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The Paraprofessional Polemic: Investigating the Case of the Paraprofessional in the Community Mental Health Center

William Joseph Riley
Western Michigan University

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THE PARAPROFESSIONAL POLEMIC: INVESTIGATING
THE CASE OF THE PARAPROFESSIONAL IN THE
COMMUNITY MENTAL HEALTH CENTER

by
William Joseph Riley

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
April 1976
ACKNOWLEDGMENTS

In a moment of nihilism, Nietzsche remarked, "If it doesn't kill me, it will make me a stronger person." Since I have survived, it can be concluded that this thesis strengthened my research ability. With this theme, I extend gratitude to those who have helped me the most in this endeavor.

Drs. Morton Wagenfeld and Stanley Robin, a dynamic duo, warrant appreciation on many fronts: first, for providing the data analyzed in this thesis; second for the intimate exposure to the research art they have given me; and finally for the continual support and guidance they provided. I also hold respectful admiration for the insights Mr. Robert Wait contributed.

The decision of who deserves the foremost recognition is not difficult. I dedicate this thesis to my parents, Phyliss and William, who always permitted me to make my own decisions and supported those which were made.

William Joseph Riley
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Western Michigan University, M.A., 1976
Health Sciences, mental health

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CHAPTER I
INTRODUCTION AND HISTORICAL BACKGROUND

Introduction

The role of the paraprofessional worker in community mental health centers is sometimes not easily understood. There is frequently controversy and disagreement revolving around what functions a paraprofessional is to perform and what place he has on the treatment team. Ideally, the paraprofessionals in community mental health centers are indigenous poor who have been drawn from the community in order to serve the community. A domain assumption underlying the use of indigenous paraprofessional is that the values of the community differ from the values of the agency.

This study investigates the role of the paraprofessional in the community mental health center as it is determined by their position in the center and the expectations which are put on them as occupants of that position. The role and position of the paraprofessional needs to be understood so that the problems associated with it can be examined. These problems concern whether the paraprofessionals actually represent the values of the community from which they come or if they are coopted into the values and expectations of the community mental health center. Consequently the question which may be raised is whether the paraprofessional serves the needs of the center or the
needs of the client and community.

A historical review will prove useful in clarifying these issues. An understanding of the current position of the paraprofessional in the community mental health center cannot be adequately achieved without first examining the short history of the community mental health movement. A knowledge of the growth and expansion of the contemporary mental health movement will also reveal the initial structure of the policies and guidelines that shaped how the mental health program grew to accommodate the paraprofessional worker within its ranks.

In the Beginning

World War II did more than save the world for democracy. It also alerted the general American public to the apparently pervasive phenomenon that many people encounter emotional problems in the course of everyday living.

The military may have been the first to recognize that substantial emotional problems did exist among the general public. Psychiatric screening of inductees caused huge numbers to be rejected on the assumption that those with obvious neurotic symptoms would not make the tremendous adjustment to military life and combat conditions (Joint Commission on Mental Illness and Health, 1961). In addition, the military was concerned about the adjustment problems a soldier would encounter when returning to civilian life. There was apprehension
expressed that the public might not understand the psychological behavior of returning combat veterans.

The end of World War II also brought increased awareness of the generally deplorable conditions of mental hospital facilities. As the nation turned its attention to peacetime pursuits, critics began unveiling the distressingly poor quality of care available for the mentally ill (e.g., Deutsch, 1948). In a piercing exposure of mental institutions, Deutsch revealed that he saw hundreds of sick people "shackled, strapped, straightjacketed and bound to their beds (p. 448)."

It was this muckracking by journalists combined with the experience of the military with emotional problems that precipitated a growing awareness of mental illness. In 1946, Congress verified the authenticity of this trend by passing the National Mental Health Act (P. L. 79-487). Essentially this monumental legislation authorized the U.S. Public Health Service to initiate research on causes of mental illness, train professional personnel, and to provide financial assistance to the states in treating mental disorders. This legislation has been viewed by some as the most important single development in the history of mental health (Arnoff, Jenkins & Speisman, 1969a; Romano, 1967).

For the purposes of this project, the most significant ramification of the National Mental Health Act was the formal establishment of the National Institute of Mental Health in 1949. The establishment
of a central agency was inexorably crucial in the subsequent phenomenal development of mental health services in the last 15 years.

According to Arnoff, et al. (1969a), the next major stepping stone of the community mental health escalation was passage of the Mental Health Study Act by Congress in 1955. This legislation directed the initiation of what has come to be known as the Joint Commission on Mental Illness and Health.

The Joint Commission on Mental Illness and Health was instructed to "analyze and evaluate the needs and resources of the mentally ill in the United States and to make recommendations for a national mental health program (Joint Commission, 1961:vi)." The Joint Commission completed its assigned task in 1961. The final report, entitled Action For Mental Health, represented a thorough and conscientious attempt to assess the entire picture of the status of the mentally ill.

The recommendations presented by the Joint Commission encompassed three broad areas: pursuing new knowledge, better use of present knowledge, and the costs involved in implementing new changes. The Joint Commission also tried to come to grips with a crucial concern of how to increase the amount of manpower capable of providing services to those who needed it. It will be demonstrated shortly that the Joint Commission accurately diagnosed a problem which eventually led to unforeseen complications in the community.
mental health center today.

Executive interest in mental health was openly manifested in 1963 when President Kennedy advocated his now famous "bold new approach." This encouragement, combined with the final report of the Joint Commission on Mental Illness and Health, was sufficient impetus for Congress to pass the Community Health Centers Act in 1963 (P. L. 88-164).

Essentially this legislation provided funds to construct mental health centers and specified the types of services that must be provided by the center. The community mental health movement is considered significant by many (Bellak, 1964; Schulberg & Baker, 1969). A distinguishing feature is its difference from more traditional mental health approaches. A greater emphasis is placed on sociocultural determinants of illness and a concern with prevention as well as treatment separates the community mental health ideology from the more traditional treatment approaches (Wagenfeld, Robin & Jones, 1974).

Congressional involvement culminated in a piece of legislation passed in 1965 (P. L. 89-105). This action authorized funds to assist in staffing the community health centers which Congress created a few years earlier.

This review has covered some of the highlights of the community mental health movement which has been created in the last 25 years. It has been demonstrated that an aroused public began to
recognize both the prevalence of emotional instability in the general population and the inadequacy of treatment facilities. As this problem became defined, a sequence of commissions and committees initiated action in an elaborate attempt to achieve resolution of the problem. Over 300 centers are in operation today (USDHEW, 1973). There is no question that the community mental health centers are well entrenched.

It is an elementary notion that whenever the United States government decides to pour millions of dollars into a frontier that previously has not been opened (e.g., the space program), there is going to be a very startling impact. The Joint Commission on Mental Illness and Health anticipated some of the problems which would be associated with attacking mental illness. A foremost concern of the Joint Commission and many others was the manpower shortage which would result if the federal government embarked on a concerted effort to improve mental health.

In striving to maintain its aspiration to conduct a "thorough and conscientious" study, the Joint Commission on Mental Illness and Health enlisted Dr. George Albee to do an extensive analysis of manpower trends in the mental health professions. Albee completed the study in 1959 and reported the findings in Mental Health Manpower Trends. Albee pessimistically concluded that it did not seem possible to eliminate the glowing deficiencies in mental health care without a
tremendous increase in the recruitment and training of mental health manpower.

The Joint Commission acknowledged this assessment and sagaciously recognized that if the United States government intended to embark on a massive mental health excursion, there would be a critical shortage of professional manpower to accommodate the newly defined needs. Since that time there have been countless symposia, books, and articles specifically struggling with the question of how to ease the manpower shortage. A review of the literature reveals that in the developing years when the community mental health centers were getting started, many were concerned with the manpower shortage (David, 1969; Klarman, 1969; Cowen & Zax, 1967). Yet others saw it as a chance to increase the position or prestige of certain groups (Allerhand & Lake, 1972; Schwartz, 1972; Bindman, 1966; Pearl & Riessman, 1965). And, as could be expected, some ignored the problem of the manpower shortage and concentrated on other issues (Greenblatt, Emery & Glueck, 1967; Reiff & Scribner, 1964; Health-Pac, 1971; Golann & Eisdorfer, 1972).

Being painfully aware of the already existing shortage of professional mental health manpower, the Joint Commission was naturally apprehensive about the manpower problems created with a large-scale program expansion. Therefore the Joint Commission reconnoitered the entire labor force in search of any related ancillary
professions which might be of benefit in solving the shortage. The surveillance was apparently productive because the Joint Commission cited a host of persons already quasi involved in mental health principles and practices. This group consisted of clergymen, family physicians, teachers, probation officers, public health workers, and even scoutmasters who could be recruited and utilized to help alleviate the expected manpower shortage. Incidentally, the Joint Commission identified these people as subprofessionals.

It is obvious that since the inception of the mental health program, one of the most critical problems has been the lack of trained manpower to provide care and treatment. The fields of psychiatry, social work, clinical psychology and psychiatric nursing have traditionally been regarded as the bastions of mental health care. For the most part, anyone not trained specifically in one of these disciplines was regarded as not being quite as well qualified as those who did have the training. Anyone not having the sanction of a specific degree was regarded as a "subprofessional."

Enter the Paraprofessional

An examination of the initial congressional legislation and commission recommendations in the community mental health movement draws out an interesting perspective. It seems that none of those engaged in the planning process of creating the community mental health center seriously entertained the possibility of looking
for people who could be trained as technicians and consequently ease the work load of the professional.

Ironically, the first study charged with assessing the man-power trends was not impressed with the idea of utilizing "paraprofessionals." In his report of Mental Health Manpower Trends conducted for the Joint Commission of Mental Illness and Health, Albee considered the possibility of implementing psychiatric aids, but tersely dismissed the notion of asserting that "the lack of specific qualification has made it possible for some persons with serious personality problems of their own to drift into this occupation (1959: xviii)." Albee acknowledged that a preponderance of the care in the large mental health institutions was traditionally performed by the custodial duties of aides and attendants. However, he saw no place for a modern counterpart in the progressive, yet still embryonic, mental health movement which was sweeping the land.

The Joint Commission on Mental Illness and Health accepted Albee's conclusion uncritically and did not offer any better alternatives except the possibility of using subprofessionals or volunteers. A case was cited where Radcliff and Harvard volunteers participated in a mental health project. It is beyond doubt that the use of Harvard and Radcliff volunteers is far removed from the active employment of indigenous poor.

The landmark legislation which created the community mental
health center in 1963 was not particularly concerned with manpower needs (P. L. 88-164). In fact, the only aspect of the law which even dealt with personnel was the appropriation authorization. The stipulation in the appropriation authorization called for an "assessment of local needs for mental health services, designing mental health services programs, obtaining local financial and professional assistance. . . . (P. L. 88-164)." The obvious conclusion from this statement suggests that the focus was on obtaining professional services. The only conclusion which can be made regarding anyone other than a professional person is the conspicuous absence of any reference to him.

In 1965 legislation was passed which was specifically intended to assist in staffing the community mental health centers. The substance of this act was to "authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers (P. L. 89-105)."

The significant word in this legislation is "technical." The significance is that for the first time there was reference to employing someone other than the professionally trained person in the new mental health movement.

As can be seen in this review of events, there was never any specific design to involve nontrained or partially trained personnel in direct treatment in the new movement of community mental health.
The evidence which has been presented here seems to suggest that in the abundant assessments of manpower needs, and in the planning of the community mental health centers, there was never any serious consideration given to employing the indigenous poor.

The appearance of the indigenous poor as a worker in the community mental health center seems to have come from a convergence of forces. It has been demonstrated that the initial planning of community mental health centers did not intend to include this type of worker, despite the critical manpower shortage.

Summary and Implications

It is crucial to understand the historical perspectives underlying the development of the community mental health center in order to understand its staffing priorities. It was shown that although a manpower shortage did exist and was recognized, the utilization of poor people to alleviate the shortage was not considered a viable solution to the problem.

In order to understand fully where the concept of a paraprofessional worker was conceived, it is necessary to examine a parallel social movement which became viable at about the same time period. This coterminous phenomenon was the antipoverty movement.

It is not necessary to trace the historical perspectives in order to understand the antipoverty legislation. It is sufficient to know that Michael Harrington's book, The Other America (1963), was
one of the catalysts in the prevailing mood which activated a public campaign against poverty in America.

In 1964 Congress initiated an innovative program to wage a war against poverty in the United States. This legislation was entitled the Economic Opportunity Act (P. L. 88-452) and it established the Office of Economic Opportunity (OEO).

Until the passage of the Economic Opportunity Act, there were no training programs existing primarily to help the poor (Spring, 1973). In view of this, the Economic Opportunity Act was intended solely to mobilize human resources and eliminate the "paradox of poverty in a nation of wealth." The Economic Opportunity Act not only proposed to help the poor help themselves, it also demanded that there must be a "maximum feasible participation" of the poor (Title 11). So, the Economic Opportunity Act was significant not only in the sense that it aspired to help eradicate poverty in America, but also that the poor must be included in policy decisions.

Of course nobody can be openly opposed to helping the poor. However, it seems that some were either tacitly or openly opposed to having the poor participate in the decision-making policies which would affect their lives (Richmond, 1967; Health-Pac, 1971).

It is important to remember that the Economic Opportunity Act was not concerned with mental health. The foremost responsibility was to aid those who were living in poverty. Yet in January,
1965, the Lincoln Hospital Mental Health Services, Albert Einstein College of Medicine, received support from the Community Action Program, which came under Title 11 of the EOA. This grant enabled the hospital to open two Neighborhood Service Centers and train over 50 nonprofessional mental health aides under the supervision of mental health professionals (Peck & Kaplan, 1969).

At about the same time as the Lincoln Hospital endeavor, a new phrase "new careers" appeared in the title of a book. The book, written by Pearl and Riessman, was entitled New Careers for the Poor and it advocated the use of nonprofessionals in human services. It is significant that they had no particular case for paraprofessionals in community mental health. Rather, their real interest was in the "unforgivable shame of poverty" in America (Pearl & Riessman, 1965).

Armed with an articulated resolution to eradicate poverty, Pearl and Riessman surveyed the job market to determine where reconstituted jobs could be created for poor people. They found one answer in the community mental health field.

Just as Albee did several years earlier, Pearl and Riessman recognized that psychiatric aides had been used for a long time in custodial care for mental patients. However, unlike Albee, they saw a natural extension of these aides into community psychiatry. Pearl and Riessman suggested the indigenous poor person might be able to
relate better to the lower-class client than a professional. Incidentally, the use of indigenous poor to help bridge the gap between high-class professionals and low-income communities was not unknown (Korbin, 1959; Brager, 1964; Riessman, 1963). The novelty of Pearl and Riessman was the idea of employing the indigenous poor as nonprofessionals in order to train them for a career. This training would subsequently enable trainee to climb out of poverty. That indigenous nonprofessionals can relate better and more effectively to clients is not entirely agreed upon. This assertion is at best only tentative. Indigenous nonprofessionals may help, but there have not been enough long-range, large-scale evaluative studies to confirm or deny this assumption (Ritzer, 1974).

The excurses on the origin of the role of mental health para-professionals has revealed several points. It has been shown that the paraprofessional in the community mental health center did not arrive at that destination by design. Rather, through a confluence of several forces, including a manpower shortage, the antipoverty movement, and the humanistic preachings of Pearl and Riessman, the paraprofessional became a member of the treatment team.

However, the emergence of the paraprofessionals in the mental health field and other helping professions has been a controversial issue. The paraprofessionals have endured a barrage of both support and dispute since their debut. Several prominent issues
recur and seem to be the focus of the most controversy. These issues include: (1) the manpower shortage; (2) whether the paraprofessional has the superior ability to relate to the indigenous population; (3) the career ladder which allows the paraprofessionals to increase their education and job position; (4) the problem of the paraprofessional being coopted into the values of the center; and (5) the propensity for the paraprofessional to violate the expectations of the center. Chapter II will discuss these issues to determine their importance and saliency to the paraprofessionals.
CHAPTER II

STATEMENT OF THE PROBLEM AND REVIEW
OF THE LITERATURE

Introduction

The purpose of this thesis is to determine if cooptation has occurred among paraprofessional workers in community mental health centers, or if the paraprofessional workers can be considered activists in the community mental health centers. In addition to this objective, several other prominent issues involving the paraprofessionals will also be delineated. These issues: (1) the manpower shortage, (2) the bridgeman function, and (3) the career ladder, will be examined because of the close association which they have with the polemic of cooptation and activism. It is the basic perspective of this study that if cooptation does exist among the paraprofessionals, then the cooptation can have a fundamental influence on the nature of some of these related issues.

In this chapter the above-mentioned issues will be explored. Evidence will be presented which suggests that many of the popular assumptions involving these issues are wholly inadequate. The inadequacy of these assumptions are partially the result of the disappointingly few empirical studies of paraprofessional workers which enjoy methodological integrity. A great proportion of the
articles have noticeable methodological errors and usually do not even try to account for confounding variables. Indeed, even the validity of simplest assertions about paraprofessional workers goes unattended far too often. For example, Minuchin (1969) declared that paraprofessionals are "by definition untrained, poor, and black (p. 727)." In spite of the fact that Minuchin's article is cited frequently in the literature, this statement has gone unchallenged. As will be demonstrated, there are several factors which indicate that Minuchin's contention is erroneous.

In one of the few descriptive articles available, Sobey (1970) points out that the new nonprofessional workers have been described and romanticized, yet the overall nature of nonprofessional utilization is remarkably nebulous. In view of the important role paraprofessionals have acquired, and the controversies surrounding their utilization, it is amazing that as recently as 1969 not even simple descriptive facts concerning the number of paraprofessionals and what they do were known (Greenfield & Brown, 1969).

Even discussion of the definition of what constitutes a paraprofessional involves considerable disagreement. For the purpose of illustrating the definition of the paraprofessional, it is necessary to identify three categories of workers: (1) the professional worker, (2) the paraprofessional worker, and (3) the indigenous paraprofessional worker. The professional is considered a highly trained worker
who has advanced educational degrees in the service area. The para-
professional, however, is a worker who lacks this training and educa-
tion in the specific service. His function is to provide assistance to
the professional and perform ancillary duties. A distinction must be
made within the ranks of paraprofessions; a paraprofessional is not
necessarily an indigenous paraprofessional. This distinction is neces-
sary because in the literature there is a flagrant tendency to combine
these two notions. The distinguishing characteristic which separates
the indigenous paraprofessional from other paraprofessionals is that
he "is poor, from the neighborhood, and is often a member of a
minority group (Reiff & Riessman, 1965:7)."

At first glance, the utility of the distinction between a para-
professional and an indigenous paraprofessional may seem question-
able. However, Pearl and Riessman (1965) were quite clear in their
conceptualization of the indigenous paraprofessional. His essential
function was to act as interpretator, communicator, and expeditor
for the client, who was considered a fellow victim of poverty. Pres-
sumably, this is a function which a paraprofessional could not perform
as effectively as an indigenous paraprofessional.

The confusion underlying the definition of a paraprofessional
is indicative of more serious shortcomings in the literature. For
every article which states one position, another can be found which
refutes it. Essentially, the articles concerning paraprofessionals
appear to be of two types: descriptive and proscriptive. When juxta-
posing some of the proscriptive assertions in the literature with the
descriptive findings in research some unsettling disparities appear.
The precision which is necessary in distinguishing between paraprofessionals and indigenous paraprofessionals is highlighted by Sobey's
(1970) finding that only one-third of the paraprofessionals in her
research even came from the same neighborhood in which they worked,
and Gottesfeld, Rhee and Parker's (1970) data that 40 percent of the
paraprofessionals in their sample were college graduates.

These findings inexorably demonstrate that not all paraprofessionals are indigenous. In addition, the word "paraprofessional" is
definitely not a synonym for the "untrained, poor, and black (Minuchin,
1969). Minuchin's error can be prevented if close attention is given
to the relation between the descriptive and proscriptive articles when
referring to the paraprofessionals. Therefore, the first appropriate
step in this analysis is the identification of the major descriptive
studies of paraprofessionals in community mental health centers.

Descriptive studies of paraprofessionals include those done by
Gottesfeld, et al. (1970); Sobey (1970); Levenson and Reff (1970); and
Hallowitz (1968). The most massive survey heretofore has been con-
ducted by Francine Sobey. This study covered over 10,000 nonpro-
fessionals working in over 185 National Institute of Mental Health
sponsored projects across the country. Unfortunately, her study did
not include community mental health centers; it was limited to projects funded through the Hospital Improvement Program (HIP) and the Mental Health Projects Grant Program (MH). Nevertheless, the results are relevant here because the project included 96 percent of all National Institute of Mental Health funded projects which employed nonprofessionals.

Sobey found an overall ratio of six nonprofessional workers to one professional. Her findings concerning the educational level of the nonprofessional were nebulous, due to the style of presentation, but it appears that the majority of projects employed nonprofessional with at least a high school diploma. A significant finding in terms of this thesis was that in only one-third of the projects (68) did the nonprofessionals live in the same neighborhood or belong to the same social class or ethnic group as the clients. In addition, only 42 projects (out of over 185) even attempted to hire indigenous persons with similar social, cultural and ethnic backgrounds.

Studies which dealt specifically with community health centers are even more revealing. In 1969, an analysis of the projected staffing priorities from grants to 80 community mental health centers was done (Levenson & Reff, 1970). It was found that 42 percent of the 3,830 full-time positions were listed as nonprofessional mental health personnel. Although this does not nearly approach the 6 to 1 ratio found by Sobey, it is still critical to realize that nearly 50

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percent of the staff of these community mental health centers were nonprofessionals.

In another study of 10 community mental health centers in New York City, Gottesfeld, et al. (1970), found that paraprofessionals seem to be of two types. One type consisted of recent college graduates. This group comprised 41 percent of the paraprofessional staff. The second type of paraprofessional was quite different; this person rarely had an educational background beyond high school.

Finally, Emanuel Hallowitz (1968), codirector of the Lincoln Hospital Mental Health Services Neighborhood Service Center Program, provided a description of the range of activities performed by the indigenous paraprofessionals in that program. These activities included sociotherapy, services to post-hospital patients, expediting, and services to the disturbed in the community.

These four studies help clarify how extensively the paraprofessional is being utilized. To recapitulate, Sobey found that less than one-fourth of the agencies in her study even attempted to hire indigenous persons with characteristics similar to the client. Levenson and Reff found that 42 percent of the community mental health center staff in their survey were listed as paraprofessionals, and Gottesfeld, et al., reveal that almost 50 percent of the paraprofessionals in their study had college degrees.

The utilization of paraprofessionals is not restricted to men-
tal health. They are employed abundantly by school systems as teachers' aides, by community and government agencies as assistants, as well as by mental health centers as translators, community specialists and quasi-therapists. It is not surprising then that the literature dealing with paraprofessionals is overwhelming in volume. Incidentally, there are better research articles available in these cognate areas which employ paraprofessionals. Therefore, to establish a solid theoretical framework, this review of the literature will at times draw from studies conducted on paraprofessionals outside of the community mental health center.

Each issue in this thesis will be isolated and examined in terms of the respective forces which constitute its definition as a problem. Considering the propensity in the literature to combine, confuse, and distort the issues concerning the paraprofessional in community mental health, it is clear that each issue must be initially examined in its own terms. For example, an analysis of the "bridgeman function" cannot be examined in terms of the manpower shortage post hoc ergo propter hoc.

There are many problems and issues precipitated by the presence of paraprofessionals in community mental health centers. However, as indicated previously, several prominent issues appear to be recurrent. These are: (1) the manpower shortage, (2) the bridgeman function, (3) the career ladder, (4) the issue of cooptation, and (5) the issue of activism. These five issues will be delineated and examined.
carefully. In order to prevent bias, articles will be cited which present both sides of the issue under scrutiny.

The issue concerning the manpower shortage primarily involves consideration of the growth and expansion of the community mental health center movement and how this expansion related to an increased need for human service personnel. Intimately involved in this issue is the question of utilizing paraprofessional workers to help relieve the manpower shortage. The bridgeman function controversy is an issue dealing with the question of whether the paraprofessional has an ability superior to the professional in relating to the indigenous population. The paraprofessionals are referred to as bridgemen because they possess characteristics which enable them to bridge the communication gap between the lower-class client and middle-class professional therapist. As indicated previously, the "career ladder" concept was originated by Pearl and Riessman. The controversy surrounding this issue involves the question of whether the paraprofessional workers are, in fact, improving their level of education, job status, and income level; and if they have access to the ultimate option of becoming a professional themselves.

The last two issues, cooptation and activism, are closely related. The polemic revolves around the controversy of whether the paraprofessionals are more concerned with the values and expectations of the community mental health center than with the expectations of the clients.
and community. Those who maintain that the paraprofessionals are more concerned with the former embrace the assertion that the paraprofessionals have been coopted. On the other hand, those who embrace the latter assert that the paraprofessional workers are activists who have a potential capacity to disrupt the smooth operation of the center by nature of being an advocate for the client and community.

It is crucial to point out an implicit assumption embedded in this controversy: that the values and ideology of those served by the community mental health centers are different from those professionals providing the service. Since the assumption that the values of the community mental health center are not the same as the values in the community which it serves is basic in the literature, it will be taken as given in this thesis. Keeping this contingency in mind, the five issues will be examined objectively.

Manpower Shortage

The introductory chapter, which illustrated the historical perspectives and social trends behind the community mental health center, provided a fairly comprehensive background concerning the emergence of the paraprofessional. In this final addendum it will be shown that in just a few years the paraprofessional became effectively entrenched in the functioning of these centers.

In 1964 the Regional Mental Health Planning Conference for the Far West was held in Portland, Oregon (McKnickle & Higman, 1964).
In most respects this could be construed as just a routine strategy meeting to plan for the construction and staffing of community mental health centers. However, it was significant in the sense that the notion of implementing paraprofessional workers was not even mentioned in the official proceedings. To be sure, there was adequate concern for the lack of professional manpower. In fact, the most striking characteristic of the mental health manpower scene was portrayed as the gap between the supply of professionals and the demand for service (Littlestone, 1964). Apprehension was also expressed about the difficulty encountered when different professions are intermingled (Boucher, 1964), and if new techniques should be implemented to train the community mental health professionals (Branch, 1964). Although these professional planners were duly concerned with the manpower supply, it is significant that they did not even consider the usage of paraprofessionals to help alleviate the shortage.

Yet, only three years later, the National Institute of Mental Health sponsored a symposium with the explicit intention of embracing the pressing problem of manpower for mental health. By this time the literature was becoming inundated with the notion of utilizing paraprofessionals to help ease the manpower shortage (Pearl & Riessman, 1965; Reiff & Riessman, 1965; Arnoff, et al., 1969; Cowen & Zax, 1967).

The formal papers presented at the symposium were gathered
in Manpower for Mental Health (Arnoff, et al., 1969). The symposium represented a diligent effort to cope with the manpower shortage. Contentions were made that the manpower shortage in mental health was not unlike the shortage of engineers in the 1950's. In this case the shortage of engineers could be more accurately identified as a shortage of supporting personnel--technicians, draftsmen, etc. (David, 1967). The same reasoning was applied to the shortage of mental health personnel; the easy solution would be to utilize paraprofessionals.

In addition, the economic aspects of staffing costs were not overlooked. It was suggested that substituting cheaper personnel with less training for more expensive personnel is a desirable objective from an economic standpoint (Klarman, 1967). Interestingly, in 1969 Levenson and Reff found that in terms of remuneration, the 42 percent nonprofessional contingency was listed to receive a meager 25 percent of the salary allotment, which leaves 75 percent of the salary for the professional staff. This finding indicates that Klarman's suggestion of substitution from an economic standpoint might be accurate.

It was mentioned previously that federal legislation did not make any overt provisions for paraprofessionals in community mental health centers until the Community Mental Health Centers Construction and Staffing Act. Yet even then the provision was nebulous and only referred to "technicians." Finally, in 1970, the Amendments to the Mental Retardation Facilities and Community Mental Health Centers

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Construction Act of 1968 "had provision for training and employment of paraprofessionals (Gartner, 1971:9)."

Through this elucidation it should be understood that the paraprofessionals gradually became embedded in the community mental health centers and were considered an integral part of the treatment team performance.

However, by 1970 a curious reversal began to occur. Serious questions were being raised concerning the function of the community mental health center. Statman assailed the center because it was a part of a pacification effort aimed at the poor communities. He admonished these programs by asserting that "regardless of the altruistic intent of the staff, federally funded community mental health programs aimed at the ghetto often serve solely to pacify the neighborhood--to mystify and mollify justifiable outrage and thereby prevent action for meaningful change (Statman, 1970:274)."

Others began attacking the community mental health center movement on similar grounds--first, that it was not in the interest of the client population (Haugh & Sussman, 1969; Miller, Robey & Steenwijk, 1970), and second that indigenous paraprofessional involvement is a palliative cooptation (Ritzer, 1974; Haugh & Sussman, 1969).

Arnoff also took up this cause and began asking the abrasive question "Manpower for What? (Arnoff, 1972; Arnoff & Boneau, 1972)."

Although he had been instrumental earlier in defining the manpower
needs, it seems that Arnoff began taking a second look at the situation. Essentially he contended that a supply tends to create its own demand and that there has been a lack of willingness to look at societal trends and values concerning mental health. The classic statement by Thomas is applicable: if a situation is defined as real, then it is real in its consequences (Thomas, 1923).

Arnoff exemplified this statement by asking "How much of today's behavior, the 'new mental health' problems that manpower is so scarce to treat, is being produced by discernible, definite trends that are embedded in the current science? (Arnoff, 1968:188)."

These critics provide sagacious insight which the planners failed to understand years previously. It is central to understand the manpower shortage in terms of the definition of need. For example, on December 31, 1973, the American Psychiatric Association quickly eliminated hundreds of thousands of mentally ill people by declaring that homosexuality was no longer a mental illness. This is an ultimate ludicrosity, yet it demonstrates vividly how the definition of need will vary.

In conclusion, it is critical to realize that the manpower shortage did not happen. Rather, it was created by both a definition of need and the federal funding to deal with it. A shortage exists because the need was created by current definitions of reality.
The Bridgeman Function

The presence of paraprofessionals in community mental health centers has lead many to speculate about the relationships, whether amenable or reluctant, created between the interaction of professionals and paraprofessionals (Levenson, 1972; Allerhand & Lake, 1972; Riessman, 1967). In addition, there have been several studies concerning the opinion of the professional worker regarding the paraprofessional (Sobey, 1970; Gottesfeld, et al., 1970; Moogan, Golan & Freeman, 1969). Interestingly, there have not been any studies to ascertain the opinion of paraprofessionals regarding the performance of the professionals. This is, no doubt, a subtle indicator of the priorities which influence the topic selection by researchers.

However, the intensity of compatibility or hostility among professionals and paraprofessionals is not the real issue. Any attempt to look at the degree of resentment between these two types of workers would be a mistake because the true issue which underlies this would become confused. Rather than looking at whether or not the paraprofessionals and professionals are compatible, it is more important to examine why they would be incompatible.

Since effective interaction with the client population is the most important variable for anyone aspiring to provide human services, it seems that the core of resentment between professionals and paraprofessionals could revolve around this issue. Therefore,
the next issue which demands attention is the contention that indigenous nonprofessionals are indispensable because of their communication skills. If indeed the indigenous paraprofessional does communicate better with the client than a trained professional, then it is understandable that the presence of an indigenous paraprofessional could potentiate some envy and animosity from a professional who does not have this ability. Taking this position, *reductio ad absurdum*, it could be wondered that if only the indigenous paraprofessional can effectively relate to the community, what good is the professional?

There have been numerous assertions that the paraprofessional can be more effective than the professional in providing services to the client (Pearl & Riessman, 1965; Kaplan, Boyajian & Meltzer, 1970; Reiff & Riessman, 1965; Schwartz, 1972). This argument has been built on the simple assertion that the client relates better with him (Torrey, 1969) and that certain qualities of the therapist produce effective treatment (Truax & Carkhuff, 1967).

However, these are all second-order justifications for using the paraprofessional worker. The initial value of the indigenous non-professional was seen as his capacity to act as a bridge between the middle-class professional and the lower-class client (Pearl & Riessman, 1965), *not* as someone to give more efficacious treatment. The inherent assumption of the bridge concept is that the lower-class paraprofessional has special skills for establishing communication.
Some assert that this ability of the indigenous paraprofessional is rooted in his background. It is not based on things which he has been taught, but on what he has acquired from his environment (Reiff & Riessman, 1965; Goldberg, 1965). But others assert that lay counselors are useful only after they have been carefully trained and closely supervised (Berenson & Carkhuff, 1967; Rioch, Elkes, Flint, Udansky, Newman & Silber, 1963). Regardless of this duality, it is felt that they have a special sensitivity and compassion by nature of their poverty background (Arnoff, et al., 1969), and they are able to relate better to the client because they have common cultural outlooks in contrast to mental health professionals who are sociologically estranged from the client (Schwartz, 1972).

These propositions are based on the assumption that if both the recipient and helper have experienced a similar problem, therapeutic understanding and interaction will increase (Kaplan, et al., 1970; King & Janis, 1956; Volkman & Cressey, 1963).

It seems that the most popular method used in the literature to establish authenticity is by stating that "there is considerable agreement (e.g., Sobey, 1970)." For example, after reviewing studies on indigenous therapists, Torrey (1969) suggests "they all conclude the same thing, that indigenous therapists are often effective in producing positive therapeutic changes (p. 368)." However, Ritzer replied to that
statement poignantly by saying "this claim is grounded in few hard
data (1974:219)." Ritzer's retaliation is indirectly supported from
another quarter when Arnoff, et al. (1969), reported that there is
absolutely no research to show differential effects on patients as a
function of one group of therapists in contrast to another group.

In other words, the high ideals promulgated by Pearl,
Riessman, and others concerning the bridgeman and communicative
function of the indigenous paraprofessional do not appear to be apo-
dictically verified. The popular consensus regarding their effective-
ness in communication is not supported by any conclusive evidence.

In the beginning stages of the indigenous paraprofessional
movement, Pearl and Riessman suggested that some of the reasons
for their potential success was that they did not have to validate them-
selves, and they had an insider's know-how (Pearl & Riessman, 1965).
In reference to this, Gartner believes that "research done in 1965 and
1966 on the first large-scale efforts at using indigenous aides (in the
OEO's community action program) corroborated these assertions
1971:12)." Some of the reasons given to support this assertion were
because the indigenous paraprofessionals were "enthusiastic and
hardworking (Yankelovich, 1966)," and because they functioned
"above anticipated levels (Lynton, 1967)."

These "proofs" involve no empirical verification and have
spoken for themselves. It is not necessary to comment on their
validity.

The conclusion regarding the effectiveness of paraprofessionals vis-a-vis the professional's inability to communicate to clients is only tentative. Barr summarized this conclusion impeccably by saying that "being poor, per se, does not enable the indigenous worker to see problems differently or to perform better (1966:12)." It can be assumed, however, that a person who displays warmth and understanding can be utilized effectively in helping others, regardless of whether or not he is indigenous.

In science it is understood that the prevailing zeitgeist tends to mold the perception of how a phenomenon is perceived. In the community mental health movement, perhaps the absence of tangible evidence and the concomitant interest in paraprofessionals can be looked at in terms of the zeitgeist. Although the effectiveness of the paraprofessional is not supported by any evidence, there is nevertheless a tendency to accept the notion that he is beneficial. Thus, a preponderance of the literature will support this position.

It has been assumed in most of the literature that the value of the indigenous paraprofessional lies in his priceless, esoteric ability to communicate with both the client and the professional. If this valuable asset is an inherent characteristic of the indigenous worker, an immediate question comes to mind: Will the "innate" communicative value of the paraprofessional become contaminated and besmeared if he is exposed to any educative or training tactics in empathy.
listening and intervention techniques?

This question is clearly related to the amount of training and advancement the paraprofessional receives. The next issue to be considered, the concept of the career ladder, examines the educational opportunities which have been provided for the paraprofessionals.

The Career Ladder

As was indicated previously, Pearl and Riessman (1965) were the initial architects of the career ladder movement. The principal intention of the career ladder was to enable the poor to climb out of poverty through a combination of meaningful employment while simultaneously becoming educated and trained for better positions.

The ideas and concepts put forth by Pearl and Riessman were so popular that they became contagious. More legislation was passed subsequent to the Economic Opportunity Act of 1964. This legislation included a number of programs intended to provide jobs for paraprofessionals in diverse areas ranging from teachers' aides to law enforcement and correction positions.

One of the most important laws was the Nelson-Scheuer Amendment to the Economic Opportunity Act which became law on November 8, 1966. The language of the amendment clearly indicated its purpose. It provided authorization to "pay all or part of the costs of adult work training and employment programs for unemployed or low income persons (Gartner, 1971:6)." In fact, the Department of Labor

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even referred to this authorization as the New Careers Program, a title which apparently reflects the influence of Pearl and Riessman.

However, it is significant that in the field of mental health, "no single piece of legislation or even portion of a bill contains new careers language (Gartner, 1971:8)." To be sure, there has been legislation which is directly concerned with the nonprofessional in the community mental health center (the Community Mental Health Center Construction Act and later amendments). However, the limits of accuracy would be stretched if it were concluded that these legislative acts were passed in the interest of providing career ladders to the poor.

It was concluded earlier that Pearl and Riessman did not seem to have a particular interest in community mental health centers per se. Rather, they were interested in its potential to provide career ladders to the poor. The schemata of Pearl and Riessman's grand plan basically called for two types of training: the paraprofessional worker would first be exposed to training at the agency in which he worked; then after this initial assimilation, he could begin course work at an accredited institution and climb further up the ladder (1965).

Pearl and Riessman's dream of training the paraprofessional at the agency itself was fulfilled remarkably. The literature is replete with reports of how a particular agency trained its paraprofessionals.

The training provided by the agency for the paraprofessional can be divided into two types: pre-service and inservice (Bennett & Falk, 1970; Jacobson, Roman & Kaplan, 1970). A slight aberration of the pre-service training occurred when some universities received grants to conduct their own pre-service programs. For example, Mitchell reported a program operated by the Institute for Youth Studies and the Center for Mental Health and Behavioral Sciences of Howard University College of Medicine to train and employ youths to serve in group treatment programs (1969). Other programs were developed by Georgetown University and the Newark Board of Education (Goldberg, 1969). However, the number of pre-service programs offered by formal institutions was small compared to the number conducted at the specific agency.

Another component of the new careers concept called for new roles for the professionals because they would be enlisted to train the newly arrived paraprofessionals (Pearl & Riessman, 1965). Essentially, the new roles for the professionals consisted of supervising trainees and acting as innovators rather than as direct providers of service (Specht & Grant, 1969).
The final instrument in Pearl and Riessman's ladder was that the paraprofessionals could begin formal education after they had begun their jobs in the agency. In a review of the formal education opportunities, Gartner (1971) painted a bright picture illustrating that paraprofessionals are enrolling abundantly and performing impressively at Ohio State (Steinberg, 1970), the University of Minnesota (Knop, 1969), and at Kent State and New York University, to name a few. In another study, Gartner and Johnson (1970) found more than 20,000 employed paraprofessionals in degree-granting programs at more than 100 institutions of higher education.

At first glance, these reports appear impressive. However, after the initial glow erodes, some variables appear which may confound the issue. For example, it was not determined if the paraprofessionals enrolled in the formal institutions were indigenous paraprofessionals, a distinction which is overlooked continually. In addition, Riessman estimated in 1967 that at least 150,000 nonprofessional positions had been established. Twenty thousand is a small proportion of this number and there is no means to determine if they intended to obtain a degree in the spirit of new careers or if they were enrolled ephemerally. Finally, it was not ascertained whether these paraprofessionals would have been enrolled regardless of their job as a new careerist. (The method usually implemented to prevent this confusion is called a control group.)
It has been demonstrated that training programs for the para-professional workers do exist. Nevertheless, the career ladder concept has been demeaned vociferously. Grosser indicates that "since training programs do not produce quantitative results in terms of funding, some of the in-service training schedules were either sporadic or did not exist at all (1969:140)." Kadish (1969) speaks of the expanding two-year college and its opportunities; however, he does not provide data about how many paraprofessionals utilize them. Talking of new careerists in community mental health centers, Fields (1968) says that "without academic degrees, licensures, or credentials they have virtually no job mobility, whether vertically or horizontally (p. 58)." Bennett and Falk (1970) apparently support this assertion by saying that the effectiveness of on-the-job training has "had little experimental testing (p. 79)."

These notions culminate in Ritzer's indictment that "Riessman's provision of the ultimate option of becoming a professional can only be regarded as a cruel joke (1974:222)." Haber (1968) suggests the reason for this anomaly is that new careers implies radical changes that professionals were not about to allow.

The discussions involving the three previous issues are preparatory for an examination of cooptation and activism, the last two issues. It will become apparent how they are closely connected with each other.
Cooptation and Activism

These last two issues will be dealt with simultaneously. Although they cannot legitimately be considered the obverse of one another, they can nevertheless be looked at as somewhat mutually exclusive. Presumably if an individual has been coopted into a set of organizational values and ideals, then it is unlikely that extreme activism or deviation from the organizational norms will occur. On the other hand, if the behavior of an individual exceeds what is considered normal by members of the organization, then one would wonder how thoroughly the cooptation process has occurred, if at all. This section will explore these issues in depth.

It has been mentioned previously that there exists little hard data about paraprofessionals. This is especially true when referring to the issues of paraprofessional activism and cooptation. To be sure, there is no lack of speculation and polemics, but empirical verification seems to be conspicuously absent.

Further complications arise because no concise definitions are available to explain what the various writers even mean by cooptation and activism. These words are presented in the literature as common-sensical terms for which presumably everyone knows the meaning. In common-sense word usage, however, a word means something different to everyone who uses it. Consequently, it is not difficult to understand that the subjective definitions of what constitutes "activism" and "cooptation" varies enormously with the
Cooptation

The first issue to be examined will be cooptation. In view of the pervasive confusion at hand, a pressing task is to investigate both the conceptual meaning of the term and also the meaning which it has been given in the paraprofessional literature.

The issue of cooptation of paraprofessionals has been discussed by many (Ritzer, 1974; Miller, et al., 1970; Goldberg, 1969; Haugh & Sussman, 1969). Even Pearl and Riessman (1965) mentioned that cooptation was an event which had to be guarded against. Some imply that differential selection procedures of paraprofessionals constitutes cooptation. Others maintain that if the paraprofessional loses his identity with the community, then he has been coopted. And some say that either or both circumstances can be looked at as cooptation.

But the fundamental question remains unanswered: What do these writers mean by cooptation? The answer to this confusion lies partly in that the original conceptual meaning of cooptation does not directly lend itself to any of these notions.

Cooptation is a term introduced by Selznick (1948). He defined cooptation as "the process of absorbing new elements into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence (p. 34)." In
other words, Selznick viewed cooptation strictly as a defensive
mechanism for an organization. It involved an attempt by the organ-
ization to undermine opposition groups by placing members of the
opposition into positions of leadership.

Under these circumstances, several factors indicate clearly
that Selznick's definition of cooptation is not applicable to parapro-
essional involvement in community mental health centers. First of
all, it was demonstrated that paraprofessionals were brought into the
community mental health centers primarily because there was a
manpower shortage in the mental health field and because funding
from the poverty programs encouraged paraprofessional utilization.

In short, the manpower shortage provided the opportunity,
and the career ladder movement and bridgeman function provided the
reasoning to introduce paraprofessionals into the centers. There
seems to be no reason to suspect that the paraprofessionals were
recruited from the community as a defensive maneuver of the com-
munity mental health center.

Conceptually, cooptation involves the absorption of opposition
of an organization into the leadership of an organization for the purpose
of maintaining itself. Those concerned with the "cooptation" of para-
professionals strongly assert that cooptation occurs most noticeably
in the selection and recruitment phase.

Miller, et al. (1970), claim that "creaming" occurs during the
selection process of hiring paraprofessionals. They have asserted that those who control the entry of people into the indigenous non-professional position have methods to insure that "people whose behavior does not conform closely to middle-class styles are encouraged to leave or are dismissed prior to completion (p. 43)." Ritzer (1970) vociferously charges that this creaming constitutes cooptation.

Definition of Cooptation

The meaning of the word cooptation, as coined by Selznick, is apparently not the same meaning as that given by those who charge that cooptation occurs in the selection process of paraprofessionals. Three strategies are available in trying to pursue a consistent and consequently useful definition of cooptation:

1) The first strategy is to consider only Selznick's meaning of cooptation. This method would serve to eliminate confusion; however, its utility would be tenuous because it would only be applicable to opposing groups and subsequent leadership absorption.

2) Another approach is to consider only the lexical meaning of cooptation. This meaning involves a definition to the effect that members of an outgroup are absorbed into an organization. This meaning is somewhat more appropriate for the paraprofessional situation; however, it lacks the strong conceptual exploration which Selznick
has developed.

3) A suitable meaning to describe the alleged cooptation process of paraprofessionals could be found by selectively combining the two previous meanings. The immediate advantage is that the conceptual dynamics of Selznick could be maintained while using the lexical definition of cooptation. In this fashion the leadership element in Selznick can be avoided, yet the remaining concepts involving absorption of an outside group into a set of organizational values could be retained.

This method seems to be the most heuristic approach; therefore, the third meaning will be utilized in the following discussion. This meaning of cooptation seems to provide the "best fit" for the analysis of the introduction of paraprofessionals into the community mental health center.

Camson (1968) succinctly summarizes a foremost element of cooptation by maintaining that cooptation involves the "manipulation of access (p. 125)" to the organization. In essence, he suggests that the authorities in the organization normally admit elements most susceptible to control.

Since a foremost meaning of cooptation includes the absorption of outside elements into an organization, it seems appropriate to look at the process of how paraprofessionals are recruited,
selected and trained. In order to thoroughly understand this process, a fairly comprehensive analysis of the literature dealing with the selection and training programs of paraprofessionals is necessary to identify any elements of creaming or manipulation of access. The next section will deal with this content analysis.

Recruitment, Selection, and Training Procedures

The content analysis of the literature dealing with the selection, recruitment, and training procedures reveal some interesting results. Sobey (1970) described the career of the paraprofessional as having three distinct phases. First they are recruited, then trained, and finally, after these initiation rites, they are subject to ongoing supervision by professionals. The appropriate place to begin this review, then, would appear to be the recruitment and selection process.

Bennett and Falk (1970) have investigated the recruitment process and conclude that "there are no formalized recruitment policies anywhere (p. 68)." They also noticed a polarization in recruitment procedures; that is, agencies tend to move toward an "open entry" recruitment policy or adopt a "selective" recruitment procedure (pp. 59-92).

Allerhand and Lake (1972) suggest that the selection procedure should be designed to identify and place poor people. The reasoning underlying this contention rests on the notion that living in poverty is the only criterion to be considered in the selection of a paraprofessional.
fessional. In addition, most authors are explicit in asserting that anyone has a chance to participate in their training programs. Klein (1967) represents this view when he said "no attempt was made to pick out the best of the applicants (p. 144)."

However, a review of the literature indicates that most of the training programs did not reflect this outlook. Despite the spirit of new careers, it was advised that "trainees must be carefully selected (Johnson, 1971:234)" and that "an interviewer should not totally ignore his intuitive hunches, his liking or disliking a particular candidate (Willcox, 1970:350)." Another source confirms the general apprehension regarding selection when Hadley, True & Hepes (1970) expressed concern over the quality of personnel at the subprofessional level.

The model presented by Bennett and Falk implies that an agency has the potential to develop either an "open entry" or a "selective" recruitment procedure. The spirit of new careers strongly contends that any person who is indigenous to the catchment area should qualify, on that basis alone, as a candidate for a nonprofessional position.

From the review of the literature, it appears that although it is maintained that everyone has an equal chance to be selected as a paraprofessional, most programs endorse, at least tacitly, the "selective" recruitment procedures rather than the "open entry" recruitment procedure.
In summary, an element of cooptation seems to be confirmed. The evidence just presented suggests that Ritzer (1974) was not completely erroneous when he charged that the standards of selection are hardly likely to insure that a cross section of workers from the indigenous community will be selected.

After the selection of paraprofessionals occurs, the next step is to train them (Sobey, 1970). The next concern, then, is to ascertain if these training programs contain elements of cooptation in regard to the expected degree of commitment and adjustment to the agency.

Training

The training of paraprofessionals has been defined as the "overall attempt to modify behavior so that trainees become more capable of performing tasks (Schmais, 1967:49)." As the movement to involve paraprofessionals accelerated, a multifarious assortment of training programs sprouted to initiate the paraprofessional into the agency (Morrison, 1970; Klein, 1967; Lynch, et al., 1968; MacLennan, Klein, Pearl & Fishman, 1966; Hadley, et al., 1970; Christmas, et al., 1970; Jacobson, et al., 1970).

The evidence gleaned from the descriptions of the various training programs inexorably suggests that the intent of these programs is to inculcate some particular attitude or behavior in neophyte paraprofessionals. For example, after training a group of
paraprofessionals, Christmas, et al. (1970), concluded that as a result "the change in behavior is most striking (p. 650)." Others (Morrison, 1970; Christmas, 1966) praise how effective group training is and how the paraprofessional is "far more accessible to attitudinal influences from a group of his own peers than almost any other sources (Willcox, 1970:352)."

Moreover, the literature explaining the training programs indicates that the training is intended to accomplish more than a behavior change. The paraprofessionals are also expected to display commitment to the agency, and the training appears to be structured to achieve a transformation of the paraprofessional toward middle-class values. For instance, one program thought it was important for the paraprofessionals to read classical literature like Plato's Republic or Antigone (Lynch & Gardner, 1970:1475). This impression is further supported by a paraprofessional's testimonial that "each week we had to learn ten new words (Hines, 1970:1467)", including the correct spelling and pronunciation.

In general there seems to be some support for the comment that changes occur within the paraprofessional in the "direction of the status quo (Miller, et al., 1970:43)."

Summary and Conclusion

The review of the training programs revealed helpful insights in understanding what is meant when it is charged that "in a sense
the indigenous nonprofessionals have been coopted (Albrecht, 1974: 248).

The discussion on cooptation can be summarized in the following manner. First, it was necessary to arrive at a suitable definition of cooptation which accurately reflected the meaning of those who were using the term. Briefly, cooptation redefined has been identified as the absorption of a group into an organization. This does not suggest that a power struggle or leadership is involved. However, it does include the idea that not everyone has an equal chance to become a paraprofessional and that the organization takes steps to insure that desireable elements will be absorbed.

The measures taken by the centers to selectively recruit and train paraprofessionals echo the dynamics involved in Selznick's concept of cooptation. Selznick (1948) asserted that mechanisms of adjustment affect those who are coopted and that these mechanisms result in involved commitment to the organization (pp. 27-33).

Using this definition, the caustic attacks of Ritzer, Miller, et al., and others are not inappropriately labeled cooptation. An examination of the selection procedures and training programs of paraprofessionals does help support the contention that differential selection of candidates does occur. The selection procedure could be considered to contain elements of cooptation because it is one of the mechanisms of adjustment.
The training programs also appear to contain mechanisms of adjustment. The following statement by Sobey (1970) is instructive:

"a training program will not be successful if it assumes that the non-professionals all enjoy being considered representative of the group they serve (p. 120)." One is led to believe that the intention of these programs is to foster behavior change and express commitment to the organization.

This issue encompasses a substantial research question and will be looked at more closely in the theoretical section. Essentially the question at hand is to determine if the mechanisms of adjustment within the organization do induce the paraprofessionals to come to identify with the organization and become subject to its value system.

Activism

In view of the discussion just presented concerning cooptation, it is paradoxical that there also has been a plethora of attention alerting the professions that a large degree of activism will accompany the introduction of paraprofessionals into community mental health agencies. Ironically there are no clear terms to define what activism means. The literature is obscure about what constitutes activism, yet many have expressed interest in it (Boyette, Blount & Petaway, 1971; Grosser, 1969; Fields, 1968).

A review of the literature revealed that activism seemed to be regarded in at least three different ways; confusion is fostered because
the word is used interchangeably to connote several different phenomena. The following delineation will illustrate this point:

1) Paraprofessionals have been called activists in the sense that they are truly concerned about the services rendered to "their own" people and thus less interested in the priorities of the agency (Boyette, et al., 1971). This implies that if there was a conflict between the expectations of the community mental health center and the expectations of the community, the paraprofessional would be inclined to accommodate the expectations of the community.

2) Secondly, the paraprofessionals have been referred to as activists because of the "explosive social problems which the new careerist might uncover (Willcox, 1970:348). " The focus here seems to be on the political exigencies of the community and methods which can be used to "assert power (Albrecht, 1974:249)."

3) The final meaning given to the work activism is that paraprofessionals are actively involved in their own welfare and career advancement. The meaning contained in this version of the word is expressed as the need of the paraprofessionals to "gain power and control over their own lives (Christmas, et al., 1970)."

These three interpretations of activism are entitled to a
separate delineation. This method will expose the conceptual distinctions behind the different meanings.

The first version is represented by Minuchin (1969). He asserts that paraprofessionals in community mental health are seen as "activators." This label is significant because he goes on to say that these activators are seen by the establishment as trying to "repair a watch with a hammer (p. 724)."

This meaning of activism can be described as the inclination of the paraprofessionals to consider the needs of the client more important than the expectations of the center. An inherent factor to be considered in this meaning is the assumption that the expectations of the community are in fact different from the expectations of the center.

The second meaning of activism comes from the notion that the paraprofessional is committed to the political activities of the community. This meaning contains the fear of "explosive realities" and is tenuously verified in the literature. Ahearn (1970) suggests that the longer the paraprofessional is in an agency, there is a possibility that in some cases he will become more militant. The essence of this position is expressed in a statement by Albrecht (1974) that "mental health centers have served as a political background in many locales, and the community has used them to assert power (p. 248)."

Presumably Albrecht was referring in part to paraprofessional activities like the 1968 sit-in of the administrative offices of Lincoln
Mental Health Services (Health-Pac, 1971), the strike at Topeka, Kansas (Efthim, 1968), and the disruption of the 1969 annual meeting of the American Orthopsychiatry Association (Werry, 1969).

However, a critical scrutiny of the issues involved in these political activities reveals that the paraprofessionals were also concerned about their own interests. Enough can be gleaned from inspecting the demands they issued in each situation to conclude that the phrase "striking for the good of the patient (Efthim, 1968)" can ultimately be considered a euphemism for increasing the benefits of the workers.

This leads to the final meaning of the activism attributed to the paraprofessionals. In a content analysis of the transitions affecting the New Professionals Newsletter, Ritzer (1974) poignantly concludes that "little is seen in the newsletter about helping the poor, but a good deal is written about solidifying the position of the new careerist in the establishment (p. 231)."

This final rendition of the word is supported by a cursory review of the organizations with which the paraprofessionals have become affiliated. It seems they are keenly aware of how to organize into power coalitions in order to acquire benefits for themselves. Gartner (1971) concludes that the paraprofessionals have recognized that it is impossible to win their demands without "joining unions in large numbers, such as the American Federation of Teachers, the American Federation of State, County, and Municipal Employees, the
Summary and Conclusion

The various meanings of the word "activism" and the problems they create can be resolved in the same manner as the meaning of cooptation. Three different meanings of activism were identified in the literature: activism in the sense of community needs taking priority over the expectations of the center, activism in regard to political activities, and activism in terms of the paraprofessionals expressing interest in improving job stability and welfare.

A suitable definition of activism can be found if the first meaning is combined with elements of the second meaning. The third meaning of activism does not seem relevant or useful because it implies that the paraprofessionals are actually becoming absorbed into the values and reward system of the center.

If paraprofessionals are defined as activists simply in terms of being excessively concerned about the needs of the client and community it is not very helpful because the purpose of the center is to help them. However, if activism is defined as a willingness to violate the center's expectations in the pursuit of helping the client or community, the meaning becomes more sophisticated.

Activism can then be considered as the degree to which the paraprofessional is willing to help the client or community, especially
if it involves violating the expectations of the community mental health center.

It is now possible to juxtapose cooptation and activism. Cooptation is regarded as the absorption of outside groups into an organization through mechanisms of adjustment, and it is expected that the coopted elements will express commitment to the organization. If the paraprofessionals are viewed as being coopted into the community mental health center then it is expected that they will express commitment to the goals and expectations of the center.

On the other hand activism has been defined as the willingness of the paraprofessional to violate the expectations of the center. Therefore, it seems consistent to conclude that a coopted paraprofessional will not be an extreme activist. In the next chapter the issues of cooptation and activism will be considered theoretically.
CHAPTER III

ROLE, IDEOLOGY AND HYPOTHESES DEVELOPMENT

Introduction

The review of the literature provided an understanding of five of the main issues which have confronted the paraprofessionals since their appearance in the community mental health center. The issues involving the manpower shortage, career ladders, the bridgeman function, cooptation and activism have been examined in toto. In each of these it was found that it is difficult to arrive at any conclusion with absolute certitude. It was demonstrated that when these issues are examined comprehensively, they are inconsistently addressed in the literature. In an effort to clarify the prevailing misunderstandings, both sides of each issue were presented.

The two final issues, cooptation and activism, are of particular importance because of the paucity of conceptual consistency and empirical verification. These issues have been approached extremely haphazardly and treated so improperly that it becomes difficult to distinguish the core issues from the emotive surroundings in which they are nurtured.

It is apparent that the definitional dilemmas involving cooptation and activism are unresolved if the terms are not given special meanings appropriate to paraprofessionals. For example, the term
cooptation as applied to paraprofessionals is almost a misnomer because Selznick (1948) applied it mainly to tension between groups and attempts to resolve it through absorbing the leadership of the opposition.

In the previous section two definitions were proposed which would embrace the appropriate meanings for paraprofessional cooptation and activism. The strategy of this section is to put the issues within the framework of role theory. A theoretical investigation should provide a productive understanding of the cooptation and activism polemic.

In this theory the paraprofessional will be examined in terms of occupying a role position which is subject to the expectations of various groups. It will be suggested that both role conflict resolution strategies and the acquisition of an ideological orientation are instrumental in determining how the paraprofessional adjusts to his role position in the community mental health center.

Role Position

Goffman (1959) contributes seminal insight into understanding organizational behavior with his concept of "social fronts." A social front is that part of the performance which regularly functions in a general and fixed fashion. These fronts tend to become institutionalized in terms of the stereotypes which become expected of an established role (pp. 20-35). A knowledge of fronts tells us that different actors per-
form programs and that these programs are partially contingent on the expectations of the audience.

However, an explanation of fronts does not adequately distinguish the various positions among actors and why some actors carry proportionately more influence and prestige. Linton helps to clarify this question with his distinction between status and role. A status is a collection of rights and duties associated with a position. But when an individual in that particular status puts these rights and duties into effect, he is performing a role (Linton, 1945:114).

Linton's notion of status and role indicates that there can be several fronts in an organization, and that each front has a status. Therefore it can be concluded that different actors have different fronts, and each front has a contingent status. A social front is simply a performance which tends to become fixed. To illustrate how fronts are related to each other it is necessary to identify the positions of different actors in a particular social structure.

By position it is mean the "location of an actor or class of actors in a system of social relationships (Gross, McEachern & Mason, 1966:48)." The meaning of position in a system of social relationships is fundamentally the same as the meaning of status in Linton's paradigm since they both refer to the place which an actor occupies in a particular structure. However, the concept of position can be utilized more effectively than status to foster a better
understanding of an actor's performance in relation to others.

Gross, et al., contend that a position cannot be described adequately until other positions to which it is related have been specified. Newcomb (1951) precipitated this assertion by emphasizing that "since every position is a part of an inclusive system of positions, no one position has any meaning apart from the other positions to which it is related (p. 277)."

Therefore, in studying the roles associated with a particular focal position (actor), it is necessary to consider his relationship to other role positions (counter positions). The important point to consider is that a position is an element of a network of positions. As Newcomb suggests, in order to comprehend the meaning of a position, its counter position must be examined because the counter positions are fundamental in providing its meaning.

Merton (1940) assumes that "each position carries with it definite prescriptions toward behaving toward other persons in related positions (p. 564)." Gross, et al., view the actor in a role position somewhat differently. They maintain that if an analysis is concerned with how actors should behave, then expectations have to be considered. An expectation is defined as "an evaluative standard applied to an incumbent of a position (1966:58)." Sarbin (1954) elaborates this point by suggesting that a particular role position acquires expectations and that the actor learns these expectations through occupying
the position (p. 225). It seems clear, then, that some of the expectations which an actor comes to hold as an incumbent of a position is a function of his relativity to other positions and the expectations which are placed upon him.

Competing Audiences and Role Conflict

The importance of understanding a position as the location of an actor in a social system has been delineated. It has also been stressed that expectations seem to be crucial in ascertaining both how a position is evaluated and the manner in which an actor's performance is shaped.

These expectations, to a large extent, emanate from the counter positions. The expectations of a counter position are created by the actors in that position who constitute an audience for the focal position. If the same expectations are applied to the incumbent of a particular social position, then it can be assumed that consensus exists (Biddle & Thomas, 1966). However, a dilemma can be encountered if an actor is exposed to differing expectations from those in differing positions, or if consensus does not exist among the occupants of a single counter position.

Under these circumstances, the position of the actor (focal position) can be looked at in terms of "competing audiences (Gross, et al., 1966)." A situation of competing audiences exists when there are conflicting expectations from competing audiences. The presence
of competing audiences generates a phenomena known as "role con-
flict (Parsons, 1951; Gross, et al., 1966)."

In an examination of the literature concerned with role conflicts, Gross, Mason & McEachern (1958) indicate that the term has been given different meanings by different social scientists. For example, role conflict can exist when there are contradictory expectations for a single position, or it can be specified when an actor occupies two or more positions simultaneously which have conflicting expectations.

Gross, et al. (1966), consider role conflict to exist in any situ-
ation "in which the incumbent of a focal position perceives that he is confronted with incompatible expectations (p. 248)." A concept closely related to role conflict is the notion of role strain. Goode (1960) identifies role strain as the "felt difficulty in fulfilling role obligations (p. 483)." The defining characteristic of role strain is that the role relationship usually demands several activities or responses from the individual.

Parsons (1951) provides a theoretical framework in an attempt to explain why the actor experiences discomfort when he is confronted with role conflict. According to his system, value standards act to define institutionalized role expectations. These expectations eventually assume a degree of moral significance and conformity to them becomes a matter of obligation. These expectations also create a shar-
ing of common values and subsequently a solidarity is created among
those who are involved.

Parsons refers to the actors concerned in this type of situation as members of a collectivity, and within the collectivity there is an expectation that the actor is committed to the achievement of certain goals. In short, the collectivity concept is essentially an orientation posing the question of confidence, "Are you one of us or not? (p. 97)."

An apparent shortcoming in Parsons' scheme is the assumption that if role conflict exists, the actor must choose one alternative and sacrifice the other (p. 286). This all-or-nothing dichotomy makes theoretical understanding easier, but it does not appear to be realistic. An individual can readily devise numerous compromise solutions when faced with role conflict or role strain.

The following discussion explores aspects of several conflict resolution strategies. Unlike Parsons, other theorists maintain that the individual does not have to commit himself completely to one collectivity or the other.

Role Conflict and Role Strain Resolution

The insights of Parsons are valuable when considering how an actor in a focal position eventually comes to incorporate the expectations of a particular audience. However, his explanation is not flexible enough to demonstrate how an actor may adjust slightly to a role but not completely.
Goode (1960) maintains that in a situation of role strain the individual experiences a sequence of role bargains. In this sequence of role bargains, the individual's choices are shaped by mechanisms through which he organizes his total role system (p. 483). According to Goode, an individual can utilize two main sets of techniques for reducing role strain: those which determine if he will enter or leave the role, and those which have to do with a role bargain (p. 486).

The meaning of "bargain" is the same as in economics; if there are limited resources to be allocated, the individual faces a problem. The same problem is encountered in role strain and the individual, in a sense, has to bargain. An interesting assumption of Goode is that dissensus, nonconformity, and conflict among roles is normal in social systems (p. 495). Since the individual cannot satisfy all of the demands in his role, he moves through a continuous sequence of bargains. Goode's explanation of role strain resolution succinctly illustrates how the actor can adjust to expectations through a bargaining process.

Role conflict resolution strategies have been investigated extensively by Sarbin and Allen (1968) and Gross, et al. (1958). Sarbin and Allen refer to role conflict resolution strategies as "adaptive responses." They maintain that in a situation of role conflict, the actor adapts to some part of the situation to minimize strain. Role enactment is treated as a major variable which depends
on role expectations, role location, and role demands.

A fundamental premise in Sarbin and Allen's schemata is that cognitive strain is produced when multiple roles are contradictory. The problem associated with multiple role obligations is basically that the person must determine how his commitment and energies will be allocated. The existence of cognitive strain, then, leads to an increase in behavior toward a resolution of the unpleasant condition (pp. 541-555). This resolution falls into five categories or modes of adaptive responses:

1) Instrumental acts--this strategy is aimed at externally performing the most necessary role.

2) Attention deployment--this technique operates on the sensory input but not the source of the role conflict itself. The cognitive strain is minimized by ignoring one of the incompatible inputs.

3) Change the beliefs--in this technique, the actor makes the incompatible inputs congruent by changing his belief about one or both inputs. This resolution strategy is on the cognitive level and requires a cognitive reorganization of the beliefs of the actor.

4) The use of tranquilizers and releasers--this category modifies the arousal component but not its antecedents. Tranquilizers (e.g., chemicals, food, and sleep) ephemerally
reduce the experiential aspects of the strain. Releasers include conduct engaging in intense muscular and motor activity such as exercise and formal games. It is important to emphasize that this category of adaptive techniques only deals with the effect of the cognitive strain, and not its source.

5) No adaption or unsuccessful adaptations—in this case, cognitive strain persists at a high level. The inability to reduce it produces a variety of somatic and behavioral effects. The cognitive strain produces low satisfaction, little confidence and high tension.

In summary, Sarbin and Allen maintain that under conditions of cognitive strain, the actor will have a propensity to utilize an adaptive technique. If the adaptive techniques are not used, or they are unsuccessful, the strain will persist and an increase in tension will ensue.

Gross, et al. (1958), view conflict resolution somewhat differently. They take the actor's definition of the situation as the starting point for any conflict to be resolved. It is assumed that the actors have perceptions of whether or not the expectations to which they are exposed are legitimate, and, furthermore, the actor understands what sanctions he will be exposed to if he does not conform to each of the expectations (p. 292).

Consequently, the conflict resolution is explained according to
whether the actor is primarily oriented toward legitimacy or sanctions in carrying out his role behavior.

In pursuing a method to predict behavior during situations of role conflict, Gross, et al. (1958), characterize three orientations which the actor can embrace. The first type is concerned with the person who considers the legitimacy of expectations placed on him. His definition of the situation "places stress on the right of others to hold their expectations and de-emphasizes the sanctions he thinks will be applied to him for nonconformity to them (p. 292)." They label such a person as one who has a moral orientation to expectations.

The second type of response to expectations is called expedient. This type of individual gives priority to the sanctions of others if he does not conform to their expectations. In a role conflict situation, such a person will act to minimize the negative sanction. Essentially, this individual will conform to the expectations which he perceives have the strongest sanction.

The last type of orientation to expectations is called moral-expedient. A person with this definition of the situation considers both the legitimacy and sanctions available and behaves according to a perceived "net-balance."

Although both Sarbin and Allen and Gross, et al., are explaining strategies for conflict resolution, it appears they stress different aspects of the phenomenon. Sarbin and Allen seem to place the
emphasis on the method the actor selects. For example, he can either perform instrumental behavior or change his beliefs. On the other hand, Gross, et al., are concerned with the actor's perception of the situation, and how he acts according to that perception. Despite the difference in emphasis, both viewpoints have crucial insights which are indispensible in understanding conflict resolution.

Summary

The essential properties of role theory suggest that an individual can be examined in terms of his role position in a particular social structure. In certain situated roles an individual may find himself exposed to conflicting expectations. This is known as role conflict and a central concern of role theorists is addressed to understanding how individuals behave when faced with such conflicts.

Three theories (by Goode, Gross, et al., and Sarbin and Allen) which explain resolution strategies were examined. Goode and Gross, et al., appear to have a common base by clearly asserting that the individual does not have to adjust completely to a collectivity. Rather, they agree that the actor can take measures to reduce the strain or conflict by bargaining or expediency.

These three theories each have unique insights into resolution strategies and will be utilized to explain the adjustment of the para-professional to the role of a community mental health worker.
Application of Role Theory to the Paraprofessional Worker

This research is concerned with the problem of how the paraprofessional worker adjusts to the expectations he confronts when entering the community mental health center. Therefore an identification of the paraprofessional's role position in the community mental health center is fundamental in understanding how role conflict might occur, and how it is resolved.

In the previous chapter a distinction was made between professionals, paraprofessionals and indigenous paraprofessionals. It was pointed out that the professional comes into the agency with sophisticated training and an accumulation of credentials while the paraprofessional enters the agency by right of his inexperience.

Linton's formulation of status and role helps to distinguish the paraprofessional from the professional by looking at them in terms of the status they occupy in a hierarchy. The professional, who is trained and licensed, has more rights and privileges and thus is in a higher position. The role of the paraprofessional is featured by a status which falls below the professional in the organizational hierarchy. The very concept of career ladders implies that there is a distance between the status of the professional and the paraprofessional. Since this ladder was meant by Pearl and Riessman to be climbed, it also suggests that professionals occupy a higher status than the paraprofessional.
It can be gathered from role theory that the paraprofessional worker is influenced to some degree by the expectations he holds for himself and the expectations others hold for him. In addition, it can be assumed that his location or position in the structure of the community mental health center influences the standards he or others apply to his behavior.

The concept of role can be used productively to ascertain the position of the paraprofessional. This is important because of evidence gleaned from role theory suggests that the position of the individual will determine, to a large extent, his role enactment.

Role position was defined earlier as the location of the actor in a system of social relationships. The relationship of the paraprofessional (focal position) to his counter position can be seen in Diagram 1.

In studying the roles associated with the paraprofessional, it is necessary to consider his relationship to other positions. A cursory examination of Diagram 1 indicates that the paraprofessional is exposed to more than one audience.

The paraprofessional has counter positions emanating from both the center he works in and the community he works for. A problem immediately presents itself. There is an implicit assumption in the literature that the values of the community mental health center are not the same as, or consistent with, the values of the
indigenous community. If this assumption holds true, then the position of the paraprofessional can be looked at in terms of competing audiences. In this position he has to contend with three sets of expectations: those of the community mental health center, his own, and the expectations of the community. If these expectations are not compatible, role conflict is said to be generated.

In terms of role theory the paraprofessional is exposed to incompatible behavior expectations from competing audiences. Parsons contends that in this dilemma the actor must choose one alternative and sacrifice the other. However, this position seemed to be somewhat inadequate. Goode and Gross, et al., presented less drastic adaptive strategies which seemed to be more heuristic. In other words, a compromise strategy could be available for the paraprofessional who is confronted with competing audiences.

Parsons' notion of a collectivity is concerned with a solidarity
and common values among members of a particular social structure. Ideally, both the community mental health center and the indigenous community can be looked at as collectivities. The review of the literature dealing with cooptation and activism strongly implied that the values of the community mental health center are not the same as those of the community.

Therefore if the paraprofessional is attracted more toward the collectivity in the community, then we could speculate that he would tend to be more active. On the other hand, cooptation would exist if the paraprofessional shared the values of the center. Theoretically it seems reasonable to assume that in a situation of role conflict the paraprofessional will conform to a particular collectivity and its set of expectations. Since both the community and the center constitute a collectivity, it can be expected that both will exert pressures on the paraprofessional.

The theoretical development at this point suggests quite conclusively that when the paraprofessional enters the community mental health center he is confronted with three sets of expectations. The competing interests generated by these expectations indicate that the paraprofessional is in a situation of role conflict or role strain.

In Diagram 1, a simple model was presented which suggests that the paraprofessional is only exposed to conflicting expectations from the center and the community. However, a further elaboration
of counter positions reveals that there is no reason to suspect the existence of two unanimous counter positions (Diagram 2).

Diagram 2

Focal Position of Paraprofessional
(Multiple Expectations)

That is to say, within each counter position, the paraprofessional is likely to encounter different expectations. So, although the agency and the community are considered collectivities, it is likely that there are competing expectations within each collectivity.
The next step is to investigate the nature of conflict resolution strategies which the paraprofessional is likely to take. The three role theories surveyed suggest that the anxiety caused by expectations from different audiences creates role conflict. This conflict encourages the paraprofessional to take measures to reduce the strain caused by these conflicting expectations.

Sarbin and Allen's model of adaptive responses indicates roughly what alternatives the paraprofessional has in resolving the conflict. Gross, et al., demonstrate how the paraprofessional comes to justify the adaptation through the definition of the situation. Finally, Gross, et al., and Goode's position indicate that the paraprofessional does not have to adjust totally to one audience. It is likely that certain mechanisms of adjustment will lead to a definition of the situation for the paraprofessional. This definition of the situation presumably provides a comfortable role position which accommodates the expectations and enables him to carry out his function in the community mental health center.

Ideology and the Paraprofessional

The final conceptual variable in this theoretical construction is consideration of ideological forces which can influence the behavior of an individual. An ideology is defined by Gould (1964) as a pattern of logically interrelated beliefs which explain social phenomena with a view of directing and simplifying choices facing individuals (p. 315).
The function of ideology has been examined cogently by many, including Gould (1964), Geertz (1964) and Marx (1969). Geertz points out that it is the nature of ideologies to make incomprehensible situations meaningful and to act purposefully within them (p. 64). Essentially an ideology can be looked at as a "guide for conduct (Wagenfeld, 1972; Wagenfeld, et al., 1974)," when the definition of the situation is either unknown or inadequate.

A need to understand the ideology of community mental health is of central importance. As indicated in Chapter I, community mental health resulted as a culmination of a series of developments in mental health. These developments included the recognition that custodial facilities in mental health were grossly inadequate, and a change in the consciousness of society at large concerning mental illness.

In addition, many studies (for example, Hollingshead & Redlich, 1958; Srole, Langner, Michael, Opler & Rennie, 1962) indicated an inverse relationship between socioeconomic status and the prevalence of mental disorder and a similar inverse relationship between socioeconomic status and treatment resources. Building on this, a major goal of community mental health was to lower the incidence of mental disorder in the community, especially among the poor.

This novel emphasis of community mental health led to the
emergence of a different role for the community mental health worker—that of an agent of social change. It was contended that "the fundamental issue in mental health in the 1960's articulated around the nature of these new roles; was the community mental health worker to be a social activist or change agent, or was the worker to be essentially a clinician operating within an expanded public health framework? (Wagenfeld & Robin, 1976:3-4)."

The question of whether community mental health ought to be more traditional in its orientation or whether it should involve social change is not an issue which can be answered empirically. It is at this point that the investigation of ideology becomes important. The question of what role the community mental health worker should take is not a scientific question in the sense of having a degree of empirical falsifiability. However, the question of what workers perceived to be their role could be investigated.

The choice of what would be the new role of the community mental health worker, combined with scarce empirical explanations of the etiology of mental illness, leaves the worker with no clear definition of what is meaningful. Geertz (1964) pointed out that it is the function of ideologies to make incomprehensible situations meaningful and to act purposefully within them. To make sense out of the emerging roles for community mental health workers, advocates desiring the workers to be change agents or social activists based
their call on largely ideological grounds. In short, the emergence of the ideology of community mental health, like other psychiatric ideologies, was fostered by a lack of scientific direction for a method of treatment and the need to make this situation meaningful for the workers providing treatment.

Baker and Schulberg (1967) were among the first to address the question of ideology and community mental health. They viewed the emergence of the community mental health center as a collectivity which is organized on the basis of commonly held beliefs. Essentially these beliefs act to "redefine social action in the treatment of mental illness (p. 216)."

According to Baker and Schulberg, the ideology of community mental health entails the view that the etiology and treatment of mental disorder lies in the community. More specifically, the ideology of community mental health involves five aspects: population focus, primary prevention, social treatment goals, comprehensive continuity of care, and community involvement. The population focus emphasizes that the community mental health specialist should be responsible for the community as well as the patient. Primary prevention involves the idea that mental disorder can be lowered by counteracting harmful forces. The question of social treatment goals focuses on helping the patient to achieve social adjustment rather than to reconstruct the personality. The comprehensive continuity of
care deals with providing an integrated network of care to the patient. Total community involvement deals with extending the effectiveness of the mental health specialist by working with other people in the community.

Baker and Schulberg considered it vital to understand and measure the ideology of community mental health because the ideology of the worker is important in shaping his conduct as a change agent. If the community mental health worker considers it appropriate to alter the life circumstances of the poor, then the worker would have assumed the role of change agent and would become engaged in various forms of social action. Underlying the role of change agent is the ideological assumption that social conditions are etiologically associated with mental disorder.

It is apparent that the meager etiological knowledge of mental illness, the relation between mental illness and poverty, and the level of activism among community mental health workers are ultimately connected. Theoretically, it has been suggested that in order for the community mental health worker to assume the role of change agent as a treatment strategy he will need a community mental health ideology to serve as a guide for conduct.

The paraprofessional's level of community mental health ideology is a topic of special interest. If the paraprofessionals strongly endorse the ideology of community mental health, then it
can be expected that they will have a corresponding tendency to
assume the role of change agent. On the other hand, if the paraprofessionals do not strongly endorse the ideology of community mental health, then it can be expected that their level of change agency will also be lower.

Presumably the professional workers come to grips with ideological questions during their professional training. It has been shown that the discipline to which a professional belongs will affect his level of endorsement to the ideology of community mental health (Baker & Schulberg, 1967). Unlike the professionals, there is no reason to suppose that the paraprofessionals have a community mental health ideology prior to employment at the center. It is likely that they could have isolated beliefs involving, for example, population focus (i.e., responsibility for the community as well as the patient). However, it is unlikely that they could have a systematized set of ideological beliefs regarding community mental health because of the esoteric nature of several dimensions. For example, the novice indigenous paraprofessional coming directly from the community could hardly be expected to have an ideological perspective on questions such as primary prevention or social treatment goals. In short, it does not seem likely that the paraprofessionals will have a systematic community mental health ideology until after they have been exposed to the community mental health center.
The theoretical discussion of the dynamics of role conflict and conflict resolution strategies can also be applied to the paraprofessional's acquisition of the community mental health ideology. In terms of role theory it has been illustrated that the paraprofessionals perform adjutive techniques in response to the competing expectations exerted by different audiences. Theoretically the paraprofessionals will have to develop an ideology which is consistent with their level of role activism. Therefore the paraprofessionals will go through appropriate mechanisms of adjustments in acquiring a community mental health ideology. These adjustments are in response to the expectations of the competing audiences.

In view of the discussion of activism and cooptation in Chapter II, the following assumptions can be drawn. If the paraprofessionals are role activists, they will probably display a strong endorsement of the community mental health ideology. On the other hand, if the paraprofessionals have been coopted, they will be more likely to endorse the ideology at a level which is consistent with the expectations of the community mental health center.

Summary and Conclusion

The focus of this investigation is centered on the paraprofessionals in the community mental health center. It was indicated in the review of the literature that a controversy surrounds the question of whether the paraprofessionals are activists in the community mental
health center or whether they have been coopted. Activism was defined as the absorption of the paraprofessionals into the values and goals of the center.

In the review of the literature a strong case was made indicating that the adjustment mechanisms of the paraprofessionals are likely to be in the direction of the expectations placed on him from the center. Adjustments in this direction suggest cooptation. Therefore, the possible processes of cooptation of the paraprofessionals will be examined more thoroughly.

Three versions of cooptation were delineated in Chapter 13. These were (1) Selznick's conception of cooptation (involving leadership absorption, (2) absorption of outgroup members into an organization, and (3) a combination of both which served to retain Selznick's conceptual dynamics yet eliminates the notion of leadership. A matter which warrants serious consideration is the process which is involved in becoming coopted. The theoretical development suggests that cooptation is a response to the expectations of competing audiences. If cooptation of the paraprofessionals does occur, it is important to ascertain where these adjustment responses take place and how long the adjustment process occurs.

Several competing conclusions can be gleaned from the literature. At least four alternative explanations are viable in examining the process of cooptation. These are (1) Cooptation is an ongoing
process which is slow yet involves persistent change in the paraprofessional, (2) Cooptation is a sudden event which occurs early and "totally" during the recruitment and training of the paraprofessional, (3) Creaming of the paraprofessional occurs, or (4) It is not necessary for cooptation to occur because the values of the community are not different from the values of the agency.

The processual version of cooptation suggests that it is an ongoing but gradual process. In this instance, the paraprofessionals would be drawn into the center and the change from holding the values of the community to holding those of the center would be a gradual process possibly involving years.

The second possibility is that a "sudden cooptation" occurs as opposed to a gradual cooptation. The dynamics involved in this circumstance suggest that the paraprofessionals make a sudden switch of values from the community to the values of the agency. This change of values would presumably occur during the recruitment and selection procedures. This strategy is closely related to Gamson's (1969) contention that cooptation involves a "manipulation of access" and that the paraprofessionals admitted to the community mental health center would be susceptible to immediate control.

There are two more alternatives under consideration which are unique because they actually do not involve a change in values. One possibility is that the community mental health center selects
paraprofessionals who already hold the values and expectations of the agency. In this case, there would be no need for the paraprofessional to undergo a transformation in values.

This strategy is referred to by Miller, et al. (1970), as "creaming." It is important to emphasize that creaming does not denote cooptation. In the strictest sense of the word, cooptation involves a value change. Creaming is a situation in which paraprofessionals are selected who already possess the desired values. There was strong support for creaming in the literature review. For example, trainees were "carefully selected (Johnson, 1971)" and interviewers were advised not to ignore "intuitive hunches (Willcox, 1970)" regarding the desirability of a particular candidate.

A final consideration has been delineated in a previous caveat, and warrants an underscoring at this point. It is crucial to keep in mind that implicit in the literature is the assumption that there is a difference between the values of the community and the values of the community mental health center. If no difference between the agency and community existed in the first place, the entire issue would quickly dissipate.

In short, the previous discussion indicates that several alternatives must be considered when interpreting the data. If the data suggest that cooptation has occurred among paraprofessionals in the community mental health center, careful analysis will be needed to
determine where the cooptation occurs.

To summarize this chapter, role theory has been used as the theoretical mode of analysis. The paraprofessional (focal position) has been examined in terms of the expectations placed on him from the counter positions. Expectations for the performance of the paraprofessional are held by the agency, the community, and himself. Competing audiences have been identified which expose the paraprofessional to role conflict or role strain. In order to resolve this condition of conflict, it is expected that the paraprofessional goes through a series of bargains and mechanisms of adjustment which help shape his/her role enactment.

In addition the concept of ideology has been examined. The ideology of community mental health warrants consideration because the ideological stance of the community mental health worker appears to have some impact of the workers' role perceptions. It has been theorized that the paraprofessional adjusts to an ideology of community mental health at a level of endorsement which is compatible with his/her degree of role activism. The following hypotheses bring together the issues in the literature and the theory which has been developed in this chapter.

Hypotheses

HYPOTHESIS I--A foremost feature in the literature on paraprofessionals deals with a discrepancy between activism and coopta-
tion. Some assert that the paraprofessionals have been coopted, while others claim that they are activists. Cooptation, as defined here, consists of the notion that the paraprofessionals embrace the ideology and goals of the center. Activism is defined as the inclination of the paraprofessionals to reject the expectations of the community mental health center, and to be more active in ideology, community involvement, and politics than the other workers.

It was developed in the theory section that when the paraprofessional enters the community mental health center, he is exposed to competing audiences and will go through mechanisms of adjustment to resolve this discomfort. It has also been shown that the process of selecting and training paraprofessionals functions to bring "desirable" paraprofessionals into the center.

Professional workers go through a socialization process during their professional training which determines in part their ideological orientation toward community mental health. Paraprofessionals, on the other hand, lacking systematic professional socialization, develop their ideological socialization within the center. It is logical to assume, then, that the only mental health ideology the paraprofessional acquires is that acquired from within the community mental health center.

The selective recruitment process, combined with the strong expectations of the paraprofessional from the center, is highly likely
to lead to the development of an ideology which is consistent with the ideology of the other workers and not antagonistic. It seems that the mechanism of adjustment would shape an ideology which could be considered as cooptative in nature rather than active. This leads to the first hypothesis:

HYPOTHESIS I: IT IS PREDICTED THAT THE PARAPROFESSIONALS WILL DISPLAY AN IDEOLOGY EQUAL TO OR LOWER THAN THE IDEOLOGY OF OTHER WORKERS IN THE COMMUNITY MENTAL HEALTH CENTER

HYPOTHESIS II--Several meanings of activism were shown to prevail in the literature. These meanings of activism were examined and a suitable definition of activism was introduced. A paraprofessional is considered an activist if he is willing to go beyond his expected role in the center and include multifarious social problems as part of his worker role.

As an activist he would be willing to violate the expectations of the center and become involved in activities which will serve the needs of the client or community. The theory which has been developed suggests that the paraprofessionals go through mechanisms of adjustment which shape them toward the expectations of the center. In other words, the paraprofessional's adjustment process to the various expectations will resemble cooptation rather than activism.
A second hypothesis is subsequently generated:

**HYPOTHESIS II:** RELATIVE TO OTHER WORKERS IN THE CENTER, IT IS PREDICTED THAT THE PARAPROFESSIONALS WILL BE LESS ACTIVIST IN COMMUNITY MENTAL HEALTH ROLE DEFINITION

**HYPOTHESIS III**—Closely related to the paraprofessionals' level of activism is the degree to which they exclude themselves from various issues encountered as community mental health workers. Like the level of activism, the rate of exclusion indicates the tendency of the paraprofessional to adjust to the expectations of the center. This leads to the third hypothesis:

**HYPOTHESIS III:** IT IS PREDICTED THAT RELATIVE TO OTHER WORKERS, THE PARAPROFESSIONALS WILL EXCLUDE THEMSELVES FROM ISSUES IN COMMUNITY MENTAL HEALTH TO A GREATER DEGREE

**HYPOTHESIS IV**—It was indicated in the review of the literature that the paraprofessionals actively participated in securing a job in the agency. Therefore it is assumed that they displayed cooperative interests and acknowledged the values of the agency during the recruitment and selection procedure. This behavior could easily be considered a mechanism of adjustment.
In addition, the hiring of paraprofessionals has been identified as a "selective" recruitment procedure. It is assumed that selective hiring constitutes a mechanism which tends to exclude paraprofessionals who manifest tendencies which are regarded as too radical or active for the organization. In short, the paraprofessionals are expected to maintain a strong commitment to the community mental health center and adjust behaviorally to its expectations.

However, there is a possibility that the paraprofessionals could have personal preferences which differ radically from the organizational expectations. In this case, there would be a large discrepancy between the organizational role of the paraprofessional and the preferred role. The literature review and theory development do not suggest that the paraprofessionals will experience a discrepancy of this nature. This generates the fourth hypothesis:

HYPOTHESIS IV: IT IS PREDICTED THAT RELATIVE TO OTHER WORKERS, THE PARAPROFESSIONALS WILL HAVE A SMALL DISCREPANCY BETWEEN COMMUNITY MENTAL HEALTH ROLE ACTIVISM AND PERSONAL PROFESSIONAL ACTIVISM.
CHAPTER IV
RESEARCH METHODS

Introduction

This chapter explains the methodological aspects of the research in three sections. The first section delineates the sample, selection and method of data collection. The second section contains a description of the questionnaire construction. Following that the operationalization of the hypotheses is specified, and attention is given to the methods used in analyzing the collected data.

Sampling

The data analyzed in this thesis came from a larger study conducted to ascertain the emerging roles of community mental health workers.¹ A sample consisting of 20 community mental health centers was selected to represent the universe of 200 operating centers which existed in 1969.

The logic of the sampling procedure encompassed several factors. The community mental health centers were selected on the basis of six variables. Three of the variables dealt with characteris-

¹A larger part of this section and other sections in this chapter were paraphrased from Chapter III of Emerging Roles of Community Mental Health Workers (Wagenfeld & Robin, 1976).

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tics of the catchment area and three variables were concerned with the organization of the center.

The three variables dealing with the characteristics of the catchment area were: socioeconomic status, the ethnicity, and demographic complexity. The first variable, socioeconomic status, was obtained by utilizing the federal designation of the catchment area as either "poverty" or "nonpoverty" on the basis of the proportion of families living at or below a specified level of income (Federal Register, 1971).

Ethnicity, the second variable, was characterized by the percent white population. The centers were classified as having 0-39 percent, 40-79 percent, or 80-100 percent white population in their catchment areas.

The demographic complexity is the final variable used in identifying the characteristics of the catchment area. Demographic complexity refers to the nature and location of the populations living in the catchment areas. Each center in the universe of community mental health centers was identified as either inner city, urban, rural, urban-mixed, or rural-mixed. All rural catchment areas were identified by the Mental Health Center Directory issued by the Community Mental Health Center Support Branch (NIMH, 1973). Inner city and urban designations of catchment areas were also derived from Community Mental Health Center Support Branch data.
The urban-mixed and rural-mixed distinctions were made for those catchment areas which contained a variety of types of communities; if an urban area was involved the designation was urban-mixed, a catchment area without an urban area was designated as rural-mixed.

The three variables involving organizational characteristics of the centers were auspices, organizational complexity, and accountability. The auspices of the community mental health centers were defined as the applicant for the grant establishing the center. Using data from the Community Mental Health Center Support Branch, four types of auspices were identified: Public/Governmental; Agency/Board; University; and Hospital.

The organizational complexity was a variable which classified the center according to its number of components. A component refers to single agency. Basically the concern is whether the worker is from a single-agency or multiple-agency program. Data from the Community Mental Health Support Branch involving the number of components was used. The centers were classified as being a single agency center, a center comprised of two or three components, a center of four to six components, or a center consisting of seven or more components.

The final variable, accountability, refers to the location of the locus of responsibility to which the center is responsible. Each center was designated as local, distant, or mixed regarding locus of
accountability. The information regarding the locus of accountability was furnished by Socio-Technical Systems Associates and Community Change Inc.

A model was created based on the intersect of the variables to represent all the variables describing the catchment area and organizational characteristics. All variables were completely represented in the selection of centers. However, all possible intersects of the six variables were not found because some combinations of variables do not occur in the population (for example, 40-79% white, urban-mixed, poverty).

In summary, the universe of community mental health centers was categorized on the basis of six model variables. These six variables: socioeconomic status, ethnicity, demographic complexity, auspices, organizational complexity, and accountability were then used to distinguish the centers and to designate a representative sample. Twenty community mental health centers were selected which represent these major catchment area and organizational characteristics. In addition, the 20 centers also represent all geographic areas of the United States and are located in 16 states.

Questionnaire Distribution and Collection

A typology of community mental health centers was developed using two major elements: the various demographic and socioeconomic characteristics of the catchment area and the organization of the center.
After the desired characteristics of the centers were identified, several centers with each set of desired characteristics were chosen randomly from the population of functioning centers.

After a series of adjustments based on contingencies such as recent reorganization and director refusal to cooperate, the sample of 20 centers was selected. During the process of selection six centers were eliminated. In no cases were all the centers with a desired set of characteristics unavailable. Also the two centers whose directors did not wish to cooperate were replaced randomly with centers from the same category.

Each center director was contacted for permission to conduct the study, and then consented to an interview. A letter was sent to each staff member explaining the nature of the research. The letter also asked for the worker's cooperation and notified him/her that a questionnaire would be distributed in about a week.

After the director was interviewed, packets were distributed to the workers. Each packet contained a cover letter, questionnaire, a response reporting postcard, and a self-addressed stamped envelope. The completed questionnaires and response cards were mailed directly to the researchers.

The method developed by Glock and Stark (1966) indicated which workers had not returned questionnaires yet still maintained anonymity of the respondents. A process developed by Robin (1965) involving a series of five pre- and follow-up letters, was imple-
mented to encourage the nonrespondents. The results of these efforts are shown in Table 4.1. It is seen that 889 (55.8%) community mental health workers responded to the survey. While 62.1 percent of the professional workers responded to the survey, the return rate of the paraprofessionals was 39.6 percent.

TABLE 4.1. --Number and percent of paraprofessional and professional workers responding to questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Professional</th>
<th>Paraprofessional</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>All Center Staff</td>
<td>1,139</td>
<td>71.3</td>
<td>457</td>
</tr>
<tr>
<td>Respondents</td>
<td>708</td>
<td>62.1</td>
<td>181</td>
</tr>
</tbody>
</table>

Measurement of Variables

The Baker-Schulberg Community Mental Health Ideology Scale (Baker & Schulberg, 1967) was used to measure the endorsement of community mental health ideology. The Ideology Scale consists of 38 items which are scored on a seven point Likert Scale. The scale scores ranged from a low of 38 to a maximum possible of 266. High scores represent a strong adherence to community mental health ideology.

The Community Mental Health Ideology Scale tapped five dimensions. They are: Population Focus, defined as "The mental health specialist should be responsible not only for the patient in contact but also for the entire population of the community"; Primary
Prevention, "The rate of mental disorder can be lowered by counteracting harmful forces"; Social Treatment Goals, "The primary aim of treatment is not to reconstruct the personality but rather to help the patient achieve social adjustment"; Comprehensive Continuity of Care, "There should be a continuity in professional responsibility to provide an integrated network of care-giving services"; and Total Community Involvement, "Mental Health Specialists can extend their effectiveness by working with and through other people (Baker & Schulberg, 1967)."

Baker and Schulberg have reported that the scale has a corrected split-half reliability of 0.95 and a test-retest reliability of 0.92. The scale has been used successfully in prior research (e.g., Langston, 1970; Poovathumkal, 1973; Wagenfeld, et al., 1974; and Robin & Wagenfeld, 1975) and appears to be ideal for the present investigation.

The Community Mental Health Worker Role Inventory (CMHWRI) was developed to approximate the behavioral level of the worker as closely as possible. The CMHWRI consists of a series of 18 highly specific vignettes. Each vignette represented a community situation which a worker might encounter. Nine areas of community life were represented: economic, political, police, family, medical, welfare, school, community (organizational) and housing. Each vignette had five possible responses. The first response was an
"exclusion" response which stated that the worker would not become involved in the issue because it was not within the realm of the worker's role. The four remaining responses ranged from 2 (least activist) to 5 (most activist). The sum of the scores over 18 vignettes comprised the activism score.

The potential range of the scale was 18 to 90. Similar to the Baker-Schulberg Scale, the CMHRI acquired the most meaning when the scores of one group are compared with the scores of another group or groups. The CMHWRI has been used to reveal significant differences between several professional groups (Robin & Wagenfeld, 1975a).

Community Mental Health Worker Role Activism

The CMHWRI is a valuable instrument because it has several dimensions. As mentioned previously, it was designed to measure the role behavior of the workers as closely as possible. Therefore, the worker was asked to respond twice to each vignette. First, the worker was asked to respond from the perspective that he/she thought the community mental health center would expect him/her to behave (CMHC expectations). In addition, the worker was asked to respond to the vignette in the manner which he/she felt was most appropriate (personal-professional expectations).

This resulted in two views of the worker's role. The first view measures the degree of community mental health role activism...
because the worker responded to the role choices in a manner which was felt by him/her to be expected by the center. The second view was quite different and provided different insight into the worker's role.

The measurement of personal-professional role activism was explained above. The advantage of having the worker respond twice to each vignette is quite clear. In contrast to a single response, there is no confusion as to whether the worker is responding to what he/she personally feels about the proper role or if he/she is responding according to the expectations of the center. It is also possible to ascertain if a discrepancy exists between the degree of role activism the worker feels compelled to act by the center's expectations and the degree of activism he/she is most comfortable in manifesting.

The last consideration leads to another measure, the role discrepancy score.

The role discrepancy score highlights the differences between the community mental health center role activism score and the personal-professional activism score. The discrepancy score was computed by subtracting the personal-professional activism score from the community mental health center activism score for each respondent. Scores could range from -4 to +4.
Operational Specification and Hypotheses Testing

Paraprofessional

It was indicated in the review of the literature that confusion underlies both the definition and function of the paraprofessional worker. The definition of the paraprofessional has been varied. The Joint Commission on Mental Illness and Health suggested that workers already quasi-involved in mental health could be used as paraprofessionals. Pearl and Riessman, on the other hand, designated the indigenous poor of the catchment area as ideal candidates for the paraprofessional possession. Yet Gottesfeld, et al. found a type of paraprofessionals consisting of a cadre of recent college graduates.

The various functions attributed to the paraprofessionals have been described with remarkable versatility. They have been credited with providing many diverse services including socio-therapy, orderly duties, interpreting, counseling, representing the community, and performing outreach and community service technician duties.

With these diverse contingencies to adjudicate, the operationalization of the paraprofessional was a considerably meticulous process. The procedure involved three stages. First, rosters were obtained from each community mental health center in the sample. This roster specified the individual staff members in each center, along with his/her specific title and job function. Next, each center was contacted to determine which job title referred to a paraprofessional.
The final stage involved a classification of the paraprofessional on the questionnaire based on job title and self-reporting of worker affiliation. In other words, the paraprofessional was asked to designate his worker affiliation, and this was cross validated by asking the "title of your position at CMHC" and "highest degree earned" as ancillary data.

Cooptation and Activism

The concept of cooptation has been defined as the process by which the paraprofessional comes to absorb the goals, values, and expectations of the community mental health center. Activism, as a concept, has been defined as the willingness of the paraprofessional to violate the expectations of the community mental health center so that the needs of the community or client can be served.

These concepts have thus been defined in a fashion that suggests that if one phenomenon occurs, it is highly likely that the other will not. The Baker-Schulberg Scale measures the degree of ideological adherence to the goals of community mental health. Since an ideology is a function of attitudes and beliefs, the Baker-Schulberg Scale is an instrument which can be used to measure the attitudes of paraprofessionals toward mental health.

On the other hand, the CMHWRI measures the role performance of the paraprofessionals. The role behavior can be measured in both the "real" sense (community mental health center role activism) and
the "ideal" sense (personal-professional role activism). In summary, the Baker-Schulberg Scale measures the beliefs of the paraprofessional, while the role activism scale more accurately approximates the behavior of the paraprofessional.

The Baker-Schulberg Ideology Scale measures the beliefs the paraprofessionals have concerning community mental health; therefore, the ideological beliefs of the paraprofessionals will be compared with the ideological beliefs of the other workers. The CMHWRI is a measure of role behavior. Again, in order to understand the meaning of the paraprofessional's score, it will be compared with the score of the other workers.

Paraprofessional activism is an attitude and set of behaviors which can only be defined in terms of comparing the beliefs and behavior of the paraprofessional with the beliefs and behavior of the professional worker. Therefore, activism is a term which assumes significance if the paraprofessionals score higher than other workers in the areas of ideological beliefs and role activism.

Cooptation will be viewed as the opposite side of the same coin. This concept, as a property of the paraprofessional, will also be considered to assume meaning when compared with the other workers. It is proposed then that these two concepts are mutually exclusive and will not appear in the presence of each other.
Hypothesis Testing

This section specifies the method implemented to test each hypothesis.

**Hypothesis I:** The paraprofessionals will display a community mental health ideology equal to or lower than other workers in the community mental health center.

The Baker-Schulberg scale was used to measure this variable. The mean score of the paraprofessional on this scale is obtained and compared with the mean scores of other workers.

The data are analyzed using t-tests between the paraprofessionals and eight other groups of professional workers. A one-way analysis of variance is also used to compare two groups: the paraprofessionals juxtaposed with the professional workers as a whole. The level of significance is set at .05 for both procedures.

**Hypothesis II:** Relative to other workers, the paraprofessionals will not view problems and controversies within the community as proper areas of concern.

This variable is tested using the community mental health role activism portion of the CMHWRI. The procedure of comparing the paraprofessionals with the professionals is conducted in the same manner as Hypothesis I. Identical statistical tests, the t-test and one-
way analysis of variance are also used. The level of significance is set at .05.

**Hypothesis III:** Relative to other workers, the paraprofessionals will exclude themselves to a greater degree in community mental health role activism.

The community mental health role exclusion score is also derived from the CMHWRI. As in the previous hypotheses, the paraprofessionals will be compared with the professional workers. The level of significance for the t test and one-way analysis of variance is set at .05.

**Hypothesis IV:** Relative to other workers, the discrepancy of the paraprofessional between community mental health activism and personal-professional activism will be small.

Again, the scores of the professional workers will be used as the anchor on which to ground the scores of the paraprofessional. In this case the differences between the community mental health role activism score and personal-professional activism score will constitute the discrepancy score.

The discrepancy score of the paraprofessional will be compared with the discrepancy score of the professional workers. A one-way analysis of variance is conducted to ascertain any differences
between the two groups. Then the professionals will be broken into eight specific groups and a t-test against the paraprofessionals is run on each of the eight groups.
CHAPTER V
FINDINGS

Introduction

A descriptive profile of the paraprofessionals reveals interesting and some unexpected results. However, a pressing methodological question prevents immediate inspection of the profile. Although 181 paraprofessionals returned useable questionnaires measuring the degree of ideological endorsement, only 95 of the returned questionnaires were complete.¹

The completed returns (N=95) constitute a biased subset when compared to the total (N=181). Therefore a comparison of the complete 95 returns with the uncompleted 85 returns was required. Consequently a Chi-square analysis of six variables—sex, age, educational degree, socioeconomic status of the catchment area, geographic complexity, and percent white of the catchment area—was conducted to compare the completed returns with the uncompleted returns. These six variables characterize salient areas of

¹The Baker-Schulberg CMHI Scale was completed by all 181 respondents. Of the 181, 86 did not have a completed Community Mental Health Worker Role Inventory (CMHWRI). A research decision was made to eliminate the 86 incomplete returns because they were less useful in terms of measuring role activism. However, the CMHI scale of the 86 has total integrity and can be used heuristically.
concern and were selected for comparison as a result of a research decision.

Table 5.1 indicates a significant difference between the completed and uncompleted returns when the sex of the respondent is considered; males completed proportionately more questionnaires than females. It is seen in Table 5.2 that a significant difference also exists when age is used as the variable of comparison, the younger paraprofessionals were more likely to return useable surveys than the older paraprofessionals. Table 5.3 shows another significant difference. This time the variable is the educational degree of the paraprofessional. It is indicated in Table 5.4 that when the socioeconomic status of the catchment area is considered, there is a significant difference. Paraprofessional workers in non-poverty catchment areas returned proportionately more useable surveys than those in poverty areas. In Table 5.6, a significant difference is again found. This time the variable considered is the geographic complexity of the catchment area. The final comparison, shown in Table 5.7, demonstrates a significant difference when the percent white of the catchment area is considered.

This series of tables yields significant differences between the paraprofessional returning complete questionnaires and the paraprofessionals returning incomplete questionnaires in every comparison. A finding of this nature definitely suggests that the
subset of 95 completed questionnaires is biased. In order to understand the nature of this bias more thoroughly, a comparison of the ideology scores was performed.

It has been indicated that the study of ideologies is an important area of concern because it furnishes an index of belief systems that guide behavior (Wagenfeld & Robin, 1975). Therefore this variable can be considered crucial in terms of comparing the completed returns with the non-completed returns of the paraprofessionals.

Table 5.8 shows the results of comparing the CMHI of the completed returns (N=95) and the uncompleted returns (N=86). It will be recalled that high scores indicate a strong adherence to community mental health ideology. Interestingly, the ideological endorsement is significantly higher among the completed returns than the uncompleted returns.

The results of the comparison between the 86 incomplete returns and the 95 used in this research can be summarized in the following manner. Characteristics of the paraprofessionals: sex, age, and educational degree were examined. In all cases, there are significant differences between the incomplete returns and the complete returns. Males are represented more than females, and the younger paraprofessionals were more likely to return completed questionnaires. A strong relationship also exists between the educational level of the paraprofessional and the inclination to complete
the survey.

TABLE 5.1. Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: sex

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>47</td>
<td>48</td>
<td>95</td>
</tr>
<tr>
<td>Column %</td>
<td>66.2</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Row %</td>
<td>49.47</td>
<td>50.53</td>
<td></td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>24</td>
<td>61</td>
<td>85*</td>
</tr>
<tr>
<td>Column %</td>
<td>33.8</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Row %</td>
<td>27.91</td>
<td>70.93</td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>71</td>
<td>109</td>
<td>181</td>
</tr>
</tbody>
</table>

\[X^2 = 9.56\] \[P = .008\] \[1 \text{ DF}\]

*The total is 85 because of a nonresponse

TABLE 5.2. --Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: age

<table>
<thead>
<tr>
<th></th>
<th>25</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>36</td>
<td>37</td>
<td>10</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Column %</td>
<td>72</td>
<td>58</td>
<td>34.4</td>
<td>34.6</td>
<td>25</td>
</tr>
<tr>
<td>Row %</td>
<td>37.89</td>
<td>38.95</td>
<td>10.53</td>
<td>9.47</td>
<td>3.16</td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>14</td>
<td>27</td>
<td>19</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Column %</td>
<td>28</td>
<td>42</td>
<td>65.6</td>
<td>65.4</td>
<td>75</td>
</tr>
<tr>
<td>Row %</td>
<td>16.28</td>
<td>31.40</td>
<td>22.09</td>
<td>19.77</td>
<td>10.40</td>
</tr>
<tr>
<td>Total N</td>
<td>50</td>
<td>64</td>
<td>29</td>
<td>26</td>
<td>12</td>
</tr>
</tbody>
</table>

\[X^2 = 19.09\] \[P = .0007\] \[4 \text{ DF}\]

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TABLE 5.3. --Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: educational degree

<table>
<thead>
<tr>
<th></th>
<th>BA</th>
<th>AA</th>
<th>High School or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>18</td>
<td>48</td>
<td>29</td>
</tr>
<tr>
<td>Column %</td>
<td>39</td>
<td>77.4</td>
<td>39.7</td>
</tr>
<tr>
<td>Row %</td>
<td>18.94</td>
<td>50.43</td>
<td>29.11</td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>28</td>
<td>14</td>
<td>44</td>
</tr>
<tr>
<td>Column %</td>
<td>61</td>
<td>22.6</td>
<td>60.2</td>
</tr>
<tr>
<td>Row %</td>
<td>32.56</td>
<td>16.28</td>
<td>50.49</td>
</tr>
<tr>
<td>Total N</td>
<td>46</td>
<td>62</td>
<td>73</td>
</tr>
</tbody>
</table>

\[X^2 = 22.35\] \[P < .001\] \[3 \text{ DF}\]

TABLE 5.4. --Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: poverty

<table>
<thead>
<tr>
<th></th>
<th>Poverty</th>
<th>Non-poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>Column %</td>
<td>45.2</td>
<td>62.6</td>
</tr>
<tr>
<td>Row %</td>
<td>50.53</td>
<td>49.47</td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>58</td>
<td>28</td>
</tr>
<tr>
<td>Column %</td>
<td>54.8</td>
<td>37.4</td>
</tr>
<tr>
<td>Row %</td>
<td>67.44</td>
<td>32.56</td>
</tr>
<tr>
<td>Total N</td>
<td>106</td>
<td>75</td>
</tr>
</tbody>
</table>

\[X^2 = 5.32\] \[P = 0.02\] \[1 \text{ DF}\]

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### TABLE 5.5. --Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: geographical complexity

<table>
<thead>
<tr>
<th></th>
<th>Inner City</th>
<th>Urban</th>
<th>Rural</th>
<th>Metro Mixed</th>
<th>Rural Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>32</td>
<td>8</td>
<td>8</td>
<td>34</td>
<td>13</td>
</tr>
<tr>
<td>Column %</td>
<td>42.1</td>
<td>53.3</td>
<td>80</td>
<td>64.1</td>
<td>48.1</td>
</tr>
<tr>
<td>Row %</td>
<td>33.68</td>
<td>8.42</td>
<td>8.42</td>
<td>35.79</td>
<td>13.68</td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>44</td>
<td>7</td>
<td>2</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Column %</td>
<td>57.9</td>
<td>46.7</td>
<td>20</td>
<td>35.9</td>
<td>51.9</td>
</tr>
<tr>
<td>Row %</td>
<td>51.16</td>
<td>8.14</td>
<td>2.33</td>
<td>22.09</td>
<td>16.28</td>
</tr>
<tr>
<td>Total N</td>
<td>76</td>
<td>15</td>
<td>10</td>
<td>53</td>
<td>27</td>
</tr>
<tr>
<td>$X^2 = 9.412$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$P = 0.051$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4 \text{ DF}$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 5.6. --Chi-square analysis of completed and noncompleted returns for paraprofessionals on variable: percent white

<table>
<thead>
<tr>
<th></th>
<th>80-100</th>
<th>40-79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed returns (N=95)</td>
<td>36</td>
<td>59</td>
</tr>
<tr>
<td>Column %</td>
<td>70.5</td>
<td>45.3</td>
</tr>
<tr>
<td>Row %</td>
<td>37.89</td>
<td>62.11</td>
</tr>
<tr>
<td>Uncompleted returns (N=86)</td>
<td>15</td>
<td>71</td>
</tr>
<tr>
<td>Column %</td>
<td>29.5</td>
<td>54.7</td>
</tr>
<tr>
<td>Row %</td>
<td>17.44</td>
<td>82.56</td>
</tr>
<tr>
<td>Total N</td>
<td>51</td>
<td>130</td>
</tr>
<tr>
<td>$X^2 = 9.33$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$P = 0.00225$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1 \text{ DF}$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 5.7. --t-Test of CMHI scores of completed returns compared against total returns and incomplete returns

<table>
<thead>
<tr>
<th></th>
<th>CMHI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessionals</td>
<td>N</td>
</tr>
<tr>
<td>Incomplete returns</td>
<td>86</td>
</tr>
<tr>
<td>Complete returns</td>
<td>95</td>
</tr>
</tbody>
</table>
Characteristics of the catchment area were also examined--socioeconomic status, geographic complexity, and percent white--and again significant differences in all cases were found. The paraprofessionals in the poverty-designated and inner city areas were not as likely to return useable questionnaires. In addition, the paraprofessional in catchment areas with 80-100 percent white population were more likely to return questionnaires than those in the 40-79 percent white population areas.

As a result of the above comparison, the following caveats are issued. It is cautioned that in the comparison of six variables between the 95 useable questionnaires and 86 unuseable questionnaires, significant differences were found. This establishes that the 95 paraprofessionals used in the following analysis constitute a biased sample.

The integrity of this research could be strongly questioned since the low-educated paraprofessionals working in inner city and poverty areas are not proportionately represented. However, an examination of the CMHI scores indicates that the 95 paraprofessionals used in this research scored significantly higher on ideological endorsement of community mental health than the 86 paraprofessionals who returned uncompleted questionnaires. Since a high ideology score is not in the direction of supporting the hypothesis, it is concluded that the above biases are conservative.
estimates of the results.

Therefore, keeping these cautions in mind, it appears legitimate to proceed with the analysis of the 95 paraprofessionals. Attention can now be turned to a profile of the paraprofessionals in this research.

Profile of the Paraprofessionals

The paraprofessionals in this study are split almost evenly by sex (47 male and 48 female). In addition, over three-quarters (77%) are under 35 years of age and almost two-thirds (61%) have worked in the center for two years or less.

Table 5.8 indicates that over 50 percent of the paraprofessionals have degrees beyond high school. Surprisingly, almost one-half (44%) have at least a baccalaureate degree. These findings seem to undermine partially Minuchin's conviction that paraprofessionals are "... by definition poor, untrained and black" (bearing in mind the biased nature of the subset).

HYPOTHESIS I: THE PARAPROFESSIONALS WILL DISPLAY IDEOLOGY EQUAL TO OR LESS THAN OTHER WORKERS IN THE COMMUNITY MENTAL HEALTH CENTER.

The ideology of the community mental health workers was measured using the Baker-Schulberg Scale (CMHI). Table 5.9 shows a
comparison of scores between the paraprofessionals and all other workers in the sample of community mental health workers. An examination of the table reveals that the paraprofessionals have a significantly lower endorsement of CMHI than the rest of the workers.

TABLE 5.8.--Distribution of paraprofessional's educational degree
(N=95)

<table>
<thead>
<tr>
<th>Degree</th>
<th>Frequency</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. A.</td>
<td>1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>B. A.</td>
<td>41</td>
<td>43.2</td>
<td>44.3</td>
</tr>
<tr>
<td>A. A.</td>
<td>7</td>
<td>7.4</td>
<td>51.7</td>
</tr>
<tr>
<td>LPN</td>
<td>2</td>
<td>2.1</td>
<td>53.8</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>28.4</td>
<td>82.2</td>
</tr>
<tr>
<td>No response</td>
<td>17</td>
<td>17.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

TABLE 5.9.--Comparison of paraprofessionals with all other workers on the Baker-Schulberg Scale (CMHI)

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>207.4</td>
<td>29.20</td>
<td>128-256</td>
</tr>
<tr>
<td>Professional</td>
<td>500</td>
<td>213.4</td>
<td>28.09</td>
<td>83-264</td>
</tr>
</tbody>
</table>

\[ t = 1.84 \; \quad P < .05 \; \quad \text{(one tail)} \]

It appears, then, that the paraprofessionals display an ideology which does not lend itself as strongly to the ideals of the CMHI as does
the ideology displayed by the other workers.

In order to understand the differences between paraprofessionals and other workers fully, the ideology scores were broken down by worker affiliation. Table 5.10 reveals the results of this procedure. The results indicate that as a group, the paraprofessionals rank among the lowest endorsers of community mental health ideology and rank significantly higher than only the psychiatrists. Equally as important, the psychologists, social workers, researchers and administrators, and educators and counselors and "others" endorsed the ideology of community mental health to a significantly higher degree than the paraprofessionals.

HYPOTHESIS II: RELATIVE TO OTHER WORKERS IN THE CENTER, IT IS PREDICTED THAT THE PARAPROFESSIONALS WILL BE LESS ACTIVE IN COMMUNITY MENTAL HEALTH ROLE BEHAVIOR.

The paraprofessionals view of their appropriate role within the center was measured by their responses to the community mental health activism portion of the Community Mental Health Workers Role Inventory (CMHWRI). The 18 vignettes in the CMHWRI depicted situations that a community mental health worker might encounter in areas of community life. The response to the vignettes represents the degree of role activism which the paraprofessional considers
TABLE 5.10. --t-Test of CMHI scores of paraprofessionals against specific worker affiliations*

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>t</th>
<th>P(one tail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>72</td>
<td>194.8</td>
<td>31.1</td>
<td>2.83</td>
<td>.002</td>
</tr>
<tr>
<td>Non-psychiatric M.D.</td>
<td>10</td>
<td>204.5</td>
<td>35.1</td>
<td>0.321</td>
<td>.370</td>
</tr>
<tr>
<td>Rehabilitation workers</td>
<td>35</td>
<td>207.3</td>
<td>26.8</td>
<td>0.129</td>
<td>.445</td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>95</td>
<td>207.4</td>
<td>26.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>96</td>
<td>210.2</td>
<td>28.8</td>
<td>-0.689</td>
<td>.214</td>
</tr>
<tr>
<td>Other**</td>
<td>27</td>
<td>218.6</td>
<td>21.8</td>
<td>-2.01</td>
<td>.020</td>
</tr>
<tr>
<td>Psychologists</td>
<td>96</td>
<td>218.8</td>
<td>23.2</td>
<td>-3.19</td>
<td>.001</td>
</tr>
<tr>
<td>Social Workers</td>
<td>140</td>
<td>220.9</td>
<td>26.4</td>
<td>-3.85</td>
<td>.000</td>
</tr>
<tr>
<td>Education &amp; counseling</td>
<td>24</td>
<td>223.2</td>
<td>20.2</td>
<td>-2.75</td>
<td>.003</td>
</tr>
</tbody>
</table>

*The more conservative Scheffé Test (which tests for the significance of differences between all combinations of means) was not used in this analysis because the comparison is between the paraprofessionals and each specific professional group. Therefore, the t-Test was considered an appropriate statistical device.

**Other includes researchers and administrators

Table 5.11 compares the community mental health activism scores between the paraprofessionals and all other workers. It can be seen that the paraprofessionals have a slightly lower range. However, the mean scores are almost identical to each other. It will be recalled that the potential range of responses for community mental health role activism is from a low of 0 to a high of 90. Although it is
important to note that the difference between the paraprofessionals and other workers is minimal, it is even more significant to point out that the paraprofessional's response to role activism is relatively mild. In fact, the response of the entire center staff to community mental health role activism is less than half as strong as the potential response.

TABLE 5.11.--Comparison of community mental health center activism scores between paraprofessionals and all other workers

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>37.4</td>
<td>10.0</td>
<td>17-65</td>
</tr>
<tr>
<td>Professional</td>
<td>500</td>
<td>37.8</td>
<td>8.7</td>
<td>18-69</td>
</tr>
</tbody>
</table>

\[ t = .363 \quad P > .05 \]

An elaboration of the differences in community mental health role activism between the paraprofessionals and other worker affiliations is presented in Table 5.12. It is notable that there are no significant differences between the paraprofessionals and any other group of workers. This seems to suggest that there is a fairly consistent socializing influence upon the workers in the community mental health centers.
TABLE 5.12. --t-Test of community mental health role activism scores of paraprofessionals against other workers

<table>
<thead>
<tr>
<th>Worker Affiliation</th>
<th>N</th>
<th>( \bar{X} )</th>
<th>SD</th>
<th>t</th>
<th>P(one tail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>140</td>
<td>36.8</td>
<td>8.7</td>
<td>.4927</td>
<td>.311</td>
</tr>
<tr>
<td>Rehabilitation worker</td>
<td>35</td>
<td>37.3</td>
<td>9.7</td>
<td>.0678</td>
<td>.474</td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>95</td>
<td>37.4</td>
<td>9.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>72</td>
<td>37.5</td>
<td>7.8</td>
<td>-.0434</td>
<td>.482</td>
</tr>
<tr>
<td>Psychologists</td>
<td>96</td>
<td>37.8</td>
<td>7.9</td>
<td>-.2841</td>
<td>.388</td>
</tr>
<tr>
<td>Nursing</td>
<td>96</td>
<td>38.0</td>
<td>7.7</td>
<td>-.4661</td>
<td>.312</td>
</tr>
<tr>
<td>Other*</td>
<td>27</td>
<td>39.8</td>
<td>10.4</td>
<td>-1.0810</td>
<td>.191</td>
</tr>
<tr>
<td>Education &amp; counseling</td>
<td>24</td>
<td>40.8</td>
<td>7.3</td>
<td>-1.5780</td>
<td>.058</td>
</tr>
<tr>
<td>Non-psychiatric M. D.</td>
<td>10</td>
<td>41.6</td>
<td>8.6</td>
<td>-1.2790</td>
<td>.102</td>
</tr>
</tbody>
</table>

*Others include researchers and administrators

HYPOTHESIS III: RELATIVE TO OTHER WORKERS, THE PARAPROFESSIONALS WILL EXCLUDE THEMSELVES TO A GREATER DEGREE IN COMMUNITY MENTAL HEALTH CENTER ROLE ACTIVISM.

This variable was measured by the community mental health exclusion scores. Table 5.13 shows no significant difference between the paraprofessionals and other workers.

The community mental health role exclusion score was broken down by worker affiliation. Table 5.14 yields the results of this
procedure. The paraprofessionals' mean score is not significantly
different for seven of the eight disciplinary groups. The only signi-
ficant difference is with the educators and counselors.

TABLE 5.13. --Comparison of community mental health exclusion
score between paraprofessionals and other workers

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>5.43</td>
<td>5.46</td>
<td>0-18</td>
</tr>
<tr>
<td>Professional</td>
<td>500</td>
<td>4.47</td>
<td>4.74</td>
<td>0-18</td>
</tr>
</tbody>
</table>

\[ t = 1.61 \quad P > .05 \quad \text{(one tail)} \]

TABLE 5.14. --t-Test of community mental health exclusion score of
paraprofessionals against other worker affiliations

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>X</th>
<th>SD</th>
<th>t</th>
<th>P(one tail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education &amp; counseling</td>
<td>24</td>
<td>2.88</td>
<td>4.3</td>
<td>2.13</td>
<td>.018</td>
</tr>
<tr>
<td>Non-psychiatric M. D.</td>
<td>10</td>
<td>3.40</td>
<td>2.9</td>
<td>1.15</td>
<td>.125</td>
</tr>
<tr>
<td>Other*</td>
<td>27</td>
<td>4.11</td>
<td>5.1</td>
<td>1.12</td>
<td>.131</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>72</td>
<td>4.26</td>
<td>4.7</td>
<td>1.45</td>
<td>.075</td>
</tr>
<tr>
<td>Nurse</td>
<td>96</td>
<td>4.32</td>
<td>4.7</td>
<td>1.49</td>
<td>.065</td>
</tr>
<tr>
<td>Psychologist</td>
<td>96</td>
<td>4.38</td>
<td>4.5</td>
<td>1.45</td>
<td>.076</td>
</tr>
<tr>
<td>Rehabilitation workers</td>
<td>35</td>
<td>5.00</td>
<td>5.5</td>
<td>.40</td>
<td>.346</td>
</tr>
<tr>
<td>Social worker</td>
<td>140</td>
<td>5.04</td>
<td>4.8</td>
<td>.58</td>
<td>.282</td>
</tr>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>5.43</td>
<td>5.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Others include researchers and administrators
HYPOTHESIS IV: IT IS PREDICTED THAT RELATIVE
TO OTHER WORKERS, THE PARAPRO-
FESSIONALS WILL HAVE A SMALL
DISCREPANCY BETWEEN COMMUNITY
MENTAL HEALTH ROLE ACTIVISM AND
PERSONAL-PROFESSIONAL ROLE
ACTIVISM.

The CMHWRI consisted of two dimensions: the community
mental health center role activism, and the personal-professional
role activism. The former dimension is concerned with the degree
of activism the worker felt expected to manifest as an employee of
the center. On the other hand, the personal-professional role
activism is a measure of the worker's personal and professional
role preference free from organizational constraints.

Table 5.15 compares the paraprofessional personal-profes-
sional activism scores with the scores of the other community
mental health workers. It is indicated that there is no significant
difference between the paraprofessionals and the professional workers.

A further breakdown between the paraprofessionals and other
workers was conducted. Table 5.16 reveals that the psychiatrists
and nurses represented the only worker affiliation which scored
significantly lower than the paraprofessionals.
TABLE 5.15. --Comparison of personal-professional role activism between paraprofessionals and professionals

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>$\bar{X}$</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessionals</td>
<td>95</td>
<td>44.9</td>
<td>9.3</td>
<td>21-65</td>
</tr>
<tr>
<td>Professionals</td>
<td>500</td>
<td>44.1</td>
<td>9.2</td>
<td>18-83</td>
</tr>
</tbody>
</table>

$ t = .769 \quad P > .05 $

TABLE 5.16. --$t$-Test of paraprofessional personal-professional role activism scores against the scores of professional workers

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>$\bar{X}$</th>
<th>SD</th>
<th>$t$</th>
<th>$P$(one tail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>72</td>
<td>40.3</td>
<td>8.5</td>
<td>3.316</td>
<td>.001</td>
</tr>
<tr>
<td>Nurses</td>
<td>96</td>
<td>42.8</td>
<td>8.5</td>
<td>1.681</td>
<td>.047</td>
</tr>
<tr>
<td>Non-psychiatric M.D.</td>
<td>10</td>
<td>43.4</td>
<td>9.1</td>
<td>.502</td>
<td>.305</td>
</tr>
<tr>
<td>Psychologists</td>
<td>96</td>
<td>44.4</td>
<td>8.3</td>
<td>.466</td>
<td>.320</td>
</tr>
<tr>
<td>Rehabilitation workers</td>
<td>35</td>
<td>44.6</td>
<td>10.9</td>
<td>.169</td>
<td>.434</td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>95</td>
<td>44.9</td>
<td>9.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers</td>
<td>140</td>
<td>45.5</td>
<td>9.4</td>
<td>- .414</td>
<td>.339</td>
</tr>
<tr>
<td>Education &amp; counseling</td>
<td>43</td>
<td>47.7</td>
<td>8.0</td>
<td>-1.317</td>
<td>.095</td>
</tr>
<tr>
<td>Other*</td>
<td>27</td>
<td>48.5</td>
<td>10.4</td>
<td>-1.703</td>
<td>.045</td>
</tr>
</tbody>
</table>

*Others include researchers and administrators

The preliminary analysis of the personal-professional role activism score of the workers has provided the foundation to examine the discrepancy between the preferred role enactment and the degree of activism under organizational constraints.
A comparison of the discrepancy scores between the paraprofessionals and other workers is shown in Table 5.17. It is seen that there is no significant difference between the paraprofessionals and other workers. These results were not anticipated.

**Table 5.17. Comparison of paraprofessionals' discrepancy scores with the discrepancy scores of other workers**

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>N</th>
<th>$\overline{X}$</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>-3.62</td>
<td>5.08</td>
</tr>
<tr>
<td>Professional</td>
<td>500</td>
<td>-2.87</td>
<td>4.91</td>
</tr>
</tbody>
</table>

$t = 1.32 \quad P > .05$

Table 5.18 provides a further analysis of the discrepancy scores. It is clearly seen that the paraprofessionals do not have a low discrepancy score when compared with the other workers. Unexpectedly, the paraprofessional had a significantly higher discrepancy score than several professional affiliations.

The final hypothesis has not been supported. The role discrepancy score yields valuable information about, and is a strategic indicator for, the polemical question concerning cooptation and activism. With this in mind, a supplementary analysis was conducted to understand the role discrepancy scores more thoroughly.

The theoretical development leading to Hypothesis IV assumed that the discrepancy score of the paraprofessionals would be smaller than the discrepancy score of the professional worker. Closely
related is the assumption that the discrepancy score of the paraprofessional diminishes as the time in the center increases. The amount of time spent at the center is also a crucial factor in understanding the nature of organizational role activism and preferred role activism.

### TABLE 5.18. -\textit{t}-Test of activism discrepancy between paraprofessionals and other worker affiliations

<table>
<thead>
<tr>
<th>Professional Affiliation</th>
<th>N</th>
<th>Activism Mean (X)</th>
<th>Discrepancy SD</th>
<th>t</th>
<th>P(one tail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-psychiatric M. D.</td>
<td>10</td>
<td>-0.60</td>
<td>1.43</td>
<td>-1.8640</td>
<td>.032</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>72</td>
<td>-1.11</td>
<td>3.00</td>
<td>-3.7230</td>
<td>.001</td>
</tr>
<tr>
<td>Nurse</td>
<td>96</td>
<td>-2.10</td>
<td>3.98</td>
<td>-2.2900</td>
<td>.011</td>
</tr>
<tr>
<td>Educator &amp; counselor</td>
<td>24</td>
<td>-2.96</td>
<td>5.30</td>
<td>-0.5650</td>
<td>.221</td>
</tr>
<tr>
<td>Psychologist</td>
<td>96</td>
<td>-3.09</td>
<td>4.33</td>
<td>-0.7720</td>
<td>.220</td>
</tr>
<tr>
<td>Rehabilitation worker</td>
<td>35</td>
<td>-3.51</td>
<td>6.28</td>
<td>-0.0994</td>
<td>.461</td>
</tr>
<tr>
<td>Paraprofessional</td>
<td>95</td>
<td>-3.62</td>
<td>5.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>-3.93</td>
<td>5.19</td>
<td>0.2730</td>
<td>.341</td>
</tr>
<tr>
<td>Social worker</td>
<td>140</td>
<td>-3.95</td>
<td>5.92</td>
<td>0.4420</td>
<td>.324</td>
</tr>
</tbody>
</table>

Given the nature of the previous findings, it appears that the amount of time at the center must be examined in order to determine the processes involved in the mechanisms of adjustment of the paraprofessional. Table 5.19 shows an analysis of variance between the discrepancy scores and time at center for both the professionals and paraprofessionals.
TABLE 5.19. --Analysis of variance between discrepancy score and time at center for professional workers and paraprofessionals

<table>
<thead>
<tr>
<th>Discrepancy Score</th>
<th>1 year or less</th>
<th>2-4 years</th>
<th>5 years or more</th>
<th>Total</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>N 162 238 100 500</td>
<td>9.57 &gt; .05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( \bar{X} ) -4.1 -2.6 -1.5 -2.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>N 40 42 13 95</td>
<td>0.28 &lt; .05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( \bar{X} ) -3.2 -3.9 -4.2 -3.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results indicate that time at the center has no statistically significant influence on role discrepancy for the paraprofessionals. However, time does have a significant affect on the discrepancy score of the professional worker. It appears that the longer the professional worker is employed at the community mental health center, the more congruent his/her community mental health center role activism and personal-professional role activism have become.

The analysis was expanded by examining the difference in discrepancy scores between the paraprofessionals and professionals holding constant time at the center. Table 5.20 indicates that the paraprofessionals who have worked in the center for one year or less have a significantly lower discrepancy score than the professionals, while the paraprofessionals at the CMHC from two to four years and 5 years and more have a significantly higher discrepancy score than the professional workers.
TABLE 5.20. - Test between professionals and paraprofessionals discrepancy scores and time at center

<table>
<thead>
<tr>
<th>Time at Center</th>
<th>Discrepancy Score</th>
<th>Time at Center</th>
<th>Discrepancy Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professionals</td>
<td>Paraprofessionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
</tr>
<tr>
<td>1 year or less</td>
<td>-4.1</td>
<td>5.5</td>
<td>-3.2</td>
</tr>
<tr>
<td>2 - 4 years</td>
<td>-2.6</td>
<td>4.8</td>
<td>-3.9</td>
</tr>
<tr>
<td>5 years or more</td>
<td>-1.5</td>
<td>3.6</td>
<td>-4.2</td>
</tr>
</tbody>
</table>

Two competing explanations for the occurrence of this phenomena are (1) the paraprofessionals are not becoming less discrepant as the time in the center increases or, (2) the greater discrepancy for the paraprofessionals who have been at the center longer reflect differential hiring practices. A look at the constituents of the discrepancy score (the organization role activism and preferred role activism) will shed light on this matter.

Table 5.21 shows an analysis of variance between organizational role activism and time at the center for both the professionals and paraprofessionals. The results show that time at the center does not have an influence on the organization role activism for the paraprofessionals. However, the level of organizational role activism increases significantly with time for the professionals.

Table 5.22 shows an analysis of variance between preferred role activism and time at the center for both the professionals and paraprofessionals. The results show that the level of preferred role
activism of the professionals significantly decreases with the length of time at the center. The time at the center does not have an influence on the preferred role activism for the paraprofessional.

TABLE 5.21.--Analysis of variance between organizational role activism score and time at center for professional workers and paraprofessional

<table>
<thead>
<tr>
<th>Mean CMHA Score</th>
<th>1 year or less</th>
<th>2 - 4 years</th>
<th>5 years or more</th>
<th>Total</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>N 162</td>
<td>238</td>
<td>100</td>
<td>500</td>
<td>3.15</td>
<td>&lt;.05</td>
</tr>
<tr>
<td></td>
<td>X 37.5</td>
<td>37.2</td>
<td>39.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>N 40</td>
<td>42</td>
<td>13</td>
<td>95</td>
<td>1.67</td>
<td>&gt;.05</td>
</tr>
<tr>
<td></td>
<td>X 39.3</td>
<td>35.4</td>
<td>38.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 5.22.--Analysis of variance between personal-professional role activism score and time at center for professional workers and paraprofessionals

<table>
<thead>
<tr>
<th>Mean Personal-Professional Score</th>
<th>1 year or less</th>
<th>2 - 4 years</th>
<th>5 years or more</th>
<th>Total</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>N 162</td>
<td>238</td>
<td>100</td>
<td>500</td>
<td>5.29</td>
<td>&lt;.006</td>
</tr>
<tr>
<td></td>
<td>X 46.1</td>
<td>43.2</td>
<td>43.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paraprofessionals</td>
<td>N 40</td>
<td>42</td>
<td>13</td>
<td>95</td>
<td>1.25</td>
<td>&gt;.05</td>
</tr>
<tr>
<td></td>
<td>X 46.3</td>
<td>43.3</td>
<td>46.4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results of Tables 5.21 and 5.22 show that the levels of organizational role activism and preferred role activism for the para-
professionals do not change over time. These findings suggest why
the discrepancy scores of the paraprofessionals do not change over
time. On the other hand, the organizational role activism of the
professionals increases over time while their preferred role activism
decreases. This pattern explains the significant decrease in the role
discrepancy scores of the professionals.

It is apparent that the length of time at the center is not a factor
in the organizational and preferred role activism scores and role dis-
crepancy score of the paraprofessionals. These findings have strong
implications regarding the process of cooptation and will be discussed
in Chapter VI.

The level of endorsement of community mental health ideology
has also been considered an indicator of cooptation. Since the para-
professionals scored significantly lower than the professionals in
endorsement of community mental health ideology, an analysis of
the variable over time is important.

Table 5.23 shows an analysis of variance between community
mental health ideology and time at the center for both professionals
and paraprofessionals. The results show that time at the center does
not have an influence on the ideology scores of the professionals or
paraprofessionals. These implications will be discussed in Chapter
VI.
TABLE 5.23.--Analysis of variance between community mental health ideology and time at center for professional workers and paraprofessionals

<table>
<thead>
<tr>
<th>Mean CMHI Score</th>
<th>1 year or less</th>
<th>2 - 4 years</th>
<th>5 years or more</th>
<th>Total</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals N</td>
<td>162</td>
<td>238</td>
<td>100</td>
<td>500</td>
<td>.372</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>X</td>
<td>212.4</td>
<td>213.2</td>
<td>215.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals N</td>
<td>40</td>
<td>42</td>
<td>13</td>
<td>95</td>
<td>1.03</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>X</td>
<td>213.5</td>
<td>202</td>
<td>206.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The analysis of the data in this chapter was guided by four hypotheses.

Hypothesis I, the paraprofessionals will display a community mental health ideology equal to or lower than other workers in the community mental health center, seems to be firmly supported. The ideological adherence of the paraprofessional was measured and compared with other workers because it constitutes an index of the belief systems which the paraprofessionals hold as members of the community mental health center. The paraprofessionals had an ideological adherence to community mental health of 207.4 which was significantly below the score of 213.4 for the other workers.

Compared to the potential range of 83 to 264, the scores indicate that the paraprofessionals endorse the ideology of community mental health fairly strongly. However, even more important, the...
paraprofessionals do not endorse the ideology as strongly as the other workers, and they do not endorse it to the maximum extent. It can be concluded that although the ideological commitment of the paraprofessionals to community mental health is high, it is not as high as the ideological commitment of the workers as a whole. Therefore, in terms of ideology, the evidence suggests that the paraprofessionals do not hold beliefs about community mental health which are stronger than the beliefs of the center as a whole.

Hypothesis II, relative to other workers, the paraprofessionals will not view problems and controversies within the community as proper area of concern, was not supported. The organizational role activism scale appears to be a straightforward measure of what the paraprofessional actually considers his role in the center. It will be recalled that the potential range of responses for organizational role activism is 0 to 90. The paraprofessionals' response of 37.4 to organizational role activism appears to be relatively mild. The implications of this score will be discussed shortly.

Hypothesis III, relative to other workers, the paraprofessionals will exclude themselves to a greater degree in community mental health role activism, was also unsupported. The organizational role exclusion score indicates the degree to which the worker excludes himself from controversial issues. The range is from 0 to 18. The paraprofessionals' score of 5.43 is not significantly different from the
Hypothesis IV, relative to other workers the discrepancy of the paraprofessional between community mental health role activism and personal professional role activism will be small, also remained unsupported. There is no significant difference between the discrepancy scores of the paraprofessionals and the aggregate of other workers. However, the paraprofessionals did have significantly higher discrepancy scores than several professional affiliation categories.

The motivating assumption of these hypotheses was that the paraprofessionals have adapted the values and goals of the community mental health center. Since the concept of cooptation implies a time development, the organizational and preferred role activism scores, role discrepancy score, and ideological endorsement were analyzed according to the length of time at the center. This procedure revealed that the paraprofessional workers did not change over time in terms of both organization and preferred role activism scores, the discrepancy score, and ideological endorsement of community mental health.

Chapter VI will deal with an interpretation of these findings, their theoretical significance, and the implications for further research.
CHAPTER VI

INTERPRETATIONS AND IMPLICATIONS

Most statements regarding paraprofessionals have been made largely on impressionistic and speculative levels. We are restricted to knowing how it is thought that the paraprofessionals have conducted themselves in the community mental health center. This investigation has provided empirical evidence concerning the beliefs and behavior of paraprofessionals working in community mental health centers.

In the initial chapter the history of the contemporary mental health movement was carefully traced to understand how the community mental health center grew to accommodate the paraprofessional worker within its ranks. A confluence of several historical exigencies have been identified as crucial variables in this process. First, a need was defined in terms of a mental health manpower shortage. Next, the paraprofessional worker was identified as a possible solution to this shortage. And finally, the advent of community action programs (CAP) and the community mental health center (CMHC) secured the notion of involving paraprofessionals as mental health workers.

The impetus to conduct this research was precipitated by contradictory views in the literature regarding paraprofessionals. In Chapter II it was pointed out that a controversy existed regarding
the issue of whether the paraprofessional workers have been coopted or if they are activists. The research reported here examines this issue. The controversy has remained, heretofore, as an unconfirmed polemic.

In the course of reviewing the literature and closely examining the issues, it became clear that the phenomenon of cooptation seemed to characterize the paraprofessionals rather than activism. To refine the distinction between these two concepts, it was assumed that the paraprofessionals would either be coopted or activated, and that activism and cooptation would not simultaneously exist in the behavioral repertoire of the paraprofessionals. It also became clear that paraprofessional activism and cooptation could only be measured in terms of their relation to other workers in the center.

Four hypotheses were formulated which predicted that the paraprofessionals have been coopted in the sense that they embrace the goals and values of the community mental health center. Although only one hypothesis has been supported, the results of the investigation have still provided clear data regarding the ideological and behavioral position of the paraprofessional in the community mental health center.

Robin and Wagenfeld (1975) have found that the ideology of the community mental health worker is significantly correlated with his actual role performance. Following this line of reasoning, the
paraprofessionals have been examined on several dimensions to ascertain the nature and consistency of their beliefs and behavior. When compared with the professionals on the Baker-Schulberg Scale (CMHI), the paraprofessionals endorse the ideology of community mental health to a significantly lower degree. The adoption of a low CMHI by the paraprofessionals suggests that they have conservative beliefs concerning community mental health ideology.

Noting that the CMHI serves as a guide for behavior (Wagenfeld & Robin, 1975), the next step was to see if the paraprofessionals are as conservative in community mental health role activism and exclusion as they are in ideology. The two hypotheses which separately tested these factors were not supported. However they provide conspicuous information by demonstrating that the paraprofessionals are not statistically different from the professional workers as a whole regarding organizational activism and exclusion. This suggests that in terms of activism, the "explosive realities" to which Willcox (1970) referred do not appear to be embraced by the paraprofessionals in this research. It can be assumed that if the paraprofessionals were willing to disregard the expectations of the center for the sake of the client or community, they would have demonstrated a much higher score on the organizational role activism and role exclusion scales. As it stands, the paraprofessional responses to organizational activism and exclusion are not remarkable in terms of being
different from the other workers.

The conclusion to be drawn from the first three hypotheses points strongly in the position of rejecting the concept of activism, and leaning more favorably toward accepting the notion of cooptation. These findings support the contention that the paraprofessionals, as community mental health workers, can be considered coopted in terms of ideology and organizational role behavior. However, there is a strong need to understand the nature and extent of this phenomenon.

The role conflict resolution strategies delineated in Chapter III suggest that adaptation to role conflict is a mechanism of adjustment to the expectations of competing audiences. The evidence from the first three hypotheses clearly indicate that the paraprofessionals are either more conservative or no different from the professional workers when the CMHI and organizational behavior are considered. This suggests strongly that the paraprofessionals have adjusted to the expectation of the community mental health center rather than to the expectations of the community and clients. However, the conflict resolution strategies of Sarbin and Allen (1968) and Gross, et al. (1958), do not maintain that the adaption to the expectations placed on a particular role position must be total or absolute. On the contrary, there can be bargains and compromises in the process of adjusting to the expectations on the position of paraprofessional. The final hypothesis, which measured the role discrepancy score of
the paraprofessionals, represented an attempt to ascertain the nature
of their resolution strategies and the consequent mechanisms of
adjustment. The findings revealed that the paraprofessionals are not
significantly different from the professional workers. This suggests,
in part, that the paraprofessionals are not torn with conflict between
their preferred role behavior and actual behavioral manifestations.
There is no evidence to conclude, then, that the paraprofessionals
experience more difficulty adjusting to organizational role expecta-
tions than the professional community mental health workers.

An analysis of variance of the discrepancy score for the paraprofessionals showed that their discrepancy scores were not influenced
by the number of years at the center, while the discrepancy scores of
the professional workers were significantly influenced. Anomalously,
paraprofessionals who have worked at the CMHC for one year or
less have a significantly lower discrepancy score than the profes-
sionals in the same category. Yet paraprofessionals who have worked
at the CMHC two years or more have a significantly higher discrepancy score than the professionals. This is a noteworthy reversal and
furnishes information concerning the nature of the socialization
process affecting the paraprofessionals in the CMHC.

There appear to be two competing explanations for this occur-
rence. On one hand it can be contended that the paraprofessionals
become more discrepant than the other workers as the time in the
center increases. More accurately, the data suggest that the professional workers become less discrepant as time increases. Either way, this suggests that rather than becoming coopted into the values of the center, the paraprofessionals are in fact becoming more amenable to rejecting the values of the center in favor of the client and community relative to the professionals. This implies that the paraprofessionals are actually becoming more active the longer they remain in the center.

However, the analysis of variance revealed that the discrepancy scores of the paraprofessionals did not change significantly over time. To be sure, the discrepancy score of the professionals did change, and become significantly lower over time. In addition, the discrepancy score of the professional initially is significantly higher than the paraprofessionals, and over time becomes significantly lower. In other words, the discrepancy scores of the paraprofessionals are not changing over time, while the discrepancy scores of the professionals change drastically. This suggests that the paraprofessionals do not become more discrepant over time, rather the professionals are becoming less discrepant. If this is the case, the theoretical explanation is demonstrably connected with the socialization process of the paraprofessionals.

Recall that the hypothesis construction was motivated by the reasoning that the paraprofessionals would maintain consistent dis-
crepancy scores because of the recruitment and selection procedures to which they were exposed. This portion of the hypothesis has been supported. Considering the problem from this perspective, the anomalous discrepancy scores can be explained in the following manner. The paraprofessionals came into the CMHC after careful selection and being fully aware of the high expectations for their performance. Their selection resulted in part from their expression of commitment to the CMHC. It is not startling, then, that the discrepancy between their preferred role behavior and organizational role behavior is consistent over the years. They are made aware of the organizational expectations from the beginning and adjust immediately to this audience. The results from the other three hypotheses strongly confirm the assertion that the paraprofessionals behave in a fashion which is consonant with the values of the center.

In Chapter III, four competing alternatives were delineated to account for this apparent cooptation of the paraprofessionals. It was suggested that (1) cooptation of the paraprofessionals is a gradual process, (2) cooptation occurs suddenly and totally during the recruitment and training of the paraprofessionals, (3) creaming occurs, or (4) the values of the community are no different from the values of the CMHC.

The data analyzed in this research strongly suggest that the first alternative, gradual cooptation of the paraprofessionals, does
not occur. An analysis of the ideology score, discrepancy score and organizational and preferred role activism scores reveal that the paraprofessionals do not change on these dimensions as the time at the center increases. The finding that paraprofessionals maintain consistent discrepancy scores over the years is congruent with the review of the literature in Chapter II and the theoretical development in Chapter III. In addition, the finding that the endorsement of community mental health ideology does not change over time indicates that paraprofessional beliefs about community mental health are consistent with their role activism scores. This finding permits closer examination of the other three alternatives.

The domain assumption in the literature is that the values of the CMHC are different from the values of the community. Since this assumption underlies the rationale for the use of paraprofessionals to begin with, it will be taken as given in this research that the values of the CMHC and the community are different. This strategy serves to eliminate the fourth alternative and two alternatives remain to be considered.

At this point it can be concluded that there is either a sudden cooptation of the paraprofessionals or they have been "creamed." If the paraprofessionals have been coopted suddenly, it would suggest that the CMHC's are manipulating the access of the paraprofessionals by admitting those most susceptible to immediate control. If the
paraprofessionals have been creamed, it suggests that they have not been coopted at all. In the strictest sense of the word, cooptation involves a value change while "creaming" involves the selection of paraprofessionals who already hold the desired values. Unfortunately the data do not permit examination of the issues beyond this point. It is recommended that further research be conducted in this area.

In conclusion, the principal issue in this research, the question of cooptation of the paraprofessionals, has been examined and buttressed with hard data. Although the exact process of cooptation of the paraprofessionals has not been identified, it has been narrowed to two alternatives. In spite of this shortcoming, the following summary can be made regarding cooptation.

The paraprofessionals in this research embrace the values and manifest the expected organizational role behavior of the community mental health center. Some differences between the paraprofessionals and specific disciplines have been noted, although these variances are not consistently found among the same disciplines (e.g., the paraprofessionals have a significantly higher CMHI than psychiatrists in this study, but they are not significantly different from each other on organizational role activism). The commitment of the paraprofessionals to the CMHC, as indicated by the role discrepancy scores, is consistent over time and does not change from the point of entrance, as does the commitment of the professionals.
The conclusions of the principal issue lead to the critical examination of several related contingencies. In Chapter II it was pointed out that Pearl and Riessman (1965) regarded the paraprofessionals highly as community mental health specialists because of their unique ability to represent the indigenous population. Interestingly, the data in this research indicate that the intended differences between the paraprofessionals and professionals have been reduced drastically. Indeed, the paraprofessionals are more conservative than or no different from the professionals on the variables measured. In other words, the paraprofessionals do not express a greater amount of concern for the clients and community than the professionals. This has serious implications.

The spirit of the CAP programs, the CMHC movement, and new careers designates the paraprofessionals as the representatives of the indigenous population. They were seen as having "something extra" in terms of representing and communicating the needs of the indigenous client. However, this does not seem to be the case. There is some doubt cast that the paraprofessionals can serve their unique function in the CMHC if they have the same organizational values and beliefs as the other workers. The presence of cooptation (or creaming) seems to have dissipated the unique characteristics of the paraprofessionals and their subsequent value could be diminished. A further analysis of the relation between paraprofessional cooptation,
the organizational nature of the centers, and characteristics of the catchment area served is recommended to understand the ramifications of this issue completely.

Another point of examination involves the idea that the paraprofessionals can use their position in the CMHC to become upwardly mobile. Yet climbing the career ladder (Pearl & Riessman, 1965) is a process which implicitly involves cooptation. It is hardly likely that the paraprofessionals can become educated and gain access to promotions without expressing the appropriate values and behavior. It is quite clear that the paraprofessionals represented in this research display the proper demeanor and values in order for any promotions to occur. The concept of career ladders and its relation to cooptation is a point which needs close examination. It is strongly suggested that a further analysis of the relation between the educational level of the paraprofessionals and the variables measured in this research be pursued.

In closing, it is cautioned that the data analyzed in this research are a biased subset of the returned questionnaires. Paraprofessionals representing critical characteristics were not proportionately expressed in the analyzed data. However, it was demonstrated that the bias does not appear to be in the direction of supporting the hypotheses. In spite of the defined methodological warnings, it is still felt that the conclusions reached in this chapter have strong support. The
accretions leveled by Ritzer (1974) appear to be somewhat confirmed. However, the pejorative tone of Ritzer implies that cooptation is an evil element which must be exorcised. The temperate approach of sociological analysis used in this research fosters more useful results. Cooptation has been rigorously defined and methodically investigated in order to make salient conclusions and recommendations. It is not necessary to view cooptation in an acrimonious manner.

Although it appears that cooptation of the paraprofessionals in the CMHC does occur, referring to the paraprofessional simply as being coopted subtly distorts the true situation. This process seems to take place early in the selection and training stages and does not change over time. In other words, Gamson's (1969) assertion that manipulation of access occurs, or the "creaming" process pointed out by Miller, et al. (1970), seem to demonstrate the phenomena with more accuracy. This conclusion has important implications and should be helpful for administrators and policy makers who are interested in making informed decisions regarding their paraprofessional workers.

Most important of these implications, it should be recalled that in the beginning the paraprofessionals were considered the legitimate representatives of the community. In the spirit of the EOA, they were to have "maximum feasible participation (Title 11)." As suggested previously, the evidence strongly indicates that the para-
professionals manifest the expectations of the CMHC rather than the expectations of the client and community. It is possible that the para-professionals never held the expectations of the clients and community. If this "creaming" has occurred, then the notion that the paraprofessionals are representing the interests of the client and community is spurious. If this is the case, it would behoove concerned administrators to seriously examine their selection and recruitment procedures to ascertain if "creaming" is incorporated into the hiring practice of the agency. Obviously the decision to investigate this possibility rests on a fundamental contingency. If the administrators do not want their paraprofessionals to "rock the boat," then the evidence in this research indicates that the best strategy would be to maintain and fortify extant selection and training procedures.

A closely related issue involves the "bridgeman function." In the literature, the paraprofessionals have been highly regarded as CMHC specialists because of their unique ability to communicate the desires of the indigenous population. However, if the intended differences between the paraprofessionals and professionals have been drastically reduced, it becomes a matter of concern that they still have the ability to bridge the gap between the client and professional.

Once again, the decision involved in this issue seems quite bifurcated. It is important to stress that the decision to implement changes depends on the priorities of the CMHC. This research
endeavor has examined the case of the paraprofessional closely. An effort was made to represent the issues with accuracy. At this point, attention is removed from the paraprofessionals and the scrutiny becomes focused on the administrators and policy makers. It becomes their responsibility to assess the findings of this research and determine if they need to examine the relevancy of their own programs.
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COMMUNITY MENTAL HEALTH WORKER SURVEY

1. Are you attached to a particular component or service of the CMHC (e.g. in-patient, partial care, community organization, consultation)?
   ____ Yes   ____ No
   If yes, which one?

2. Title of your position at the CMHC

3. Years at this CMHC

4. Sex
   ____ M   ____ F

5. Age
   ____ Less than 25
   ____ 25-34
   ____ 35-44
   ____ 45-54
   ____ 55-64
   ____ 65 and over

6. Professional affiliation (e.g. psychiatrist, social worker, paraprofessional, clergyman, nurse, non-psychiatric physician):

7. Highest degree earned
   ____ MD, Ph.D., or other doctorate
   ____ MA, MSW, or other Masters
   ____ BA, BS, or other Bachelors
   ____ AA or AS
   ____ RN
   ____ LPN
   ____ Other (specify)

8. Have you completed a post-degree training program in Community Mental Health or Community Psychiatry?
   ____ Yes   ____ No

9. Would you estimate the percentage of time spent in each of the following activities (total of 100%):
   ____ Administration
   ____ Direct services to clients or patients
   ____ Indirect services (consultation, education, etc.)
   ____ Other (specify)

10. What is the title of the person to whom you are immediately responsible?

11. Are you administratively responsible for supervising any other persons?
   ____ Yes   ____ No
   If yes, how many?
Next, we would like some idea of how you -- as a Community Mental Health Worker -- would act in the following three situations. Please circle the one response that you would most likely make in the situation.

A COMMUNITY MENTAL HEALTH WORKER SHOULD:

1. Meet the needs of his clients, even if this requires violating stated professional standards.
   Absolutely must  Probably should  Probably should not  Absolutely should no

2. Carry out agency policy, even if this requires violating stated professional standards.
   Absolutely must  Probably should  Probably should not  Absolutely should no

3. Act according to professional standards, even if this requires violating community expectations.
   Absolutely must  Probably should  Probably should not  Absolutely should no

The following are a series of statements about community mental health and different aspects or ways of viewing life. Please read each of the statements carefully, in the order in which it appears, and for each one indicate to what extent you personally agree or disagree with it. You should do this by circling next to each statement the one of the six symbols which best represents your own feeling about the statement.

Circle AAA, if you strongly agree  Circle DDD, if you strongly disagree
Circle AA, if you moderately agree  Circle DD, if you moderately disagree
Circle A, if you slightly agree  Circle D, if you slightly disagree

1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.
   AAA  AA  A  D  DD  DDD

2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.
   AAA  AA  A  D  DD  DDD

3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.
   AAA  AA  A  D  DD  DDD
4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.

5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.

6. Such public health programs as primary preventive services are still of little value to the mental health field.

7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.

8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.

9. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.

10. The mental health specialist should seek to extend his effectiveness by working through other people.

11. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.

12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.

13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.
14. The control of mental illness is a goal that can only be attained through psychiatric treatment.

AAA AA A D DD DDD

15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.

AAA AA A D - DD DDD

16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.

AAA AA A D DD DDD

17. Our professional mandate is to treat individual patients and not the harmful influences in society.

AAA AA A D DD DDD

18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.

AAA AA A D DD DDD

19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.

AAA AA A D DD DDD

20. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.

AAA AA A D DD DDD

21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.

AAA AA A D DD DDD

22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.

AAA AA A D DD DDD

23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.

AAA AA A D DD DDD
24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.

AAA       AA       A       D       DD       DDD

25. The mental health center is only one part of a comprehensive community mental health program.

AAA       AA       A       D       DD       DDD

26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.

AAA       AA       A       D       DD       DDD

27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.

AAA       AA       A       D       DD       DDD

28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.

AAA       AA       A       D       DD       DDD

29. It is poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.

AAA       AA       A       D       DD       DDD

30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.

AAA       AA       A       D       DD       DDD

31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.

AAA       AA       A       D       DD       DDD

32. Social action is required to insure the success of mental health programs.

AAA       AA       A       D       DD       DDD

33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.

AAA       AA       A       D       DD       DDD

(Over Please)
34. Each mental health center should join the health and welfare council of each
community it serves.

35. The responsible mental health professional should become an agent for social
change.

36. We can make more effective use of our skills by intensively treating a limited
number of patients instead of working indirectly with many patients.

37. By and large, the practice of good psychiatry does not require very much
knowledge about sociology and anthropology.

38. Community agencies working with the patient should not be involved with the
different phases of a patient's hospitalization.

39. "The Government" unfairly controls every aspect of our lives; we can never be
free until we are rid of it.

40. The United States needs a complete restructuring of its institutions.

41. There are two kinds of people in this world: those who are for the truth and
those who are against the truth.

42. The solutions for contemporary problems lie in striking at their roots, no
matter how much temporary disorder might occur.

43. Most people just don't know what's good for them.

44. Even though institutions have worked well in the past, they must be destroyed
if they are not effective now.
45. The highest form of government is a democracy and the highest form of democracy is a government run by those who are the most intelligent.

AAA AA A D DD DDD

46. Most people just don't "give a damn" for others.

AAA AA A D DD DDD

47. Even though freedom of speech for all groups is a worthwhile goal it is unfortunately necessary to restrict the freedom of certain groups.

AAA AA A D DD DDD

48. Some CMHC's are organized primarily as medical facilities, while others are strongly social service oriented. On the line below is a scale. Place a ✓ at the place where you would see this CMHC. Now place an X where you would see CMHC's in general.

<table>
<thead>
<tr>
<th>Social Service Agency</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Facility</td>
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<td></td>
</tr>
</tbody>
</table>
The following are a series of capsule descriptions of situations that might be encountered by a community mental health worker. For each situation, put a + next to the course of action that you would most prefer and a next to all other courses of action that you would be willing to employ. We are asking that you do this from two perspectives: 1) FROM THE PERSPECTIVE OF WHAT YOU PERCEIVE THAT YOUR CMHC WOULD EXPECT OF YOU IN THESE SITUATIONS (CMHC EXPECTATIONS), 2) WHAT YOU THINK BEST TO DO AS A COMMUNITY MENTAL HEALTH WORKER (PERSONAL-PROFESSIONAL EXPECTATIONS). In some situations, these perspectives may coincide; in others, they may differ. In any event, please indicate the appropriate responses in each column. In so doing, assume that this set of circumstances has emerged in your community.

<table>
<thead>
<tr>
<th>CMHC</th>
<th>PERSONAL-PROFESSIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local union has met with representatives of management and pointed out the detrimental effects upon mental health of depressing working environments and rigid working rules. Specific suggestions for changes were proposed. The management representatives replied that changes were out of the question; the factories had always been run in this fashion and the funds to make suggested changes would not be available for this purpose. A union representative has contacted you and asked for help.</td>
<td></td>
</tr>
<tr>
<td>I would do nothing, since this is not part of my job as a community mental health worker.</td>
<td>I would advise and help to organize a protest, work stoppage or demonstrations.</td>
</tr>
<tr>
<td>I would attempt to develop a program of mental health information independent of management to better enable those workers interested and in need to understand and cope with the stresses of their working situations.</td>
<td>I would attempt to bring management and labor together again and help them to reach a settlement with concern for the mental health aspects of the problem.</td>
</tr>
<tr>
<td>I would urge the union representative to file a complaint with a government labor relations agency or initiate some legal action.</td>
<td></td>
</tr>
</tbody>
</table>
In both major political parties in your county, efforts at more representative participation have failed and the political party apparatus remains in the hands of a powerful few. The reformers have asked for your assistance.

This is not a community mental health issue; I would decline to get involved.

I would try to meet informally with political influentials to try to change the situation.

I would be willing to help organize and advise a community development project designed to force the political parties to acquire more representation.

I would attempt to meet with the heads of the local political parties to try to point out the positive effects on mental health of participation of those not now involved in the political process and the potential danger of alienation.

I would encourage the reformers to contact attorneys about filing lawsuits of "class action" including damage awards to those who have been excluded.

Minority group residents in your catchment area have alleged that they have been subject to harassment and brutality by the police. While the police have investigated complaints, no officers have been reprimanded or disciplined. Residents feel that they only solution lies in the establishment of a civilian Police Review Board -- a move which the police strongly oppose.

This is not a community mental health responsibility; I would decline to get involved.

I would try to help a group of minority residents to launch a referendum campaign to place a statute for a Police Review Board on the next ballot.

I would try to arrange a meeting between the police and representatives of community minority groups to achieve a solution agreeable to both sides.

I would try to informally communicate with influential persons in the community and try to enlist their support for the Police Review Board.

I would help organize the minority residents to stage a sit-down demonstration in the Mayor's office until a police Review Board was established.

(Over Please)
The population in your catchment area suffers from a seriously high unemployment rate due largely to a lack of education and marketable skills. The unemployment rate among youth is especially high. It has been suggested that major companies establish local branches in the community to teach skills and generate jobs. There is general enthusiasm for the idea but no effective steps seem to have been taken to bring the idea to fruition. In order to make this idea a reality organization and explanation are needed. You are asked to help.

I would not become involved since this is not an appropriate function of community mental health.

I would try to meet with appropriate business concerns and explain to them the needs and benefits of such a program.

I would advise and help organize community residents to convince stockholders of target companies to turn their proxies over to those who would force the companies to assume more social responsibility.

I would advise or help organize boycotts of target companies that were unresponsive to this idea.

I would meet with representatives of trade organizations, unions, the National Association of Manufacturers, and the Chamber of Commerce for informal suggestions and ideas.

Family planning services and services for one-parent families in your community are virtually nonexistent and you -- in your work -- have observed a need for such services. On occasion, clients have made direct requests of you for information or referrals in these areas. While the other human services agencies have agreed to the expansion of services in these areas, nothing seems to be happening. You have been asked to help make something happen.

This is not a community mental health worker function, so I would decline to get involved.

I would be willing to take the initiative by organizing direct services independent of the agencies in line with my training.

I would advise and help organize a group of women who wanted these services and have them stage protest demonstrations.

I would be willing to conduct a feasibility study and present the findings to a meeting of agency executives in order to demonstrate the need for and feasibility of such a program.

I would be willing to urge the agency boards to replace agency directors with others giving this matter a higher priority.
The people in your community are becoming increasingly concerned about drug abuse -- particularly among the young. Services are under-developed and those that do exist are uncoordinated and emphasize punitive approaches. There is general agreement among lay persons and social service professionals who provide these services that something needs to be done but nothing seems to have happened.

PERSONAL-

I would do nothing since this is not part of my job as a mental health worker.

PROFESSIONAL

I would advise and organize citizens groups to picket and hold sit-ins in the social agency offices until they did something about the problem.

I would help organize a campaign to have the governing boards of the agencies -- in accordance with their established procedures -- replace present personnel with others most effective.

I would provide the various persons working on this problem with information about similar programs in other communities in order to serve as a model for a coordinated program or approach.

I would use resources from professionals outside of the community to develop a program and initiate it as a demonstration project.

It has been charged by a local organization of ADC mothers that their treatment by social agencies and welfare workers has been insensitive, degrading and traumatizing. The agencies have agreed that this sort of treatment has occurred in the past. After several attempts at reconstructing client-agency interactions, both parties have turned to you, as a mental health worker, for help.

PERSONAL-

This is not a community mental health concern, I would decline to help.

PROFESSIONAL

I would attempt to develop an independent system of direct services to the ADC mothers who felt that they were most affected by this relationship.

I would urge the ADC mothers to file a complaint with the State Human Relations Commission.

I would help the ADC mothers to organize a protest that would bring this matter to public attention through the mass media.

I would meet with both parties in order to help them reconstruct the relationships with emphasis on the mental health of the clients.
The Welfare Department has suggested that ADC mothers could be trained to be para-professional mental health workers. This would provide work for some but would also allow a team approach where community problems could be communicated and translated into a system where primary prevention could occur. Several black organizations object strongly. They claim this is co-optation, and a demonstration that the black community cannot solve its own problems. Since your Center has contact with both sides, your participation has been requested.

**PERSONAL- PROFESSIONAL**

This is not in the domain of the mental health worker, so I would decline to become involved.

---

I would try to organize the interested ADC mothers to develop their own program independent of and in opposition to the other parties.

---

I would try to help develop a program within the Welfare Department that would allow for meaningful policy input by the black groups.

---

I would try to organize the interested ADC mothers and have them appeal to the State Department of Welfare and the national headquarters of the black organization to put an end to the bickering.

---

I would try to develop a small independent demonstration program to show how para-professionals can be trained to the satisfaction of both parties.

---

An independent university examination of the secondary school system in your community has shown that various educational "tracks" coincide with class and race of students to a large extent. The school administration claims these data are inaccurate, tracking reflects the interests and abilities of the students and that they system is successful. Parents have claimed that it should be changed since it perpetuates social inequality and have asked you to enter the situation.

**PERSONAL- PROFESSIONAL**

This is not a mental health problem and I would not get involved.

---

I would urge the parents to file complaints with the state antidiscrimination agency to force the end of tracking.

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I would try to arrange a meeting between the school officials and the university researchers in order to convince the administration of the validity of the research.

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I would help to organize under CMHC auspices -- a series of public round-table discussions of the problem to try to resolve it on "neutral" ground.

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I would advise or help organize the parents in occupying one of the high schools as a means of registering protest.
A regional airport authority is trying to expand the local airport into a community in your catchment area. Residents are being pressured to sell their property and the airport administration has not been enforcing noise abatement regulations. As a result, an organization of residents have complained about being unable to sleep at night and of being awakened early in the morning. The airport authority has been unresponsive to their first concern and has denied the validity of their second. The community has not been able to mobilize to fight the authority because there are no effective community organizations. You have been contacted by some of the residents for help.

I would not become involved, since this is not a community mental health issue.

I would advise and help organize the residents to stage a "mill in" at the airport in order to disrupt traffic and airport operations so that the practices of the airport authority could be brought to the attention of the public.

I would be willing to go to the regional airport authority and offer expert testimony on the harmful mental health effects of airport expansion.

I would urge the community residents to file complaints with the Federal Aviation Agency in order to halt airport expansion.

I would try to contact politically influential figures, local and state, to ask the airport authority to consider the needs of the local residents in making their plans.

In response to a request from a group of late adolescents and young adults living in your catchment area, plans have been made to organize a congress devoted to a discussion of the ethics of "alternative family organizations." The police chief has stated that he will break up any such congress and arrest the participants. He refuses to discuss the matter. The young people are angry and turn to you for help.

This is not part of the community mental health worker role; I would not help.

I would urge them to hold the congress and be prepared to defy the Chief of Police.

I would inform the Chief of Police that I am recommending the postponement of the congress and with this as evidence of good faith re-open the matter with him.

I would informally contact people at a higher level of authority and request that they negotiate further with the Chief.

I would encourage the congress organizers to go to the city council and demand the over-ruling of this extra legal threatened action.

(Over Please)
The Community Relations Board has been meeting with community groups in an attempt to reduce feelings of alienation and apathy in the lower SES sections of town. A proposal has been developed and agreed upon by the community groups that a voter registration drive, and development of indigenous candidates for city council be undertaken. The Board has agreed to help in the effort and has turned to you for additional help.

**PERSONAL-PROFESSIONAL**

This is not a concern of community mental health; I would not assist.

I would meet with the Community Relations Board and discuss the implications for positive mental health of community participation and involvement.

I would actively campaign and support indigenous political candidates to replace others in political office.

I would take an active part in helping organize a self-governance movement, "locking horns" with other community groups and interests.

I would informally use my contacts with local citizens groups in order to generate interest in the registration drive.

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It has been proposed that a free medical clinic be provided for those who do not have access to the usual medical channels or who are not willing to use them. A group of local physicians have agreed to provide these services in a collective, voluntary effort. The County Medical Society is strongly opposed, the plan has been shelved. Some physicians have asked for your help to get the plan reconsidered.

**PERSONAL-PROFESSIONAL**

I would not help since this is not part of my role as a community mental health worker.

I would help develop temporary direct health services in order to demonstrate the value of such an approach.

I would advise and assist the physicians and pro-clinic community persons in filing complaints with the State Medical Society.

I would help organize a public boycott of the physicians who are decision-makers in the County Medical Society.

I would attempt to convene a meeting of representatives of the Medical Society, local physicians, and community groups to arrive at some agreeable means to secure approval for the plan.
A group of non-white parents in your community has asserted in public meetings that the most serious mental health problem for their children is racism. They have been particularly concerned with the inadequate attention paid to minority history and culture in the school curriculum. They have publicly called on the school system to remedy these defects. While school officials have agreed that a remedy should be found, more than a year has passed and no positive results have been seen. The Superintendent of Schools thinks that the participation of a community mental health worker would be beneficial.

CMHC

This is not a community mental health problem; I would decline to become involved.

I would help the black parents to organize a school boycott until effective action has been taken.

I would encourage and help parents to contact educators at a prestigious black university for their help in providing resources to establish an after-school Black Studies program.

I would offer my help to the school system in conducting a study of successful programs of Black Studies in other communities.

I would encourage the black parents to protest directly to the Board of Education about the ineffectiveness of the school administration.

The Police Department has requested training in family crisis intervention. The goal of the program would be to demonstrate the convergence of police activities and mental health techniques. Both time and money are problems in getting the proposed training program off the ground. The Police Department has asked your help in solving these problems.

CMHC

This is not a legitimate community mental health problem; I would not get involved.

I would research the various federal and state sources of funding and present these findings to the police.

I would try to develop a coalition of community organizations to put pressure on the Police Department to re-order its priorities so as to find the funds for the program within the existing budget.

I would help develop an informal training program for individual policemen on a voluntary basis.

I would meet with the police chief and city officials and demand that they re-order the priorities of their present budget.

(Over Please)
The majority of residents in your catchment area live in seriously dilapidated houses and tenements. Numerous instances of fires due to faulty and overloaded heating equipment are reported during the winter and the local hospital has recorded an increasing number of cases of lead poisoning in children due to eating paint. Attempts have been made by local residents through court action, to compel landlords to make necessary repairs, but the fines have been small and the owners have been unwilling to comply. The residents have asked you to participate in their efforts.

This is not a Community Mental Health concern, I would not participate.

I would be willing to advise or help organize a rent strike and other similar forms of dramatic protest.

I would be prepared to give expert testimony on the dangerous living conditions and health hazards in the area.

I would urge the tenants to organize to make repairs and collectively sue the landlords for the costs of the repairs.

I would be willing to personally contact persons in the local government and urge them to take action.

A year-round program to teach crafts and artisanship to the aged has been proposed by the Adult Education Division of the Public School System. This program would provide for finding these persons, teaching the skills, providing materials and sponsoring exhibitions for the finished products. While there is no real opposition to this idea, no one seems to know how to organize. You are approached for help in this task by the local Senior Citizens Group.

I would decline to become involved since this is not a community mental health concern.

I would request that the CMHC organize a program for demonstration purposes.

I would contact the American Association of Retired Persons and ask them to help bring pressure on the school system to hire experts in their area and initiate the program immediately.

I would organize a campaign to vote down bond issues and millages until this program is initiated.

I would try to arrange a meeting between the school officials and the State Office of Aging to explore ways of initiating a program.
The central section of your city is in a serious state of decay and municipal officials are going to apply for an urban renewal grant. Plans call for the development of low cost public housing. A committee of residents and municipal officials have asked your assistance in developing the grant proposal.

This is not a community mental health concern, I would not assist.

I would be willing to develop an anticipatory guidance program to help persons adjust to relocation and a move into public housing.

I would organize "visiting delegates" to Washington and sit in the federal offices until positive action is assured.

I would be willing to meet with them and discuss the mental health aspects of relocation and public housing.

I would help organize the residents to present the needs of the area to their congressman to apply pressure to the federal officials to award grant.

Now, we'd like to get some idea of your experience as a professional or as an informed citizen with certain types of social or community changes. Please check the single response for each situation which best describes your experiences both as a professional and as a citizen.

Yes, I'm often involved in this
Yes, on several occasions
Yes, I've had one or two such experiences
No

1. Tried to work through a particular change in the community which nearly everyone agreed ought to be done.

2. Tried to bring about change in the community in spite of strong opposition from opposing parties.

THANK YOU FOR YOUR COOPERATION!