Two questions that embarrass community psychologists are: "What do community psychologists do?" "What's the difference between community psychology and clinical psychology?" A conceptual model is proposed to help to find answers to these questions. The model describes a process whereby psychosocial stress leads to psychopathology. The argument is developed that the apparently disparate activities of community psychologists are uniformly directed at undermining the stress process but, given the complexity of this process, vary because they tackle it at different points.

A question that seems to be a source of chronic embarrassment to community psychologists is "What do community psychologists do"? Since community psychology originated when a rebel band of discontented clinical psychologists got together at Swampscott, Massachusetts in the Spring of 1965, another version of this question is "What's the difference between community psychology and clinical psychology?" I will propose a conceptual model that I think may help us to find answers to these persistent and vexing questions.

Let me start by introducing some assumptions and a bias or two. The first assumption is that community psychology is concerned with reducing the amount of psychopathology in the population at large, an assumption with which I think you will all agree. The second assumption is that when community psychologists tackle this problem they are guided by a strong etiological hypothesis; specifically, that psychosocial stress is important in the causation of psychopathology. This assumption is, I think, also widely accepted.

As for my biases, I will present most of them packaged in a model specifying how psychosocial stress leads to psychopathology. I present this model, however, not because I want to be contentious about the causation of psycho-
PSYCHOLOGICAL MEDIATORS:
ASPIRATIONS AND VALUES, COPING ABILITIES OR DISABILITIES, ETC.

Fig. 1. A model of the process whereby psychosocial stress induces psychopathology and some conceptions of how to counteract this process.

pathology but because I find that it provides a framework within which the apparently disparate activities of community psychologists take on a satisfying coherence and directedness. Our activities are, I will argue, uniformly directed at undermining the process whereby stress generates psychopathology but, given the complexity of this process, vary because they tackle it at different points. In order to present this argument, I will first discuss a stress model, which is described in the squared boxes in Figure 1. For the moment we will ignore the rounded boxes at the top and bottom of the figure.

A MODEL OF THE STRESS PROCESS

Let me note first that the process described in this model starts with a proximate rather than distant cause of psychopathology, with recent events in the life of an individual rather than with distant childhood experiences. It
describes an episode that is initiated by the occurrence of one or more stressful life events and is terminated by psychological change, for good or ill, or by return to the psychological status quo ante.

Since the concept of a stressful life event is central to the model, let me start by taking up the issue of what defines a life event as stressful. One could, of course, rely on definition after the fact: A stressful life event is a life event that generates stress in the person who experiences it. This tautological definition is inappropriate, however, for a model concerned with understanding how stressful life events lead to psychopathology. For this purpose an independent definition of stressful life events is needed. We must, therefore, consider the argument between those who believe that change and the associated demands on the individual for readjustment are the critical conditions that make an event stressful (e.g., Holmes and Rahe, 1967) and those who believe that it is the undesirability of the event that makes it stressful (e.g., Gersten, Langner, Eisenberg, & Orzek, 1974; Vinokur & Selzer, 1975).

Although I may have been partly responsible for the development of this issue (B. S. Dohrenwend, 1973a), I now think that it is a false one, at least in its either/or form. Underlying my reasoning is the fact that, on the average, the undesirable events that have been studied entail considerably more change than the desirable events (Vinokur & Selzer, 1975, p. 334). For example, applying the change scores developed by Holmes and Rahe (1967) to a list of events used in our research in Washington Heights in Manhattan (B. P. Dohrenwend, 1974, pp. 281-282), I calculated that the average score for the undesirable events on our list was 413 while the average for the desirable events was only 225 (B. S. Dohrenwend, 1973a, p. 172). Given this kind of difference, one cannot argue that the effect of change has been excluded when one finds that, on the average, undesirable events have stronger effects on health than desirable events. There is the finding that change scores of undesirable events correlate with various outcomes while change scores of desirable events do not but the finding does not demonstrate that amount of change has no effect (cf. Gersten et al., 1974; Vinokur & Selzer, 1975). In order to find out to what extent the stressfulness of events is a function of the amount of change they entail and to what extent it is a function of their undesirability, we will need to obtain equally refined measurements of these two dimensions, and examine their joint and separate effects. Meanwhile, on the basis of the evidence now available all we can say is that stressful life events seem to be events that involve change, the amount of change generally being greater when the event is undesirable than when it is desirable.

Turning now to the steps in the stress model, the first step specifies that stressful life events vary in the extent to which they are determined by the environment or by psychological characteristics of the central person in the event. For example, at one extreme, if a person is laid off from his or her job
because a plant or office is closed, the event is clearly determined by environmental factors, probably largely economic, rather than by psychological characteristics of the laid off individual. In contrast, when an individual is fired for cause one infers, unless a grave injustice has been done, that the explanation of the event will be found to a large extent in some failing in the fired individual. By including this first step in the model I recognize the complexity of the causal relation between stressful life events and psychological outcomes. Specifically, this step implies that an individual may take part in creating the very events that appear later to cause him to undergo psychological change.

The next step in the model rests on a distinction emphasized by Selye (1956), and made by others as well (e.g., B. P. Dohrenwend, 1961), between a stimulus or event that initiates a stress response and the reaction to that stimulus or event. However, in making this distinction I do not want to imply agreement with Selye's well-known argument that "The pattern of the stress-reaction is very specific" (1956, p. 54). This argument, you will recall, rests on Selye's observations of a standard pattern of physiological reactions. However, there is now evidence suggesting that physiological reactions to stressful stimuli may vary considerably (Mason, 1975b, pp. 25-27). More important, the evidence concerning psychological responses to stressful events clearly indicates that they take many forms, including mood changes and a wide range of apparently pathological symptoms (e.g., B. S. Dohrenwend, 1973b; Markush & Favero, 1974; Myers, Lindenthal, & Pepper, 1974; Sheatsley & Feldman, 1964), even including some symptoms usually associated with serious psychotic disorders (Noyes & Kolb, 1963, p. 456).

What I do want to propose is that although the immediate psychological reaction to a stressful life event may resemble one or another type of psychopathology, a common characteristic of all these forms of stress reaction is that they are inherently transient or self-limiting. The evidence to support this proposition comes from studies of community reactions to disasters, which have shown repeatedly that most people who are exposed to these stressful events develop psychological symptoms, and that these symptoms are almost always transient, unless perpetuated by secondary gains (Dohrenwend & Dohrenwend, 1969, pp. 110-125).

In the next step of the model I suggest that what follows after the immediate, transient stress reaction depends on the mediation of situational and psychological factors that define the context in which this reaction occurs. Situational mediators are conditions in the environment that are external to but impinge on the individual and, I have suggested, include material supports or handicaps and social supports or handicaps. Let me note that for some theorists it is some of these relatively constant deprivations, particularly those associated with disadvantaged ethnic status and poverty, that are construed as the primary
cause of stress reactions instead of passing stressful events (e.g., Langner & Michael, 1963). I am, however, not prejudging the relative importance of precipitating events as against situational constraints that mediate their impact, a question that can be answered empirically. Situational constraints may play the more important role in determining the nature of the outcome but, I am arguing, are not ordinarily sufficient by themselves to explain the occurrence of substantial changes in an individual.

One general hypothesis about situational mediators is then, that other things equal, an individual whose financial or other material resources are strained by the demands of a stressful life event is likely to have a worse outcome than a person with adequate material resources. Similarly, lack of social support is hypothesized to increase the likelihood of a negative outcome (e.g., Gore, 1974; Kaplan, Cassel, & Gore, 1977; Nuckolls, Cassel, & Kaplan, 1972).

Psychological characteristics of the individual also mediate the impact of stressful events. These mediators, which include "values" and what I have labeled, generically, "coping abilities" have been the subject of extensive research by Lazarus (1966) and his colleagues, as well as Hinkle (1974), Horowitz (1976), and others. The results of this research indicate that intrapsychic predispositions and processes play an important role in determining the outcome of exposure to stressful events, but that the ways in which they interact with a stress reaction to determine the ultimate outcome are too complex to lend themselves to summary in one or two hypotheses (cf. Mason, 1975a, p. 11).

The final step in the model indicates that a transient stress reaction interacts with situational and psychological mediators to produce any of three general outcomes. First, a person who experiences stressful life events may undergo psychological growth as a result. That is, he may be judged to have matured or, in more general terms, to have changed his values and aspirations, or developed new capabilities in ways that are adaptive to and valued by others in the social setting in which he lives.

Another possibility is that the person resumes his life without notable change once the stressful life events and his immediate, transient stress reaction are over. The outcome is, then, that the events produce no substantial psychological change in the person.

Finally, an individual may develop psychopathology as a consequence of exposure to stressful life events. In the stress model that I am presenting, this outcome is defined as a dysfunctional reaction that contrasts with a transient stress reaction in that it is persistent and appears to be self-sustaining. Moreover, because the symptoms of persistent dysfunctional reactions and the symptoms of transient stress reactions often do not differ, the conception that psychopathology is self-sustaining and a stress reaction is not, is the critical distinction between them.
STRATEGIES FOR REDUCING THE RATE OF PSYCHOPATHOLOGY IN THE COMMUNITY

Clearly, we would all like to promote positive outcomes and prevent negative outcomes among individuals who are exposed to stressful life events. The value of this goal is indisputable. Disputes have developed, however, about what should be done to reduce the prevalence of psychopathology. Where one stands in these disputes depends, I suggest, on where one chooses to tackle the stress process. Let us, therefore, look at this process from the perspective of what to do about it, starting with the outcome and moving back through the model.

Treatment of Psychopathology

There is no disagreement that the individual who has developed self-sustaining psychopathology should be treated, with the aim of effecting a cure if possible. To this end, a wide range of psychological and psychopharmacological therapies have been developed. The relation of these therapies to the stress process is indicated in Figure 1 by showing that corrective therapies are designed to tackle established psychopathology.

These varied therapies are themselves a source of many disputes, with each type of therapy having its adherents as well as its critics. Even among the most dedicated adherents of particular methods, however, I think there are few who would argue that there is an established cure for psychopathology in general or for most particular types. Thus, in the face of considerable frustration and discouragement about the possibility of curing fully developed psychopathology, many psychologists have proposed that intervention be moved back to an earlier point in the stress process.

Crisis Intervention

Specifically, they have proposed that therapy be provided when the individual is experiencing a stress reaction, before self-perpetuating psychopathology has developed. As I have indicated in Figure 1, this approach is designated "crisis intervention." I should note that I am using this term in the narrow sense of providing brief psychotherapy during a life crisis (cf. Lindemann, 1944). I will come later to other types of aid that may be provided by various community agencies during a crisis, which are sometimes also called crisis intervention.

Therapy during a life crisis, it has been argued, is cost-effective compared to many kinds of traditional psychotherapy on two counts. First, clinicians believe that psychotherapy has greater impact on the client at the time of a stress reaction than later on, after the immediate crisis has passed (Bloom, 1975,
pp. 134-138). Second, because therapy provided as crisis intervention can be relatively brief it is less costly than extended psychotherapy.

Note, however, that these arguments for the cost effectiveness of crisis intervention are put forth in the context of providing therapeutic services to persons who apply or are referred for them. What if we raise our sights and aim to provide crisis intervention for the entire community? The first problem is that we cannot assume that everyone who might need professional help in managing a life crisis will seek it. On the contrary, available evidence indicates that the great majority of people in psychological trouble never contact professionals trained to help them (e.g., Srole, Langner, Michael, Opler, & Rennie, 1962, p. 275).

Let us see, then, what might happen if an attempt is made to reach these people. Specifically, I will examine the results of a study of crisis intervention involving all persons in a community experiencing a particular stressful life event. In this experiment by Polak, Egan, Vandenbergh, and Williams (1975) families in one county who experienced a sudden death were identified through the coroner's office and assigned either to the experimental group, who were offered services, or to a control group, to whom services were not offered. An additional control was provided by studying families who were matched to the experimental and control groups on demographic characteristics but had not experienced a recent death.

The results of this study were not encouraging, since neither at the 6-month follow-up nor at 18 months (Bloom, 1975, p. 165) was there any evidence that the intervention had been effective. This study was flawed, however, by the investigators' inability to control precrisis levels of functioning in the families, so that the bereaved families were functioning more poorly than nonbereaved families before they entered the study as well as after. Nor were the investigators able to control assignment of families to the experimental and control groups, so that it turned out that the experimental group contained more families in which the death had been very sudden or by suicide. Bloom (1975) argued on this basis that the study did not provide an adequate test of the efficacy of crisis intervention in a general community population. Be that as it may, neither does the lack of evidence of improvement in the experimental group encourage adoption of community-wide crisis intervention as a method of reducing the incidence of psychopathology in the population.

Moreover, let me point out that if there were good evidence of the effectiveness of crisis intervention as a method of community psychology, we would still have at least two serious problems in implementing it. The first concerns identification of persons in the community facing life crises. Sometimes individuals' life crises arise from a community-wide disaster such as a flood or tornado. Others occur in the context of a milestone event, such as starting school, that occurs at the same time for each age cohort in the community.
However, many life crises do not result from such highly visible or regularly occurring events but from events that are particular to the lives of the affected individuals. Polak and his colleagues (1975) could, through the coroner’s office, identify families in their community who were experiencing one specific type of stressful life event. However, it is difficult to conceive of equally effective ways of locating all the other people who, at any particular time, are experiencing stressful events related to their work, their family life, their friends, or any of their other life spheres. And if we could locate them, a second problem would have to be faced. Could we really afford to provide therapeutic aid to all of them? It seems unrealistic to suppose that we could, given the acknowledged insufficiency of mental health services (e.g., Bloom, 1975, p. 221). Therefore, I conclude that, for lack of evidence of effectiveness, because of difficulties that would be encountered in case-finding, and because the cost would probably be prohibitive, crisis intervention holds little promise as a method of reducing the incidence of stress-related psychopathology throughout a community population.

Although community psychologists have not explicitly arrived at such a critical assessment of crisis intervention, they have clearly been searching for other means of reducing the incidence of psychopathology. In looking for alternative strategies, the general tactic of community psychologists has been, as I see it, to tackle the stress process at still earlier stages.

**Individual Skill Training**

Moving back from crisis intervention at the time of the stress reaction, Figure 1 shows that the next point of attack on the stress process is on personal factors that mediate the impact of stressful life events. In abstract, what is wanted here is training that will develop a high level of ability to face and solve complex social and emotional problems. The necessary abilities have been described to some extent by the careful work on reactions to stressful stimuli and events by investigators such as Hinkle (1974), Horowitz (1976), and Lazarus (1966). Their work has not, however, been translated directly into training programs, nor am I sure that it lends itself readily to such translation. Instead, community psychologists are tackling this aspect of the stress process mainly through educational experiments with children. Often this work is done in schools with children who have exhibited more or less severely dysfunctional behavior in that setting (Cowen, 1973, pp. 450-453). From one perspective, this kind of school-based program is engaged in secondary prevention of psychopathology, since it aims to correct problems after they have become visible. My predecessor, Emory Cowen, made this point in his presidential address to Division 27 when he claimed that the Primary Mental Health Project, in which he and his colleagues provided special training aimed at maladapting primary school children,
was misleadingly named (1977, p. 3). Looked at in this way, these programs belong with other treatment strategies at the end of the stress process. I think, however, that there is more to this strategy than Cowen's disclaimer allows. From the perspective of the stress model of psychopathology the Primary Mental Health Project and others like it can be seen as aiming to strengthen the personal skills with which the individual will confront stressful events later in life and thereby reducing the likelihood of his developing psychopathology on these later occasions. Moreover, some community psychologists who have implemented this kind of childhood intervention project have explicitly done so not only for the sake of children in trouble but also for the sake of the adults these children will become (e.g., Sandler, Duricko, & Grande, 1975, p. 31).

**General Education and Socialization**

Programs designed to help children who are in trouble have the advantage that the dysfunctional behavior of the child provides some guide as to what kind of help is needed. On the other hand, the weakness of this approach, conceived as primary prevention, is that it rests on the assumption that without intervention children who show identifiable problems will grow into ineffective adults and, conversely, that children who do not show such problems will very likely become effective adults. Moreover, selective intervention with problem children runs the danger of stigmatizing the children who receive special treatment. Considerations such as these have led to primary prevention programs which, instead of being aimed at children who are in trouble, are designed to improve the education and socialization either of children in general or of demographically defined high-risk groups, usually children starting life at the bottom of the socioeconomic system. Some of these programs are, like those aimed selectively at troubled children, designed to teach skills that may serve as coping mechanisms when stressful events are encountered later in life. In addition, however, particularly when the target population is a high-risk group, some of these programs seem to be intended to provide the child with skills needed to avoid occupational and interpersonal crises, such as job losses and family breakups, that might arise from their own failings as much as or more than from their life circumstances. As others (e.g., Zax & Spector, 1974) have noted, however, most of these programs are designed primarily to improve cognitive skills, with the explicit or implicit hope that there will be spillover into the kinds of general social competence that might prevent later crises in interpersonal relationships.

With programs of this kind we have, it seems, pushed back to the very origin of the stress process and have, therefore, moved as far as possible from treatment of individual cases of psychopathology into the realm of primary prevention. Indeed we have, so long as we focus on the skills and competence of the individual community member.
The stress model shows, however, that there is another path that can be taken in moving back through the stress process. We have seen that the outcome of the stress process is dependent not only on the individual's ability to cope with stressful events but also on the material and social supports that are available to him. Another preventive strategy that community psychologists have adopted, therefore, is to build or strengthen support systems in the community.

*Development of Supportive Social Agencies*

I noted earlier that the term "crisis intervention" has sometimes been given broader meaning than I gave it. Although I have limited this term to brief, professional therapeutic intervention at the time of a stress reaction, others have used it to designate any supporting services provided in the context of a stressful event (cf. Bloom, 1975, ch. 8). I think it is useful, however, when describing the activities of community psychologists to distinguish between instances in which the psychologist, another professional, or someone under direct professional supervision provides therapeutic support to persons who have recently experienced stressful events, and instances in which the professional's role is to help community members build or strengthen their own support systems. In the latter situation the professional has no direct responsibility for the individuals who receive help from these systems. Moreover, his work with community members is not usually initiated by or limited to the time of particular stressful events.

One example of this strategy is the series of training projects developed by Bard with the New York City Police Department, the New York City Housing Authority Police, and a suburban police department. Each training project was based in part on what had been learned by the community psychologists from the previous project, and all were cumulatively designed to train the police to change their orientations and procedures so that they would function as effective agents of social support as well as social control on the frequent occasions when they are called on to deal with familial and other interpersonal conflicts (Bard, 1975).

*Political Action with Disadvantaged Status Groups*

In reporting their work, Bard and his colleagues pointed out that one reason for working with the police is that they are the agents that lower-class community members are most likely to call on during interpersonal crises (Bard & Berkowitz, 1969). Recall also that the status group often chosen as the target of programs designed to increase personal competence and coping ability is also the disadvantaged lower class, who are frequently minority group members.
In general, the activities of community psychologists of the kinds that I have described up to now are most often directed at serving the poor, particularly poor minority groups.

Thus, despite the diversity of activities that characterizes community psychology one aim they have in common is helping the socioeconomic underdogs of our society. Noting this common aim, some community psychologists have taken the logical step of asking what we can do to eliminate the status of socioeconomic underdog (e.g., Rappaport, 1977, pp. 119-123). Viewed from the perspective of the stress process, they have asked how they can help this group get access to resources that would prevent avoidable stressful life events. Concretely, the questions are such as how to get stable jobs so as to avoid periodic unemployment, and how to get adequate health care so as to avoid unnecessary illnesses and deaths. Although the answers to these questions that have evolved from the experience of community psychologists are not simple (e.g., Heller & Monahan, 1977, pp. 371-411; Rappaport, 1977, pp. 188-213), at their core is the idea that political action by the disadvantaged groups is the *sine qua non* of programs designed to reduce the stressfulness of the lives of those who are impoverished and discriminated against in our society.

The stress model suggests, I think correctly, that with this strategy community psychologists have moved as far away as possible from the strategy of providing therapy for persons who have developed psychopathology. With the strategy of political action, community psychologists have also moved into an area of maximum controversy, some of it among themselves. On the one hand, some have argued that political action, at least to the extent of supporting the existing distribution of wealth and power in the social system, is always implicit in the activities of the helping professions. From this premise it follows that community psychologists cannot avoid political action but can either, through indifference, opt for a policy of no social change, or, if concerned with the psychological problems generated by poverty and discrimination, engage in political action designed to promote social change. This position has been argued both by elder statesmen in our field, notably Robert Reiff (1971), and by more junior spokesmen such as Julian Rappaport (1977, pp. 4-5).

Other community psychologists have, however, taken a pessimistic view of the possibility of community psychologists becoming successful political activists, expressing the view that psychologists cannot and should not arrogate to themselves the responsibility for righting the social and economic wrongs of our society. Notable among these critics are Kessler and Albee in their *Annual Review of Psychology* article on primary prevention (1975, pp. 560, 577-578). From the perspective of the stress model, however, it seems possible to legitimize political action as an activity of community psychologists if it is clearly and explicitly directed at reducing the incidence of avoidable stressful life events. Perhaps, therefore, it will not be necessary to arrive at a full resolution of this
controversy within community psychology, which would be difficult to do in any case, given its heavy ideological loading.

CONCLUSION

Let us return to the questions with which I started: What do community psychologists do? What is the difference between community psychology and clinical psychology? To answer the second question first, I suggest that the critical distinction that divides community from clinical psychology can be described by drawing a line through the model of the stress process between mediating factors and the stress reaction. Clinical psychologists come into the picture at the earliest when a reaction to stressful events has occurred. In treating the stress reaction or, more often, established psychopathology, they may aim to strengthen the individual’s coping abilities and to prevent him from creating stressful life events for himself, but their task is basically to overcome current distress and dysfunction.

Community psychologists, I would argue, are distinguished from clinical psychologists by the fact that their strategies are directly concerned only with the earlier elements in the stress process, the preexisting mediating factors in the person or his environment and factors, again in the person or his environment, that tend to promote or prevent the occurrence of avoidable stressful life events.

Beyond suggesting this distinction between community and clinical psychology, my aim in presenting this stress model and its implications for action is to be descriptive rather than prescriptive. For the sake of providing an organizing scheme I have, I fear, presented a rather simplified description of the activities of community psychologists. I have not, for instance, explicitly included the fact that we do research designed to predict what strategies will be most effective with what persons or what type of potential psychopathology and to evaluate the effectiveness of strategies that have been implemented. In further explanation of the description based on the stress model, I should note that I do not mean to indicate that the categories of activities described in the domain of community psychology are mutually exclusive. The same program may be designed both to improve the quality of mediating factors, that is, individual coping skills or community supports, and to reduce the incidence of avoidable stressful life events. It seems, however, to be less common that a single program tackles these components in the stress process at the individual and at the organizational or community level at the same time.

With these qualifications, I hope that my schematic description of what community psychologists do, and do not do, is at least grossly accurate. I hope so, in part, because I would not want to misrepresent the field. In addition, however, I hope that it is accurate to say that the diverse activities of community psychologists are generated by strategies that complement each other in such a
way that their effects will cumulate and multiply so as to reduce the amount of psychopathology in the communities we serve.

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