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Congruence and Development of Beliefs and Hierarchic Position among Institutional Mental Patients

Keith T. Handell
Western Michigan University

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CONGRUENCE AND DEVELOPMENT OF BELIEFS
AND HIERARCHIC POSITION
AMONG INSTITUTIONAL MENTAL PATIENTS

by

Keith T. Handell

A Thesis
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Faculty of The Graduate College
in partial fulfillment of the
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Western Michigan University
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CONGRUENCE AND DEVELOPMENT OF BELIEFS
AND HIERARCHIC POSITION
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Keith T. Handell, M.A.

Western Michigan University, 1981

The institutional mental patient is trained to function within the institutional setting. Relegated to the lowest organizational stratum, the inpatient adjusts his behavior accordingly. The present study was designed to find support for the contention that these institutionally induced changes are internalized. It was expected that (a) evidence of congruence between inpatients' beliefs and their organizational status would be detected, and (b) belief system change as a function of institutional experience would also be discernible. The results generally supported these main hypotheses; however, due to the nature and number of uncontrolled variables, the data are inconclusive. Alternative interpretations of these data, the implications of various included demographic variables, and possible modifications for future research designs are considered.

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Keith T. Handell

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INTRODUCTION

Concern with the effects of mental institution environments and practices upon the patient's present and future well-being is not new. Shortly after World War II, with the development of ego psychology and its concomitant focus on the individual's environmental adaptation, social scientists began investigating and criticizing mental hospitals. Several pointed essays by such researchers as Barton (1959), Goffman (1961), and Vail (1966) argued that mental institutions were "too large, dehumanizing, and infantilizing," and that these conditions "quite probably led to chronicity and iatrogenic symptoms" (Herz, 1972, p. 69). Essentially, they contended that between the patient's necessary adaptation to the "total institution" culture (Goffman, p. 3), and the hospital's privilege system which confused conformity to rules with mental health, the patient became "mindless" (Vail, p. 11), developed an "institutional neurosis" (Barton, p. 7), and pursued for much of his/her potentially productive life the "mental patient career" (Goffman, p. 14). Instead of reclaiming these people, mental institutions apparently served as major contributors to the patients' social and psychological segregation.

During the 1960s, with the advent of psychotropic medication, a newly affluent American society was galvanized to respond to this situation by a vigorous, socially aware President. The effort to de-institutionalize mental health care by developing effective, full-range mental health service delivery systems within individual com-

munities was initiated. The underlying philosophy of this deinstitutionalization movement, according to Smith and Hart, was, "if persons received vigorous, early treatment, close to home, and could stay in the community with the help of medication, chronic mental illness would disappear" (Bachrach, 1978, p. 573). To implement this effort, laws were written at federal, state, and local levels, funds were appropriated, programs were developed, and patients began being deinstitutionalized -- discharged, en masse, from state hospitals.

Over the next fifteen years, according to figures reported by Bachrach (1978, p. 574), the patient population of the nation's state-run mental hospitals declined by some two-thirds, from over one-half million persons institutionalized in 1960, to fewer than 200,000 in 1975.

The deinstitutionalization effort was based upon the following treatment principle, according to Wolins and Wozner (1977):

People are made into healthy human beings by their interaction with a competent social environment . . . which usually exists outside, and rarely exists inside the institution. (p. 605)

This principle was not lost on institutions, and changes in treatment practices within them were initiated so as to more closely approximate the noninstitutional setting. Some of the more noteworthy alterations, according to Cox (1978), included: (a) increased, behaviorally specific documentation, (b) increased and improved staffing and staff training, (c) individualized, goal-oriented treatment plans, (d) legal counsel, (e) monetary compensation for in-hospital labor, (f) minimally restrictive living conditions, (g) opportunities for

self-development through educational/training services, and (h) increased opportunities for social interactions within and beyond the institution. Overall, the intention was to devise a growth-promoting environment by eliminating many elements which had been determined through research to stifle development.

As the deinstitutionalization movement has evolved, a network of mental health care agencies has been developed within many communities. The state institution, once the receptacle for the entire spectrum of mentally ill, impaired, and/or deficient, has come to serve only those individuals deemed "too troubled or troublesome to remain in the community" (Wolins and Wozner, pp. 605-6). Bachrach has further categorized the present institutional population into three subgroups: 1. old, long-stay patients who were admitted many years ago, and who have remained despite deinstitutionalization efforts (@65%); 2. recent admissions suffering short-term psychotic episodes (@25%); and, 3. new, long-stay patients who will not be considered good risks for community placement (@10-15%). It is this composite population that state mental institutions are currently charged with the responsibility of reclaiming; that is, to "help improve in a tangible or spiritual sense; to enable to leave the hospital with more options available than they had upon admission" (Wolins & Wozner, pp. 607-8).

Unfortunately, despite the environmental alterations, the literature of the 1970s suggests that these institutions are failing in their reclamation efforts with this target group. In fact, the impact of the institutional experience seems, overall, to be

deleterious to adjustment, post-release. Harris (1970) determined that mental hospitals, "by fostering feelings of dependency, subordination, and submissiveness, . . . tend to inhibit the patient from developing a healthy give-and-take emotional response to others" (p. 24). Wolins and Wozner found that mental institutions were currently "socializing toward dependency, disturbance, and disability" (p. 606). Other researchers reached similar conclusions, speaking of the institution's "highly regressive atmosphere" (Herz, 1972, p. 72) and its non-demanding, "poor man's resort" nature (Braginsky & Braginsky, 1973, p. 32). Apparently, the impact of the institution goes somewhat beyond Rappaport's (1977) assessment that "mental hospitals prepare patients for discharge, but fail to provide them with the necessary resources to remain living productively in the community" (p. 279).

A considerable amount of recent research has been directed toward identifying the factors within the institutional environment which are responsible for these undesirable outcomes. Harris (1970) and Kiger (1970) determined that bureaucratic organizational structure typical of institutional treatment settings tends to negatively impact upon staff-initiated innovation, at all levels. The consequence of this, they found, was a general effort to maintain the status quo, with little investment in attempting change and/or trying new treatment methods. Studies by Braginsky and Braginsky (1973), by Cohen (1968), and by Wolins and Wozner (1977) determined that sympathetic, solicitous staff attitude tended to create a contrived, essentially conflict-free atmosphere. Their general conclusion was

that such an atmosphere, while amenable to static-free functioning within the hospital, did not allow the patient to adequately prepare for the competitive milieu of open society. And, finally, research by Herz (1972), by Schmieding (1968), and by Smith (1970) has shown that the typical institutional hierarchic organizational structure yields stratas differentiated by power, responsibility, privilege, and reward, with the patients occupying the lowest stratum, thereof. Lower level employees were found to attain status at the expense of these patients, thereby inducing and maintaining a "less than equal" conception among them (Herz, p. 69).

These various studies basically support the contention that elements within the institutional environment can and do induce changes in patients in the directions determined by Harris and by Wolins and Wozner. Institutional mental patients, it seems, are transformed into acquiescent institutional beings, via these environmental factors. The ultimate outcome of this transformation process, according to Schmieding (1968), is a person trained to exist within the highly structured, institution-like setting. Conversely, the outcome is not a person prepared to successfully navigate within a more loosely structured social environment, such as open, competitive society. As she states:

The behaviors requisite for being a "good patient" are the antitheses to those necessary for coping with the outside world, where independence, assertiveness, participation in problem-solving and decision making, and a sense of self-esteem are among the requirements for functioning. (p. 211)

Given, then, that patients are changed by elements within the institutional environment, and given that these changes occur in the

direction of increased acquiescence, there remains the issue of the extent of change so induced: To what depth/degree are these changes inculcated?

Depth of change, according to Kelman (1961), is best defined through the "motive forces" which elicit the changed behavior, attitude, or opinion (p. 57). These motive forces operate at three different levels, with varying implications for amenability to alteration and behavior prediction at each level.

The level of least depth Kelman terms "compliance". Changes of this depth involve the individual exhibiting particular behaviors, attitudes, and/or opinions "so as to achieve a favorable reaction" from an influencing agent (p. 64). This includes changes exhibited so as to avoid punishment. Compliance is externally imposed and manipulated, and is elicited only when the influencing agent is immediately present. An example of change at this level would be a patient who quits screaming to avoid being put into solitary confinement.

The mid-level of change Kelman terms "identification". It involves change motivated by the individual either attempting to emulate another person, or by the need to maintain a relationship with a significant other. Such a change, while occurring with less conscious awareness on the changer's part than compliance-motivated change, nevertheless, is maintained only so long as the influencing agent is within range to monitor and impact. Identification would be exemplified by the patient who attends church services and meaningfully professes to beliefs of "peace and brotherhood", but who is constantly

involved altercations on the ward. While s/he may have meant what was said within the religious situation, the beliefs were situation specific and would not transfer beyond it into everyday living.

The change level of greatest depth, "internalization", involves alterations in the individual's basic belief system. Such a change yields a state of congruence between exhibited behaviors, attitudes, and opinions, and the individual's underlying beliefs. The motive force is internal, and, hence, "may be as compelling, or even more compelling, than external force" (Wolins & Wozner, p. 609). An example would be the patient who, upon admission denies the need for treatment, but who, two months later, actively seeks it out.

The importance of determining depth of change, as Kelman points out, is that:

If we know something about the determinants and motivational bases of particular behaviors, attitudes, and/or opinions, we should be able to make predictions about the conditions under which they are likely to be expressed/exhibited, the conditions under which they are likely to change, and the behavioral consequences to which they are likely to lead. (p. 60)

Thus, by determining that the changes toward increased acquiescence are mainly either "compliance" or "identification" based, Kelman suggests that such changes would persist and be exhibited only within the limits of the influencing agent's range. However, should such changes be determined to have been "internalized", then, according to Kelman's theory, these changes should show strong resistance to alteration, should persist beyond the limits of the influencing agent (institution), and should be expected to affect behavior in a consistent manner, post-release.

There is some evidence that institutional mental patients internalize heightened acquiescence as a consequence of their institutional experience. According to Wolins and Wozner, "voluntarism" evidences the final state of the internalization process: the patient who voluntarily exhibits acquiescent characteristics and who remains in the institutional setting without external constraints has achieved internalization. Prior to release, almost 80% of institutional mental patients achieve at least a partial voluntaristic status; that is, for specific periods of time, they are allowed free access to the hospital grounds where there are no obvious constraints to impede escape (Braginsky & Braginsky, p. 25). Further evidence of internalization is apparent in high recidivism rates, which Herz (1972) and Schmieding (1968) interpret as indicating the transcendence of the institution's impact, post-release. As noted by Bachrach, "In 1975, a total of 69% of all admissions to state mental hospitals had had prior care in psychiatric inpatient facilities" (1978, p. 574). And, in quite recent research, Herz, Endicott, and Spitzer (1977) compared brief- with long-stay institutional patients and found that "briefly hospitalized patients spent significantly less time as inpatients, and showed less psychopathology and impairment in role functioning" (p. 502).

The present study was designed to detect a more direct form of evidence that institutionally inculcated changes are internalized. Schmieding (1968), White (1972), and Wolins and Wozner (1977) determined that the ultimate impact of the institutional experience was to prepare the patient to function within the bureaucratic organi-

zational structure of the hospital in the bottom-of-the-totem-pole, lowest stratum position. Further, they found that principle changes required of the patient to adequately execute this role involved subordinating and submitting to the control of others, relating formally with staff, and unquestioningly obeying rules and regulations. It was the intention of the present study's design to detect congruence of patient-held beliefs with this bottom stratum position. Further, by relating the development of these beliefs with duration of institutional exposure, support for the argument that institutionally induced changes are internalized would also be ascertained.

The objectives of this research, then, were: 1. to find supporting evidence of congruence between lowest-stratum patient status and patient-held beliefs, and 2. to examine the contention that these beliefs develop commensurately with institutional exposure. It was expected that the results of this research would support both the contention of congruence, and the contention of belief development commensurate with institutional exposure.

METHODS

Approach

The study's first objective, detecting congruence of beliefs with patient status, was approached by comparing institutional mental patients' "bureaucratic orientations" with those of normed occupational groups representing selected organizational strata. Bureaucratic orientation is a psychological construct hypothesized and defined by Gordon (1973), which measures degree of affinity toward basic characteristics of bureaucratic organizational structure (see Construct and Measurement Instrument, METHODS section). By using stratified, normed occupational groups' bureaucratic orientation mean scores, and then comparing the orientation mean-score of voluntaristic, open-ward institutional patients, it was thought that belief - status congruence among the patients should become apparent.

This approach entailed developing an orientation index from among the normed occupational groups. According to Zald (1971), the typical American bureaucratic organization has four basic strata, each with the potential of containing several levels. These four strata, from least to most "powerful" (Zald, p. 36) are: 1. workers/non-specialists; 2. front-line managers/supervisors; 3. technicians/specialists; and, 4. administrators/professionals. By relating appropriate occupational examples of Zald's basic strata with the normed occupational groups provided by Gordon (1973), representative groups, per stratum, could be selected, and an orientation index

developed.

This procedure was followed, with these results: the worker-stratum was represented by Gordon's "warehousemen" group; the manager-stratum was represented by the "corporation foremen" group; the specialist-stratum was represented by the "salesmen" group; the administrator-stratum was represented by Gordon's "corporation department heads" group. With this as the orientation index, the study's expected result based on the contention of congruence, was that the institutional patient group's mean score would differ significantly from those of all the representative groups except for that of the lowest stratum "warehousemen".

The second objective, examining for belief development related to institutional experience, was approached through (a) a correlation of orientation scores with duration of institutional exposure, and (b) a comparison of institutional and noninstitutional patients' bureaucratic orientations. If the beliefs under study were directly impacted upon by the institutional experience, then a significant and positive correlation should be found between the degree of belief under study and the amount of exposure to the institutional environment. Conversely, since patients treated through community services lack institutional exposure, no such significant correlation was expected to be found among them.

Comparison of institutional and noninstitutional patients' bureaucratic orientations was expected to yield differential treatment environment effects. If, indeed, belief system change in the direction of increased affinity for characteristics of bureaucratic sys-

tems develops as a consequence of institutionalization, not mental illness, then clear differences should exist between patients treated within an institution and those not treated in one. It was expected that inpatients would show significantly greater affinity than non-institutional (out-) patients.

To provide some additional insight into the nature and development of these beliefs among these patient groups, other demographic variables were included in the research. Age, education, job status, marital status, job satisfaction, and sex were examined in this regard. It was anticipated that one of these might show significant relationship with the beliefs evidenced among the outpatients.

Construct and Measurement Instrument

The Work Environment Preference Schedule (WEPS) was designed expressly to measure the bureaucratic orientation construct. Gordon (1973) defines this construct as the composite of the individual's attitudes toward four different aspects of organizational bureaucracies:

Self-subordination - a willingness to comply fully with the stated wishes of a superior and to have decisions made for one by higher authority;

Impersonalization - a preference for impersonal or formal relationships with others on the job, particularly with individuals at a different organizational level;

Rule Conformity - a desire for the security afforded by adherence to rules, regulations, and standard operating procedures;

Traditionalism - a need for the security provided by organizational identification and conformity to the in-group norm. (p. 3)

By quantifying these attitudes, a bureaucratic orientation score is obtained. According to Gordon:

High scores on the WEPS typify individuals who accept authority, who prefer to have specific rules and guidelines to follow, who prefer impersonalized work relationships, and who seek the security of organizational and in-group identification. Low scores are made by individuals who do not so characterize themselves. (p. 3)

Bureaucratic orientation score "Norms Tables" are provided, which distinguish among various job groupings. According to these tables, the more responsible, skilled, and professional the position and the higher the commensurate organizational stratum, the lower the bureaucratic orientation group-mean score. Conversely, the less responsible, skilled, and professional the position and the lower the commensurate organizational stratum, the higher the bureaucratic orientation group-mean score. As such, the highest scores existed among such occupations as warehousemen, deliverymen, V.A. residents, mental hospital service personnel, and military re-enlistees. The lowest scores were found among school superintendents, supervisory nurses, vocational counselors, independent businessmen, lawyers, and professors. Such findings are interpreted by Gordon as supporting the construct's basic premise that bureaucratic orientation should correlate positively with the individual's actual willingness to remain in a highly structured organizational environment: the higher the bureaucratic orientation, the greater the willingness.

It is this aspect of the construct which is pertinent to the aims of the present research. It seems that an appropriate interpretation of a bureaucratic orientation score, given that it is a measure of "willingness to comply, a need for security, a preference for

impersonal relationships, and a desire for structure" would be that it evaluates acquiescence to bureaucratically structured organization. The individual scoring the highest evidences the greatest degree of bureaucratic acquiescence, while the person scoring the lowest evidences the least amount of bureaucratic acquiescence. It is precisely this type of conformity that mental institutions apparently inculcate within patients, and this should become evident through examination of patients' bureaucratic orientations.

Composition and Scoring

The WEPS is constructed of twenty-four statement-type items arranged in a rotating category sequence, so that every fourth item examines a similar aspect of bureaucratic orientation. For example, the first item in the WEPS is:

People at higher levels are in the best positions to make important decisions for people below them. (WEPS, 1973(a), p. 1)

and the fifth item is:

A person's first real loyalty within the organization should be to his superior. (p. 1)

The participant responds to each item by indicating if s/he "Strongly Agrees" (scored two points), "Agrees" (also scored two points), is "Undecided" (scored one point), "Disagrees" (also worth one point), or "Strongly Disagrees" (scored zero points) with the statement (Gordon, 1973, p. 4). Special scoring instructions for omitted and double-responded items are provided, also. Consequently, WEPS scores may range from zero to 48 points.

Participants

The clients of two mental health agencies were involved in this study. The "inpatient" population consisted of residents of a continuing care unit at a state-operated regional psychiatric hospital, while the "outpatients" were clients of a community-based mental health facility.

Inpatients

The regional psychiatric hospital is a continuous care facility housing approximately 800 mental patients. Of these 800 patients, between two-thirds and three-fourths are males lodged in the six male units, or in a branch unit housing both men and women.

The unit selected for inclusion in this study functions as a "pre-release", reorientation unit, wherein male patients whose presenting symptoms are in remission, are prepared for return to the community. These patients will re-enter the community either completely independently (@60%), or through some type of foster care living arrangement. While the unit has a capacity of 90 residents, its census at the time of the study was 82 residents.

The patients on this unit enjoy freedoms and privileges not available to patients on other units, such as unlimited grounds access during certain hours, opportunities to leave hospital grounds alone or accompanied by guardians or hospital personnel, and relative freedom of choice concerning daily activities. This freedom of movement without monitoring allows these patients the opportunity to

"escape". That they do not do so attests to their "voluntaristic" status (Wolins & Wozner, 1977, p. 609).

Work is encouraged among these patients. Jobs are available within the hospital at the laundry, the print shop, the sheltered workshop, and with the grounds crew, among others. Patient-workers are compensated at an hourly rate ranging from \$1.30 to \$2.60 per hour.

Outpatients

The community-based mental health facility operates four programs centering on mental health. In order to perform the desired comparison between the inpatients and the outpatients, it was necessary to focus on the outpatient group which was most similar in mental health status (had illnesses of similar severity) to the inpatients. Consequently, the target population of outpatients consisted of clients partaking of the facility's day-night rehabilitation-resocialization program. It was thought that since this was the group which required the most intensive treatment and the greatest amount of agency contact and structure, and yet had the same goals of social rehabilitation and community re-establishment, that it would be the most appropriate group to focus upon.

The clients of this program are referred for care by state (@10%), community (@60%), and private (@30%) agencies. Clients are selected for program inclusion based upon their perceived ability to take advantage of, and benefit from, the program's various offerings. Prior to acceptance into the program, the prospective client may be

required to indicate his/her willingness to commit himself/herself to the program's goals by working at an "outside" (non-agency controlled) job, either as a volunteer or paid employee, for a specified period of time (up to two months).

For the most part, clients maintain their own residences within the community and have contact with the agency from three to five times weekly. About 20%, however, reside at a dormitory-like unit situated away from the agency, which is affiliated both with the agency and a community hospital. Of the 193 clients involved with the program at the time of the study, 41 clients (21%) were dormitory residents.

Procedure

A four-page questionnaire "packet" was developed to obtain the required information (see APPENDIX). The first page was introductory, and was intended to solicit cooperation and participation from prospective participants. The second page was for obtaining demographic information, and had three sections: 1. general personal information, 2. work and educational information, and 3. program involvement information (duration of treatment). The last two pages constituted the assessment instrument (WEPS), exactly as published.

These questionnaire packets were administered to the two populations in similar manner and during the same time period. At both facilities, a box of questionnaires with an attached sign, "Take One", was placed in a heavily traversed location, but one which was not under employee observation (to reduce the risk of "identifica-

tion-based" responses). A second box labelled "Completed Questionnaires" was placed beside the first box and the participants were instructed to "complete the questionnaire and place it in the box labelled "Completed Questionnaires". (Pencils were also provided.)

This procedure, rather than a direct-contact, researcher-participant format was employed to eliminate at least that potential source of bias. Also, with the outpatient facility in operation for 16 hours per day, and the hospital operating on a 24-hour basis, it would not have been possible for the researcher to have been present enough at both facilities to assure adequate sampling.

The questionnaires were made available from Monday, January 23, 1978, to Friday, January 27, 1978, at both facilities. Completed questionnaires were collected nightly at both places, and supplies of "fresh", uncompleted questionnaires were replenished.

RESULTS

The study was performed as described in the preceding section. Thirty-four inpatients and 40 outpatients voluntarily participated. Tables 1 and 2 provide comparative data between the participant samples and the populations from which they came.

One somewhat dismaying revelation apparent from Table 1 is the significant difference in racial composition between the participant groups and the total populations among both the inpatients and the outpatients: in both cases, all participants were, by their own report, "white". Although there is no available research indicating significant differences in bureaucratic orientations between races, neither is there evidence to the contrary. The fact that only whites chose to participate indicates at least a difference in attitude toward voluntary participation between races. At any rate, the findings of this study will be justifiably relevant only to populations of similar racial composition as participated in this study.

A second difference of note in Table 1 is that of the sexual composition between the two participant groups. The inpatients were all males, while the outpatient group was about half-and-half, male/female. Since "sex" was included as one of the demographic variables, it was possible to determine if it accounted for a significant degree of bureaucratic orientation score variance among the outpatients. Table 5 indicates that what difference did exist between the male and female outpatients' bureaucratic orientation scores, 1.5 points, was

TABLE 1

Demographic Comparisons between the Population
and the Participant Sample

Variable	Group	% in \underline{N}^a	% in \underline{n}^b	$\% \underline{N} - \% \underline{n}$	SD _{diff.}	\underline{Z}
Employment status						
	Inpatients:					
	% working	47	59	-12	.086	1.40
	Outpatients:					
	% working	59	45	14	.078	1.79
Marital status						
	Inpatients:					
	% single	54	68	-14	.085	1.65
	% married	16	12	4	.063	.63
	% div/sep'd ^c	30	20	10	.079	1.27
	Outpatients:					
	% single	40	40	0	.077	(0)
	% married	33	30	3	.074	.41
	% div/sep'd	26	30	-4	.069	.58
Race						
	Inpatients:					
	% non-white	24	0	24	.073	3.28*
	Outpatients:					
	% non-white	21	0	21	.064	3.26*
Sex						
	Inpatients:					
	% female	0	0	0	(0)	(0)
	Outpatients:					
	% female	50	55	-5	.079	.63

^a $\underline{N}_{\text{inpatients}} = 82$; $\underline{N}_{\text{outpatients}} = 193$

^b $\underline{n}_{\text{inpatients}} = 34$; $\underline{n}_{\text{outpatients}} = 40$

^cdenotes "divorced/separated" (see "Results" text)

* $p < .01$, two-tailed test

TABLE 2

Demographic Comparisons between the Population
and the Participant Sample: Continuous Variables

Variable	Group	^a Mean _{<u>N</u>}	^b Mean _{<u>n</u>}	$\frac{M}{N} - \frac{M}{n}$	(df)	SD _{dif}	<u>t</u>
Age (yrs.)							
	Inpatients:	33.8	31.4	2.4	(114)	2.16	1.11
	Outpatients:	32.6	34.1	1.5	(231)	1.47	1.02
Education (yrs.. formal)							
	Inpatients:	11.2	11.8	.6	(114)	.50	1.20
	Outpatients:	11.4	11.7	.3	(231)	.43	.70

^a $\frac{N}{n}$ _{inpatients} = 82; $\frac{N}{n}$ _{outpatients} = 193

^b $\frac{n}{n}$ _{inpatients} = 34; $\frac{n}{n}$ _{outpatients} = 40

not significant. Therefore, combining their scores for comparative purposes seemed justifiable.

So far as the process of data collection and analysis were concerned, the data were scored and analyzed utilizing various calculating instruments, and employing standard statistical formulae. The variables were treated, and are presented, as mean differences (Tables 3, 4, & 5), and correlations (Table 6). Most of the variables and divisions within such are obvious; "marital status" (Table 5), "work attitude", and "program time involvement" (both Table 6) require some clarification.

Divisions under the "marital status" variable of "single", "married", and "divorced/separated" refer, essentially, to the participant's self-perceived status, and ignore the issue of connubial living arrangement. It is assumed that those who considered themselves as "single" had simply never been married. It is assumed that "married" included those who were such in a legal sense, at least. "separated/divorced" included those who had been married at one time, but were no longer participants in a marital relationship.

"Work attitude" was measured as the participant's subjectively reported degree of satisfaction with his/her current work situation. Only presently employed patients were included in the study of this variable.

"Program time involvement" was also subjectively reported. The participant was asked to indicate how long s/he had been participating in their current treatment program, in weeks, months, or years.

Tables 3, 4, 5, and 6 disclose the existence of several signi-

ficant relationships among the variables. For the most part, the findings were as hypothesized.

Evidence of congruence between patient status and inculcated beliefs materialized, as expected, through the comparisons of the institutional patient group's bureaucratic orientation mean-score with those of the various normed occupational groups. Table 3 reveals that the difference between the inpatient group's mean and that of the "warehousemen", 2.1 points, was not significant, as predicted. The inpatient group's mean, 37.5 points, was found to be significantly greater than those of the remaining occupational groups.

Table 3 also shows that, in terms of belief congruence, the outpatients differed significantly from all occupational groups except the highest stratum, "corporation department heads", where the difference between group means was only .9 points. The greatest difference, 12.4 points, was found between the outpatients and the "warehousemen". Whereas, the inpatients were found to be most similar to this occupational group representing the lowest stratum end of the acquiescence index, the outpatients were found to be most similar to the occupational group representing the highest stratum end of the scale.

Support for the contention that the institution was responsible for inculcating the beliefs under study is also discernible from these results. Table 4 shows that the anticipated significant difference between the inpatient and outpatient groups' mean-scores did occur, $t(72) = 8.44$, $p < .01$. This finding is interpreted as supporting the idea that beliefs congruent with low-level organizational

TABLE 3

Differences Between Bureaucratic Orientation Means:
Patient Groups vs Occupational Groups

Group	<u>n</u>	<u>M</u>	<u>SD</u>	$\frac{a}{M_p} - \frac{b}{M_o}$	(<u>df</u>)	$\frac{c}{SD_d}$	<u>t</u>
Inpatients <u>vs</u> Occupational Groups							
Inpatients:	34	37.5	4.6				
<u>vs</u> Warehousemen	171	39.6	6.7	2.1	(203)	1.21	1.74
<u>vs</u> Foremen	72	31.4	4.9	6.1	(104)	1.01	6.04**
<u>vs</u> Salesmen	138	29.7	5.8	7.8	(170)	1.08	7.22**
<u>vs</u> Dept. Heads	30	26.3	5.1	11.2	(62)	1.23	9.11**
Outpatients <u>vs</u> Occupational Groups							
Outpatients:	40	27.2	5.3				
<u>vs</u> Warehousemen	171	39.6	6.7	12.4	(209)	1.58	7.85**
<u>vs</u> Foremen	72	31.4	4.9	4.2	(110)	1.00	4.20**
<u>vs</u> Salesmen	138	29.7	5.8	2.5	(176)	1.03	2.43*
<u>vs</u> Dept. Heads	30	26.3	5.1	.9	(68)	1.28	.70

^a patient group mean

^b occupational group mean

^c standard deviation of the difference between means

* $p < .05$

** $p < .01$

TABLE 4

Differences between Bureaucratic Orientation Means:
Inpatients vs Outpatients

Group	<u>n</u>	<u>M</u>	<u>SD</u>	^a $\overline{M}_{in} - \overline{M}_{out}$	(<u>df</u>)	^b \overline{SD}_d	<u>t</u>
Inpatients	34	37.5	4.6				
Outpatients	40	27.2	5.3	10.3	(72)	1.22	8.44*

^a $\overline{M}_{inpatients} - \overline{M}_{outpatients}$

^b standard deviation of the difference between means

* $p < .01$, one-tailed test

TABLE 5

Differences between Bureaucratic Orientation Means
Among Patient Groups:
Selected Demographic Variables

Variable	Group	<u>n</u>	<u>M</u>	<u>SD</u>	^a <u>M₁-M₂</u>	(<u>df</u>)	^b <u>SD_d</u>	<u>t</u>
Employment status								
Inpatients:								
	working	20	38.7	3.3				
	not working	14	35.8	4.1	2.9	(32)	1.31	2.21*
Outpatients:								
	working	18	27.8	4.0				
	not working	22	26.7	5.8	.9	(38)	1.65	.55
Marital status								
Inpatients:								
	single	23	38.3	5.2				
	married	4	36.2	3.7	2.1	(25)	2.82	.75
	single	23	38.3	5.2				
	div/sep'd	7	35.6	3.9	2.7	(28)	2.20	1.23
	married	4	36.2	3.7				
	div/sep'd	7	35.6	3.9	.6	(09)	2.63	.23
Outpatients:								
	single	12	29.7	4.4				
	married	16	27.9	5.1	1.8	(26)	1.91	.94
	single	12	29.7	4.4				
	div/sep'd	12	23.8	4.6	5.9	(22)	1.92	3.07**
	married	16	27.9	5.1				
	div/sep'd	12	23.8	4.6	4.1	(26)	1.94	2.11*
Sex: Outpatients, only								
	males	18	28.0	5.9				
	females	22	26.5	4.7	1.5	(38)	1.72	.87

^afirst couplet mean - second couplet mean

^bstandard deviation of difference between means

*p < .05

**p < .01

status are a phenomenon peculiar to institutional mental patients.

Further support for this second hypothesis was found in the significant correlation between bureaucratic orientation score and duration of institutional exposure ("program time involvement") among the inpatients, $r = .63$ (Table 6). The same variables, when correlated among the outpatients, did not show a significant relationship, $r = .18$. Finally, a test of the difference between these two correlations further showed that the variables interacted in significantly different ways between the two patient groups, $z(31, 37) = 2.30, p < .05$.

Other findings of note involve the various demographic variables that were included (Tables 5 & 6). Significant relationships were discovered between bureaucratic orientation scores and the variables of "work attitude" (Table 6), "marital status" (Table 5), and "employment status" (Table 5).

"Work attitude" showed a strong, positive correlation with the bureaucratic orientation scores of the working outpatients, $r = .79$. No such significant correlation was found among the working inpatients, where $r = .24$. The difference between these two correlations was found to be significant, $z(15, 17) = 2.33, p < .05$.

"Marital status" (table 5) showed some significant differentiation among the outpatients, but none among the inpatients. The "divorced/separated" outpatient subgroup had a significantly lower bureaucratic orientation mean, 23.8 points, than both the "singles" and the "marrieds". The difference between the latter two outpatient subgroups was not significant.

TABLE 6

Correlations: Bureaucratic Orientation Scores
With Continuous Variables among Patient Groups

Correlated Variables	Group	<u>n</u>	<u>r</u>	(df)	<u>F</u>
Age, Bureaucratic Orientation Score					
	Inpatients:	34	.23	(1, 32)	1.79
	Outpatients:	40	.30	(1, 38)	3.76
Educational Attainment (yrs.formal), Bureaucratic Orient. Score					
	Inpatients:	34	.30	(1, 32)	3.16
	Outpatients:	40	-.16	(1, 38)	1.00
Program Time Involvement, Bureaucratic Orientation Score					
	Inpatients:	34	.63	(1, 32)	21.06*
	Outpatients:	40	.18	(1, 38)	1.27
Work Attitude ^a , Bureaucratic Orientation Score					
	Inpatients:	20	.24	(1, 18)	1.10
	Outpatients:	18	.79	(1, 16)	26.56*

^aincludes working patients, only

*p<.001

The working inpatients were found to have a significantly higher bureaucratic orientation mean-score than the non-working inpatients, $t_{(32)} = 2.21, p < .05$. Among the outpatients, no such significant differentiation occurred.

Finally, neither "age" nor "educational attainment level" correlated significantly with the orientation scores of either patient group. (Table 6).

DISCUSSION

The study was designed to examine the following two hypotheses:

1. congruence between beliefs and lowest stratum organizational position exists among voluntaristic institutional mental patients;
2. these beliefs develop as a consequence of institutional exposure.

While the data support both of these hypotheses, they also provoke a variety of concerns and raise issues not previously considered.

The purpose in testing for congruence of beliefs with organizational position was to support the more general assertion that changes inculcated during institutionalization are internalized. These changes, as noted by Harris (1970), by Schmieding (1968), and by Wolins and Wozner (1977) are in the direction of increasing acquiescence. By using normed occupational groups representing four different organizational strata as the index of bureaucratic acquiescence, it was found that, indeed, voluntaristic institutional mental patients possess beliefs most similar to those of the lowest stratum occupational group, the warehousemen. Stated alternatively, the inpatients were found to have a significantly higher level of bureaucratic acquiescence than all but the lowest stratum comparative occupational group. This finding supports the first hypothesis. However, there are two concerns to be addressed regarding the interpretation of this finding. These are: 1. its generalizability, and 2. the implications of other data generated in this study.

The main problem concerning the ability to generalize the find-

ing of congruence lies in the fact that, by using a strictly voluntary sample, an adequate representation of the population was not obtained. There were, however, two reasons for employing the strictly voluntary format: 1. issues of confidentiality prevented the utilization of other sampling approaches, and 2. the possibility of identification-based responses, rather than internalization-based, was to be avoided. The confidentiality issue is quite apparent: There are many laws in effect intended to protect patients from unnecessary invasions of privacy. Patients may choose to divulge information, but they may also choose not to. The second reason for employing the voluntary format was to reduce the potential of bias that would yield identification-based beliefs, rather than internalization-based beliefs. The difference between these depths of inculcation, according to Kelman (1961) is that, if the belief is expressed in the absence of a significant other, then it has probably been internalized; if not, then it probably hasn't. Consequently, it was thought that any testing situation contrived to require participation could be construed as institutionally initiated/sponsored. While voluntary participation would not eliminate this possibility altogether since the testing setting was within the institutional environment, this format was expected to reduce this source of potential bias.

The price for employing this format seems to have been the potential for generalizing the congruence finding to the total voluntaristic inpatient population. As already noted, no non-whites chose to participate. Therefore, although there is no evidence to indicate that non-whites perform significantly differently from whites on this

instrument, the finding of belief-status congruence is most appropriately applied to the white population.

There may also be some difficulty in generalizing to the white population, since it would seem that there could be a common factor between voluntary participation and bureaucratic acquiescence which might bias the results of this study. Conjecture would suggest that this could very possibly be the case. The beliefs under study concerned the individual's conception of him/herself in relation to organizations. In this study the participants constituted the volunteers among the voluntaristic inpatients. Since voluntarism is one manifestation of internalization, according to Wolins and Wozner, it could be reasonably argued that those who chose to participate did so because they had achieved the greatest internalization of bureaucratic acquiescence; that is, they were the patients upon whom the institution had had the greatest impact. Consequently, while the overall direction of the participating inpatients' bureaucratic orientation scores was probably reflective of the total inpatient population (minus non-whites), the expectation would be that the orientations of the non-participating inpatients would be somewhat lower, indicating a lesser degree of bureaucratic acquiescence.

Beyond the problem of generalizeability is that of the appropriateness of interpreting the findings in terms of congruence. Using normed occupational groups as the congruence index, the predicted relationships between the inpatients and this index were found to exist. This utilization of established norms is common practice in current research; such norms provide a meaningful framework for

interpretation. With respect to the present study, these data show that voluntaristic inpatients possess beliefs which have been determined through prior research to typify persons functioning in lowest stratum occupational positions. This finding supports the contention that the institution shapes patients to fit a lowest stratum organizational position.

However, the concept of utilizing normed groups as an index suggests that the outpatients' beliefs are most similar to (congruent with) those of the group representing the highest organizational stratum (department heads). Since it was known that, vocationally, these participants maintained jobs falling within the two lowest occupational strata, this finding raises the question of what factors besides true occupational status can impact WEPS scores, and how does this relate to the validity of interpreting the normed occupational group index as a measure of congruence?

These data show that two variables, marital status and job satisfaction, relate significantly with bureaucratic orientation scores among outpatients. In re-examining the marital status data, a significant depressing effect can be ascribed to the low orientation mean-score of the "divorced/separated" subgroup. Had this latter subgroup's mean been 2.2 points higher, the total outpatient mean would not have differed significantly from that of the second highest index group. The strong, positive correlation between job satisfaction and WEPS scores among the outpatients could suggest a skewed sample in the direction of over-representation of less satisfied working patients. Re-examination of the data revealed that this

distribution did not significantly depart from the normal curve, thereby discounting this potential source of bias. Of course, a third possible source of variance would be treatment effects, but the one "test" of this, correlation of WEPS scores with length of treatment environment exposure, was not significant for this group. Consequently, these data suggest that numerous variables may have impacted upon the overall outpatient group mean-score to yield this unexpected result. None of the factors examined in this study, however, was found to be exclusively responsible for this finding. Therefore, the possibility that the normed occupational group index is not appropriate as a measure of congruence for these populations cannot be entirely ruled out. Future investigators might gain by developing indices based on appropriate local norms, such as the entire institutional population, staff and patients. These local norms, of course, could then be related to those presented by Gordon.

There is support for the first hypothesis in these data. However, they do not conclusively prove that congruence exists between voluntaristic inpatients' organizational status and their beliefs for two reasons: 1. the findings may not be broadly generalizeable, and 2. the index of congruence may not be valid. The use of normed groups as standards of comparison is a common, accepted practice in current research. While locally established norms may be preferable, this does not invalidate the use of previously normed groups. It seems clear that additional research will be necessary to more fully explain the nature and extent of these findings as measures of congruence.

The second hypothesis under study involved determining the role of the institution in the development of increased bureaucratic acquiescence among voluntaristic inpatients. It was theorized that the institutional environment significantly contributes to the patient's internalization of acquiescent beliefs. This institutionally induced belief system change was expected to be made apparent through a significant and positive correlation between degree of acquiescence and amount of institutional exposure. Additional support was anticipated in the forms of (1) a significant difference in bureaucratic acquiescence between inpatients and outpatients (greater among the inpatients), and (2) a lack of significant correlation between degree of acquiescence and program exposure among the outpatients. The data indicated that all of these hypothesized relationships existed among the participant groups. The issue remaining is that of the strength of these findings as evidence of institutional inculcation.

The significantly positive correlation between the inpatients' orientation scores and their time of program involvement is the principle support for the contention of institutional impact among inpatients. In a strictly interpretive sense, this correlation shows that a significant degree of covariance exists between the two variables -- orientation scores and time within the institution -- among the inpatients. This could be a cause-effect relationship, wherein increased environmental exposure results in increased bureaucratic acquiescence. There are, however, other plausible explanations.

One alternative explanation is that the degree of acquiescence determines the duration of program involvement: patients with lesser

degrees of bureaucratic acquiescence remain in treatment for shorter periods of time. While this is also a cause-effect relationship, the first interpretation assumes changes within the members of the inpatient group, while the second interpretation implies changes in the composition of that group. Of course, it's possible that there is no cause-effect relationship between these variables, but merely the common effects of a third variable, such as a particular type/degree of mental illness which can result in both reactions.

The remaining two relationships of relevance to this inculcation issue are the difference between the inpatients' and outpatients' acquiescence levels, and the lack of significant orientation score-treatment time correlation among the outpatients. As predicted, the inpatients were found to possess significantly higher levels of bureaucratic acquiescence than the outpatients. The major apparent difference between these two groups was that of treatment environment. One viable conclusion would be that this finding supports the hypothesis. However, some other possible sources for this difference include nature and degree of illness and vocational history.

A selection process occurs prior to treatment, in which the appropriate course of intervention for each patient is determined. For the most part, patients treated through the community facilities are deemed to be behaviorally less dangerous to themselves or others, and/or more capable of meeting their own basic needs than patients placed in institutional programs. Whether or no such differences in pre-treatment populations might relate to differences in levels of

bureaucratic acquiescence cannot be answered from these data. It would seem likely that a difference in attitude toward established bureaucratic systems could develop as a consequence of being provided treatment within the community, or being committed for treatment to an institution.

Another variable not controlled in the present study was vocational history. This would include the various work experiences that the patient endured prior to treatment. Since one key aspect of the institutional inculcation issue is the contention that environmental factors can impact upon basic beliefs, significant differences between groups in pre-treatment vocational experiences could also have affected propensity for and direction of belief change during treatment. To the extent such pre-treatment information is available for future research, it should be given due consideration.

The lack of significant correlation between treatment time and orientation scores among the outpatients shows that these two variables do not covary for this group as they do for the inpatients. This finding, combined with the fact that significant covariation was found between outpatients' WEPS scores and levels of job satisfaction, suggests that bureaucratic acquiescence is related to the treatment situation for inpatients, and to the vocational situation for outpatients. This is in line with the institutional inculcation hypothesis; at the least it support the possibility of cause-effect relationship between environment and beliefs among the inpatients.

There is, then, some support within these data for the second hypothesis. The predicted correlation between length of program in-

volvement and degree of bureaucratic acquiescence among the inpatient participants did occur. Also, the anticipated differences between the inpatients' and outpatients' orientation mean scores, suggesting possible differential treatment environment effects, was obtained. Lastly, the contrast in correlations for the two patient groups may be construed as evidence that a significantly greater treatment environment impact existed among the inpatients than among the outpatients. While these data support the contention of institutional acquiescence inculcation to the level of internalization, they do not show conclusively that a cause-effect relationship exists. This leaves open the possibility of other explanations for these results. Stronger, more conclusive support for the case of institutional inculcation could conceivably be generated through a test-retest format using a locally normed index. Such a format involving the entire organizational spectrum of the institution, patients and staff, could eliminate and/or substantiate many alternative interpretations of these data.

The overall concern of this study was with the extent of impact of the institutional environment upon patients: Could evidence be found to support the contention of belief system change as a direct consequence of institutional exposure? Tentative support for this contention was found through this study; however, the need for additional research utilizing a format of a different design is also apparent. The present study did nothing to disprove the possibility of institutional inculcation of increased acquiescence within pa-

tients; it simply did not control for enough other potentially influencing variables to make a strong case for institutional culpability.

The findings from this research do tend to fit with previously cited studies. Heightened acquiescence was reportedly found to characterize long-term institutional patients by Harris (1970), Schmieding (1968), and Wolins and Wozner (1977). One difference between the present and previous studies is that, rather than focusing on interpersonal acquiescence, this study examined bureaucratic acquiescence; i.e., how patients perceive themselves in relation to bureaucratic organizations. The principle finding of this study was that bureaucratic acquiescence might be acquired and internalized during hospitalization.

The determination that the participant inpatients possessed a high level of bureaucratic acquiescence should not be construed to mean that heightened bureaucratic acquiescence is a sign of mental illness. In examining Gordon's "Norms Tables" (1973, pp. 6-13) a number of organizational/occupational groups apparently average a similar or higher degree of bureaucratic acquiescence, without any apparent problems in functioning. These groups include military reenlistees, domestic workers, and high school students. What is of concern is the direction and degree of change that these data suggest may occur within institutional patients: Are patients being prepared to function independently within open society, or are they being readied to function optimally within a structured environment? The data from this research tend to support the latter contention.

Inasmuch as these data are inconclusive, it would be inappropriate to condemn institutions as possessing non-/anti-therapeutic environments. Certainly, when one considers the double-bind expectations under which these agencies operate of (1) providing a safe, secure situation for both the community and patients, and (2) effectively reclaiming patients to a socially productive status, an obvious potential exists for one responsibility to become dominant. Typically, as Wolins and Wozner assert, the need for security will prevail.

For the patient within a security-oriented treatment situation, cooperation, compliance, non-demandingness, and acquiescence are characteristics which would facilitate organizational operations. The problem occurs when these characteristics interfere with the individual patient's growth and development. If training an individual to function within an institution moves him/her in a direction which ultimately will handicap his/her efforts to adjust, post-release, then there is a legitimate cause for concern. Evidence that such may be the case with mental hospitals, including the results from this study, continues to accumulate.

Clearly, there is a need to accurately determine the full effects of institutional care and treatment, and to delineate the responsible factors. With respect to the present study, follow-up research using a test-retest format as previously suggested could provide valuable and deeper insight into the institutional patient as an organizational being. Many more issues were raised than resolved by these data, a number of which relate to differential treatment

environment effects. The further pursuit of these issues is important not only with respect to mental institution populations, but to other "total institution" populations as well.

If iatrogenic symptoms resulting from institutionalization are an actual phenomenon, then these should be understood more fully so that they could be more readily changed. It is especially critical in those settings where the ultimate objective is reclamation to eliminate elements which impede growth. A fuller understanding of how these elements operate should provide valuable avenues of exploration for introducing growth promoting factors. After all, the majority of current research, including the present study, indicate that the institutional environment can induce change quite effectively. The problem for the future seems to be that of learning to manipulate the institution's change-inducing mechanisms to achieve somewhat more desirable outcomes than those of increased dependency and acquiescence.

APPENDIX

Dear Client of [REDACTED]

The purpose of this letter is to introduce myself, and to ask for your help in a research study. I sincerely hope you will be kind enough to finish reading this letter and then take a few minutes to answer the enclosed questionnaire. In return, I will offer important and interesting information to [REDACTED] which has never before been available.

My name is Keith Handell. I am attending Western Michigan University as a graduate student in Industrial Psychology.

The study I am doing is to try and find out how various groups of people feel about living/working in different kinds of environments. I am not concerned with your individual questionnaire by itself, but rather with the entire groups' questionnaires. Consequently, please complete the questionnaire carefully, but do not put your name on it.

I want you to answer each question according to how you personally (not your family or friends) feel about the statement. When you have finished the questionnaire, please place it in the box marked "Completed Questionnaires".

After I have received all the questionnaires, I will analyze them. When the analysis is finished, and I have tabulated the results, I will then provide a copy of my report for the use of [REDACTED]
[REDACTED]

Thank you for your time. I appreciate your help with this project. I hope you find the questions in this study thought-provoking and interesting.

Sincerely,

Keith T. Handell

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Age: _____ years. Sex: M F

Race: Black White Other _____

Marital Status: Married Single Divorced Separated
Other _____

Circle the highest grade of regular (formal) schooling you have completed:

Grade: 1 2 3 4 5 6 7 8 High School: 9 10 11 12

College: 1 2 3 4 Graduate School: 1 2 3 4 5 6

Have you had any special skill training at any time? Yes No

If so, how long was the training, and what was the skill involved?

Do you have a job at the present time? Yes No

If not, how long has it been since you last held a regular job? _____

If so, are you working: Full time (at least 30 hrs./week)_____

Part time (less than 30 hrs./week)_____

In general, are you:

very satisfied	satisfied	so-so
somewhat dissatisfied		very dissatisfied

with this job? (Circle one)

How long, approximately, have you been participating in the program at _____
(Please indicate weeks, months, or years.)

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