Introduction: Historical Background

HISTORICAL BACKGROUND
Social Movements
Swampscott

WHAT IS COMMUNITY PSYCHOLOGY?

FUNDAMENTAL PRINCIPLES
A Respect for Diversity
The Importance of Context and Environment
Empowerment
The Ecological Perspective/Multiple Levels of Intervention

CASE IN POINT 1.1 Clinical Psychology, Community Psychology: What’s the Difference?

OTHER CENTRAL CONCEPTS
Prevention Rather Than Therapy

CASE IN POINT 1.2 Does Primary Prevention Work?
Social Justice
Emphasis on Strengths and Competencies
Social Change and Action Research
Interdisciplinary Perspectives

CASE IN POINT 1.3 Social Psychology, Community Psychology, and Homelessness

CASE IN POINT 1.4 The Importance of Place
A Psychological Sense of Community
Training in Community Psychology

PLAN OF THE TEXT

SUMMARY

Until justice rolls down like waters, and righteousness like a mighty stream.
—Martin Luther King, quoting Amos 5:24

Be the change that you wish to see in the world.
—M. Gandhi
Part I • Introductory Concepts

My dog Zeke is a big, friendly Lab–golden retriever–Malamute mix. Weighing in at a little over 100 pounds, he can be intimidating when you first see him. Those who come to know him find a puppy-like enthusiasm and an eagerness to please those he knows.

One day, Zeke got out of the backyard. He scared off the mail delivery person and roamed the streets around our home for an afternoon. On returning home and checking our phone messages, we found that we had received a call from one of our neighbors. They had found Zeke about a block away and got him back to their house. There he stayed until we came to retrieve him. We thanked the neighbor, who had seen Zeke walking with us every day for years. The neighbor, my wife, and I had stopped and talked many times. During those talks, Zeke had loved receiving some extra attention. Little did we know all this would lead to Zeke’s rescue on the day he left home.

As an example of community psychology, we wanted to start with something to which we all could relate. Community psychology is about everyday events that happen in all of our lives. It is about the relationships we have with those around us, and how those relationships can help in times of trouble and can enhance our lives in so many other ways. It is also about understanding that our lives include what is around us, both literally and figuratively.

But community psychology is more than a way to comprehend this world. Community psychology is also about action to change it in positive ways. The next story addresses this action component.

We start with two young women named Rebecca and Trisha, both freshmen at a large university. The two women went to the same high school, made similar grades in their classes, and stayed out of trouble. On entering college, Rebecca attended a pre–freshman semester educational program on alcohol and drug abuse, which introduced her to a small group of students who were also entering school. They met an upperclassman mentor, who helped them with the mysteries of a new school and continued to meet with them over the semester to answer any other questions. Trisha did not receive an invitation and so did not go to this program. Because it was a large school, the two did not have many opportunities to meet during the academic year. At the end of their first year, Rebecca and Trisha ran into each other and compared stories about their classes and their life. As it turns out, Rebecca had a good time and for the most part stayed out of trouble and made good grades. Trisha, on the other hand, had problems with her drinking buddies and found that classes were unexpectedly demanding. Her grades were lower than Rebecca’s even though she had taken a similar set of freshman classes.

Was the pre–freshman program that Rebecca took helpful? What did it suggest for future work on drug and alcohol use on campuses? A community psychologist would argue that the difference in experiences was not about the “character” of the two women, but about how well they were prepared for the demands of freshman life and what supports they had during their year. And what were those preparations and supports that seemed to bring better navigation of the first year in college?

By the end of this chapter, you will be aware of many of the principles by which the two stories might be better understood. By the end of the text, you will be familiar with the concepts and the research related to these and other community psychology topics and how they may be applied to a variety of systems within the community. These topics range from neighborliness to the concerns and crises that we face in each of our life transitions. The skills, knowledge, and support that we are provided by our social networks and the systems and contexts in which these all happen are important to our navigating our life. A community psychology provides direction in how to build a better sense of community, how to contend with stresses in our life, and how to partner with those in search of a better community. The interventions are usually alternatives to the traditional, individual-person, problem-focused methods that are typically thought of when people talk about psychology. And the target of these interventions may be at the systems or policy level as well as at the personal. But first let us start with what Kelly (2006) would term an “ecological” understanding of our topic—that is, one that takes into account both the history and the multiple interacting events that help to determine the direction of a community.

We first look at the historical developments leading up to the conception of community psychology. We then see a definition of community psychology, the fundamental principles identified with the field, and
other central concepts. We learn of a variety of programs in community psychology. And finally, a cognitive map for the rest of the text is provided. But first, back to the past.

**HISTORICAL BACKGROUND**

Shakespeare wrote, “What is past is prologue.” Why gain a historical perspective? Because the past provides the beginning to the present and defines meanings in the present. Think of when someone says “Hi” to you. If there is a history of friendship, you react to this act of friendship positively. If you have no history of friendship, then you wonder what this gesture means and might react with more suspicion.

In a similar way, knowing something of people’s developmental and familial backgrounds tells us something about what they are like and what moves them in the present. The history of social and mental health movements provides insight into the state of psychology. These details provide us with information on the spirit of the times (zeitgeist) and the spirit of the place (ortgeist) that brought forth a community psychology “perspective” (Rappaport, 1977) and “orientation” (Heller & Monahan, 1977).

These historical considerations have been a part of community psychology definitions ever since such definitions began to be offered (Cowen, 1973; Heller & Monahan, 1977; Rappaport, 1977). They also can be found in the most recent text descriptions (Kloos et al., 2011; Nelson & Prilleltensky, 2010). A community psychology that values the importance of understanding “context” would appreciate the need for historical background in all things (Trickett, 2009). This understanding will help explain why things are the way they are, and what forces are at work to keep them that way or to change them. We also gain clues on how change has occurred and how change can be facilitated.

So what is the story? We will divide it into a story of mental health treatment in the United States and a story of the social movements leading up to the founding of the U.S. community psychology field.

In colonial times, the United States was not without social problems. However, given the close-knit, agrarian communities that existed in those times, needy individuals were usually cared for without special places to house them (Rappaport, 1977). As cities grew and became industrialized, people who were mentally ill, indigent, and otherwise powerless were more and more likely to be institutionalized. These early institutions were often dank, crowded places where treatment ranged from restraint to cruel punishment.

In the 1700s France, Philip Pinel initiated reforms in mental institutions, removing the restraints placed on asylum inmates. Reforms in America have been attributed to Dorothea Dix in the late 1800s. Her career in nursing and education eventually led her to accept an invitation to teach women in jails. She noted that the conditions were abysmal and many of the women were, in fact, mentally ill. Despite her efforts at reform, mental institutions, especially public ones, continued in a warehouse mentality with respect to their charges. These institutions grew as the lower class, the powerless, and less privileged members of society were conveniently swept into them (Rappaport, 1977). Waves of early immigrants entering the United States were often mistakenly diagnosed as mentally incompetent and placed in the overpopulated mental “hospitals.”

In the late 1800s, Sigmund Freud developed an interest in mental illness and its treatment. You may already be familiar with the method of therapy he devised, called psychoanalysis. Freud’s basic premise was that emotional disturbance was due to intrapsychic forces within the individual caused by past experiences. These disturbances could be treated by individual therapy and by attention to the unconscious. Freud gave us a legacy of intervention aimed at the individual (rather than the societal) level. Likewise, he conferred on the profession the strong tendency to divest individuals of the power to heal themselves; the physician, or expert, knew more about psychic healing than did the patient. Freud also oriented professional healers to examine an individual’s past rather than current circumstances as the cause of disturbance, and to view anxiety and underlying disturbance as endemic to everyday life. Freud certainly concentrated on an individual’s weaknesses rather than strengths. This perspective dominated American psychiatry well into the 20th century. Variations of this approach persist to the present day.
Part I • Introductory Concepts

In 1946, Congress passed the National Mental Health Act. This gave the U.S. Public Health Service broad authority to combat mental illness and promote mental health. Psychology had proved useful in dealing with mental illness in World War II. After the war, recognition of the potential contributions of a clinical psychology gave impetus to further support for its development. In 1949, the National Institute of Mental Health (NIMH) was established. This organization made available significant federal funding for research and training in mental health issues (Pickren, 2005; Schneider, 2005).

At the time, clinical psychologists were battling with psychiatrists to expand their domain from testing, which had been their primary thrust, to psychotherapy (Walsh, 1987). Today, clinical psychology is the field within psychology that deals with the diagnosis, measurement, and treatment of mental illness. It differs from psychiatry in that psychiatrists have a medical degree. Clinical psychologists hold doctorates in psychology. These are either a PhD, which is considered a research degree, or a PsyD, which is a “practitioner–scholar” degree focused on assessment and psychological interventions. (Today, the practicing “psychologist,” who does therapy, includes a range of specialties. For example, counseling psychologists, who also hold PhD or PsyD degrees, have traditionally focused on issues of personal adjustment related to normal life development. They too are found among the professional practitioners of psychology.) The struggle between the fields of psychiatry and psychology continues today, as some psychologists seek the right to prescribe medications and obtain practice privileges at the hospitals that do not already recognize them (Sammons, Gorny, Zinner, & Allen, 2000). New models of “integrated care” have been growing, where physicians and psychologists work together at the same “primary care” site (McGrath & Sammons, 2011).

Another aspect of the history of mental health is related to the aftermath of the two world wars. Formerly healthy veterans returned home as psychiatric casualties (Clipp & Elder, 1996; Rappaport, 1977; Strother, 1987). The experience of war itself had changed the soldiers and brought on a mental illness.

In 1945, the Veterans Administration sought assistance from the American Psychological Association (APA) to expand training in clinical psychology. These efforts culminated in a 1949 conference in Boulder, Colorado. Attendees at this conference approved a model for the training of clinical psychologists (Donn, Routh, & Lunt, 2000; Shakow, 2002). The model emphasized education in science and the practice of testing and therapy, a “scientist-practitioner” model.

The 1950s brought significant change to the treatment of mental illness. One of the most influential developments was the discovery of pharmacologic agents that could be used to treat psychosis and other forms of mental illness. Various antipsychotics, tranquilizers, antidepressants, and other medications were able to change a patient’s display of symptoms. Many of the more active symptoms were suppressed, and the patient became more tractable and docile. The use of these medications proliferated despite major side effects. It was suggested that with appropriate medication, patients would not require the very expensive institutional care they had been receiving, and they could move on to learning how to cope with and adjust to their home communities, to which they might return. Assuming adequate resources, the decision to release patients back into their communities seemed more humane. There was also a financial argument for deinstitutionalization, because the costs of hospitalization were high. There was potential for savings in the care and management of psychiatric patients. The focus for dealing with the mentally ill shifted from the hospital to the community. Unfortunately, what was forgotten was the need for adequate resources to achieve this transition.

In 1952, Hans Eysenck, Sr., a renowned British scientist, published a study critical of psychotherapy (Eysenck, 1952, 1961). Reviewing the literature on psychotherapy, Eysenck found that receiving no treatment worked as well as receiving treatment. The mere passage of time was as effective in helping people deal with their problems. Other mental health professionals leveled criticisms at psychological practices, such as psychological testing (Meheh, 1954, 1960) and the whole concept of mental illness (Elvin, 2000; Szasz, 1961). (A further review of these issues and controversies can be found.)
If intervention was not useful, as Eysenck claimed, what would happen to mentally ill individuals? Would they be left to suffer because the helping professions could give them little hope? This was the dilemma facing psychology.

In the 1950s and 1960s, Erich Lindemann’s efforts in social psychiatry had brought about a focus on the value of crisis intervention. His work with survivors of the Cocoanut Grove fire in Boston demonstrated the importance of providing psychological and social support to people coping with life tragedies. With adequate help provided in a timely manner, most individuals could learn to deal with their crises. At the same time, the expression of grief was seen as a natural reaction and not pathological. This emphasis on early intervention and social support proved important to people’s ability to adapt.

Parallel to these developments, Kurt Lewin and the National Training Laboratories were studying group processes, leadership skills for facilitating change, and other ways in which social psychology could be applied to everyday life (www.ntl.org/inner.asp?id=178&category=2). There was a growing understanding of the social environment and social interactions and how they contributed to group and individual abilities to deal with problems and come to healthy solutions.

As a result, the 1960s brought a move to deinstitutionalize the mentally ill, releasing them back into their communities. Many questioned the effectiveness of traditional psychotherapy. Studies found that early intervention in crises was helpful. And psychology grew increasingly aware of the importance of social environments. Parallel to these developments, social movements were developing in the larger community.

**Social Movements**

At about the same time as Freud’s death (1930s), President Franklin D. Roosevelt proclaimed his New Deal. Heeding the lessons of the Great Depression of the 1920s and 1930s, he experimented with a wide variety of government regulatory reforms, infrastructure improvements, and employment programs. These efforts eventually included the development of the Social Security system, unemployment and disability benefits, and a variety of government-sponsored work relief programs, including ones linked to the building of highways, dams, and other aspects of the nation’s economic infrastructure. One great example of this was the Tennessee Valley Authority, which provided a system of electricity generation, industry development, and flood control to parts of Tennessee, Alabama, Mississippi, Kentucky, Virginia, Georgia, and North Carolina. This approach greatly strengthened the concept of government as an active participant in fostering and maintaining individuals’ economic opportunities and well-being (Hiltzik, 2011). Although the role of government in fostering well-being is debated to this day, newer conceptions of the role of government still include an active concern for equal opportunity, strategic thinking, and the need for cooperation and trust (Liu & Hanauer, 2011).

There were other social trends as well. Although women had earlier worked in many capacities, the need for labor during World War II allowed them to move into less traditional work settings. “Rosie the Riveter” was the iconic woman of the time, working in a skilled blue-collar position, doing dangerous, heavy work that had previously been reserved for men in industrial America. After the war, it was difficult to argue that women could not work outside the home, because they had contributed so much to American war production. This was approximately 20 years after women had gained voting rights at the national level, with the passage of the 19th Amendment to the Constitution (passing Congress in 1919 and taking until 1920 for the required number of states to ratify it). Throughout the 1950s, 1960s, and 1970s, women—once disenfranchised as a group and with limited legal privileges—continued to seek their full rights as members of their communities.

In another area of social change, the U.S. Supreme Court in 1954 handed down their decision in *Brown v. Board of Education of Topeka, Kansas*. This decision overturned an earlier ruling that racial groups could be segregated into “separate but equal” facilities. In reality, the segregated facilities were
not equivalent. School systems that had placed Blacks into schools away from Whites were found to be in violation of the U.S. Constitution. This change in the law was a part of a larger movement by Blacks to seek justice and their civil rights. Notably, psychologists Kenneth and Mamie Phipps Clark provided psychological research demonstrating the negative outcomes of segregated schools (Clark, 1989; Clark & Clark, 1947; Keppel, 2002). This was the first time that psychological research was used in a Supreme Court decision (Benjamin & Crouse, 2002). The Brown v. Board of Education decision required sweeping changes nationally and encouraged civil rights activists.

Among these activists were a tired and defiant Rosa Parks refusing to give up her bus seat to a White passenger as the existing rules of racial privilege required; nine Black students seeking entry into a school in Little Rock, Arkansas; other Blacks seeking the right to eat at a segregated lunch counter; and students and religious leaders around the South risking physical abuse and death to register Blacks to vote. The civil rights movement of the 1950s carried over to the 1960s. People of color, women, and other underprivileged members of society continued to seek justice. The Voting Rights Act of 1965 helped to enforce the 15th Amendment to the Constitution, guaranteeing citizens the right to vote (www.ourdocuments.gov/doc.php?flash=true&doc=100&page=transcript).

In the 1960s, the “baby boomers” also came of age. Born in the mid-1940s and into the 1960s, these children of the World War II veterans entered the adult voting population in the United States in large numbers, shifting the opinions and politics of that time. Presaging these changing attitudes, in 1960, John F. Kennedy was elected president of the United States (www.whitehouse.gov/about/presidents/johnfkennedy). Considered by some too young and too inexperienced to be president, Kennedy embodied the optimism and empowerment of an America that had won a world war and had opened educational and occupational opportunities to the generation of World War II veterans and their families (Brokaw, 1998). His first inaugural address challenged the nation to service, saying, “Ask not what your country can do for you—ask what you can do for your country.” During his tenure, the Peace Corps was created, sending Americans overseas to help developing nations to modernize. Psychologists were also encouraged to “do something to participate in society” (Walsh, 1987, p. 524). These social trends, along with the increasing moral outrage over the Vietnam War, fueled excitement over citizen involvement in social reform and generated an understanding of the interdependence of social movements (Kelly, 1990).

One of President Kennedy’s sisters had special needs. This may have fueled his personal interest in mental health issues. Elected with the promise of social change, he endorsed public policies based on reasoning that social conditions, in particular poverty, were responsible for negative psychological states (Heller, Price, Reinar, Riger, & Wandersman, 1984). Findings of those times supported the notion that psychotherapy was reserved for a privileged few, and institutionalization was the treatment of choice for those outside the upper class (Hollingshead & Redlich, 1958). In answer to these findings, Kennedy proposed mental health services for communities and secured the passage of the Community Mental Health Centers Act of 1963. The centers were to provide outpatient, emergency, and educational services, recognizing the need for immediate, local interventions in the form of prevention, crisis services, and community support.

Kennedy was assassinated at the end of 1963, but the funding of community mental health continued into the next administration. In his 1964 State of the Union address, President Lyndon B. Johnson prescribed a program to move the country toward a “Great Society” with a plan for a “War on Poverty.”

President Johnson wanted to find ways to empower people who were less fortunate and to help them become productive citizens. Programs such as Head Start (addressed in Chapter 8) and other federally funded early childhood enhancement programs for the disadvantaged were a part of these efforts. Although much has changed in our delivery of social and human services since the 1960s, many of the prototypes for today’s programs were developed during this time.
Chapter 1 • Introduction: Historical Background

Multiple forces in mental health and in the social movements of the time converged in the mid-1960s. Dissatisfaction with the effectiveness of traditional individual psychotherapy (Eysenck, 1952), the limitation on the number of people who could be treated (Hollingshead & Redlich, 1958), and the growing number of mentally ill individuals returning into the communities combined to raise serious questions regarding the status quo in mental health. In turn, a recognition of diversity within our population, the appreciation of the strengths within our communities, and a willingness to seek systemic solutions to problems directed psychologists to focus on new possibilities in interventions. Thus we have the basis for what happened at the Swampscott Conference.

Swampscott

In May 1965, a conference in Swampscott, Massachusetts (on the outskirts of Boston), was convened to examine how psychology might best plan for the delivery of psychological services to American communities. Under the leadership of Don Klein, this training conference was organized and supported by the National Institute of Mental Health (NIMH; Kelly, 2005). Conference participants, including clinical psychologists concerned with the inadequacies of traditional psychotherapy and oriented to social and political change, agreed to move beyond therapy to prevention and the inclusion of an ecological perspective in their work (Bennett et al., 1966). The birth of community psychology in the United States is attributed to these attendees and their work (Heller et al., 1984; Hersch, 1969; Rappaport, 1977). Appreciating the influence of social settings on the individual, the framers of the conference proceedings proposed a “revolution” in the theories of and the interventions for a community’s mental health (Bennett et al., 1966).

WHAT IS COMMUNITY PSYCHOLOGY?

Community psychology focuses on the social settings, systems, and institutions that influence groups and organizations and the individuals within them. The goal of community psychology is to optimize the well-being of communities and individuals with innovative and alternate interventions designed in collaboration with affected community members and with other related disciplines inside and outside of psychology. Klein (1987) recalled the adoption of the term community psychology for the 1963 Swampscott grant proposal to NIMH. Klein credited William Rhodes, a consultant in child mental health, for writing of a “community psychology.” Just as there were communities that placed people at risk of pathology, community psychology was interested in how communities and the systems within them helped to bring health to community members.

Iscoe (1987) later tried to capture the dual nature of community psychology by drawing a distinction between a “community psychology” and a “community psychologist.” He stated that the field of community psychology studied communities and the factors that made them healthy or at risk. In turn, a community psychologist used these factors to intervene for the betterment of the community and the individuals within it. In the 1980s, the then Division of Community Psychology (Division 27 of the APA): was renamed the Society for Community Research and Action so as to better emphasize the dual nature of the field.

The earliest textbook (Rappaport, 1977) defined community psychology as an attempt to find other alternatives for dealing with deviance from societal-based norms . . . [avoiding] labeling differences as necessarily negative or as requiring social control . . . [and attempting] to support every person’s right to be different without risk of suffering material and psychological sanctions . . . The defining aspects of this [community] perspective are: cultural relativity, diversity, and ecology, [or rather] the fit between person and environment . . . [The] concerns [of a
TABLE 1.1 Four Broad Principles Guiding Community Research and Action

1. Community research and action requires explicit attention to and respect for diversity among peoples and settings.
2. Human competencies and problems are best understood by viewing people within their social, cultural, economic, geographic, and historical contexts.
3. Community research and action is an active collaboration among researchers, practitioners, and community members that uses multiple methodologies. Such research and action must be undertaken to serve those community members directly concerned, and should be guided by their needs and preferences, as well as by their active participation.
4. Change strategies are needed at multiple levels to foster settings that promote competence and well-being.

Source: From www.scra27.org/about.html.

Community psychology reside in human resource development, politics, and science . . . to the advantage of the larger community and its many sub-communities. (pp. 1, 2, 4–5; boldface ours)

This emphasis on an alternative to an old, culture-blind, individual-focused perspective was restated more recently in Kloos and colleagues (2011), who provide two ways in which community psychology is distinctive. It “offers a different way of thinking about human behavior . . . [with a] focus on the community contexts of behavior; and it [expands] the topics for psychological study and intervention” (p. 3).

Both Kofkin Rudkin (2003) and Kagan, Burton, Ducket, Lawthom, and Siddiquee (2011) have noted that continual reconsiderations of the definition of community psychology accommodate a flexible and dynamic conceptualization of a field that is sensitive to the continual input of science and theory as well as considerations of the details of time and place.

Community psychology is born out of dissatisfaction with the limitations of the traditional psychotherapy approaches. The “radical” theory- and research-based position it took was that individuals were best understood within the contexts in which they were embedded, that these contexts demanded an appreciation of the cultural and ethnic diversity of backgrounds, and that the individual and the context provided both opportunities and problems for health and well-being. Studying communities would yield a better understanding of this position and would provide new approaches to programming toward the health of those communities and the individuals within them.

At the beginning of the 21st century, the Society for Community Research and Action (Division 27 of the APA) surveyed its membership. From those results, a divisional task force compiled four basic principles for community psychology (see Table 1.1). These principles may be summarized as a respect for diversity, a recognition of the power of context, an appreciation of a community’s right to empowerment, and an understanding of the complexity of ecologically relevant interventions. The following exploration of these four fundamental principles provides us with a good example of community psychology in application.

FUNDAMENTAL PRINCIPLES

“Principles” are (1) the theoretical assumptions on which a concept (i.e., community psychology) is built, or (2) the values that influence and motivate action in the field. The framers of these principles hoped to portray what were commonly agreed-on fundamentals of a community psychology, but they also noted that these were aspirations.
At one time, psychology was in search of universal principles that would transcend culture or ethnicity. However, the group sampled to establish these universals tended to be White, middle-class college students. The irony in this did not escape psychologists in the 1960s or today (Guthrie, 2003; Pedersen, 2008; Rappaport, 1977; Trimble, 2001). Recognizing and respecting differences in people and their cultural and ancestral heritage is important to a community psychology. Trickett, Watts, and Birman (1994) and Hays (2008) have noted that diversity extends beyond culture, ethnicity, and race and includes considerations of gender, disability, sexual orientation, and those who have been marginalized and oppressed. Hays (2008) included 10 categories in her system for noting diversity (Table 1.2), the ADDRESSING system. Okazaki and Saw (2011) would add to this list an 11th category, that of Immigrant Status.

Rappaport (1977) called for the acceptance of “the value of diversity and the right of people to choose their own goals and life styles” (p. 3). If diversity is respected, how might that affect our thinking? Certainly, different would not mean inferior (lower) or deficient (lacking). Early models of abnormality that assumed such positions would have to be discarded, and new models that appreciated the contribution of social and cultural factors would have to be incorporated into our conceptions of health and pathology (Sue, Sue, Sue, & Sue, 2013). The assumptions of merit and achievement would also need to be reconsidered, along with resource distribution and the criteria for allocations. From a belief in the diversity of people also comes a recognition of the distinctive styles of living, worldviews, and social arrangements that are not part of the perceived mainstream or established traditional society but that more accurately characterize our society’s diversity. Moreover, a recognition of these distinctions keeps diverse populations from being compared with perceived mainstream cultural standards and then being labeled as “deficient” or “deviant” (Snowden, 1987). Such a recognition of diversity increases our ability to design interventions that are culturally appropriate and thus more effective (e.g., Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Marin, 1993).

Sue (1977), early in the community mental health movement, pointed out the differential treatment and outcomes for ethnic minority group clients in the system. He called for provision of responsive services to these populations. These demands for more cultural competency in treatments, emphasizing the importance of understanding relationships and context in our interventions, have continued over several decades (Sue, 2003). Sue believes these variables of cultural capacity to be just as important, if

**TABLE 1.2 The ADDRESSING Framework for Diversity**

| Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, Gender. |


A Respect for Diversity

At one time, psychology was in search of universal principles that would transcend culture or ethnicity. However, the group sampled to establish these universals tended to be White, middle-class college students. The irony in this did not escape psychologists in the 1960s or today (Guthrie, 2003; Pedersen, 2008; Rappaport, 1977; Trimble, 2001). Recognizing and respecting differences in people and their cultural and ancestral heritage is important to a community psychology. Trickett, Watts, and Birman (1994) and Hays (2008) have noted that diversity extends beyond culture, ethnicity, and race and includes considerations of gender, disability, sexual orientation, and those who have been marginalized and oppressed. Hays (2008) included 10 categories in her system for noting diversity (Table 1.2), the ADDRESSING system. Okazaki and Saw (2011) would add to this list an 11th category, that of Immigrant Status.

Rappaport (1977) called for the acceptance of “the value of diversity and the right of people to choose their own goals and life styles” (p. 3). If diversity is respected, how might that affect our thinking? Certainly, different would not mean inferior (lower) or deficient (lacking). Early models of abnormality that assumed such positions would have to be discarded, and new models that appreciated the contribution of social and cultural factors would have to be incorporated into our conceptions of health and pathology (Sue, Sue, Sue, & Sue, 2013). The assumptions of merit and achievement would also need to be reconsidered, along with resource distribution and the criteria for allocations. From a belief in the diversity of people also comes a recognition of the distinctive styles of living, worldviews, and social arrangements that are not part of the perceived mainstream or established traditional society but that more accurately characterize our society’s diversity. Moreover, a recognition of these distinctions keeps diverse populations from being compared with perceived mainstream cultural standards and then being labeled as “deficient” or “deviant” (Snowden, 1987). Such a recognition of diversity increases our ability to design interventions that are culturally appropriate and thus more effective (e.g., Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Marin, 1993).

Sue (1977), early in the community mental health movement, pointed out the differential treatment and outcomes for ethnic minority group clients in the system. He called for provision of responsive services to these populations. These demands for more cultural competency in treatments, emphasizing the importance of understanding relationships and context in our interventions, have continued over several decades (Sue, 2003). Sue believes these variables of cultural capacity to be just as important, if
not more important, than specific treatment techniques. Padilla, Ruiz, and Alvarez (1975) also called attention to the barriers of geography, class, language, and culture that led to a lack of Spanish-speaking and -surnamed populations in mental health systems. The recommendations of barrio-neighborhood and family-focused services have been models for what community-based services should be. In particular, the emphasis continues to be on respect for cultural context in devising treatments. When interventions fail, it is not necessarily the fault of the client or patient. The system and its assumptions can also be at fault and must be examined. Bernal and Sáez-Santiago (2006) described a framework (Table 1.3) for deriving what Pederson (1997) called a “culturally centered” community intervention. The APA has adopted Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (APA, 2003) in recognition of the importance of diversity in psychology.

In terms of research, the recognition of diversity within populations has slowly but steadily been rising. In early issues of community psychology journals, about 11% of the articles addressed ethnic minority populations (Loo, Fong, & Iwamasa, 1988). Martin, Lounsbury, and Davidson (2004) found this rate to more than double in the time period from 1993 to 1998, with approximately 25% of the articles in the American Journal of Community Psychology addressing diversity issues.

The study of ethnic minority groups is really the practice of good science (Sue & Sue, 2003). Given our understanding of population (the people in whom we are interested) and sample (a subset of those people), accurate sampling requires recognition of who is the population. The cultural variations in ethnic groups make them different “populations” for study. Considerations of culture and community are integral to one another (Kral et al., 2011; O’Donnell, 2006). O’Donnell proposed the term cultural–community psychology because all communities were best understood within their specific cultural contexts. Building on the work of Trickett (1996), who described the importance of both culture and context in understanding and working in diverse communities, O’Donnell commented that all community phenomena and interventions should be preceded by the phrase “it depends.”

Given the emphasis on diversity and the appreciation of cultural and ethnic factors, it is not surprising that 23% of the membership of the Society for Community Action and Research self-identifies as ethnic minority (Toro, 2005). In comparison, approximately 6% of the APA membership self-identifies as ethnic minority.

---

**TABLE 1.3 Framework for Culturally Centered Interventions**

<table>
<thead>
<tr>
<th>Language (Native language skills)</th>
<th>A carrier of culture and meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal relationships</td>
<td>Especially as might be influenced by similarities or differences in ethnicity and race</td>
</tr>
<tr>
<td>Metaphors</td>
<td>The ways in which meaning and concepts are conveyed</td>
</tr>
<tr>
<td>Cultural knowledge</td>
<td>Traditions, customs, and values</td>
</tr>
<tr>
<td>Theoretical model for intervention</td>
<td>The psychological bases for action</td>
</tr>
<tr>
<td>Intervention goals</td>
<td>Need for agreement as to what is to be accomplished</td>
</tr>
<tr>
<td>Intervention methods</td>
<td>Culturally sensitive and respectful of the community</td>
</tr>
<tr>
<td>Consideration of context</td>
<td>The historic, social, political, and economic setting are seen as important to the person, the setting, and the intervention</td>
</tr>
</tbody>
</table>

Notably, certain marginalized groups continue to be ignored or underserved—for example, homosexuals, individuals with disabilities, and women (Bond, Hill, Mulvey, & Terenzio, 2000). Bond and Harrell (2006) caution that there is little work on the subtleties, contradictions, and dilemmas that arise from working with the many diversities that exist within our communities. Along with the obvious issues of competing ethnic groups, there are the intersections of gender and ethnicity, the combinations of sexual orientation and class, or all of these considerations together creating practical challenges to the practice of community psychology. Although diversity has a history of recognition within the field, its implications are still being worked out and understood.

The appreciation of diversity has been important to community psychologists’ work in various groups and communities. However, research has found that community is created most easily within homogeneous populations. This tension between diversity and homogeneity is an area that community psychology must better address (Townley, Kloos, Green, & Franco, 2011).

Of note is Toro’s (2005) comment on how the field has become so diverse. This diversity extends to the many theories, approaches to problems, issues addressed, and populations served. Although some may call this a lack of focus, Toro believes it to be an indication of health and vitality as the field expands its boundaries and takes on new challenges.

You will see numerous studies on specific ethnic groups in this text. There are also growing numbers of studies focusing on other aspects of diversity. We will not reference one particular chapter that deals with this topic. That is because diversity is integral to any of the considerations within the field. This is very different from what was found in the 1960s. Community psychology was one of the areas in psychology that championed the need for inclusion of diversity in the mainstream of the discipline.

The Importance of Context and Environment

Our behaviors are governed by the expectations and demands of given situations. For example, students’ behavior in lecture classes is different from their behavior at a dance. Even the levels of our voices are governed by where we happen to be. At a ball game or sports event, we are louder. At a funeral, or in a church or temple, we are quieter. Raising our children, we may tell them to use their “inside” voices, or allow them to use their “outside” voices when the occasion permits it.

Kurt Lewin (1936) formulated that behavior is a function of the interaction between the person and the environment \( B = f(P \times E) \). A social–gestalt psychologist, Lewin intended to capture the importance of both the individual and his or her context. To consider the individual alone would provide an incomplete and weak description of the factors influencing behavior. It would be like a figure without a ground. Therefore, any study of behavior must include an understanding of the personal dispositions and of the situation in which the person finds him- or herself.

Roger Barker (1965), one of Lewin’s students, studied the power of “behavior settings” in guiding the activities of a setting’s inhabitants. People in a given setting acted in prescribed ways. Violation of these environmentally signaled patterns was punished. As a result, these patterns persisted over time. Barker observed and analyzed the social and psychological nature of these settings. For example, in a dining room, we dined. We did not play football there, or so we were told. If we were to go up to a person and rub his shoulder instead of shaking his hand, we would get curious looks. If we were to get into an elevator and face inward instead of outward, people would become nervous. These behavior settings held a powerful influence on what we did.

One aspect of the setting that Barker studied was the number of people it took to maintain that setting. To run a grocery store requires a certain number of people—for example, the checkout clerk, the stocker, and the people to make and accept deliveries. We have all been at a checkout area when there were not enough checkout clerks. There is a demand on people to work harder, and everyone feels that
there are not enough people to do what needs to be done. If there are more customers, there might be a call for more checkers to come to their stands. The number of people required is flexible, and the store has made provision to have more or less as the needs change.

Each setting has an optimal level of staffing. When there are too many staff members, it is likely that the setting will be more selective about who is allowed to perform the tasks. There will be competition to fill those positions. Barker (1965) called this a case of overmanning, or rather, too many people for the situation. Newcomers are less likely to be welcome, because they would add to the competitive pool. On the other hand, if there are not enough people to complete a task, there is more environmental demand to use every available individual and to recruit more. With a lot of work to be done and not enough personnel to do, there will be less competition for positions. As we might guess, new members will be welcome. This is a case of undermanning, or insufficient personnel to accomplish the required tasks. In this case, the social environment is more open and positively inclined to newcomers.

It might be noted that in economically difficult times, where there is competition for scarce jobs, the attitude toward newcomers and immigrants is usually negative. When there is a need for more workers, there is more willingness to take in new people. Often these positive or negative attitudes toward newcomers can be manipulated by perceptions of overmanning or undermanning. For example, attitudes toward new workers can be made more negative by instilling a belief that there are too many people, even though newcomers might be performing tasks that others would not do.

Barker’s and Lewin’s works have underscored the importance of environmental factors in behavioral tendencies. Regularities of behavior are not determined solely by personality and genetics. Behaviors are also the result of environmental signals and pressures on the individual. Different environments bring different behaviors. Change the environment, change the behavior.

Behavioral community psychology reinforces the importance of context from a learning theory perspective. Discriminative stimulus and setting control are contextual terms. In behavioral terminology, the “context” can be construed as the discriminative stimuli within a setting that, as individuals or groups have learned, signal the display of certain behaviors leading to consequences that are desirable or undesirable. The expectation of reinforcement or punishment for the behaviors is the basis of the community learning. Certain behaviors are reinforced in a given setting, increasing the probability of those behaviors in those settings; if other behaviors are punished in that setting, the probability of those behaviors decreases (Figure 1.1). A “No Smoking” sign usually suppresses smoking behavior. People drinking usually increases the likelihood of others drinking in that setting. When picking up dog waste on a walk through certain urban neighborhoods was reinforced, people picked up their dog waste in those neighborhoods (Jason & Zolik, 1980). This is a Skinnerian explanation of setting control (Skinner, 1974).

Beyond this strict behavioral interpretation of context, Mischel (1968) argued for the importance of setting as well as personality in determining behaviors. That is, certain behavioral tendencies might appear stronger in particular settings and weaker in others. For example, we might not see friendly behaviors in one setting (final exams), but in another setting, friendliness overflows (parties). Behavioral community
Empowerment is another basic concept of community psychology. It is a value, a process, and an outcome (Zimmerman, 2000). As a value, empowerment is seen to be good. It assumes that individuals and communities have strengths, competencies, and resources and are by nature nonpathological. As a process, empowerment is a way in which individuals and communities feel that they have some say in and control over the events in their lives, the structures that shape their lives, and the policies that regulate those structures. Community psychology emphasizes the value of the democratic process. As an outcome of democracy, people can feel empowered. In psychological terms, a feeling of efficacy is the belief that one has power over one’s destiny. It is the opposite of helplessness. It is what Bandura (2000, 2006) has called agency (being an actor within one’s world, and not merely a passive observer), self-efficacy (a belief that one can make a difference), and collective efficacy (a belief of a group or community that together they can bring about change). Beyond these cognitive components, empowerment includes action on one’s own behalf.

Empowerment is viewed as a process: the mechanism by which people, organizations, and communities gain mastery over their lives. (Rappaport, 1984, p. 3)

At the community level, of analysis, empowerment may refer to collective action to improve the quality of life in a community and to the connections among community organizations and agencies. (Zimmerman, 2000, p. 44)
Empowerment is a construct that links individual strength and competencies, natural helping systems, and proactive behaviors to social policy and social changes. Empowerment theory, research, and intervention link individual well-being with the larger social and political environment. (Perkins & Zimmerman, 1995, p. 569)

Perkins and associates (2007) note that empowering individuals through learning and participation opportunities eventually leads to higher level organizational and community transformations.

There are many ways to feel empowered within a work setting (Foster-Fishman, Salem, Chibnall, Legler, & Yapchai, 1998). Job autonomy (control over and influence on the details of the work setting), gaining job-relevant knowledge, feeling trusted and respected in the organization, freedom to be creative on the job, and participation in decision making were examples found through interviews and observations at a given work site. Studies of empowering organizations found that inspiring leadership, power role opportunities, a socially supportive environment, and group belief in the power of its members all contributed to feelings of empowerment in community organizations (Maton, 2008; Wilke & Speer, 2011).

And yet, empowerment processes are not simply giving initiative and control over to people. We are reminded that attempts at youth empowerment have come in a variety of forms with differential success. Reviewing relevant youth programs, Wong, Zimmerman, and Parker (2010) noted that empowerment attempts took forms ranging from total control by youth to total control by adults, and included a shared-control model involving both youth and adults in decision making and action as the middle ground. Empowerment was found to be a transactional process, with both adult and youth contributing to the outcomes (Cargo, Grams, Ottoson, Ward, & Green, 2004). Adults contribute by creating a welcoming and enabling setting. Youth contribute through engaging with others in positive and constructive change. Actions by both adults and youth are required. Together, their contributions build on each other’s behaviors and produce an empowering and productive environment.

As an example of empowerment outcomes, Zeldin (2004) found that youth increase in their sense of agency and in their knowledge and skills when they participate in community decision-making activities. This reminds us that agency, or the feeling that a person can influence a situation, is linked to self-efficacy, a cognitive attitude that has been shown to result in better persistence, effort, and final success in dealing with problem situations (Bandura, 1989, 2006). Empowerment situations may lead to feelings of self- or collective group efficacy.

Maton and Brodsky (2011) make the distinction among psychological empowerment, where individuals gain a sense of mastery; social empowerment, where individuals rise in status; and civic empowerment, where there is a gain in rights and privileges. Although related to each other, these forms of empowerment are different. Such distinctions need to be considered in examining both processes and outcomes.

The concept of empowerment has not gone without criticism. Empowerment often leads to individualism and therefore competition and conflict (Riger, 1993). Empowerment is traditionally masculine, involving power and control, rather than the more traditionally feminine values and goals of communion and cooperation. Riger (1993) challenged community psychologists to develop an empowerment concept that incorporates both empowerment and community. We will see a variety of attempts at empowerment in our exploration of community applications throughout the text. It is interesting to note to what end? With what results?

The Ecological Perspective/Multiple Levels of Intervention

In the developmental literature, Urie Bronfenbrenner (1977) described four layers of ecological systems that influence the life of a child. At the center of the schema is the individual, and in ever-growing circles lie the various systems that interact with and influence him or her. The “immediate system” contains the
person and is composed of the particular physical features, activities, and roles of that person. This is called the **microsystem**. Examples of microsystems include a playroom, a home, a backyard, the street in front of the house, or a classroom. Microsystems could include the school or one’s family. These microsystems directly influence the individual, and the individual can directly influence the system.

At the next level out is the **mesosystem**, which holds the microsystems and where the microsystems interact with each other. Examples of this would be places where one microsystem (school) and another microsystem (family) come together. A mesosystem is a “system of microsystems” (Bronfenbrenner, 1977, p. 515). Note that the child/individual is an active member within the mesosystem. Research has shown the advantages of clear and demonstrated linkages between the school and the family for the child’s school adaptation and academic performance, and this has led to direct calls for better collaboration between schools and communities (Adelman & Taylor, 2003, 2007; Warren, 2005). In turn, there are also findings that schools seen as a part of their community are more likely to be supported and less likely to be the target of vandalism. Children who feel connected to family, school, and neighborhood may feel the responsibilities of membership and the supportiveness of their holistically integrated social and psychological environment. The “system” then can lead to feelings of connection or disconnection among the microsystems; to the collection of social, material, and political resources; or to the alienation of the various components from each other.

The next circle out is the **exosystem**, an extension of the mesosystem that does not immediately contain the child or individual. The exosystem influences the mesosystem. Examples would be government agencies that influence the meso- and microsystems (school boards, city councils, or state legislatures, which influence the schools and families but do not have them as members) or work situations for family members (who in turn populate the micro- and mesosystems).

At the furthest level outward is the **macrosystem**, which does not contain specific settings. The macrosystem contains the laws, culture, values, or religious beliefs that govern or direct the lower systems. Being in the southwestern United States brings certain cultural and legal assumptions that may differ markedly from those in Vancouver, Canada; Barcelona, Spain; Auckland, New Zealand; or Hong Kong, China. Bronfenbrenner (1977) proposed that any conceptualization of a child’s development needed a comprehensive examination of all these systems to provide an adequate understanding of the processes that influenced the child. Interventions to address this progress should have a comprehensive and conceptual basis addressing multiple levels. Anything less provides an artificial perspective on what really happens in the life of an individual or a group of individuals. Graphic descriptions of Bronfenbrenner’s ecological model showed circles embedded in larger circles. This described the nature of the systems embedded in larger systems.

Kelly (2006) saw the ecological model as an alternative to the reductionistic attempts to describing phenomena. If the world was complex and dynamic, it required concepts and processes that captured those qualities. Among the ecological principles were **interdependence, cycling of resources, adaptive capacity, and succession**.

With **interdependence**, the elements of an ecosystem are seen to be related to each other. Changing one element affects all elements in some way. Kelly (1980) described a baseball game as a good example of interdependence. Billy Martin, the onetime manager of the New York Yankees, said that every pitch in every game was different (Angell, 1980). Each pitch required calculations of factors such as weather, wind, time of day, ballpark, personnel, positioning, order at bat, pitcher, and number of pitches. You can see the shifts in the infield and outfield, types of signals given, types of swings attempted, and other changes in strategy and tactics. Everything is interdependent. To the uninvolved or uninvolved, baseball can seem a quiet, leisurely sport with which one can be intermittently engaged. To those who know, its complexity is never-ending and a source of continuing fascination. Action in the community requires a similar calculation of various interacting parts. Resources, players, activities, traditions, values, history, and culture are some of the interdependent elements of community psychology.
The second principle of Kelly’s ecological model is the cycling of resources. This follows the first law of thermodynamics, which states that the amount of energy in a system remains constant: If there is an expenditure of energy in one area, it is the result of transfer of energy from another area. In the ecological model, for resources to be dedicated to one area, they must come from another area. Therefore, the community must choose where to attend and where to expend its energy or resources. To provide more funds for education, some roads may not be repaired; to provide more funds for roads, schools may have to get by with less money. This becomes especially apparent in economically lean times.

The third ecological principle deals with adaptive capacity to a given environment. Those who are better able to deal with their environment are more likely to survive, and those who can deal with a broader range of environments should find more settings in which it is possible to live. What matters is not just adaptation to one environment, but also the adaptive range that enables the organism to survive across more situations. One might figure that the argument for flexibility and openness to social and cultural variation would allow a person to do well in more social and physical situations. Community cultures allowing us to learn and to live and to change our living situations across a wide array of settings allow for more successful adjustment to change. If our weather changes, how open are we to changing what we do? One of the authors went from Hawaii to upstate New York. When winter came, it got cold. One day, the winter skies cleared. In Hawaii, clear skies meant warm weather. Blue skies in upstate New York in the middle of winter meant the exact opposite. It was colder. Much colder. Make that mistake once, and the person who lives to talk of it again learns very quickly, or risks death. A community that notes warming or cooling, changes in economic opportunities, or shifts in demographics needs to adapt to deal with these changes, or it will fail. Those who do this better survive and thrive.

Kelly’s final ecological point is that of succession. One thing follows another in a fairly predictable manner. Consider the queen of England and who will succeed her when she is gone. Which of the princes or princesses comes next? And after him or her, who else? They have it all worked out. This person follows, and when they are gone, the next in line follows, and so on and so on. A similar type of consideration is made with the president of the United States. If he or she is incapacitated while in office, the vice president takes charge, and if the person who is vice president is unable to do the job, the Speaker of the House is next in line. Of course, the president can also be succeeded after an election: The process of moving from one president to the next is laid out in predictable fashion, from the elections in November to the inauguration in January. All of this is to say that with time, changes occur. These changes follow a predictable sequence, just as the queen of England will not always be queen, or the president remain the president. With the passage of time, there will be someone new. Settings and organizations change as well. Just as a college student moves from freshman to senior, and spring follows winter, a decline in one industry leads to opportunity for new industries, and particular groups of people decrease and other groups increase in an area. Succession requires the community psychologist to pay attention to these changes. We can see these ecological principles summarized in Table 1.4.

<table>
<thead>
<tr>
<th>TABLE 1.4 Ecological Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interdependence—Elements of the environment influence each other.</td>
</tr>
<tr>
<td>2. Adaptation—An organism must be able to change as the environment changes.</td>
</tr>
<tr>
<td>3. Cycling of resources—Resources are exchanged in a system, such as money for goods.</td>
</tr>
<tr>
<td>4. Succession—Change occurs; nothing is static.</td>
</tr>
</tbody>
</table>

The ecological model also calls attention to person–environment fit. Does the person have the characteristics to succeed, given the environmental expectations and demands? Will someone who is short do well in a place where all the important objects are placed seven feet off the floor? Or (and one author has observed this) can a tall person live comfortably in a basement apartment with six-foot ceilings? This person–environment fit works in psychological terms as well, being quiet when appropriate and loud when appropriate. The person–environment fit concept is well embedded in community psychology (Pargament, 1986; Trickett, 2009). Early on, Rappaport (1977) explained that the ecological perspective required an examination of the relationship between persons and their environments (both social and physical). The establishment of the optimal match between the person and the setting should result in successful adaptation of the individual to his or her setting.

Moos measured person–environment fit by assessing a person’s perception of the environment and that person’s desired environment according to Social Climate Scales (Moos, 1973, 2003). The discrepancies between the real and the ideal could be compared. Where there were few differences (good fit), we would expect the person to be happier. In contrast to this, most psychological evaluations focus on the person alone. The assumption is that people are the most important contributors to their own well-being. This purely trait-type focus has been critiqued by social–behavioral personality theorists Mischel (1968, 2004) and Bandura (2001), where the person and what he or she carries within them is the sole determinant of success or failure. The more recent social–behaviorist personality theories are interactionist or transactionalist.

Labeling the person who does not fit the setting as a “misfit” and blaming the problems on the individual alone is not helpful or realistic. Rather, the ecological perspective recognizes that with people and environments, the influence is mutual. Individuals change the settings in which they find themselves, and in turn, settings influence the individuals in them (Bandura, 1978, 2001; Kelly, 1968, 2006; Kuo, Sullivan, Coley, & Brunson, 1998; Peterson, 1998; Seidman, 1990). If something is awry with the individual or the environment, both can be examined and perhaps both changed. A study of the person–environment fit of urban Mexican American families in the southwestern United States yielded several findings supporting the importance of setting and families. Economically distressed families did better in low-income neighborhoods, and successful, acculturated families did less well in a nonmatching neighborhood. Although single-parent families were generally at risk and dual-parent families generally more adaptive to settings, the match of neighborhoods influenced adjustment capabilities (Roosa et al., 2009).

Given the ecological framework, community psychology research and action must consider more than the individual. It must include the environment that contains the individual. That environment, or context, needs to be expanded to include the variety of situations that influence behaviors. The more completely the ecology can be understood, the more effectively the interventions can be devised and implemented. Communities are complex and reciprocal systems by nature and must be dealt with as such. A more recent description of ecological thinking included (1) thinking interdependently (as before); (2) understanding the cultural contexts (macrosystemically); (3) ensuring the development of trust between the researcher and the community; and (4) realizing that the researcher is transformed in the discovery process, just like the communities he or she studies or intervenes in (Kelly, 2010).

We think systemically, ecologically, and with appreciation for the differences we bring to our social milieu. Beyond the principles outlined here, several concepts have high currency within the field. We examine them next. Note that the differences between clinical and community psychology are elaborated in Case in Point 1.1.
Clinical psychology and community psychology both grow out of the same motivation to help other individuals using the science of psychology. Clinical psychology’s orientation has traditionally been on the individual and the internal variables that influence their lives. Among those internal variables are emotions, cognitions, neural structures, and behavioral tendencies. Clinicians tend to speak of personality and what has influenced personal qualities. Given the assumption that a clinician is called into service when there is an identified personal problem, clinical skills include testing and assessment, diagnosis, and psychotherapy (Plante, 2011). Essentially, a clinician is trained to deal with psychopathology.

Among the clinical psychologist’s work settings may be a hospital, a health clinic, a group or private practice office, a university, or a research setting. You may note the medical nature of most of these sites. American clinical psychology traces its origins back to the late 1800s. Lightner Witmer is credited by many as the father of American clinical psychology. His work in the first part of the 20th century focused on schoolchildren and their treatment, learning, and behavioral problems in the psychological clinic.

In contrast to clinical psychology, community psychology is oriented to groups of people and the external social and physical environments’ effects on those groups—that is, communities. External variables include consideration of social support, peer and familial environments, neighborhoods, and formal and informal social systems that may influence individuals or groups. There is interest in social ecology and social policy. The orientation is toward prevention of problems and promotion of wellness. Skill sets include community research skills; the ability to understand community problems from a holistic perspective: skills in relating to community members in a meaningful and respectful manner; attention to the existing norms, system maintenance, and change; appreciation for the many ways in which context/environment influences behaviors; being able to assemble and focus resources toward the solution of a community problem; and training that enables thinking outside the established normative world. A review of three community psychology texts support these descriptions. Among the earliest of texts on community psychology, Rappaport (1977) dedicated many of his chapters to social interventions and systems interventions. A few years ago, Kofkin Rudkin’s (2003) book included chapters titled “Beyond the Individual,” “Embracing Social Change,” “Prevention,” “Empowerment,” and “Stress.” Kloos et al. (2011) had chapters entitled “Community Practice,” “Community Research,” “Understanding Individuals within Environments,” “Understanding Diversity,” “Stress and Coping,” “Prevention and Promotion,” and “Social Change.” None of these community texts had sections on psychopathology, assessment, or psychotherapy.

Community psychologists might be working for urban planners, government offices, departments of public health, community centers, schools, or private program evaluation agencies, as well as universities and research centers. They are not usually found in medical settings doing therapy but might work there examining delivery systems and community accessibility programs. There are clear differences between clinical and community psychology topics. Common interests include providing effective interventions for the human good and understanding phenomena from a psychological perspective. Many community psychologists were trained as clinical psychologists. The Swampscott Conference attendees were clinicians. Clinical psychology has taken on the themes of pathology prevention and health promotion in a significant way. The discussion of the limitations of traditional one-on-one clinical psychology has continued among clinicians (Kazden, 2010). The questions remain the same. How can we more efficiently and more effectively bring psychological and physical health to larger segments of the population? Community psychology argues that its approach brings new perspectives to help answer this question.

OTHER CENTRAL CONCEPTS

Besides the principles that have been identified as foundational to a community psychology, several concepts are central to the field. Among them are the ideas of prevention, a strength focus, social change and action research, a sense of community, and an interdisciplinary perspective.
Prevention Rather than Therapy

The Swampscott Conference’s focus on prevention rather than treatment was inspired by public health (Heller et al., 1984; Kelly, 2005) and work in child and social psychiatry (Caplan, 1964). In very basic terms, prevention is understood to be “doing something now to prevent (or forestall) something unpleasant or undesirable from happening in the future” (Albee & Ryan, 1998, p. 441). What one specifically does may be determined by what one is specifically trying to prevent, of course, but the underlying premise remains.

The main argument for prevention is that traditional psychological interventions often came too late in the illness development process; they were usually provided long after the individual already had developed a problem. Emory Cowen (1980) stated,

We became increasingly, indeed alarmingly, aware of (a) the frustration and pessimism of trying to undo psychological damage once it had passed a certain critical point; [and] (b) the costly, time-consuming, culture-bound nature of mental health’s basic approaches, and their unavailability to, and effectiveness with, large segments of society in great need. (p. 259)

Such concerns continue to this day (Vera & Polanin, 2012).

On the other hand, prevention might counter any trauma before it begins, thus saving the individual and perhaps the whole community from developing a problem. In this regard, as stated earlier, community psychology takes a proactive rather than reactive role. For example, community psychologists believe it is possible that sex education before adolescence, teamed with new social policy, can reduce the teenage pregnancy rate. Kirby (2007) provides clear research-based guidelines on pregnancy prevention programs. In the following chapters, you will read about a variety of techniques in prevention: education, altering the environment, development of alternate interventions, and public policy changes.

Community psychologists recognize that there are distinctions among levels of preventive intervention. Primary prevention attempts to prevent a problem from ever occurring (Heller, Wyman, & Allen, 2000). Levine (1998) likened primary prevention to an inoculation. Just as a vaccination protects against a targeted disease, primary preventive strategies can help an individual fend off problems altogether. Primary prevention refers most generally to activities that can be undertaken with a healthy population to maintain or enhance its physical and emotional health (Bloom & Hodges, 1988)—in other words, “keeping healthy people healthy” (Scileppi, Teed, & Torres, 2000, p. 58). Which preventive strategies are best (or whether they are equally efficacious) is part of the current debate in community psychology (Albee, 1998).

Cowen (1996) argued that the following criteria must be met for a program to be considered truly primary preventive:

- The program must be mass- or group-oriented.
- It must occur before the maladjustment.
- It must be intentional in the sense of having a primary focus on strengthening adjustment of the as yet unaffected.

Levine (1998, 1999) added further characteristics. Primary prevention interventions should do the following:

- Evaluate and promote synergistic effects and consider how to modify countervailing forces.
- Be structured to affect complex social structures, including redundant messages. They should be continued over time.
- Examine institutional and societal issues, not just individual factors.
- Recognize that whatever the program, it is just one part of a much larger cultural effort.
- Acknowledge that because high-risk behaviors tend to co-occur, several behaviors should be targeted.
Later, once there are some signs of problems beginning to arise (e.g., risk factors emerge or are identified), secondary prevention attempts to prevent a problem at the earliest possible moment before it becomes a severe or persistent problem. In other words, at-risk individuals are identified and an intervention is offered because of their increased likelihood of developing the problem. This is different from primary prevention, which would be targeted at all individuals, regardless of whether they were at risk. For example, students at a particular high school whose parents are substance abusers or addicts might be helped by secondary preventive efforts directed at keeping the students from becoming habitual users.

Tertiary prevention attempts to reduce the severity of an established problem and prevent it from having lasting negative effects on the individual. It is seen as similar to therapy, in that it attempts to help the affected person to avoid relapses (Heller et al., 2000). An example of tertiary prevention would be designing a program to help hospitalized persons with mental disorders return to the community as soon as possible and keep their symptoms under control (Scileppi, Teed, & Torres, 2000) or a program that helps teen mothers reduce the likelihood of having more children during their adolescence. Many argue that this is not really a form of prevention, in that it is conceptually different from primary prevention and the methods used may vary dramatically from those for primary prevention. Whereas psychoeducation, or teaching skills or information about a particular problem, might be effective for individuals who are not involved in risky activities, it is likely to be ineffective for those already exhibiting a particular problem.

A second method for defining prevention is provided by Mrazek and Haggerty’s (1994) Institute of Medicine (IOM) report. They describe three types of prevention based on the target populations involved. The first is a universal prevention program, which addresses the general public. Here the effort is to help the total population, as is the case with most primary prevention efforts. The second is a selective program, aimed at those considered at risk for future development of problems, as is the case with most secondary prevention efforts. These risk factors may be biological, social, or psychological. Last, there are indicated prevention programs for those who are starting to show symptoms of a disorder. This category is not analogous to tertiary prevention, however. The IOM definitions of prevention are clear that once a problem has already manifested, the intervention is no longer considered prevention; thus, relapse prevention would be considered treatment in this model. The definitions also make a distinction between illness prevention programs and health promotion programs. The authors point to the difference between programs that focus on the avoidance of symptoms and programs that focus on the development of personal potential and sense of well-being. The first type of program is successful when a phenomenon does not appear (e.g., a symptom), and the second type of program is successful when a phenomenon (e.g., a new skill set) does appear. Cowen (2000), Romano and Hage (2000), and Weissberg, Kumpfer, and Seligman (2003) argue for a synthesis of the prevention and promotion components. They point out that promotion of well-being does have a positive effect on the prevention of disorder. Romano and Hage (2000), for example, broadened the definition of prevention to include the following: (1) stopping a problem behavior from ever occurring; (2) delaying the onset of a problem behavior; (3) reducing the impact of a problem behavior; (4) strengthening knowledge, attitudes, and behaviors that promote emotional and physical well-being; and (5) promoting institutional, community, and government policies that further physical, social, and emotional well-being. This more inclusive definition of prevention emulates the evolution that has occurred within the field in conceptualizing the different facets of prevention.

A review of the literature (see Case in Point 1.2) examining the efficacy of primary prevention programs has come to the conclusion that primary prevention works. These reviews also highlight an important differentiation in the prevention literature, namely the difference between person-centered
Does Primary Prevention Work?

Community psychologists respect prevention efforts, especially those aimed at primary prevention. Can one demonstrate, however, that primary prevention works? As mentioned previously, it is complicated to show that a problem that does not (yet) exist has been successfully affected by a prevention program. Primary prevention programs, however, have been around a long time. Some have been individually evaluated, but not until the 1990s did researchers set out to determine whether, overall, primary prevention works. Fortunately, several major statistical reviews of the literature, called meta-analyses, have been performed in the past 20 years. Each set of researchers came to the same conclusion: Primary prevention does work! It is helpful to understand why the converging conclusions of these studies are rather astonishing.

In the early 1990s, at the request of the U.S. Congress, the Institute of Medicine (Mrazek & Haggerty, 1994) performed a statistical review of the mental health literature. Using "reduction of new cases of mental disorder" (p. 9) as its definition of primary prevention, the Institute of Medicine gathered 1,900 journal citations on primary prevention of mental health problems. Overall, the institute found that primary prevention, as previously defined, does work. A quote from the final report divuges their conclusions: "With regard to preventive intervention research . . . the past decade has brought encouraging progress. At present there are many intervention programs that rest on sound conceptual and empirical foundations, and a substantial number are rigorously designed and evaluated" (p. 215).

Durlak and Wells (1997) completed a statistical review of the literature on primary prevention of mental health disorders. In this instance, the researchers examined programs only for children and adolescents. Using 177 programs designed to prevent behavioral and social problems, such as depressive reaction to parental divorce, they, too, found empirical support for primary prevention. For example, the average participant in primary prevention programs surpassed the performance of between 59% and 82% of children in control groups, depending on the study. In their journal article, Durlak and Wells summarize their findings supporting the notion that primary prevention, at least of mental disorders, is effective: "Outcome data indicate that most categories of primary prevention programs for most categories of primary prevention programs for children and adolescents produce significant effects. These findings provide empirical support for further research and practice in primary prevention" (p. 142).

Psychologist Emory Cowen (1997a) compared both of these statistical literature reviews and concluded that although there was amazingly little overlap in the citations each set of researchers used, the concept of primary prevention is sound. One other point he made is that each meta-analysis used a different definition of primary prevention. Recall that the Institute of Medicine's study definition was "reduction of new cases of mental disorder." Durlak and Wells defined primary prevention as reducing potential for mental health problems (like the Institute of Medicine) as well as increasing the competencies (or well-being) of the prevention program participants. After his comparison, Cowen concluded that research on primary prevention programs is both positive and encouraging for the future.

In 2010 and 2011, Durlak and his colleagues updated the literature on whether programs that increase specific competencies for children and adolescents work. One study (Durlak, Weissberg, & Pachan, 2010) looked at the success of after-school programs that seek to promote personal and social skills in children and adolescents. Results from 75 reports evaluating 69 different programs (the majority conducted after 2000) were included in the meta-analysis. In general, after-school programs yielded positive effects on participants compared to control groups. Furthermore, the researchers found that programs that contained all the following characteristics were more effective than those that did not: Sequenced: Does the program use a connected and coordinated set of activities to achieve their objectives relative to skill development? Active: Does the program use active forms of learning to help youth learn new skills? Focused: Does the program have at least one component devoted to developing personal or social skills? Explicit: Does the program target specific personal or social skills? After-school programs that had these characteristics were associated with significant increases in participants’ positive feelings and attitudes about themselves and their school (child self-perceptions [effect size = .37] and school bonding [effect size = .25]) and their positive social behaviors (.29). In addition, problem behaviors were significantly reduced (effect size = .30). Finally, there was significant improvement in students’ performance on achievement tests (.20) and in their (Continued)
and environmental-centered prevention efforts. Person-centered interventions are those that work directly with individuals who may be at risk for developing disorders and typify many prevention strategies (e.g., skill building, psychoeducation) (Conyne, 2004). Environment-centered interventions work indirectly to benefit individuals by affecting the systems in which those individuals reside. Metaphorically, this process involves enriching the soil so that plants will thrive. The systems targeted in environment-centered interventions may be familial, community, or organizational. Based on Bronfenbrenner’s Ecological Systems Theory (Bronfenbrenner, 1979), which you just read about, environment-centered interventions might be aimed at the participants’ microsystem, which includes peers, school, family, child care, and neighborhood; the mesosystem, which contains the relationships among entities in the microsystem; the exosystem, which includes places of business and industry, federal and state governments, social media, health and social services agencies, school organizations, and extended family members; or last, the macrosystem, which includes cultural values, attitudes and ideologies, and dominant belief systems. Although community psychologists have a preference for environment-centered prevention over person-centered, you will read about both types of prevention in forthcoming chapters.

Throughout this text, you will also read about the uses of preventive programs in various settings in which psychologists work, whether they are industrial settings, law enforcement agencies, mental health agencies, or sports programs in communities. It is incumbent on psychologists, no matter where they work, to be knowledgeable about appropriate interventions and prevention techniques (Price, Cowen, Lorion, & Ramos-McKay, 1988). As Felner (2000b) cautions, the true preventive program is one that is intentional with regard to its theoretical basis, its understanding of causal pathways, and the purposeful planning and execution of programs to intercept those pathways to gainful ends.

Social Justice

Another core value of community psychology is the goal of social justice. Social justice is a value or aspiration that is best understood in contrast to social injustice. Examples of social injustice abound within our society and around the world. Inequality in educational opportunities, racial disparities in many categories of health and well-being, discrimination experienced by members of particular ethnic, gender, or religious groups, and the homophobia to which gay, lesbian, and bisexual individuals as exposed are examples of social injustices that you will read more about in this text. Although society has developed many laws intended to protect people from being harmed by injustices, it is unfortunately true that we do not yet live in a world of legitimate “equal opportunities” for all to reach their potential. In other words, the playing field in our society is not yet level.
So how then is social justice to be defined? On the one hand, it could be argued that when resources are all equally distributed and all citizens experience a level playing field of opportunity, social justice has been achieved. This was the philosophy behind communism. However, others have argued that true social justice is not merely examining how resources are ultimately distributed, but rather creating equitable processes to determine the allocation of resources (Vera & Speight, 2003). In a definition of social justice that focuses on process versus outcome, some groups may temporarily have more resources than others, but it will be because the group as a whole has decided that this should happen, perhaps for a particular reason.

Various definitions of social justice are found in theology, political science, and education, but for our purposes, the overall goal of social justice is “full and equal participation of all groups in a society that is mutually shaped to meet their needs. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure” (Bell, 1997, p. 3). Note that in this definition, the word equitable is used instead of equal when talking about resources. Resources should be fairly distributed, but perhaps not equally. This allows for the possibility that in some situations, we may want some groups to have greater access to a set of resources, in the case of affirmative action, for example. A community may decide that it wants to encourage more women to have careers within science or technology fields, so it may decide that creating college scholarships for women who have such interests is an equitable distribution of resources. The point is that if the society as a whole decides that this is a good policy (i.e., until there are more women in the fields of science and technology), it would be considered a socially just decision.

So how do community psychologists contribute to this goal? Vera and Speight (2003) argued that psychologists can make the most meaningful contributions to social justice by attending to the societal processes through which injustices result. For example, in Young’s (1990) conceptualization of social justice, social structures and processes are evaluated to elucidate practices of domination, privilege, and oppression. Thus, inequities are not solved by merely redistributing wealth or resources. Rather, the processes that facilitated unequal outcomes to begin with must be scrutinized and transformed. Typically, marginalization (i.e., exclusion) is the main process by which social injustice is maintained. Young argued that in the United States, a large proportion of the population is expelled from full participation in social and political life, including people of color, the elderly, the disabled, women, gay men, lesbians, bisexuals, transgendered people, and people who are involuntarily out of work. Thus, issues of social justice are important for the statistical majority of the population, not just minority groups. Such a conceptualization of justice, then, is logically related to issues of multiculturalism and diversity.

Many community psychologists have contributed to the discussion of social justice within the field of psychology. Prilleltensky (1997) argued that human diversity cannot flourish without notions of justice and equality. Several other prominent community psychologists have articulated the connections among social justice, underserved populations, and the overall profession of psychology in recent years (Albee, 2000; Martin-Baró, 1994; Nelson & Prilleltensky, 2010; Ramirez, 1999). Martin-Baró (1994) discussed a form of psychology called liberation psychology that is specifically concerned with fighting injustice. He noted that liberation psychology focuses “not on what has been done [to people] but what needs to be done” (p. 6). This is relevant for action-oriented community psychologists, who may seek to transform the world, not just understand the world. Efforts to engage in such transformations are described throughout this text.

**Emphasis on Strengths and Competencies**

Closely related to the idea of empowerment (see Principles) and prevention is the notion of competence and strength. The field of clinical psychology has historically focused on individuals’ weaknesses and problems. Freud planted the seed of pathology focus that was cultivated by later clinicians.
Marie Jahoda (1958) directed a turn in focus toward mental health following a review of clinical research. She highlighted the advantages of examining our strengths. In particular, she pointed out that the absence of mental illness did not make one mentally healthy. Health was defined by the presence of positive attributes—such as a healthy sense of self—and an orientation to growth and development (Table 1.5). Soon after, Robert White (1959) wrote on the importance of competence, by which he meant a sense of mastery when interacting with the environment. Jahoda’s and White’s ideas offered a conceptual change for psychologists concerned with how clinical psychology was mired in its focus on negative behavior.

Ryan (1971) claimed that our usual response to problems was to “blame the victim.” It might be blatant, such as claims of laziness, lack of intelligence, incorrect priorities, or “asking for it.” It could also be more subtle, such as claims of inferior cultural opportunities, lack of adequate mentoring, or the need for more services. These all place the individual victim in a place of inferiority. What if the individual’s problem was not seen as the result of “deprivation, deficits, or weakness”? What if these populations had strengths and had the resources to make the break from their confines? Ryan argued that the cause of many problems is the lack of power.

These historic challenges to the pathology-focused fields of psychiatry and psychology have more recently been joined by the Positive Psychology movement (Seligman, 2007; Seligman & Csikszentmihalyi, 2000). Positive psychology primarily focuses on the strengths of the individual (Seligman & Csikszentmihalyi, 2000). The parallels with community psychology’s shift to a wellness focus (Cowen, 1994) are apparent but not clearly described (Schueller, 2009). Positive Psychology’s research has been on the individual and thus has lacked consideration of positive environments. Those in community psychology have studied the necessary components of a high-functioning environment (Moos, 2003). Three environmental factors working together led to well-being and productivity: strong social ties, emphases on personal growth, and a clear structure. And as Keyes (2007) pointed out, “mental flourishing” has been a better indicator of well-being than has the absence of mental illness.

A strength and competence focus was embraced from the very first days of the Swampscott Conference (Bennett et al., 1966). This orientation had linkages to empowerment and to ecological principles. The focus on positives in communities and in their members shifted research and interventions toward the ways in which people were successful. These strengths can be commonly found, can be readily mobilized, and are both effective and appealing to the community (Masten, 2009). We will see examples of the research that contributed to these conclusions in Chapter 3 when we look at Stress and Resilience.

<table>
<thead>
<tr>
<th><strong>TABLE 1.5 Jahoda’s Positive Mental Health Attributes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive and realistic sense of self</td>
</tr>
<tr>
<td>Orientation to growth and development</td>
</tr>
<tr>
<td>Integrated and coherent self</td>
</tr>
<tr>
<td>Grounded in reality</td>
</tr>
<tr>
<td>Autonomous and independent</td>
</tr>
<tr>
<td>Successful adaption to the environment (in love, relationships, and problem solving in general)</td>
</tr>
</tbody>
</table>

Social Change and Action Research

Community psychology has called for social change from its beginnings (Bennett et al., 1966; Hill, Bond, Mulvey, & Terenzio, 2000; Rappaport, 1977; Seidman, 1988) and continues to incorporate it within its operational frameworks (Revenson et al., 2002; Tseng & Seidman, 2007). Social change may be defined as efforts to shift community values and attitudes and expectations as well as “opportunity structures” to help in the realization of the inherent strengths of all within a population. The promise of community psychology is that of social change (Prilleltensky, 2008, 2009).

Research grounded in theory and directed toward resolving social problems is called action research. In community psychology, much action research is participatory, where affected individuals are not merely “subjects” in a study but participate in shaping the research agenda (Nelson, Ochocka, Griffin, & Lord, 1998; Rappaport, 2000). An active partnership between researcher and participants is the norm (Hill et al., 2000; Nelson, Prilleltensky, & McGillivary, 2001). Ryerson Espino and Trickett (2008) presented a framework for ecological inquiry, which incorporated input from those under study into the process.

Chapter 2 describes and discusses how action research is conducted. At this point, it is important to remember that social problems are difficult to resolve, and research in community settings is complex. For instance, if one wanted to change a human services agency so that it better addresses community needs, one would probably have to research the whole agency and the people involved, including clients and staff, as well as all of their interrelationships and processes within the agency. A special issue of the American Community Psychologist presented articles reviewing the state of the science-practice synthesis reached in community action research. Although community psychology has successfully influenced a variety of fields within the larger psychology discipline, there continue to be creative tensions between the search for empirical validation and the need to be relevant to the context. Linney (2005) pointed to four themes arising from the science-practice issue:

1. Effective strategies to bridge science and practice, so as to strengthen the capacity to do both within the community
2. Changing who determines what is important, that is, giving the community power in determining what is important and useful, the direction of the decision making changing from a science directing practice, to a model where the community is a full partner in decision making
3. A broadening of the definition of good science beyond the “narrow” laboratory-based experimental designs
4. Dealing with the difficulty of implementing the values and ideals given the contingencies under which many psychologists work—for example, publish or perish, the valuing of true experimental designs, and the devaluing of quasi- or nonexperimental designs

As you will see in this text, community psychology sees social change and action research as an integral part of its conceptual and intervention framework.

Interdisciplinary Perspectives

Community psychologists believe social change can be better understood and facilitated through collaboration with other disciplines (Kelly, 2010). Multidisciplinary perspectives are a means of gaining more sweeping, more thorough, and better reasoned thinking on change processes (Maton, 2000; Strother, 1987). Community psychologists have long enjoyed intellectual and research exchanges with colleagues in other academic disciplines, such as political science, anthropology, and sociology, as well as other areas of psychology, such as social psychology (Altman, 1987; Jason, Hess, Felner, & Moritsugu, 1987a). There are renewed calls for interdisciplinary efforts (Kelly, 2010; Linney, 1990; Wardlaw, 2000).
with other community professionals, such as substance-abuse counselors, law enforcement personnel, school psychologists, and human services professionals.

Kelly (1990) believed that collaboration with others gives new awareness of how other disciplines experience a phenomenon. A benefit of consultation with others such as historians, economists, environmentalists, biologists, sociologists, anthropologists, and policy scientists is that perspectives can be expanded and new perspectives adopted. Kelly believed that such an interdisciplinary perspective helped to keep alive the excitement about discovery in the field (Kelly, 2010). In that same article he acknowledged the influence of philosophy, anthropology, social psychiatry, and poetry on his work.

Stokols (2006) described three factors necessary to have strong transdisciplinary research among researchers: (1) a sense of common goals and good leadership to help deal with conflicts that can arise; (2) proactive arrangement of contextual supports for the collaboration (institutional support, prior collaborative experience, proximity of collaborators, electronic linkage capabilities); and (3) “preparation, practice and refinement” of the collaborative effort. Stokols cautioned that work between researchers and the community increases the potential for misunderstanding. Participation of both researchers and community members in all phases of project development is helpful in these circumstances, deemphasizing status differences and establishing clear goals and outcome expectations.

Case in Point 1.3 demonstrates integration of social and community psychology theories, and Case in Point 1.4 provides us with an example of anthropological concepts and methodology contributing to a community psychology intervention.

**CASE IN POINT 1.3**

**Social Psychology, Community Psychology, and Homelessness**

You have learned in this chapter that community psychologists have issued a call for collaboration with other disciplines both within and outside of psychology. In response to that, we agree that community psychologists and social psychologists have much to learn from each other (Serrano-Garcia, Lopez, & Rivera-Medena, 1987). In some countries, community psychology evolved from social psychological roots. This was the case in New Zealand and Australia (Fisher, Gridley, Thomas, & Bishop, 2008).

Social psychologists study social phenomena as they affect an individual. They may have the answer as to why the media, the public, and other psychologists blame a person’s homelessness on the person. Social psychologists have developed an explanation using attribution theory, which explains how people infer causes of or make attributions about others’ behaviors (Kelly, 1973). Research on attribution has demonstrated that people are likely to place explanatory emphasis on the characteristics of the individual or use trait explanations for another’s shortcomings (Jones & Nisbett, 1971). That is, when explaining the behavior of others—especially others’ problems—people are less likely to attend to the situation and more likely to blame the person for what is happening.

Does this theory apply to homelessness? Can this theory explain why the media and the public often blame the victim, the homeless person, for his or her problem? Victim blaming (Ryan, 1971) is a phrase that describes the tendency to attribute the cause of an individual’s problems to that individual rather than to the situation the person is in. In other words, the victim is blamed for what happened to him or her. Social psychologists believe that blaming the victim is a means of self-defense (e.g., if a bad thing can happen to her by chance, then it can happen to me; on the other hand, if the person was to blame for what happened, then it won’t happen to me because I am not that way). In the case of the homeless, did their personalities create their homeless situations? Did something in their environment contribute to it? The average person who blames the victim would blame homeless people for contributing to their homelessness.
Shinn, a prominent community psychologist, reviewed research on homelessness and conducted a monumental and well-designed study on the issue (Shinn & Gillespie, 1993). She concluded that person-centered explanations of homelessness, although popular, are not as valid as situational and structural explanations of homelessness. Specifically, Shinn suggested that the research explanations for homelessness are twofold—that is, person-centered and environmental. She reviewed the literature on each and concluded that person-centered or deficit explanations for homelessness were less appropriate than environmental or situational explanations.

Shinn found studies suggesting that structural problems offer some of the most plausible explanations of homelessness. For example, Rossi (1989) found that between 1969 and 1987, the number of single adults (some with children) with incomes under $4,000 a year increased from 3.1 to 7.2 million. Similarly, Leonard, Dolbeare, and Lazere (1989) found that for the 5.4 million low-income renters, there were only 2.1 million units of affordable housing, according to the U.S. Department of Housing and Urban Development standards. Poverty and lack of affordable housing seem to be far better explanations for today’s phenomenon of homelessness than person-centered explanations. Solarz and Bogat (1990) would add to these environmental explanations of homelessness the lack of social support by friends and family of the homeless.

What is important about Shinn’s review is not so much that it illustrates that the public and the media may indeed suffer from fundamental attribution error—the tendency to blame the person and not the situation—but rather that Shinn offers these data so community psychologists can act on them. Public policy makers need to understand that situations and structural problems produce homelessness. Psychologists and community leaders need to be convinced that temporary solutions, such as soup kitchens, are merely bandages on the gaping wound of the homeless. Furthermore, shelter managers and others have to understand that moving the homeless from one shelter to another does little for them. Families and children, not just the stereotypical old alcoholic men, are part of today’s homeless (Rossi, 1990). Being in different shelters and therefore different school systems has negative effects on children’s academic performance and self-esteem (Rafferty & Shinn, 1991); homeless children lose their childhoods to homelessness (Landers, 1989). Something must be done about the permanent housing situation in this country. On this point, both community and social psychologists would agree.

**CASE IN POINT 1.4**

**The Importance of Place**

Anthropological methodologies were used in a study of communities recovering from a forest fire in British Columbia, Canada (Cox & Perry, 2011). Case studies presented ethnographic data, using intensive and longitudinal interviews, observations, and documents in natural settings aimed at understanding the “meanings” of a group’s or culture’s behaviors. A participant–observer approach was used, where the data collector became an active engaged member of the group being studied (Genzuk, 2003). The role of social capital (a sociological concept), which related to a sense of place in the land, seemed to mediate the communities’ ability to adjust to the changes brought about by the fire. Social capital is defined as those supports, assets, or resources that come to a group or an individual as the result of social position within a system. The studies’ findings illustrated a process of disorientation and a search for reorientation in individuals and in their communities. The assumptions as to home and its meanings were reexamined and either reinforced or discarded. The assumptions of social capital also had to be reexamined and adjusted. Identity and sense of place as defined socially and physically were challenged and required rebuilding. The research noted that rebuilding efforts were focused on material and individual-oriented goals—the survival of the person and restoration of their property. Ignored in the restoration efforts were the community’s own social capital, that is, natural residential resource networks. As well, there was little attention to recovery of members’ “sense of place” in their world. Recommendations were made for attention to these details at the policy level and in direct interventions.
A Psychological Sense of Community

Early discussions of community psychology noted the seeming contradiction in the terms community and psychology. Community was associated with groups and psychology with individual experience. Proposing a possible answer to those unfamiliar with the field, Sarason (1974) suggested the study of a “psychological sense of community” (PSC). PSC has become one of the most popular concepts to emerge from community psychology: it is an individual’s perception of group membership.

If environments and individuals are well matched, a community with a sense of spirit and a sense of “we-ness” can be created. Research has demonstrated that a sense of community, or what is sometimes called community spirit or sense of belonging in the community, is positively related to a subjective sense of well-being (Davidson & Cotter, 1991).

In an optimal community, members probably will be more open to changes that will further improve their community. On the other hand, social disintegration of a community or neighborhood often results in high fear of crime and vandalism (Ross & Jang, 2000), as well as declines in children’s mental health (Caspi, Taylor, Moffitt, & Plomin, 2000) and increases in school problems (Hadley-Ives, Stiffman, Elze, Johnson, & Dore, 2000), loneliness (Prezza, Amici, Tiziana, & Tedeschi, 2001), and myriad other problems. Community disorder may intensify both the benefits of personal resources (such as connections to neighbors) and the detrimental effects of personal risk factors (Cutrona, Russell, Hessling, Brown, & Murry, 2000). Interestingly, research has demonstrated that happiness and the sense of satisfaction with one’s community are not found exclusively in the suburbs. People living in the suburbs are no more likely to express satisfaction with their neighborhoods than people living in the city (Adams, 1992) or small towns (Prezza et al., 2001). Many laypeople and psychologists believe that residents of the inner city are at risk for myriad problems. However, research has found that some very resilient individuals are located in the most stressful parts of our cities (Work, Cowen, Parker, & Wyman, 1990).

Community has traditionally meant a locality or place such as a neighborhood. It has also come to mean a relational interaction or social ties that draw people together (Heller, 1989b). To these definitions could be added the one of community as a collective political power. Brodsky (2009) also notes that we have multiple communities to which we may have allegiance.

If those are the definitions for community, what is the sense of community? Sense of community is the feeling of the relationship an individual holds for his or her community (Heller et al., 1984) or the personal knowledge that one has about belonging to a collective of others (Newbrough & Chavis, 1986). More specifically, it is

the perception of similarity to others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, the feeling that one is part of a larger dependable and stable structure. (Sarason, 1974, p. 157)

If people sense community in their neighborhood, they feel that they belong to or fit into the neighborhood. Community members sense that they can influence what happens in the community, share the values of the neighborhood, and feel emotionally connected to it (Heller et al., 1984).

A sense of community is specifically thought to include four elements: membership, influence, integration, and a sense of emotional connection (McMillan & Chavis, 1986):

1. Membership means that people experience feelings of belonging in their community.
2. Influence signifies that people feel they can make a difference in their community.
3. Integration, or fulfillment of needs, suggests that members of the community believe that their needs will be met by resources available in the community.
4. Emotional connection implies that community members have and will share history, time, places, and experiences.
Although there have been a variety of criticisms and alternatives to this conceptualization of psychological sense of community (Long & Perkins, 2003; Tartaglia, 2006), the operational definition of this sense by McMillan and Chavis (1986) remains the definitive model for this concept. Long and Perkins (2003) found a three-factor structure for their data: social connections, mutual concerns, and community values. Tartaglia (2006), using an Italian sample, produced a three-factor measure that included attachment to place, needs fulfillment and influence, and social bonds. In its newest evolution, Peterson, Speer, and McMillan (2008) have produced an eight-item Brief Sense of Community Scale, which produces all four of the McMillan and Chavis (1986) elements with significant statistical validity.

A scale developed by Buckner (1988) measured neighborhood cohesion or fellowship. Wilkinson (2007) found validation of Buckner’s conceptualization of neighborhood cohesion, and a three-factor structure to his data, taken from a Canadian sample. In Wilkinson’s study, “cohesion” was based on a psychological sense of community, neighboring (visiting others and being visited), and attraction for the community (“I like being here.”).

Among the many groups whose psychological sense of community has been studied are Australian Aboriginals (Bishop, Colquhoun, & Johnson, 2006), Native American youth (Kenyon & Carter, 2011), Afghan women (Brodsky, 2009), German naval cadets (Wombacher, Tagg, Bürgi, & MacBryde, 2010), gay men (Proescholdbell, Roosa, & Nemeroff, 2006), churches (Miers & Fisher, 2002), university classrooms (Yasuda, 2009), and the seriously mentally ill (Townley & Kloos, 2011). As Peterson and colleagues (2008) said, sense of community is a “key theoretical construct” of community psychology.

A related but separate concept to sense of community is that of neighborhoods. These are defined as local communities that are bounded together spatially, where residents feel a sense of social cohesion and interaction, a sense of homogeneity (or sameness), as well as place identity (Coulton, Korbin, & Su, 1996). Research has demonstrated the utility of conceptualizing “sense of community” separately from “neighborhoods” (Prezza et al., 2001), but they can be related. Although neighborhoods are primarily based on geographic boundaries, they are best defined by their inhabitants and do not necessarily conform to political or formal maps. They are psychologically defined. One can see from the description found in Table 1.6 that the questions relate to individual’s perceptions.

### Training in Community Psychology

There are established training programs for those interested in studying community psychology. Students are trained to conduct research and to intervene from a set of community psychology theories and values. Just as the practice of community psychology is varied, so are the perspectives provided. See the accompanying four tables of graduate training programs (Tables 1.7 through 1.10).

#### TABLE 1.6

<table>
<thead>
<tr>
<th>The Brief Sense of Community Scale by Peterson, Speer, and Hughey (2006) seeks information on:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationships/Social Connection</strong>— I talk to others; I know others here</td>
</tr>
<tr>
<td><strong>Mutual Concerns</strong>— We want the same things</td>
</tr>
<tr>
<td><strong>Bonding/Community Values</strong>— It feels like a community to me; I like it here</td>
</tr>
</tbody>
</table>

### TABLE 1.7 Doctoral Programs in Community Psychology

- DePaul University, Department of Psychology—Chicago, IL
- Edith Cowan University, School of Psychology and Social Science—Joondalup, Australia
- Georgia State University, Department of Psychology—Atlanta, GA
- Instituto Superior de Psicologia Aplicada, (ISPA), Department of Psychology—Lisbon, Portugal
- Michigan State University, Department of Psychology—East Lansing, MI
- National-Louis University, Department of Psychology—Chicago, IL
- Pacifica Graduate Institute, Department of Psychology—Carpinteria, CA
- Portland State University, Department of Psychology—Portland, OR
- University of Hawaii, Department of Psychology—Honolulu, HI
- University of Illinois at Chicago, Department of Psychology—Chicago, IL
- Université Laval, Department of Psychology—Québec City, Canada
- University of Maryland, Baltimore County, Department of Psychology—Baltimore, MD
- University of Quebec, Department of Psychology—Montreal, Canada
- University of Virginia, Department of Psychology—Charlottesville, VA
- University of Waikato, School of Arts and Social Sciences—Hamilton, New Zealand
- Wichita State University, Department of Psychology—Wichita, KS
- Wilfrid Laurier University, Department of Psychology—Waterloo, Canada

*Source:* From www.scra27.org/resources/education/academicpr.

### TABLE 1.8 Doctoral Programs in Clinical–Community Psychology

- Arizona State University, Department of Psychology—Tempe, AZ
- Bowling Green State University, Department of Psychology—Bowling Green, OH
- California School of Professional Psychology, School of Professional Psychology—Los Angeles, CA
- DePaul University, Department of Psychology—Chicago, IL
- George Washington University, Department of Psychology—Washington, DC
- Georgia State University, Department of Psychology—Atlanta, GA
- Michigan State University, Department of Psychology—East Lansing, MI
- Rutgers University, Graduate School of Applied & Professional Psychology—Piscataway, NJ
- University of Alaska, Department of Psychology—Anchorage or Fairbanks, AK
- University of Illinois, Champaign-Urbana, Department of Psychology—Urbana-Champaign, IL
- University of La Verne, Department of Psychology—La Verne, CA
- University of Maryland, Baltimore County, Department of Psychology—Baltimore, MD
- University of South Carolina, Department of Psychology—Columbia, SC
- Wayne State University, Department of Psychology—Detroit, MI
- Wichita State University, Department of Psychology—Wichita, KS

*Source:* From www.scra27.org/resources/education/academicpr.
TABLE 1.9 Doctoral Programs in Interdisciplinary Community and Prevention Programs

- Clemson University, “International Family and Community Studies,” Institute on Family and Neighborhood Life—Clemson, SC
- Georgetown University, “Psychology and Public Policy,” Department of Psychology—Washington, DC
- North Carolina State University, “Psychology in the Public Interest,” Department of Psychology—Raleigh, NC
- Penn State University, “Human Developmental and Family Studies,” Dept. of Human Development and Family Studies—University Park, PA
- University of California—Santa Cruz, “Social Psychology with a Social Justice Focus,” Department of Psychology—Santa Cruz, CA
- University of Guelph, Ontario, “Applied Social Psychology,” Department of Psychology—Ontario, Canada
- University of Kansas, “Applied Behavioral Science,” KU Workgroup for Community and Health Development—Lawrence, KS
- University of Michigan, “Health Behavior and Health Education,” Department of Health Behavior and Health Education—Ann Arbor, MI
- University of North Carolina, Charlotte, “Community Health Psychology,” Department of Psychology—Charlotte, NC
- University of North Carolina, Greensboro, “Community Health,” Department of Psychology—Greensboro, NC
- University of Wisconsin–Madison, “Human Development and Family Studies,” School of Human Ecology—Madison, WI
- Vanderbilt University, “Community Research and Action,” Department of Human and Organizational Development—Nashville, TN

Source: From www.scra27.org/resources/educationc/academicpr.

One might note that programs can be selected from around the world. The doctoral programs include both community psychology and clinical–community specialties. There is also a category of interdisciplinary doctoral programs, which include areas such as public health, family studies, and applied social psychology.

Clinical–community programs train in both the traditional clinical skills of testing and therapy, and the community-oriented skills of preventive community interventions. Freestanding community psychology programs emphasize ecological and systems orientations to assessment and interventions. Courses at the graduate level might include program evaluation, social action research, applied social psychology, consultation, grant writing, and community field work.

O’Donnell and Ferrari (2000) collected essays on community psychologist employment from around the world. They found that the training of community psychologists had prepared them for a diverse set of opportunities. Although university positions were among the jobs mentioned, individuals found many other types of work: for example, as consultants, evaluators, grant writers, directors of people’s centers, researchers, and policy makers.
**Part I • Introductory Concepts**

**TABLE 1.10 Master’s Programs in Community Psychology**

<table>
<thead>
<tr>
<th>Program Name</th>
<th>City, Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Adler School of Professional Psychology</td>
<td>Vancouver, Canada</td>
</tr>
<tr>
<td>The American University in Cairo</td>
<td>Cairo, Egypt</td>
</tr>
<tr>
<td>Antioch University, Department of Psychology</td>
<td>Los Angeles, CA</td>
</tr>
<tr>
<td>University of Brighton, School of Applied Social Science</td>
<td>Brighton, UK</td>
</tr>
<tr>
<td>Central Connecticut State University, Department of Psychology</td>
<td>New Britain, CA</td>
</tr>
<tr>
<td>Edith Cowan University, School of Psychology and Social Science</td>
<td>Joondalup, Australia</td>
</tr>
<tr>
<td>Manchester Metropolitan University, Faculty of Health, Psychology, and Social Care</td>
<td>Manchester, England</td>
</tr>
<tr>
<td>University of Massachusetts Lowell, Psychology Department</td>
<td>Lowell, MA</td>
</tr>
<tr>
<td>Metropolitan State University, College of Professional Studies</td>
<td>St. Paul, MN</td>
</tr>
<tr>
<td>University of New Haven, Department of Psychology and Sociology</td>
<td>West Haven, CT</td>
</tr>
<tr>
<td>Pacifica Graduate Institute, Department of Psychology</td>
<td>Carpinteria, CA</td>
</tr>
<tr>
<td>Penn State Harrisburg, School of Behavioral Sciences and Education</td>
<td>Harrisburg, PA</td>
</tr>
<tr>
<td>Portland State University, Psychology Department</td>
<td>Portland, OR</td>
</tr>
<tr>
<td>The Sage Colleges, Department of Psychology</td>
<td>Albany, NY</td>
</tr>
<tr>
<td>Instituto Superior de Psicología Aplicada</td>
<td>Lisbon, Portugal</td>
</tr>
<tr>
<td>The University of the Incarnate Word, Psychology Department</td>
<td>San Antonio, TX</td>
</tr>
<tr>
<td>Victoria University of Technology, School of Psychology</td>
<td>Melbourne, Australia</td>
</tr>
<tr>
<td>University of Waikato, School of Arts and Social Sciences</td>
<td>Hamilton, New Zealand</td>
</tr>
<tr>
<td>Wilfrid Laurier University, Department of Psychology</td>
<td>Waterloo, Ontario, Canada</td>
</tr>
</tbody>
</table>

*Source: From www.scra27.org/resources/educationc/academicpr.*

**PLAN OF THE TEXT**

Now that you are on your way to understanding community psychology, you probably would like to know what the rest of your journey through this text will be like. The remainder of Part I, which is the introductory portion of the text, introduces you to research processes (Chapter 2) and the stress and resilience models (Chapter 3) from which work in community settings takes direction. Researchers in community psychology employ some of the venerated methods used by other psychologists as well as techniques that are fairly unique and innovative. You then explore the stress and resilience models for understanding adaptation and adjustment to the social environment.

Part II consists of two chapters on social change (Chapter 4) and interventions (Chapter 5). The first chapter outlines some of the reasons for social change. The second chapter describes some strategies for community interventions.

Part III (Chapters 6–12) examines systems to which community psychology can be applied. From mental health settings and issues, community psychologists have easily moved into social and human services, school systems, criminal justice, health care, and organizational settings.

Part IV, the final chapter of the text, looks ahead at what the future holds for the field of community psychology.
Summary

Community psychology evolved from social science attempts to understand the human condition and effectively improve it. Lewin’s and Lindeman’s legacies have been apparent in the themes of social change and community research. With a belief in the power of diversity, an understanding of the influence of context on individual actions, a realization of the advantages of a multilayered ecological perspective on behavior patterns and how they can be effectively changed, and a conviction that empowered individuals can be healthier individuals, community psychology addresses the prevention of pathology and the promotion of health. Embedded in these principles is the assumption that we all seek and need community. Without it, we are alone and alienated. With it, we are grounded and secure. The area has grown from a set of ideas to an organized and developing approach to psychological research and interventions. For those interested in pursuing graduate studies in this area, there are a variety of options available. Finally, the text organization is outlined to provide a cognitive map of what is to come.