An Internship Experience at the Riverwood Community Mental Health Center

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AN INTERNSHIP EXPERIENCE
AT THE
RIVERWOOD COMMUNITY MENTAL HEALTH CENTER

by

LeRoy Stanley Carter

A Project Report
Submitted to the
Faculty of The Graduate College
in Partial Fulfillment
of the
Specialist in Education Degree

Western Michigan University
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A number of persons have contributed directly to my internship experiences and I feel indebted to them. My appreciation to Dr. Robert Betz, my advisor, for the workable suggestions he provided me so that the experience could be satisfying.

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LeRoy Stanley Carter
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CHAPTER I

Introduction

The primary purpose of this Project Report is to provide an account of my internship experience at the Riverwood Community Mental Health Center and to show how this experience influenced my personal and professional growth. No effort, therefore, will be directed to deal with every phase of the above center. The writer is only concerned with those areas from which he gained a meaningful experience.

Rationale for the Experience

My professional background has been in church oriented activities, in schools, and in school counseling. For thirteen years, I worked as a clergyman, youth leader, and educator in Jamaica, West Indies. In 1965, I came to the United States as a graduate student of Andrews University and was graduated in 1967 with a Masters' Degree in Counseling and Personnel Services. After teaching mathematics at the junior-senior high schools for four years I became a Counselor of the Benton Harbor High School, Benton Harbor, Michigan.

My role and function centered around meeting the social, emotional, and academic needs of adolescents. Some activities included assistance in developing communication links where communication gaps have arisen between the student and his peers, between parent and child, between teacher and student, and between teacher and parent. At times, certain problems were beyond the scope of the high school counselor and it...
became necessary to refer these cases to the Community Mental Health Institution. Somehow, I felt the need to know not only what mental health counsellors were doing for the community, but how they were doing it.

This, therefore, is my primary reason for choosing the Riverwood Community Mental Health Center to do my internship. This setting could provide me with a comprehensive experience in dealing with family dynamics especially the dynamics between parent and child. In addition, the experience could provide me with some insights as to how to relate to the mentally ill through an understanding of the approaches which are utilized in therapy.

Internship Goals

For some time the writer felt that an experiential knowledge of the Riverwood Community Mental Health Center would not only be an enrichment of his present counseling experience, but would add certain dimension to his skills and be beneficial in the following ways:

1. To facilitate professional dialogue and consultation with mental health professionals in the community.

2. To facilitate correct and accurate referral.

3. To obtain enrichment in individual and group process and group dynamics as they affect families and the mentally ill.

4. To be a participant, therapist, and a co-therapist in group therapy sessions.

5. To understand the role and functions of the community mental health center.
Methods of Achieving Goals

In order to reach definite goals specific procedures must be determined. Through the following strategies, the intern hopes to achieve the goals outlined:

1. Working as co-therapist with mental health therapists in the Family Workshop, the Inpatient Unit, and the Day Treatment Center.
2. Becoming an active participant in group counseling sessions.
3. Working with specifically assigned cases.
4. Participating in special projects conducted by the center as a service to the clientele.
5. Reviewing materials pertaining to the history of mental health, the various approaches in treating the mentally ill, and the role and function of the community mental health center.
6. Meeting regularly with Mr. Robert Tollaksen, my supervisor, to appraise my personal and professional growth.
7. Having personal interviews with unit directors and intake personnel.

Summary

The community mental health program seems to be the most exciting and important concept in the field of psychology in many years. We have seen the favorable impact of milieu therapy and group therapy, the introduction of new drugs, and the advances in genetics, biochemistry, and physiology that are directly relevant for psychiatry. It has become increasingly possible to treat mentally ill patients in the community.
This trend has encouraged the study of family relationships and the possibility of constructive intervention in a period of crisis in the interpersonal relationships of family members. It has enhanced interest in rehabilitation and aftercare, and has changed community attitude toward the mentally ill.

When I chose mental health as the area in which I would do my internship, I came to the situation with a need to understand the mentally ill and to relate to them in a therapeutic situation. I set some specific goals and organized definite ways in achieving them. Undoubtedly I felt that my background as a counselor and clergyman prepared me to maximize this experience.

In the next chapter selected literature pertinent to the beginning and development of mental health in the United States is reviewed and discussed. The third chapter includes a detailed account of my log of experiences which is followed by Chapter IV, a summary and evaluation of my field experience.
CHAPTER II

REVIEW OF SELECTED LITERATURE

It is not the intent of this section to present a comprehensive review of the literature regarding mental health. However, the writer believes that crucial to the understanding of the function of the mental health institution is a knowledge of its historical development. Within the limits of this Project Report, the writer will review a brief history of mental health in the United States.

Early Beginnings

On May 6, 1908, Clifford Whittingham Beers met with a small group of people in New Haven, Connecticut, to organize the Connecticut Society for Mental Hygiene. This was the first association of its kind and the beginning of mental health movement in America.

The basic objectives of this nucleus body were: "To work for the conservation of mental health; to prevent nervous and mental disorders and mental defects; to raise the standard of care . . . ; to secure and disseminate reliable information." (Ridenour, 1961, p. 1).

Under the leadership of Clifford Beers, that same year, the Connecticut Mental Health Society was organized as a pilot effort. On February 19, 1909, Beers also invited a group of twelve persons to meet in New York City's Manhattan Hotel for the purpose of starting the National Committee for Mental Hygiene.
During this period events which would later have an impact on the mental health movement were taking place. Dr. William Haley was conducting the first meetings to discuss the Juvenile Psychopathic Institute in Chicago. In Baltimore, Henry Phipps had recently offered funds to Dr. William H. Welch to build a psychiatric hospital on the grounds of John Hopkins University. The St. Lawrence Hospital was starting a clinic for advice and treatment of incipient mental cases in New York State. In Massachusetts, the state legislature was in the process of passing an appropriation for the psychopathic hospital to be built in Boston. This was the first in a state hospital system and one which would be training many leaders in the field of psychiatry for the next fifty years.

Important things which would affect the mentally deficient were also happening. At the Training School at Vineland, New Jersey, Dr. Henry H. Goddard was starting to use a new-test-scale devised by two French psychologists, the Doctors Binet and Simons, who had developed the concept of "mental age." These tests later revised by Terman and known as the Stanford-Binet or "IQ" tests were the first important breakthrough in the description and classification of intelligence. On the Hudson River, New York, the Eastern New York Custodial Asylum was built. Letchworth Village as it was later known became one of the most progressive, pioneering institutions for the mentally deficient.

In 1908 most medical schools were operated for profit. Medical schools were not connected to any universities and applicants required very little academic preparation prior to admission. Abraham Flexner, under the auspices of the Carnegie Foundation for the Advancement of
Teaching, presented his report which startled the entire educational world and later became one of the forces revolutionizing all medical training and, therefore, all psychiatric education, making it necessary for psychiatrists to get their psychiatric training "by exposure."

In 1908 no one knew very much about the mentally ill. There were no list of institutions, no list of psychiatrists, no uniform system of reporting, no central repository for information about mental patients, no minimum standards for the care of patients in institutions and few laws for their protection either before or after commitment. Indeed, the new mental hygiene societies faced a tremendous task.

The National Committee For Mental Hygiene and Activities

Clifford Beers discovered that the problems that plagued new reform movements were no respectors of persons. For several years he was not only forced to use his own funds but to borrow for his organizing work. In November 1911, Dr. Welch received a letter and a check for $50,000 (fifty thousand dollars) from Henry Phipps towards ameliorating the insane in public and private institutions. The amount was turned over to the National Committee for Mental Hygiene.

Dr. Thomas W. Salmon, a young bacteriologist investigating an epidemic of diphtheria at Willard State Hospital in New York and under the tutelage of Dr. Russell, became the first medical director of the Committee in 1912 and, Beer, its first secretary.

One of the first official functions of the Committee was to adopt a resolution urging Congress to provide for adequate mental examination
of immigrants. The plight of the mentally ill aliens was tragic and deplorable. They were deported, but many never reached home and their relatives were unable to find out what had become of them. Finally, with the help of the National Committee, some of the worst of the abuses were corrected, and the entire system of reception and examination was reorganized.

As the new organization started the small staff was compelled to provide some type of service at once. They prepared lists of psychiatrists, of public and private mental institutions, and a bibliography on nervous and mental diseases, neither of which existed before. They began collecting and analyzing laws pertaining to the mentally ill and making them available to legislative bodies and civic groups. They began recruiting and training psychiatrists, and they created the American Board of Psychiatry and Neurology which examines candidates for certification. Some of the psychiatrists who were trained before 1919 were certified under the "grandfather clause."

In the annals of the National Committee, there were two foundations that supported them constantly: the Rockefeller Foundation and the Commonwealth Fund. Much of their support was behind the scenes and was not well known to the public. Their contributions both in leadership and money have been generous. There were others who made significant contributions, however, space would not allow the writer to include them.

Psychiatry which was regarded as the "Cinderella of medicine" began to assume its proper place. From institutional isolation psychiatry began to emerge between 1900 and 1914 and the early member-
ship which was under 500, now exceeds 11,000.

Interestingly enough psychopathic hospitals provided the setting for some of the most important contributions of the emerging psychiatry. The hospitals were the clearing houses for cases. Where diagnosis or disposition was uncertain, they gave first care to the patient before commitment. They provided short, intensive therapy for incipient cases, they trained medical and psychiatric personnel, they were the centers for outpatient services and research.

Perhaps the most exciting of the new ideas, which were to see rapid development during the decade within which this history begins, was the evolution of the idea of psychogenesis; the concept that mental illness and other symptoms were produced by mental and emotional factors as opposed to organic ones.

A more important development of this period was the rapid growth of therapy and research. It is generally agreed that the first breakthrough in psychiatric research was the discovery in 1913 that the syphilis spirochete causes paresis. That was followed by the discovery of the efficacy of fever treatment for paresis in 1917. Here then in a short four-year span, both the etiology of an important mental disorder and a specific treatment for it had been discovered.

Much excitement over potential "cures" came in 1933, with the discovery of insulin shock treatment by Sakel in Vienna, followed shortly by metrizol, both of which were introduced into the United States about 1936, and then by electric convulsive shock therapy in 1938. Psychosurgery was first carried out on mental patients in Portugal in 1933,
and like various other therapies has become a subject of controversy. With the sudden appearance of the tranquilizing drugs in the early 1950's came the next dramatic breakthrough. Even though the first extravagant hopes were not fully realized, tranquilizers nevertheless proved far more effective than shock therapies and have been one of the factors responsible for the larger number of discharges from mental hospitals within the past decade.

Child Guidance Clinics, Residential Treatment, and Child Psychiatry

The child guidance clinic movement began with people who were concerned with juvenile delinquency which was regarded as a grave problem and punishment was extremely severe.

In 1917, Dr. Healy and his gifted psychologist associate, Dr. Augusta Bonner, were invited to go to Boston to head the new Judge Baker Foundation which was to become the prototype of all child guidance clinics.

As soon as the National Committee's new Division on the Prevention of Delinquency was established in 1922, it began to send out psychiatric field service teams to organize clinics in different cities. The teams quickly learned that if a child guidance clinic is to succeed, it must have the support of a number of concerned community organizations and that in order to prevent delinquency it is necessary to reach a child long before he/she arrives at the juvenile court stage.

In 1927, the National Committee broadened its concept of the function of child guidance clinics and established a Division on
Community Clinics, which served as a clearing house and advisory service for child guidance clinics. It also administered the fellowship training program with the result that the number of child guidance clinics increased rapidly.

Developing directly out of the child guidance movement were two important professional organizations—the American Orthopsychiatric Association and the American Association of Psychiatric Clinics for Children.

The development of inpatient treatment of mentally ill children has lagged far behind child guidance clinics and there are yet only limited facilities in the country. This means that mentally ill children, if hospitalized, must of necessity be placed in wards with adults, or be at home under unprofessional care.

In the early days several child guidance clinics were established in communities that were not ready for them; consequently, The Child Welfare League of America decided not to recommend any new residential centers in a community if basic child care services were still lacking, or if the community had substandard institutions.

Partly because of the untold difficulties which were experienced by these residential centers, some centers were now experimenting with new patterns of day care which seemed promising for the future.

During the early 1960's the biggest single problem in providing good psychiatric care for children was finding well trained personnel. Astonishingly, there were not even one hundred "qualified" child psychiatrists in the United States. The question remains unanswered as to why more young psychiatrists do not choose child psychiatry and why the
few who are trained do not practice on children after training.

The Care of the Mentally Retarded

Curiously enough there was no acceptable word for the mentally retarded in institutions. They were called "children," but of course most of them were "adults." "Patient," "retardate" are other neologisms. "Inmate" had an undesirable prison connotation, so the phrase, "mentally retarded" was commonly used.

The mentally retarded have not been submitted to any cruelty compared to that of the mentally ill, nevertheless, they have suffered more than their share of neglect. At the turn of the century, "idiot" was still the generic term for the mentally defective. An institution for them now called either "school" or "hospital and school" was then known as "asylum for idiots" and "feeble-minded."

From the beginning, the National Committee had included institutions for the mentally defective along with those for the mentally ill in its surveys, and had discovered much of the wretched conditions which were now seen by concerned citizens groups. With the support from the Rockefeller Foundation, the institution surveys were extended, and as a result, institutions for the mentally defective were enlarged and improved in many states. Through the efforts of Dr. Henry H. Goddard the mentally defective were classified into three levels of feeblemindedness--idiot, imbecile, and moron. These terminologies are still in use today.

The excitement aroused by pseudoscientific reports of the menace of the feeble-minded led to drastic legislation. Several states passed
a law of compulsory sterilization of "confirmed criminals, idiots, imbeciles and rapists." In 1927, the constitutionality of sterilization for eugenic reasons was upheld by the United States Supreme Court. Present-day opinion questions the efficacy of sterilization of the mentally defective.

In recent years, it has become apparent that the classification of the mentally retarded includes many individuals who are mentally ill and not mentally defective, and who should be receiving an entirely different type of treatment. Some of the mentally retarded are defective in certain mental functions only, though not in all functions, and are potentially educative when the right techniques are found.

Just what the outlook is, for significantly reducing the numbers of the mentally retarded is not yet clear. It can be said, however, that research into the causes of mental deficiency is moderately encouraging.

International Mental Health

As early as 1919, Beers had begun to implement his dream of a worldwide mental hygiene movement. Eleven years later, in 1930, the first International Congress on Mental Hygiene was held in Washington, D. C. with more than 3,000 participants representing some fifty countries.

In 1937, there was a second International Congress in Paris. From 1930 through World War II some of the national societies had ongoing programs, but some existed principally on paper and there was little that could be called "international" in the sense of exchange between nations.
Early in 1947, the International Committee for Mental Hygiene was reactivated and elaborate plans were set in motion to hold a Third International Congress on Mental Health in London, in August 1948. At the Congress the functions of the International Committee were taken over by the World Federation of Mental Health, which had been created upon the recommendation of the United Nations' World Health Organization and UNESCO, because they needed a nongovernmental mental health organization with which they could cooperate.

Having official consultative status with the United Nations and several specialized agencies, the World Federation for Mental Health is in a position to influence some of the United Nation's decisions and some aspects of its program. The two United Nation agencies with which World Federation work most closely are the World Health Organization (WHO) and the United Nation Educational, Scientific and Cultural Organization (UNESCO). From the point of view of its toilers in the mental health movement both WHO and UNESCO got off to a brilliant start.

Legal Protection for the Mentally Ill
and Government's Expanding Role

Many well-intentioned legal decisions, regarding the responsibility of the insane, have raised more questions than they have solved. The concept of the "irresistible impulse" has been accepted in some states since 1844, and it is now part of the law in seventeen states. The "right and wrong" test is even more complex. As an outcome of the M'Naghten case in England, the House of Lords made the statement that "the party accused was laboring under such a defect of reason, from dis-
ease of the mind, as not to know the nature and quality of the act he was doing or if he did know it that he did not know he was doing wrong." (Ridenour, 1961, p. 72). In 1954, the Durham decision states that "an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." (Ridenour, 1961, p. 73).

Many conscientious psychiatrists are reluctant to testify in court because of the danger of being brought into "a battle of the experts" which could result in discrediting the profession.

Traditionally commitment procedures have resembled criminal procedures. Since the beginning of the mental health movement, attorneys and other professionals and citizens' groups have been struggling to abolish archaic procedures. Another aspect of the problem is the widespread practice of detaining mental patients in jails pending admission to mental hospitals.

The safeguarding of patients once they are in hospitals is less a matter for legislation than for regulation through professional care, although laws are important, especially in preventing abuses in the use of mechanical restraints. Within the last few years the complexion of the problem has been changed with the advent of tranquilizers.

Beginning in its first year, the National Committee for Mental Hygiene advocated the principle of complete state care, that is, mental institutions to be owned and operated by the state governments. Today a few states utilize county care in addition to state care. In the federal government, significant developments affecting the mentally ill have occurred in every decade since 1908. In 1946, the passage of the National Health Act was perhaps the most important event since the
beginning of the mental health movement.

The act greatly expanded the functions of the Mental Hygiene Division of Public Health Service which was reorganized and became the National Institute of Mental Health (NIMH), one of the National Institute of Health of the Public Health Service which was then under the Federal Security Administration, now the Department of Health, Education, and Welfare. Having started with relatively modest sums the first few years, in 1960, Congress voted over $100,000,000 for National Institute's 1961 budget. NIMH makes grants for research, for professional training and for the development of community mental health programs.

At the local level, a recent important development is the devise for encouraging the expansion of community facilities by offering subsidies out of state funds through the Community Mental Health Service Acts. Complications in administering state-wide community mental health services acts are very great indeed, with the danger of two closed systems competing with each other for funds and personnel, plus the almost insuperable difficulties attendant upon establishing laws and policies workable in both urban and rural communities. The past decade has seen dramatic increase in the use of public monies for such services as community clinics, rehabilitation, the training of professional personnel, research, and public education.

The Present Status of Mental Health

It is evident that this summary attempted to describe briefly the current scene in mental health movement and has only allowed the writer
to touch upon the high points. To do justice to the many activities under way would require many more pages. Yet this account seems incomplete without a brief review of present status and trends. These include: improvement in the care of the mentally ill, changing attitude of the public, and the permeation of mental health ideas.

Thousands of mental-health patients in the United States are getting better care than they ever had before. In 1956, the number of patients in the United States decreased and the downward trend has continued through 1960. In many states, the median length of stay of patients is being reduced so that, despite increased admissions, the patient load is decreasing. This is attributed to a combination of factors, among them the large-scale use of drugs, intensive treatment of new patients, milieu therapy, and open-ward policies.

Granting, there is much cause for rejoicing, it is necessary to keep the whole picture of hospital care in perspective. Psychiatrists in the United States keep reminding us that there is still only one doctor to nearly 200 patients in our big hospitals. As to costs the national average is still about $3.50 to $4.00 a day for mental patients, with some below $2.00 a day and none over $7.00, whereas it takes $25.00 to $30.00 a day to run a bed in a general hospital exclusive of medical attention. In many mental hospitals, dedicated doctors at best can treat only a tenth of their hospital population, while the other nine-tenths vegetate, waiting to die. It is difficult to congratulate ourselves based on the present limited success.

As for the future, it is hoped that some of the changing concepts of what constitutes good care will speed better care. Some measures
proposed for relieving pressures in hospitals and improving care of patients are: psychiatric services in general hospitals; in mental hospitals, more flexible patterns such as "open door" hospitals, day hospitals, night hospitals, small regional hospitals, voluntary commitments; family care and nursing homes; rehabilitation programs to serve the needs of convalescent and discharged patients; community facilities of many kinds including the full range outpatient clinical services for children and adults, and the steady development of responsibility at the level of the local community; earlier and more effective work by related professions. As local communities gradually assume more responsibility, more patients would be kept in the community, or if removed, more of them would be returned in shorter time, thereby relieving the state government of a sizable portion of its present burden of custodial care. Along with its traditional responsibility for financial assistance, the state could devote more attention to consulting and coordinating functions, setting standards, channeling funds, and conducting demonstrations, experimentation, education, and research.

Changes in public attitude are apparent everywhere: in the mandates of the people to their government, in their voluntary organized effort and in their spontaneous expressions of interest and concern. In 1958, an opinion pole indicated that next to education, the American people are willing to be taxed for the care of the mentally ill, than for any other major public service.

The National Association for Mental Health reported that in 1960, in addition to the state mental health associations, there were some
800 affiliated mental health associations in forty-two states with a total registered membership and volunteer participation exceeding 1,000,000.

The path of voluntary mental health is still beset with problems of structure and relationship, however, it is hoped that the great body of experience, workers are now accumulating will facilitate the effectiveness of mental health associations in the future.
CHAPTER III

LOG OF EXPERIENCES

Introduction

When I began my Specialist Degree Program, I thought of doing my internship in a parochial school setting. However, two main occurrences convinced me to turn to mental health for the experience. In the first place, there were increased referral of students from myself and my colleagues to the community mental health center; next came my major decision to enter a marriage and family counselor training program. I discussed this with Dr. Betz, my advisor, who collaborated with me to do my internship at the Riverwood Community Mental Health Center.

Before the Spring of 1977, I consulted with Mr. Robert Tollaksen, Director of Consultation and Educational Services, at the Riverwood Community Mental Health Center, and arranged to work under his supervision as an intern at the above institution. We discussed my objectives and the various agencies that were under the umbrella of community mental health and how I thought I could benefit from them.

I was quite impressed with the idea that mental health was not only concerned with the mentally ill, but offered services to many who were undergoing stressful situations that would perhaps lead to poor human relations. "The Weekly Family Workshop" for instance serves such a purpose.
The interview with Mr. Tollaksen excited me, and although I was not officially registered at Western Michigan University for my Internship Experience, Course 712, yet, I arranged with him to start immediately.

On April 4, 1977, I began my involvement in the "Family Workshop" which convenes each Monday night with Mr. Tollaksen as group facilitator. Mr. Tollaksen arranged with Mr. Frank Sanders, Director of Inpatient Services, for me to start my experience on May 2, 1977, and Mr. Joseph Opalski, Director of Day Treatment Services agreed that June 13, would be a suitable starting date for him.

Family Workshop April 4 to May 27

The Family Workshop meets at Riverwood, St Joseph, each Monday, except holidays, from 7:30 p.m. to 9:00 p.m. The meetings are conducted for adolescents and parents. Mr. Tollaksen's handout states:

Where we explore family stresses and options to resolve them. There are usually no innocent bystanders in a family with problems . . . We will try to make you aware of who is doing what and how . . . and help you develop skills of coping with your particular difficulties. It is up to each person to present their needs as they feel like doing so, as there is no pressure to participate.

No charge the 1st session . . . $2.00 per family thereafter if you can afford it . . . no bills are sent, and no records are kept.

What we share here-stay here-to maintain confidentiality.

Each participant responds to a workshop sheet with the following seven questions:
On the above date, I met with an informal group. Members were not introduced to each other by name; no one was asked to participate if he did not choose to take part. This was an "open" group.

Confidentiality was carefully stressed. No one was free to disclose any problem that was discussed in the group. Tape recorders were not allowed nor were notes permitted to be taken.

I discussed this approach later with Mr. Tollaksen who felt that open groups do better at self-disclosing with the absence of formal introductions.

There were four families represented. The following provides a brief description of the status and problem of each family represented.

Family 1. Female—36 years old.
This is her second marriage. She has a seventeen year old son by her first husband and there is very poor communication between her and her present husband. They are sleeping in separate beds in the same house.
Family 2. Female—55 years old.
Her husband is deceased, and her twenty year old niece lives with her. She feels that her niece is unable to maintain her friendship with men because she refuses to be engaged in premarital sex.

Family 3. Female—35 years old and her daughter.
She has been married for sixteen years and has two children, a son age fifteen and a daughter age thirteen. Her daughter is obese and has been in constant conflict with her peers.

Family 4. Female—35 years old.
She has been married to her second husband for ten years, and has five children ages, 17, 15, 10, 6, and 4. The first two were children of her first marriage. The seventeen year old is in conflict with her and his employer, and there is constant conflict between both sets of children.

The above data about families supply the following information:
1) only the wives and children were present at the session although it was open to the family; 2) two of the four wives present were into their second marriage; 3) there was a clear communication gap among members of families; 4) the marriages which had ended in divorce were performed while the parties were in their teens.

The session was extremely fulfilling for me. I observed members of families work with problems that were developed among them; and other families, who were undergoing similar stressful experiences, joined in the problem-solving process. It was threatening and risky for them, but therapeutic. Although this was my first session with the group, I became involved as co-therapist.

April 11 - Evening

In the first group meeting, I observed that the group, not the
therapist, set the tone and direction. At the beginning of the session members discussed topics which seemed unrelated to family problems. My concern was, how does the therapist focus attention on relevant material and not shut off member participation. In keeping with my thoughts the facilitator put the responsibility for the refocusing on group members by asking various questions and this approach really worked. At the second session there were ten participants present, one family from the previous meeting returned and four new members. Here is a brief description of the group members, their status, and problems.

Family 1. Male 47, divorced, living with his mother whom he hates and does not verbally communicate with, but feels he needs her to cook for him; he thinks he is ugly, unattractive, and unable to attract women.

Family 2. Female: mother 35, three children, ages: boy 17, girl 16, boy 12. Husband deceased; girl defies mother's authority and thinks that she can protect herself and does not need mother's supervision.

Family 3. Female: mother 30 and 12 year old son present. She is separated from husband. Son is brilliant, but an under-achiever in school.

Family 4. Male: father 38 and son 11 years old present. Father and son are in conflict; son thinks school does not allow for much individual development; no time is allowed to choose what he wishes to read if he is through with classwork; father feels son should conform.

Family 5. Female: wife and mother of five, in second marriage, returned to the group with her son, 10 years old; son's friends smoke "pot" in the home; mother says only members of the family are allowed to smoke "pot" in the home.

I observed two things about the second group: the whole family was...
not present—only mothers, children, adolescents; problems invariably deal with resistance to authority. During the session the therapist utilized the resources of the group by calling upon peers present to explore to come up with alternatives or to test similarity of experiences. I was very surprised when the 47 year old male who lived with his mother suddenly withdrew from the session at a certain point in the discussion. At a subsequent meeting the therapist confronted him on the reason for his behavior. He quickly retorted that the girl was "rude" and "impertinent" to her mother in the presence of the group. The therapist explained that she was merely being honest by stating exactly how she felt. As the group worked with this member, it became evident that this "polite, well-spoken" gentleman had suppressed his childhood hostility toward his mother (to date his mother does not know that he hates her) and when he heard the young girl speak so frankly to her mother, he hated himself for being a coward. The situation was too much for him to tolerate, so he left the session.

April 18 - Evening

Family 1. Female: mother 31; son 12 years old and daughter 9. Mother has been through three divorces and is now "living with" a married man who was her lover of fifteen years ago. Her son is "skipping" school; he does not like school; yet is attempting to "run" her life.

Family 2. Female: mother 36; her 20 year old stepson who was on vacation from the University of Michigan was with her. Mother was in her second marriage; and finding it difficult to trust people. She also has difficulty relating closely to her second husband.

Much of the discussion centered around the twelve year old who was a
truant. An interesting point was raised by the University of Michigan student. He felt that parents have a right to want to be listened to because they are parents, but kids should also be listened to, because they are persons and have something to say. Their lives are theirs and they should have a say in deciding on the direction they wish to take. The group aided the twelve-year old in making some definite commitments about attending school.

April 25 - Evening

At this session, the only families present were: the mother of the truant son, and another mother with her fourteen year old daughter. I will briefly state the nature of the problem for each family.

Family 1. Mother and nine year old daughter were present without her son; her son ran away from home; he was pressuring his mother to return to the home of her last husband who is his real father. The mother does not wish to go.

Family 2. Mother and fourteen year old daughter. Mother describes daughter as disrespectful; the daughter reported that her mother distrusts her, spies on her, and gives her no freedom; she questions her about every contact she makes with boys.

I observed that in this small group the therapist assumed "control"; he asked more questions; he gave direction and presented alternatives. When questioned about this change of leadership style, he explained that in certain situations it becomes necessary to modify one's style, and this depends on the client's level of maturity and awareness of his problem.
May 2 - Evening

At 7:30 I was alone at the venue. Mr. Tollaksen arrived five minutes later. We discussed poor attendance, some of the causes, how the therapist reacts to this positively and negatively and some ways of increasing attendance. Already the each-one-tell-one method was in use. I suggested that: 1) an "ad" be placed in the daily newspaper; 2) ask the clergymen to make announcements in their churches and, 3) leave "fliers" at super-markets in the community. Mr. Tollaksen seemed very reception to my suggestions. It was after 8:00 and since no one else had arrived, we utilized the remaining moments to discuss my professional growth.

May 9 - Evening

I was unable to attend workshop this evening.

May 16 - Evening

This evening at 7:30, Mr. Tollaksen was absent. Nine persons were present. I was acquainted with all group members, except one female. No one mentioned that Mr. Tollaksen would be absent, therefore, I anticipated his arrival at any time. The meeting focused on the mother and her truant son. The mother was very angry and frustrated because she was still finding it difficult to keep her son in school. She expressed fear of the possibility of his being sent to the Juvenile Center in Berrien Springs. Most of the time was spent working with the boy. I assumed the therapist role and initiated many things. During
the session I noticed that the new female member of the group became deeply involved. The group session terminated and nothing was said regarding Mr. Tallaksen's absence. Later I discovered that Mr. Tollaksen had an emergency and had asked this lady to be his substitute.

May 23 - Evening

There were eight persons present, including two new members—a mother and her daughter. The mother was 33. Her husband was deceased and she had no immediate plans for remarriage. Her life revolved around her three children: two boys, ages 16 and 15 years, and one girl 13 years old. The boys were not allowed to smoke in the house because she did not smoke and was upset by smoke odors. The mother objected to the girl remaining at the bowling alley until after midnight. The session was devoted to this girl and her mother. The group discovered that she was a grade behind in school and was not doing well because she was not spending much time on school work. After exploring many alternatives, the girl committed herself to using her time more wisely.

During this session, Mr. Tollaksen spoke only when it was highly necessary to keep the group moving. He encouraged some group members of approximate age to react to certain situations, and this proved extremely effective.

At the end of the meeting, Mr. Tollaksen informed me that he would be doing a screening for the courts on May 27, at 2:30 p.m. and invited me to join him.
May 27 - Afternoon

I obtained permission from my building principal to attend this screening meeting which convened during my working hours.

At 2:15 p.m. I was with Mr. Tollaksen and Mrs. Neldine Watson, his secretary, in his office. Mr. Tollaksen briefed us on the purpose and procedure of the screening. There was an opening for a Turn-key in the St. Joseph County Jail and these men were being screened for the position. Prior to this meeting, the men were administered an "Anger-Self-Report" Test. During the interview, they were being observed for: reactions to under-stress situations, racial or sex biases, homosexual tendencies, and leadership skills.

At 2:35 the two men joined us, and were introduced. Male A: 32 years old; 6'1" tall; weighs 215 pounds; unmarried; ten years experience in the Marines. Male B: 26 years old; 5'8" tall; weighs 165 pounds; married, two children, four years experience in the Army.

The situation was informal and very relaxed. In the interview which lasted for ninety minutes, we focused on the above biases, reactions, skills, and tendencies. Hypothetical cases were posed, and the verbal, as well as non-verbal reactions of the candidates, were observed. After the candidates left, Mr. Tollaksen asked us for feedback. He checked our impressions and after briefly deliberating with us, we then voted on one of the two men for the position. The decision was relayed to the Sheriff.

This ended a very meaningful experience in Family Workshop for me. Various needs were met within the group. Adolescents were provided with
suggestions, support and insights on how to face the problems of maturation within the family setting. Mothers and wives gained helpful suggestions on being better parents and wives in meeting their own needs and the needs of their spouses and families.

I observed that communication was a major problem among members of families. Parents as well as children need to learn how to meet the needs of members of the family. I could not help reviewing my function as a husband and father.

In-Patient Unit -
May 2 to June 6

I arranged a meeting with Mr. Sanders for April 25. On that date he introduced me to his staff and welcomed me to the unit. We discussed in detail my goals and how the In-Patient Unit could help me to achieve them. He gave me an overview of the program and outlined the daily schedule. We felt that Psychiatric Staffing, which was held every Tuesday at 3:15, would be helpful. We discussed legal protection and he mentioned that in order for me to have proper protection there must be a contract between Memorial Hospital and the sponsoring University. We arranged the days I could come, at what time, and how many hours daily. We also decided how long the experience would last.

With regards to the contract, I wrote Dr. Betz a letter on May 5 explaining the situation and suggested how he could get in touch with Mr. Sanders, if it was necessary.

May 3 - Afternoon

I began my internship at the In-Patient Unit of the Memorial
Hospital at 3:15 that afternoon. At Psychiatric Staffing, I was introduced to Dr. Chen, Clinic Psychiatrist, and other members of the staff. The purpose of these meetings was to give a brief description of each of Dr. Chen's patients; to review their condition, and to decide on their future—whether they would be dismissed, transferred to the state hospital, or remain in the inpatient unit. At that meeting, I was assigned two cases which were described as catatonic schizophrenia.

May 4 - Afternoon

This afternoon, I began observing and making notes of my clients' behavior. Case 1 was withdrawn; never started a conversation; was silent at meals; spent much time in his room. Case 2's behavior was similar to Case 1, in addition, he would either be staring in space or eating a snack.

Community Meeting

It seems appropriate to describe a community meeting, at this point, to supply the reader with an approach to milieu therapy. This meeting is held Monday, Wednesday, and Friday of each week from 4:00 to 5:00 p.m. It is conducted by the patients with all staff members present. The meeting is called to order by the chairperson who begins with "introductions." Each person (patient) who is at the meeting for the first time, gives his name and reasons for his/her attendance. The chairperson then informs the group of those who were "dismissed," since the last meeting. At this point, a chairperson for the next meeting is selected. This chairperson must be either on level two or level three.
(Levels will be explained in the next paragraph). This is followed by a discussion of problems which affect community living. Concerns center around unacceptable behavior, such as unhygienic habits, failure to return things to their proper places, destruction of hospital property, or delatory actions on behalf of staff members. At 4:25 the first half of community meeting ended.

**Level Privileges**

The level at which a patient is rated indicates his privilege at the inpatient unit.

**Level I.** Patients will be expected to attend all scheduled activities and are not allowed to leave the ground floor or go to other floor activities without staff escort. No dot is given on the patient's identification bracelet for Level I. If the patient has an emergency need to go out, it must be with a custody pass. Activities within occupation therapy and recreation therapy will be restricted at the staff's discretion. Patients may serve on activity planning committees.

**Level II.** The patients should have met the requirements of Level I, demonstrate ability to fulfill all ward expectations, and take responsibility for their own behavior and personal hygiene. Privileges include the right to leave and return to the ground floor during free time, to go to public areas of the main hospital or walk on the hospital grounds between the hours of 7:30 a.m. and 2:30 p.m. Off-unit privileges are limited to one hour at a time. Parents are to be informed when a minor receives Level II privileges. A blue dot is applies to the patient's
identification bracelet; the patient may obtain passes without custody for special purposes, and be considered for up to a 36-hour weekend pass—8:30 a.m. Saturday to 2:30 p.m. Sunday. All passes must be ordered by a physician; may use special equipment in occupational therapy or recreation therapy at the discretion of the occupational therapy staff; may be considered for chairperson of the community meeting if no one with Level III privileges is available.

**Level III.** Patients will have met the requirements of Level I. Privileges include those of Level II. May be special staff assistant. If a patient is working as a special assistant, the staff may invite the patient to eat noon lunch and/or take coffee break in the hospital cafeteria with the staff. May obtain overnight pass during the week and full weekend pass, Friday 5:00 p.m. to Monday 8:00 p.m. May be considered chairperson of community. Minor patients will require parents' approval for Level III. A green dot will be applied to the patient's identification bracelet. All passes are by order of a physician.

At 4:30 p.m. only those applying for changes, those on Levels II and III, and staff members remain at level change meetings. Only staff members and patients on Levels II and III are allowed to vote. This meeting is conducted by a member of the staff. The name of each applicant is presented. The chairperson then asks if anyone has reasons why this person's name should not be considered. If no statement is made, the chairperson proceeds to vote on behaviors, like: following level privileges, interacting on group and individual sessions, taking care of needs and living environment, involvement in appropriate interpersonal
relationships within the community, being in good control of behavior, taking initiative in all activities, making constructive plans for the future. Twenty points are the minimum requirement for level change. On the above date, three persons applied for level change and all were granted the changes.

Supper is served in the dining room on the ground floor at 5:15 p.m. When the time came, I joined them on the elevator and rode to the ground floor. Some time elapsed before supper arrived, so I chose to work with one of my assignees. I asked him if he understood the meaning of level changes; he said, "not so good." I asked him if he would like to have me explain it; he said, "yes." Since he was on Level I, I asked him if he wished to go to Level III; he replied to the affirmative. I explained in full detail, and he seemed very pleased. I assigned him some definite things to do for our next meeting.

During supper, a member of the staff announced that there would be summary meeting soon after supper. The patients were divided in groups and met in different rooms. I chose to be with a group of eight persons. This meeting was very interesting. The leader suggested that each patient write the problem he now sees; choose what he wishes to work at; review the day's activities, and evaluate them. The group leader assisted each one in coming up with alternatives and in choosing a course of action. The meeting lasted for nearly one hour. This was my first day of working with the mentally ill. The therapists emphasize the psychoanalytic and the behavior modification techniques. This type of therapy combination seems to produce observable behavior changes in the patients.
May 9 - Afternoon

In order to gain more understanding of my clients, I reviewed their case history, discussed them in more detail with the psychiatrist and social worker, read about causes and current ways of treatment of the schizophrenia, and finally continued observing their present behavior.

1. The history of Case 1 revealed that he was 19 years old; dropped out of high school; and had used marijuana. His mother, 45 years old, was described as a religious fanatic who dominated his life. His father, 46 years old, was depicted as irresponsible and non-nurturing.

2. The records of Case 2 indicated that he was on his third admission; was 20 years old; catatonic; and attached to his sister's baby. Mother, 42, was on welfare, and an alcoholic. Father was not living at home.

I recognized that this was the beginning of a new and challenging experience for me as I started to work with Case 1. In our first session, I focused on his home and family life, and his uninvolvment with the activities in the unit.

As we talked during supper, Case 1 seemed very nervous and blamed himself for "messing up" his life. However, he expressed a desire to try for level change in the unit.

Community Meeting

Inclusive of the staff, there were thirty-six persons present. The meeting was called to order and introductions and announcements were made. Three persons were dismissed from the unit and three were admitted.
I will briefly describe those admitted and give reasons why they were admitted. One married woman, 27, mother of three, was admitted because of attempted suicide. As I later learned, this happened after her jealous husband had cut her breast and belly in several places. A male, 65, retired six months earlier, entered as an alcoholic. A widow, 51, remarked that her thoughts were not together, so she turned herself in to receive help.

In the discussion that followed, several observations were made. A member of the staff mentioned that patients were delaying too long in the dining room after meals. Some patients were very annoyed at the methods used to awaken them in the morning. Some needed towels. It was brought to their attention that the towels were located in a certain room and they were free to take what they needed. Mention was made of the lost popcorn popper. Each one was asked to join in the search for the popper.

At the level change meeting, three persons applied for level changes. Two were accepted and one denied. The one who was denied did not accept it very gracefully, and he challenged the decision of the group. After much discussion, he seemed accepting of the decision.

During our break period preceding supper, I visited with the patient who seemed so depressed after his weekends at home. He was making an effort at behavior change; it was slow, but he showed some progress in his interaction with people and in personal hygiene.

May 10 - Afternoon

Psychiatric Staffing:
During the meeting we discussed the patients individually. I gave a summary report on the patients I was working with, the methods I used and the responses I observed. One of my patients whose response seemed so slow was described by Dr. Chen as catatonic schizophrenia. He has been a patient before and there was not much that could be done for him in the unit. I continued working with him, but he was released after two weeks.

This same afternoon I had a very interesting experience. Lyda Barlow, a social worker who cojointly supervised me with Mr. Sanders, assigned me a particular case. This was a female, 62, single; has been in two psychiatric wards; paranoid schizophrenic; has been a missionary; has had a remorseful experience with a male; finds it difficult to relate to men.

With this history, I began working. At first she was extremely negative. She was not responding verbally. Nonverbally she was saying, "Go away, I don't want to talk to you." In short, she wished to be left alone. I did two things: one, I focused on the area of her religious experience, made some assumptions; then I related the past with her present behavior. Soon she began to respond verbally. This was a very exciting moment for me because I was experimenting and it worked.

Later that evening Lyda informed me that Dr. Chen did not wish me to continue working with this patient, because she had a court case pending and he was afraid of the possibility of my being involved.

I spent the rest of the evening introducing myself to several patients who I did not know very well. After talking with them briefly, I began to focus on other cases that were not assigned to me, and for
which I did not have the "go ahead." In other words, I was risking. I chose not to sit around doing nothing in the presence of people whom I thought I could help.

I started working with a patient described as "difficult." He was a male, 22 years, has been in inpatient units before; described as cata
tonic schizophrenia; he was distant, withdrawn, not eating, and not interacting with his environment. I worked with him for twenty minutes. There was no obvious physical or verbal responses. I ceased; promising to return at a later date.

Earlier, Mr. Sanders told me that he would be taking a case history. We discussed this, and I decided to join him the same afternoon. Just then, things began to happen. Some of the patients whose acquaintance I had made, requested that I see them. The husband of one would be in that afternoon and she had asked me to be in on the conference. Another whose sons were my counselees at the Benton Harbor High School asked to see me the following afternoon.

The case history was an extremely valuable experience for me. Mr. Sanders handled it very efficiently. He asked the patient questions which gave the answer not only on the relation with her husband, but the intensity of it. Since her husband was a retiree, we wanted to know how he was spending most of his time, what he was doing, and with whom. We wanted to know the history of his alcoholism and just what happened before he started. We tried to find out her present perception of him and others who were relating to him.

The working hours of Mr. Sanders and Mrs. Barlow are from 8:00 a.m. to 5:00 p.m. However, there were several times when they were there
beyond 7:00. This evening was no exception. The patient's husband arrived around 5:00 p.m. The session was very stormy. The patient reiterated past experiences and expressed her hurt at his behavior. She declared her hate for him and said she wanted a divorce. She even mentioned that she was in love with another man. Mr. Sanders and I said very little during the session which ended after two hours.

May 11 - Afternoon

This afternoon, I arrived early and reviewed the previous session with the patient. I shared with her my observations during the period. We looked at her husband's approach; he was very honest in admitting that his behavior contributed to her illness and constructed a plan of action for the future. We looked at her responses; she unearthed the unlovely past, and created "road-blocks" for the future. I made the observation that she had no wish to be without her husband and she was desperately in love with him, but was afraid to admit it, but was trying to manipulate him. At that moment she burst into tears, and admitted that I was so right. I asked her why not be honest, confront her husband, and give herself to him as she did when they were in college. The following day she asked Mr. Sanders to set up a meeting with her husband for Monday, May 16. It was 4:00 p.m. so we turned to Community Meeting.

Community Meeting

The chairperson called for introductions. There were three: 1) a male, 27, married, has one son, separated from his wife; "hooked" on
heroin for six years; (2) a female, 33, married, no children, husband a construction worker, away from home most of the time; she fell from a twenty-foot stairs; is suffering from amnesia; (3) female, 25, unmarried; alcoholic, attempted suicide. There were two dismissals.

After the chairperson for the next meeting was selected, problems facing the inpatient community were discussed. Bedmaking, pop cans, and coffee cups left behind were among the most recurring problems.

There were no level change applicants and someone moved that the meeting be adjourned. It was seconded and voted, and the community meeting ended twenty-five minutes early.

At the first community meeting I attended, I observed that there was a woman who slept during the meeting. She was awakened several times, but soon returned to sleep. On May 11, she was knitting in the lounge, I joined her and discovered that she was the mother of two of my counselees. We talked very briefly and I promised to see her again.

**May 16 - Afternoon**

This was my third week at the inpatient unit. Somehow, I felt as if I had been there for several months. All members of the staff, doctors and nurses, were extremely cooperative. I was treated as a member of the staff. Mr. Sanders, Mrs. Barlow, and I developed a very close working relationship. The patients looked daily for my coming. I was truly aware of "accepting" and "being accepted" and it was beautiful.

As soon as I arrived, Mr. Sanders said that the woman whose children I counseled at school wished to see me. The other lady who had set
up the conference with her husband informed me that she requested my presence at the session which would convene later in the afternoon.

Community Meeting

Community meeting began as usual with introductions and dismissals. There were two introductions and three dismissals. A female, 39, married with five children, was admitted because of depression; a male, 29, unmarried, who wanted to get his mind together. The male that I described earlier on heroin was on Level II. He went for a walk and never returned. He was officially dismissed. One of the young males with whom I was working was sent to a foster home. Following the election of the chairperson for the following meeting, the discussion centered around a T. V. Guide for the lounge. The concensus was that someone on Level II would purchase one for the group each week. A group member mentioned that some were still leaving towels in the bathroom.

At level change meeting, four persons applied and four were accepted. Before supper time the husband of the patient who arranged the conference, arrived. I discussed a few things with him, we reviewed the marriage, where it had been, and where it was then. We talked about his wife's "true feeling." He stated his "true feeling," said he was "running out" of patience, however, he wanted to give it another try. After supper the wife joined us. During separate interviews we touched base with self-awareness; they became conscious of their needs and how these could be satisfied; they wanted to be with each other. This meeting was indeed a contrast to the first. There was a searching
of self, not of the other. There was a conscious attempt to communicate, and communication was achieved. The following week the wife was dismissed from the unit and is living with her husband.

May 17 - Afternoon

This afternoon, I attended psychiatric staffing, and did a case history with Mr. Sanders. Dr. Chen did a very extensive review of some cases. He told us that one patient had left on his own; another was transferred to the State Hospital; another was sent to a home; another was transferred to the intensive care unit at Memorial Hospital because she had a heart attack. To date, I had worked with several patients and felt well rewarded.

Case History

Perhaps, I should say that the purpose of a case history is to uncover or discover what the people who are closest to the patient have contributed to the illness, what they are contributing and how they can facilitate the patient to recovery.

This session centers around the husband of the woman who suffered amnesia as a result of a fall. Dr. Hunter, Mrs. Barlow, and I were sitting in on this conference. Dr. Hunter asked most of the questions which gave a knowledge of the history of the marriage; the husband's daily and weekly schedule, the wife's daily and weekly activities; what he knew of the fall and what he did after the fall. I focused on their present marital relation in view of his mitigating behavior—he comes home late and leaves early.
He was very compromising. Significantly, however, he mentioned that people said that she read the Bible too much. Here he implied that this could have contributed to her illness. He seemed to want to blame something for his wife's illness, but he was not sure what. I shared my observations with Dr. Hunter and she concurred with the observations.

Following this, I had my first long interview with my counselees' mother. Her records indicated that she had a church-going mother, but her father was an alcoholic. The night before she was committed to the inpatient unit, she had a fracas with someone. Something negative transpired and she suffered amnesia.

In the interview it became very clear that she was experiencing internal conflict. After we had talked for nearly forty-five minutes, I communicated to her that she was someone who has been accustomed to a certain "life style" but had changed it and was uncomfortable with the change. She agreed with me. I asked her if she wished to change. She said, "yes." We identified some problems, generated some solutions, and she decided on some things she wanted to try to pull herself together. Before the session was over she expressed that she was feeling better already.

Reflecting on the techniques I used when I started this internship experience I realized that I was acquiring some new counseling skills and changing some of the previous approaches. Although eclectic in my approach, I leaned toward a nondirective model. I attempted to create a warm, permissive atmosphere in which the client feels free to discuss his problems frankly. I feel that the client is in the best position
to resolve his own problems. I prefer to refrain from advising, interpreting, or intervening except to offer encouragement and occasional restatements of the client's remarks for clarification. But in my work with the mentally ill, I sensed a deep need for structuring, directing and suggesting. I used this approach several times and things began to happen; patients were responding and seemed able to handle their gut-level feelings.

May 23 - Afternoon

When I arrived, another patient wanted me to counsel her. I spoke briefly with this patient and promised to see her at a later date. I checked with the patient that I counseled the day before. She informed me that she was feeling very well. She continued by remarking that I was doing more for her than her doctor. I took this with ambivalence; I was happy to know I was helping, but I had no wish to be in competition with the doctor.

Community Meeting

We joined the group of twenty-nine persons in community meeting. I mentioned earlier that a married woman was committed because she attempted suicide after she was physically hurt by her jealous husband. The husband was invited to a conference by the psychiatrist. No sooner than he arrived, a policeman was there who advised him to commit himself to the inpatient unit or he would be taken to jail. He surrendered and his wife was released. Another case was that of a male, 22, paranoid
schizophrenia; calls himself "Jesus Christ;" claims he completed high school in one day, and is now studying law. During the business session of the community meeting, the chairperson reiterated the one-cigarette-per-meeting rule, and that each person should put his hand up to be recognized by the chairperson before he speaks. The chairperson for the following meeting was chosen and the discussion was directed to those with unhygienic habits—"body odor" and "bad breath." Some solutions to these problems were discussed.

**Level Change**

There was one level change and the meeting ended fifteen minutes ahead of schedule. While we waited for supper, I counseled a patient who was deeply depressed because she felt rejected by her daughter. The session was brief, but I suggested some skills that hopefully would enable her to cope with rejection.

Summary group assembled after supper. There were seven persons in the group. As each patient reviewed his problem, it was evident that some had improved, but others were still deeply depressed. Each one reviewed the activities of his/her day, evaluated them, and set goals he/she wished to attain. The therapists spent some time to rap with each patient regarding his special problem. This was a very caring and concerned group; each one was listened to and received feedback from the group.

Sometime that evening, I talked with a depressed mother. She seemed deeply concerned with the unfair treatment that she received from her daughter.
May 24 - Afternoon

At psychiatric staffing Dr. Chen discussed the progress of the repeaters. The three were dismissed and another was transferred to the state hospital. The others in his caseload remained in the inpatient unit.

That afternoon, Mr. Sanders invited me to accompany him to a court hearing on a child abuse case on May 31, at 4:00 p.m. He submitted to me a file on the history of the accused, the allegation, and a history of the abused child. The mother, 55, married to a twenty-year old man who was unemployed. She feels that she does not have the emotional strength to cope with her fifteen-year old daughter who was on "pot" and an underachiever in school. I discussed with the therapist this very sensitive aspect of his job, the caution, the care, and the courage one must have in order to sit in his chair. Despite his certainty of the facts of the case, he appeared very concerned. Before I left that afternoon, he again invited me to sit in with him on a medical history.

May 25 - Afternoon

I decided to miss community meeting this afternoon so as to be on the medical history team.

There were five of us present at the conference: Dr. Hunter, Mr. Sanders, the patient's son and daughter-in-law, and I. The purpose of the history is to understand the case from the standpoint of the family and related circumstances.
Patient 81 years old; has four sons, one sister in the state hospital for approximately forty years, lived with mother for forty years. Patient was confined to another institution for nine months. Most recently she lived with a son and his wife, who describe her as two-faced, unable to handle any form of criticism; she steals; people of different races scare her. She does not get along with grandchildren. While she was confined to the other institution, she fought some patients and was involved in a case in which another patient's hip was dislocated. She would break furniture and did many bizarre things. However, her son and his wife did not wish to have her committed to a state hospital.

The interview lasted for nearly two hours. Only a few questions were asked by us. We ascertained the names and addresses of the other three brothers and concluded the interview.

I returned to counsel with the mother of my counselees. She gladly informed me that within another week she would be out. She told me that she was reading her Bible before bed each night and was being emotionally helped by this practice. I encouraged her to maintain this exercise, since it was helping.

May 31 - Afternoon

On this day, I arrived at the court at 3:10 p.m. where Mr. Sanders, a mother, daughter, and attorneys were present. There were also two mental health workers who were subpoenaed to court. There was a similar case in session, so we were obliged to wait for two hours.

After the case we entered the courtroom and waited another thirty minutes before the Judge entered. The court was called to order and declared in session. The facts of the case were reviewed very carefully. The focus of the court hearing was on protecting the child's welfare. The child wanted to return home, but the court ruled that she be placed
in a foster home, especially when it was pointed out that the step­
father was but a few years older than the girl.

The court further recommended that the mother and stepfather con­
tinue receiving psychiatric care. The procedure lasted for forty-five
minutes and at the end, the mother and daughter embraced for a long
time. The daughter was returned to the inpatient unit for a limited
time.

As I reflected on their case, I was favorably impressed with the
manner in which the court assumed its responsibility for the child's
mental health. As the case was carefully reviewed and evidence from
both sides was presented and analyzed, the court concluded that the
home environment was unhealthy and, despite the child's wish, proceeded
to procure a different home situation which to them would be more con­
ducive to the proper development of mental health for the child. I
concurred with this judgment, because the mother felt she did not have
the emotional strength to enter into a nurturing relation with the
child. Despite the fact that the foster parenting does not always
achieve the desired goal, the action reveals that a legal "parent body"
is concerned with the child's mental health.

June 1 - 6

The next two community meetings I attended were of the same struc­
ture. I utilized the time in completing the work I started with
patients.

During the period I spent at the inpatient unit, I counseled nine
persons. How successful or unsuccessful I have been, I can only rely on the positive comments of Mrs. Barlow, Mr. Sanders, the patients, and my own feelings of satisfaction.

June 7

I attended my last psychiatric staffing, discussed a number of cases and thanked the staff for the opportunity of allowing me to serve my internship in the inpatient unit.

Day Treatment Program

Soon after I learned that I would be serving a partial internship in the Day Treatment Program, I made an appointment with Mr. Joe Opalski, director, for May 17. On this afternoon I was introduced to the staff: Mr. Opalski, Mr. Johnson, Ms. Koprowski, and later Ms. Edinger. We talked about the objectives of the program, the general schedule, and how the Day Treatment Program could help me achieve my goals. In our conversation he remarked many things which were of interest to me. However, I was highly impressed when he said, "we work primarily with groups." I started out my internship experience by working with groups; then I moved to individuals and groups; now I am concluding with groups. I immediately arranged to begin June 13 just after school closes. I would be there Monday, Wednesday, and Friday of each week from 8:00 to 12:00 noon.

The Day Treatment Program primarily serves persons living in Berrien and Cass Counties. If persons from other countries are to be
served, financial matters will be arranged on an individual basis. The broad objectives are as follows:

1. To deliver a part-time treatment program for those who are not yet able to function in an outpatient setting, but who are no longer in need of twenty-four hour treatment.

2. To provide therapeutic programs which provide a recreational, social, and vocational activity as well as treatment.

3. To operate the program with well-trained, competent staff, including psychiatrists, social workers, psychologists, psychiatric nurses, occupational and recreational therapists, paraprofessional workers, stenographic personnel, and volunteers.

4. To initiate or seek out changing concepts in treatment approach and incorporate these changes into the program when the needs of the client will be served more effectively.

In keeping with my plan, I started the final stage of my internship experience at the Riverwood Day Treatment Services on June 13.

The weekly program is planned by the group. The group is composed of patient and staff. Mr. Opalski explained that the members of the staff were regarded as members of the group.

The program provided for:

1. Exercise:

   Daily exercise is a method of keeping in "shape" and maintaining good health.

2. Community Meeting:

   To encourage the group to work together as a unit about matters concerning the program. To provide opportunity for group independence, decision-making, carrying responsibility, and developing leadership skills. Opportunity to test one's ideas and strengths in a communal living situation.
3. Occupational Therapy (O. T.):

To provide an outlet for expression of feelings. To provide an opportunity to work on improvement of self concept and enhance self-esteem. To provide an experience to work as a member of a group in a unit project. To help discover latent creativity and skills with various media.

4. Recreational Therapy (R. T.):

To provide a physical outlet for feelings, such as tension, anger, and anxiety. To promote group spirit and teamwork. To build confidence through use of the physical self in games and competitive situations as well as in individual exercise programs.

5. Introduction to Community Resources:

Intended to introduce group members to community facilities, recreational, occupational and educational; for the purpose of developing an interest in using these to an advantage.

6. Group Luncheons:

To provide opportunity to learn (or relearn) organizational, interactional, and leadership skills in a group project that affords a climate of relaxation, friendliness and a degree of reward for personal participation. Includes menu planning, shopping, table preparation, and clean-up.

7. Weekly Self-Evaluation:

A forum which is intended to provide the opportunity for introspection, gauging personal growth, setting realistic goals with the help of a written summary invite feedback from peers and staff about one's self, negotiating or renegotiating the contract with the group and staff regarding further use of and/or adjustment in the program. For example, the evaluation time is the most fitting for termination plans to be announced. The proceedings during the evaluation comprise the chief entry into the program and center files.

The main sources for referrals into the program have been in the following order: private psychiatrists center, After-Care Service Center, In-patient Service Center, Out-patient Service Center, client's Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
family friends or others in the community who know about the Day Treatment Program, and community agencies.

Week of June 13 to 17

To avoid monotony, I will present a weekly report instead of a daily account since with little variation the program remains constant.

On Monday, June 13, at 8:00, I met Mr. Opalski on the ground floor of the Riverwood Community Mental Health Center, where clients are treated. We made coffee and arranged chairs in a circle in preparation for the group. By 9:00 fourteen persons had arrived. There were ten besides the staff. All but three of the participants were married; ages ranged from 25 to 47. Some of these persons were on disability, some on welfare, and some hoping to be well enough to return to work.

The weekly program provided for varied experiences. It included daily exercise, community meeting, occupational therapy, recreational therapy, exploring community resources, planning and self-evaluation. At the beginning each person introduced himself and said briefly why he was there.

I noticed that some persons did not sit in the circle and did not participate in the exercises, while others were working on weight, building muscular strength, or improving their breathing. I talked to a single female who was concerned about her weight. She felt it was "impossible" for her to use the skipping rope. I convinced her that she could do it, and she has been doing it since.

In occupational therapy, the participation level was much higher.
The main project chosen was the "pot holder" or "hot pad." Some were learning to use a sewing machine for the first time. Some had machines but needed some help on using patterns. There was so much enthusiasm that it was included in planning for the next three weeks.

Excepting two members of the group who had problems in balancing, everyone took part in recreational therapy. Volleyball was the game selected. Here I could very clearly observe a demonstration of emotion, frustration, anger, and self-concept. There were some who were excellent at the game, others who were poorly coordinated. Significantly enough, no one attempted to be critical of another's errors. The experience was very healthy.

During community meeting members of the group usually worked on personal or group concerns. Feedback is given by group members. There are three main problems that are common to the group. They are: self-concept, decision-making, and dependency. Working on concerns in the group is voluntary. No one urges anyone to work on a problem. Two males, ages 21 and 23, of low-self concept, asked for help. Both kept coming until one was dismissed from inpatient. The other is still coming. He plans to leave his grandfather's and be on his own. This is an evidence of growth.

In milieu therapy there is much sharing done by the group. It was very rewarding for me to observe the listening skills, the sensitivity, and the concern of the group for the individual. In sharing there was a frankness and openness in revealing personal experiences.

On Friday, June 17, the group toured WAUS, Andrews University Radio Station. As our tour guide described and explained what they were doing,
the group asked several questions. This was my first visit to a radio broadcasting station. It was a learning experience for me.

Planning is done on Friday of each week. There are two types, personal and group. Personal proves so difficult for these persons that Mr. Opalski has decided not to include it as a regular weekly feature. It might be helpful to include a prototype of a general weekly program planned by the group. This is for the week of June 27 to July 1.

<table>
<thead>
<tr>
<th>Monday (June 27)</th>
<th>Wednesday (June 29)</th>
<th>Friday (July 1)</th>
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<tr>
<td>9:00 - 9:30</td>
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<td>10:00 - 11:00</td>
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<tr>
<td>VOLLEYBALL</td>
<td>TRIP: BENTON</td>
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<td>HARBOR RECREATION CENTER</td>
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<td>11:00 - 12:00</td>
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<td>MOVIE</td>
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<td>BEACH WALK</td>
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This is an example of the programs that are planned weekly. However, "there is nothing fixed;" as Mr. Opalski explains, whatever the group decides that is what goes.

On the week of June 20 to 24, I was away from the group because of a previous appointment with Florida State University, where I have been accepted into the Marriate and Family Program. I had arranged this with Mr. Opalski a week before.
Week of June 27 to July 1

During the week of June 27, there was an increased participation in exercise. Surprisingly, even an extreme schizophrenia case began to respond and has been constantly taking part in exercises. There is another male who constantly sits without the group and does not interact in community meetings. There are two who attended once the first week and have not returned since. I discussed these cases with Mr. Opalski in order to understand what the program was actively doing for these persons. He explained that although several contacts have been made with them for some reason they are still absent. Nevertheless, they continue to maintain contacts with these clients.

One cannot predict the form community meeting will take. There is hardly any left-over matters. Problems which arise are dealt with at once; should a group member choose not to return, he may not. On Wednesday, June 29, there was a dead silence for about one minute. One member of the group became uncomfortable about it. The group explored her feeling to discover that silence connotated danger and death to her. The group utilized psychodramatic activities which gave her much insight into her problem.

Week of July 4 to 8

This was a short week, because Monday, July 4, was Independence Day. Except for the case of the above male who does not sit with the group, everyone else had to some extent been exercising. Within the community meeting, we felt that there was a need to understand the principles of
Transactional Analysis. This was scheduled for Friday, July 8. A week before the date, Mr. Opalski said that with my teaching skills he felt I was best suited to present transactional analysis. I accepted the responsibility. I spent several hours in preparation. I read several books which provided information on the background of transactional analysis and its development and present therapeutic application.

On Friday morning, July 8, I made a two-hour presentation of transactional analysis and invited questions. Several questions regarding the structure of transactional analysis were asked, and a request to continue was made. In the planning period another presentation was scheduled.

At the end of the July 8 session, I received a "while-you-were-away" message. It was from Dr. Chen, who asked me to make an appointment with a patient whom I had seen in the inpatient unit, as soon as possible. I contacted the patient to find that she has been doing well since dismissal. As a counselor to her two children, she was requesting me to indicate on a ADC form that they were currently attending school.

Even after some patients are dismissed from the inpatient unit they continue to utilize the facilities of the Day Treatment Program. One case is that of a 27-year old female, catatonic schizophrenia, who has been married for six years; has no children, and who was a previous patient. When I met her as a patient in the inpatient unit, she was in an "ugly" not-relating condition. She was screaming for a divorce from her husband. I engaged her in therapy. She was dismissed from the inpatient unit one week afterward, is now in Day Treatment, is living
with her husband, and reports that her coping skills have improved considerably.

Week of July 11 - 15

During the Planning Session someone suggested that thirty minutes seemed too much time for exercise. After much discussion it was decided that for the week of July 11, fifteen minutes would be used for exercises and fifteen minutes for relaxation—to relieve the pressure and allow time to rest before community meeting.

Definite changes were taking place in community meetings. During Personal Review and Goal setting time, those who were silent proposed to be more talkative and involved; those who were withdrawn were attempting to participate more in group activities. One female who had been very grouchy, proposed to exercise more self-control in the group. Personal Review is usually done on Mondays, when one can look back at what the last week has been and plans on his activities for the week ahead of him. This is indeed a moment of "consciousness," when one evaluates his personal growth.

Week of July 18 - 22

This week there was good news from an exercise participant who earlier felt she could not use the skipping rope. With a broad smile on her face, she reported that she had lost twelve pounds through a combination of diet and exercise. I gave her a "warm fuzzy."

At first goal setting was tiring; now everyone seems eager and articulate. Some were increasing their time at skipping rope, some
wanted to be more patient in groups, some resolved to smoke less in
group, some wished to interact with members of the group more, some
were working on independence and decision-making, while some wished to
continue to dialogue with me on transactional analysis.

On Wednesday, I made my second presentation of transactional anal­
ysis. I did a quick review of the principles enunciated at the first
presentation and focused on the day-to-day application of transactional
analysis. Here I involved the group at every step. After the occasion,
Mr. Opalski said it was excellent and the group thanked me.

The group planned a picnic at Riverview Park for Friday, July 22.
Each member voluntarily shared in the responsibilities of shopping and
cooking, making and putting out fires, games and clean-up, and each one
responded very well to his area of commitment. For me it was very
relaxing. I got away from the confines of four walls and associated
with people outdoors.

**Week of July 25 - 29**

By plan, this was the last week of my internship experience. I
have watched many members of the group grow. I, myself, have exper­
ienced growth. Community meetings, occupational therapy, recreational
therapy, goal review and the rest have been valuable techniques which
have contributed to my experience.

One of the therapists who was on vacation asked me to assume some
of his duties which extended my time to August 5. This concluded six­
teen consecutive weeks of a very satisfactory experience at the River­
wood Community Mental Health Center.
CHAPTER IV

CONCLUSION

Everyone has emotional ups and downs, anxiety, anger, fear, depression, and mistrust, affecting us at some time or other. Usually the mentally healthy person does not get bogged down in such feelings. Things may happen—the loss of a job, the death of a loved one, a child’s leaving home, a major illness—that causes mental pain. Yet the individual faces up to the challenge of life. However, there are times when the changes come too rapidly and the person is unable to cope with the stresses; at such times professional help is needed. The mental health center provides a wide range of services to aid in coping with behaviors.

Statistics show that more people are in hospitals for mental illness than for all other illnesses combined. The mental health organizations in America advocate that community clinics, outpatient services, foster-care programs, and after-care centers be established to take care of patients within the local community. The Riverwood Community Mental Health Center is one such institution. For sixteen weeks I had the privilege of being involved in some of the services offered to patients of the center. The project experience acquired by the intern has been in accordance with objectives outlined in Chapter I of this paper. This involvement has been of considerable benefit to me and it is not without much satisfaction that I retrospect my experience. As a
means of summation, I will view the internship from the standpoint of its "strengths," what it contributed to my emotional and intellectual growth, its "weaknesses," and areas that could be improved.

1. **Strengths.** Two areas were of major concern to me: the type of program offered and the methods of handling emotional problems. The therapeutic program includes both supportive and dynamic individual psychotherapy, group therapy, couples therapy, and family therapy. Most of the groups operate with more than one therapist; consultation is considered to be an integral component of the comprehensive mental health care; services to the mentally retarded are considered a concern of the center; the severely ill with high probability of state hospital care are given due consideration, which could create important reductions in state hospital admissions. That the patient receives whatever level of care is appropriate at any particular point in his illness, is the whole basis of the center. There is a constant flow of formal and informal communication among all levels of the staff: the staff members seem well trained, capable, highly motivated, and dedicated to the task of helping people cope effectively with emotional strain and stress.

2. **Emotional and intellectual growth.** I have achieved in many dimensions. As I read the literature and worked closely with other therapists, I expanded my knowledge about interpersonal relations; I became more aware of the need for understanding motivation in order to cope with many of our current social ills, and seemed to develop a search for depth in the interpretation of the dynamics of human behavior.
Working with mature adults was very stimulating. Some of them longed not only for help with their problems, but for positive goals of living; when behaviors like these were achieved, it gave me a good feeling. Through this experience I acquired a microcosmic view of the qualifications of a marriage and family therapist, an area in which I have much interest.

3. Weaknesses. For a more indepth experience, it would have been more beneficial to spend the sixteen weeks in one program. More changes in public attitude would be apparent if the center increased its utilization of the mass media for education and awareness programs. For example, the attendance at the Family Workshop sessions could be enhanced if people were aware of the services and its effectiveness.

In my work at the high school, there seemed to be a disconcerting ambiguity of the concept of mental health, which evokes anxiety and resistance if referral becomes necessary. Some students seem unwilling to accept this type of help; they feel uncomfortable going to the center. I refer to publicity as a weakness, but the insufficiency of staff members to handle the present case load could be one of the deterents to advertising. To work for the conservation of mental health, to help prevent nervous and mental disorders and mental defects is a mammoth job, and trained personnel is the main ingredient.

The field of mental health strives to bring to bare scientific information on the age-old problem of love and hate, fear, tension and anxiety; human aspirations and failures; man's relations to his fellow-man, including his inhumanity; his war with himself—in short, the
entire gamut of human behavior. To attain its goals, the body of knowledge about mental health must not be limited to any one profession or group of professions, but must be incorporated into the body of knowledge of all the helping professions and all those who work with people. Its success should be measured not by specific accomplishments or by a few groups, but by the effectiveness with which its ideas are taken over into the work of others, and finally, become part of the knowledge and understanding of more and more people. I am happy to be one of those people who accumulated some of this body of knowledge and skill.
APPENDICES
Please complete and return to the Counseling and Personnel Department by the beginning of the final week of the semester/session.

Name of Student ____________ LeRoy Carter _________ Semester __Spring__ 1977

Interning Organization __Riverwood Community Mental Health Center________

Organizational Supervisor __Robert E. Tollaksen________

1. Description of student's job activities and training.

C & E - Jail guard screening

Co-therapist - Family Workshop - weekly

Inpatient - individual counseling - three weekly, plus one weekly staffing, plus community meetings (milieu), plus several marital sessions

Day Treatment - participation in OT, group therapy to commence 6/13/77 daily for 4-6 weeks

Substance Abuse - for orientation and observation to commence approximately 6/13/77

Intake - to be arranged - an introduction

Outpatient - to be arranged - an introduction

2. Evaluation of the student's performance on the job and training activities.

The Family Workshop was an ice-breaking kind of introduction to conjoint family therapy for LeRoy. He was open to this new experience and acquired new techniques. I appreciate his seriousness and openness to learning. I enjoyed watching his emerging self confidence. The supervising social worker, Frank Sanders (MA, MSW, CSW) on the inpatient unit, reports that he is very relaxed and comfortable with a wide variety of hospitalized psychiatric patients, shows great initiative in his counseling with them and demonstrates a heightened sensitivity to peoples' motives and behaviors.

3. Performance:

Satisfactory ___ Unsatisfactory ___

For the Faculty Sponsor:

Grade: Credit _____
No Credit _____
Incomplete _____
Credit hrs. completed _____

Organization Supervisor's Signature ________________________

Date: 6/8/77

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Please complete and return to the Faculty Sponsor by the beginning of the final week of the semester/session.

Name of Student: LeRoy Carter Semester Spring 1977

Interning Organization: Riverwood Community Mental Health Center

Organizational Supervisor: Robert E. Tollaksen

My participation and involvement in the mental health program provided me with a rich experience through several avenues. I became familiar with the comprehensive responsibilities of the center and the concerns of federal, state, and community agencies for mental health and the mentally ill. As a co-therapist in the various programs, I acquired some skills which provided me with guidelines in helping clients under stress as well as mental patients. Through arrangements, which were made by Mr. Robert Tollaksen, I came in touch with a cross-section of mental health staff and personnel with whom I developed a good working relation.

Suggestions for Improvement 712:

Although I have had a very rewarding and self-actualizing experience, yet I feel that a minimum of ten weeks in each area would be adequate time for the intern.

Student's Signature
REFERENCES

Books


**Periodicals**

