitudinous factors that may or may not be significant. Qualitative research is concerned with meaning and process—with how people interact and how they feel and think, as well as with the resulting behaviors. Qualitative research tends to analyze data inductively, to piece together the puzzle as the data are collected and examined. There is no assumption that enough is known prior to data gathering to develop tight, fully testable hypotheses. This present research is exploratory, providing background and raising questions that may generate further studies in the future.

Phenomenology is generally the underlying approach to qualitative research. In its broader usage, phenomenology refers to discovering and describing phenomena "as we actually live them out and experience them....Description through discipline replaces the experiment as method while structure replaces cause-effect relationships as content...." (Valle & King, 1978, p. 15). Phenomenology then is defined in this paper as the researcher's method of getting inside the experience of the subject, of perceiving the phenomenon as the subject perceives it.

Phenomenology seems a particularly appropriate approach for analyzing healing communities since the success of therapy is in the perception of the therapist and client, rather than measured against fixed standards.

A more specific descriptor for the research activities of this study is field research using participant-observer techniques for data collection. Bogdan and Bikler (1982) described field
methodology. Diesing (1971), Reason and Rowan (1981), and Valle and King (1978) all referred to the use of field research in psychology, though in the past it has been primarily regarded as a sociological or anthropological technique. Participant-observer methodology is used in this study to mean participant-as-observer, observer-as-participant, or observer (Gold, 1958). The researcher may fully participate in the activities of the group or may interact with group members but in actuality not personally enter into events.

Diesing (1971) has referred to precedents for cross-disciplinary methodology in psychological research. Such an integration avoids the error which Van Leeuwen (1982) has condemned as currently limiting psychological inquiry—namely, prescribing a set methodology within a discipline and then forcing all research into that method.

**Research Procedures**

**Initial Steps**

Utilizing the considerations discussed above, the following activities were carried out.

A literature survey was done to clarify the problem and need, to ascertain what research is currently being done that is related to this project, and to examine existing alternative models for delivery of mental health services. A partial survey was accomplished prior to the first observation, and further study continued to gain more information relevant to each community observed and to the overall findings.
During the early stages of the study, the researcher's presuppositions, personal expectations, intuitions, and a general description of the model were discussed with advisors.

The original intent was to observe four to six programs that function as healing communities for the purpose of identifying and describing the therapeutic or growth-producing elements and comparing these findings to the problems to be solved in constructing an alternative model for outpatient counseling programs.

To qualify for observation, a program had to meet the following criteria:

1. It must involve a distinct group of people interacting on a regular basis for a set of common goals and be clearly visible to the observer as an entity, not an occasional collection of persons.

2. It must declare itself to be an intentional community for some purpose related to mental health. For example, a communal farm that is a residential treatment center for mentally handicapped adults may qualify. A communal farm for survivalists will not qualify.

3. The group must fulfill four out of five of the criteria common to healing communities and related alternatives as described in the literature. (It is unlikely any community other than Jones' own would in theory and practice fulfill all five criteria--particularly so for non-psychiatric settings.)

The five criteria are as follows:

A. Open, two-way communications among all members of the community regardless of rank or expertise.
B. Decision-making by democratic process at the level of persons most affected.

C. Striving for development of a positive, therapeutic growth-enhancing culture in such aspects as role relationships, values, and attitudes.

D. Recognized, accepted leadership on multiple levels.

E. Use of social learning to enhance personal development of all participants.

Finding Observation Sites

Finding appropriate sites for observation was the next step in research procedure. It was desirable to observe diverse settings with differing populations and varying activities or services to provide data that would reveal therapeutic principles operating in community in general—to distinguish foreground from background, to distinguish elements that bring healing from the obvious programming. For example, if the therapeutic effect of keeping a psychological journal was being investigated, and if all programs observed were schools, then distinguishing the effects of journals from the effects of academic factors on the clients' self-reported maturation could be impossible. However, if clients in a school, a hospital, and a day camp all made similar reports implying that journals were therapeutic, then the background has been separated from the foreground, the setting from the effect of journals. The distinction would be heightened if in a halfway house, residents consistently complained that their growth is hampered by rules prohibiting writing down their feelings. Then a journal has definitely been identified as therapeutic in itself, not just a part of one setting. Also the
camp might consider outdoor activities essential for health, but if clients in no other setting mentioned the outdoors, then outdoors was specific to camps and not a general therapeutic factor in community.

Another consideration in selecting sites for observation was accessibility. Some government-sponsored programs that might have been valuable for study were open only to researchers from programs in that same bureaucratic structure. Travel for observations was limited by time and expense to two trips of major length. Other observations had to be within a 200 mile radius of the researcher's home.

A further factor was that sites should include a variety of types of people and problems likely to be seen in alternative counseling centers based on the new model. Problems or diagnoses to be included were as follows: problems of normal adult living, such as marriage, parenting, or personal adjustment; religious struggles; adult neuroses; psychoses; mental retardation and/or brain injury; adolescent adjustment problems; delinquency; drugs and alcohol problems; and problems of childhood, such as hyperactivity, learning disabilities, teacher-student conflicts, abuse, and adjustment disorders. Though logically some problems would be seen more often, in accordance with the general population incidence figures, as many types of difficulties as possible should be included in the observations. A variety of ages was considered advantageous.

Organisation of Information

As observation sites were located, the problem then became the method of collecting, categorizing, and analyzing data. Although numerous schemes were considered, none seemed clearly superior.
Interestingly, the real life experiences provided the answers to this methodological dilemma.

The first site visited was a rural, self-contained village with mentally handicapped permanent residents, young adult volunteers and three permanent staff. The researcher entered the experience with five typed pages of guidelines and questions only to discover the first day that neither the staff nor residents were the least interested in answering a prescribed set of questions.

The Villagers were interested in integrating the researcher into their normal life routine, in making her one of themselves, in giving her a taste of the experience they had had as newcomers. Experiencing and understanding, rather than intellectual, verbal knowing, were valued in the Village (and in all but one of the later sites). It was obvious that the researcher's stay was going to be more phenomenological and experiential than she had anticipated, and that if she wanted to obtain any valid information, she must adapt.

During the course of the five days at Innisfree, the researcher groped for questions that would yield the most information without bringing on the unwanted effect of the contact persons either clamming up or walking away (which happened numerous times). On the final day, the researcher met with the Director and founder of the Village, a man thoroughly versed in the community and rehabilitation. As a former university professor, he provided guidance and insight for the research project in general, as well as discussed the Village itself.

By the end of the second observation, (a church that lives in community), the researcher had identified the most important
information needed for the eventual development of the model and had formulated the four research questions used for the remainder of the study. (1) What originally brought you to _____? (2) What effect has being at _____ had on you? (3) What brought about these changes? (4) What are the stresses here?

After the observation of this community, the first step was to organize the many pages of information obtained into some usable form. Several factors entered into this organization. Being true to the spirit of healing communities (as treated by both Jones and Almond) required preserving the unique flavor of each community. Therefore, the written record of each observation was begun with an Introductory Imagery section to give the reader a momentary, sensory experience of the community.

Second, the facts concerning the programs, combined with the researcher's observations, needed to be conveyed in a form applicable to all the communities in this study and compatible with categories used in other literature on healing communities. Categories used in the factual sections of this paper are Facts and History, Roles, Activities, Beliefs, Support, Communication, Decision-making Process, and Psychological Sense of Community. Sarason's term psychological sense of community was chosen, rather than Jones' group identity which could raise associations with the popular term, groupie, connoting weak personal development. Jones, like Sarason, intended group identity to imply personal power and maximal development within the context of the group. Social learning, an important aspect of community, was treated under the label, Activities.
Third, the amount, kind, and quality of the contacts with each community were relevant to understanding the information obtained; therefore, a Contact section was included in each observation.

Fourth, the actual research questions and answers of the participants needed to be presented and analyzed. Deciding upon classifications of the answers was difficult. The answers to the questions were read repeatedly until certain patterns emerged. Those patterns suggested the five categories into which the answers were finally classified—Interpersonal, Intrapersonal, Professional, Physical, and Religious. Interpersonal refers to characteristics, effects, or changes in relationship between individuals or between the individual and the group. Intrapersonal refers to changes or experiences internal to the individuals. These two categories overlapped unavoidably at times, but both were deemed necessary since there may be internally perceived change that is not yet expressed in relationships with other people. The Professional category has to do with either a change in professional skills of the respondent or a need for assistance that requires professional expertise. Physical refers either to the general physical environment, including schedules and physical exertion, or to provision of the material necessities of life. Religious refers to church doctrine or to individual spiritual beliefs and practices.

In the written account of questions and answers, categories were listed under each question in order of importance for that question as determined by both the number and significance of the responses of persons at that observation site. Responses quoted were
those representative of the group or those that have special significance for this study. Not recorded were the highly ideographic or tangential responses given by more severely impaired individuals or by persons wishing to avoid the question. When no answer was given that fit a category in the researcher's judgment, the category was marked as "no response".

To preserve anonymity, contact persons were grouped according to their status in the healing community so that groups at different sites were somewhat comparable. Group A is persons officially in authority, corresponding to administrators or psychiatrists in a therapeutic community. Group B is middle level staff, well enculturated in the community, with limited leadership duties. Group C is lower level staff or community members with no particular leadership duties. Group D is new members, clients, or persons perceived as needy.

The final task in organizing material was repeatedly reading the entire set of observations to identify principles applicable to a model for counseling centers.

Constructing the Model

After observations were completed, the model was constructed. The original intent had been to build a new pattern for programs that regard themselves as Christian counseling centers. However, as the study progressed, it seemed the model could be used by any group of professional and lay persons who wanted to provide mental health services in a unique, interactive environment. The author did not wish to be elitist and imply that only Christians could benefit from this research; therefore, she dropped the use of the term Christian
counseling center in the majority of the paper. However, the fact was that the original impetus for the study came from Christian convictions and world-view and that churches would utilize the model in special ways. Therefore, the writer included certain statements directed to the interests and beliefs of Christians, particularly in the conclusion of the model.

**Summary**

The research procedures used in this study were ever unfolding as the real life experiences progressed. Somehow, that progression from experiences seems particularly appropriate for research that deals with complex interrelationships and takes a phenomenological perspective.
CHAPTER IV

RESEARCH FINDINGS

The following sections contain the research findings from observations of five healing communities. The presentation of each set of findings is explained in the Methodology chapter.

Innisfree Village—A Community of Normal and Handicapped Adults

Introductory Imagery

Nestled in a spacious valley of the Blue Ridge Mountains is Innisfree Village, an interdependent community with sixty normal and mentally handicapped adults welcoming people of diverse socio-economic, religious, and national backgrounds. Innisfree, named from Yeat's idyllic poem, is located on four hundred acres of rolling farmland near Crozet, Virginia.

To reach Innisfree, a two-mile gravel lane winds from the highway, through woods and cultivated fields, past the farm, and back to the village itself. Out in the community gardens alongside the white antebellum home, the original Innisfree house, a dozen blue-jeaned workers chop weeds from the red clay soil. One straightens, smiles the broad smile of Down's syndrome, and waves her straw hat at a visitor. Down at the main complex of modular wooden buildings, a man emerges from his efficiency apartment, broom in hand, and leisurely sweeps the sidewalks. No one hurries on a hot Southern day; no one ever hurries at Innisfree. Its tranquility and
methodical life-style are reflected even in the names of the fourteen buildings that house the living quarters, office, woodworking shop, weavery, and bakery—names like Halcyon and Honeysuckle.

Facts and History

Innisfree Village, the home of thirty-four mentally handicapped and twenty-six volunteers, was founded by Dr. Heinz Kramp in 1960. A geneticist, educated in the rigid German system prior to World War II, Dr. Kramp became interested in the plight of the handicapped adult while teaching equestrianism. While working in the Washington, D.C. area, he made friends with several brain-injured adults and, through them, met wealthy families who were searching for appropriate living arrangements for their retarded offspring. Dr. Kramp led these families in organizing a not-for-profit corporation and board of directors to found a community in which people labeled as handicapped live and work as equals with those who wear no such labels. The present location for the community was chosen because it offers the simple country life with lower levels of stimulation than the city, yet it is only fifteen miles from the resources of a major university and medical center. Thus began Innisfree.

Roles

Director

Dr. Kramp, or Heinz as he is known in the community, bears the ultimate responsibility for Innisfree and controls all relations with the corporation and board of directors, as well as with funding and governmental agencies. Often he must make difficult choices between what he believes is advantageous for the community and what
is expected by bureaucrats and by some families of the handicapped residents.

Though Dr. Kamp originally lived in the Village, he currently maintains a residence in the city to give him more accessibility to public resources and to allow the younger leaders to assume more responsibility in the community.

Heinz Kramp definitely "leads from the rear," seeing his present role as training and educating other staff members. In Innisfree meetings, he often listens to the lengthy discussions, allowing the volunteer staff to struggle with weighty problems, speaking himself only when the basic Innisfree philosophy is at stake.

**Coordinators**

Mr. and Mrs. Sato, known as Phyllis and Sato, have the on-the-spot supervision of Innisfree activities. They are the more visible leaders of the community, but they too yield responsibility to the volunteers whenever possible.

**Volunteers**

The staff or volunteers are young adults with two to six years of college, working at Innisfree for terms of one to three years, paid only enough to cover expenses. Volunteers represent the professions of nursing, special education, civil engineering, and agriculture. Contrary to usual employment practices, a staff member is not hired to do a specific job. Instead, he first becomes a member of the community, working at whatever needs to be done, learning new skills, attitudes, and perspectives. Often he learns
the beginning steps of the crafts of weaving, woodworking, baking, and gardening from the more experienced handicapped co-workers.

Volunteers often experience an initial culture shock and identity crisis when coming to Innisfree, as they learn to live in a close society and to relate to the retarded, brain-injured, and mentally ill co-workers on an egalitarian basis. Abruptly the college graduate is learning from a person with a sixth grade or lower reading level, from a person whose speech may be slow and minimal, who may have grotesque physical deformities or spastic movements. Not only do the handicapped know the crafts which the volunteer must learn, but they are the experts on the Village history, norms, traditions, values, and daily activity patterns. The Village is the co-workers’ permanent home; the new volunteer is temporary and in the disadvantaged position.

The new volunteer also learns from the more experienced volunteers. Five volunteers stated that, in the initial adjustment period, the empathy, acceptance, and guidance of senior volunteers had been the stabilizing factors. Three volunteers stated that they had never had close, supportive, open relationships with peers previously and that they treasured the quality of interpersonal relationships among volunteers and would seek to build similar relationships upon returning to general society.

Volunteers and co-workers share the houses. The volunteers are responsible for budgeting the monthly house allowance for food, utilities, and any special recreational projects or equipment. Each house has a garden and preserves food stuff. For many of the volunteers from financially advantaged backgrounds, Innisfree is
their first experience in budgeting, balancing a checkbook, or conserving resources.

Co-workers

In theory, co-workers are the core of the community. They are expected to assume responsibilities and exhibit behaviors appropriate for citizens in any community in a democratic society. At weekly community meetings, they are expected to take part in the discussion and decision-making process, to vote, and to elect representatives to committees. Co-workers hold jobs on and off the grounds, earn wages and pay expenses, travel to the city for shopping and recreation, and keep in touch by phone or letter with friends and family.

In interpersonal relationships, co-workers are expected to express their feelings, wishes, and preferences. Even the lower functioning and the non-verbal Villagers are encouraged to express themselves through gestures. Aggressive behavior and inappropriate physical affection are not tolerated and are infrequent except among the newer, low functioning residents.

When unacceptable behavior occurs, it is met with the same type of sanctions as in general society. For example, on a picnic the first evening of the researcher’s stay, volunteers and co-workers were traveling several miles by van. One of the male co-workers slapped a woman co-worker on the leg. She exclaimed, "Don't do that!" Someone else chimed in, "That doesn't make friends." A non-verbal woman in her fifties put her finger in the young offender's face and gave him a lecture by gestures. When the young man did not respond to peer pressure and again hit out, the volunteer stopped the van and
in the tone of a city bus driver announced, "Hitting is not allowed on this bus. If you do that again, you will have to get off the bus and miss the picnic." When the offense occurred again, the van was returned to the Village, the offender placed in his room under the supervision of a volunteer, and the group jolted off again as if nothing had happened.

For the co-workers, the major difference between Innisfree and general society is that the pace is slower, the intellectual and social processes needed are simpler, and someone is available to supplement whatever a co-worker cannot do for himself.

Though the Village attempts to have similar roles for volunteers and co-workers, there are differences that disturb the higher functioning handicapped. First is the short stay of the volunteers; by the time co-workers really get to know a volunteer, his term is over and he leaves. A related issue is that the permanent residents are paying (about $800 a month) to be at Innisfree while the temporary volunteers are paid to be there. All status jobs, such as committee chairmen and work supervisors, are held by volunteers. Volunteers also have control of their sexual relationships as long as they are discreet. Co-workers are told that physical sexual contact is not allowed (primarily because of the wishes of parents rather than the Innisfree staff). To some co-workers, these differences are quite enough to arouse the feeling that Innisfree is a place of staff and clients, rather than an egalitarian community.

Attempts to reduce some of these differences have been made but have so far been unsuccessful. One such attempt was bringing in,
as a volunteer, a person who had been brain-injured as an adult, who was physically impaired but normal mentally. Unfortunately, this person was not accepted by either the volunteers or the co-workers.

Beliefs

The basic premise of Innisfree is that all people are equal. All have assets. All have limitations. A familiar phrase on the grounds is "All of us are handicapped to some degree. Some of us just have not been labeled."

The egalitarianism is such that, the first day the observer had difficulty distinguishing between volunteers and co-workers. Blue jeans, long hair, sandals, guitar playing, and singing are bonds that cover a multitude of differences. Several co-workers who were on the picnic had lived and worked in general society, and their mannerisms were more those of "hippies" than those usually associated with even mild retardation.

At the picnic, the volunteers extended the egalitarian attitudes not only to high functioning residents, but even to the nonverbal, autistic man in the party. The man, K., was sitting with a group of young men who were singing, cracking jokes, and with a little beer in their systems, getting slightly bawdy. By gestures, K. inquired the location of the latrine and was directed down the path. When one of the staff men looked up and saw K. standing in autistic fashion by a rock half way down the path, he yelled out at K. with exactly the same tone of voice he had been using in joshing with his fellows. Though this volunteer had worked in institutions
for the retarded, there was not a hint of superiority or condescension that usually characterizes professionals or attendants speaking to patients.

Another belief at Innisfree is that community, with its intense sharing and caring, is an ideal way to live. Community itself is therapeutic for labeled and non-labeled individuals. A man whose handicap was diagnosed as schizophrenia, who has normal intellectual capacity, approached the researcher, saying that he heard she was interested in starting a community like Innisfree. "There should be one in each state. Innisfree is a good place to live. You would enjoy residing here. We are hoping other people will want to build their homes in the Village. There are some beautiful tracts of land by the creek." The man then explained a detailed and workable plan for starting a similar community. This man is skilled in woodworking and contracts with metropolitan stores for specialty items. At Innisfree, he appears quite normal but his case history indicates that when he lived with his parents, he was unable to cope with the requirements of upper class social life and was floridly psychotic. Not only the handicapped speak of community as an ideal way to live, but many volunteers say that they will seek to build similar relationship or to enter other established communities after leaving Innisfree.

Activities

Participation in total Village life is considered a growth-producing experience for labeled and non-labeled persons. Every person, at some time, works in the garden, the farm, the bakery, the woodshop, and the weavery, as well as taking over responsibilities in
the houses. Every person has the opportunity to exercise rights of
citizenship in community meetings. Every person has the right to
build numerous interpersonal relationships of differing types. The
only limitations are those that the person carries within him—at
least in theory.

At Innisfree, there is no therapy as such. Living together
is the therapy. However, the past two years, as the community has
achieved more maturity and has tackled more complex issues such as
sexuality for the retarded, a consulting psychologist has been
working with the volunteers and has led educational discussion groups
for the whole Village. More efforts are planned to provide pro-
fessional level education for the volunteers.

Communications

Communications is a major strength of Innisfree. In fact,
there is so much time spent talking, discussing, and working through
issues, between individuals and in committees, that some members are
critical of the amount of communications and contend that there
should be more doing and less talking.

Decision-making Process

Decisions concerning Innisfree and outside agencies are made
by the director. Crisis decisions within the Village are made by the
director, the coordinators, or sometimes by whatever staff is
present. Decisions about certain policies and activities, such as
accepting new volunteers, are made by committees. Decisions to
change major elements of Village life that affect everyone are made
through consensus at weekly Community Meetings.
Support

Support is at a superior level at Innisfree. There is so much positive emotional support that it is not noticed until incidents of critical, condemning behavior arise, and incidents seem totally out of character for the community.

Psychological Sense of Community

Group identification is high at Innisfree, particularly among higher functioning residents. A young woman with severe facial deformities from neurofibromatosis asked if she could help me with writing about Innisfree. "This is my home, and I love it. I feel responsible to see that people understand our Village." Many volunteers also feel a psychological sense of community with Innisfree. Several said they wished they could stay there indefinitely, but the British government does not grant longer passport for volunteers. (Even for Americans, the Village does not encourage long-term stays for volunteers.)

In summary, Innisfree is a democratic therapeutic community carried far beyond Jones' proposals. It is a fascinating experiment in true democratic egalitarianism among people with very different levels of ability and backgrounds.

My Contacts

Having read about Innisfree in a text on mental retardation (Schulman, 1981), I wrote to the Village and received a warm invitation to live in the Village and do research for a week. The phrasing of the letter was typical of Innisfree: "In community meeting we decided to ask you...."
During my five-day visit, I lived in one of the houses and attempted to blend in, to experience the feelings of a new volunteer, as much as possible without losing my research perspective. I worked in the weavery and spent time in the bakery and woodworking shop. Often I felt decidedly inadequate and inferior to the handicapped Villagers in my utter lack of understanding of the crafts and lifestyle. I ate at various houses, getting to know the volunteers and co-workers in their daily routine. My research queries were integrated into the normal group and one-to-one conversations of community life. Staff and co-workers were open and honest about their feelings toward the program. Inadequacies, problems, and personal dislikes were expressed concurrently with praise and enthusiasm for the community. When I questioned certain practices, there was little defensiveness. Senior volunteers, and occasionally co-workers, would explain the reason for the practice or ask for my input in solving the problem.

Because of the volunteers' busy schedule, it was impossible to do in-depth personal interviews. Fourteen volunteers interacted with me on some or all of the research questions.

Mr. and Mrs. Sato spent two hours explaining the history and philosophy of Innisfree. Dr. Kramp took time for a lengthy discussion, not only concerning Innisfree but also concerning the concept of research into community.

Persons Interviewed

GROUP A: Administration

1. H.K. is director, former professor at the University of Chicago, a researcher, and by age, a senior citizen.
2. P.S. is coordinator with eight years at Innisfree.
3. H.S. is accountant and coordinator with eight years at Innisfree.

GROUP B: Volunteers. Most volunteers are in their 20's and 30's and single and are at Innisfree from one to two years. A few have long-term status.

4. P.W. is British and a special educator.
5. J.W. is a psychology major with a bachelor's degree and working at his first job.
6. P.A. is holding her first job after earning a degree in elementary education.
7. M.F., a former rehabilitation counselor, now heads the farm at Innisfree, and has three years there.
8. L.D., ending a two-year term, is in charge of the office.
9. L.L. is a British social worker on leave.
10. M.L. is a British psychiatric nurse on leave.
11. C.S., a middle-aged volunteer and researcher into the dynamics of community, has a retarded son in another community.
12. F.N. is an elementary teacher with her first job.
13. P.S., married, in her third year here, is in charge of the weavery.
14. M.S., husband of the above, is in charge of the bakery.
15. N.O. is British, an engineer, and a professional student.
16. A.M., a new volunteer, has her first job after college.
17. J.T. is a special educator with social work experience.

GROUP C: At Innisfree, no position is equivalent to the Group C status in other communities observed.
GROUP D: Handicapped residents, including retarded, brain-injured, and chronically mentally ill adults.

18. S.S., one of the original residents in 1970, is only mildly retarded with major physical deformity.

19. J.G. appears normal intellectually, with poor impulse control and little conscience development. She likes farming.

20. P.P., cerebral palsied, has been employed in the city but prefers Innisfree.

21. L.K., low moderate in functioning, wants to go home and is depressed.

22. M.P., moderate functional level, has no family.

23. I.F. appears low normal intellectually and had been in a psychiatric hospital for psychosis for years.

24. W.R., intellectually bright, is schizophrenic.

25. B.W., borderline intellectually, is currently psychotic and aggressive.

26. C.F. is physically impaired and has a personality disorder.

27. M.F., previously a New York executive, was brain-injured during a recreational activity as an adult.

Research Questions and Answers

Question 1: What originally brought you to Innisfree?

Interpersonal

Group A. Dr. Kramp was initially interested in a quiet country life-style for himself and his family, believing from study and experience that community was "healthier and a more sane way to live" than the usual patterns of upper middle class suburbia. He believed persons develop optimally when in "warm, real, supportive
relationships" with other humans. He said that studies indicated communities needed a purpose if they were to hold together. The purpose of Innisfree was service to the handicapped.

Mr. and Mrs. Sato had served in a community in India and wanted to continue living in community, to be of service to others, and to have a simple life-style.

**Group B.** Service and desire to experiment with community life-style were the major answers of volunteers. "I had been interested in communal living when I was in college. When I graduated, I had the opportunity to come here and try community and see if it was for me." "I wanted the closeness I never had at home or school. I was tired of being a number." "I had worked extensively with the handicapped in a school setting. I wanted a place where I could serve and be myself at the same time." "Life has been easy for me. I wanted to do something for someone else." Four other volunteers gave similar answers about service and community.

**Group D.** As would be expected, most of the handicapped had been placed here by their parents or by the state, rather than choosing to come.

A man in his twenties had chosen Innisfree and had a particularly touching story, according to his report. As a teenager, he had been diagnosed as mentally ill and placed in a state hospital at a psychiatrist's insistence. His parents expected him to be dismissed in a few months. In the hospital, "I just went down, deteriorated. I needed my family and friends." Though his family visited regularly and took him out for vacations, his condition worsened. One summer,
after five years of incarceration, his parents came to take him on a fishing trip. The staff refused to even let them see their son. The parents got an attorney and a court order for his release. The man said that he enjoyed living with his family but "after a while, it got monotonous. I wanted to work but couldn't find employment." He was also concerned that his parents were getting older and wondered what he would do when they could no longer care for him. About three years ago, he visited Innisfree and decided this would be his home. "This is a home, very different from an institution. I have my own apartment. I can cook, or I can eat here at the Laurels. I have friends. I belong."

Physical

**Group A.** The quiet, fresh air, food, and country living was attractive.

**Group B.** Several British volunteers stated that they wanted to visit America and get to know Americans and coming to Innisfree made that possible.

**Group D.** Most of the co-workers were placed here, in part, for their physical well-being.

Intrapersonal

**Group A.** No response.

**Group B.** A desire for new personal experiences and finding personal identity contributed to the motivation bringing volunteers to Innisfree. "I've tried multiple other work situations and was never satisfied. I thought I'd try a year here." "As long as I stay
in school, my parents will keep up my allowance. I might even learn something here."

Group D. No response.

Professional

Group A. No response.

Group B. Four volunteers perceived Innisfree as an opportunity to gain professional experience or occupational direction. Representative was the comment, "When I was in social work, I felt like I was under great pressure and achieving nothing. I came here to find out what I wanted to do for the rest of my life."

Religious

Groups A, B and D. No response.

Question 2: What effect has being at Innisfree had on you?

Interpersonal

Group A. "I'd say we have to keep on our toes to deal with the constant changes and demands. Life is increasingly complex. Innisfree has been growing so fast we face issues that we never thought of eight years ago. Our family has changed, too. The children grew up here and are gone." "The staff members who were here when we came, the ones we relied on, are gone and now we are the old folks. We have the responsibilities but not a lot of respect from the college kids. They are pretty distant to us." "Change? Life is change in relationships--constantly."
Group B. A new level of emotional closeness was mentioned by all but two volunteers. "My family is quite reserved. You don't express what you feel. My college was like that, too. Here I've become closer to people, freer to show who I really am."

Closeness and levels of social status was important to one young woman who had just finished college. "I would never have believed I could feel so close to people, especially people different than me. N. [a volunteer] is from a different background. He's wealthy and my family is just barely making it. But he's been a wonderful friend, a very steadying influence. And C. [volunteer], I'd have been terrified of her if I'd met her in the city. She's so dynamic, so sophisticated. But, well, she's been like a big sister here. I'm learning we're all just people. And S.S. [co-worker], the first week I cried a lot. I was scared, lonely. S.S. was always there. She understood and loved me. I've never been loved by a retarded person before. Only now I don't think of her as retarded. She's just my friend."

As part of a general conversation with the researcher, rather than in direct answer to a question, three volunteers talked about new kinds of relationships with the handicapped. "You know W.R. He's one ____ of a guy. Sometimes I think I'll go crazy, this place is so isolated. Nothing happens--no concerts, no library, not even a ballgame. Not even a class. I've always thought of myself as intellectual. W.R. caught me out on the farm by myself when I was really frustrated. You know what he said? 'It doesn't matter if you go crazy. The rest of us are. You could stay with us all the time. We want to be your friends, but so far you haven't let us.' Being
friends with W.R. and some of the other guys is a lot different from my friends in college. But maybe it's more real."

A similar response was given by a woman who has been in professional work. "What surprised me is that I learn from the co-workers as much as they learn from me, though different things. The first two months here, I didn't know how to relate to them at all. I thought I was here to take care of them, to be strong for them. I was wearing myself out. Then about two weeks ago, I noticed that P. [co-worker in her house] seemed mad at me. She wouldn't let me do her hair, or anything.... Finally, she blurted out, 'You do everything for me and won't let me do anything for you. It isn't fair.' We talked a lot since then. P's retarded but she's not dumb. She figured out a lot about me, like I was tired all the time because I was doing all the housework. So we're trying an experiment. I let P. do more of the physical work. In exchange, I take her out for a drive or I read to her. We each do what we do best. It's an experiment in working out an even trade. P. says we should be more equal, like sharing feelings. I don't know. I'm still learning."

Another man commented on his feelings about the co-workers. "I say, these people are a surprise. I started in the weavery last week. And do you know who strung the loom for me? G. [a co-worker]. He can hardly talk, but he can weave superbly. I'm all thumbs, more knots than not. Now, that's a bit hard on the ego, mine. And to top it off, yesterday, M. [another co-worker] decided to show me how to use the hoe--out in the garden--so I didn't break my back. He was right; he knew more than I did. A couple of the other volunteers
that have been here a while say you get accustomed to these people knowing things you don't, but I'm not used to it yet."

**Group D.** This question required introspection generally beyond the grasp of the residents. However, what they could not answer in direct questioning, they sometimes said spontaneously. Several residents commented on having friends at Innisfree though they did not in the outside world. A typical remark was "P. [coworker], she's my friend. I got lots of friends here. I wish I'd had friends when I was in school." Another remark made spontaneously was "I feel good when my volunteer wants to be my friend. Some of them don't, but J. does. I know I'm not pretty like her, but she likes me." The implication in the conversation was that the friendship with a person who has more social acceptance, normal physical appearance, and more intellectual ability made this handicapped woman feel good about herself.

Staff reported substantial interpersonal relational changes in many residents, particularly in the elimination of aggressive and anti-social behaviors and the acceptance of more responsibility toward other villagers.

Intrapersonal

**Group A.** No response.

**Group B.** Finding personal identity was a significant change for several volunteers. "I'm getting a sense of meaning. I never had to work for anything before. There is something about serving others that is meaningful." "The idea that we are all handicapped was a surprise. I had worked in a traditional system as a staff
member. I feel differently about the handicapped and myself now."
"When I came here, I was just out of college. I'd never worked or
done anything significant. I would have never believed I could do all
the things I have done at Innisfree. Now I know I can take on any
responsibility and handle it."

**Group D.** A few co-workers gave simple answers, such as "I
can wash my own clothes here," "I learned to weave," or "I have a
job." In conversation, one high functioning co-worker said, "When I
came here, I felt really bad about myself. I thought I couldn't do
anything right. That was a long time ago. Now I earn a pay check.
I talk to people. I swim. I go to town shopping. I do lots of good
things. I'm handicapped, but I'm important. I can even talk to you."

Staff reports indicated that co-workers have made significant
improvement in their ability to express feelings, desires, and
preferences during the past year. The lower functioning residents
have made improvements in self care.

Professional

**Group A.** The leaders saw themselves as increasing in profes­
sional skills as the community has grown.

**Group B.** Several volunteers viewed their experiences as
affecting their professional lives. "I know I don't want to go back
into social work. I'm in love with woodworking, and I think I'll
make that my occupation." "I've had another view of the handicapped
that will help me when I go back to my regular hospital duties."

**Group D.** No response.
Physical

**Group A and B.** No response.

**Group D.** Staff reports indicated that the handicapped have improved in physical health and decreased their medication levels—particularly those who had been in state institutions. One epileptic no longer needs to wear a protective helmet.

Religious

**Groups A, B and D.** No response.

**Question 3: What brought about these changes?**

Interpersonal

**Group A.** Group A members mentioned factors such as time, changes in staff, and experience. One said, "We've learned a lot from Heinz about community and the handicapped."

**Group B.** Answers related to factors in community, such as closeness of living and group norms, and to the courage of some residents. Almost all volunteers gave answers in the Interpersonal category. Some examples follow.

"You can't fake it here. You have to be yourself, and then you find you are accepted. That is a surprise."

"I used to get depressed. Now when I think of the courage of some of these people, especially the ones who have been brain-injured as adults, I think, if they can do it, so can I."

"Here you are accepted and valued, not for what you produce but for who you are. Acceptance makes a difference."

**Group D.** The staff stated that social learning and being treated as normal were responsible for improvement in the residents.
This agrees with the principle of normalization that is generally accepted in rehabilitation and special education. To date, no studies have been undertaken to measure the progress of residents systematically, and no assumption is made that the improved emotions and behaviors would continue outside of the Innisfree environment.

Professional

Group A. The demands of the community and continued study into the needs of the handicapped have brought improvement in professional skills.

Groups B and D. No response.

Intrapersonal, religious, physical

Group A. Leadership mentioned the calming effect of the rural setting.

Groups B and D. No response.

Question 4: What are the stresses here?

Interpersonal

Group A. The major stresses for the leaders were in dealing with the volunteers. Too often, the young volunteers seemed to resent the leaders stepping in to deal with problems, even though the volunteers had not been successful in finding solutions. The constantly changing volunteer population was another stress. At one time, drugs had infiltrated the Village and became a major problem that also required calling in the local law enforcement authorities and coping with bad publicity. At another point, a particular
religious sect was impacting the secular nature of the program and had to be dealt with, without losing the volunteers involved. Currently, the British volunteers seemed to be finding it difficult to be open and emotionally free in a group setting, thereby reducing the community openness. The issue of physical and emotional privacy necessary for long-term work with the handicapped had been an issue for the leaders before they acquired a dwelling away from the main village.

The differences in the expectations of the parents and corporation board, as opposed to the desires of the residents, sometimes produces stressful situations. For example, concerning standards of sexual conduct, the parents often expect their offspring to be celibate and even sexually unresponsive and expect the staff to quell any sexual activity. The co-workers contend that if they are really adult citizens, they should control their own sexual lives. Staff members vary in attitudes toward sexual freedom for themselves and for the co-workers. Another difference is in the area of how money should be spent. Some board members have felt that the director or treasurer should control all spending, that the volunteers lack good judgment, and therefore the residents suffer. The director and coordinator want to give the volunteers the opportunity to learn to budget money.

Group B. No response, except the privacy responses listed under Physical.

Group D. Numerous co-workers complained about the turnover in volunteers. "I just make friends, and they leave." "They just
learn to treat us right and then they go away. I want them to stay."
"They aren't really like us. They are all going to leave."

Missing home and family was another complaint of some co-workers, particularly those whose families are deceased or do not visit. As the researcher was writing notes, one middle-aged woman asked her, "Write a letter for me. Say, Mommie, I miss you." (Her mother is deceased.) Another lady told the researcher that her brother "lives in a beautiful big house in Texas, but he doesn't want me. He doesn't come to see me."

Two co-workers of higher intellectual ability voiced concern that while, in theory, the co-workers were in charge of their own lives, in reality the volunteers were "the bosses." They wanted real equality.

Physical

Group A. No response.

Group B. Too much required activity, no time alone, the constant physical presence of the handicapped, monotony, geographic confinement, and living on a tight budget were stresses for the volunteers. The following are representative of complaints.

"There's never any time to stop. Even on your days off, you can't get away from the work." "You are never really alone. There are the other volunteers in your house. If you go out of your room, you can't just ignore them as if they weren't there. And the co-workers don't understand time off. They still have claims on you."
"When you have time off, there is nowhere to go. Into Charlottesville, but there's nowhere to stay and not much going on. I can't afford to travel any distance, say to a ballgame or to the seashore."

"It's isolated here, and we see the same things day after day--hills, trees, rocks. I miss the city."

"I'm not used to living on such a small budget. We have to plan carefully to have enough food. I think that is rather rotten. [The researcher noted that the diets in several houses were inadequate for active young adults.]

**Group D**. No response.

Professional, intrapersonal, and religious

**Groups A, B and D**. No response.

**Summary of Questions and Answers**

What attracted people to Innisfree? For the leaders, it was the opportunities for service to others, for psychological community, and for a simple country life-style. Staff were attracted to Innisfree for the opportunities for service, by communal life-style, and by time to find themselves. A few staff originally viewed Innisfree as an educational experience, a time to "goof off" without full adult responsibilities, or as an escape. Co-workers were generally placed at Innisfree by their parents. Those who chose the community were looking for the opportunity to be full participating citizens, to have a permanent home, or to be adults in a society where their needs would be met.
What we are asking is whether the results of growing in relationships as a result of the "normal" incorporation of the community, a well-organized, self-director in work and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relationships and in self-care skills, and in work relati...
What effect did being at Innisfree have? The leaders spoke of growing in professional and interpersonal skills and wisdom as a result of the demands of the growing community. Volunteers unanimously referred to increased skill and depth of interpersonal relationships and of increased personal self-confidence or self-direction and life-meaning. An ability to readily accept new challenges and an ability to form more intimate relationships was often cited. A new appreciation of handicapped people was often mentioned. While residents could not answer directly, a few spoke spontaneously about changes in their feelings about themselves and about friendships with other residents and volunteers. Staff records indicated that Villagers have improved in citizenship skills, in self-direction, in expression of personal desires and preferences, and in work habits. Lower functioning residents have improved in self-care skills and exhibit more appropriate social behaviors.

What has brought about these changes? For the leaders, change resulted from life purpose and from changing demands of the community, as well as from the satisfactions of community living. For the staff, interpersonal relationships, particularly emotional intimacy, acceptance, and the norm of "being real" were major factors. For the residents, being treated as normal and expected to assume adult roles was a major factor.

What stresses were in the life of the community? Leaders experienced problems from the constantly changing volunteer population and from conflicting demands of residents, volunteers, and parents. Staff experienced stress from the geographic isolation and
accompanying physical closeness with little privacy. Residents experienced stress from the transientness of the volunteers.

Contributions of this Observation to the Model of Counseling Center as Community

The purpose of observing the healing communities is to extract general principles that may be useful in developing a counseling center that is a community (CCAC). Innisfree is particularly useful in understanding the plight of the chronically mentally ill and of what is helpful to them. Some CCACs will also work with retarded individuals and many will have at least a few clients who have been brain-injured as adults. The needs of staff in a CCAC are also pointed out by the experiences of staff at Innisfree. Below are some principles that may be extracted from the Innisfree observation.

1. Effective community results in continued growth for all participants in terms of self-confidence; understanding and acceptance of self and others; warm, close and varied interpersonal relationships; personal and occupational competence; increased independence and interdependence; improved social and communications skills; confidence in ability to learn new skills; and increased meaningfulness of life.

Applied to a counseling center that is community, this indicates that staff, as well as clients, benefit from the Center. Volunteers, board of corporation members, and other committed persons may benefit in some of the ways mentioned above, if the community is maximally effective.

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2. A community with persons who are permanently mentally limited offers unique learning and growth opportunities for college graduates and volunteers from advantaged backgrounds. Through close living conditions and interpersonal acceptance, such a community teaches the value of the individual for himself—"being" rather than "doing." The advantaged person learns practical skills from individuals whom society regards as inferior and stigmatized. Some advantaged young adults who have been conditioned to be socially proper have never had warm, close relationships. From the handicapped, as well as from non-handicapped from culturally different backgrounds, they can experience unconditional acceptance with positive regard and genuine caring. From relationships with more experienced members of the community, the newer volunteers learn to accept their own humanness, their weaknesses, limitations, and failures without shame.

In a CCAC, staff and volunteers have the opportunity to grow in acceptance of their own humanness, in humility, in understanding of people who are different from themselves through relationships with clients who have mental handicaps. Out-of-office activities are especially helpful for the growth of beginning professionals. There is something growth-enhancing for a male psychologist who fancies himself athletic to learn ropes and repelling from a retarded man or for a female psychologist and homemaker to learn gourmet cooking from a blind woman. Peer counselors can also be matched with counselees on this principle.
When a client who has been stigmatized shares his skill with a professional and the therapist relates effectively person-to-person, the client experiences new self-confidence, competence, and self-appreciation.

3. In a community with mentally or socially disadvantaged persons, lowering of traditional professional barriers is therapeutic because it elevates the self-perceived status of the client and therefore his self-concept as he becomes more equal with a friend-therapist, who has a solid social and personal status. In this situation, there is no danger that lowering barriers will cause the client to disrespect the counselor. However, the counselor must remember that, even in the peer relationship, he is there for the client and functions on the client's agenda and in his world. While the counselor may briefly share a present concern (such as a car that will not start or the sickness of a child), he does not pour out his troubles to the client.

4. In community, staff can form a support system for each other. Professional therapists help each other through difficult life experiences and encourage and assist each other with client problems. Volunteers can be mutually supportive and often provide practical assistance to the professionals.

5. In community, close relationships promote "being real." In a CCAC, there is much out-of-office interaction among staff, volunteers, clients, and other community members. On the other hand, too much closeness results in stress, fatigue, and occasionally in resentment. The amount of closeness needed or tolerated varies among individuals. Often the handicapped,
or clients may have a higher need for closeness and interaction than does the staff, and the staff can become drained. Long-term staff and CCAC members with heavy responsibility should be provided with a means to get away from work and the center. Private living quarters are essential in a residential setting. Geographic mobility and change help reduce stress.

Staff should also be exposed to other people in their field, outside of the community or counseling center. The center should make available conventions, workshops, and at times therapy away from the community, for the well-being of the staff.

6. Short-term volunteers can contribute new personalities, ideas, and information, and may prevent stagnation in a community. For a CCAC, short-termers may be college students doing fieldwork or local people with limited time or interest. Short-term volunteers can assume many of the instrumental tasks and act as co-therapists, but should not be given primary therapeutic responsibility in long-term therapy cases or given ongoing administrative duties. Too many short-term volunteers, in relation to the number of permanent community members, result in instability in the community and a drain on its resources.

7. Physical environment and provisions are important for optimal functioning. A community or counseling center is seriously hampered if there are not enough funds to provide basic needs of staff--adequate diet, comfortable housing, and reasonable transportation. In a residential program, funds to provide these needs of clients are also essential. While "doing without" may be a noble tradition among some religious groups, and while learning to budget
and plan is a good experience for advantaged youth, inadequate physical provisions distract from the work and may result in reduced personal and professional effectiveness.

Church Community
Introductory Imagery

The young ladies in their crisp skirts and blouses and the men in their Sunday suits looked out of place as they walked along the hot inner city street, past the close-set weather board homes with peeling paint and unkept yards. Occasionally one of the men would nod to some grizzled fellow lounging on the porch, beer can in hand. A lady might smile at a half-clad girl dandling a dirty baby on her knee. But mostly, with their usual self-preoccupation, the walkers simply ignored their neighbors as they traversed the three blocks from the main church building to the house church. They did not mean to be cruel. Their minds were still caught up in the words of the sermon and the glory of the morning's synaxis; their thoughts were reaching ahead to the Sacrament of Eucharist. In a few minutes, when they gathered inside the house that was their destination, their "upper room", there would be sharing, peace, healing, and joy.

Among the squalor of this neighborhood sandwiched between giant industry and the railroad tracks, these people lived in their own world, reaching upward toward God with their hearts and out to each other with their hands—but only to each other and those from similar backgrounds whom they deemed qualified for their elite community.
Facts and History

This church, an entity unto itself in the inner city, is composed of 205 adult members, approximately 200 children, and 50 to 100 interested "friends of the church" who seek to live in community for the growth and well-being of the individual and the group and for the glory of God.

The church originated about 1976 when several young adults (couples and singles) living in an apartment complex felt a need for more spiritual, emotional, and social life and growth than was provided in the churches of the families-of-origin. They began searching the Scriptures and early church history, as well as communicating with other young people already living in community. Educationally, the group members were well prepared for their search; most of them possessed two to six years of college and several had Bible college or seminary degrees. The men, and several of the women, had responsible, technical, white collar jobs which provided a minimally adequate economic base for the group.

As group cohesion increased and theological and personality issues began to be resolved, the participants dedicated themselves to forming a church as a permanent community in which they could play out the most important aspects of their lives. They affiliated with the Evangelical Orthodox Church, a denomination that was forming nationally as a result of the work of leaders in para-church organizations such as Campus Crusade. The local group also brought in kith and kin perceived as being needy and worked collectively to bring about their emotional, social, and spiritual healing.
Founders of the group discovered that, under a government program, they could purchase older homes in a deteriorating, working class neighborhood at manageable monthly payments. Desiring to be geographically close together, families and singles purchased homes, remodeling them into comfortable, attractive dwellings, usually including apartments or guest rooms for persons whom they believed God would bring into the community for healing and fellowship.

Thus, a community of well-educated, articulate persons from rural or middle class backgrounds is now located in an industrial area and from thence reaches out to persons with physical, emotional, social, and spiritual needs.

Roles

Roles in this community are well defined and tightly structured.

Pastors

Three full-time church-supported priests have offices in the central church building, an old wooden structure purchased from another congregation. Though the priests encourage, support, and consult with one another, their actual duties are distinct. The Bishop is responsible for doctrine, policy making, and relationships with the denomination and organizations outside of the parish. One pastor bears the responsibility for in-depth spiritual development of seasoned parishioners. The other pastor is the evangelist, responsible for the physical and social well-being of the people, for counseling with potential and new members, and for relating to the neighborhood.
Elders

Elders preside over the house churches, smaller units of about forty adults who meet in the elder's home and function as an extended family. The elder is responsible for seeing that each member is cared for, physically, emotionally, and socially, as well as spiritually. He is expected to have a personal relationship with each house church member and to identify problems or potential problems in their early stages. For example, if a husband is being abusive to his wife, the elder is to recognize what is occurring and tactfully approach the couple about their need for help. The actual counseling will probably be done by the counseling pastor.

Qualifications to be an elder are in part taken from the Biblical text of I Timothy 3. Elders are married, are employed in the business or industrial system, and are expected to provide adequately, but not lavishly, for their families. They are expected to value church over job and church-family over family-of-origin, so that if they are needed for a church function, other loyalties are set aside. The elders' wives are expected to be prepared to entertain house guests, for prolonged periods of time if necessary.

Deacons and deaconesses

Deacons and deaconesses deal with the daily welfare of smaller numbers of persons. If a new member is having difficulty adjusting to the city, her deaconess may help her learn to drive around the city. If a single woman is facing temptations resulting from loneliness, her deaconess will be there for her or find other supportive women who will be present for her daily.
Qualifications for deacon are also taken from I Timothy 3. Several deaconesses are single women, since they do not have the childcare responsibilities of the married women.

Members

Members are persons who have committed themselves to live out the rest of their lives in church community, either in this congregation or in a related congregation. Members are officially under the authority of the pastors, the elders, and the deacons, and much is made of this authority system. However, it appears that there is great variation among the members in how pervasive the community life is for various members and how seriously members regard the authority system. Reports by several single women who are professional persons indicate that they have numerous relationships outside the church community and that they utilize the authority system for their convenience and disregard it or even directly challenge the authority figures when that is more personally comfortable. Married women with small children, on the other hand, tend to make all their contacts within the church and to feel that it is in their best interest to conform to their husbands' expectations, and that then their husbands will conform to the authorities' expectations. Such an arrangement is quite convenient for the women with several small children since it provides a system for reducing their responsibility level, for gaining help with childcare, for dealing with overly-demanding husbands, and for avoiding the necessity of working outside the home. None of the married women interviewed work outside the home and all state that they are glad that, with the church system, outside employment is unnecessary.
Catechumen

Persons who have visited the church for a significant amount of time and have been perceived as meeting the general standards, specified and unspecified, may apply to study to become members of the church. If a person is accepted by the elders, he then becomes a catechumen and attends classes on church doctrine and practice. He is allowed to participate in a limited amount of church functioning but may not vote or publicly voice personal opinions. He is under close scrutiny for conformity to community norms and values. If he passes the catechumen period, he may then become a member. He may also decline to become a member at that time, declaring he prefers to be a friend of the church until he is more certain of his relationship to the community.

Penitents

Penitents are members who, for open transgressions, are refused the sacraments and who may be limited in the kind or amount of contact they are allowed with other church members. According to the report of several members, the penitent role is assigned to a member by church leaders only after a year or more of counseling and other strategic interventions and only for open sins which affect the whole community, such as adultery, uncontrolled alcoholism, or consistently illegal or anti-social conduct. If a change in life occurs during the penitent period, the person is restored to full membership rights.
Activities

For a newcomer, the first involvement is usually a combination of initiating and receiving. The newcomer is expected to be active in getting to know community members and to enter a counseling relationship with the evangelist. However, he is also to be receptive to what the community can do for him, in terms of the norms of the community. Many people are given lodging, food, and other physical necessities when they first come to the church community. When the counseling pastor was discussing the researcher's interest in the church, viewing her as a potential member, he said, "How would it be if you just move here and let us take care of you until you find a job?" Allowing oneself to be taken care of by the church is considered to be an activity that will result in personal healing.

The counseling relationship is a change activity that continues through the catechumen period and often intermittently throughout the member's life in the community. Counseling may be not only with the pastor but also with the house church elder. Women may participate in the peer counseling program that is supervised by a lay woman, who is warm-hearted and believed to have the gift of counseling. A few persons, including one of the pastors, receive professional therapy from a psychologist outside of the community, paid for by the church.

The weekly Eucharist and liturgy are considered to be primary forces in personal change, growth, and maturation. Officially, the mystic qualities of the Eucharist are emphasized as bringing the person into direct contact with God and thereby changing him. However, during interviews with the church members and lay leaders, the
effect of the Eucharist was rarely mentioned. This discrepancy may indicate that the ordinary church member finds the Eucharist less influential in his life than the official position states, or it may be that the Eucharist is too personal to communicate readily.

Formal classes for catechumens and for members are agents of change. A number of members are engaged in an ongoing study of the gift of insight, seeking their own spiritual perfection.

Participation in the house church activities is crucial for growth in the community. House churches have work projects and social activities at least weekly. During the period of the research observations, the house church men were putting a new roof on a porch and remodeling a newly-purchased house for one of the single women. The women were frequently visiting back and forth and sharing childcare responsibilities. For example, on one street, a mother walked the kindergarteners to school and another mother walked them home. Such involvement is considered essential for being a part of the community.

Beliefs

The church community has a number of religious beliefs unique to their system which do not relate to this research. More interesting for the purpose of understanding community are underlying social-psychological assumptions.

One assumption is that the group knows better and can make better decisions than the individual. A corollary is that the church authorities, as designates of God, often know what is best for a person and assume responsibility for instructing that
person in what to do. If the person follows that counsel, then the
authorities are responsible for the outcome. The church's court
system is based on this assumption. In a recent situation, a male
catechumen, recently divorced, was showing much interest in single
women in the church. The women felt that his attentions, while
flattering, were not in good taste. Instead of dealing with the man
themselves, the women asked that a court of pastors and elders be
called to discuss the problem with the man. The verdict was that the
man was not allowed to date women in the church. When the researcher
asked what would happen if a single woman decided to date the man in
spite of the counsel of the court, she was told that the church
leaders would contact the woman, talk with her, but in the end would
"allow her to hang herself"—to date and take the social conse­
quences.

A related assumption is that the individual is incomplete
without the group, that people who live in community are healthier
psychologically than people who do not. Standing alone as an
individual is not considered a strength but a sign of some hidden
psychological damage that needs to be healed. In conversations with
the researcher, the counseling pastor made it clear that he thought
she had hidden hurts that needed to be healed by living in community,
and when she was unresponsive to the idea of letting the church "take
care" of her, he was more convinced that she needed the healing of
being in community.

A constructive aspect of the community beliefs and practices
is the pattern of face-to-face confrontation with an individual who
has given offense. During the observation period, gossip had been
spread about a minor issue concerning one house church member. The researcher witnessed a conversation in which the offended person told the elder about having confronted the offender and about a renewal of goodwill between the parties. The researcher also tested the system by making strong comments disagreeing with a leader and found that leader did not easily take offense and was more than willing to work out the issue with the researcher.

Members make life-long commitments to live in community, and that commitment includes sharing whatever they have with any person in need. While incomes and living standards vary from subsistence to middle class, no member is allowed to be without the necessities of life. If a single mother becomes ill and unable to work, her housing, food, medical bills and the children's needs are provided with no expectation of repayment.

The overall picture seems to be that the church has developed a belief pattern that perpetuates cohesiveness, interdependence, and group identification. That pattern is highly functional for the singles and families in the preschool family stage (Walsh, 1982). However, it is questionable whether the belief system will continue to be advantageous as the adults age and the children pass through adolescence and leave home.

Communications

Communications are a strength of this community. While the official rhetoric emphasizes communication by the leaders to the people, in practice the people communicate intensely with the leaders and with each other. In fact, communications are at such intensity that the researcher questioned the amount of emotional privacy that
is possible. Several persons interviewed had difficulty even conceiving of the question. They seemed to assume it was nonsense that they might not want to tell everybody about themselves. Other more mature members (mature chronologically and in years of membership) said that they communicate what they desire to be known and keep private any information they do not want to reveal, but if they tell one person in the church, they are sure that most of the rest of the church will soon know. The researcher found that her correspondence with the counseling pastor was being shared with an elder and a church member and that the member (a friend when they both lived elsewhere) had told the counseling pastor intimate details about the researcher. No one in the church group seemed to find this disturbing; any concept of confidentiality was totally lacking in their thought structure. (In actuality, the researcher did not object to the information being known by these three persons but would have preferred to tell it herself.)

Decision-making Process

Decision-making in this community is by authority, by delegation, by shared decision-making process, and by consensus. The authorities make all decisions concerning the denomination, doctrine, and theology. Decisions related to practical living activities are delegated to the elders and deacons. The shared decision-making process is used to allow variations among house churches, with persons most affected by the decisions making them. Consensus is used in courts; all persons in the court must agree before any decision becomes binding. Of course, in actuality, each adult is responsible for his own life and chooses whether or not to agree or
to cooperate with the group decisions, and whether to continue in the church.

Support

The supportiveness of members of the church community is extremely high. Each person interviewed expressed a feeling of security and comfort within the community and an intent to be supportive of other members. The researcher observed situations in which the church is financially, emotionally, socially, and spiritually supportive of its members.

Psychological Sense of Community

The psychological sense of community is high in this group. For many of the younger persons (in their early 20s), group identity almost supercedes individual identity. The leaders speak of being incomplete themselves without the community. The researcher asked two experienced members if there were a clear choice between individual freedom and continuing to be a member of the church, which they would choose. The members said that could not happen, and furthermore they could not truly be free and be themselves apart from the community. One person said, "First I am a Christian and a member of (church); then I'm a woman, then I am anything else."

My Contacts

My initial contact with this healing community was through a friend (CD) who moved from my hometown to the city to be a part of that church in April, 1984. For two years, CD had suffered from a clinically significant depression related to an unhappy marriage and divorce that destroyed her self-confidence as well as her career.
plans to be a missionary. Conventional therapy at the public mental health center had brought some insight but no major improvement in symptomology, either before or after the divorce. Her psychological functioning prevented her from utilizing her master's level education and resulted in unsatisfactory experience on two jobs. CD had no family to whom she could turn and her local social network in my hometown could not provide adequate support.

When I visited CD four months after she had moved into an apartment in the church community, she had recovered from the depression and was hopeful about her future. During those four months, the church leaders had told her to rest, to build relationships, and to do whatever she needed to recover. She was in counseling with the pastor, who assumed a paternal role, a role missing in CD's adolescence. Financial assistance with basic living needs was available.

During that first five-day visit, as I became acquainted with the counseling pastor and other church leaders, I was intrigued with the caring and sharing among these people and with the stories of psychological and social healings in this community. In fact, I experienced a measure of that healing myself, after a professionally difficult summer.

In December, 1984, I again visited CD and the community, primarily to lay the groundwork for doing research there. My original impression that this church functioned on the model of a healing community was confirmed.

In September, 1985, I spent nine days as a participant-observer in the church community. I lived with the family of a house
church elder and was included in family and church activities. I interviewed thirteen church members and casually interacted with numerous other persons in the community. The church was accustomed to opening itself to guests who have passed the screening process (my two initial visits) and who the leadership believe may be potential members. Though I stated I was doing research, I was treated as a potential member. Since I had a genuine personal interest and attraction to the people and the community, I let myself slip into this role during the day, withdrawing in the late evening to reframe my findings in a research perspective. The role of potential member was enhanced in that I was given the privilege of receiving the Eucharist, an honor not often awarded to outsiders. This status facilitated members trusting me and being open in a way they could not with a person they perceived as an outsider and a researcher.

A bias that resulted from the close, trusting relationship was that in writing up the observation I felt extremely protective of the identity and personal confidences of my contacts.

Interviews with my contacts were informal. Information was primarily gained while sharing in the daily lives of the community members. In one case, I talked with my contact while we stripped woodwork. One session included my feeding a toddler while his mother prepared lunch for the other children as she talked. These women would not have been interested in providing data for research; they were highly motivated to share with someone who wanted to understand and to be a part of their world.

Entering the reality of the members facilitated gaining their perspective on the personal significance of their involvement with
the community, its assets and its stresses. Several of my contacts also discussed the changes and processes of the group as a whole and compared and contrasted counseling within the church to that in standard mental health settings.

The people I interviewed constituted a cross section of the church in age, sex, occupation, years in the community, and status in the community. The vast majority of church members were under forty years old. The "average" member was married with preschool children.

The following section gives the results of the research questions as answered by the community members.

Persons Interviewed

GROUP A: Official church leaders

1. R.E., evangelistic and counseling pastor, married with children, in his 30s, is a former professional jazz musician, a product of the restless 60s, and a member of the original community. R.E. dedicates his gifts to building up other people, rather than using them now for self-aggrandizement.

2. J.E., spiritual life pastor, married with young children, in his early 30s, has unusual insight into the spiritual and psychological worlds and channels his insight into the process of self-actualization, seeking the perfection of Christ.

3. J.S., priest working in administration, married with children, in his late 30s, works in the secular world at a white collar job and was a part of the original founding group.

4. B.A., a house church leader, married with children, in his late 20s, works at a technical skilled job.
GROUP B: Women in semi-official positions in church or with many
years in the church.

5. C.S., married, in her late 30s, mother of five, devotes herself
to her children, to study and writing about women's religious
issues, and to supervising the peer counseling program.

6. E.G., single, in her late 30s, a member of the founding group,
has a professional interest in the mental health areas of
community life.

7. P.S., single, in her mid-20s, is employed in a technical job in
the secular world. She has a part in shaping new leadership
roles for single women in the church and is a self-actualizer
with emphasis on transcendent experiences in worship.

GROUP C: Follower in good standing with official membership.

8. S.A., engaged, in her mid-20s, has been involved with the
church for four years and is a white collar worker.

9. B.S., one of the few single males, in his mid-20s, is a doctoral
student in science and has just passed his catechumen period.

10. C.S., mid-30s, was a professional mental health worker prior to
birth of her children but now stays home by dictates of the
church.

11. C.D., single, in her early 30s, is an aggressive professional in
administration and social sciences and fairly new to the church.

12. J.S., single, in her late 20s, is a professional with a deep
sensitivity to people and the fine arts.

13. L.A., married, in her late 20s, is devoted to making a home for
her family and often hosts guests for a month at a time.
GROUP D: People in need who are not yet church members or eligible to study because of psychological and spiritual difficulties.

Research Questions and Answers

Question 1: What brought you to this church?

Interpersonal

Group A. Group A members talked about their own developmental needs as young adults for belonging and discovery of personal identity in a church context. "In the beginning [of the church], we were a lot of idealistic young people, products of the '60s, rebelling against our own background, our churches, their emptiness, and the crazy society. We needed to belong. We needed each other."

"I'd had a pretty good life as a kid, but I ran with the crowd. I needed to find myself. I needed people who would help me discover who I was in the Lord."

Groups B and C. These members talked about belonging, acceptance, and development. "I needed a father figure, a spiritual father who could be an authority and help me grow up. My dad couldn't. Father ____ did that for me." "My boyfriend was in the church and I wanted to be with him." "I visited my sister on weekends. She was in the church. I liked the people." "I liked the commitment of staying in the church. You don't make friends and then they move away." "The church wanted me and took me in. Father _____ really loved me." "When I was laid off my job, a couple in the church took me in and made me a part of the family, and I've been here ever since."

Group D. No response.
Physical

Groups A and B. The leaders talked about the church supplying physical needs of others but not about themselves.

Group C. Thirteen people mentioned that they came to the church initially because the church supplied economic or physical needs. A typical comment was, "After I lost my job, I needed somewhere to go. The church found me a place to stay and helped me get a job."

Group D. The comment of one disturbed person was obtained indirectly. "When I lost my job because of my problems, Pastor ____ found me a room with his family. I was too sick to work a regular job, but they let me be church janitor and do odd jobs to earn money."

Religious

Group A. Group A contacts emphasized the religious quest upon which they had embarked in the formative period of the church. "We wanted to return to the beliefs and practices of the early church" [first century Christianity]. "The American church has lost its historic roots." "We wanted to return to the teachings of the Church fathers, to liturgy, and to the Sacraments."

Group B. Three mentioned religious attraction to the church. "The people were so enthusiastic about worship." "In liturgy and the Eucharist, I found what I had been longing for." "I knew God called me to the celibate life and in this church we have a religious order, so there is a place for me."
Group C and D. One new person said, "I was attracted to this
church because of the definite doctrines. These people knew what
they believed and why, no doubts, no arguing."

NOTE: These were the only comments about religion as an attractor
and were always secondary to interpersonal responses.

Professional, intrapersonal

Groups A, B, C and D. No response.

Question 2: What effect has being in the church had for you?

Intrapersonal

Group A. The leaders gave a variety of answers. "The direc-
tion of my life has turned around. My excitement is in living to
help others and for God, rather than selfishly." "I've progressed
from rebelliousness and selfishness to love and being a servant,
from rootlessness to commitment, to living for what I can give
rather than what I can get." "I have had deep inner healing. There
was a lot of pain and deep problems in my life, conflicts with
people, and even drugs. I needed professional therapy and the church
and the grace of God and the Sacraments to bring the healing I
needed." "The parts of my personality that were destroying me and
hurting others now bring me to God in the quest for perfection in the
Lord." "I've had the rough edges smoothed off. And I never thought
I could take a position of leadership and responsibility until my
elder encouraged me and so many people gave me feedback."

Group B. Representative of Group B statements are the fol-
lowing. "Oh, my God has just made so many changes in me. I had to
learn to accept the authority of my husband and the Bishop. God's
humbled me and now He's giving me a ministry." "We've all changed. When we started, we thought we knew it all. Then we ran into real problems. Like people on drugs and Satan worship. We had experiences we didn't expect and had to learn to trust each other and to trust God in a different way." "Now I'm getting to do what I always wanted to. I found gifts I didn't know I had, and under authority, I am allowed to use them." "I can work out conflicts with people and still be in a positive relationship with them. I couldn't do that before." "I solve problems instead of burying them." "I am on an exciting quest, for the perfection of God." "I had to learn to trust. I grew up not trusting anyone." "There's been a lot of deep healing and I'm still struggling with depression. But I know it is all right to struggle, that no matter how bad it gets, the church will accept me." "I've learned to love people."

**Group C.** The following are a representative sampling of Group C comments. "I trust my own decisions. I am content." "I learned to sacrifice my own wants. I'm much more flexible and tolerate change better." "I have much more self confidence. I am adventurous. I like to experiment with new ideas and doing new things." "I learned respect for authority." "Really I haven't changed." "I got my college degree and enjoyed working, but I don't know if I changed much from the community." "I feel accepted. I have a sense of belonging." "I feel secure." "It's like big holes in my life have been filled, and I'm an entire person. When I came to the church, I felt dependent, inadequate. Now I'm becoming more independent."
Group D. These people are still in major struggles for change. Reports indicate that intrapersonal change is not yet evident in their conversation or behavior.

Interpersonal

Many statements under Intrapersonal also have interpersonal implications and will not be repeated here.

Groups A and B. The leaders emphasized having moved from living for themselves and their desires to living for other people, as well as being emotionally intimate and valuing people, rather than using them. The acquisition of a service orientation was specified by all leaders as the most important change in their lives.

Group C. Besides the statements that overlap between categories, this group made statements such as the following. "I can ask authorities for advice but I decide what to do. I appreciate their counseling" [in contrast to a previous position of rebellion she had just been describing]. "I realize I'm not alone in life now. There are other people to consider and if I don't talk over things or share my life with them, they will be hurt." "I learned to rely on other people and let them depend on me." "I no longer tromp over people like an elephant." "I can accept authority without feeling threatened." "Love, I learned to love and accept other people's love for me. I can let other people know who I really am and know they will accept me." "I'm not as idealistic. I'm much more cautious about what I say, almost cynical sometimes."

Group D. These persons who are considered sufferers were reported by church leaders to be more responsive to the love and
caring of the community, to be more willing to conform to expected 
moral and legal behaviors, to be less withdrawn and unhealthily 
dependent, and to be able to communicate with others better than when 
they entered the community.

Physical

Groups A, B, C and D. Numerous contacts mentioned, in 
passing, that they had to make conscious adjustments to city living 
when coming to the community. Two mentioned feeling physically 
unsafe, afraid of crime, at first and then learning to feel safe in 
the inner city. Most reported having adjusted well and like the 
convenience of shopping, cultural activities, and recreational 
facilities.

Religious

Group A. The leaders originally were from fundamentalist 
backgrounds and made a change to a liturgical church. All spoke of 
God becoming primary in their lives during the formative days of the 
congregation.

Groups B, C and D. Most of these people moved from nominal 
church affiliation (two from no church background), to intense 
involvement in religious life in this church.

NOTE: For persons in all groups, the church change has produced 
considerable tension with their families-of-origin.

Professional

Groups A and B. Though the leaders were reluctant to talk 
about themselves in terms of professional skills, other persons
described the leaders' growth. In social and psychological knowledge, counseling skill, preaching, scholarship, leadership, and the ability to bear up under heavy responsibility, these men and women have grown with the community.

Groups C and D. No response.

Question 3: What brought about these changes?

Interpersonal

Group A. Representative comments are as follows. "Years of searching and learning together as a community, that's changed us. Learning under the authority of wiser men. The experience of heavy responsibility, of knowing people depend upon me for counseling, has made me sensitive. Feedback from the people and the Bishops has helped me recognize my mistakes and where I need to improve." "I have to be real. We live too close together to fake it." "The couple who brought me into the church spent hours and hours with me." "When people look up to me and expect things from me, that helps my confidence." "I've been privileged to be a real part of what God is doing in His Church. It's belongingness, relatedness, being used." "The pastors and the Bishop counseled me intensively when I was new. They were there daily when I faced temptation. They used their authority and disciplined me when I was in sin." "We have all grown together from those early days. So many experiences. We have a deep bond."

Group B. Counseling relationships were especially valued by this group. "At first, Father _____ was really like a father to me. Then he let me grow up and try things out for myself. The first time
I saw something in him that needed changing I was afraid to talk to him. But when I did, he accepted it graciously. Now we have a mutual relationship. That makes me feel really good. Mature. Respected. I respect myself more." "The experiences we've had together over the years have brought us so close. There's a deep bond that has changed me."

"Counseling has been important. I'm counseling with Father _____ now each week. He sees my life and can point out things I would not see myself. It's different than going to an outside professional therapist. I can pour out my deepest secrets, my guilt, my pain to Father ____. Then that evening we can be sitting on the porch swing and he doesn't treat me any different. I know he has accepted me and so I feel acceptable. With a professional psychologist, he might just be pretending to accept me. Also, I can trust Father ____ because I know what he believes, and I can see his life. In this church, counseling and changes are the norm, not something to be embarrassed about."

"It's the life-long commitment to each other. I'll never be alone in the world." "You are expected to change in this community. Counseling is not stigma; it's normal. If you don't change, you'll hear about it."

Group C. "The authority structure helped me grow because I could rely on the leader's judgment. Knowing someone is there to depend on makes me able to be independent." "Counseling in the church is different. If I tell everything to an outside therapist, pretty soon they are gone and I'll never see them again. And they'll
know all about me. Also, they can't be there when you need them, just at your appointment time. In the church, someone is always there, even at 2:00 in the morning." "Community is life-long commitment. We'll always be there for each other. At first I needed people to be there for me mostly. Now I can be there for the other women. The church leaders watch your life and talk to you if you need it." "They [the leaders] judge you. If they say you are doing well, they know. And you know." "I am having a hard time in the church right now, but we've weathered too many storms together to leave." "They accepted me just like I was when I came. I kept expecting them to try to change me, but they didn't. There was so much love that I changed. I like me now." "My husband's responsibilities made me take more responsibility. That is good for me." "The sharing, that's important. Sharing the work, too. One of us walks the kids to school and another one goes after them." "Sharing the job of taking care of the kids helps me to be a better mom." "I learned about being a good mom from watching the other women. I didn't have a good model at home. So this is all new for me." "It's the constant feedback, the learning to get along." "It's being accepted and cared about."

Group D. "Knowing that I will not be turned out in the street, that these people care." "Having someone come over when I'm feeling like ending it all, talk to me like I'm okay." "They love me, and so I guess I'll keep trying."
Physical

Group A. "We need to live close together, in one neighborhood, so that we are just naturally around each other."

Group B. "Living near the people you love, that helps."

Group C. "When I don't have something, I can borrow. We swap. I use someone's washer in exchange for babysitting." "Once I got used to the city, it is convenient to be close to things. It's efficient." "I know that if I'm seventy and can't take care of myself, I will be taken care of by the community."

The researcher questioned the thirteen Group C members who said they had received economic or material help from the church concerning whether that help had kept them in the community or caused personal change. Each member said that the physical help in itself was appreciated but was not a cause for change. However, the caring and love with which the assistance was given was a major factor in their making a permanent commitment to the community and in personal change.

Group D. "I am safe here; no one is going to hurt me." A group D member had recently commented to an elder that "you guys always bail me out of jail. Why? I don't deserve it. Don't you get tired of me?" In fact, the church is considering sending this young man to a farming community remote from the temptations to which he succumbs in the city. Another person said, "As long as I'm in the church, I'll never be hungry or cold again. Or alone. There will always be someone to take care of me."
Religion

Group A. "The Eucharist brings the power of Christ for change." "The power of God flowing through liturgy and Eucharist, that makes a difference."

Group B. "The joyfulness of worship. I can't be depressed at synaxis." "I've gone to worship worried. The power in the liturgy and the music gives me strength. God's word through the authorities relieves my worries." "Sometimes I feel like I'm already in heaven; it's a transcendent experience."

Group C. "The worship releases a creative part of me." "The strength I gain through the Eucharist enables me to endure the stress of the week." "Knowing the truth has changed me."

Group D. No response.

Professional

Group A. The church has utilized outside professional therapists to help its leaders. It has also been the stimulus for a leader to continue his education. "The church insisted that I have professional counseling, paid for it, and backed me up." "I have had to develop my gift in counseling because of the needs in the community."

Group B. No response.

Group C. Group C members referred to professional therapeutic skills in and out of the community as helpful. "The church sent me for professional counseling. They could see I needed
it when I didn’t think I did." "Father ____ may not have a
doctorate in psychology, or a lot of education like you do. But he
knows people. He understood me and helped me find myself."

**Group D.** All Group D persons are receiving professional
psychotherapy, as well as counseling within the church. When
necessary, the church pays for the treatment. One difficulty church
leaders mentioned about using outside therapists is that the psychia-
trists or psychologists will not provide information to the pastors
about how to help the client. Also, outside therapists frequently
have different moral and behavioral standards which puts the
disturbed person in a quandary.

**Intrapersonal**

**Groups A, B, C and D.** No response.

**Question 4: What are the stresses here?**

When questioned about stress, more contacts answered that the
community was helpful or that they did not know of any stress for
them in the community. All comments about stress were interpersonal
and are recorded as follows.

**Interpersonal**

**Group A.** "The amount of responsibility. The heavy schedule.
But it's stress that stretches me and makes me grow."

**Group B.** "Sometimes I am not understood, or think I'm not by
the people in the same house. That really bothers me. There can be
too much closeness." "I have to watch what I say about what and to
whom." "The church has difficulty in dealing with strong emotions like mine."

**Group C.** "Too much activity. Sometimes I'm tired of people and I just don't want to go to something, and people don't understand." "Having my schedule constantly interrupted." "Not being able to work because of community attitudes. I really enjoyed my job." "My educational expertise is not being used in the community and that leaves--." [The sentence was unfinished. The whole conversation indicated that this person was feeling undervalued and unappreciated and stifled.]

**Group D.** "The only problem is that these people won't let me get by with anything. They keep after me to be good. No matter what I do, I can't turn them off." "Stress? Well, facing my inadequacies and faults is difficult. I used to feel extremely successful, as though I could do anything. Now I have to be vulnerable. I have to listen to what other people tell me about myself. And I don't like that sometimes." "They don't know when to butt out. Sometimes I feel like telling them what I'm going to tell you. It's none of your business."

Intrapersonal, professional, religious, physical

**Groups A, B, C and D.** No response.

**Summary of Questions and Answers**

What originally attracted people to the church community?

Among the founders of the church, the interpersonal relationship factors, such as commitment, interdependence, and belonging, and the
religious factors, particularly sacramentalism and liturgy, were the primary attractors. Among all contacts, interpersonal relationships were the primary attractors. Factors were feeling loved and accepted, caring shown through practical assistance, friends, family, a benevolent paternal figure, the opportunity to belong, and the help of others in finding one's own identity. The church's policy of providing housing and economic assistance for people in need was a secondary factor for several members. The doctrines and worship style were of major importance in the formative years but seem to have less emotional significance currently than community caring and sharing.

How have individuals changed as a result of being in this church community? Personal maturation and inner healing are the dominant themes. Specific changes are improved self-confidence, independence, finding oneself, freedom to be oneself, loss of fears, humility, assuming responsibility, development of ability to trust, removal of pathological pain and behavior patterns, moving from selfishness to other-centeredness, facing reality, contentment, and developing respect for authority.

The second major type of change is in interpersonal relationships. These changes are intertwined with the intrapersonal changes. Aspects of interpersonal change are an increasing ability to give and receive guidance and advice, becoming other-centered and God-centered, becoming sensitive to and considerate of others, and learning to be real with other people. Improved adjustment to a new geographic environment was mentioned occasionally. All of the contacts have experienced major changes in doctrine and worship style,
but only a few referred to religious change spontaneously. The
church leaders have had major changes in their professional skills
related to their duties in the community. Two individuals felt that
the changes they are currently experiencing may be negative.

What has brought about these changes in the community
members? Again, interpersonal relationships are the major change
agents. Specifically mentioned by all but two contacts were the
acceptance, belongingness, and commitment that characterizes
community. A related dynamic is the ability and responsibility to
help others. Several chronologically younger contacts mentioned that
a paternal figure helped them mature and then accepted them as peers.
Two contacts discussed the benefits of counseling within the church,
where change and counseling are normative. Several felt that the
authority structure and the ability to depend upon others helped them
achieve independence and to trust their own judgment. The newer
community members emphasized the benefits of someone being available
at all times and in a long-term committed relationship. Physical
environment is perceived as helpful in bringing the members together
in a close contact as neighbors. The physical protection and provi-
sions by the church were important for several contacts when they
first entered the community. The religious aspect was often
mentioned but only three persons dwelt on it as a major contributor
to personal change. The church's utilization of a professional
psychotherapist was significant for one of the leaders and for
several newer persons.

What was stressful in the church community? There were few
statements concerning stress, as compared to other questions. The
leadership experienced some stress from the amount of responsibility but perceived the stress as resulting in growth. Women in lower level leadership positions felt they were sometimes misunderstood and that there was too much closeness and passing on of information about people in the church. Most members did not express any feelings of stress connected with church life. A few mentioned over-activity, interruptions, and a heavy workload. One mentioned not being used in the community, being unfulfilled.

To summarize, in the church community, positive, accepting, understanding interpersonal relationships attracted people and helped them heal and mature in their feelings about themselves and other people. Though this community exists for religious purposes, formal religious doctrines and practices seem of less importance than relationships among its people.

Contributions of this Observation to the Model of Counseling Center as Community

Observation of the church community contributes to the model an understanding of the growth-enhancing dynamics in community among people who are essentially normal and whose activities are those expected within the mainstream of American life—job, children, marriage, church, and recreational activities. This community most closely depicts the lifestyle that staff and members of a CCAC are likely to have. The fact that interpersonal interactions in the context of community were perceived as therapeutic and/or growth-producing by the majority of persons interviewed is cause enough in itself to consider developing counseling centers that are
communities. Below are specific principles and applications drawn from observation of the church community.

1. Psychosocial maturation among normal adults can be enhanced through participation in a healing community in a religious setting. Not only is intrapersonal and interpersonal growth the norm, but healing of deep emotional wounds and pathological symptomology can result from experiences with the community.

2. Within community, pastoral counseling and peer counseling may be of as much or more value than professional therapy for certain individuals. Individuals who have not responded adequately to professional therapy alone may benefit from a combination of community involvement, lay counseling, and professional therapy. Individuals with deep seated pathology or destructive life-styles particularly have benefited from a continued combination of community, lay counseling, and therapy.

3. A positive, supportive relationship among the psychotherapist, pastoral or peer counselor, and the community can be beneficial to the person being helped. Mutual sharing of information among the helpers enables each to relate more effectively to the person being helped. Such information allows friends and fellow workers in the community to understand better the person, to neither expect too much of him nor to treat him as someone to be feared. This is particularly true in cases of psychosis and personality disorders with overt perplexing or disturbing behaviors. A positive relationship among helpers eliminates the bind of conflicting allegiances and contradictory expectations in which a needy person is often trapped. (The pastor says, "Be good." The therapist says,
"Express your feelings." Friends say, "It's silly to feel that way.") Such sharing relationships also may be used to provide support, reduce stress, and provide valuable learning experiences for the therapist, pastor, peer counselor and community member. Issues of philosophy, mutual trust, and confidentiality would be crucial for the success of such a relationship among helpers. In a CCAC, the therapist or director would be in a position to bring about such relationships.

4. Within community, persons with ordinary problems of living or needs for continued personal development may benefit greatly from knowing their counselor outside of the formal counseling room. Frequently neighborly or peer interaction may improve trust, encourage independence rather than dependence, and provide a role model in actual life situations. Such dual relationships require that the counselor be a well developed, competent, secure individual who is flexible, self-aware, not easily threatened, and able to talk through the conflicts that will inevitably arise.

5. Community in the psychological sense can exist in many different settings, including a church congregation.

6. The setting, participants, and purposes of the community influence the amount of structure and formal organization needed by the group. In a community of peers in a new setting not defined by social conventions, the formal definition of roles, hierarchy, beliefs, procedures, and relationships is important. During the early stages in the life of the community, natural status and barriers do not exist and must be created to prevent perpetual power struggles and confusion. In this situation, a certain amount of
rigidity does not interfere with community. As the group matures, the need for formal hierarchy and procedures may decrease. Gaps may appear between official rhetoric and actual practices. Within reasonable limits, the gaps are more misleading to outsiders than detrimental to the participants.

A new CCAC benefits from well-defined roles, philosophy, program, and procedure. As the center matures, these lines may blur and these characteristics become less important. Keeping verbal descriptions of the program current with actual practice is advantageous in dealing with the public.

7. In community, a hierarchy for the division of labor may improve interpersonal relationships, as long as there is egalitarianism in personal worth and in opportunity for fulfillment. For example, a pastor may have a stronger, more positive influence by training ten people with whom he can relate closely as counselors than he has by occasionally counseling a hundred members. Another example is that a deacon can be available to help with daily living needs of many members if he does not have the weight of broader decisions and responsibilities.

8. A clear system of resolution of problems among community members is helpful. Checks and balances are needed to insure that such a system is not abused and does not become oppressive. Using terms such as "social learning" or "living learning situation" seems more therapeutic than terms like "court" for a system of problem resolution.

9. Individuals vary in the amount and type of involvement with the community that is personally beneficial. According to
community members' reports, some need total life involvement and life-time commitment. They thrive on continuing close relationships in a stable setting. Confidentiality and personal privacy do not seem to be issues for them. The long-term, in-depth relationships generate security, trust, freedom to make decisions, growth in independence and self-confidence. Other persons need contacts and activity outside of the community, less comprehensive involvement, and more emotional and social privacy. They feel stifled, unfulfilled, and exposed if too confined by the community. Probably this difference in efficacious levels of involvement varies not only between individuals but within the adult lifespan of the individual. There is no evidence in this community that self-chosen total involvement was detrimental as long as the person felt there was room for full personal expression and movement.

In a CCAC, therapists, peer counselors, volunteers, and clients will differ in the amount of involvement that is comfortable and efficacious for the individual. The Center should be structured to allow for individual differences.

10. According to members' perceptions, positive interpersonal relationships in community create individual change and growth. Negative relationships are a major source of stress. Though pleasing physical facilities and the meeting of physical needs brought people into the community, these things did not cause them to continue with the group nor did they create personal change. People who accepted material help but did not form interpersonal relationships did not remain in the community.
For the CCAC, it is desirable to have a physically adequate, attractive building and to assist clients with material needs, but it is more important to provide satisfying interpersonal relationships. "Handouts" are not effective motivators for community involvement and probably do not produce personal change.

11. For newcomers, some type of screening process and early education or orientation system is necessary so that persons becoming involved with the community have the same general purpose and vision as the group.

Not all good therapists will fit in or enjoy the counseling center that is community. Therapists should be screened and given additional training in the particular CCAC in which they start working. The same principles of screening, orientation, and training are applicable to volunteers, and, to a lesser degree, to clients.

12. The top leadership needs opportunities for interaction with other persons in their field outside of the community. In CCACs, this means providing opportunities for attending conventions and workshops and sometimes providing therapy for the director and other leaders with heavy responsibilities.

13. When considerable disparity exists between the community and its geographic locality, there is likely to be much misunderstanding on both sides. A CCAC will benefit from being located among the people to be served and from presenting itself in a manner comprehensible to those people.
Juvenile Center Residential Treatment Program

Introductory Imagery

On a low hill and amid orchards and cultivated fields stands an ordinary one-story brick and block structure with a basketball court behind it, and at one side, blue vans with the official seal of the state department of corrections. The large windows open outward and have no bars or security screens. The lock on the front door is designed to keep intruders out but opens always from within. Nothing about the building implies that it houses young men with criminal records ranging from breaking and entering to gang rape.

Inside, in the spacious day room, several teenage boys are stretched out on couches in front of the televisions, while others, at tables, bend over their schoolwork. Abruptly, a commotion breaks out: a shoe flies across the room. "Hey, man, give me my shoe," yells a large black adolescent, rising angrily from the couch. "Check yourself," says a friend nearby. "You showing your problem." exclaims another group member. "Get yourself in check, man." Fists clenched, the angry owner of the shoe glares at the offender, ready to attack. Then, unexpectedly, his fist shoots straight up in the air, and he yells, "I call group--Group 1."

In a moment, half a dozen boys gather around him, talking to him, helping him control his temper. The shoe is returned. Through the dynamics of Positive Peer Culture--kids helping kids--a fight in the correctional center has been averted.

Facts and History

The Juvenile Center Residential Treatment Program, serving a geographically large county in a midwestern state, was the first
community-sponsored residential unit to be accredited by the commission on Accreditation for Corrections and has been designated as one of three model resource facilities nationwide. The Center, part of a larger juvenile corrections system, has a capacity of twenty-six residents, with eighteen to twenty-one being therapeutically optimal with the present number of staff. Though founded several years previously, the present program was begun four years ago by the current director. Rather than punishing the teenage criminals, the goal of the Center "is to provide an environment within which youngsters may achieve the development of healthier self-concepts; learn skills for coping with problems they encounter at home, at school, and in the community; achieve greater success experience; learn to accept responsible behavior and become a contributing member of society" (Berrien, 1984).

To achieve these goals, the Center utilized Positive Peer Culture, a therapeutic model for working with delinquents, developed in the United States by Harry Vorath at about the same time as Therapeutic Community was developed in mental hospitals in Great Britain. Like TC, Positive Peer Culture (PPC) emphasizes group process, social learning, communications, responsibility, involvement, democratic decision making, and multiple leadership. In PPC, young people work together in a cohesive group, and in a residential setting, that group is together twenty-four hours a day. The group is responsible for helping its members, and each member is responsible for building the group. Adult staff maintain definite roles as guides and facilitators, but not controllers, always turning
responsibility for behavior back to the group members. (See Literature Review for further information on PPC.)

Though PPC is a detailed model of treatment, the Center has its own culture for implementing the model, as would be expected.

Roles

Roles at the Treatment Center were distinct and well-defined.

Director

The director is responsible for the overall program. The director takes the position that he is a role model and educator, relating to the staff as they should relate to the residents. Building positive, open, trusting relationships with each staff member is a high priority. Consequently, the director habitually works many extra hours, coming in to talk with night shift personnel or early in the morning to visit with the teachers. He has relocated his office into an area where he can see and hear what is happening among staff and residents and can be readily available. He encourages staff to come in and talk about problems in their relationships with each other and the residents and even, on occasion, to talk about personal problems affecting their work. He works at accepting criticism from staff members and at turning the disagreement into a profitable learning experience. A familiar phrase of the director's is "I can still learn more on this job. I learn from you and you learn from me."

Though establishing close relationships, the director also maintains enough distance so that in a crisis or disciplinary
situation he is the "boss" with authority to make final, binding decisions.

**Aftercare worker**

The aftercare worker counsels with residents' families while the youth are in the Center to assist parents in providing a better home environment upon the child's release. The aftercare worker deals not only with issues of behavior control but also with problems of the parents, such as depression or spouse abuse. He holds conjoint family sessions to improve communications between the resident and his family. Upon the youth's release, he follows up with home visits and contacts with the school for three months. Unofficially, he has maintained contact for longer time periods with families who welcome his help.

**Recreation therapist**

The recreation therapist is in charge of sports, field trips, and the community service projects. He coaches the boys' basketball team that plays other residential institutions. Monthly field trips planned by the recreational therapist include museums, historical and cultural events, and major local events. The community service projects provide the boys with satisfying experiences of helping other people and of being valuable parts of society. The boys help to set up and clean up at the county youth fair, do yardwork for senior citizens, entertain at a nursing home, assist in a program for severely mentally handicapped children, and do other similar activities.
Group leader I

The Group leader I position has two employees who are responsible for clothing, laundry, supplies, and other physical needs of the group and for helping the boys become more responsible for their own physical needs.

Group leader II

The Group leader II, or PPC group leader, is responsible for the emotional and social development of the group. He directs the daily group meetings. Through appropriate questions and short comments, he helps the group take responsibility for itself. His role is precisely spelled out in PPC literature and the leader at this facility follows the prescribed pattern.

The group leader writes the Individual Treatment Plan for each resident. At the beginning of the stay of each boy, the group and treatment team discuss and define the resident's problems in PPC terminology. PPC recognizes three behavior patterns—inconsiderate of self, inconsiderate of others, and low self image—and nine problems—drug and alcohol, stealing, authority, misleads others, easily misled, lying, fronting, aggravating, and easily angered. Charts showing levels of progress in each area specified for that resident are included in the Individual Treatment Plan folder. Every two weeks, the group leader has an individual session with each boy to review progress on the Treatment Plan chart. The leader adds his comments in writing, the boy enters his own comments, and both sign the chart. During such counseling sessions, the group leader is direct and factual. When the researcher was observing, the boys responded with honest discussion of their progress and difficulties.
Teachers

Three teachers are employed and supervised by the county special education district and are assigned permanently to the Juvenile Center. The classes are academic, prevocational, and vocational. Each student has an individually prescribed program for developing skills needed in practical living. School records indicate that the boys make more progress in the Center than they made in the regular schools.

Youth specialists

Youth specialists work on the floor, overseeing the day room, cafeteria, and dormitory. Currently, there are seven youth specialists. All but two have college backgrounds in some area of the humanities.

Treatment team

Each adult staff member is part of the treatment team and is expected to have a therapeutic effect on the youngsters and to work within the team for the benefit of the Center as a whole.

Though PPC literature seems to indicate that adults have limited contact and relationships with the youngsters, in this Center there is frequent staff-resident interaction and evidence of some strong bonds having been formed. There are no prescribed therapeutic dyads. Each staff member is free to relate to any young person. In contrast to more traditional models, staff members also work outside their prescribed roles with youngsters. For example, teachers may accompany boys to a community Christmas party, or the group leader may participate in a recreational event.
Lowering of staff-client barriers is not advocated in PPC literature, as it is in therapeutic community. In working with adolescents, the difficulty is not in reducing boundaries but in keeping enough distance to maintain respect. In this Center, there are no white coats, uniforms, or other demarcations of authority found in hospitals, and no badges, weapons, or prominently displayed keys as in prisons. Therapeutically effective boundaries are maintained by mature, adult demeanor.

Residents

The role of residents is active involvement in changing their own behavior and in helping other group members. Responsibility, involvement, caring and concern, and self-control are emphasized.

Activities

Residents

For residents, the primary therapeutic involvement is the group. The daily group meeting is the focus of group life.

In the first part of a group meeting, each boy has the opportunity to label and take responsibility for his own behavior that day. One boy may say, "I showed an 'easy angered' problem when Sam drew on my notebook. Problem, easy angered....I showed an authority problem when I didn't do what Mr. _____ said. I just sat there. Problem, authority." If group members remember that the speaker "showed" other problems, they remind him, "You showed a low self-image when you said you was quittin' on yourself yesterday." The boy usually accepts responsibility for the problem, but occasionally there are disagreements over the events or the proper label of the
problem. Heated arguments that arise are resolved by (1) the boy reluctantly confessing the problem; (2) an experienced group member acting as mediator and moving the group forward; (3) the leader clarifying what is occurring in the group.

The second step is "vying for the meeting," attempting to get the group to spend the meeting helping with one's problem. One youth may say, "I see me on my fronting problem. I need help so's I don't get in trouble so much."

The next in the circle may say, "I see me on my life story, so's I can start working on my problems and get my release quick."

After every group member has at least two opportunities to speak, the group debates who will be awarded the meeting. Debates often become loud, with several members speaking at once. The leader allows tension to build until group members are ready to settle the arguments themselves. Upon occasion, the whole meeting is spent in vying for the meeting, particularly if one member is silly or stone-walling. According to the PPC model, in an effective group, vying for the meeting requires about ten minutes.

The third segment of the meeting, occupying most of the ninety minutes, is giving and receiving help. For example, in a life story meeting experienced members guide the newcomer through the process. A newcomer must tell his life story, including the reason he was convicted, so that the group can identify his problems for his treatment plan. The new boy is asked such questions as where he was born, what was the first thing he can remember, what he did with his family for fun, when he started getting into trouble, and what he has been doing in school. Though in other institutions teens frequently
brag and joke about their illegal activities, in these group meetings no such "fronting" is allowed. The serious faces and voices of the group communicate that they expected the plain, dirt truth about life.

When a member is awarded the meeting on a specific problem, the group tries to help him understand his behavior, to find a way to use the group to overcome his problem, and to learn to handle himself under pressure.

Outside the daily meeting, the group continues to be the therapeutic agent. In school or in the dormitory, if a member begins to "show a problem," a group member will say, "Check yourself," providing immediate notice on the unacceptability of the behavior and calling on the youth to control himself. If the behavior continues, the group confronts him, making him aware of the negative effects of his actions on others. If neither checking nor confronting are effective and if the problem is serious, such as an attack on another resident, the group will contain the boy, surrounding him, even physically restraining him if necessary.

Thus, the primary therapeutic agent for the residents is the activities of the group.

Staff

The primary growth activity for staff is the weekly treatment team meeting. Team meeting is an opportunity to talk out their frustrations as a group, to work to improve communications and functioning as a team in a supportive relationship, and to solve problems concerning the Center as a whole.
In team meeting, the first activity is reviewing the progress of three residents. The group leader reads the Individual Treatment Plan of a resident and comments about treatment or progress. Then each team member comments about progress or contacts with the boy. Secondly, the staff work on problems that have arisen for them during the week. The director brings out issues about which he is concerned. There is a great deal of discussion frequently concerning practical issues of implementing the program. When contrasting opinions arise, each team member is expected to be honest and open and is generally supported in his right to his convictions, even by those who disagree with him.

Beliefs

PPC programs hold that each individual, staff or resident, is capable of being responsible for his own actions. All feelings are acceptable, but feelings must be expressed in socially appropriate and constructive actions or words.

Language is a powerful tool for problem solving, control of behavior and attitudes, and development of personality. PPC literature redefines connotations of words for both residents and staff. Hurting behavior is defined as weak; helping behavior, as strong. Caring becomes fashionable. In the researcher’s opinion, the staff at this Center have not incorporated and do not effectively use PPC language and communication patterns, thereby reducing the amount of mental reprogramming of attitudes and personality of the residents.
In PPC, problems are regarded as opportunities for growth. The researcher commented to the group leader that the rate of disturbed behaviors in the dayroom was much higher than in the traditional adult-controlled programs in which she had worked. The leader replied that if the problem behaviors did not occur, there was no opportunity to help the boys learn to deal with the feeling and behaviors—no opportunity for long-term personality change.

Communications

Openness of communications is outstanding in this program. There is a free flow from bottom to top as well as from administration downward. Even the residents have access to the administrator when appropriate.

Decision-making Process

Well-defined decision-making procedures allow for decision by consensus, shared decision-making, or unilateral action, depending on the level of the decision and the effect on the Center as a whole. In general, decisions affecting the Center's relations with outside agencies are made by the director and other justice system administrators. Decisions affecting the daily life within the Center are made by the staff by consensus.

Support

Both staff and residents voice the opinion that there is a high level of mutual support within the program. The researcher observed the boys working to support and assist each other. In the team meeting observed, staff often supported each other emotionally, though they disagreed concerning the content of the discussion.
According to the director, one of his main objectives has been developing a supportive relationship with each staff member and among the treatment team as a whole. The director states that he receives support through interaction with other administrators in the juvenile justice system.

Psychological Sense of Community

For the residents, the psychological sense of community is a mixed concept. They are in the Center against their will; yet, they are expected to develop intense group loyalty.

Many of the employees show evidence of a strong sense of belongingness. One Youth Specialist stated that the Center was almost like family for him; he works extra hours simply because he wants to be there. One teacher stated that she hopes she can work there for many years; she feels at home with the staff and young people.

Because the Center is either employment or temporary residence, the sense of community has a different, more superficial meaning than in a community which has life-time voluntary commitment.

My Contacts

My initial contact was an hour interview with the director to gain a basic understanding of the Center to determine if the program met the guidelines of this study, and to gain permission to observe the program.

Subsequently, I observed for five days under the supervision of the group leader. I observed two group meetings on each of four days, ate in the cafeteria, and observed the activity in the dayroom.
The group leader spent much time answering questions and explaining the program. He also discussed the PPC theory as it had been applied in a public school program in which he was part of the team. The aftercare worker allowed me to accompany him on a home visitation and school contact and explained the role of family counseling in the program. I observed a two-hour team meeting. One teacher shared her after-school preparation time with me. The director then granted a long follow-up interview.

While I had substantial and substantive contact with the professional staff, interaction with the floor personnel and the residents was limited by the reluctance of delinquent adolescent culture to relate honestly to a stranger, by my own reticence in an aggressive male culture, and by the short time of the observation. The best observations of the boys came on the last two days when the boys were more accustomed to my presence and less inclined to act out to get attention.

Because of the highly structured nature of this program, I was strictly an observer and researcher, not a participant.

Persons Interviewed

Group A: Administration

1. T.M., program director, in his late 30s, holds a B.A. and M.A. in psychology, sociology and the Administration of Corrections. Prior to coming to this program, he had eleven years of experience in a large state training school that used PPC. In that school, he had a variety of jobs, from building and maintenance to group leader and administrator.
Group B: Professional Staff

2. P.C., PPC group leader, in his 30s, holds a master’s degree in corrections and criminal justice from a prestigious school. He has been a police officer and worked in an experimental PPC program in schools.

3. B.W., aftercare worker, has military experience, and holds a bachelors degree in criminal justice.

4. C.L., group-leader-in-training and currently recreational therapist, began here as a substitute teacher with a license in physical education.

5. L.K., teacher, with a bachelor’s degree in emotionally disturbed, K-12, worked in a PPC program in New York state before returning to her home state and beginning to work at this center two years ago.

6. M.N., teacher with several years experience at this center, holds a masters in special education.

Group C: Floor Staff, Youth Specialists

7. M.Q., in his late 50s with eleven years at the Center, a high school graduate, spoke of enjoying his work but disliking the present treatment approach. He also talked about his numerous family and personal problems.

8. O.J., in his mid-20s, a graduate of a local college with a major in psychology, is looking for a job that uses his degree. He spoke positively of the present treatment program.

9. M.P., probably in his 30s, with five years experience, enjoys working with the kids. He is from a background similar to theirs and relates well to them.
Group D: Residents

10. A.X. has a drug and alcohol problem and has been at the Center about three months.

11. B.X. had a stealing and alcohol problem. He is being considered for discharge.

12. C.X. is about half way through the program and has a history of violent behavior.

13. D.X. is in his second week and currently a "troublemaker."

Research Questions and Answers

Question 1: What originally brought you to the Center?

Professional

Group A. The director had worked in another PPC institution for several years. He perceived this present job as an opportunity for advancement and challenge.

Group B. All Group B members answered the questions in terms of employment opportunity. For three persons, it was the job available at the time in their field of training. For one, it was a challenge and promotion.

Group C. For floor staff, the Center offered employment in an area of interest.

Group D. Residents were committed for criminal offenses and are at the Center for rehabilitation.

Intrapersonal, interpersonal, religious, physical

Groups A, B, C and D. No response.
Question 2: What effect has being at the juvenile center had on you?

Intrapersonal

**Group A.** The director states that he derives great personal satisfaction from his work.

**Group B.** One person verbalized that she gained much personal satisfaction from working with the boys. Another used the term "fulfilling" for the work. All Group B members in some way expressed enjoyment of the work.

**Group C.** No response (This group was evasive in answering questions, either changing the subject or making an excuse to leave the conversation.)

**Group D.** Group D is the group in this community in whom change would be expected.

One of the more verbal residents said, "You learn to stop and think and then choose....I didn't do that before." Two others made similar comments. One said, "This place helped me stop and take a look at my problems and think what I wanted to do with my life." Another responded using a PPC goal, "I have to be able to handle myself in all situations."

Interpersonal

**Group A.** The director spoke of forming good working relationships with his staff, in contrast to the hostile bickering that he experienced when first arriving.

**Group B.** One person answered that she understands adolescents better than before working at the Center.
Group C. One person stated that he enjoys coming to work to be with people, that he is bored at home alone.

Group D. In group meetings, the boys talked about improving inter-personal problems of "easily angered", "fronting", and "authority." For example, a staff member had deliberately provoked a resident. The boy stated in group that as long as the staff member behaved in that manner, he would act up. Several boys informed the group member that they had felt that way, too, but when they changed their own behavior, the staff member changed his. In essence, they were learning to take the initiative in interpersonal relationships.

Professional

Group A. The director spoke of his professional growth since entering the position.

Group B. All members mentioned improving their professional skills, especially communications and understanding of people.

Group C. One person commented he had found out more about what type of job he wants through working at the Center.

Group D. No response.

Physical

Groups A, B and C. No response.

Group D. Some of the boys who came in "skinny" and malnourished are now physically healthier.
Religious

Groups A, B, C and D. No response.

Question 3: What brought about these changes? What works?

Interpersonal

Group A. The director spoke of his effort in communications as changing his relationship with the staff.

Group B. Two members said that being a part of helping the kids makes a difference. One said, "Doing things with kids, having them look up to me."

Group C. No response.

Group D. Two members made comments that reflected what many of the boys said in group meetings. "Someone is always there watching you, and talking to you. A lot of the staff, they care. And the teachers want you to do good." "It makes me feel good when I can help the other guys."

Intrapersonal

Groups A, B and C. No response.

Group D. "The program helps you to help yourself. It's up to you. You learn to stop and think. When you get out on the streets, well--maybe it will--what you do is up to you." "You want to get out of here and you know you have to be able to handle yourself to get your release."

Professional, religious, physical

Groups A, B, C and D. No response.
Staff's perceptions of what makes changes in the residents

This category was not used in other observations but is important here because (1) the boys do not have a great deal of insight and are reluctant to express themselves to a stranger; (2) the staff have been with the boys long enough to have experienced what brings about change; (3) it is possible that the staff project their own psychological change patterns onto the boys, and therefore in a general sense, describe what brings about change in themselves as community members.

Interpersonal

Group A. "Positive Peer Culture brings about changes by making the kids responsible for themselves. These kids are not going to have moms and dads taking care of them. They have to be responsible for themselves. Most of them have been on the streets two or three years before they came here."

Working with the families is an important part of the program, from the director's perspective. The director and aftercare worker have often written to families, called, or gone to the homes, if parents were not visiting the boy regularly.

Providing a wide variety of intellectually and socially stimulating experiences was considered important.

Community service projects and other endeavors in which the boys help other people is effective in changing self concept. "Keeping the youngsters in their home community and helping them to get experience contributing to their community is important."
Group B. The experience of helping, instead of hurting, was the major theme expressed as important for change. "What works? The group. PPC. It's their job to help. It makes them feel good. They are in here. When we see films on jobs, you'd be surprised how many want to help other people--jobs like teachers and social workers. It makes them feel good about themselves when they can help others."

The adult role model was viewed as important. "One thing that is often neglected is adult role models. Any activities that the adult and kids do together forms a bond. They see how the adult does things, how he handles himself. They haven't had good models before." One Group B staff member takes boys home to do outdoor chores with him and pays them. They eat with his family and play with his children, so that they see how a healthy family behaves.

Group C. Adult-to-youth interactions were seen as significant. "They need adults to sit and listen and talk to them. Some [staff] are like fathers or big brothers. I try to be a good role model. To let them see how I handle myself. That's something they haven't had."

Eliciting cooperation, rather than forcing good behavior through power plays, was seen as effective by all but one of the floor staff. "I don't try to force anyone to do something. They got to want to. I don't like anyone trying to force me. I feel a lot better if I volunteer." Another person said, "You don't play with other people's lives."

The stop-and-think element of PPC was considered important by two staff members. "Kids stopping and taking a look at what they are doing, helping each other, that works. You've got to be around here
three or four months to really see how it works." Setting goals—
they don't call it goals. A kid says to himself, "I been here for
months and what have I done. I better work on my problems so's I can
get out. I better be able to handle myself when I hit the streets."

Physical

Group A. The normality of the building is important. "We
try to make it like a home....It should be neat and clean with nice
furniture.... It's better than it was four years ago but it still
should be neater and cleaner sometimes." The director also saw
release from physical incarceration as a motivator for change. "The
major goal that the boys see is getting out. They will change their
behavior to get out of here."

Group B. The desire for release from incarceration was
viewed as an effective motivator for change, though the staff
realized that the change might not continue after release. In rare
cases, the physical environment of the center has worked in reverse.
One youth who has an aversive home situation acted out whenever he
thought he might be coming near release. He had been in institutions
for many years and was more comfortable in institutional settings
than in his family or community.

Group C. No response.

Professional

Group A. The director stated that professional training was
important for persons working with the boys to be effective. At
least one job title has been upgraded in educational requirements
recently. Continued inservice training for staff helps them be more effective in meeting the needs of residents.

Groups B and C. No response.

Religious

Group A. No response.

Group B. One staff member spontaneously brought up that what would make a difference with these boys was getting God into their lives. He would like an opportunity to teach them the Bible.

Group C. No response.

Intrapersonal

Groups A, B and C. No response.

Question 4: What are the stresses here?

Interpersonal

Group A. The director discussed not only what causes stress and burnout for him and for the staff, but also what was being done to reduce stress.

The director perceived the primary category of stress in residential treatment programs as unsatisfactory interpersonal relationships. Antagonism among employees, deliberate pitting of administration against higher officials in the correctional system bureaucracy, deliberate pitting of the director and staff members against each other, authoritarianism by higher administration, lack of emotional support, lack of communication or inaccurate communications, lack of involvement or commitment to the program and to its
success, and perpetual petty arguing—all were major sources of stress when the director first came to this job.

To reduce stress, the director stated he had worked to develop open trusting communications. He felt it was important that the staff know he cares about each person as an individual. Because of his wide variety of work experiences, he felt, "I can slip off my shoes and stand in his [employee's] shoes."

**Group B.** Group B staff emphasized the problems of getting along with different personalities. One member referred to incidents in which staff personality clashes had detrimental effects on the residents. He also stated that the director had been able to work out many such problems. The need for open communications among staff needed to be balanced by realism and confidentiality.

**Group C.** The problem of differing personalities working together was mentioned by all Group C members. One person discussed "tattletaling" to the administration about employee infringement of the rules, particularly that another employee had told on him. He talked about contradictions in employee handling of resident policy, such as whether the boys should have highly sugared food. [The researcher noted that the employees who wanted to restrict sugar intake were thinner and those not concerned were overweight.]

Personality styles complicate the residents' program and add stress, according to Group C members. An employee said he never tried to force any boy but he set an example. Another floor worker who said he yelled at his own children saw nothing wrong with being loud, confrontive, and aggressive with the boys.
One staff member cited stress from interaction with parents of the boys, particularly during visitations. "Some parents side with the kids against us."

**Group D.** Only one resident was willing to comment directly to the researcher about stresses at the Center. "If the group members give you good help, that's okay. But sometimes they give you the wrong help. That really messes you up."

In group meetings, interpersonal stresses were obvious. The difficulties in coping with staff members who are aggressive and make deprecatory remarks to the boys emerged. Getting along with new group members is stressful. Several newer group members had determined how to aggravate the more explosive boys and did so regularly, impeding the progress of group and causing chaos in the dormitory.

**Professional**

**Group A.** The director believed that mental stagnation and too much sameness creates stress. He believed that in-service education is important in reducing stress and burnout and enhancing the quality of the experience for the worker. Each new staff member receives 120 hours of in-service in the first year and a minimum of 40 hours yearly thereafter.

The amount of paperwork of a government agency is a source of aggravation for the director.

**Group B.** The amount of time required to do paperwork was perceived as interfering with time available to relate to residents. The state bureaucracy's allocation of money for supplies and
equipment was mentioned by two Group B members but perceived more as an annoyance than as stressful.

The problem of developing programming that brings about successful experiences for the boys, while still maintaining standards of safety and professional credibility was mentioned by a Group B member.

Groups C and D. No response.

Physical

Group A. A neat, clean building with attractive furnishings was seen as important for staff and resident morale. The director felt that though the building was more attractive now than four years ago, but there was still much to be done.

Group B. No response.

Group C. The need for more recreational equipment was mentioned by two Group C members, but not perceived as a major issue.

Group D. Physical incarceration itself was perceived as stressful by the residents.

Religious, intrapersonal

Groups A, B, C and D. No response.

Summary of Questions and Answers

What brought people to the juvenile center community originally? For adults, available employment in an area of qualification or interest was the original factor. For a few, the challenge of developing a unique program and of extending one's skill
were factors. For the residents, court commitment had placed them in the facility for treatment.

What effect did working in the PPC treatment facility have on staff? For some staff, personal professional growth in understanding adolescents, developing professional competency, and increasing personal effectiveness were significant. The work resulted in fulfillment, satisfaction of helping young people, or at least escape from boredom. It was interesting to the researcher that no one mentioned pay scale or fringe benefits, positively or negatively.

The residents expressed interpersonal and intrapersonal change. An opportunity to help others, to stop-and-think and choose and to learn to handle oneself were changes they perceived in themselves.

What brought about changes? Interpersonal relationships were most often cited as an agent for change in the community, the staff, and the residents. Good communications, the satisfaction of helping others, the status of leader, and being looked up to as a role model were sources of positive experience for the adults. For the residents, the answer was in intrapersonal and interpersonal terms. Other people intimately involved in one's self and the opportunity to change oneself were the major answers.

What did the staff perceive as bringing about changes in the boys? Positive adult-to-youngster relationships and peer-to-peer relationships were important in bringing about changes. The satisfaction of being a helper was important to the boys. The building was significant in that it set an atmosphere. The boys'
desire to be free from incarceration was a motivating factor to produce temporary behavior change.

What was stressful for the staff? Developing new programs that result in good experiences for the residents was difficult. The amount of paper work and the governmental bureaucracy, including monetary limitation, was a minor source of stress. What could be done to reduce stress? According to the director, relationships among the treatment team, communications, emotional support, and a positive attitude toward each other are helpful in reducing the stress caused by various personalities with differing values and styles of self expression. The director viewed himself as responsible for setting the pattern for the rest of the staff, for being and behaving toward them as he wanted them to be toward the residents. The example he set would increase or decrease stress. Professionally, stagnation and burnout were combatted through team interaction and in-service education.

The researcher was interested that no staff member commented that aggressiveness or other characteristics of the boys was a major source of stress.

For the residents, the stresses were the same factors that were also therapeutic—incarceration, close interpersonal contact with other youth, and certain behaviors of the staff.

Out of the categories of this study, interpersonal relationships was the primary effective factor in bringing about change for residents and adults. This focus on interpersonal relationships—as contrasted with materialism, professional status, research, or other possibilities—is characteristic of healing communities.
Contribution of this Observation to the Model of Counseling Center as Community

1. A healing community can be developed in a short-term correctional program for adolescents, though neither staff nor residents are in the program from the explicit desire to be in community. As in a hospital therapeutic community, leadership, communications, decision making, social learning, and group process are vital elements.

This observation reinforces the premise that healing communities can exist in a variety of settings, including an employment setting such as a counseling center.

2. Well-defined roles, procedure, and model can increase efficiency, effectiveness and interpersonal comfort without precluding warmth, sharing, and flexibility. The counseling center as community can be well-organized and articulated without losing emotional closeness or becoming bureaucratic.

3. In helping adolescents with anti-social behavior problems, a combination of adult leadership and peer interaction can be effective. Positive peer groups can be combined with individual therapy in a counseling center.

4. In working with anti-social youth, the effective form of boundaries between adult and child, staff and client, is not uniforms, badges, white coats, professional titles, or special mannerisms. Therapeutically effective boundaries are naturally established by a mature, adult demeanor. When the adult demonstrates effective communication, social, and emotional skills, self-confidence, and self control, he is modeling what the adolescent is not yet but can become. In the counseling center that is community,
the therapist has opportunity to be a role model in real life situations.

5. A unified treatment team is important. These young people are adept at pitting adult helpers against each other. In a counseling community working largely with anti-social youth, all staff and volunteers must have opportunity for input, sharing of feelings and information, and being a part of the decision-making process.

6. In a counseling center, as in this program, the director's own behavior sets the tone for the entire program. The director's commitment to the program, care and concern for the staff, ability at communications and decision-making, and insight into staff and client needs provides the example for the staff to emulate in relating to the clients.

In this program, the director's full energies and time have been required to bring the center to its present level. The director of a new counseling center community may find it demands his full commitment, leaving little personal time. This raises the question whether the director of a counseling community should be a person without family responsibilities.

7. With guidance, youth can help each other learn new behaviors and overcome problems. Constant contact between youth attempting to help each other may be desirable. In a counseling situation, youth who are in the same school and classes may be used to monitor and support each other. A few counseling centers may cooperate with school to set up small groups to help adolescents help each other.
8. In peer group counseling, especially in a non-residential setting, the issue of confidentiality must be spelled out carefully.

9. Provisions for continued staff training, in and out of the particular work situation, are important. Regularly scheduled sessions are essential for the workplace to become a personally satisfying living-learning situation.

In a counseling center, the community needs to frequently articulate its identity and purpose, as well as work together to learn from solving group and client problems.
Emotions Anonymous, Inc.

Introductory Imagery

Around the folding table sit eleven men and women, chatting quietly or just staring at the centerpiece, a literature display with a sign "What you see here and what you hear here, let it stay here." The faces of many in the group seem sad and drawn and their eyes full of pain; there is a calmness about them as though, for this moment, the inner battles are stilled. Familiar aromas of percolating coffee, tobacco, and tired bodies add to the feeling of "at-homeness" --or depression--depending upon the interpreter.

A woman in her sixties, absently fingering one of her many necklaces, announces, "I think everyone is here. Let us say the Serenity Prayer." In unison the group drones, "God, grant me the serenity to accept...." After the prayer, the leader smiles at two visitors and reads from a printed card. "We welcome you to this chapter of Emotions Anonymous. We invite you to discover as we have that our EA Fellowship of weekly meetings is warm and friendly, and that it is also important in achieving and maintaining emotional health....The program will show you how to find solutions that lead to serenity. So much depends on our own attitudes, and as we learn to place our problems in their true perspective, we find they lose their power to dominate our thoughts and our lives. The loving interchange of help among members and the daily reading of EA literature makes us ready to receive the priceless gift of Serenity."

Laying aside the card, she continues, "We have two new people tonight. Let’s introduce ourselves. We use first names only. If you would like, you may sign the book and put down your phone number
or copy anyone else's phone number. We call each other during the week when we need someone to talk to."

After the introductions, the leader calls on a member to read the Twelve Traditions and the Twelve Steps of Emotions Anonymous. Then picking up a small book, she says, "Our topic tonight is fear and anxiety. Jeanie, would you like to read page eighteen?"

A pretty young woman picks up the book in front of her. "Hi, my name is Jeanie and I'm powerless over my emotions." She then reads from the devotional-style book, published by Alcoholics Anonymous. At the end of the reading, Jeanie talks in vague terms and disjointed sentences about her need for the group's help to be strong to deal with the problems of her husband and children. Group members do not look at her or show much expression. Jeanie concludes, "I feel much better now. I knew you'd understand and I'd feel better if I came to a meeting tonight."

The meeting progresses with each member taking a turn in the same fashion. Only rarely does another member look at or openly respond to the speaker; yet, the speaker usually expresses appreciation for being listened to and understood.

After the leader passes a basket to collect for group expenses, the members stand and recite the Lord's Prayer.

A heavy-set woman approaches one of the visitors. "Now's the best part. We always have hug therapy after the meeting. Can I hug you? Here's a card with my phone number if you want to talk during the week." The leader then comes over and explains that the group is going to a fast-food restaurant for a social time and that the new
people are welcome to join them. She hopes the newcomers will return the following week.

The meeting is over and the members slowly drift away.

Facts and History

The national organization of Emotions Anonymous, Inc. was formed in 1971 and has 1,000 chapters in eighteen countries, according to correspondence from a service coordinator at the national headquarters in St. Paul, Minnesota (Linder, personal communication, December 23, 1985). An information sheet in a publicity packet from EA states that chapters and the central organization are supported by members' voluntary contributions and reject outside involvement of any kind. Each chapter is autonomous, tied to the headquarters only by the use of the name, literature, and a promise to remain within a few guidelines. The central organization does not monitor local chapters nor claim any responsibility for their activities. There is no official organizational history, compilation of demographic data, or studies on the efficacy of the program. "The feeling has been that [such] information does not help us achieve our primary goal, i.e. carrying the Twelve-Step message to those who struggle with emotional problems" (Linder, personal communication, December 23, 1985).

The local chapter observed for this research was started in 1978 by a woman who had recently suffered a physically and emotionally debilitating auto accident. She had been a long-time member of Alcoholics Anonymous and wanted to carry those same principles into coping with emotional dysfunction. According to the founder, the local chapter has had an uneventful history, meeting weekly in the
same country church with an average attendance of eight to ten persons per week.

Roles

Roles in EA are egalitarian. The contact person assumes responsibility for relating to the public and the national headquarters. The chairman for a particular meeting opens and closes the meeting and calls on each member. These roles are only instrumental with little power to shape the group or change the content of the meeting.

The role of each member is to participate by being present, by making personal comments about himself, and by listening without reacting while others speak. He is not to comment on another member's statements nor show emotional involvement. Eye contact is almost entirely lacking. In one meeting, the researcher made eye contact with the speakers and made reflective, empathic responses. She was informed that "we don't give advice," "we don't show sympathy," and "we are all on the same level, we don't relate from a position of strength."

Experienced members never directly ask questions of each other during the meeting. When the researcher experimented by asking about the purpose of the group, three of the thirteen persons present responded with short answers without looking at the researcher. The other members focused their eyes elsewhere.

Activities

Meetings are the primary activity of EA groups. Official EA literature described both open and closed meetings. (Information
packet, Emotions Anonymous, Inc.) The purpose of the open meeting is to inform the public of the nature and opportunities of EA. In these meetings only the designated speakers are allowed to be heard; the audience only listens. Often speakers are EA members telling about their recovery through EA. The EA chapter observed for this study does not hold open meetings. Closed meetings are the primary activity that is expected to be therapeutic. A typical closed meeting for the chapter observed is described in the Introductory Imagery section of this paper.

This local chapter has a unique feature of an after-session meeting at a restaurant. While attending two of these after-sessions, the researcher found that discussion of what transpired during the regular meeting was not permitted. The topics and tone of conversation were that typical of a small social club.

It was interesting to note that, though meetings were expected to be supportive and growth-producing, they were so structured that concerns of members were never actually discussed in a group situation.

Officially, telephone conversations among members were encouraged; however, in practice such conversations seemed more related to the member's occupation and life-style than to a therapeutic need. Two homemakers maintained regular phone contact during the week. Four members who had been in a half-way house together talk occasionally by phone or in person. Two men acquainted through business transactions mentioned in a group meeting that they get together about once a month. None of the other group members mentioned interacting outside of the meetings.
Beliefs

Emotions Anonymous is essentially a faith approach to emotional well-being. Official literature and local practice hold that uncritical following of the Twelve Steps, the Twelve Traditions, the Serenity Prayer, the Slogans, and other EA material will result in a "New Way of Life [that] has proved itself over the past fifteen years...." and that "having had a spiritual awakening as a result of these steps, we try to carry this message and practice these principles in all our affairs" (Publicity packet, Emotions Anonymous, Inc., 1985). The official literature is borrowed, with little adaptation, from Alcoholics Anonymous. Correspondence indicates that there has been no attempt to examine if the principles effective in treating alcoholism are also appropriate for emotional disorders or whether the EA program is therapeutic or growth-enhancing for members (Linder, personal communication, December 23, 1985).

EA literature refers to members as emotionally ill, a term that is interesting in light of the current trend in human services to move away from the stigma of regarding emotional difficulties as illnesses. A sheet in the publicity packet states, "Emotional illness can cripple us mentally, physically, and spiritually." Emotional illness is then described, not in terms of psychopathological symptomology, but as lack of self-esteem, unrealistic ideals and goals, and ineffective response to disappointments. Cognitive attitude change is the key to "emotional health and happiness," according to the EA literature. The major points of change are recognizing one's powerlessness over emotions, surrender to an undefined higher power, lowering of unrealistic expectations of self
and others, adjusting to social and physical reality instead of trying to change the world, and focusing on the present rather than the past or future. To the researcher, this type of solution seems more appropriate for coping with an environmental stressor or for living with a permanent handicap than for bringing about healing of an "illness".

EA rejects involvement of professionals. The publicity material states, "Meetings are conducted by the members of EA only. Medical, social, or religious professionals are not permitted to lead meetings unless they are EA members and are participating as such." Professionals are not used as consultants. They are not allowed to attend or observe closed meetings unless they declare themselves sufferers in need of the program. Though many local EA members are in professional therapy, they do not mention therapy during the meetings. EA's anti-professional stand has limited the possibility for evaluation of the effectiveness of the program.

Communications

Communications are open, uncomplicated, and usually clear. There is no evidence of a hidden agenda among the members of the group observed. Each member is free to communicate with any other member outside the structured meetings.

Decision-making Process

Decision-making is a minimal part of group life. The structure is established and does not change. Decisions concern only such matters as who will make the coffee or who will chair the next meeting. Persons volunteer to take such responsibilities. The
decisions to attend meetings, to attend the after-session, or to make contact during the week are strictly individual decisions.

Support

The dimension of emotional support is the heart of the local EA chapter, as expressed by the members' comments. Members stated that in the group they felt comfortable, secure, accepted, encouraged, understood, and supported. Support is expressed by listening without reaction. Material or instrumental support are not part of the program and are forbidden in EA literature.

Psychological Sense of Community

For a group that meets only two hours per week, there is a strong sense of community. Several members have been in the group since its beginning seven years ago. They expressed intentions to remain in the group indefinitely. One person stated that the group is a major part of who she is, that she cannot be herself without the group.

Whether strong, long-term identification with a group that focuses on emotional disorders is desirable is a value judgment and can be debated. In the researcher's opinion, strong psychological sense of community and permanent commitment to the group may be advantageous if such involvement leads into a position of health and leadership in helping new members; it may be detrimental if it requires remaining "powerless over emotions", inadequate, or minimally socially competent as requisites to be part of the group. The researcher doubts that a person who acquires self-confidence and
competency in social relationship will be accepted in this particular chapter of EA.

My Contacts

Emotion Anonymous as an organization had come to my attention through newspaper notices in another state. From the information available, EA appeared to be closer to a democratic therapeutic community than a similar program, Recovery, Inc., appeared to be.

To begin investigating EA, I obtained the phone number of the local contact person from a county-wide telephone information and referral agency. I called the contact person for the local chapter, identified myself as a student and researcher, and asked for general information about Emotions Anonymous. I was told that it was a program for persons with emotional problems and that the meetings were not open to observers or professionals. At another time, I called the contact person, changing my voice slightly and identifying myself as a person with emotional problems, and the contact person was then quite gracious, answered a few questions, stated she was getting ready to leave for a meeting that night, and invited me to attend.

Under an assumed identity, I attended five closed meetings and was treated with care and hospitableness, but no pressure was applied for self-revelation or undue conformity. I socialized at the after-session gathering twice, declining at other times by saying the sessions were too late at night. One member was a public school teacher whom I had met at a social function. Though he repeatedly said that he thought he should know me, he could not remember the specific occasion of meeting and finally accepted my statement that I
did not know him. Internally, I felt a bit awkward, as though I were spying on innocent people, using them for my own purposes without their knowledge. However, I also felt that, since I could not attend the meetings as a professional, in this case the end justified the means as long as I did nothing to injure any member of the group. After attending the meetings, I would like to have called two of the better adjusted members, revealed my research interest, and asked more specific questions; however, I was convinced that such an action could undermine the group's trust and security and would be irresponsible on my part.

My information for the members' answers to the research questions came from spontaneous comments during the meetings, from questions I asked of individuals at the meetings, and from challenges I made during the meeting. Some of the answers are reiterations of EA literature; others are quite personal.

In general, I felt I obtained an accurate picture of this particular chapter of Emotions Anonymous. Whether this chapter is representative of the whole organization is unknown. A search of the research literature in *Dissertation Abstracts, Psychological Abstracts,* and *Sociological Abstracts* revealed no other studies of a chapter of Emotions Anonymous; therefore, I could not compare what I had observed with any other chapter. Unfortunately, time and distance did not allow visiting any other chapters during the course of this study.

Persons Interviewed

In this observation, community members cannot be grouped as in other observations, since there are no distinct roles or status
separation in the group. It is truly egalitarian. Except for the observer and for visitors whose responses are not recorded, the group consists of persons who have been involved for at least a year and who appear to have incorporated the group norms and values.

1. S.L., founder and contact person for the group, about sixty years old, was a secretary before a debilitating auto accident.

2. M.S., a homemaker in her 40s, is currently taking courses at the local community college to enrich her life.

3. J.K., a homemaker in her 20s, has two small children and an unemployed husband.

4. C.S., a woman in her 30s, currently living in a half-way house and learning basic living skills, has a legal status of permanent psychiatric disability.

5. J.T., a man in his 20s with a history of arrests for drunkenness, disorderly conduct, and being a vagrant, is currently in a sheltered living situation under psychiatric treatment at the public mental health center.

6. E.R., an elderly man, a chain smoker who rarely talked in the group, is in psychiatric treatment and regards himself as permanently disabled and hopeless.

7. F.L., a public school teacher in his 30s, entered EA to cope with his wife's schizophrenia.

8. B.D., an independent businessman whose small firm is a major satisfaction to him, did not disclose significant personal problems at meetings observed.

9. M.T., a woman in her 40s, is confined to a wheelchair and has an emotionally restricted life-style.
K.F., a pretty blonde girl just entering adulthood, has little family life or social life and is receiving intensive professional care.

Research Questions and Answers

Question 1: What brought you to Emotions Anonymous?
Interpersonal

Three persons had come at the suggestions of their therapists. Two had been brought by friends. One man had come to learn about emotional illness to better understand his wife's psychosis. Other members were noncommittal.

Physical, religious, professional, and intrapersonal

Group. No response.

Question 2: What effect has being in EA had on you?
Interpersonal

The majority of answers were interpersonal, some with intrapersonal components. "I'm really proud to be in EA. I was ashamed when I first came. Now I think I'll be here the rest of my life. I've learned to get along with people, that other people feel the same way I do. I'm not weird." "The whole world should be in the program. Everyone has problems or needs. Too many people just ignore their problems or blame someone else. I used to do that. Now I face my problems." "I feel like I'm alive again. I can give to other people and that makes me feel good. I like the children I babysit." "I'm a lot calmer. I don't yell at the kids and my husband as much, but I've got a long way to go. This headache
tonight is just because I let them get to me today." "I'm trying to learn to walk away from my work, to leave it at the office instead of being grumpy when I get home. It's not my wife's fault if I didn't make a sale, but I used to take it out on her all the time." "I guess I'm learning that other people have rights, too. I can't just walk on them and then expect them to be there when I want them."

Intrapersonal

Acceptance of self and others and learning life skills were major themes. "I know myself and like myself now. Before I was in EA, I just kept going. I wasn't really a person." "I come here to learn how to live. No one at home ever taught me anything. Here I learn how to think and feel and relate to people. I'm a lot better than I was when I came." "I can accept life better than when I first came. I don't get disappointed so easily and I don't expect so much." "I used to think about suicide most of the time, now just some of the time, when I'm alone. Then I call _____, my friend here, and we just talk about anything and I feel better." "I can accept my handicap better. I have hope. I just take it one day at a time."

Religious

One member mentioned a religious change in her life. "I found out there is a loving God since I've been here. I never paid any attention to God before. _____ helped me to see that there is Someone who loves me just for me. I still don't go to church, but I'm reading my Bible a lot recently."
Professional, physical Group. No response.

Question 3: What has brought about these changes?

Interpersonal

Interpersonal relationship was the primary response. "I can say anything here and no one will get upset or yell at me." "This is the only place I can be myself. I have friends and family, but I can't really talk to them about what bothers me. I need the program and my friends here. This is really my family." "Here we empathize but never sympathize. We accept but never give advice. We share hope and experience. This is very different than the world." All other members gave similar responses about acceptance and understanding.

Religious

Several members mentioned the spiritual component of EA literature as helping them to change. Though the literature is nebulous concerning the nature of the Higher Power to which members are to appeal, this group interprets the literature in terms of traditional Christian beliefs. "I like the spiritual part of the program. When I have a hard day, I pray the Serenity prayer over and over, and I know God hears me." "______ has convinced me—God always answers prayer. Maybe not the way I want Him to, but the best way for me." "Love—God's love, people's love, that's what I never knew before I came to EA." "It's only by admitting we are powerless over emotions and surrendering to God that we can live each day to its fullest."
Professional

Though the EA literature emphasizes a specific plan and following specific steps as leading to success, none of the members mentioned an intentional following of the plan. Several did comment that reading EA literature helps them remember what they learned at the group meetings.

Physical, intrapersonal

Group. No response.

Question 4: What are the stresses here?

When the researcher asked this question, either to the group or to individuals, the members had blank expressions and either changed the subject or did not respond.

Summary of Questions and Answers

What brought people to the local EA chapter was interpersonal relationships, either with a therapist or with a friend already participating in EA.

Change resulting from EA participation was intrapersonal or interpersonal. Gaining an understanding of social reality, improving social and communications skills, and acquiring a better self concept were major themes. Religious growth was a minor theme.

Acceptance, empathy, understanding, and sharing of experience were seen as bringing about change. Religious elements in the program, and the religious input of specific members, were also perceived as helpful.
The EA members were unable to respond concerning stress involved in the group. The researcher's own experience was that the smoke-filled air and heavy coffee drinking, along with the late hour of adjournment and the after/session, could produce stress.

Contributions of this Observation to the Model of Counseling Center as Community

1. From the perspective of persons involved, a self-help group assists in positive personality development. Acceptance, empathy, and sharing with people of similar experience were perceived as leading toward knowing and accepting oneself and toward improving relationships with significant others outside the group. Reading inspirational literature was also helpful.

2. Self-help programs may try to apply a set of principles effective for one disorder to a different syndrome. From a professional psychological viewpoint, this application may be inappropriate, and even detrimental. There was no firm evidence that application of Alcoholics Anonymous principles to problems of living, neuroses, and character disorders was detrimental in this group; however, many group members did express considerable dependence on the group. No member spoke of becoming increasingly independent or self-directed. Also, there is a possibility that a self-selection process eliminates persons who would not profit from this group.
In the CCAC, the director or therapist should be responsible for matching clients with the appropriate self-help or support group, when such groups are deemed helpful.

3. In peer-helper situations, people are often receptive to Christian beliefs, when they will not accept the same material from a professional.

In a CCAC that is church-related, peer counseling and support systems may be a valuable method of reaching people spiritually.

4. A professional in mental health may view elements of a program as harmful that are not apparent to the group participants—elements such as heavy smoking in a small room, coffee drinking, and late night hours. Lay persons may be genuinely unaware of the negative effects of such factors on their psychological functioning. Some persons may fear offending friends if they suggest the needed changes for the group.

In a CCAC, the therapist or director assumes responsibility for being aware of such detrimental factors and correcting them.
The halls of the old school house echo with laughter and running feet as the twenty-five students, ages seven to seventeen, take advantage of the ten-minute break from studies to talk to each other and to show off their work from the first two classes of the day.

Sturdy, shaggy-headed little Justin skids down the concrete floor, worn slick from fifty years of use by public school children, and bumps against the director's desk. "Look, Sister Miriam, look. See what I did." He grins, holding up a work page of "like and different" figures.

"You can do good work, Justin, when you try." Sr. Miriam smiles benevolently at the seven-year old. "I guess we'll drive past your favorite spot tonight when I take you home."

Justin beams. Like all the other children at Benet Learning Center, he treasures attention from the nun who founded this non-sectarian program for children needing one-to-one education.

The bell rings, and most of the other youngsters crowded around the director's desk wander off to class. A young woman approaches Justin. "Let's go, Justin. Time for class."

"No, I don't want to. No!" Protesting loudly, Justin flings himself down on the floor.

Calmly, Sr. Miriam looks up from her work.

"Justin, do you want me to take you home tonight?"

The yelling stops, but Justin still lies on the floor. The young teacher explains, "If you work hard in class, we can make paper
airplanes at the end." Justin is on his feet in a moment, walking beside the teacher to her cubicle in the primary level classroom.

Fourteen-year old Karen stands alone in the hall. "Sister, I don't have a teacher this hour. My teacher isn't here today." The girl swishes her long braid and waits, seemingly unperturbed by the lack of direction. Sr. Miriam suggests, "Go find Gail and tell her."

"Gail is with the boys. I'll go find a teacher. Maybe Grandma Pat will help me." She minces off down the hall toward the secondary classroom.

Soon the building is quiet as pairs of teachers and students settle into their work. Sr. Miriam enters her office and, smoothing the wisp of gray hair that slipped from under her headcovering, plunges into the pile of correspondence on the shelf. Such is a typical morning with "the children who fell between the cracks."

Facts and History

Benet Learning Center was founded in 1973 in Fort Wayne, Indiana, by Dr. Miriam Schultheis, a Benedictine nun, to provide one-to-one education for children and adults not adequately served in regular school programs. Many of the children in the full-time day school program have been rejected by the public schools because of acting-out behavior. Others have such severe learning disabilities that they cannot profit from group instruction but can learn in a one-to-one situation in which the teacher "teaches to the ability and remediates the disability." All students have the potential to learn academic skills and many have high general intelligence levels.

At the time of the research observation, eleven elementary and nine high school students were in the day program. Fifteen
youngsters in regular school programs came to the Center for special assistance in the evening. Several adults placed at the Center by Vocational Rehabilitation or the Veteran's Administration were studying in an adult basic education or GED program. Four adults with learning disabilities, formerly Benet students as children, were enrolled in regular college classes and returned to the Center a few hours a week for special tutoring. In total, Benet Learning Center was rendering between 700-750 hours of service weekly.

Though Benet Center is officially an educational program, Sr. Miriam has always conceived of it as bringing about major changes in behavior and mental health of students. One publication concerning the Center states, "It had become evident that at least 80% of the work done in the Center focuses on building better self concept, for children who have experienced nothing but failure after failure feel they have no worth....The Center uses bibliotherapy and other techniques enabling him/her to develop a better understanding of self and to discover ways to overcome his/her problems or learn to cope with them. It is also a means of helping others to have a better understanding of certain individuals and realizing why they feel and act as they do."

In talking about the change in lives that occurs at the Center, one young woman told the researcher, "When I came to Benet Center in high school, I was a mess emotionally, physically, every way....I weighed 350 pounds. I was a disciplinary problem....The schools just passed me on. No one understood me. I sat detention almost every day because I didn't have my homework. It wasn't that I didn't want to. I couldn't....I was in a psychiatric unit for a
while but Sr. Miriam should take all the credit. Now I've graduated from high school. I'm 150 pounds. I have a beautiful little boy. And I'm going to start college....It's hard to put this place into words. It's discipline with compassion. Just the smell of it, here in the hall, it's home."

When Sr. Miriam has talked about the Center to the researcher over the past several years, she has spoken not only of concern about the mental health of the students but also of the teachers. She pictures Benet as a place for help for troubled teachers who have excellent academic educations but who cannot cope with standard employment because of physical or psychological difficulties. At the time of the research, three of the teachers had major psychiatric disorders and two readily discussed their disorders as related to their work at the Center with the researcher. One said, "Let's face it. Most of us here could not find employment elsewhere." Sr. Miriam has worked to help the teachers overcome their disabilities, improved their self-confidence, and teach effectively in spite of their difficulties. She has fought to keep teachers in order to help them. When the board wanted to fire a teacher whose recent trauma was affecting her work, Sr. Miriam told them, "She [the teacher] has nowhere else to go," and that ended the discussion.

In Sr. Miriam's description of the Center, the researcher recognized elements more common to healing communities than to institutional or medical model programs. An interview with Sr. Miriam and the chairman of the board of the Center plus the first day of observation confirmed that Benet Center was, in ideal, a healing community. Since a service delivery model has never been fully
formulated at the Center, the program cannot be expected to conform as closely to the healing community or therapeutic community as other programs observed. The gap between the ideal and the actual has also been widened by recent financial and staffing difficulties. Nevertheless, this Learning Center meets the basic criteria to qualify to be studied for this research project.

Following is a description of Benet Learning Center as a healing community.

Roles

In theory, roles at the Center are rigid. In actuality, there is a certain fluidity of roles, as in most communities, such that persons assume each other's roles under situations of need. With acquisition of experience and skill and personal commitment to the program, the person may move upward from one role to the next.

Director

The director of the Center has final authority in all matters concerning the Center. She carries the responsibilities for all administrative and organizational matters. She is a highly visible figure, leading from the front. Problems of both children and teachers come directly to her, and it is her approval that is sought by the students and dedicated staff members. As the founder, she carries the vision of what the Center is to be in essence, the history of what it has been, and the hopes for its future.

The director has strong credentials for the position. Sr. Miriam holds an Ed.D. in education and certification in Reading, Guidance and Counseling, and Psychometry. She is active in the
International Reading Association and the Association for the Study of Perception. She has published a Guidebook for Bibliotherapy and has held workshops on the subject across the country. She has many years of teaching experience in elementary schools and in colleges.

**Supervisors**

The primary (elementary) and secondary (high school and adult) supervisors have responsibility for the teachers in their departments. They oversee curriculum for each child and monitor all activities in the department. They make recommendations to the director concerning the matching of teachers and students, scheduling, and other curricular matters.

Both supervisors have formal educational qualifications for the position. One holds a master's degree in elementary education, certification in Remedial Reading and Mental Retardation, and has twenty years of public school experience. The secondary supervisor has a master's degree in secondary education and has several years of classroom experience.

**Teachers**

Teachers are responsible for one-to-one educational and psychological development of the students. They plan the curriculum for the student or carry out the plans of the supervisor. With an occasional exception, teachers change students and/or subject areas each hour of the six-hour school day. Some teachers also tutor children or adults who are not in the day program after school hours. Most teachers work a full six periods, though a few, particularly those with psychological difficulties, teach less hours.Teachers
are paid minimum wage for the hours actually taught. Upward mobility from teacher to supervisor has been possible in the past.

**Aides and Volunteers**

Several community agencies supply volunteers who assist the teachers. Four "foster grandmas" are present in the morning in the primary section. In cases of absences of teachers, the grandmas assume responsibility for teaching. On the first day of the researcher's observations, the supervisor and a teacher were absent. The grandmas not only taught, but also scheduled the students whose teachers were absent and instructed the researcher, whom they assumed to be a new teacher.

**Students**

Students are children, adolescents, or adults learning on a one-to-one basis. The school-age students have emotional difficulties or learning disabilities which the public schools were incapable or unwilling to deal with, in spite of the federal and state laws mandating them to provide for all children. The high school students have been expelled from their schools for behavior problems.

Students are expected to be actively involved within the framework established for them. They keep track of their own schedule, find their own classes, and know what materials they are using and what they are to do in each book. They were able to tell the researcher how she should help them when she substituted for their regular teachers. When their teachers were temporarily out of the work station, most children continued their work.
Though students are active in learning, they are active within structure; they are not expected to initiate studies or to work on projects requiring independence and self-reliance.

Students are expected to exhibit behaviors appropriate for their age; however, maladaptive behaviors occur frequently and are treated as routine, to be stopped and replaced with proper behavior but not to be punished.

In general, students contributed to building relationships with the teachers. However, in practice, the researcher notes that some students have not formed bonds effectively. The supervisor consulted the researcher about one adolescent who was not relating to any of the staff. On the other hand, the four-year old autistic child has formed a deep, positive bond with his teacher and, from the security of that relationship, is reaching out to meet new adults and is attempting to play with the other children.

Though the role of the student is usually one-to-one with an adult, there are opportunities for group involvement, such as the Christmas play. Transition to group identity seems to be difficult for the young people. During practice for the Christmas play, there was excessive acting out for attention. It must be remembered, however, that these students had not been successful as a part of a classroom group before coming to the Center.

Activities

The primary change activity at the Center is learning--academic, behavioral, social, and emotional learning. In the one-to-one student-teacher relationship, the student responds as the teacher praises, corrects, guides, and encourages. Response to the teacher's
initiative is perceived as a change activity, among other elements of the relationship. Doing the prescribed work and succeeding at each step is seen as resulting in feelings of success and competence and as undoing the failure set found in the children, a set often created in the regular classroom.

The curricular materials are such as to require active responses—workpages, written papers, or teaching machines. When textbooks are used, the material is read aloud to the tutor, or the material is discussed section by section.

Bibliotherapy, the use of stories related to problems in an individual's life, is encouraged by the director and is emphasized in the official literature about the Center. Though the researcher did not observe bibliotherapy being used, a dramatic account of its use was given by an adult student whom bibliotherapy had helped.

A man blinded several years ago by street assailants had been through conventional Vocational Rehabilitation counseling and had worked in a sheltered workshop, but still found life very unsatisfying. His self-esteem and self-confidence and trust in social reality had been so seriously damaged that he was pathologically depressed. After coming to the Benet Center, he began to find hope, according to his account to the researcher. He began to believe he could be a whole person again. His teacher and Sr. Miriam read to him from books about blind persons who overcame their handicap. They encouraged the man to get a guide dog, which would allow him to get around the city independently. Because he had failed to pass the training necessary to receive a dog previously, he felt the matter was hopeless until his teacher read to him Follow My Leader. The
book inspired him to make another attempt, and this time he passed the course. When the researcher met the man, he was all smiles and very proud of his beautiful white Labrador, his new set of eyes.

At Benet Learning Center, perceptual motor training to reduce the fundamental impairment of learning disabilities had been an important activity. Results of the training in overcoming perceptual problems and general awkwardness and in increasing self-confidence had been encouraging. However, the staff trained in the method has left the Center, and there is a lack of equipment. Therefore, the perceptual motor program was infrequently used at the time of the research observation.

Involvement in special activities, such as the Christmas program, and in group classes, such as gym and aerobics, is expected to improve social adjustment and ability to work and play cooperatively with peers.

A few adolescents have a counseling relationship with a teacher who had previously worked in a hospital psychiatric ward.

For the staff, the responsibilities of teaching and the rewards of helping someone else to become successful are expected to have a positive effect on psychological health. Having a respectable job and a "place to be, to belong" are emphasized by the director as important for the mental health of several staff members.

Beliefs

Belief in the effectiveness of a one-to-one relationship is the cornerstone of the Center; such a relationship sets this program apart from other educational programs. Because of the one-to-one approach, there is less group involvement among the students than
would be normal in regular school. For example, at break time, the youngsters were observed making one-to-one contacts with the director, a favorite teacher, or a peer. There was little standing about the halls in groups by the adolescents and little spontaneous group play among the younger children.

Written literature about the Center emphasizes the importance of self-concept, successful experiences, and a feeling of confidence. This belief is reflected in phrases frequently heard among students and teachers, phrases such as "You can if you try", "there is no such word as I can't", and "we will do it together." If a student has difficulty with a workpage, he is helped to find the correct answers, rather than told to finish the page and given a failing mark. (In practice, the majority of teachers followed this principle. A few allowed students to fail and then complained about them; however, the supervisors were taking steps to remedy this violation of the belief system.)

An effective personality match between teacher and student is considered essential for success.

Communications

Two-way communications are a mark of the community model. Officially at Benet Center, communications are primarily from the top down, with the director holding firm control over all aspects of Center functioning. However, the researcher observed that in actuality there were open communications, though at the time of the research much of the communication was strained and uncomfortable. Parents of children at the Center voice their desires and feelings to the director and feed back information from the public to her.
Teachers feed back information to the director about other teachers and about their opinions of what needs to be done. Adult students interact with teachers and the director about what is and is not working for them and have a voice in their own educational and personal experience at the Center.

While the volume and directionality of communications is adequate for community, two elements lacking are clarity and an established forum or process for communication. Teachers and students often commented to the researcher that they would like to tell the director, a supervisor, or a teacher something but were not certain that it was permissible or helpful. A few stated that they feared negative consequences for themselves if they voiced their true opinions. Currently, there were no regular meetings of the entire student body or the entire staff to share feelings, ideas, and needs. During the conflict a year ago, the regular faculty meetings had been discontinued. The director stated that she was planning to reinstitute those meetings after the holidays but expected opposition from the teachers. She also stated that she would be more than glad if a group of teachers would band together to have morning devotions or would take some other form of action to develop a more positive attitude in the school. The director implied that she desires open, positive communications with the staff and students and among the staff, but that she resisted attempts of the staff to dictate to her how to run the Center.

Decision-making Process

In the community model, decision-making is by delegated authority, by shared decision-making, and/or group consensus,
depending on the importance of the decision, the amount of emotional involvement of persons with the decision, and the state of internal organization of the group. Studies of therapeutic communities have indicated that during periods of high turnover of staff or patients and during times of internal disorganization, the decision-making reverts to the administrator (Jones, 1976). The latter condition is predominant at Benet Learning Center.

Officially, significant decisions are made by the director, unilaterally or in conjunction with the Board of Directors, with occasional unilateral decisions by the supervisors.

The director does delegate responsibility in certain matters. For example, a supervisor had volunteered and been given total responsibility for the Christmas presentation. Since this event could have a significant effect on public relations, this may be regarded as delegating major authority. In problems with the Center building and landlord that arose during the observation period, the director delegated responsibility to a board member and expressed confidence to the researcher that the problems would be solved. Later in the week, she commented that the needed work was being done and that she appreciated having a competent, effective board to make decisions and to solve problems.

Coexistent with the formal system for decision making, the researcher observed an informal system of consensus in which persons involved made on-the-spot decisions independently and with the assumption that they had a right to make those decisions. For example, as was mentioned previously, on the researcher's first day at the Center, the staff assumed she was a new teacher, and the
teacher and volunteers present collectively discussed what cubical and what assignments to give her. No mention was made of consulting the director or the supervisor of the other department. The teacher and volunteers also decided how to provide for students whose tutors were absent because of inclement weather.

A similar process of decision-making occurred when the teacher in charge of the Christmas program had a medical appointment during the afternoon classes and practice time. At the lunch table in the teachers' lounge several staff, the secretary, an adult student, and the teacher discussed whether she should leave work to go to the appointment or whether she must cancel it, since another teacher was already absent. Collectively, they devised a plan to cover the classes and practice time, and decided that the teacher should keep her appointment.

On occasions, students made decisions about their own schedules and the staff seemed to accept those decisions. For example, when a sixteen-year old boy did not have a teacher for a class period, he found the researcher and informed her, in the presence of staff, that he wanted her to be his teacher that hour and that he would show her what to do. The other staff seemed to accept this behavior as normal. When a fourteen-year old girl did not have a teacher, she asked one of the adult students to help her.

Interesting to the researcher was the fact that the staff and students who seemed more active in informal decision-making were less critical of the director than teachers who went to the director for all decisions. Those persons observed frequently approaching the director for decisions were the ones who most frequently told the
researcher that the director wanted to hold all the power and that she disapproved of their taking any initiative. Was the actual issue, perhaps, the comfort of individuals in decision-making by consensus and/or their past judgment concerning which specific issues should be dealt with by the informal processes?

Support

Support among students and staff is essentially a one-to-one phenomenon. The director expresses her support for teachers through conversations with individuals, through helping them with practical problems, and through a positive attitude toward those having the most emotional difficulties. The director has often taken teachers to the doctor, taken them home in inclement weather, let them know she was praying for them during a crisis, and has even allowed one teacher to live in the Center building until he could find an apartment. Interviews indicated that the teachers who have experienced the most emotional distress are the most grateful to be working at the Center, are the most committed, and the most supportive of the director.

Individual teachers express their support for the director through direct conversation and through mementos such as cards, flowers, and notes.

Teachers express their support for students through positive statements to them. Students express support for teachers in ways common for their ages, from drawing pictures to physical contact to verbal statements.

Parents express support for the director, the teachers, and the Center as a whole through raising funds, improving the public
visibility, providing testimonials, writing letters to governmental
and industrial officials for funds, and other similar measures. A
few parents have developed close, emotionally supportive relation­
ships with the director and keep in regular personal contact with
her.

Unfortunately, in the severe monetary crisis the previous
year, the element of support diminished within the Center as a whole.
Cliques formed among the teachers and volunteers. Many staff
exhibited negative attitudes, and, at a time when the director needed
support, they added to her stress. The strained expression on Sr.
Miriam's face when she talked about the present lack of support among
the staff as a whole indicated something of the distress she experi­
enced as the actual fell short of the ideal.

Psychological Sense of Community

Though Sr. Miriam has often spoken of the Center as a com­
munity, as a place to belong, and though many of the former students
have spoken of the Center as a second home, the current psychological
sense of community is at a low level. When asked about their school,
the students replied in terms of individual teachers or Sr. Miriam,
not in terms interpreted as referring to the school as a whole or to
school spirit. While some teachers were grateful for having a job at
the Center, none spoke of being proud to be a part of the program.
When asked what efforts the teachers had attempted to build up the
program, one supervisor replied that they had formed a grievance com­
mittee to make recommendations to the director. The teacher's
conversation was consistently about fixing the ills of the program,
not about improving the quality of the Center to which she was
emotionally committed. The other teachers who had over a year of experience gave similar responses.

One major impediment to the psychological sense of community seems to be the crucial question, "What is Benet Learning Center?" Sr. Miriam has frequently spoken of Benet as a mission, a community, a place of heart-felt commitment, a place of love and caring, a place to belong. She has talked about students and teachers who were there several years ago and have frequently returned to visit and to share their lives. The researcher noted several former teachers or students dropping by to see Sr. Miriam. The pride in their voices when they spoke of the Center was apparent.

On the other hand, many current teachers seem to regard the Center as a job—a place to work and collect a paycheck. They focused on monetary problems, and on lack of organization and record keeping that are standard for educational institutions, and on feelings of floundering alone on the job. They did not express any concept of community, working together to solve their problems, giving of themselves for others, or support for each other. A few staff members expressed awareness of Sr. Miriam’s deep concern for them.

A resolution of these differences in expectations and mental pictures of what Benet Center is and should be—a community of sharing and caring, or a standard educational place of employment—would facilitate the development of a stronger sense of community.

My Contacts

During my master's studies, Sr. Miriam was a professor instrumental in stimulating my thinking about alternative programs for mental health development. In our contacts at that time, I
caught something of her concept of community and of education as intimately related to personality and to psychological well-being.

Though our contacts since my graduation in 1972 have been sporadic, I have followed the work of Benet Learning Center. When I began my background inquiry for this present research project, I asked Sr. Miriam for assistance with the concept of community, since the Catholic orders have a long history of experience with community and since in recent years the sisterhood has worked in depth with the dynamics of interpersonal relationships in close living situations. As we discussed the research project, the conversation consistently returned to Benet Center for examples. I heard in Sr. Miriam’s vision for the Center the basic concepts of a healing community, though those concepts were phrased in religious or educational language rather than psychotherapeutic terminology.

During a discussion with Sr. Miriam and the chairman of the board concerning my research proposal, the idea of observing at Benet Center emerged. Though educational in purpose, Benet Center did result in personality change for both staff and students, and the discussion indicated that the program met the five criteria set for this study, even if in different manner from programs that were intended to be community or mental health programs.

I spent four school days at Benet Learning Center, as participant and observer. The first day I taught students, accepting the staff’s assumption that I was a new teacher. However, it was obvious that if I continued as a full participant, the staff would expect me to be with students consistently and would also be hesitant to answer certain research questions. Having already demonstrated to the staff
my willingness to be one of them, I now needed more freedom. On the second day, I worked with students in the first part of the morning and then let it be known that I was doing research concerning Benet Center. When I communicated that identity would be protected in my write-up and that I would not disclose to the director my negative material in any way that would bring unpleasant consequences to the staff member or student, both staff and older students were more than willing to talk with me. Frequently, it was possible to interview teachers for fifteen to thirty minutes individually. Most of them were open in their expression of both positive and negative feelings. Questioning of the students occurred as a natural part of working with them as a new teacher. Former students willingly talked about their experiences at the center and their continuing contacts with the program.

The major difficulties for research were the short period of time that I was at the center and my own loyalty to Sr. Miriam. In interviewing teachers and students, I had to be alert to my tendency to defend the director and to remind myself that, by being neutral, I could accomplish more in terms of research and in terms of whatever I could do to help the Center. A third difficulty for me personally arose in analyzing and interpreting my observations because of the discrepancies in the ideal and the actual—the psychoeducational ideals I had learned as a student of Sr. Miriam's and the ideals she had shared with me for Benet Center as opposed to the actual, present functioning as I perceived it. Being critical, fair, honest, and tactful simultaneously was not easy.
NOTE: Following the writing of the majority of the material on Benet Learning Center, a month after the initial observation, I returned for a day of follow-up. After observing classes, counseling with an adult student at her request, and serving as a consultant to teachers concerning the emotional problems of students, I had a strong impression that Benet Center was moving forward from its past problems into a stronger position as a school and as a community. In a lengthy conference, Sr. Miriam confirmed that there is improvement in attitudes of teachers. Some of the less qualified persons and the discontent teachers have left since the research observation period. Two new licensed teachers had been hired. Weekly teacher meetings were scheduled to begin. Sr. Miriam seemed confident that problems at Benet were being resolved.

Persons Interviewed

Group A: Administration

1. M.S., director and founder of Benet Learning Center, a Benedictine nun, holds an Ed.D. with licensure in Guidance and Counseling, Reading, and Psychometry and has taught on the graduate level in various colleges, as well as holding workshops.

Group B: Staff with more than a year of experience at the Center and with personal commitment to the work.

2. V.S., supervisor in the elementary department, a retired public school teacher, holds a master's degree in elementary education with endorsements in Remedial Reading and Mental Retardation and has worked at the Center since 1980.
3. G.A., secondary level supervisor, has a master's degree in secondary education and experience in the regular classroom and three years experience at the Center.

4. N.A., teacher in the secondary department, holds a master's degree with an endorsement in Mental Retardation and Learning Disabilities and has worked at the Center since 1974.

5. J.A., a primary level teacher, has certification as a mental health technician and has been at the Center for three years.


GROUP C: Teachers who are new to the program this year or who have less commitment.

7. K.C. holds a master's degree in art education and teaches part time.

8. T.C. has a background in accounting and is teaching until she finds another job.

9. M.A. has a B.A. in psychology and has been at the Center three months and plans to work for one more year while her husband finishes college.

10. B.C., former worker in a psychiatric setting and now physically disabled, teaches older students and counsels the adolescents, and has been at the Center since February, 1985.

11. G.C., a volunteer placed through the city Foster Grandparent's Program, has worked in the primary department for three months.

12. G.A., a foster grandparent volunteer, has worked with the retarded previously and has been at the Center nine months.
13. G.P., a foster grandma for nine months, teaches in the primary department.

GROUP D: Students and former students

14. K.D., an adult student placed by Vocational Rehabilitation, has a high IQ and excellent verbal skills but a specific learning disability and an orthopedic handicap.

15. J.D., an adult woman, studies basic reading and math.

16. R.D., a sixteen-year old expelled from public school for disruptive behavior including hitting a teacher and principal, is doing well at the Center in behavior but is academically on a second-grade level.

17. K.D., a fourteen-year old unable to function in a regular classroom, works hard on seventh-grade material at the Center as long as she is frequently reassured.

18. T.D., eight years old, rejected by school for hyperkinesity, thrives on the one-to-one relationships and is doing well in first grade.

19. D.D., seven years old, rejected by schools because of serious emotional disturbance, is still acting out at the Center but is improving and is doing kindergarten work.

20. A.D., a four-year old diagnosed as autistic, unable to walk or communicate upon arrival at the Center a year ago, now walks and plays with a large ball, communicates nonverbally, enjoys people, and is learning speech and motor skills.

21. J.T., a former student who now helps in the business office is enrolled in a college business course.
22. D.B., a former student, returned to ask Sr. Miriam for help when she enters college this summer. She has a severe learning disability which she compensates for through her verbal intelligence.

Research Questions and Answers

**Question 1:** What originally brought you to Benet Center?

**Professional**

**Group A.** The director stated that she originally saw the need for one-to-one education when directing a reading center as part of her college teaching. Though most children could learn in small groups, one hyperactive boy who had been unable to work in the group blossomed in a one-to-one relationship. Later she encountered an adolescent who asked if he could come to her for tutoring full-time because he had been expelled from school and wanted to finish his high school education. When she and the sisters working with her began Benet Learning Center, it was primarily a tutorial program for children in school. The staff worked extensively with bibliotherapy to reach the children emotionally. Though the after-school program is still active, the director's primary focus is on young people and adults who have no other educational opportunities and require extensive one-to-one contact to learn academically and personally.

**Group B.** Teachers perceived the Center as a place to use their professional skills in a unique setting. For example, one teacher said, "I came to give Sr. Miriam some old teaching materials I had stored in my attic. I had recently retired from public schools. She met me with several students and I have been here ever
since." Another said, "This is a unique place to teach. I had taught in the classroom. When Sr. Miriam offered me this job, I wanted the experience....I am investing in my future."

**Group C.** These teachers usually came to the Center because they needed employment and income. One stated that he needed a place to use his skills and try out his ideas. The volunteers stated that they became involved with the Center because they wanted to help others or to work with children, and because they were placed there by the volunteer coordinating agency.

**Group D.** Students all said they had come to the Center because they needed an education. The children had been brought here by their parents for that reason. One adult said, "I came here to learn to read enough to get a driver's learner's permit and I got it....Sr. Miriam don't know it yet but I'm going to ask her for them GED books so's I get to study more and get my diploma."

**Interpersonal**

**Group A.** No response.

**Groups B and C.** Two teachers said they came to the Center as a result of being brought by a friend who already worked there and then becoming fascinated with the children and the general approach of the Center. One teacher originally came because of a close relationship with Sr. Miriam; she indicated that while she needs money, the relationship with Sr. Miriam and the children was and is the primary attraction.
Group D. One adult student said that her Vocational Rehabilitation counselor suggested she visit the Center, but she was hesitant to go back to school. "I thought it would be degrading to go back to school as an adult. But Sr. Miriam called me and practically pleaded with me to come for just one day, just to try it. The Voc Rehab report from a psychologist said I couldn't learn math; it was hopeless. Sr. Miriam didn't agree. She said nobody is hopeless. She said I could learn. So finally I came just to visit. I'm here because Sr. Miriam and teachers cared."

Physical, religious, intrapersonal

Groups A, B, C and D. No response.

Question 2: What effect has being at the Center had on you?

Intrapersonal

Group A. The director stated that the work was satisfying. When she used to leave other sisters in charge of the Center during the summer while she was a guest professor at a university, she missed the children. But now that she is removed from college teaching entirely, she misses the college community. Interspersed in her conversation, the director referred to former students who are now successful in school or in adult life; she obviously derived a great deal of pleasure from being a part of their success.

Groups B and C. No response.

Group D. Students and former students answered with a mixture of intrapersonal and interpersonal responses. One adult said, "I've learned I can do almost anything, if you can find the
right way to teach me....It's been harder for me to accept the
learning disability than the physical disability....I'm learning to
accept that now without feeling embarrassed." Another adult who had
thought she was "dumb" because of previous school failure said she
had learned "If you make up your mind and pray enough, there ain't
anything you can't do. I ought to know." Her son, an adolescent
student who was failing in regular special education classes said,
"Boy, I'm getting As and Bs here already," and showed by his actions
that he was enthusiastic about learning. He also talked about being
violent in the regular classroom but stated he would never act that
way at Benet Center because teachers cared.

A former student stated that he had been close to failing
ninth grade. When his parents brought him to Benet Center for his
sophomore and junior years, "it brought me up in a lot of skills I
didn't pick up earlier. I don't know why. I had good teachers and
my folks say they had tried to help me a lot....When I went back to
high school for my senior year, I could do the work and I kept up my
grades. I was on a winning football team....I couldn't have done
that without Sr. Miriam." One young woman who had been a student
intermittently for several years gave a glowing testimony that she
"had been a mess, emotionally, physically, in every way....Sometimes
I just say 'Look at me now'." Obviously, she is quite pleased with
whom she has become.

The younger children were not capable of answering this
question directly. However, in conversations, they made comments
that indicated improvement in self-concept, self-confidence,
independence, security, and the ability to trust.
Interpersonal

**Group A.** No response.

**Group B.** A teacher said, "You mean what are the rewards of working here? First, knowing that I helped a particular student grasp and comprehend a certain thing and they have been able to do it on their own later. Second, the satisfaction of a job well done. Then [young student] has shown me more love than any person I've known. We've grown emotionally attached. Also, there's organization. I can be organized and work the way that is comfortable for me. I don't have to organize everyone else or worry about them. I can just do my own work." Another teacher immediately changed the subject from the effect on her to the success stories of students she has had; yet she seemed to be saying that the student's success makes her feel successful and competent, feelings she does not experience in many situations because of her deep-seated personal problems. Another teacher seemed totally perplexed by the question. When the researcher then asked, "You don't need to work. Why do you stay?", the teacher answered, "There have been bad times but I have certain kids that are attached to me. And then I'm always thinking of my Grandmas. They need me."

**Group C.** One teacher commented that he did not know what effect the Center had on him, but it must be something good because every time he quit, he came back. "I love the kids. I love Sr. Miriam, and I love the function of this place...." A volunteer stated that she felt needed and wanted and that helping the children was very satisfying.
Group D. Students and former students frequently mentioned the importance of interpersonal relationships. One boy said that he could get along with the teachers here but not in regular schools. An adult said she had learned to understand other people better and so could put up with things that once really bothered her. Another adult who has now been tutoring the younger children said she was developing patience from trying to help them.

Professional

Groups A and B. No response.

Group C. Though obviously the staff members with no teaching experience have improved their teaching skills, it seemed an area of less concern than others.

Group D. Students talked about the academic skills they had acquired, from basic reading to college level composition.

Religious

Group A. Sr. Miriam clarified that Benet Center is a non-sectarian program; however, she fully believes that she is doing God's will and work in the lives of the students and teachers.

Group B. A teacher commented that being at Benet Center and working with Sr. Miriam had increased her faith.

Groups C and D. No response.
Question 3: What brought about these changes?

Interpersonal

Group A. The director spoke frequently of interpersonal relationships being the satisfying factor in the work. She smiled brightly as she said, "I have a wonderful board. They are all people who understand what I'm doing. Top notch people. They do everything for me--legal, public relations." The director indicated that she values being able to give of herself to the teachers who are having psychological or personal difficulties. Her greatest joy is the students and their families--the reason for the existence of the Center.

Group B. Many teachers spoke of interpersonal relationships as the key to change for the students. These are typical responses. "The key to results is promoting a positive attitude toward learning, and that comes in a good match of student and teacher personalities. Each student has one favorite teacher that is their emotional support." "To teach here you need to know that somewhere in that person they have a wonderful personality....At the Center, students either go into themselves or they find who can help them restructure their personality, bring out that person inside." "The students in the secondary program are society's throw aways. Here they find a place where they can fit in--or they become delinquents permanently." "For ______ it's a place to be. The place gives him a feeling of responsibility of belonging. He is a janitor. He can work. He is accepted."
Group C. Group C teachers were less definite about what is effective in bringing about change. One teacher talked about interpersonal relationships. "What works? The one-to-one relationships with the students. Also, I'm a role model. The kids see me handle situations and that helps them learn." However, two other teachers made negative comments. "Nothing works. We are supposed to be relating to the children, to help them have a positive self-concept, but I don't see that happening." "The kids are just shuttled around. I get along with them, but I'm not close to any of them."

Group D. Students emphasized interpersonal relationships as the factor that is different at the Center from regular school. An adolescent said, "The teachers are different. They care about you. They listen to you. They give you work that you can do." Another said, "My teachers are nice, most of them. They listen to me and tell me things." Two younger students commented, "Sr. Miriam is nice to me. She doesn't get mad." "What's good? The teachers. They like me and help me." An adult said, "The teachers are in there working with you. They don't just hand you the work and walk away." Another adult commented, "You get out and meet different people. You are you. You don't have to try to be you. The teachers here don't laugh at you or tell you that you are dumb. No one laughs at you. Everyone tells you 'You can do it.'" "I like having teachers my own age. It makes me feel more relaxed. I don't want some old person who can't understand me."

A former student who is now in college said, "The one-to-one makes the student feel like someone really cares....The teachers saw
your strengths to bring up your weaknesses." An enthusiastic graduate said, "What generates this place is love. All the tutors do the work with you. They share in your learning....When I came here, I didn't like authority figures, especially teachers. It's hard to know that something isn't right in your head, and you take it out on someone else. But here, once they get you in the room, they work with you and they make it enjoyable. So I learned to accept authority." "It's discipline with compassion."

Professional

Group A. Related to professional skills, the director said, "I've had some good teachers, but then they apply for other jobs, and I give them a good recommendation and then I lose them." The director values professional expertise.

Group B. Three teachers referred to matters related to professional teaching skills. "Being organized is important. The desk is a great help. I have to be organized in terms of having materials ready for the student, to find them quickly and easily....Breaks help. Students need a rest, particularly the hyperactive ones. They ought to schedule breaks for the teachers." "To help the child develop self-worth is important. You have to start where they are and progress from there." "You can't demand that they do a certain level of work because of their age....We work until we get a few problems or a few sentences correct. "It's better to get a little done correctly than to do more and do it wrong. Then we take the last five to ten minutes of class to do something fun that they can succeed in."
Group C. "What works? Consistency, when the teacher does the same thing every day so children know what to expect. But sometimes teachers aren't consistent, like they are late or aren't prepared and then the students get lazy and don't put out effort."

Group D. No response.

Religious

Groups A, B and C. No response.

Group D. One former student mentioned a religious factor in her personal change. "I knew Sr. Miriam was praying for me, especially when I felt the worst. Her prayers helped me keep trying."

Physical, intrapersonal

Groups A, B, C and D.

NOTE: Interesting to the researcher was that, though there are abundant teaching materials and audiovisual equipment, neither teachers nor students mentioned materials as being effective in bringing about change.

Question 4: What are the stresses here?

NOTE: Children were asked, "What's hard here?"

Interpersonal

Group A. The director was open about stress in interpersonal relationships. An immediately pressing matter was terminating a secretary who had been at the Center for several years but was increasingly unable to perform her job. The director found talking
to her about dismissal quite stressful. She also disliked dismissing volunteers, even when she realized they were unfit for the work. The bickering and cliques that had developed among the teachers was highly stressful for the director, particularly when it resulted in teachers not attending to their students properly.

**Group B.** A teacher mentioned an interpersonal factor.

"If you are the type of person who has to have everything in its place, you can't work here. You must roll with the punch. Adjust to whatever is needed for you." Another teacher said, "There has been a lot of complaining where there shouldn't have been. Teachers need to work as a unit to educate the students that walk through these doors. One teacher tried to look at the problems from the director's point of view. "Sr. Miriam cares for her staff. She tries to be an administrator, to take care of the building, to help the staff and the students. She takes it all on her shoulders, and it is too much."

**Group C.** No response.

**Group D.** The students looked at interpersonal stress from an interesting perspective. "What's hard? They won't let you quit." "One of Sr. Miriam's favorite sayings is 'There is no such word as I can't.'" "If you aren't good, then the teachers feel sad." An adult student who has recently begun tutoring the children said, "It's weird to be both a student and a teacher." She regarded tutoring others as her way of paying back what has been done for her, as good but stressful because it is unfamiliar.
Professional

Group A. The director's problem of having too much responsibility for too many areas of Center operation could be regarded as professional stress, though she did not express that explicitly.

Group B. Most teachers were explicit that professional matters of organization and lack of procedural standards usual in educational institutions were stressful. These remarks are representative. "It's hard to work here. I was a reading specialist and I know how a reading lab should be run and this is nothing like it. It is poorly organized. Sr. Miriam knows how to administer it but it's too much for one person. She needs help." "Public schools do not send students here because of the kind of teachers and how the program is organized. We do not keep records that show what we have done or prove that the program is effective. If we could bring this school up to standards, then it would qualify for certain monies. Then Sister could have a business manager and an executive secretary." "The Center needs more organization. If it is to have a positive effect on the Fort Wayne community, it also needs more contacts and visibility." "Communications need to be improved.... There is a problem with turnover of teachers. You must be committed and some aren't."

Group C. The newer staff members also emphasized the organizational problems. "Last year a lot of things happened that shouldn't have. Teachers were even complaining to students about not being paid. When they were paid, there was still lack of performance. They were not at all professional in the way they behaved."
"This place is not organized. It was like chaos at the Thanksgiving Dinner. The kids didn't know where they were supposed to be or when." "When I came here, I was a mass of confusion. No one told me what was going on. No one told me what materials there were or what to use. I have never taught before. I didn't know anything about the students I had. I had to just dig around and find what they were supposed to do." "We need a 'how to' manual to tell new teachers what they should do. There needs to be an orientation period. And when a new student comes in, there should be a conference so that the teachers know about him, at least what level he is on....We need an announcement system, so that we all know when there are changes in schedule. Like I didn't know my student was suppose to be practicing for the program and I was hunting all over for him." "We have one problem, organization."

Group D. No response.

Physical

Group A. The director described a monetary crunch that had occurred the previous year and the constant struggle to just keep ahead financially. She frequently reiterated that she wished she could pay her teachers more; they deserved it, and they needed more to live on. The director also talked about the long standing difficulties with the building and the landlord, and was obviously frustrated with the situation.
Group B. Teachers mentioned money only as part of the organizational and interpersonal problems. They did not mention the physical plant.

Group C. Several teachers mentioned the financial problems. One teacher said she really enjoyed the children and would like to stay with the job but had to support herself and could not on minimum wage. Two Group C teachers brought up the physical plant. "We have some problems we can't do anything about right now. We need different physical facilities, separate rooms with walls all the way to the ceiling. Now when two students who know each other pretty well are close, they talk over the wall and don't do their work.

Group D. One adult student stated that being in the same area with children was distracting for her and that she hoped when the new section of the building was ready, she would be studying away from the distractions.

Religious, intrapersonal

Groups A, B, C and D. No response.

Summary of Questions and Answers

What originally brought people to the Center? For the director, it was the vision of young people needing a special kind of help with educational and personal change. The staff was attracted to the Center because of a need for employment, either for money or personal/professional fulfillment. A few were attracted from loyalty to the director or by a contact with a friend. Volunteers were attracted by the opportunity to serve and to work with children.
What effect had the Center had on individuals? The director and several teachers spoke of intrapersonal satisfaction and of interpersonal relationships, particularly with students. Students talked about personal and educational change as a result of the type of interpersonal relationships at the Center. They particularly referred to acquiring a feeling of competency, determination, and the ability to succeed. The ability to understand and relate to other people, particularly authority figures, was mentioned as a change in interpersonal relationships by some students. The acquisition of academic skills was important to the students, particularly the adolescents and adults. Though the Center was founded by nuns, religious growth was relatively unimportant.

What brought about the personal changes? What worked? The staff related change to the students. The one-to-one relationships with a good match between student and teacher personalities, a positive caring attitude toward students, the ability to adapt and deal with students' immediate emotional concerns were seen as important. Students emphasized the importance of the relationships with their teachers, its difference from regular school, and the love and concern from the teachers as the major change agents for them. Teachers also perceived professional matters such as consistency, preparedness, information, and overall Center organization are important to bringing about student change, as well as personal satisfaction.

What are the stresses at the Center? For the director, it is negative interpersonal relationships, particularly when she must take a disciplinary position toward a staff member. The dissension among
teachers is another major interpersonal stress for her. Teachers emphasized strongly the problems in organization, educational standards, and finances, and the undue responsibility placed on the director.

The researcher would add some observations of her own. It appears that Sr. Miriam began the work from a sense of God's calling her to meet a special need of special young people, as mission, while the staff came to the Center for all the usual reasons for seeking employment. Students came for an academic education. These differences in initial motivation for involvement with the Center created an immediate divergence that continues to be a source of tension at the Center. There was unity among the director, staff, and students that what was effective was the one-to-one relationships when carried out in a relatively responsible, caring manner. The major stress that is being termed "lack of organization" could as well be called a lack of a unified model. Some people are unconsciously trying to live out community, with its emphasis on casualness, informality, free discussion, individual self-direction, and emotional dimensions of relationships. Other people are pulling toward an institutional model of records, measurable results, accurateness, financial stability, and general accountability. Other persons are floundering, pulling and pushing according to their individual tastes and mood of the moment. While there is definite leadership, there is no clear, unified concept of what the Center is or how it is to function. In the researcher's opinion, this Center has been an excellent place for study for it illustrates what can occur when a new and effective concept is put into practice without
adequate theoretical underpinnings in terms of operational model. It is also an illustration of the gap that often exists between the real and the ideal, particularly when the person who carries the vision is placed in impossible stress situations. With time and adequate support for the director, the problems of this Center are solvable so that it can become a community for change and growth for staff as well as students and an important model for other programs integrating academic and psychological education.

Contributions of this Observation to the Model of Counseling Center as Community

1. An educational program can be a healing community for teachers as well as students. A counseling center oriented to children may include a school as part of its community.

2. School success or failure is a major factor in the psychological development of children and adolescents. A child with a severe learning disability or deep emotional disturbance who cannot profit from the regular school program available to him, a child who is failing thirty hours a week at his major task, will benefit little from one hour a week with a therapist. The greatest good the therapist may be able to accomplish is to find a situation in which the child can have a positive, supportive, success-oriented environment.

3. Adults, such as some teachers at Benet Center, may have professional expertise but be unable to use that expertise in the usual marketplace because of physical or emotional handicaps. It is noble to advocate that regular school should employ teachers who are epileptic, diabetic, or hearing impaired or teachers who have stamina for only a half day of work. But noble sayings do not help teachers
or other professionals who simply will not be employed by the system. Though therapy may ease the pain for these people, only employment—
the mark of a responsible adult in our society—will provide a real answer.

After becoming well established, the Counseling Centers As Community may have many possibilities for utilizing and directing the talents of handicapped professionals. A school or tutoring program in the counseling center is one possibility.

4. One-to-one teacher-to-student relationships are effective in helping children develop healthy self-concepts, work habits, and social-emotional adjustment. Each child needs at least one adult figure in his life in whom he can confide. A good match between personalities is necessary for the relationship to be effective therapeutically.

In a Counseling Center As Community, the director should be responsible, in conjunction with the therapist, for matches between teacher and student, or helper and client.

5. When too wide a gap occurs between the vision of the leader of a program and the outlook of other persons involved, instability and discontent occur. Convincingly articulating and promoting the purpose and approach of a counseling center that is community is an important and difficult task for the director.

6. Financial instability can impair a program and reduce willingness to form strong group identification among persons employed in a community. Financial problems can occupy a director's time and attention to the extent that he is less effective in relating to staff members. Disorganization and lack of clarity of
communication, as perceived by staff, can result in negative attitudes among staff and other persons in the community.

7. Community is enhanced by a clear system of communications and decision-making in which each person shares. Regular meetings of each part of the community, if not the community as a whole, are essential for effective living-learning relationships.

Summary of Research Findings

Five healing communities were observed for the purpose of identifying the therapeutic principles active in such settings. The observations included a variety of programs, mental health programs, ages of program participants, and geographic settings.

Innisfree, a communal farm, represented the problems of adult retarded, brain-injured and chronically mentally ill and adjustment problems of young single adults.

The church exemplified community in a Christian context that emphasizes long-term commitment. It provided information from single and married adults in their twenties and thirties, including persons with normal maturational needs and those with definite pathology.

The juvenile center provided information about community that is an employment setting for the adults and a correctional program for the teens.

The self-help group was intended to tap into the dynamics of a major movement in mental health today. The group included persons ages 25 to 65, with neuroses, psychoses, character disorders, and adult adjustment problems.

Benet Learning Center, an educational setting, is a community that has resulted directly from the love of one teacher and
counselor, as that love has spread to her students and employees. At Benet, ages range from preschool to senior citizens. Problems include learning disabilities, physical handicaps, neuroses, psychoses, and childhood and adult adjustment disorders.

Though professional expertise is considered important in the two employment settings, the major healing and growth-producing dynamic in all the programs is warm, accepting interpersonal relationships, including a secure feeling of belonging to an important group and the experience of giving of oneself to others.
CHAPTER V

THE MODEL FOR A COUNSELING CENTER
AS A COMMUNITY

Introduction

In complex, mobile, rapidly changing society in which millions suffer from rootlessness, lack of psychological community or sense of belonging, a society composed of subcultures within subcultures—in such a society, delivery of mental health care poses vast challenges. To expect one system, approach, or method to fit all citizens is absurd. The longhouse tribal meetings effective for the Iroquis Indians are hardly appropriate for the modern, middle class suburbanite. No more appropriate is the office system and public mental health policy for many an Indiana farmer, a counter-culture adolescent, or a lonely single woman in an unfriendly town. A multicultural society demands multiple models for providing counseling, therapy, and continuing opportunities for psycho-social growth.

One alternative approach for mental health care and development that has emerged since 1950 is community. This approach when used in psychiatric settings is called therapeutic community. When used in settings for adolescents and delinquents, the term is Positive Peer Culture. Communitization is the term used for establishing secular villages or small units where the mentally handicapped live as citizens. A layman’s form of this approach is
self-help and support groups. Christians—from mentally retarded to the self-actualizers—are choosing to live in egalitarian, interdependent relationships in close geographic proximity, sharing the most significant aspects of their lives. They call themselves a church or simply community.

The movement toward mutually dependent, minimally hierarchical, open, non-labeling interactions suggests a possible alternative to the present office therapy system that may benefit not only clients but also therapists. The counseling center may be organized as a healing community.

In this chapter, the Counseling Center As Community will be described in categories similar to those used in analyzing each community. The section of Program corresponds to Activities in the Research chapter. The subsection Support Group is related to the Support sections of the observations. Roles, Decision-making, Communication, and Psychological Sense of Community are like those in the Research chapter. The discussion of community meeting is related to Jones' writings. The Model concludes with a section on reaching the people when starting a CCAC and a section on Christian perspective.

Characteristics of a Counseling Center as a Community

The counseling center that is a community has characteristics similar to other healing communities in this study, in terms of quality of interpersonal relationships, appropriateness of physical environment, expectations concerning professional therapists, and religious orientation.
Interpersonal Relationships

Relationships are the primary emphasis of the counseling center that is a community (CCAC). Interpersonal relationships of many varieties were cited by present community participants as the primary therapeutic and growth-producing agents. Certainly the professional therapist-to-client relationship will continue to be important but will differ from traditional office practice in that its context provides for more than once-a-week contact. As shown at Innisfree and the church, casual role-free contact between client and therapist is helpful in reducing the client's self-imposed stigma, in raising self-esteem, in reducing the pain left over from self-exposure during the therapy hour, and in improving the client's certainty that he is accepted and acceptable. For clients in early stages of therapy or those working through dependence issues, it is important to know that the therapist or another trusted person is available when needed, not just by appointment as in the business world. For the client to know that there is a realistic possibility of continuing contact with the therapist after termination of formal therapy reduces the temptation to remain "sick" just to keep a valued relationship. (The new relationship would then be task or growth oriented.)

The Counseling Center As Community can realistically provide casual and continuing contact by involving clients or former clients in the operation of the center. Such involvement shifts the client from being "sick" or "needy" to being a valued member of the community, an active person supporting the program, helping to meet his own needs. The therapist becomes a community leader, a role
allowing him to keep the slight measure of distance, authority, and mystery necessary to be therapeutically effective without being isolated from the persons for whom he pours out his life energies.

A Counseling Center As Community encourages interaction among persons who have come for help. Client interactions can be channeled to create constructive experiences, as described by persons interviewed in this study. An obvious asset of having positive interactions among clients is the reduction of the feeling of being different or alienated for simply seeking counseling. Similarly, even superficial discussion among clients can reduce the feeling that the client is the only one with that problem. For example, it is comforting to learn that other mothers have children who get "sick" every school morning but never on weekends.

As persons move from traditional passive patient roles to active involvement, they experience mutuality, giving help as well as receiving it. They have opportunities to experience their strengths, to use their abilities, to be appreciated and emotionally rewarded, an experience which directly counterbalances learned helplessness and self-preoccupation so often accentuated by professional therapy. With the leader's guidance, the community can be a safe place to try out new behaviors and to learn new interpersonal skills.

Community members working together help each other meet instrumental needs which are inhibiting psycho-social growth or reducing the effectiveness of therapy. More experienced members serve as role models for new clients. For example, a mother who is successfully replacing her former habit of screaming and hitting her
children with more effective discipline may model these skills to a young mother with similar problems, to their mutual advantage.

Community members provide emotional and social support for each other and can be available more readily than the therapist. With minimal training, more experienced community members may become effective, empathic listeners. They also share information and give guidance that is important in a crisis. For example, if a member is sexually assaulted, another member who has been through the experience may be emotionally supportive, guide the victim through dealing with the medical and legal system, and help her in relating to her family.

What relationships are there for the therapist in community? The CCAC provides emotional support for the therapists and the leader. In a small center with only one therapist and an assistant, the community may form a supportive core group made up of caring people, some of whom may be former clients or family of former clients. This core group allows the leader to be human, to air his concerns, worries, discouragement, or elation about the center or non-intimate aspects of his personal life. Core groups may also be the leader's eyes and ears, feeding back information that is relevant from the center or general society, preventing problems and enhancing the program's effectiveness. In a larger center, staff form their own support network. Experienced community members may be supportive of the counselor in practical ways, from sending a thoughtful card to sharing their time or expertise in maintaining the center itself. In a Counseling Center As Community, the therapist is no longer in the
position of always giving until he is worn out; regularly he receives emotionally, socially, and spiritually.

Thus, a counseling center that is a community can offer a variety of interpersonal relationships, not only professional therapy, but also a support system and a continuing opportunity for service and growth.

Physical Environment

In terms of physical environment, a CCAC is highly adaptable. The purpose of a counseling center building is to provide a setting that is attractive, comfortable, and non-stigmatizing in the perception of the people coming for help. The building should offer both private areas for individual and group counseling and areas that encourage interpersonal interaction. If clients are from the lower working class in a small town and live in single-family wood-frame homes, the counseling center should be in a similar home. For ghetto dwellers or counterculture youth, a renovated section of an old apartment building or a remodeled warehouse, done in bright colors with modern decor, may be appropriate. It may be desirable to have the center building and grounds just slightly more aesthetically pleasing and comfortable than the clients' own residences to stimulate the feeling that coming to the center is a privilege. In location, the building should be geographically close and easily accessible to the people served. Some centers may have outdoor areas for walking, thinking, quiet conversation, or recreation.
Professional

Persons interested in a Counseling Center As Community are likely to be less interested in the therapist's academic and professional credentials than in his actual caring, dedication, skills, and personal charisma. The therapist is personally involved with clients, ex-clients, volunteers—with all levels of community members. He must be willing to be open, honest, nondefensive, and able to accept the correction or challenge by a community member as a growth experience. As Almond observed, the leaders of healing communities are "one of us but not quite."

Because of the healing community's norm of acceptance and growth and the emphasis on applied interpersonal skills, a large center with experienced leadership may provide an excellent training ground for beginning counselors.

Religious

The CCAC model is adaptable to several Christian settings. An individual congregation of sufficient size may develop its own internal counseling community as an extension of the church body life. In actuality, however, such congregational centers are unlikely for economic and other reasons. More feasible are interdenominational centers sponsored by a group of churches in a geographic locality. Interdenominationally-sponsored centers offer the opportunity for people from various Christian traditions to come together in community, working for a common purpose and, in so doing, to transcend differences that historically divide Christianity.

Another form of organization is the non-sponsored center founded by individual Christians who desire community in a mental
health context. As few as five individuals have formed a corporation and have begun such a program; one of them was a professional who donated her expertise until the program could become economically stable. The extent and nature of religious involvement of such a program is determined initially by the founders and continuously reshaped by the community itself. Selah Christian Center, Inc. is such a program (see Appendix A).

Secular groups, particularly those of idealistic humanistic philosophy, have established centers with concepts similar to this model, particularly in the youth counterculture (Holleb and Abrams, 1975). Secular group may be able to adapt this model of the Counseling Center As Community, particularly if humanism is itself viewed as a religion.

Summary of Characteristics

To summarize, the Counseling Center As Community offers a variety of healing and growth-enhancing relationships between counselor and client, and among all those who choose to be community members. The interpersonal relationships are the most important therapeutic distinctions of the CCAC. Professionally, the center provides high quality therapy, with the added feature of support and growth activities. The physical environment is designed to be comfortable to the community members. The center may be located within a congregation, may be interdenominational, may be independent of any denominational sponsorship, or may be totally secular.
Organization and Program

Academically speaking, the concept of Counseling Center As Community is reducible to professional therapy plus support system with an optional but recommended educational component.

Professional Therapy

The professional therapy program—individual, family, and/or group—is in the hands of therapists trained in standard techniques and procedures appropriate to the clients served, with at least one licensed psychologist on the staff. Persons contacting the center for assistance usually enter through this program. The nature of the professional staff and program will be further explained in a later section.

Support System

The support system is the major organizational difference between this model and the traditional model. The importance of the support system to mental health has been demonstrated in the Literature Review and Research sections. Though some clients may have an adequate social network and opportunity for service and some may choose to be only office clients, it is assumed that most persons who self-select to come to a center based on community will want or need an added support system. The center supplies what is missing in the individual’s social network, thereby reducing or changing the nature of stress, providing new social learning experiences, and meeting instrumental needs that interfere with healing or growth, thus enhancing the effectiveness of the professional therapy.
Whether the support system only enhances therapy or is itself growth-producing is the same issue debated in therapeutic community literature and will not be argued here. It is believed by the researcher that, for the client with clear pathology or longstanding psychological difficulties, the support system is a valuable adjunct, sometimes essential to the person's regular attendance at therapy. For the averagely adjusted client well into the process of resolving deeper difficulties, the participation in the support system is itself therapeutic and growth-producing.

The support system program will arbitrarily be titled in this study the Caring and Sharing Network. Each center will of course choose its own name.

The Caring and Sharing Network is made up of at least four parts: practical assistance, center-related activities, peer counseling, and support groups. Participants in any of these sub-programs may be new clients, experienced clients, ex-clients, volunteers who have not been clients, or staff. The Caring and Sharing Network is the focus of community life.

Practical assistance

The practical assistance program is probably the first interaction a new client will have in the community. As the therapist gets to know the client, he decides if the client is in need of help with instrumental tasks. For example, it may be clear that transportation and child care are essential for the client to be regular at counseling appointments. A distraught mother of preschoolers who is in temporary acute crisis may need relief from child-related responsibilities for a few hours a day to work on her own problems.
A young single who is depressed may not be able to make the effort to cook and eat properly; the inadequate diet then aggravates the depression.

To establish initial contact between a new client and the community, the counselor briefly explains the concept of the Caring and Sharing Network, that people at this center routinely help each other, and he offers the needed assistance. If the client seems open, even though surprised or hesitant, the counselor then matches the client with one or more helpers and asks the helpers to come into the center to meet the client. Using the center as a meeting place provides emotional security for both the client and the helper. The counselor is present to diplomatically facilitate a relationship between the two people. If the helper has incorporated the concept of community and acceptance, the relationship itself can be as important to the newcomer as the accomplishment of the task. In some geographic localities, public agencies can be used to meet client needs, though this sacrifices the development of positive relationships in the community and places the quality and nature of the service outside the counselor's jurisdiction, as well as losing therapeutically valuable information that the helpers feed back to the counselor.

What specifically can be done by the Caring and Sharing Network for the three examples cited above? If an unemployed father is at home with the baby during the day while his wife drives the car to work, another man in the CCAC might pick him up for his counseling appointments. A volunteer at the center could care for the baby.
during the therapy hour. To relieve a distraught mother of preschoolers, another mother might ask the little ones over to play for certain hours during the week. If the community is fortunate enough to have older ladies, a "grandmotherly" person might go into the home and assume child care and household duties for a few hours daily for a limited time span, allowing the mother to get away from the house. A young, single adult could be matched with a caring, well-adjusted family that has grown or older teen children. The young adult could be encouraged to take his major meals with the family. Occasionally the young adult might live with the family for a short time to gain more support and structure. Alternately, a young adult might be matched with another (same sex) young person who is nurturing and who has the energy and time to cook and provide support. These examples are only a few possibilities of what a creative community can do. Each community and each therapist will work out what is useful and possible in their own context.

The opposite aspect of the practical assistance program is the opportunity to give, to share, to help. Many individuals with emotional or behavioral difficulties have a deep desire to help, as indicated in the Research section of this paper. They derive a sense of responsibility, integrity, and maturity from the experience. Being a practical helper for other clients also may be a way for experienced clients to continue to grow and for ex-clients to keep valued involvement with the community. Driving a new client to appointments, painting an elderly woman's porch, weeding a small garden, and caring for clients' children are examples of relatively simple, time-limited tasks. In making any such arrangements, the
counselor should be careful that the helper is giving assistance in
an area that is a personal strength and that the giving will not
require excessive time or energy. The pairing of helpers with
clients and the supervision of the interaction is the counselor's
responsibility.

Center-related activities

Center activities provide opportunities for almost any client
to experience giving help. Even children can be practical helpers at
the center. A fourth grade girl who is ashamed and tearful that
everyone else is helping her, that she cannot do anything right, may
be instructed in washing dishes or vacuuming and given the responsi­
bility for those chores one day a week at the center.

New adult clients will probably have their first experiences
in giving help in the counseling community as part of center activi­
ties because the tasks can be simple and the counselor or supervisor
of volunteers can be present to ensure that the experience is ther­
apeutic. For example, a person with artistic talent may be asked to
come in to the center to make posters. The counselor may arrange for
another more experienced community member who is not artistic to be
in the work area, to show where the supplies are, thereby beginning
to integrate the new person into the community.

A more advanced center-related assignment may be for a former
music teacher who has withdrawn from social involvement to come into
the center to teach a short music lesson to a needy, withdrawn child.
The counselor would be present to provide the direction and rein­
forcement to make the experience profitable to both adult and child.
Inviting a new client with low self-esteem to attend a center
business meeting, introducing her as a new volunteer, and asking for her ideas and suggestions, creates a sense of belonging and of being valued that improves self-esteem for the client. When a new person learns, through spontaneous conversation, that the counseling center is primarily operated by former clients—people just like her—any remaining embarrassment about being in therapy is relieved.

Community members can be a major source of stress reduction in center operation for the leader and therapists. The physical aspects of the center—cleaning, decorating, moving and so forth—can be the responsibility of a committed community member, who then enlists others to assist. Clerical work (except client files) can be done by volunteers, freeing staff time. Volunteer receptionists can assist the therapist by having the clients relaxed and feeling "at home" before they go into sessions, thus lowering their resistance and facilitating therapeutic process. Volunteer receptionists can greet people as equals, show new persons around the building, baby-sit during parents' appointments, and with training, handle emergencies until the counselor is available. Public awareness and public relations for the center can be handled in part by community members. Freeing the counselor in these areas allows him to direct his energies toward the community's emotional, social, and spiritual needs.

Peer counseling

A third, and major, aspect of the Caring and Sharing Network is peer counseling. Numerous programs have demonstrated that often people will accept help from peers with similar experiences as well or better than they accept help from professionals (see Literature
Review). Giving help to peers improves self-confidence, self-concept, and solidifies new learnings. In a counseling center, the peer program may function on several levels.

A peer counselor may be a well-trained, empathic listener available to CCAC members in general. The empathic listener's function is to be available by phone or appointment to support other community members with the ordinary, daily frustrations of life. The empathic listener would fill the role often described as a "natural helper", someone who is a natural part of the lives of the community members. Among women, the empathic listener probably would be a homemaker whose children are in school or grown, who has ample time to interact, and who has been in the CCAC for over a year and has incorporated its norms and values.

A peer counselor may be a "veteran" of a particular experience and available to help community members and new clients with that experience. A man who has been unemployed for an extended time period and has resolved his own feeling about unemployment and has now found work can be an effective helper for other men suffering ego devaluation and family problems from unemployment. A woman who has been sexually abused and worked through her own feelings can often be more emotionally supportive to another woman going through an immediate post-rape crisis than can a male therapist.

A peer counselor can be trained to be supportive in natural disasters. For example, in time of earthquakes or hurricanes, peer counselors can do much to be supportive of community members who have sustained loss. A peer counselor who has flexible time can be available to people of the locality to go to the scene of such disasters.
as house fires, to help the victims on the spot through emotional support.

A peer counselor may function as a teacher and role model to assist clients in acquiring specific skills. A mother who has learned to use behavior modification techniques to control her learning disabled child's acting out can function as a role model for another mother whom the therapist is instructing in the same techniques. What the therapist can only talk about, the peer counselor-mother can demonstrate repeatedly and in various situations in her own home. Providing help to others will, in turn, solidify the newly learned skill for the helper.

The most advanced level of peer counseling is actual involvement in the ongoing therapeutic process. At this level, the peer counselor functions almost as a co-therapist, with duties and limitations clearly defined by the professional counselor. Involvement can be complete, with the peer counselor sitting in on some or all therapy sessions and following up with peer sessions during the week, or it may be partial with only the during-the-week sessions. The peer counselor acts as a sounding board to assist the client with re-thinking and integrating into daily life the content of the therapy hour. During periods of high stress, the peer counselor provides a cathartic release valve, monitors client behavior during suicidal periods, checks on medication or diet and sleep for psychotic clients, and assists with difficult activities such as dealing with the legal, social work, or business systems. For example, if a landlord is threatening eviction to an acutely distressed client, the peer counselor may act as liaison to help the
landlord understand the client's situation and help the client in obtaining any financial relief appropriate from the social work and welfare system.

All peer counselors need a substantial amount of training in basic nondirective and supportive counseling techniques. In each assignment they should be closely supervised by the therapist or supervisor of volunteers and instructed in what is expected of them and what are their boundaries. Off limits to peer counselors is giving psychological advice, contradicting the therapist, and making moral or religious judgments to the clients.

The peer counselor must be a person who not only relates well to the client but who has an open communication and respect for the therapist. When disagreements between the therapist and peer counselor arise, they must be able to talk out the differences and use the problem as an opportunity for growth for themselves, as well as for the good of the client. While a certain amount of natural personality factors are involved, a therapist who is committed to the concept of community can do much to teach this type of interaction to peer counselors, who will in turn teach it to those they help.

Peer counselors, the therapist, and those receiving help must work out the issue of confidentiality together, so that they have a mutual understanding of what to expect from each other.

The relationship between professional therapist and peer counselor can be one of the beauties of community. As trust and emotional closeness grow and the peer counselor's skills increase, the therapist can rely more on the peer counselor to back him up either with the community in general or with individual clients.
The therapist gains support from the peer counselors, thus reducing his level of stress. In turn, the peer counselor has the opportunity for continued personal growth and skills development.

**Support groups**

Social support is an important deterrent to psychological dysfunction and a major asset in coping with stress or in recovery from illness, as indicated in the Literature Review. Support groups in a counseling center provide emotional and informational support and, when necessary, tap into the Practical Assistance program of the Caring and Sharing Network. The particular types and content of support groups will vary depending on center size, clientele, and resources.

Self-help mutual-support groups composed of people with similar problems can be a valuable asset to the CCAC. With supervision from a professional staff person, community members can form such a group to help themselves and, with proper screening, may open the group to persons from the geographic locality. Meetings are weekly or bi-weekly. The following are examples of possible groups: a sexual assault recovery group; an information, referral, and support group for the neurologically injured or impaired; an advocacy group for parents of children with learning disabilities; a support group for parents whose children have life-threatening illnesses; or a support group for the unemployed.

Unique to the Counseling Center As Community is the organizing of community members to provide psycho-social support for professional staff, a group which could be called the Council for
Staff Well-being. In traditional counseling and educational programs, staff members continuously give but are rarely given to. Monetary fees and the gratification of successful clients do not balance the giving-receiving scale for therapists. The rate of burnout among the helping professions is abnormally high (Cherniss, 1980).

In community, the director and assistant are constantly on display, and all staff have more frequent and intense interactions than in a setting in which counseling is merely employment. As demonstrated at Innisfree, burnout occurs quickly in community unless there are safeguards. A system of checks and balances for the staff by the community members can be effective, as seen in the church community in which leaders have carried heavy responsibility for seven to ten years with no sign of burnout.

In a CCAC, the Council for Staff Well-being not only sets up guidelines and provides assistance to prevent burnout but also actively promotes physical, mental, and spiritual health of the staff. For example, a director can easily become so immersed in his work for so long that he does not think about himself, does not recognize that he is neglecting his own needs and showing signs of stress visible to those close to him. He is not likely to listen to his family's complaints or to ordinary advice from friends. Persons on the Council have enough contact with all staff members to recognize when they are becoming over-stressed. In such a case, the Council has the authority to go to the director, in love and respect, to point out what he is doing to himself and ultimately to the
community, and if necessary to hand him a plane ticket and reserva-
tions for a favorite vacation spot. What the director will not do
for himself, he can hardly refuse to accept from friends who are
doing exactly what he has taught them to do.

To be effective, the Council must be in touch with the
personal lives of the staff. Council members are the persons to whom
staff members are free to go at the end of a difficult day, according
to CCAC norms. By the nature of the relationship, staff members may
pour out their personal frustrations without worrying about a Council
member thinking less of them or spreading gossip. By accepted pro-
cedure, Council members are also people to whom family, friends, or
other community members may go to discuss their concerns about staff
members, particularly if a staff member is having personal diffi-
culties that affect his work. Council members are chosen on the
basis of personality and compatibility between Council members and
staff members. Members must be thoroughly trustworthy, sensitive
persons with an accurate perception of social reality, an uncritical
attitude, and long-standing commitment to the center community. In a
small center, the Council may be two or three persons who are also on
the board of directors. In a larger center in which the board is
more concerned with business matters, the Council may be two to four
committee members who can relate well to the professional staff. To
ensure a good working relationship, the Council should meet a minimum
of once a month, even though there seem to be no particularly pressing
matters.

In function and in interpersonal relationships, the Council
resembles the checks and balance system observed in the church
community, with its bishops, house churches, elders, pastors, and
court system.

Educational Component

Learning is the major dynamic for change in community. Jones
(1968) focuses on social learning through guided discussion of
experiences on the therapeutic community psychiatric ward. In
reviewing healing communities in non-Western cultures, Almond (1974)
emphasizes learning of life patterns through participation. In
ordinary American life, learning is associated with a classroom
environment (Sarason, 1976).

Classes for children

For children, learning in the school classroom is their
primary activity, equivalent to employment for adults. Self-concept
and psychological development are intimately tied to school. There­
fore, a counseling center working with children may find an educa­
tional program to be an invaluable part of child therapy. Such a
program may take many forms, depending on the resources of the center
and the nature of the problems of the children being seen.

Tutor-counseling program

Some children develop poor self-concepts and diminished
psychological growth simply because of failure in the regular school
classroom. Reasons for failure may not be in-depth emotional
disturbances but factors related to American education, such as
inadequate teaching or poor child-school match, or from factors
beyond the usual control of the child or significant adults, such as
the child's chronic illness, delayed development, sensory or motor
impairments, or inadequate neurological organization. Learning
disabilities and socioculture deprivation within a middle-class
school system are major causes of school failure and associated
psychological difficulties (Cruickshank, 1980). The child internalizes
chronic failure as being his fault; he is "bad," "dumb," or "no good."

Obviously, none of these problems are remediable through in-
office once-a-week therapy. Although psychologists find it
comfortable to shift the responsibility to the schools, the schools
simply cannot meet the needs of all children, and blaming the school
does not help the child who is hurting from school failure.

What is effective for these children is a one-to-one
relationship with a teacher who can meet their needs, who can teach
to the ability and remediate the disability, who can create success
experiences that undo the failure set, who can impart academic and
behavioral skills that enable the child to succeed in the regular
classroom. The therapeutic teacher-child relationship may be in a
special day school, such as Benet Center, or part of child and family
therapy, such as the after-school tutor-counseling program at Selah
Center. Seven years of experience with underachieving children at
Selah Center indicated that the most profound and long-lasting
personality changes in children occurred when (1) the child was in
tutor-counseling for one hour a day three to five days per week; (2)
the child and parents learned improved relational and communication
skills and attitudes in family therapy; (3) one or both parents were
seen for brief individual counseling to process feelings about these
changes; (4) one or more family members continued to be involved in
center activities after formal therapy was terminated, particularly if that person became a helper of others.

Specific instructions for programming for a therapeutic day school or tutor-counseling program are beyond the scope of this paper but can be obtained from Dr. Schultheis, Benet Learning Center, 1671 Spy Run Avenue, Fort Wayne, Indiana 46805, or from the researcher's paper to the Christian Association for Psychological Studies annual convention, 1980 (Fair, 1980).

Enrichment classes

For children, as for adults, the intent of the Counseling Center As Community is not only remediation but growth to full potential. Learning experiences beyond the scope of the regular schools can be used to bring about optimal development. For example, a small group summer class on nature study can not only teach vocabulary and science, but also develop sensory alertness and accurateness of observations and interpretation of environment and improve skills in cooperative working together, while simultaneously encouraging individual initiative, creativity, and assertiveness. In such classes, children frustrated by the school's lack of appreciation of their intellectual prowess or artistic gifts find a place where they are praised and rewarded, a place where they belong. They can learn to exhibit their talents without being "stuck-up" or defensive, to share their abilities freely with children of differing capacities.

Enrichment classes might be open to all families in the CCAC or to children from the geographic area. A screening process is used to determine which children are likely to benefit from the classes and to combine personalities into groups that will work well
together. In these classes, children who are emotionally and socially well-adjusted are matched with children who need good role models, and with guidance from the teacher-therapist, all can benefit.

The child therapist may find these enrichment classes a refreshing break from direct contact with psychopathology, giving her the rejuvenating experience of the joy and enthusiasm of children in healthy situations.

**Classes for adults**

For adults, educational experiences as part of remedial or growth therapy can take many forms, from adult basic education classes (either at the CCAC or in conjunction with a public program) to continuing education programs for professionals.

The unique and essential educational program in CCACs is the personal growth class for clients, volunteers, and newer staff members, and with screening, the general public. Though conventional mental health centers offer workshops in such topics as assertiveness, more extensive information in psychology is difficult to obtain for persons who desire to understand their own species but are not able to take college upper level and graduate classes. With the assumption that people are entitled to knowledge, personal growth classes present material from psychological and mental health literature in a manner intelligible to the high school graduate with minimal reading and composition skills.

For example, most people can benefit from improved skills in empathic listening and communications. In the CCAC, peer counselors must be trained in basic counseling techniques. Classes can be
offered in how to help upset friends, using lay materials such as The Art of Listening with Love by Schmitt (1977) and How to Help a Friend by Welter (1978). More advanced classes may use counseling or communications models such as Egan (1975) or Grinder and Bandler (1979). Classes in child and adolescent development, personality dynamics (Coleman, 1960), or learning theory may be taught. Such classes would apply academic information to real life experience.

Personal growth classes may also be used to make a bridge between the counseling center and the public by offering topics of local interest. For example, if the cultural patterns of a rural town are being disrupted by the influx of city dwellers as new industry moves into the town, the counseling center may offer a seminar in "Communities in transition: the problems of mental health".

In summary, learning is a major dynamic for personal change in the CCAC. Formal instructional situations can be devised to enhance the growth and development of both children and adults in the community and to extend the center to the people of the geographic locality.

Roles in the CCAC

Staff

The staff are professional persons employed to use their skills for the good of clients and of the community. Staff members are integral parts of the community, being in certain situations on an equal footing with non-professional persons, rather than in positions of authority. However, for purposes of clarity, this paper will refer to staff and community members as separate categories.
The number, types, and forms of remuneration of staff will vary among counseling centers. For a new center, the minimum staff is a director and an assistant.

**Director**

The director has the same responsibilities for organization and programming as in a conventional mental health center. In addition, the director is responsible to and for the members of the community. The director carries the vision for the center and conveys it to community members and staff.

In a new center, the director will probably be the therapist, teacher, and founder of the program. As the center matures and adds new staff, the director's duties may become more administrative or he may choose to remain primarily a therapeutic and inspirational figure, hiring a business administrator for lesser duties. The researcher's bias is that the director hold at least a master's degree in psychology and have a wide background of experience. Licensure in psychology would greatly simplify the early stages of development of the center, in terms of receiving grants and public credibility. However, the director's academic credentials are less important than his personal characteristics.

**Assistant**

In a new CCAC, the assistant to the director fills the jobs of secretary, bookkeeper, and public relationships person, as well as assuming any counseling or teaching duties for which he is qualified. As the center grows, the assistant may shift to being the director's representative, to supervising volunteers, and interacting with
community members. Clerical duties may be delegated to volunteers or a paid secretary.

Therapists

Therapists are professional persons with academic training in mental health and psychology (or special education for child therapists) who work with clients, peer counselors, or other volunteers for the healing and growth of the individual and the community. Each center will decide the types and level of academic training needed for therapists. Some centers may choose to employ only persons with doctorates. Others, particularly those in rural or underprivileged areas, may have staff members with two to four years of training in social work, mental health technology, or counseling. If these persons indigenous to the geographic locality are personally mature and have a sound grasp of human psychosocial functioning, they may be excellent therapists.

Characteristics of staff

More important than the academic backgrounds of the staff are their personal characteristics. An understanding of and desire for community and personal identification and commitment to the center are basic for staff members to be successful and satisfied in centers following this model.

In a Christian center, staff members need a close relationship with God from which flows the desire to reach out to other people with Christ-like love. Through identification with Christ, the counselor relates to others, including the most needy, as "we", instead of "I--they". Since Christian counseling centers are likely
to be financially limited, a counselor oriented toward materialism is likely to be discontent, while a counselor with a missionary spirit whose deepest satisfactions are interpersonal and spiritual is likely to feel fulfilled.

Because the therapists and especially the director are constantly on display, certain basic personality traits are helpful in experiencing less stress—-an open, honest, "upfront", and trusting nature, a strong internal sense of security, versatility and flexibility, a wide range of skills and practical experiences, natural warmth and compassion, and an intuitive understanding and rapport with the culture of the people involved in the center.

Members

Members means all persons concerned with the CCAC, except clients who choose to be uninvolved and receive only in-office therapy. The term member denotes the egalitarian aspect of community, treating as equals the secretary of the board of directors and the newest client. Members are usually involved in some aspect of the Caring and Sharing Network, though some members may be only interested persons who give prayer or financial support to the community and do not personally interact with other members.

Volunteers

Volunteers are members who assume specific duties, such as transportation, building maintenance, fund raising, or peer counseling. Volunteers are the givers in the Caring and Sharing Network. They vary in the type and extent of duties, skills, and personal development. Volunteering for a simple center-related
activity may be the first step a client takes toward identifying with the community.

**Clients**

Clients are persons receiving professional therapy regularly. As clients internalize the beliefs of the community, identify with the group, and commit themselves to caring about others in the community, they become members. Though some centers may choose to make firm lines between clients and members, as the church community makes a firm distinction between members and friends-of-the-church, at newer centers the roles are likely to blend and change spontaneously.

Clients are encouraged to become active in the Caring and Sharing Network. Group identification and constructive pride in the center reduces or eliminates self-imposed stigma related to therapy. Giving to others counters the learned helplessness that so frequently is part of professional therapy. Acceptance by more experienced community members and casual social contact with a peer counselor or therapist who is aware of the client's problems build feelings of confidence, esteem, and of being acceptable. Any activity in the Caring and Sharing Network prevents the client from the hiding behaviors which only increase shame and guilt and are characteristic of clients seen in office practice.

**Corporation members**

A center organized as a not-for-profit corporation (501-c-3) is legally composed of members who vote, make policy, and hold office under the laws of the state and federal government. Corporation
members usually elect a board of directors to directly manage busi­ness affairs. In the communities observed for this study, the corporation members were not always persons in the community but were outside advisors. However, because of the nature of a counseling center as community, it is recommended that corporation members and the board be persons deeply committed to the life and philosophy of the group. A separate advisory board with no legal control may be used to bring in outside expertise.

Role Boundary Issue

In a CCAC, boundaries between roles are low and there is substantial blurring of actual behaviors and attitudes, as would be expected in an essentially egalitarian philosophy. One individual may fill several roles that in a bureaucratic center are mutually exclusive. For example, a single woman may be a paid secretary in the morning, see a therapist for counseling in the afternoon, and be a crisis peer counselor that evening. Persons are themselves first, roles second. Though such mixing of traditionally separate roles may seem confusing from an academic perspective, the statements of persons in communities, as well as the researcher's own experience in two similar communities, indicates that the actual experience is "If I can do it, I do." The experience is freedom to use one's full potential without artificial restrictions to growth.

Daily Interactions in the Center

Community Meetings

Since the heart of the Counseling Center As Community is interpersonal relationships and since relationships require time and
interaction to mature, regular community meetings are as central to
the counseling center as the therapeutic community in-patient ward.
Frequent group interaction is necessary to overcome defenses that
have built up from past experiences from unproductive or emotionally
threatening meetings in other settings (Jones, 1976, p. 21). Though
in an in-patient ward all persons meet together, in a non-residential
setting, a large assembly of all staff, clients, volunteers, and
interested persons is not practical or even desirable. Instead,
interaction occurs in smaller groups and in informal social or
therapeutic contacts, such as described in the Research chapter of
this paper. Daily staff meeting and core group meetings are the two
major examples of community meetings in a CCAC.

Staff community meetings

Staff members should meet daily for mutual support, com-
munications, decision-making, and social learning, which is to say,
for the furtherance of community. When a center has only a director
and an assistant and perhaps one therapist, scheduled daily meetings
may seem superfluous since these persons interact throughout the day.
However, that close contact is exactly what mandates setting aside
time for thoughtful conversation. In any close working situation,
hurt feelings and misunderstandings are inevitable, as illustrated in
the communities observed for this study. At staff meeting, the
problems of the day can be confronted in an open, trusting, accepting
atmosphere before they become major disruptions. In larger centers,
daily meetings can be training sessions in which the staff practice,
in personal interaction with each other, the dynamics of social
learning which they, in turn, use with their clients. In a Christian
setting, meetings in a special room with a worship center, meetings that include devotions as an important feature, may help the staff members to bring Christ's spirit of love and humility into their lives as a community.

Staff meetings also serve more traditional functions, such as the discussion of cases and planning of therapeutic strategies, and the solving of problems that concern the center as a whole.

Core groups

Each center will have a core of members who want to be closely related to each other and involved in the workings of the center. Support groups from the Caring and Sharing program may become intimately involved in center functioning. Certainly the Council for Staff Well-being is a core group since it needs to be aware of all that occurs at the center. Peer counselors may decide to meet regularly as a group for sharing, support, and involvement in center functioning. In some centers, the board of directors or organizational committees move from being only task-oriented to being also person-oriented. Groups at the core of the community will meet weekly or biweekly to enjoy fellowship as well as to accomplish their tasks.

Decision-making Process

Major decisions concerning center organization and function will be made jointly by staff and core groups. For example, deciding whether to accept public monies in a Christian center will be done by consensus of the staff, board, corporation members, and other core groups.
In decision-making in community, the process to be used and the people to be involved depends upon (1) the magnitude of the decision; (2) the persons directly affected; (3) the priorities of the director; (4) the interest of the group or subgroups (Jones, 1976, p. 40).

Consensus is used for major decisions affecting many members. A decision to purchase a new building for center offices affects every person connected with the center. Ideally, the decision is discussed in general meetings of the whole community, including clients; however, people being what they are, only the most dedicated members are likely to attend the meetings regularly. This concern regarding the decision-making process is less that all community members actually attend than that they have the opportunity to be included in the decision. Consensus also may be the best process for issues in core groups. For example, peer counselors may be concerned about the type of training they receive. Group processing and problem solving, resulting in consensus, may be the method of choice for dealing with the problem.

Consensus is too lengthy and complex a process to use for many decisions. Shared decision-making is preferred for ongoing decisions affecting a smaller number of people. For example, the treatment models to be used in a center will be determined by shared decisions of the professional staff according to the changing client needs, therapists' skills and beliefs, and overall center resources.

Delegation of decision-making power is effective for routine events. Though the director is responsible for the psychological welfare of the community, he may delegate to the supervisor of
volunteers all scheduling and to the therapists, the matching of clients with peer counselors.

Unilateral decision-making is used infrequently in healing communities, as compared with institutions or private practice. Generally, unilateral decisions are those moment-by-moment choices of the individual, such as the therapist's choices during a session. In crisis, when the need for immediate action does not allow for group processing, and during periods of group disorganization, the director or other authorities assume control and arbitrarily make decisions. After the period of disruption, these unilateral decisions are discussed with the group that is affected (Jones, 1976).

Communications

The complex interactions and decision-making process in community obviously require a highly developed pattern of communications. Such a pattern is not a usual part of life for most Americans. According to Jones (1976, pp. 18-19), this type of communication requires dropping the facade of normal social interaction and learning to show true feelings, to be one's true self (meaning true self as related to the task-at-hand, not meaning "Let it all hang out" as it has been misinterpreted). The group works to develop a climate of trust, warmth, and support in which each person is valued for himself and is therefore encouraged and socially rewarded for expressing his opinions and feelings. The director sets the tone by his behavior and attitudes in group meetings and individual contacts. (See Jones, 1968b for examples). Communication must be straight: what is said is what is meant. Verbal and nonverbal messages are to be congruent. The expressed agenda of a meeting is
the real agenda: no one has a hidden set of goals. There should be no subtle power play. Though common in general society, self-contradictory messages and hidden agendas are destructive to interpersonal relationships and to community.

Communications do not exist for the sake of communications in a healing community. (As a few individuals at Innisfree pointed out, it is possible to communicate too much and do nothing.) Open, trusting communications are a means of facilitating the exchange of information relevant to the individual and group needs (Jones, 1976, p. 54). Information is essential for social learning, for growth of staff and clients. In community, the flow of information is two-way --not upwards through a chain of authority as in a bureaucracy, nor from the top down as in the military, nor "undercover" as in a gossip circle. Any community member may talk to any other community member. No rules automatically govern who may discuss what with whom. Though it may not be wise, the director is free to discuss the problems of finances with the newest volunteer. A client may feed back information about another client to his therapist or may protest to the director his manner of handling an administrative problem.

Though Jones and all other advocates of community or open systems emphasize the virtues of open, two-way communications, it appears that abuses of such communications are possible. Too free a flow of information can violate the right and need for emotional privacy, a part of healthy ego boundaries. All human beings need to be confident that their thoughts and feelings are their own, to be shared only with people of their choosing.
In a therapeutic setting, the most intimate thoughts and feelings are expressed. In a healing community, clients confide not only in their therapists but also in volunteers and often in each other. Professional staff share deeply significant aspects of themselves with each other. These intimate moments of sharing in or out of formal therapy sessions must not become exposed to the whole community, or even relayed to inappropriate persons. For some persons, such exposure breaks down trust and results in withdrawal or resentment, as observed in two communities in this study. (As a minor example, the researcher will hesitate to share anything personally significant with the pastor in the church community observed since there is no assurance of whom he may tell.)

A related problem is that sensitive organizational material, such as finances, may be detrimental to the entire organization if inadvertently passed on to a client or volunteer with a poor grasp of social reality or with hostility toward the center.

Therefore, although the bureaucratic or office-practice systems for information flow are not applicable in community, another system needs to be developed to protect privacy while maintaining community. Each center needs to clearly spell out and enforce its own rules. Several guidelines for the development of such rules are suggested: (1) What occurs in staff meetings or core group meetings stays there, except for final decisions intended to be passed to the community. (2) Persons who need to further process their feelings from such group meetings are encouraged to do so, but only with their therapists or with the director. (3) Peer counselors should relay all information about counselees to the professional...

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therapist; however, the therapist relays only information actually needed by the volunteer co-therapist, and that with the client's approval. (4) Peer counselors should be thoroughly taught the rules for confidentiality and privacy and led to see the reasons for those rules and the social consequences of breaking them. Only peer counselors with histories of being discreet in communications are accepted as co-therapists. (5) No community member will be given information on clients by the therapist, except as authorized by the client. For example, a client will allow the therapist to give his address to a volunteer driver who will bring him to the Center. (6) A client, volunteer, or community member is free to share whatever he chooses about himself with any other community member. He is informed in the early stages of his involvement with the community that such communications are not necessarily confidential, unless he and the other party so agree, and that, even then, the other party is free to report any therapeutically crucial information (such as a planned suicide) to the director. (7) When an individual exhibits a problem of saying too much about himself or others for his own good or for the good of the community, the director or therapist attempts to lead him to understand and learn from his hurtful behavior.

If a client is unable to understand or control his conversations, the staff will limit his interactions with community members. A volunteer may temporarily be removed from his position or his duties may be changed in a way that will help him work on the problem. If a staff member is overly talkative, the regular staff meetings and individual sessions with the director are available to help him learn wisdom in self-expression.
The statements above are offered only as guides to stimulate thinking about confidentiality in a new CCAC. As communities mature, they will develop patterns and principles appropriate for the persons, activities, and setting of the particular center.

Psychological Sense of Community

The psychological sense of community is the secure feeling of belonging to something greater than oneself, the awareness of being a part of an interrelated, interactive group of people who care about each other, who are available in the normal "give and get" of life (Sarason, 1974, p. 1). Jones (1976, p. 63) regards a sense of community, or as he calls it group identity, as essential to healthy personality. "To feel a strong identity with one's peer group in an open system means an opportunity to evaluate constantly one's attitudes, values, and beliefs. This, in turn, leads to a feeling of self-growth with new and wider perspectives."

The positive effect of psychological community on mental health may be regarded as the initial driving force for developing the model of the Counseling Center As Community. Jones contended that if a new model for social interaction and change may result in more people developing their full potential, then that is sufficient justification for the model.

The combined works of writers on therapeutic community and healing community and the observations in this study indicate that several factors contribute to the psychological sense of community. First, there is an awareness of common needs. Second, persons set the goal of meeting those needs. Third, frequent face-to-face contact in an atmosphere of acceptance, warmth, and emotional honesty.
is necessary to create friends that are more than friends. Spontaneously there arises an affective component, be it called support, love, or kindred spirit. Fourth, there is intense sharing of information relevant to group needs and goals that continues throughout the life of the group. Concurrently, a common set of beliefs and practices evolves and continues to change over time. Finally, the core persons in the group say, "We belong. This is good."

More specifically, a counseling center that is a community begins with a few persons who feel a need for something other than currently exists in local counseling programs. They band together, developing friendship and a warm supportive style of relating that continues to attract new people. Often a leader with charismatic qualities arises to teach, guide, challenge, and inspire the fledgling group. Official programs and services in mental health are organized and publicized. With continued experience and the influx of new persons, the group formulates beliefs, practices, policies, and procedures based on their shared information. Within a fairly short time, there is a counseling center with its own unique existence, readily identifiable to outsiders as a mental health program, known to the persons deeply involved as a community with which they identify.

The psychological sense of community is related to the way in which a new CCAC is started, namely reaching out to people.

**Reaching the People--Starting a CCAC**

The process and dynamics of building a counseling center that is a community is somewhat different from building up a private practice or a public mental health organization. Paid advertising,
professional contacts as referral sources, and financial guarantees are less important (though not unimportant). Interpersonal relationships among the founders, relationship of the founders to the population to be served, and personalities of the founders are more important.

The essential motivations for starting a CCAC are love for people, dedication to a higher purpose, and a vision of what the center can become and of how it can improve life for a certain group or groups of people. Motivation of material and status gain and of practicing one's profession are inadequate, since they are not major aspects of psychosocial community.

Beginning a CCAC is essentially a process of reaching out to people, often one at a time. Hypothetical examples seem the clearest means of explaining how to reach the people.

For example, the wives of several farmers are burdened that their families and their neighbors are going through psychological and social difficulties because of the national farm crisis. Though these particular families have not lost their farms, they feel the pain of their neighbors who have lost their way of life. One woman has a master's degree in community counseling, though she has not worked professionally for years. Becoming aware that a young lady from their town will soon graduate with her doctorate in psychology, the women visit her and explain their concerns in poignant, "down-home" language. The doctoral student has many fond memories of the rural community and shares the women's concern. Though none of the farm families are well-to-do, they guarantee the young psychologist
that, if she will "come back home," she will "have it as good as we
do." She will be provided with housing, food, and other necessities.

Fired by the intensity and dedication of these women, the
psychologist returns to the farm area after graduation. She begins
calling on the women at each farm in the area, accompanied by one of
the originators of the program. Meanwhile, she and the farm-wife
with the counseling degree are training the group in peer counseling
techniques. Although some of the husbands are hesitant or skeptical,
others appreciate the new sensitivity and zest for life in their
wives and want to become involved in the helping effort.

Within a year, there is a definite community that offers
individual professional counseling, support groups, and peer coun-
seling oriented to the concerns and norms of persons in a farming
area.

Another hypothetical example is in a metropolitan setting. A
Hispanic couple who are psychologists near retirement age have a
growing burden for the Hispanic inner city residents who are under-
served and undervalued by public agencies. The psychologists have
had clients from that section of the city and, being from similar
backgrounds themselves, have been heartbroken when they could not
reach these people.

Leaving their lovely home and offices in the suburbs, the
couple moves into an apartment in the Hispanic neighborhood. Though
at first they feel overwhelmed by the enormity of the problems all
around them, they are determined to find a way to help the Hispanic
people to help themselves. The couple invite their former clients
into their home for a meal and explain that they just want to be a
part of the neighborhood. The couple asks to be called by their first names, explaining that they are more than doctors; they are Hispanic persons with the same hopes and fears and discouragements and needs as all other Hispanic people. The couple persuade their former clients to introduce them to other families. During the first months, the psychologists meet rejection--ranging from polite silence to physical threats. With persistent efforts and volunteering in the church, the club, and school--any place they can gain entrance--the couple make friends and gather a small band of people who really care and are ready to work to make their neighborhood a better place to live. The psychologists begin training the natural helpers in listening and referral techniques--the day-care attendant, the bartender, the corner cop, the beautician. Two men and a woman in the small circle of friends study the basics of peer counseling. The couple rent another apartment which, by the labor of their friends, is redecorated into offices, meeting rooms, and a kitchen. Slowly, over many months, persons who come in for help--often on a drop-in basis--find that their lives are changing, not only from individual therapy but also from becoming part of a group that has a vision of hope, courage, and a better day.

Actual examples of counseling programs that have begun as communities are The Way Inn, cited in the Literature Review, and Selah Christian Center, Inc., described in the Appendix. Though these groups developed only as far as the interpersonal relationships that characterize community, Selah intends to develop organizationally following the CCAC model over the next five years.
The communities described in these examples and in the Research section of this paper all served devalued populations or subcultures, in which people already shared common bonds, values, and needs as a basis for forming cohesive groups. Whether the model of a CCAC is viable and appropriate for middle-class society is totally unknown and may be a subject for future research. Certainly, as Peck (1978) and Sarason (1974) imply through their examples, the middle class needs love, purpose and belongingness. Whether these people are willing and able to meet their needs through a counseling center is the issue.

The examples in the Model section have obvious differences. Selah originally focused on children's psycho-educational needs and was the dream of this researcher for young people in her home town. In one hypothetical example, neighbors banded together to meet their needs and found a beginning professional to guide, teach, and counsel them. In the other example, two experienced professionals dedicated themselves to reaching people from backgrounds similar to their own in childhood.

Though the differences in these programs are obvious, the common factors are more important. These counseling communities began by reaching out with a vision of a higher possibility, with dedication and determination. They started by going to the people, by meeting people where they lived on their own terms, in their own social and cultural setting. All of these programs were based on love, as Peck (1978) defines love: "the will to extend one's self for the purpose of nurturing one's own or another's spiritual [psychological] growth." Those who would found a counseling center
that is a community must be motivated by love, for they will meet many obstacles (many from the mental health profession). Only the power of love will enable the founders to bear all things, believe all things, hope all things, and endure all things.

In spite of the difficulties, the professional or layman who is personally suited to community and who commits himself to forming a counseling center in that context will find the rewards are great. Not only does he have the thrill of seeing lives changed—maybe even neighborhoods changed—but also he has the marvelous privilege of giving of his essential self. As Peck aptly expressed it, "genuine love is a self-replenishing activity....it enlarges rather than diminishes self; it fills the self, rather than depleting it....It is in the giving up of self that human beings can find the most ecstatic and lasting, solid durable joy of life" (p. 72).

The establishing of a counseling center that is a community requires special people of vision and dedication and offers special rewards. Those who are first clients and then become helpers have a double reward, for they find both themselves and a new dimension of relationships with other people through the perpetual cycle of receiving and giving, of growth and service.

Objections and Obstacles

Throughout this paper, objections and obstacles to a Counseling Center As Community have been mentioned. As stated, only professionals with personality and beliefs suited to an egalitarian, interactive, self-giving work setting can be successful in a CCAC. Jones estimated that less than fifty per cent of professional therapists will understand the importance and potential of open systems,
such as a CCAC, and fewer are suited to work in them (Jones, 1976 and personal correspondence, November, 1985).

What other objections and obstacles interfere with therapists being equipped to work in open systems such as a CCAC? Most psychologists are from middle-class background and have assimilated norms and standards of conventionality, constricted self-expression, success as an individual striving, materialism, and social conformity—beliefs that do not facilitate community living. Professional training programs are based on middle class norms and presuppositions which neither fit the subcultures served by CCACs nor are compatible with the basic principles of community (Bachrach, 1983; Eisenhart & Ruff, 1983; Poser, 1966). For example, counselors are taught to erect professional barriers between themselves and clients—to think and act in terms of "I-they", rather than "we".

Furthermore, academic disciplines have not been particularly interested in such a mundane outlook as "we the people". Until recently there had been limited research into the therapeutic benefits of community, and it requires courage for university professors to risk encouraging their graduate students to research into uncharted territory or experiment with new therapeutic styles (Bell, 1982).

More virulent to the CCAC is the prevalence of the dark side of human nature, such as egocentrism, self-aggrandizement, corruption in response to power, and greed. There seems to be a tendency among humans—no matter how educated—to slip towards elevating self and downgrading others, and according to Christian tradition, placing of one's self in the position of a god. It seems extremely difficult
for man to thoroughly believe that it is more blessed to give than to receive. It appears to be more comfortable for the person who has worked hard through eight years of college and internship and survived the first years of practice to set himself apart, to unconsciously contend that he is entitled to status, material wealth, and the power of being the expert. The position of psychologist, and especially of administrator, seems to readily provide a role that accentuates the tendencies toward self-elevation, which prohibits community (Peck, 1983).

For the professional therapist who truly wants to be a part of the counseling center that is a community, there are still obstacles. Though not materialistic, CCACs still require funds to operate. Staff need adequate income for life’s necessities and for experiences that will allow personal growth and prevent burnout. The purchase or rent and maintenance of an adequate building is expensive. The Caring and Sharing Network requires funds to operate smoothly. Two examples of the negative effect of inadequate funds are given in the Research chapter.

Since clients served by CCACs are often in lower economic brackets and since the hours of help given within the whole community far exceed the formal, paid client hours, a CCAC needs underlying support, such as grants, endowment funds, and local contributions, to survive. One method of meeting day-to-day expenses is the underwriting of a designated number of hours of counseling time by local churches, schools, or agencies. Governmental funds are not likely to be viable sources of monies for CCACs since bureaucrats are not prone
to understand their importance, judging by the history of governmental funding for therapeutic in-patient communities. Each CCAC will have to work through the financial dilemma as is appropriate for its clients, members, and locality.

Professional jealousy and misunderstanding are obstacles for a new CCAC. One such alternative center met active opposition from the local CMHC, schools, and two churches that considered the center a threat to professional territory and funding. Only when the director and former clients were able to demonstrate that the center was cooperative, not competitive, did the pressure subside.

Suspiciousness, resistance, and misunderstanding by the very people for whom the center has been established are major obstacles. Inner city residents do not easily trust outsiders who come to their neighborhood—nor one of their own who has been educated and returns. Neither do farmers. Even after the people trust the therapists or director as individuals, they still may be reluctant to discuss personal issues. The men especially may be slow to admit personal problems. One way for a CCAC to reduce the difficulty of reaching the people is to at first focus on children (who are already assumed to need help) and on the women who are ready to accept help with parenting or marriage problems. As the center builds a reputation for helpfulness, then it has a base for reaching a wider number of persons with more services.

These obstacles and objections mentioned are only samples of problems a CCAC will encounter from the academic professions, from current mental health and education practitioners, and from the persons the center seeks to serve. Other obstacles will be
encountered in practice as each center develops; other objections will be raised against the concept of a counseling center that is a community as it takes on specific forms and/or becomes better recognized in the field of mental health.

**Christian Perspective**

From a Christian perspective, there is more to the healing and growth that occurs in a community than simply human beings meeting their own needs. The health comes from conformity to a pattern established by God as the optimal environment for human development, according to Paul in I Corinthians 12. Though Paul wrote specifically about the church as the visible body of Christ on earth, the principles of equality, acceptance, interdependence, and the unique value of each individual are universally applicable, for there is one Creator who made one unified reality. The body—the community—is one with many members. The head cannot say to the foot, I have no need for you. The director of the counseling center cannot say to the client, "I have no need for you." The ear—the empathic peer counselor—cannot say, "I am not an eye—on the board of directors—therefore, I am not of the body—I do not count." When each member in the community finds his place of growth and service, the group prospers. When any member suffers alienation or defeat, the whole body is diminished. When any part of the program receives public recognition, the whole center—its staff and members—are honored.

Indeed, whether its founders and members are cognizant of God's principles or not, the counseling center as community is an extension of the church into the field of mental health.
CHAPTER VI  
SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

This research has been an endeavor to explore the therapeutic dynamics in alternative mental health programs that are organized and function as healing communities and to develop a model for the counseling center as a healing community. Literature related to the need for a new model and to the healing communities to be observed was reviewed.

Since this was an exploratory study using a phenomenological perspective and a general existential outlook, no hypotheses were tested. Instead, observation and field techniques were used to gain data and build up a description of each healing community.

A set of four questions aided in identifying the factors important for healing, growth, and the reduction of stress for both staff and clients. Positive interpersonal relationships that include commitment and personal involvement outside a formal office-therapy setting were the major force for healing and growth. Social learning was a part of such relationships.

Following the research into the existing communities, a model for the counseling center as a healing community was constructed. The program of the CCAC is a combination of professional counseling with a support network and an optional educational program. The organization and functioning of the CCAC promote interdependence,
commitment, and a wide variety of contacts that are potentially therapeutic.

In this study, the original objectives as stated in Chapter 1 have been achieved in general, though the effectiveness of the new model in enhancing the level of help for the client and in reducing the stress for the staff can only be fully tested after the model has been implemented. This study primarily opened the path for future and more focused studies into alternative models for mental health programs.

Sections concerning Discussion of theory and Suggestions for Further Research follow. In the Discussion selected aspects of theory from three fields—social psychology, community psychology, and personality theory—will be related to some findings of this research.

**Discussion**

This study has examined five programs that have a positive effect on mental health and, from interweaving principles gained from the observations and the related literature, an alternative model for counseling centers has been constructed.

As is usual in phenomenological research, not enough information was known at the beginning of the study to start from a theoretical framework. However, after the completion of the observations and their integration into a model, it is possible to relate many of the findings to established fields of study, particularly to social psychology, community psychology, and personality theory. A few examples will be given in the remainder of this section.
First, social psychology particularly is related to what was observed in this study. For example, group dynamics, a major part of social psychology, deals with communication patterns—who says what to whom in a group.

Five networks of communication contacts seem to be generally accepted and are represented graphically as a chain, wheel, circle, Y, and a star within a pentagon (called "all-channel"). For small task-oriented groups, the most efficient network is the wheel with each group member feeding information to a central decision-making person (Leavitt, 1951). As groups become larger or as more emphasis is placed on members' emotional satisfaction, the preferred pattern is "all channel", each person communicating with every other person in the group (Shaw, 1981). Communications in the healing communities are definitely "all channel". For the CCAC, the initial pattern will probably be the wheel, with all persons feeding information to the founder. As the center grows, the "all channel" pattern is more desirable.

Another example from social psychology is groupthink, a pattern of counterproductive mechanism occurring in highly cohesive groups and limiting the ability to perceive alternative solutions or flaws in final decisions (Janis, 1972). Logically, such difficulties in information processing and decision-making seem likely to plague healing communities, as highly cohesive groups. However, in spite of strong group norms and cohesiveness, communities in this study (except Emotions Anonymous) did not display groupthink, possibly because of the internal checks and balances and the presence of independent thinkers in each group. In a CCAC, an alertness to the
problem of groupthink can prevent the group from falling into this trap in communications and decision-making.

Theories of affiliation and attraction from social psychology are related to this study, particularly to the first research question concerning the reasons that persons were attracted to the community. Studies indicate that affiliation—being with people—provides information, reduces anxiety, allows social comparisons, and is especially valued in stress situations. Many members came to the communities during periods of stress and emotional isolation. Attraction, the desire for more than a passing contact with someone, is influenced by physical proximity, physical and social desirability, similarity of values, attitudes, and personality, reinforcement of positive feelings, and complementary characteristics of the individuals involved. Members of healing communities are likely to be influenced by these factors (See Tedeschi, Lindskold, and Rosenfeld, 1985, pp. 280-300 for a more complete discussion).

For attraction to result in more enduring relationships, relevant factors are enjoyment of being with the other person, empathy and understanding, self-disclosure, caring, and intimacy, which in social psychology constitute a definition of love (Tedeschi et al., p. 301).

Observed in this study were these three levels of affiliation, attraction, and love. In the church, visitors merely attending worship services represented the level of affiliation. At the level of attraction were casual friends who came together for social functions. At the level of love were dating couples, families, and small
groups of families who were close friends. While newcomers were probably attracted by factors mentioned in the theories of affiliation and attraction, those who became members of the church reported that what held them to the community was love.

In the CCAC, the initial attractor will probably be professional help, but factors that move an individual from being a client to becoming a community member are likely to be those identified in the theories of attraction and love.

Social psychology has examined the process of giving and receiving help. Help, in social psychology, may refer to physical rescue, monetary gifts, or other events not usually a concern in mental health settings. Therefore, social psychology's generalizations should be applied cautiously to counseling situations.

According to experimental studies, people mentally weigh the costs and benefits in seeking help or giving help. (See Baum, Fisher, and Singer, 1985 for further discussion). The cost of receiving help may include lowering of self-esteem and the feeling of necessity to pay back the benefactor (the norm of reciprocity). Since it is easier to pay back a relatively poor person than a rich one, people appreciate help from a poor person more than a rich one (Fisher & Nadler, 1976). Help from a friend that implies deficiency in a socially-valued trait tends to lower self-esteem and is not appreciated. People do not usually seek or accept help from children or from those they regard as their inferiors (Tedeschi et al, pp. 260-276). However, people will accept help from friends or inferiors if it is considered better quality help.
These findings concerning giving and seeking help point out an interesting difference between social psychology and community. While social psychology states what usually happens for a statistically significant group of people, community challenges individuals to drop their social facade and to learn to be comfortable receiving help from peers and from those usually considered socially inferior, and thereby to grow themselves into more complete human beings.

A second field of study related to this paper is community psychology, which originated in the 1950s and became recognized by the American Psychological Association in 1966. Community psychology shifts the emphasis in mental health care from the pathology of the individual to the conditions in the social environment, from therapy to prevention, and from dyadic patient-therapist contacts and the medical model to human interaction and growth. Community psychology takes concern for mental health out to where people live--to the school, the workplace, the church, and the social or political organization (Beigel & Levenson, 1972; Gibbs, Lachenmeyer, & Sigal, 1980; Sarason, 1974).

Though community psychology was the original foundation for CMHCs, few centers now function on its principles of outreach and interaction, in part because the catchment areas they serve are not really communities but arbitrary zones unrelated to natural patterns of human interaction.

Although community psychology is closely related in philosophy to the Counseling Center As Community, there is an essential difference. Instead of positing an already existent, cohesive community to which people feel a sense of belonging and commitment
as does community psychology, this new model assumes that social conditions have reduced the close bonds that may have once existed in a geographic locality. Therefore, it constructs a new community in which a person is a member by choice.

A third field related to this research is personality theory. Personality theorists have long dealt with the relationships between the individual and the group and with other kinds of relationships that are important in healing communities. Adler’s theory of personality is interpersonally and communally oriented. He held that personality forms through contact with significant others and the social environment, and that moving toward maturity is moving toward social interest, toward genuine concern and caring for others. When social interest has not developed spontaneously, then deliberate involvement in societal issues and in the needs of other people directs the individual from self preoccupation and pathology to fuller participation in humanity (Sullivan, 1931).

Sullivan’s interpersonal theory implies that a personality exists only in relationship to others (Sullivan, 1931, 1940). Sullivan’s own deprived, stigmatized childhood seems to have given him special insights into the effect of social environment in bringing about health or pathology. He is especially noted for providing a warm, human atmosphere for schizophrenics in his care, for treating them less as patients and more as friends or wounded brothers. Without explicitly so stating, Sullivan seems to have held that all persons are equal and valuable, no matter what their handicap, and as in healing communities, his patients responded to his respect and love for them. Sullivan could be said to have
practiced the basic principles of healing communities, including the CCAC.

Maslow dealt with the paradox of unselfish behavior resulting in personal rewards (Maslow, 1972) and with construction of optimal environments for human development (Maslow, 1965), and with participatory approach to research (Maslow, 1966).

Although Carl Rogers' name is not usually linked with healing community, he established in psychology the existential and phenomenological philosophy that contributes to the democratic, egalitarian approach to persons in need in healing communities. In his later years, Rogers has become involved in issues of the effect of social environment on mental health of the individual (Rychlak, 1973, pp. 565-617).

In discussing the findings of this paper, many theories and disciplines could be employed, including anthropology, sociology, social work, and theology, as well as those previously mentioned. Realistically, no one written piece can give exhaustive coverage of such complex phenomena as are herein investigated, and no such coverage is attempted in this paper.

However, to do justice to the subject, one more area of theory must be mentioned to be true to what occurs in healing communities. If the researcher were now to begin a new, more focused investigation into healing communities, she would study the one interpersonal relationship that seems to be the motivating factor and the greatest healing dynamic in community--love.

One possible theoretical framework for studying love comes from the Jewish psychiatrist Erich Fromm (1954), as written in
The Art of Loving. In his chapter on "The Theory of Love," Fromm stated that "The deepest need of man, then, is the need to overcome his separateness, to leave the prison of his aloneness" (Fromm, 1956, p. 8). The aloneness results from both patterns in modern society and from the nature of man as he has evolved.

The absolute failure to achieve this aim [overcoming separateness] means insanity, because the panic of complete isolation can be overcome only by such radical withdrawal from the world outside that the feeling of separation disappears--because the world outside...has disappeared. (p. 8)

How then can man overcome isolation, according to Fromm?

Separateness, isolation, and a oneness are overcome by love.

Mature love is union under the condition of preserving one's integrity, one's individuality. Love is an active power in man; a power which breaks through the walls which separate man from his fellow men, which unites him with others; love makes him overcome the sense of isolation and separateness, yet it permits him to be himself. (p. 17)

What is love? Love is, in part, giving.

What does one person give to another? He gives of himself, of the most precious he has....he gives him of his joy, of his interest, of his understanding, of his knowledge, of his humor, of his sadness....He does not give in order to receive; giving is in itself exquisite joy. But in giving he cannot help bringing something to life in the other person, and this which is brought to life reflects back to him; in truly giving, he cannot help receiving that which is given back to him. Giving implies to make the other person a giver also and they both share in the joy of what they have brought to life. (pp. 20-21)

Herein Fromm has captured the essence of healing communities, that which brings healing to the handicapped person and the volunteer at Innisfree, the power behind the perpetual growth in the church community, the virtue of delinquent helping delinquent, the special quality of relationship in the self-help group, the life-changing
dynamic at Benet Center. Herein is the driving force of the Counseling Center As Community, the purpose of the Caring and Sharing Network, the balm in staff and core group meetings, the magic in the therapist-client encounter. Fromm has said it: the key to healing communities, to all that was observed in this study, is love.

**Suggestions for Further Research**

This study suggests a number of possibilities for future research. A question arising directly from the findings of this study was, "What are the similarities and differences in therapeutic communities in this study?"

Another possibility related to this research is to examine a specific principle or dynamic that has emerged as important in the healing communities in this study. For example, love in the sense of interpersonal caring and intimacy may be studied in these same healing communities, or in other programs that meet the basic criteria for healing communities. Another factor that may be examined is the unique roles in community. A social psychology framework may be used to generate specific questions to be investigated through phenomenological or empirical methodology.

A related approach is the use of personality theory or counseling theory to generate specific questions regarding findings of this paper. For example, Carl Rogers has suggested that, in the therapist-client relationship, the therapist's unconditional acceptance with positive regard leads to healing and maturation for the patient. In healing communities, close, committed interpersonal relationships seem to be the dominant factor producing healing and growth. This similarity suggests several questions. Is the quality
and nature of interpersonal relationships that results in healing and growth in communities the same as that in Rogerian therapy? Are there any unique features of relationships in community that can be integrated into conventional counseling settings? Are qualities that Rogers values needed in healing communities? In terms of Rogerian concerns, what are the similarities and differences among other healing communities? Are the dynamics in one healing community more closely related to Rogerian theory than in another healing community?

Sullivan's work on the effect of general social environment is another possible framework, particularly for the study of severely disturbed individuals. Since according to Sullivan, the sick society is responsible for creating the sick individual (Sullivan, 1941), can a wholesome miniature society reverse the ill affects? In essence, this study examines the effectiveness of therapy or the extent and types of growth in a somewhat self-contained setting such as Innisfree or the church community (not an employment setting such as the juvenile center).

Another type of study that the present research suggests is an in-depth examination of one healing community. Anthropological, sociological, or social psychological frameworks may be used. For example, the process of enculturation in the church community may be interesting. Using Adler's psychoanalytic theory, maturation and social interest of persons at differing levels of status and leadership in a community may be analyzed, with the expectation that the leaders in a community show the greatest degree of personal maturity and social interest. Maslow's theory of the hierarchy of needs may be used to assess the personal development of community members, with
the expectation that leaders tend to be self-actualizers and the newest community members tend to function at the level of deficiency needs. Another means of assessing personal maturity may be a psychometric study of the Rorschach and Minnesota Multiphasic Personality Inventory profiles of persons with differing levels of commitment to the community.

From a psychometric viewpoint, it could be worthwhile to compare the personality test profiles of leaders and staff in healing communities with leaders and staff in conventional organizations offering a similar program. The personality test profile of pastors, elders, and deacons in the church community may be compared with those in another liturgical church of similar socioeconomic composition. The administration and volunteers at Innisfree may be compared with staff at a hospital for the retarded. Test profiles may be compared for general adjustment or for some particular characteristics, such as respect and compliance with authority. The FIRO-B scale offers a simple approach to assessing an individual's needs to give, to receive, and to be close to people. Results of such a test may be compared between a traditional setting and a healing community, with the expectation that persons in a community have a higher degree of need to give and to be emotionally intimate.

Finally, the model of the Counseling Center As Community should certainly be evaluated through research into such a counseling program once it is established.

In short, this dissertation suggests four types of further research into healing communities: (1) the study of one aspect of several healing communities; (2) the in-depth study of one community;
(3) the comparison of persons in community with those in similar positions in conventional mental health programs: (4) the evaluation of the model constructed in this paper.
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APPENDIX

SELAH CHRISTIAN CENTER, INC.

Selah Christian Center, Inc. is a counseling and educational program for children, teens, and adults that spontaneously evolved the type of relationships proposed in the Model of this research paper. Selah was the original inspiration for this study.

Selah Center began in 1977 when the researcher, Ms. Fair, returned to live in her home town and found that a small group of women were concerned about the psychological and spiritual needs of women and children in the county. The government-sponsored community mental health center (CMHC) in the town was not tuned to the people native to the area; its services, personnel, and delivery system were not consonant with the culture and needs of this conservative, religious, rural Midwestern community. There was too rapid a turnover in therapists and programs. There was little programming for children and no services oriented especially to the needs of women. Many Christians, uncomfortable with the amoral position of the public facility, would not use it.

The group of women with which Ms. Fair became associated expressed a desire to work toward a program that (1) reached out to people; (2) upheld an interdenominational Christian world view on the nature of life, humanity, and the universe; (3) emphasized the social, emotional, and school-related needs of children; (4) upheld
the ideal of the intact family while being sensitive to the feelings of divorced persons; (5) addressed the needs of single women.

In the summer of 1977, Ms. Fair rented an apartment and began tutoring children with physical, social, and emotional difficulties.

In November, 1977, eleven people established Selah Christian Center, Inc., a not-for-profit corporation chartered under state law to assist people emotionally, socially, educationally, and spiritually. Its unique name, "Selah," can be translated "Pause and calmly think of that," or as the Center phrases it, "Stop, rest, and think."

In spring, 1978, Ms. Fair began working full time with children, teens, and women, interweaving forms of assistance that are usually in the separate fields of counseling, social work, special education, and religion. She had no guaranteed salary, and client fees ranged from three to eight dollars an hour. Members of Selah Center also contributed garden produce, labor, or other forms of practical support.

In the summer of 1978, the Selah apartment not only housed 30-35 hours per week of individual counseling and education but also was temporary home for women clients in acute distress.

During that summer, the types of close interpersonal relationships that characterize Selah began to grow—relationships among clients as individuals and in task-oriented groups (such as building a float for a local festival); friendships between Ms. Fair and former clients; growth-oriented interactions between former clients and new clients. The quality of relationships and the open
communications in the group were spontaneous outgrowths of people caring genuinely about each other.

When Ms. Fair presented an aspect of Selah's work at the Christian Association for Psychological Studies convention in Toronto, April, 1980, she was surprised to learn that Selah's program and style of functioning intrigued many of the psychologists and psychiatrists, especially those with years of experience. When she returned to Selah, she reported enthusiastically to the group about the uniqueness of what they had created with God's guidance.

The group caught the enthusiasm. For two and a half years, the involvement of supporters and corporation members of Selah steadily increased and the level of therapeutic assistance for clients grew.

Since a healing community, such as Selah Center, is experienced rather than understood through facts and abstract descriptors, a vignette of a typical day in the summer of 1980 has been constructed from the Selah log book and is presented below. (Names and identifying data have been changed.)

**Imagery**

At promptly 8:45 a.m. Monday morning, a sharp rap on the front door interrupted the summer peace in the large white house that was counseling office and classroom for Selah Center, as well as living quarters for Ms. Fair, its director and therapist. With blonde curls bounding, Becky popped into the front room, furnished as a living room, and announced she was ready for work. She glanced around at the assortment of cups, cake plates, crumbs, and papers littering the room and grimaced.
Chuckling, Ms. Fair explained that two toddlers had come with their mothers to the study group the previous evening. Since Becky was paying part of the cost for her sessions by working as a house­keeper for Selah, Ms. Fair had left the mess for her to clean up. During these first three weeks of Becky's employment, Ms. Fair had often thought it would be easier to do the work herself, but Becky needed to learn responsibility, job skills, and self-confidence, and she would learn best by doing. Ms. Fair presented the fourteen-year old with a list of tasks, divided up hour by hour, and a list of specific instructions for each job.

"No half cup of soap in the dishwasher this time, okay?" she said, grinning at Becky. Becky's mother, who suffered from major depression, had never let the girl help at home because she could not tolerate Becky's messes; consequently, Becky had not learned to exercise good judgment or to follow directions effectively.

Ms. Fair explained that this morning, for the first time, she was going to close the study door while she was with a student. Becky was to take phone messages and answer the door--to handle whatever came up without interrupting the therapy session. Besides her usual work, Becky was also to take six-year old Laura to the lake to feed the ducks. She was to be very gentle with Laura and help her get over her fear of large birds, using the same procedures Ms. Fair had used to reduce Becky's numerous fears.

Becky's volunteer tutor would come at 11:00 for her reading and math lesson. Becky's school wanted to place her in special education for eighth grade. The girl and Ms. Fair were determined that Becky would be able to handle the regular classes by autumn.
A pounding on the vestibule door indicated that hyperactive behavior-problem Larry had arrived. Ms. Fair escorted him firmly into the study, seated him at a desk appropriate for a fifth-grader, and produced a reading selection about a boy who disrupted his class to get attention. Though Larry had a genuine learning disability, his school failure and disruptive episodes at home resulted from his acquired behavior patterns and poor self-image. Larry knew he had these ten weeks of summer to improve his behavior, or he would not be allowed to return to the regular school classroom. He buckled down to work and concentrated for twenty minutes. Then he and Ms. Fair acted out the reading story, demonstrating "good" and "bad" ways to get attention.

When Larry emerged from his lesson, he passed timid Laura in the hall and pretended to punch her. Laura burst into tears. Ms. Fair ordered, "Larry, stay with Becky. Come here, Laura."

Taking the child into the study, Ms. Fair comforted and talked to her. Then she called in Larry and Becky. The four of them worked through what had happened until little Laura was laughing and Larry was truly sorry he had frightened the shy girl.

After Laura finished her session, Becky watched her from the porch as she walked the short distance home.

When Becky came in, she confided to Ms. Fair that Becky's mother had taken her to a counselor when she was small. She had not liked to go. She never saw any other children and it made her feel very much alone. She wondered if she was crazy. Ms. Fair explained that Selah was different; it was a community, like an overgrown family.
To herself Ms. Fair thought, "If this were an office, there would not have been the opportunity to let these children work out their problems in a real life situation this morning. For them, doing is better than just talking."

The next client was an adult woman who looked very weary. Becky brought in tea and left quietly, going into another room for her own lesson with the volunteer.

At 12:00 p.m. Becky and Ms. Fair had their counseling session and then ate lunch together. While Ms. Fair excused herself to rest, Becky cleaned up the dishes and got her books ready to take home.

At 2:00 p.m. when Becky's mother came for her own appointment, Becky walked to the park for an hour of sun and fun. Mrs. D. had been seeing Ms. Fair for a year and was pleased that she was coping more comfortably with daily life. Now her focus was on learning to be a good mother to a teenage daughter whom she did not understand.

The woman who came to Selah at three o'clock was working through emotional and cognitive problems resulting from a neurological injury in an auto accident. Since her husband was usually away on business and no appropriate public transportation was available, a Selah supporter drove the woman to her appointments three times a week.

The four o'clock appointment was a complex case that Ms. Fair felt needed and deserved all the help Selah Center could provide. Four weeks ago, a family who lived at the poverty level but who had too much pride to take welfare had brought their nine-year old Mary in for help because "she don't seem quite right in the head." The
first day, the child had been withdrawn, mute, and fearful of the counselor. The child’s arm was in a cast, which she picked at constantly. As Ms. Fair worked with the child, parents, and three younger siblings several times a week, trust was established and the story emerged.

During a physical fight between the parents, Mary had become almost hysterical and run between her parents to separate them. The father had hit Mary, knocking her down the steps. Although her broken arm was mending, Mary’s inner being was not.

These parents loved their children and cared about each other as they understood love and caring. They wanted a better life for their family but they were lacking in personal emotional development and in social and communications skills. The father was illiterate and unemployed. The mother, who had a vocational diploma from high school, worked at a factory for minimum pay. Neither parent had positive models of home life from their own childhoods.

As Ms. Fair saw it, the task was to help both the husband and wife develop as persons through new experiences, to help them gain inner resources and psycho-social skills they had missed in growing up. At the same time, Mary and the other children needed warmth, encouragement, security, structure, and responsible love. In-office therapy would not be nearly enough for this family.

At this appointment, Ms. Fair supported the woman as a person and then moved to helping her realize that, as a mother, there were other ways she could relate to and discipline her children. When the woman said she wanted to do better but was afraid she could not change, Ms. Fair told her of a former client who felt the same way.
but learned to control her children and enjoy them more. Ms. Fair then asked if the new client would like to meet this person who was a helper at the Center. (Ms. Fair had already prepared the Selah member to teach parenting skills to this new client.) A time was set up for the two women to meet.

Ms. Fair hoped that through the example of a peer, the troubled woman would begin to be able to change personally and to relate more effectively to her children. The therapist wished there was a man in Selah who could be a positive peer model for the husband.

Five o'clock was open-door hour when persons involved with Selah community could drop in to talk, just for a visit or for informal counseling. Since no one came, Ms. Fair had time to call the parents of several youngsters. Though she was seeing the children formally, she was equally concerned about the parents, particularly about one young woman who was new in town and had no support system. With a little encouragement from Ms. Fair, that mother agreed to stay when she brought her daughter to drama group that evening. Ms. Fair then called a Selah member who had a child in the group. The woman had been involved with Selah for several years, was a native of the town, and was naturally warm and empathic. The Selah member was free for the evening and said she would try to make friends with the new mother and discern in what way Selah could be of help to her.

Drama group for children at 7:00 p.m. was a combination of outreach to the townspeople and continuing development for children who had been in therapy. The children were preparing to perform The
Lion, the Witch, and the Wardrobe under the direction of a volunteer who had been an elementary school and speech teacher. Each evening different combinations of children practiced their lines and dramatic skills. Ms. Fair was usually present to handle emotional upsets and interpersonal conflicts that might arise and to build relationships with parents.

Helping women to get to know each other in a supportive, accepting environment was one of Ms. Fair's major goals for the summer. Women who would not seek assistance for their own problems would come to an activity for their child's sake. Through becoming involved in an activity in a milieu that emphasized positive, caring communication, women often opened up about their own troubles and needs, sometimes to a therapist, and sometimes to each other. That was the essence of Selah—people caring, and sharing, and helping each other, and thereby helping themselves.

Selah currently

Though Selah Christian Center was functioning as a community in 1980, it was only beginning to define and delineate its structure, function, and goals. The task of systematizing the Selah approach to counseling without losing its unique flavor was interrupted by Ms. Fair's return to school to obtain a doctorate, a degree necessary to comply with state statutes and to improve public credibility. Since 1983, Selah volunteers have provided educational services to children and some counseling to parents and women.

When Ms. Fair completes her degree and returns to Selah, it is hoped that the Center can become, as a result of this research, a working model of the Christian counseling center as healing community.
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