Community Project "The Living Room" (Part III)

by

Juan Campos Avillar, MD

Structuring the activities of the club, including organization of the staff, selection of activities, grouping and assignment of the members for optimum therapeutic involvement and clarification of the role of the leader in a social therapy club

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This is a report of the community project on The Living Room, which was undertaken by Dr. Juan Campos, Dr. Sheldon Waxenberg and Dr. Leila Zileli, appointed as a team of consultants by the Community Mental Health Department of the PCP. Due to the academic requirements for certification, the three consultants were asked to present separate reports on the consultative work done on The Living Room.

This is the third part of this project on The Living Room, the aim of which is to provide a structure for the activities of the club, including organization of the staff, selection of activities, grouping and assignment of the members for optimum therapeutic involvement and clarification of the role of the leader in a social therapy club.

During the progress of our community project signifcant changes took place in the administrative nature of the agency and in its position within the structure of the Postgraduate Center for Psychotherapy. The Living Room, which started as a Special Project on September 18, 1959 under the direction of Dr. Maria Fleischl (who was responsible to the Director of Therapeutic Services, Dr. Dain) was so placed in this administrative set-up until the Spring 1962. At that time the Project Living Room was designated a department at the PCP, under the name Department of Social Rehabilitation (DSR).

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During its first three years of functioning The Living Room was suffering from the natural ailments that any empirical project has, namely insufficiently formulated and clarified operational hypotheses.

The Living Room was originally designed to fill the gap between therapy and living. It was intended to overcome the difficulties some patients experience in translating into positive, constructive behavioral changes the emotional and verbal insights that they derive from psychotherapy. A way suggested in order to achieve this, was to provide these patients with a protected environment, where they would be able to test out their attempts at change, and to foster their healthy social potentialities through the interaction with other patients and the participation in social activities. It was clearly stated at that point that the aim of the club was not to provide another form of analytic therapy. Quoting Dr. Fleischl "this club aims at being a living experience, with the achievement, with the achievement of closer relationships and a more meaningful life as a goal". The activities which were planned at the club had as an aim not the achievement of deeper or clearer insight but to foster an atmosphere in which growth and development were furthered.

When we entered the client system, at the beginning of the third year of functioning of the club, we found that in spite of the fact the the club has had very good therapeutic success in the eyes of its Director and assistants, there was no objective substantiation of this and the theoretical understanding of what was going on was not more clear than at the beginning.

Our first task was then to clarify for ourselves and for the clients what was the basic underlying philosophy and the operative theoretic hypotheses. In order to do so we read the paper of Dr. Maria Fleischl "The Understanding and Utilization of Social and Adjunctive Therapies", and planned a series of interviews with the Director of the club and the staff members. These interviews with the Director were organized on a conference basis, where one or three of the members of the consulting team would participate as observers or consultants. These conferences took place at different levels of the organization, as detailed in the Preliminary Plan for a Community Project on the Living Room, Part III.

We also held regular meetings with our supervisor on the project. During the course of the project, unfortunately, we had to change supervisor three times. At first the supervisor was Mrs. Isa Brandon, then Irving Silver, then Charles Orbach, and finally we returned to Mrs. Brandon.

All these conferences, which were recorded by us, provided us with an abundant source of data, which were further discussed on many occasions in the courses 904 and 954 during the Fall '61 and Spring '62 semesters, conducted by Mrs. Arlene Wolberg. I should mention that the discussions of our outline, which took place in the classroom were one of the most helpful elements we found in the development of our project. We became aware, there, of how unclear we were in our understanding of the needs, goals and functioning of The Living Room. That forced us to ask the agency for clarification of the questions put to us, which in turn helped the agency to formulate its thinking, which was necessary to solidify the present functioning and set the foundation for future development.

The foregoing will serve as a foreword to the following report.

A Statement of Goals of The Living Room

The main purpose of The Living Room is to overcome the difficulties that emotionally disturbed patients with varying degrees of social impairment find in translating into healthier behavioral and emotional changes the insight they receive in analytical, group or individual, therapy. In order to pursue this, three main channels of action had been adopted, which in turn implied certain theoretical assumptions:

1) In any emotional disturbance there is a tendency to withdraw from social interaction, that being not only a symptom of an illness, but in itself also the cause for further emotional disturbance. Also, in any patient, no matter how disturbed he is, there is a potentiality and a wish for social interaction, which is interfered with by deep feelings of inadequacy together with anxiety and incapacity to interact in normal social settings. Based on these assumptions, The Living Room tries to create a protective environment where the needs for social interaction can be comfortably met by the patient, furthering emotional growth and development, and fostering as a consequence an improvement of mental health.

2). By participating in activities of a creative nature, the patient can develop a sense of self-esteem as well as enjoy a feeling of mastery and self-respect through his own productivity; this will assist to overcome his neurosis. This is the basis for the existence of special activity programs within the setting of the Living Room..

3) The potential for leadership, self-determination and self- development can be fostered by an environment of freedom and responsibility, which allows the patients to structure and develop the club to the requirements of their own initiatives, and within the limits imposed by the administration and the structure of the setting. This is the basis of the democratic organization of the club.

The underlying theoretical concepts in this type of therapeutic approach, namely social therapy, are based on the thinking of the pioneers in this work, Dr. Joshua Bierer, Paul Senft and others, who were highly influenced by Adlerian concepts.

For Adler the transference situation - the fundamental principle in Freudian treatment - was not the relationship of the patient to another human being in the disguise of a father or a mother figure; it was the relationship of the patient to the therapist as the exponent of the community.

Since, any other means that could represent the community, such as a therapeutic community or a social club, can be therapeutic, if it allows the patient to compulsively repeat his basic patterns of relationship - his life style - and also provides him with a new atmosphere which, by making these basic patterns unnecessary or non-sensical, will force him first to try out and then to adopt healthier attitudes and to relate more objectively to the environmental reality.

What Senft calls reciprocal action therapy, mostly provides for the patient an opportunity for renewed reality-testing. He says "reality testing in psychotherapy may begin at two different ends. Individual therapy aims at the gradual development of rational insight and success in reality testing afterwards. Group therapy, also, proceeds in most cases in the same order. Social clubs appear, on the other hand, to offer the conditions for a renewed attempt at reality testing first, and the gradual development of rational insight afterwards."

Joshua Bierer, states another of the basic principles of social therapy, which is the concept of situational treatment. "By this is meant any individually directed but impersonal measures undertaken by the psychotherapist and his assistants, with the aim of achieving a certain change of attitude in the patient. The psychotherapist and his assistants have a fuller knowledge of the analytical background of a particular patient than the patient himself. In situational treatment insight is replace d by experience and fulfillment. The question is not one of re-education, since there is no conscious process of learning, but rather of re-evaluation - a change of the patient's fundamental attitude - as the patient is made to experience things differently".

Dr. Fleischl says that the experience which patients undergo in this social club will alter their previous life experience and as a con sequence modify emotions, perceptions and attitudes. By this is meant that the patient's self-awareness is increased and their self-concept grows healthier. She states, and that is her basic assumption, "the experiencing of healthier social interactions, as provided by the protected atmosphere of the club, is reparative in itself. It encourages further emotional growth, which is followed by understanding."

Dr. Fleischl makes broad use of the concepts of situational treatment and reciprocal action therapy. However, taking into account that her social club is intended for patients who are undergoing psychotherapy, the role played by insight in the general process of the club has to be investigated and evaluated. This part has been studied by Dr. Waxenberg and Dr. Zileli.

Description of the Administrative Structure of The Living Room and Recommendations for Better Functioning.

The Living Room is a therapeutic social club, functioning under the auspices of the Department of Social Rehabilitation which in turn is under the administration of the Postgraduate Center for Psychotherapy. The Living Room is, theoretically, a democratic, self-governed and self-determined body, which functions within the limitations and policies dictated by the two higher administrative units mentioned immediately above.

The members of the club are considered patients of the PCP, and therefore have to meet the standard administrative criteria for patients of the Center. This has implications in the following three areas:

1) The membership of the club is limited to patients already admitted in the clinic and to private patients of staff members of the PCP. The latter having to be screened and diagnosed by an intake pscyhiatrist before being admitted.

In extraordinary circumstances the Director of the department has the privilege to accept other patients, providing that they are subjected to the standard procedure of admission.

Also, acutely disturbed psychotic patients or acting-out psychopaths are to be excluded, on the basis that they might interfere with the general functioning of other facilities at the clinic or the safety of the club.

This policy was instituted following the recommendation of the consulting team. Previously to that no established criteria existed and in many instances little more than the name of the patient was known.

2) Record keeping. The records kept up to the moment of the initiation of our community project, were unsatisfactory not only in regard to the functioning of the club, but also they did not meet the minimum administrative standards required by the New York State Department of Mental Health for licensed clinics.

Dr. Campos was delegated, by the PCP and the DSR, to develop and propose a system. Following is an outline of the proposed system:

A) A folder has to be kept on every patient, in which the following records should be kept:

a) Letter of referral from therapist.

b) Report of the intake interview, with diagnostic evaluation and therapeutic recommendations.

c) A chart for progress notes on the behavior of the patient in the club, kept at least at three-monthly intervals by the therapist in charge of the club, or the leader of the special activity group the patient attends.

d) Copies of correspondence with the therapist of the patient, and record of any telephone contacts.

This system was adopted six months ago at our recommendation. However, the record keeping is still very deficient, the reason being that the terapists in charge are not allotted enough time for administrative matters. It is our experience that the therapist in charge would need a minimum of ten hours per week to fulfill his administrative requirements. (It should be noted that many of these have been fulfilled by Dr. Zileli, Dr. Waxenberg and Dr. Campos during the progress of the community project).

The maintenance of these records will make it easier for the leaders of the club to perform their function, particularly in communicating with the referring therapists. Also, they will set the basis for future community projects or research, and make possible an evaluation of the therapeutic value of social club therapy.

B) A membership book is to be kept, where the attendance of the members us recorded.

C) Also, a card should be kept with the following data: Name, address and telephone number of the patient, the patient's therapist and his telephone number; so that non-clinical officers of the club can have access to it.

3) Finances. When we first started our project, the patients were to pay $1 for every meeting or activity they attended. One of the patients would be selected at random to collect the fees and to hand the total in to the front desk. No current record was kept of the collection of fees when the project started, and as a consequence there was no control over payment. Some patients did not pay their dues. During the first 1 1/2 years of the club regular collection took place and records were kept by a patient who subsequently left the club.

Our first step taken to learn what was going on, was to delegate one of the members to regularly collect these fees and record attendance at the same time. We discovered that less than 50% of the fees were being collected. Consequently we decided to change the method of collection.

We suggested a membership fee of $5 a month per patient, which entitles them to attend any of the meetings or activity groups that take place during the month. There is a membership book where fees and attendance are recorded. This method has been applied, but the efficiency has still to be evaluated.

A study of the economics of the club has to be made. At the present, due to the lack of separation between the social club and the adjunctive therapies within the DSR, the club is budgetarily not self-supporting. The use of salaried personnel for special activities in relation to the low number of patients attending is the reason for the financial unbalance.

Up to now the deficit has been covered by money raising campaigns lead by Dr. Fleischl assisted by volunteers.

Alternative solutions would be:

a) Obtaining a grant from mental health organizations.

b) Replacing salaried personnel with volunteers or patients.

c) Giving budgetary segregation to the special adjunctive therapies by charging for them separately.

Organization and Functioning of the Club

One of the most difficult problems for any social therapist is to know where to draw the line between providing a protected environment and allotting enough freedom and responsibility to the club to allow for self-determination.

The center of activities of the club is the main meeting, which takes place on Wednesday nights from 8 to 10.45 p.m. This meeting is presided by the medical director of the Living Room, assisted by two or more assistants. This meeting is divided into three parts. After a period of warming up, lead by the music or singing coach (which extends from 8 to 8.30 p.m. and during which the members are arriving and new members are introduced by the leader of the club), follows the business meeting. This is a townhall like meeting. The members sit in a circle to discuss topics pertaining to the club. This meeting has a democratic structure and is chaired by a member, who volunteers for this function. This is followed by a period during which the members engage in different activities, in small groups or individually, ending with a closing-up period when the whole club meets again for social interaction and refreshments.

Previously, the members used to elect a chairman for one month at a time. This did not work out and a new chairman volunteers for every meeting; reasoning that in this way every member should have the opportunity to exercise his capacity for leadership.

There are indications that the atmosphere in the Living Room is <u>excessively Protected:</u>

If in any such club enough freedom is allowed, the members of the club will develop their own organization and internal hierarchy. This is the case in most of the therapeutic social clubs reported in the literature. If one takes into account that those clubs are constituted by populations far more "sick" than the one of the Living Room, the fact is still more striking.

The Living Room lacks an elected chairmanship. There are no officers of administration. The committees that sporadically function for a specific purpose, do this at a very low level of efficiency. The sense of responsibility among the members is low, as shown by their reluctance to pay their fees, to volunteer for any responsibility, or even to the extreme of having to be coaxed to do the cleaning up at the end of the meeting; or that they will go without refreshments if the leader or the person delegated happens not to be there to make the necessary arrangements.

The lack of organization and hierarchy developed from within the club reinforces the authority of the social therapist and fosters dependency among the members of the club, this way defeating the main goals of the club. At the same time bewilderment and confusion is produced among the members who are verbally continuously encouraged by the social therapist to take responsibility and do with the club how they please, but are confronted with a structure and atmosphere that is not inducive to their endeavor.

My recommendations in this respect would be that the social therapist should limit himself to providing for the minimum of external structure within which the members would be able to determine their own policies and organization.

The Department of Social Rehabilitation will have to limit itself to providing for the necessary psychiatric supervision of the club, making the club aware of the limitations and requirements imposed by the department and the administration of the PCP.

The degree of necessary intervention of the social therapist in the club is a relative concept, but as Dr. Fleischl accurately points out in her paper, it depends mostly on the amount of anxiety in the terapist and on the trust and respect he feels for the patients. The implementation of this measure is not an easy one, because the members are used to a completely different approach and will not take any such radical changes without experiencing some degree of anxiety.

However, I had recently occasion to try out this hypothesis. As it coincided with the Passover vacation, the Wednesday meeting was attended by very few members, and I was the only therapist present. I left the room at the beginning of the night and I did not return until closing time. I kept on checking without the patients noticing how the meeting was developing. I have to admit that this was one of the most lively, warm and spontaneous meetings I have witnessed since I attend the Living Room.

What would happen if this type of approach was accepted as a general policy is something that is still to be seen, but there are sufficient theoretical reasons to justify its validity and making it worth a try.

To implement this policy, the patients should be made aware of it. Also, the social therapist should have to limit himself to "be around and available if required" instead of being all the time "in the club".

The implementation of this recommendation is likely to arouse anxiety in both leaders and members of the club. Continuous consultation is going to be necessary to avoid reverting to the initial attitude without giving this recommendation a fair trial.

Activities

Activities in the setting of a therapeutic social club are as much an expression of social interaction as means to favor and promote this social interaction.

Besides the activities that take place during the main meeting of the club or that are planned during this meeting to take place either on the premises or outdoors, which from now onwards will be called club activities, there is a program of special activities going on within the auspices of the club.

Originally the special activity program was intended, with the use of the teaching and practicing of creative media, to provide the basis for stimulating self-expression and social interaction. In time this program has extended itself and broadened its scopes to such a point that it now represents more than 75% of the activities of the club. It involves three out of the five meetings per week that the club holds in the PCP, requires the use of 5 special assistants, and accounts for about half of the expenses in the budget of the Living Room. Also, in many instances the name 'special activity' is not really appropriate for these activities, and the title 'adjunctive therapies' would be more appropriate.

There is no question about how helpful the use of creative media can be in a program of social rehabilitation or about the therapeutic value of these kind of activities. Music therapy, and art therapy, etc. have obtained recognition as techniques at the disposal of therapists. However, there remains an open question as to how extensively these means can be used in a therapeutic social club and how useful they are in the pursuit of its main goal.

The aim of the special activity program is not to make performing artists of the individuals, nor to promote intra-psychic changes through the uncovering of the unconscious, but, through the relationship with the leader and the other members of the group and making use of the activity as an excuse to favor social interaction.

If certain parts of the special activity program have become forms of psychotherapy, as seems to be the case in some activities that take place in the Living Room, their place is in the wider concept of the Department of Rehabilitation rather than in the Living Room itself. The therapist would have to select, screen and accept the patients for these special activities, and some kind of regular communication should be maintained between the therapist of the patient and the one who is conducting the adjunctive therapy.

My recommendation is: Within the Department of Social Rehabilitation the adjunctive therapies and the therapeutic social club should be separated and patients should be referred to one or both of these programs depending on personal circumstances.

Club Activities

The club activities are functions of the interplay of three main variables: Initiative, leadership, and participation.

The activities can be originated by the staff or by the members. In the latter case it can be by one individual member or as an expression of a group request. The activities can be lead by a staff member, a member or by no one in particular. Finally, there are different types of participation of individual members in any given activity. This can be classified in a four point scale, which goes from a complete lack of participation, to a passive type of participation, to an active participation and finally to taking a position of leadership. The aim of the therapeutic social club seems to be to help the patient to walk, as a member, up through the different points on the scale of participation. The degree of response to any given activity seems to be correlated to the way it is originated and led.

The degree and type of participation obtained in relation to by whom and how an activity has been initiated and led is an interesting topic of study, that will justify in itself a further community project. For the time being we limited ourselves to bring this topic to the discussions with Dr. Fleischl and to the staff meetings. No definite conclusions have been reached, but at least curiosity has been aroused.

The members seem to resent any excessive exercise of authority on the part of the staff, as much as they seek it. This ambivalence can be met only by the staff siding with the healthier side of the situation, namely giving the members a minimum of protection and a maximum of responsibility. This way they will be able to move from a position of 'just taking' (with a minimum

of responsibility and a maximum of dependency, which makes them social isolates) towards a progressively 'more giving' and less taking position (that will make them more socially integrated human beings). This would eventually allow them to either abandon the club, because they do not need it any longer, and start to play their role in the open society, or if they remain in the club, it will not be because of their needs, but because of what they can contribute to it.

Organization of the Staff

When we started our community project, the staff of the club, which was made up of seven members who had been directly hired by Dr. Fleischl, were not recognized as therapists by the PCP. They reported directly to Dr. Fleischl, but no regular means of communication with each other existed. We established monthly staff meetings as part of our project, which were used to coordinate treatment and to complement their training.

A great deal of my time and effort was spent on the organization, selection and training of the staff members. However, due to the fact that in the new organization of the Department of Social Rehabilitation the therapeutic social club is to be separated from the special activity programs, the so-called adjunctive therapies, this subject is outside the scope of the present report.

Role of the Leader in the Social Therapeutic Club.

The leader will have to take over the responsibilities that were taken care of by the team of consultants during the course of the community project.

That is, he will be responsible for communication with the referring therapists, admission of patients, and leadership of the club. As a leader of the club he is responsible to the Director of the Department.

His functions as a leader of the club are: To create an atmosphere in the club that facilitates mutual social interaction and individual growth in the patients. With this purpose in mind I recommend that his role should be more one of a participant observer rather than one of an on-the-spot leader. His activity has to be reduced to a minimum, limiting himself to do for the patients what he has failed to have them do by themselves. His role should be mostly one of a moderator.

His responsibility towards the individual patient is: 1) To interview the patient and reach a social diagnosis that will be helpful in selecting the best treatment plan within the available activities of the Department. 2) To introduce the patient into the social club and follow him up at least during the initial steps of his acquaintance, helping him to overcome the initial inhibitions. 3) To observe the patient in his progress in the social club in order to be able to communicate to the individual or group therapist of the patient whatever data could be helpful in the task of coordinating psychotherapy with social therapy.

He will attend the staff meetings of the Department and keep in contact with the leaders of any special activity group the patients are attending.

He will also have administrative responsibilities, such as keeping the records, and surveying and controlling the finances of the club.

Finally, he will be responsible for the selection and training of volunteers. This is in itself the subject of the next chapter.

The recommendation of one individual only, as the leader of the club, is one of the most strongly emphasized by the three consultants. We estimate that it will require a minimum of 20 hours per week from a person with adequate qualifications and training. At the present we are looking for such a person and we will cooperate with the Director of the Department in his supervision and training.

Volunteers

The Director of the Department has had many offers from volunteers. These people come from the following sources:

a) From the community at large, people with social interest and interest in mental health.
b) Patients of high social standing who are in treatment with influencial psychoanalysts and are reluctant to be treated as members of the club.
c) Patients from the club who have reached a status where they no longer need the club, but they are still interested in contributing to it.

There should be a differentiation between volunteers who work for the club and the ones who work in the club. The former do not really need to closely participate in the life of the club. They should really be working for the Department of Social Rehabilitation. The latter, it is my feeling, should be members of the club, and therefore would have to subject themselves to the procedures of admission and to fulfill the requirements of membership,

with the only exception that they do not currently have to be in treatment; but this also holds true for members who terminated treatment while attending the club.

The reason for this recommendation is that the existence of privileged citizens is not favorable to the atmosphere of the club. The admission of any other status than the one based on professional qualifications stands for discrimination between 'we' and 'they', 'neurotic' versus 'healthy'.

However, all these volunteers, the same as any members who are holding positions of responsibility in the club, require special assistance from the leader. At the present, I established monthly meetings with the working members and I keep in close contact with the volunteers which are working in the club.

If in the future, the Living Room becomes more formally organized, it should be possible to make broader use of volunteers instead of salaried personnel. It would be necessary for the leader of the club to develop a system to assist the volunteers as well as the patient-chairman and patient-officers of administration of the club.

Evolution of the consultative process.

One of the more important reasons for my becoming interested in the Living Room and for Dr. Fleischl requesting my cooperation was because of my previous experience and knowledge of the theory and practice of therapeutic social clubs. A possible gross error in consultation would have been to try to apply my previous experience to shape the club to own personal style. Of this risk in consultation I was very much aware. When the consultant is an expert in the subject, there is a likelihood of the stressing of a subjective approach on the part of the consultant. Instead of that, I tried to be as objective as possible. I kept constantly in mind that the organization for which my consultation was required was the result of the interplay of three forces: 1) Ideas, 2) People, and 3) Setting. In the case of the Living Room, Dr. Fleischl - a person with certain personality traits, motivations and background - had had an idea, a hypothesis with some goals and prospective means of achieving them. She has created a setting with some structure, and some administrative machinery, a functioning entity by which her hypothesis might be tested and put into practice.

From our first contacts with Dr. Fleischl it became apparent to us that the Living Room was an organization in the process of growing, but at such a speed that the organizational and administrative aspects had been sacrificed om favor of the functional ones. In the customary approach to consultation a first step would be to study the administrative and structural aspects of the setting. This was not possible in a comprehensive way as adequate club records had not been kept and the only approach that was left to me was to reach an understanding of the agency through the functional aspects of it. As a consequence I had to concentrate on the people who were participating in the Living Room at one or other level.

Study of the historical development of the Living Room was very helpful not only for understanding the ideology of the club, but also for clarifying the nature and sources of tis problems and difficulties. When Dr. Fleischl started the club, she asked the help of an outside therapist who was herself conducting another therapeutic club in another clinic. This assistant's experience had been mostly with psychotic patients in institutional settings. Dr. Fleischl adopted many of the techniques used by this assistant. Consequently, the club which initially had been intended for patients in ou-patient psychotherapy (mostly neurotic, with character disorders) and some borderline patients) tended toward a membership comp-osed of psychotic patients many of whom had previously been in mental hospitals. To complicate things further these patients attend other rehabilitation facilities that the community at large offers to them and they also spontaneously invite other patients to the Living Room. These visitors were often accepted without any systematic screening or diagnostic evaluation. As one can imagine, this flow of relatively unidentified members was a continuous source of anxiety for the director of the club.

Other consequences were that such a composition of the club had a direct effect on the atmosphere and made it difficult for new members at a highier level of functioning to integrate themselves into the club though it was originally intended for them. A high turnover of patients in the club resulted, with the further effect of hampering the creation of a cohesive atmosphere at one level, and of giving a poor impression to the referring therapists. As a consequence, either they stopped referring patients or refer only those whose level of functioning was lower. Such a membership required a great deal of attention and supervision on the part of the staff which made it necessary to progressively increase the number of staff members and also forced them to be more active and authoritarian than originally was intended.

When a person is simultaneously responsible for determining policy and also for carrying it into practice, he is likely to become excessively flexible and every time that he encounters difficulties in the realization of a policy he is tempted to change it. Then there is risk of losing sight of the goals that determine the policy. Such is the explanation for some of the decisions taken by Dr. Fleischl that were not completely in agreement with her ultimate intentions.

Besides that,insufficient regular means of communication among the different levels of the organization favored personal initiative but also fostered difficulties in reference to a consistent implementation of policies. If major changes of policy were to be discussed in the staff meetings before being adopted, it would reinforce and establish the structure and planning as well as facilitate the adherence of the staff to a given plan. This, in final analysis, stands as the main source of the problem.

Technique of Study

In order to be able to collect data and reach a diagnosis in reference to the nature of the problem I decided to become a member of the staff of the Living Room. That gave me the opportunity to establish a close relationship with the Director and staff as well as with the members of the club. The risk implied in this approach was that of being absorbed by the club and overwhelmed with the actual details of the functioning of the club. Being aware of this possibility I exerted conscious effort to avoid if, and I believe with some success.

In the course of consultation I made use of the following techniques depending on the purpose at hand:

1) Exploratory interviews with the director of the club, the members of the staff and the individual members of the club.
2) Observation of the staff assistants* in the exercise of their function while in the field, followed by a discussion of the observations privately or in staff meetings.
3) Temporary substitution of myself in the leader role with a twofold purpose: a) in order to achieve a subjective view of their position, and b) in order to demonstrate to the different leaders how to apply the new policies established. I have to note that 2 and 3 techniques I borrowed from the field of industrial management consultation, where are known as "job analysis" and "position training".

Techniques of solution

In order to solve the problems detected in the course of our study, we agreed that we should proceed to:

1) The creation of administrative controls

A record keeping system was suggested to and accepted by the director and staff of the Living Room as a result of discussion in staff meetings. The establishment of this system required, and still will require, continuous supervision and encouragement. The more obvious difficulty in the carrying out of the proposed, or any other, system, will arise from the shortage of time allotted to the staff for administrative purposes.

2) The Creation of media of communication

a) The participation of Dr. Fleischl in the Executive Committee of the PCP as Director of the DSR, establishes a regular means of communication with the administration of the PCP.

b) Staff meetings were established to coordinate the activities of the club staff. They were scheduled to take place every month, and the team of consultants have participated in this meeting. For next fall, Dr. Fleischl is planning a course in social rehabilitation, in which the club staff will participate in order to demonstrate and achieve further training.

c) Meetings of volunteers and working members on a monthly basis were also established. These meetings have been taking place. Their purpose is, besides giving some status to these members, to encourage, support and train them for the functions they are serving at the club.

3) In order to facilitate and secure the implementation of the above given recommendations we strongly recommended the creation of a staff position under the Director of the DSR. The hiring of a person, trained in psychotherapy, who can take over the functions that the team of consultants have planned and performed during the course of the community project, will be necessary. Dr. Fleischl has accepted the idea, and I offered myself to help her in the task of selecting this person, and later on the team of consultants is willing to cooperate in the training and supervision of such a person.

We consider the community project to have been helpful to the consulting agency. We not only recommended measures that are going to facilitate further development but we have created and instituted a system of collection of data that will make possible for other workers to do research on social therapy or to continue more easily and efficiently the process of consultation.

Evaluation of the Consultation

The usefulness and workability of the moves suggested in this community project and methodology we have utilized in its development will not be able to be appreciated for quite some time. However, immediate indications of it will be:

1) The response and comments of the referring therapists.
2) The degree of participation and responsibility adopted by the members of the club, which will be shown in their verbal communication as well as in the general atmosphere of the club.
3) The morale and comments of the staff of the Living Room.

Only future follow-ups on this community project will prove the efficacy of our recommendations.

Dr. Charles E. Orbach has made additional proposals for the consultative work on the Living Room. I consider these of interest for research and consultation, and have attached them to this report.

The therapeutic value of the different activities that take place in the club, I believe, would be still another fruitful area for investigation. I would be willing to cooperate by contributing my experience to the writing up of an outline on such a community project,if the Department of Community Mental Health considers undertaking such a further project on Social Rehabilitation at the PCP.

Preliminary Plan for a Community Project

on

THE LIVING ROOM

PART III

"This is to represent the third part of a community project on the Living Room:

To provide a structure for the activities of the club, including organization of the staff, selection of activities, grouping and assignment of the members for optimum therapeutic involvement and clarification of the role of the leader in a social therapy club."

by Juan Campos, M.D.
(Fellow, PCP)

1.) Factual Details of the Project

Last Spring, following the events described by Dr. Waxenberg in the introduction to his part of the project, Dr. Campos met with Dr. Zileli and Dr. Waxenberg to discuss the possibility of undertaking a community project on the Living Room, in order to fulfill part of their requirements for certification. Due to the broad scope of the project and to the fact that in the memorandum we received from Dr. L. R. Wolberg n February 1, 1961, it did not explicitly say anything against the established policy of previous years of fellows presenting their community project as a team work, we decided to present ours in the same fashion. - In July,1961 we contacted Mrs. Brandon, who instructed us to present in writing an outline of our project. Later on, after the submission of a "Proposal for a Community Project on the Living Room" in September 1961, we were informed by Mrs. Brandon about the decision of the Department of Community Mental Health, that the project should be presented by individuals.

A conference was called to discuss further details of the plan, which was attended by Dr. M. Fleischl, Mrs. Brandon and the three students. In this meeting, besides a discussion and clarification of the needs of the Living Room, it was agreed that the students were to present three separate outlines; and another conference was arranged with Dr. Fleischl and Mrs. Brandon.

In order to reach an understanding of the present structure, functioning and needs of the applying agency, Dr. Campos has met and consulted with the Director of the Living Room, Dr. M. Fleischl, with and without the other students on several occasions, held conferences with the staff members of the Living Room and consulted with the other members of the team for a period of time that much exceeds ninety hours.

Dr. Campos was also asked to be present at a conference which took place between Dr. Markowitz and Dr. Fleischl, in order to discuss the status of the Living Room and its members in relation to the PCP.

Besides that, Dr. Campos has been attending the weekly meetings of the Living Room since October 14, 1961. He has kept progress notes of these weekly sessions of the Living Room and also on the conferences he has attended in relation to the community project on the Living Room, which he will use for his written report of the project in case of its acceptance.

2.) Description of the existing relationship between the student and the agency

Dr. Campos first heard of the existence of the Living Room during the early part of the Fall 1959, on the occasion of Dr. M. Fleischl presenting it to the staff of the PCP in one of the departmental meetings of the Psychiatry Department.

Due to his previous interest and experience with social therapy clubs in England, Dr. Campos soon started to refer patients of his to the Living Room. This allowed him to realize the effects of a social therapeutic experience on his patients, who were under analytically oriented psychotherapy, and in an indirect way, through the comments of his patients, to become familiar with the procedures of the organization.

Further, in the Fall of 1960, Dr. Campos was assigned for supervision with Dr. Maria Fleischl, which gave him the opportunity to arrive at a closer understanding of the Living Room, its structure, operative philosophy, advantages and inconveniences.

In order to fulfill his part of the project, it was decided in consultation with the other members of the team and Dr. Fleischl, that the best way would be if Dr. Campos was able to assist to the main meeting of the Living Room as a staff member. That was impossible, since Dr. Campos at that time had other committments which he could not abandon without financial embarrassment. In order to overcome this difficulty Dr. Fleischl proposed to compensate him for the time spent with the Living Room and hired him in the capacity of Temporary Assistant Director of the Living Room. At present Dr. Campos is receiving $25 a week for three hours of work on Wednesday evening (8 PM to 11 PM). Besides this, he is holding weekly conferences a) with the other members of the team, for periods exceeding three hours per week, b) with the Director of the Living Room, more than one hour per week and c) with the other members of the staff of the Living Room, for three-quarters to one hour per week. The decision of Dr. Campos enrolling in the staff of the Living Room has proved itself, up to now, to be wise and rewarding. It has insured us the entry in the client system, facilitating him to establish a close relation with patients (members of the Living

Room), staff and director; and more than that, he has been able to receive the full emotional impact of the atmosphere of the club, giving him a clearer understanding of the needs, problems, achievements and vicissitudes of the studied agency.

The main objection that may arise in reference to this approach, namely the loss of objectivity on the part of the consulting student, due to being part of the client system, is easily met by the fact that the appointment is temporary in character, that Dr. Campos had previous experience with the Living Room as an outsider, that he also forms part of a team which is not part of the client system and finally that this approach is accepted policy in the consultative procedures or techniques in the organizational sciences.

3.) Description of the Agency and Needs

HISTORY

The project "Living Room" was presented by Dr. Maria Fleischl to the Executive Committee on September 18, 1959. In the memorandum presented by her on this date it says:

> "The Living Room" will be a Social Therapy Club designed to fill the gap between therapies and living. All analyzing will be channelled toward the group and individual therapy of each patient so that we can avoid overlapping with these; instead of another form of analytic therapy this club aims to be a living experience", with the achievement of closer relationships and a more meaningful life as a goal. The painting, acting, singing or having refreshments is to provide the atmosphere in which growth and development is fostered. No attempt will be made to make performing artists out of the patients."

On October 1, 1959, Dr. C. J. Sager, in his capacity as Director of the therapeutic services, circulated a memorandum among the staff and fellows of the PCP, where he announced the creation of a new service for the patients of the PCP.

The Living Room was described in this memo as a Social Therapy Club. This memo was accompanied by a letter from Dr. Fleischl where she described the characteristics of the club.

The first meeting of the Living Room took place on October 14, 1959 and meetings have been held since then once a week without interruptions, except for Summer vacation periods.

There were antecedents to the Living Room at the PCP. From April 13, 1953 to at least April 30, 1956, Mrs. Betty Feldman conducted a Social Therapy Group. This group, although similar in nature, and structure, was completely different from the Living Room in its basic underlying philosophy and operative theoretic hypothesis. I am quoting from a report directed to the executive committee by Mrs. Feldman on November 2,1953:

THE LIVING ROOM WITHIN THE ADMINISTRATION OF THE PCP

The Living Room has not found a place, up to now, where to belong in the departmental structure of the PCP.

It was started as an independent study project under the direction of Dr. Fleischl, who was and still is responsible to the Director of Therapeutic Services.

During the course of the year 1960-1961 the issue of placement of the Living Room within the departmental structure of the PCP was discussed by the Executive Committee. Theoretical and practical reasons, as well as personal ones, prevented the Committee from making a decision. Although Dr. Fleischl considers this issue to be of essential importance to the future development of the Living Room, she feels that a decision has to be postponed until further clarification on goals and techniques of social therapy, and a better organization which secures the continuity of the Living Room have been achieved.

Dr. Campos being aware of this issue and not in a position to comment upon it, would like to specifically point out that the clarification of it is not part of his community project.

ORGANIZATION OF THE CLUB AND ACTIVITIES

The main meeting of the club takes place on Wednesday evenings from 8 to 10:45 P.M. at the Postgraduate Center for Psychotherapy. This meeting is attended by all the members of the club. However, this represents approximately 50% of the active membership. The total membership of the club may be considered around 100 patients. Fifty of them can be considered as active members, inasmuch that they participate in some activies of the club with a frequency more than once a month. This meeting is led by the Director or Assistant Director of the club, with the help of a recreational leader and the drama coach.

On Monday evenings there is an art class conducted by an art instructor, which is attended by eight to ten members. On Thursday afternoons from 5:30 to 6:30 Dr. Fleischl conducts a discussion group, which is followed by a group art experience under the leadership of another art instructor. The attendance at these meetings has been very limited, mainly because of the hour, and the meetings are likely to be discontinued or transferred to another hour.

STAFF

Temporary Assistant Medical Director
Fee $25 for a period of three hours. Functioning as leader at the Wednesday meetings.

Recreational Leader.
Fee $15 for a period of three hours, on Wednesday evenings.

Drama Instructor.
Fee $10 for a period of three hours, on Wednesday evenings.

Group Art Instructor.
Fee $10 for two hours, on Thursdays

Art Instructor
Fee $7.50 for two hours, on Mondays.

Music Instructor
Fee $2.50 for one hour, on Wednesdays

These instructors hold outside the PCP positions as adjunctive therapists in different institutions. However, the Executive Committee of the PCP had reservations about them being called therapists, therefore, they are called instructors at the PCP.

NEEDS OF THE AGENCY

1. The Living Room has had a large turnover, which is considered by Dr. Fleischl and her staff as having undesirable effects on the atmosphere of the club.

The turnover is felt to be related not to an improvement of the patients but to some inadequacy of the club to meet the requirements of new members. This is a three-fold problem which has to be met at three levels.

a) Relationship with the referring therapist.
b) Selection of members.
c) Better organization of the available resources of the Living Room. (This is the part undertaken by Dr. Campos in this project).

II. The Director is confronted with a problem of selection, organization, training and supervision of the staff, for which she is asking suggestions and help.

III. The Director has been receiving an increasingly large offer of volunteers, which she would like to make use of for the club, but is confronted with the same problems than with the staff, namely selection, organization, training and supervision.

IV. Another need is the selection of the activities best suited for the purposes of the club in general, and how to channel the members towards activities which are most profitable to them.

V. The Director wants to assure the continuity of the Living Room as a therapeutic facility and to increase to the maximum its therapeutic potentialities. In order to meet these goals, Dr. Fleischl believes,

that the creation of a structure would allow the club to function without the actual presence herself, so that she can be substituted in the future, if necessary. Also, by setting adequate instrumental means it would be possible to evaluate and follow up the effects of social therapy on the members of the Living Room, and that is considered to be essential for the establishment of future policies.

EXPLANATION OF HOW THE PROJECT MEETS THE REQUIREMENTS FOR PROJECTS DESCRIBED ABOVE

a) The Living Room is a health service.
b) The aim of the project is to introduce techniques that will make the organization more efficient through the aegis of consultation.
c) The project will require from the student to apply his consultative skills at different levels. (Direction, staff, membership).
d) In addition to a series of conferences, the student will have to use group techniques in order to influence the policy and the direction of the agency's program.

EXPLANATION OF WHAT IS ANTICIPATED THAT THE PROJECT WILL DO FOR THE AGENCY

The student hopes, with the help of the supervision which he will receive, to meet the requirements expressed by the soliciting agency.

At this point Dr. Campos does not consider it appropriate to indicate in which way he is intending to meet the requirements, because they have not yet been discussioned in supervision.

November 5, 1961 - written
February 14, 1962.-mimeographed

THE LIVING ROOM PROJECT

Comments by Dr. Charles E. Orbach

1. What is the Living Room actually offering to the patients participating?

2. Is what being offered appropriate for a given patient at a particular point in time?

   This could be a later project and is the nucleus of Redl's formulation of a therapeutic milieu

3. The process experienced by members will be explored retrospectively by interviews. Reports by members of current behavior should be compared to the behavior manifested by the same people in the situation.

4. Information should be obtained from therapists. Why they referred specific patients and what they expected from the experience. Why patients believed they were referred and what they expected.

5. Some formalized induction procedure for new members should be established to introduce them into the living-room and to minimize dropouts.

If money can be obtained for a pilot project to follow-up the findings of the Community Project Dr. Campos is willing to spend 3-6 mos. in an investigative position.