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Social Workers, Social Activism, and the Community Mental Health Center

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SOCIAL WORKERS, SOCIAL ACTIVISM, AND THE COMMUNITY
MENTAL HEALTH CENTER

by

Sandra J. Potter

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Doctor of Philosophy

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Close friends are frequently relied upon by doctoral candidates to provide a source of sanity, without which candidates would most certainly go mad. Two friends that have been particularly patient and long suffering during the writing of this dissertation are Dr. Lew Walker and Trudy Darty. As a scholar and professor, Lew Walker is outstanding; as a friend, he is a rare treasure. Finally, I am most grateful to Trudy Darty, social worker and social activist, for giving me her unconditional positive regard during the writing of this dissertation and for teaching me that the personal really is political.

Sandra J. Potter

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CHAPTER I

STATEMENT OF THE PROBLEM AND REVIEW
OF THE LITERATURE

Introduction

The emergence of community mental health in the 1960's as a major mental health services delivery system was the result of a number of developments both within the mental health field and American society. The Community Mental Health Centers Act, passed by Congress in 1963, marked a departure from the more traditional modes of mental health care delivery in that all segments of the American population would receive sufficient care. Taking a statement from President John F. Kennedy's February, 1963, speech on mental health, the legislators christened the program a "bold new approach" to mental health care.

The role of the social worker in the community mental health movement in general and in the community mental health center in particular is one that has not been clearly delineated or understood. The advent of community mental health provided social work with the Damocian sword dilemma of professionalism verses social activism. The history of social work in America has shown that the field of social work has not permitted a preoccupation with professional, or with the acquisition of professional attributes, to impede commitment

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to social action, yet the Community Mental Health Centers Act placed social workers in community mental health centers as mental health professionals who were supposed to function as social action advocates. The central focus of the current study is an examination of the degree of social activism endorsed by social workers employed by community mental health centers and the effect that this endorsement has on social work professionalism.

This study investigates the role of the social worker as social activist in the community mental health center (CMHC) by selecting four dimensions of social activism and examining them with variables pertaining to the organizational characteristics of community mental health centers and the personal and cognitive characteristics of social workers at community mental health centers.

Understanding the social worker's role as social activist in the community mental health center cannot be achieved without first reviewing the history of community mental health, the relationship between social work and social activism, and the professionalization of social work. Following these three reviews is a presentation of the variables in the research model.

A History of Community Mental Health

The passage of the Community Mental Health Centers Act was the result of an increasing awareness of the need for a national priority in the provision of mental health services. Its historical origins can be traced to two sources. First, the community mental health center concept had its beginnings in a 1952 report of the World
Health Organization Expert Committee on Mental Health. This report suggested that facilities be built to permit a broad range of coordinated services such as inpatient care, outpatient care, part-time hospitalization, rehabilitation, research, and community education. The idea that one facility should be able to administer a wide range of coordinated services was translated into the idea that centers could provide comprehensive services. In order to receive federal funds, centers were required to offer five services: inpatient care, outpatient care, partial hospitalization, twenty-four hour emergency service, and consultation and education. Five additional services were suggested to aid in the construction of a more fully comprehensive program: diagnosis, rehabilitation, precare and aftercare for state hospital patients, training, and research, including program education (Koran, Brown, & Ochberg, 1977:142-43).

The second source of the community mental health center concept was a belief based on research (Deutsch, 1949; Stanton & Schwartz, 1954; Brill & Patton, 1957, 1959) and clinical experience that mental health services should be primarily community-based rather than state hospital-based. The move for creation of community-based services was influenced by two situations: the odious conditions and circumstances of state mental hospitals which had come to be known as "snake pits," "human warehouses," and "houses of horror"; and the introduction of tranquilizing drugs, which permitted a significant number of patients to leave state hospitals and return to their home communities. The demand for community-
based services was also emphasized by the passage of the Mental Health Study Act by Congress in 1955. This action by Congress provided the necessary legislation to initiate the Joint Commission on Mental Illness and Health. The commission 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:vii). The final report issued by the commission, *Action for Mental Health*, was a comprehensive effort to evaluate the status of the mentally ill in America. Its recommendations delineated three areas of emphasis: pursuit of new knowledge, better use of present knowledge, and the costs necessary in implementing social change.

President Kennedy's response to the commission's report was a call for new programs dealing with the care and treatment of the mentally ill. Kennedy asserted that:

mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and the personal finances of the individual families than any other single condition (PL 88-164).

Kennedy's "bold new approach" to mental health and mental retardation focused on three major objectives: (1) the discovery of causes of mental illness and mental retardation so that those causes might be eradicated; (2) the strengthening of underlying resources of knowledge and skilled manpower through aid for higher education and the expansion of existing training programs for workers
in the various occupations and professions affiliated with mental health; and (3) an improvement of the programs and facilities serving the mentally ill and the mentally retarded.

Central to Kennedy's new mental health program was community care. He, therefore, recommended that the Congress authorize grants to the States for the construction of community mental health centers, beginning in the fiscal year 1965, with the Federal Government providing 45 to 75 percent of the project cost; authorize short-term project grants for the initial staffing costs of comprehensive community mental health centers, with the Federal Government providing up to 75 percent of the cost in the early months, on a gradually declining basis, terminating such support for a project within slightly over four years; and to facilitate the preparation of the community for these new centers as a necessary preliminary to any construction or staffing assistance, appropriate 4.2 million dollars for planning grants under the National Institute of Mental Health (Chu & Trotter, 1974).

It was Kennedy's belief that the community mental health centers could utilize community resources and provide better community facilities for all aspects of mental health care. Prevention as well as treatment was to be a major activity. Located in the client's own environment and community, the center would make possible a better understanding of his needs, a more cordial atmosphere for his recovery and a continuum of treatment. As his needs changed, the client could move without delay or difficulty to different services—from diagnosis, to cure, to rehabilitation—without need to transfer
to different institutions located in different communities.

The passage of the Community Mental Health Centers Act of 1963 (P.L. 88-164) authorized federal matching funds of 150 million dollars over a three year period for construction of community mental health centers. Subsequently, Congress appropriated 135 million dollars of these authorized funds to the National Institute of Mental Health for the beginning of the centers program. The initial funds of the 1963 act were supplemented by Congress with the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1965 (P. L. 89-105), which allocated 73.5 million dollars over three years to assist in meeting the primary costs of staffing centers (Koran, Brown, & Ochberg, 1977:144).

Bloom has recorded some of the major social policies, explicit and implicit, in the Community Mental Health Centers Act which are especially characteristic of the 1960's:

(1) local communities, states, and the federal government are in an interdependent relationship such that they must work together in a spirit of mutual respect in order to achieve their individual and shared objectives; (2) the federal government has the responsibility to work toward the equalization of affluence across the country, and the states have the responsibility to do the same within their borders; (3) human services are provided best, all other things being equal, when they are provided in the geographically defined community controlled by the community, and offered in sufficient quantity to meet the needs of the community; (4) mental-health services must ultimately become an integral part of a general-health-service delivery system; (5) access to mental-health services (and, by implication, to all human services) is a civil right and cannot be denied to anyone for any reason; (6) federally supported services can be delivered best by personnel properly chosen, fairly paid and advanced, and protected from administrative whim; (7) federal funds should be used for program growth and expansion; and (8) federal funds

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should be used primarily to get programs started (Bloom, 1977:44-45).

The Community Mental Health Centers Act, like numerous other works of federal legislation, carried with it an ideology regarding social policies. The operationalization of this ideology, however, varied immensely according to the occupations or professions of the individuals staffing the community mental health centers.

Among the professionals staffing the centers, social workers have gained a reputation for social activism. Social activism in the role of the community mental health center social worker can be seen in four ways. First, is the perception of the role by the worker as a set of expectations sanctioned by the worker's community mental health center (CMHC role activism). Second, is the worker's definition of the role, independent of organizational influence (personal/professional role activism). Third, is the role discrepancy between CMHC activism and personal/professional activism, therefore determining the degree of variance between organizational and personal activism. Finally, social activism can be observed in the boundary busting activity of the social worker; that is, the willingness of the social worker to become involved in activities and institutions not considered within the domain of community mental health.

Social work and social activism were not strangers that happened to meet during the zenith of the community mental health movement in the 1960's. To understand the affinity between these two it is necessary to consider the significance that social activism encompasses for social workers.
The Social Worker and Social Activism

From a review of the history of social work in America (Cohen, 1958; Gottesfeld & Pharis, 1977; Klein, 1968; Lubove, 1965; Pumphrey & Pumphrey, 1961) it can be found that social workers have been involved in two major activities: service to people in need and social activism. Social work's primary concern has always been the effort to assist each individual in the full development of his potential. Early social work pioneers saw the way in which economic destitution, ill health, poor housing, and inadequate educational programs could limit personal growth and were in the vanguard of social reform movements.

The social workers of the 1960's were inheritors of a powerful tradition of social action. Although social work moved away from social action and social reform during the decades of professional development following World War I, they were never completely abandoned. Richmond, whose entire career had been largely devoted to the professionalization of social work, said:

I have spent twenty-five years of my life in an attempt to get social casework accepted as a valid process in social work. Now I shall spend the rest of my life trying to demonstrate to social caseworkers that there is more to social work than social casework (Bruno, 1948:186-87).

Richmond had seen reform movements as diversions from the task of learning the details of investigating individual cases. She later wrote, "during all that period, I know, it was uphill work to interest either the public or the social reformers in any reform that dealt with people one by one instead of in great
masses" (Richmond, 1930:587).

Porter (1937) has commented that much of social work in the first third of the twentieth century was characterized by a "one by one" theme and that interest in social reform appeared to continually decline. Social workers were of the opinion that leadership could only be taken in areas where social workers were technically expert. These areas were defined as casework and group work process. The flight from reform increased after the mid-1930's, but not without some words of warning and admonition from social work leaders and a great deal of discontent among the rank and file (Wilensky & Lebeaux, 1965). Lurie, for example, charged that "as a professional group we are in general tied up with the reactionary rather than with the advancing forces of social change" (Lurie, 1935:503). Hollander denounced social work as suffering from "hardening of the arteries, creeping paralysis, premature senility, heart failure (especially heart failure), sleeping sickness-almost everything except growing pains" (Hollander, 1937:118).

The 1940's were years occupied with war and the recovery of that war's devastation but the 1950's witnessed renewed attempts to involve the social worker in social action. "Social work, in principle and in tenet is not separable from social reform...reform activities...must be reintroduced into professional thinking, organization and training," wrote one social worker in 1954 (Howard, 1954: 142). Youngdahl made a similar comment when he retired as president of the American Association of Social Workers: "Is our function as social workers limited to the treatment of pathologies; or do we
also have a positive or preventive function to perform?" (Youngdahl, 1953:111) Praising social workers as "the conscience of our American society," a person that was not a social worker directed her audience of students and alumni from the New York School of Social Work toward the task of community reorganization and noted that the older professions such as law, medicine, and education "have become encrusted in bureaucracy, respectability and economic rewards." By contrast, social work "is still free--to some extent--from this lock-step towards success which most Americans worship" (Meyer, 1956:9). Wilensky and Lebeaux (1965) record that the volumes of the National Conference of Social Work have been peppered with such exhortations to social action for years.

Review of the various formulations of social action in social work literature leads to two conclusions. First, although many of the earlier writings on social action were limited to the descriptive, the more recent contributions have attempted to link social action and social science concepts in a more theoretical analysis. Second, there is no agreement on what constitutes the basic characteristics of social action.

Paul, a social work historian, defines social action as "those organized and planned activities that attempt to influence the social distribution of status, power, and resources." He surveys the social work literature of the 1960's and divides it into three categories. The first is the experiential and descriptive writings, which demonstrates a wealth of practical knowledge, some of which is related to traditional negotiating, bargaining, or legislative
models (Cohen, 1966; MacRae, 1966; Scheiderman, 1965; Teitelbaum, 1964; Wax, 1968). A second group of writings investigates the social work position on social action, extending from the traditional to the contemporary. Some of the writers give special attention to professional ambivalence and include demands that social work reexamine its posture, along with suggestions for new directions (Epstein, 1968; Hayes, 1967; Thursz, 1966; Wade, 1963, 1966). A third category of literature has examined the experience and problems of social and institutional change including social action goals and strategies, the political aspects of social action, and new conceptualizations of social action (Brager, 1968; Cloward & Elman, 1966; Eisman, 1969; Erlich & Tropman, 1969; Marris & Rein, 1967; Pruger & Specht, 1969; Slavin, 1969).

Pauli has credited the opening salvo in the social activism that so predominantly characterized the decade of the 1960's to the tired feet of Rosa Parks and the mass boycott precipitated by her refusal to move to the black section of a Montgomery bus. While this particular observation might be open to debate, it is a matter of record that a number of social workers were caught up in the social movements of that time, e.g., antiwar protests, civil rights, community action, and the war on poverty (Pauli, 1971:300).

Two other attempts to define social action and its relationship to social work are especially helpful. The first, by McCormick, burrows from the work of Thursz—"social action is the business of social work"—and operationalizes it by focusing on advocacy as the instrument of social action. According to McCormick:
The concept of advocacy has long been associated, in its general meaning, with the defense or promotion of a cause and, more specifically, with pleading the cause of another. In the first instance, the activities are political-social in character; in the second, they can be described more accurately as personal-social. In the political context, the objective is to bring active support to ideas and programs that will benefit society as a whole, as well as particular segments of it.... In the second context, the focus is on the individual in his relations with other individuals and institutions.... In both contexts, the advocate... is, in fact, a partisan in a social conflict, and his expertise is available to serve the client interests (McCormick, 1970:4).

McCormick believes that the social worker's role as advocate is a reflection of the vast changes that, by the late sixties, had taken place in American society.

A second effort to operationalize a conceptual definition of social action comes from the work of Khinduka and Coughlin (1975). Their definition of social action is "a strategy to obtain limited social change at the intermediate or macro levels of society which is generally used in non-consensus situations and employs both 'norm-adhering' and 'norm-testing' modes of intervention." They see three concepts as being fundamental to this definition: the scope of change, the use of power in effecting and resisting change, and the change strategies employed.

Khinduka and Coughlin maintain that since social action is essentially a method of effecting or preventing social change, the single most important concept in its study is social change, which may be defined as a process of "significant alterations in the structure and functioning of determinate social systems" (Boskoff, 1957:263). As change occurs at various societial levels, it is necessary to identify the specific level where strategy of social action is uniquely usable (Khinduka & Coughlin, 1975:5).

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They suggest that many otherwise useful conceptualizations of social action fail to do this and that no single type of planned change can address itself to any and all causes and targets of change.

A second major consideration in social action, according to Khinduka and Coughlin, is the role of power. They cite five factors regarding power that the social actionist should know:

1. The matter of the distribution of power is an empirical, not an ideological, question... the social actionist must be prepared to test the belief and the notion objectively through a rigorous analysis of evidence.

2. It must be recognized that in a rapidly changing society power configurations are constantly changing.

3. It is unwise and risky to assume the way power is distributed in one community is necessarily representative of the pattern of power distribution in others.

4. There is no single source of power.

5. The social actionist generally finds himself attempting to move some of these sources of power from the "haves" to the "have-nots".... This introduces the crucial question of legitimacy. Action to redistribute societal resources and privileges needs legitimation. This is done through reinterpretation of traditional values, norms, and customs, through legal structures based on rational agreements, through the special personal appeal of leaders, or through a combination of these approaches (Khinduka & Coughlin, 1975:8-9).

If, as Etzioni states it, the power to be at the top includes the power to keep others from the top (Etzioni, 1968), then Khinduka and Coughlin believe that the social actionist is confronted with the twin task of searching out possible resources of power as leverage for the underprivileged and of constructing the case on which their legitimacy will be accomplished. How this is achieved is a matter of strategy, and this is the third fundamental
concept in social action.

The Khinduka and Coughlin article attempts to contribute to the understanding of social action as a professional behavior of social workers by clarifying its definition and analyzing three major subconcepts of the definition. As they note at the conclusion of their essay, there have been scores of articles and speeches devoted to social action but few attempts to conceptually locate it in social work practice and link it to a social science matrix.

Within social work, the impact of the turbulent 1960's can be distinguished at two levels: (1) the increased recognition of the need for social workers to accept action for social change as part of the definition of their purpose and role; and (2) social action is commonly being defined as a methodology utilized by social workers whose function is to bring about societal change (Thursz, 1977:1275).

At the 1969 annual meeting of the National Association of Social Workers, the membership reaffirmed a statement made by social work educator John A. Fitch in 1919—"The interest of the social worker in social action is a test of his integrity"—by making social action one of its priorities and by allocating resources to it (Thursz, 1977:1275). Some individuals have argued, however, that social action has robbed social workers of their integrity and therefore prevented social workers from achieving the professional status granted to others in service oriented fields, e.g., medicine and law. The following literature review on the professionalization of social workers delineates the difficulties involved in social
work obtaining the designation of a profession and the problems that social activism has presented in this struggle.

The Professionalization of Social Workers

Wilensky (1964) has suggested that is is a popular generalization that occupations are becoming "professionalized." He contends that the label is loosely applied to increasing specializations and transferability of skill, the proliferation of objective standards of work, the spread of tenure arrangements, licensing, certification, and the growth of service occupations. It is his argument that these loose criteria are less essential for understanding professional organization than the traditional model of professionalism which emphasizes autonomous expertise and the service ideal. Wilensky believes that among the newer and marginal "professions," such as social work, deviations from the process can be explained by power struggles and status strivings common to all occupations.

A review of the literature on the professionalization of social work substantiates Wilensky's statements on professionalization and provides three distinctly divergent perspectives: the social worker as a nonprofessional (Flexner, 1915; Stein, 1969; Specht, 1972); the social worker as a semi-professional (Carr-Saunders, 1965; Etzioni, 1969; Toran, 1972); and the social worker as a professional (Kadushin, 1959; Meyer, 1959; Wilensky & Lebeaux, 1965; Epstein, 1970; Rein, 1970; Gurin & Williams, 1973; Clearfield, 1977).
Throughout the history of social work, the question of whether or not social workers are members of a profession has been a dominant issue. Shortly after his famous study of medical education in America, Flexner was asked if social work was a profession and answered in the negative. Flexner's primary reason for denying social work the prestige of professional status was its lack of independent identity. He viewed it more as an activity "that brings this or that (other) profession or other activity into action" (Flexner, 1915:907). Social work, for Flexner, was "not so much a separate profession, as an endeavor to supplement existing professions.... It pieces together existing professions..." (Flexner, 1915:908). Incorporated in Flexner's refusal to consider social work as a profession was his admonition that social workers cease attacking problems with such "vigor," and exercise "caution, thoroughness, and moderation," to become less the advocate and more the detached professional (Flexner, 1915:910).

More than fifty years after Flexner's pronouncement, Stein cited two types of professionals which he referred to as Group A and Group B. Group A was characterized by ranking high on one or more of the criteria of power, drama, adventure, financial risks at stake, or sophisticated material technology; such professions, according to Stein, would include medicine, law, and engineering. Group B professions were those professions exhibiting humanitarianism, compassion, artistic expression, and the constructive and ameliorative
services that make life more livable, aiding in the growth and development of people. Traditionally, such professions have included teaching, nursing, dentistry, clinical psychology, library science, and social work. Stein explains that what he has done is really not a breakdown of professions into two groupings but more in the nature of two clusters at each end of a continuum. He remarks that he had thought of calling the first group the more masculine professional grouping and the second the more feminine but decided against it, not wishing to cause offense. His characterization of masculine and feminine professions, however, should not be dismissed lightly since the preponderance of women in social work has not been beneficial in social work's struggle for a professional identify. Consider Stein's comment regarding the inability of social workers to effect change and its reflection on the lack of masculinity:

The cry for greater impact reflects the wish that the profession represent movers and shakers, that social workers be A people, and not B people. However, the frustration at our not having all that muscle leads not to scaling down our aspirations, but to intensifying our commitment to social change and social reform--in other words, to enhancing the accent on ideology. Yet, ideology without the means to achieve ends--without competence and institutionalized means to translate that competence into action--is futile for a profession (Stein, 1969:83).

Thus, Stein's conclusion that a profession without muscle is not a profession.

Like Flexner and Stein, Specht sees the social worker role of advocate as an obstacle that must be overcome before professional status can be granted:
The worker functions as a sort of half-baked lawyer or junior politician and the conception vigorously eschews the unique functions that professional social workers do have the expertise to handle.... The distinction between politics and professional social work has become somewhat blurred in recent years because a self-righteous and sanctimonious "commitment to social justice" has replaced a rigid and sanctified "commitment to professional practice." There is no simple way to achieve professionalism that can avoid the struggle of complexities inherent in reconciling both sets of commitments. The new activist spirit in social work downgrades professional practice, which it defines as ineffective in dealing with social problems. In place of professionalism the activists offer the idea that revolution will create change more rapidly than social work practice, which may be correct. But this is not what the profession prepares one to do, nor should it (Specht, 1972:6).

Gartner (1976) has explained the rejection of social activism for social work as part of the effort to professionalize the field. "The dilemma," according to Gartner, "was not whether the social action approach was desirable or appropriate, only that it could not be professionalized" (Gartner, 1976:138-39).

**The Social Worker as a Semi-Professional**

Etzioni has defined semi-professions as having shorter training, less legitimated status, less established right to privileged communication, less of a specialized body of knowledge, and less autonomy from supervision or societal control than "the" professions. He observes that a significant segment of the semi-professions aspire to a full professional status and sustain a professional self-image, despite the fact that they are often aware that they do not deserve or qualify for such status. The costs for such aspirations are those associated with individuals attempting to pass for what
they are not: guilt feelings for floating a claim to status that does not have a sufficient base and a rejection by those who hold the legitimate status. Etzioni labels teaching, nursing, and social work as semi-professions (Etzioni, 1969:vi-vii).

Carr-Saunders has described four types of professions in society:

1. The established professions of law, medicine, and the Church share two basic attributes; their practice is based upon the theoretical study of a department of learning, and the members of these professions feel bound to follow a certain mode of behavior.

2. The new professions are those which are based on their own fundamental studies such as engineering, chemistry, accounting, and on the natural and social sciences.

3. The semi-professions replace theoretical study by the acquisition of technical skill. Technical practice and knowledge is the basis of such semi-professions as nursing, pharmacy, optometry, and social work.

4. The would-be professions require neither theoretical study nor the acquisition of exact techniques but rather a familiarity with modern practices in business, administration practices, and current conventions. Examples of this type are hospital managers, sales managers, work managers, and so on (Carr-Saunders, 1965:280-81).

Carr-Saunders places social work in the semi-professional category because he attributes major importance to the autonomy of the professional practitioner. He writes:

Social workers and school teachers, for example, have a dual responsibility to the employer as well as the client. But the employer lays down the limits to the service which can be rendered and to some extent determines its kind and quality. As a result, a social worker who is, say, a probation officer is far from free to treat a person committed to his charge in a manner indicated by his professional training and experience (Carr-Saunders, 1965:283).
Toren, like Etzioni and Carr-Saunders, defines social work as a semi-profession, claiming that its ineffectiveness in obtaining stated goals is directly related to the elements responsible for its semi-professional nature. The term semi-profession, according to Toren, indicates that the profession in question is somewhere in the middle of the continuum of professionalism between the "full-fledged" professions and those occupations which are professions in name only but do not possess any of the attributes characterizing the professions, specially:

1. a basis of systematic theory
2. authority recognized by the clientele of the professional group
3. broader community sanction and approval of this authority
4. a code of ethics regulating relationships of professionals with clients and colleagues
5. a professional culture sustained by formal professional associations (Greenwood, 1962:45)

Toren describes the central dilemma in the profession of social work as the strain between social reform and individual rehabilitation, and traces its manifestations on four different levels:

1. The level of ideology and "Weltanschauung" where there is controversy between the ideas of "social reform" and "individual rehabilitation."
2. The organizational level where there is the phenomenon of differentiation and specialization of agencies according to the two functions of "welfare" and "therapy" or "intervention for change."
3. The level of the social worker's role where there is conflict between the more routine task of eligibility determination and administering financial assistance, and bringing about changes in people's norms and behavior.
4. The basic unit of interaction between the social worker and his client in the form of alternation and manipulation of instrumental and normative sanctions (Toren, 1972:26-27).

Toren, therefore, maintains that social work is a semi-profession because it lacks theoretical development, upward mobility of social workers toward a more "established" professional status is inhibited by a shortage of recognized authority by the clientele of the professional group, the lack of community sanction and approval of the authority of social work, and the lack of a strong inclusive professional association in which membership is a necessary prerequisite for the right to practice. She notes, however, that these particular features are to a great degree resultant of the fact that social workers have not been able to prove "exclusive competence" based on special training and knowledge in the treatment of clients. Less than a fifth (16%) of those practicing social work have had the two year graduate training program and only one-third of employed social workers are members of the National Association of Social Workers (Toren, 1972:41).

It is Toren's belief that the discrepancy between the present development of theoretical knowledge and the value system of social work is one of the primary factors limiting it to semi-professional status; it is difficult to claim full professional standing on the basis of commitments to aid people in need and a concern for social reform (Toren, 1972:42).

While Etzioni believes that semi-professions cannot advance to full professional status because of powerful societal limitations,
Carr-Saunders and Toren are of the opinion that any classification of a profession is, by definition more or less temporary and can be effected by issues debated within a profession. One such issue of great significance for social workers is the effect of professionalization on the goals and values of social reform. The process toward professionalization in social work has been viewed as a double-edged sword: better training and more knowledge will improve the status of social work as a professional but this process is seen with apprehension because of the increasing emphasis on techniques and methods at the price of participation in social action. Bisno (1956) has made the following comment in this regard:

In assuming the rightness and naturalness of this trend (striving for more prestige by way of professionalization) we have tended to ignore the question of the price to be paid for the higher status and whether it is "worth" it. Does it imply a weakening of the "social" in social work? (Bisno, 1956:17)

The Social Worker as a Professional

Greenwood (1962) has stipulated that one of the attributes characterizing a profession is "a basis of systematic theory." Kadushin (1959) has defended social work's right to professional status on the basis of this attribute by commenting that:

The knowledge base for social work in a comprehensive topic which encompasses the facts and theories, skills and attitudes, necessary for effective, efficient practice. The literature which details what the social worker needs to know, to do, and to feel is almost embarrassingly rich (Kadushin, 1959:39).

Agreeing with Kadushin, Meyer (1959) also credits social work with a substantial knowledge base as well as competent use of
knowledge base. He further justifies social work's claim to professional status by noting that social work: has established "professional competence" or a "professional self" among its practitioners; has norms which protect the profession against outsiders who might question the mystique represented in the "art" of the practitioner; has developed specific selection procedures (recruitment) for graduate schools of social work; and has created professional associations.

Wilensky and Lebeaux (1965) see the professionalization of social work as being the result of increasing industrialization in American society. Advantages of professional life, according to Wilensky and Lebeaux, are: the higher status of the professions; the higher income of professions; and the new meaning brought to a job due to its professionalization. Professionalization is not without its problems, however, and the two authors see a danger in what they consider the rather quick professionalization of social work:

The danger is not that it takes the steam out of reform; not that it promotes a trained incapacity to see how the social structure affects the problems of the welfare practitioner and client; and surely not that its rewards paralyze the will to press for change. The danger lies instead in the underdeveloped state of the social and psychological sciences and the tendency of oversell their immediate practical implication. Public relations experts, family relations experts, personnel psychologists, advertising men--all risk a premature packaging of limited intellectual perspectives in the hasty drive for professional status, a job territory, and expanded business. Social work, too, is exposed to the temptation to crystallize its organization around unnecessarily restricted and still loose bodies of thought (Wilensky & Lebeaux, 1965:333-34).

Epstein, like so many social workers investigating the professional nature of social work, views professionalization as resulting
in a professional community with a decreasing commitment to the problems of the poor and to radical social action in their behalf. Epstein (1970) explored the empirical relationship between social worker professionalization and social protest. Specifically, he considered the extent to which social work does, in fact, constitute a professional community, the extent to which this community is organized around a neutralist ideology of professionalism, and the extent to which integration into the professional community is associated with conservative conceptions of strategies of change for social work.

After testing the descriptive and predictive power of a neutralist-professional community model of social work, Epstein's empirical evidence indicated that his paradigm neither described the professional structure of social work nor adequately predicted the relationship between professionalization and social worker radicalism. He, therefore, found no support for the notion that social work is an integrated professional community, that it is structured around a neutralist ideology of professionalism, or that professionalism is negatively associated with radicalism. He did find that commitment to a neutralist ideology of professionalism is associated with more conservative social action commitments. Epstein suggested that his findings indicate that conservatism might be more a product of individual desire for professional status, organizational variables, and status characteristics that social workers bring to the job rather than a response to a relatively homogeneous, organized, and inherently neutralist professional
Rein (1970) cites the difficulty of defining the nature of social work as one of the obstacles to achievement of professional status. Hollis and Taylor's exhaustive study of social work education in the early 1950's concluded that "social work and social workers should be looked upon as evolving concepts that are as yet too fluid for precise definition" and it is Rein's opinion that "this fluidity has hardly become solidified" in the succeeding years. He believes that because social workers serve as policy planners, reformers, social critics, and clinicians, it is difficult to identify the single professional ideology that binds these diverse activities together but he does distinguish two trends that offer a basis on which to elicit an ideology of social work as a profession. The first is the social worker's accountability to the consumer which is a departure from the traditional professionalism, which has always been colleague oriented rather than client oriented, a distinction made explicit by Hughes' definition of a professional as someone respected by his colleagues and a quack as someone respected by his clients. The second is advocate intervention in larger systems, such as the community, rather than in the life of the individual. It is Rein's opinion that community intervention is an idea that is very acceptable among the helping professions, e.g., community psychiatry and community psychology as well as community organization in social work.

Rein is confident that social work will achieve professional status as it moves away from altering the environment on behalf of a given client to altering the environment in general without
reference to a particular client. He recommends that social work move toward a radical policy approach and that a radical casework approach, which he defines as rebellion by social workers within a bureaucracy in an effort to humanize its established procedures and policies, might provide the most beneficial strategy to pursue.

Gurin and Williams (1973) have remarked that the literature which has developed on social work as a profession has popularly described it as a "new," "young," or "emerging" profession (Kahn, 1959; Wilensky & Lebeaux, 1965) thus giving the impression that social work has not yet arrived fully as a profession when, in fact, social work can identify a history of professionalization that extends back to the early twentieth century. Citing Flexner's negative evaluation of social work, the authors note that unlike the professions that met Flexner's criteria the profession of social work is not based on standards of individual responsibility. They indicate that it has always been difficult to separate social work as a profession from the problems, policies, and commitments of the wide variety of organizations in which social workers practice. The basic problem in this situation is that the social work profession does not control most of the organizations which employ social workers. Except for rather small and limited areas, professional social workers have been largely ancillary to either politically dominated mass service systems or medically dominated professional systems.

Gurin and Williams explain that prior to the expansion of the 1960's, it had been customary to view social work as a single profession in which there were three discernible methods of
practice--casework, group work, and community organization. All were conceptualized as client-oriented, helping processes directed toward the achievement of client determined goals. There had always been a value framework that combined concern for the improvement of social conditions with help to the client in achieving better social functioning and self-realization. It is generally recognized that the drive for professionalization had the effect of stressing the individual adjusative elements in that value framework, while the social change commitment frequently received only lip service.

Adopting a social psychological perspective, Clearfield (1977) details the professional self-image of social workers from three National Association of Social Work chapters. His study provides descriptive data on the professional self-image of social workers. "Professional self-image" was defined as that part of the professional identity which concerns the evaluative attitudes towards the occupational identity and as part of the individual's personal self-concept, the nature of the professional self-image has significant implications for the occupational group and for each member of that group. The professional self-image of social workers, according to Clearfield, has considerable impact upon such professional concerns as the prestige of the group in society, the recruitment, job satisfaction, retention, the career patterns of the members of the profession, and the ability of those members to provide optimum service to their clients.

The findings of the Clearfield investigation suggest that the conventional wisdom about the professional self-image of social workers if both simplistic and inaccurate. Clearfield observes that
defining the professional self-image as the obverse of professional
prestige is erroneous since social workers seem to have developed a
self-image that discounts their negative public image and reminds
the reader to remember that what is real has less importance than
what is perceived to be real. Although the drive for increased pro-
fessionalization among social workers has been criticized as self-
serving by some, Clearfield maintains that this is important to the
professional self-image. His findings indicate that social workers' evaluations of the knowledge, competent, effectiveness, and profes-
sional autonomy of other social workers has a greater impact on their
self-image than any other single aspect of the profession. The desire
to increase professionalization, according to Clearfield, is related
to the social workers' personal and professional identity—the higher
the perceived degree of professionalization, the more likely they will
be to perform at an optimum level. The findings from the Clearfield
study carry the implication that achievement of greater professionali-
ization would serve to enhance the professional self-image of social
workers.

### Research Model Variables

If social activism is the dependent variable, the next rea-
sonable step would be to question what variables are associated with
the CMHC social worker's role of social activist. Is an expansive
perspective on the domain of community mental health and a willingness
to be involved in social action to further mental health a function
of personal characteristics, cognitive characteristics, or
organizational characteristics? In an effort to present the impinging variables, a model consisting of independent and dependent variables is presented.

The independent variables consist of characteristics of the community mental health social worker; the organization in which he/she functions—the community mental health center; and the characteristics of the social workers' cognitions of CMH ideology, CMHC orientation, and professionalism.

Previous attempts at classifying community mental health centers (Glasscote et al., 1964; Glasscote & Gudeman, 1969; Kellam & Schiff, 1966; Ozarin, Feldman, & Spaner, 1971; Schulberg, 1969, 1969; Schulberg & Baker, 1969) suggest that the major elements of administrative structure, organizational pattern, catchment area, and placement in the public or private sphere are some of the important components of a typology.

Federal guidelines define the catchment area of community mental health centers in terms of geographical service areas with a population of 75,000 to 200,000 and are concerned with the predominant socioeconomic and ethnic makeup as well as the demographic complexity (rural, suburban, urban) of the area of responsibility. Because the catchment areas are defined in terms of population, there is an interrelationship between population size and geographical size, which is likely to exert influence on service delivery patterns. In other words, the characteristics of the catchment area may have some influence on perceptions of what is appropriate or required behavior for the community mental health social worker.
The socioeconomic and ethnic character of the catchment are conceptually significant. The mental health needs of one segment of the American population characterized by particular socioeconomic and ethnic characteristics could vary greatly from another segment of the population with different socioeconomic and ethnic characteristics.

Recent emphasis in conceptualizing community mental health centers has moved away from limited descriptions of organizational forms to focusing upon the character of the network of services and constituent agencies providing these services (Schulberg, 1969; Ozarin, Feldman, & Spaner, 1971). A basic step in considering the character of the caregiving network would be the number of participating agencies. One can, therefore, think in terms of the atypical, one-agency case, the coalition of a few agencies (e.g., 2-6), and the large consortiums of cooperating agencies (7 or more).

The issue of authority and accountability in the operation of community mental health centers and the planning of services is, in a number of ways, problematic. The degree of community involvement and input varies as does the segments of the community represented. Most community mental health boards are weighted rather heavily with professionals and representatives of the power structure (Ozarin, Feldman, ...
& Spaner, 1971), yet the minority group population of the catchment area generally represent groups with the most urgent mental health needs; their presence on the board is thought to be necessary for adequate planning of mental health needs and the assignment of priorities. This suggests that two elements of concern reside in accountability and authority: one, whether the board is essentially advisory and the source of power rests at some other echelon and two, where minority groups are adequately represented on the board. One can view this in terms of "local" vs. "governmental" authority and "elite" vs. "indigenous" control. The nature of the community mental health center's accountability defined in these terms would most certainly seem to have an effect on the social activism of the social worker.

Current figures indicate that approximately half of the community mental health centers are under public auspices, with the others under private sponsorship. A review of the literature on auspices (Kellan & Schiff, 1966; Levenson, 1961; Neugeboren, 1970; Ozarin, Spaner, & Feldman, 1971) has shown that auspices is related to the willingness to engage in change agentry requiring militant tactics. Thus, the auspices of the center is a variable that should be viewed as predicting social activism.

Moving from the group of independent variables relating to organizational and catchment area characteristics, the investigator is also concerned with independent variables relating to certain characteristics of the social worker and the context within which the worker functions, i.e., the community mental health center.
The social worker's level of education and age are two personal characteristics logically related to social activism. Although higher education often serves as a conservatizing force, the nature of social work education has served in many circumstances as a motivating force toward social activism. The age of the social worker is considered significant because of the recent emergence of the community mental health movement. The younger the social worker the more likely his/her training included the conceptual values of social activism in matters relating to community mental health. For older social workers, social activism represents, at least partially, a professional resocialization.

A unique feature of the community mental health center is the requirement that it provide five essential services: inpatient care, outpatient care, partial hospitalization, emergency treatment, and consultation and education.

The first four are direct services, while the fifth is an indirect service. Direct services are primarily intramural, while indirect are carried out in the community. Given this, it was reasoned that a person involved in consultation and education would have more opportunity to be involved in the community aspect of community mental health than someone whose major concern was inpatient care. With more exposure to the community, the salience of a more activist stance might become more apparent to social workers in community mental health centers.

A third set of independent variables has been labeled as "cognitive characteristics of social workers." These cognitive
characteristic variables are "in the head" variables which cannot be seen, heard, or felt; but, are inferred from the social worker's behavior. Three cognitive characteristic variables considered to be significant in the current investigation are: community mental health ideology, organizational perception of the community mental health center (social service agency/medical facility continuum), and perceived professionalism.

It has been suggested that variation in the perception of the role of the community mental health social worker might be a function of occupational or descriptive characteristics of the worker or the organization. However, psychological and social psychological research (Adorno, et al., 1950; Rokeach, 1960; Zimbardo, Ebbesen, & Maslach, 1977) have indicated that role perceptions are not directly related to structural features of organizations or characteristics of individuals, and that some psychological or social psychological dimensions might be important. Various belief systems of the workers have generally been considered to constitute significant variables. It, therefore, seems theoretically appropriate to employ some measure of mental health ideological stance of the worker in order to assess the impact of ideology on the social activist role perception. More specifically, some measure of adherence to the beliefs associated with community mental health was needed. A reliable and valid scale measuring this has been developed by Baker and Schulberg (1967).

Social action was an increasingly popular ideology of the 1960's: the notion that societal change could be born through various demonstrations or organized protest efforts. A number of community
mental health leaders viewed social action as an important weapon in their arsenal. Social ideology, then, could be viewed as having points of convergence with community mental health but sufficiently independent of it to require its separate measurement as a variable that might possibly impinge on the social activist role of the community mental health social worker.

A second significant cognitive effect involves professionalism and professionalization. The empirical literature available on these two concepts suggest that professionals are socialized to a set of values and expectations that might vary or conflict with the norms of the organization in which they function. Frequently, workers in these situations develop patterns of polar orientation: bureaucratic and professional (Bennis et al., 1958; Bennis & Slater, 1968; Billingsley, 1964; Reisman, 1949; Wilensky, 1964).

The concepts of professionalism and professionalization have been a source of vigorous debate in the field of social work since the early 1900's (Flexner, 1915). A study of social workers by Billingsley (1964), found that they were more likely to carry out agency policies and adhere to professional standards than they were to meet client needs or community pressures. Epstein's 1968 study of New York City social workers, cited two significant points: high organizational status is inversely related to the endorsement of radical social action strategies, and professionalism acts as an intervening variable to moderate the conservatizing effects of organizational rank. Therefore, such findings indicate that some index of professionalism should be included as an intervening variable.
A final cognitive effect related to the organizational perception of the social worker regarding the orientation of his/her community mental health center, a basic point of contention in the 1960's, related to what community mental health "ought" to be. The medical model was heavily attacked and various public health and social service alternatives were proposed. Evaluation of the social worker's perception of the community mental health center as a social service agency or a medical facility can be seen as an index to the social worker's social activism.

Part of the rationale underlying the dependent variables have already been discussed in explaining the nature of the research problem. The technical details of operationalization will be covered in the third chapter. The following discussion is a bridge between the two.

The work of Roland Warren provides a framework for understanding the nature of change agent roles, i.e., social action roles. Warren (1965), in attempting to conceptualize purposive social change at the community level, delineated three types of issues around which change takes place: consensus, difference, and dissensus. Warren believes issue consensus, basic agreement about the way an issue should be resolved or about the likelihood of reaching such agreement, to be the best route for community change. He defines issue difference and issue dissensus as degrees of divergence from the consensus model. Difference is defined as a situation where there is a big possibility that consensus can be eventually reached, but there is--at the moment--no agreement that an issue exists. Issue dissensus in descriptive of
a situation where little chance of consensus exists. It is significant to recognize that the substantive nature of the lack of issue consensus in both the difference and dissensus situations may be identical but what differentiates the two is the potential for achieving consensus: where it is reasonably high, one speaks of difference, where it is remote, one speaks of dissensus.

In shifting from change situations to the endorsement of various change strategies, Epstein's study of social workers in New York City is important. Traditionally, social work leaders have urged social workers to become involved in social action and the National Association of Social Workers has officially endorsed advocacy. Epstein dichotomized social action situations as being either consensus or conflict and social action strategies as being either institutionalized or non-institutionalized. The use of the consensus-conflict dichotomy by Epstein can be viewed as a simplified version of Warren's social change model. Institutionalized strategy, according to Epstein's explanation, involved, "the use of formally organized, publicly sanctioned structure for processing pressure for social change; a non-institutionalized strategy operates outside formal structures" (Epstein, 1968:103).

Epstein conducted a survey of 1,020 members of the New York City Chapter of the National Association of Social Workers (NASW) to discover their attitudes toward social action (social change) strategies in two areas: housing reform and public welfare. There was heavy endorsement of both institutionalized and non-institutionalized consensus strategies in both arenas. Institutionalized conflict
strategies were endorsed by the majority of the respondents, but not by the same large numbers as consensus strategies. On the other hand, non-institutionalized conflict strategies were not approved by the majority of social workers. The conflict strategies, both institutionalized and non-institutionalized, were approved more frequently in the area of housing. Epstein thought that this was "...probably a consequence of the closer institutional ties between social workers and public welfare settings. Thus, while social workers generally are disciplined to support direct action strategies for the profession, they are even less likely to do so on issues that threaten institutional arrangements in which they may be involved" (Epstein, 1970a:76).

Epstein found a greater degree of differentiation of social action roles for professional and lay groups in areas of more intense institutional involvement when he questioned respondents on the single most effective strategy for social workers, middle class people, and low income people. For low income people acting on their own behalf, conflict strategies were considered to be the most effective. Conflict strategies for the poor were more likely to be endorsed by social workers in institutions in which they were less involved. One might, therefore, conclude that conservatism grows when the problem is perceived as coming too close to home.

Two dimensions appeared to be important in the conceptualization of social activism: the institutional sphere of the situation, i.e., whether the situation is depicted as involving schools, welfare, police, etc.; and the action environment of the situation, i.e.,
consensus or dissensus. Inclusion of the former was found to be necessary in order to ascertain the perceived domain of community mental health and to evaluate the accuracy of Dinitz and Beran's (1971) assertion that community mental health was a "boundaryless" and "boundary busting" system. The judgment that something was or was not within the purview of community mental health might derive from an ideological stance or, as Epstein suggests, from a reluctance to infringe on the territory of one's peers.

Epstein's work has suggested that change agent roles could operate on four levels: institutionalized consensus, non-institutionalized consensus, institutionalized conflict, and non-institutionalized conflict. The assumption being that--given a particular situation--the social worker will select one or more of these roles. What of the social worker in the community mental health center who has a more traditional, clinical orientation? Is it possible that he/she might avoid any change agent role? The role of the community mental health social worker as a change agent (social activist) appears to lie on a continuum--with rejection of the role at one end, a willingness to engage in social action (i.e., non-institutionalized conflict strategies) at the other, and several intervening points.

A role is not assumed or endorsed in isolation or without possible conflict. What one does as a member of an organization is, at least in part, a reflection of organizational policy and may be only an approximation of what one would do if one were allowed to follow personal or professional proclivities. This discrepancy between the "real" and the "ideal" role has been well studied (i.e.,
the work of Gross et al., 1957). The notion of "real" and "ideal" role permits exploration of the social worker's role as social activist within the community mental health center. It is necessary to measure the social worker's perception of the community mental health center's activism so that it can be compared to the worker's perception of his/her own personal/professional activism. If there is a discrepancy between the two, the magnitude and direction of the discrepancy can be regarded as another dimension of the dependent variable. Thus, three dependent variables are: the "real" (CMHC activism) role, the "ideal" (personal/professional) role, and role discrepancy (the difference between CMHC activism and personal/professional activism).

Boundary busting, the fourth dependent variable, can be defined as the willingness of the social worker to become involved with organizations that might be considered outside the domain of community mental health in an effort to benefit community mental health center clients. Boundary busting, as previously noted, is considered to be a form of social activism.

Summary

The passage of the Community Mental Health Centers Act of 1963 was the result of an increasing awareness of the need for a "bold new approach" to mental health and mental retardation. President Kennedy designated three major objectives of this new mental health program: (1) the discovery of causes of mental illness and mental retardation so that those causes might be eradicated; (2) the
strengthening of underlying resources of knowledge and skilled manpower through aid for higher education and the expansion of existing training programs for workers in the various occupations and professions affiliated with mental health; and (3) an improvement of the programs and facilities serving the mentally ill and the mentally retarded.

The Community Mental Health Centers Act carried with it an ideology concerning social policies. The operationalization of this ideology varied immensely according to the occupations and professions of the individuals staffing the community mental health centers. Among the professionals employed by the centers, social workers gained a reputation for social activism.

The current study has undertaken the examination of the social worker as social activist in the community mental health center and the ultimate effect of this activism on social worker professionalism. The independent variables utilized in the research are: organizational auspices, organizational accountability, organizational complexity, social worker's age, social worker's level of education, social worker's tenure at community mental health center, the proportion of time spent by the social worker's adherence to community mental health ideology, the social worker's organizational perception of the community mental health center as based on a social service agency model as opposed to a medical facility model, and the social worker's perceived professionalism. The dependent variables are: community mental health center activism, personal/professional activism, role discrepancy (the discrepancy between perceived CMHC activism and perceived personal/
professional activism), and boundary busting.

Three literature reviews were presented in chapter one. The first provided a brief history of the community mental health movement. A second literature review dealt with the relationship between social work and social activism with particular attention being given to social work and social activism in the 1960's since social workers first began their work at community mental health centers at that time. The final literature review gave information on the professionalization of social workers from three distinctly different perspectives: the social worker as a nonprofessional; the social worker as a semi-professional; and the social worker as a professional.

The final section of this chapter focused on the nature of the variables in the research model.
CHAPTER II

THEORETICAL FRAMEWORK AND HYPOTHESES

Introduction

The central focus of the current study will be the examination of the degree of social activism endorsed by social workers employed by community mental health centers and the effect that this endorsement has on social worker professionalism. The nature and extent of social worker activism will be investigated through an analysis dealing with the variation of social activism endorsement among social workers at community mental health centers. Role theory is considered to be an important conceptual tool in this study because in the words of S. F. Nadel:

its usefulness, in simplest terms, lies in the fact that it provides a concept intermediary between "society" and "individual." It operates in that strategic area where individual behavior becomes social conduct, and where the qualities and inclinations distributed over a population are translated into differential attributes required by or exemplifying and obtaining social norms (Nadel, 1957:20).

Studies on role have been influential in clarifying the relationship between role and personality; they have conceptualized a social system as consisting of two basic dimensions: the nomothetic and the ideographic. The nomothetic dimensions contains: role expectations, which delineate the normative rights and duties associated with a
status, and which jointly define role; roles are complementary and
taken together comprise the unit of institution. The ideographic
dimension has three aspects: need-dispositions, which denotes
tendencies to act in certain ways and which combine to define per­
sonality; personality represents a specific mode of reaction to the
environment by the individual. Getzels and Guba (1968) have repre­
sented the nomothetic and ideographic dimensions as follows:

Normative (nomothetic) dimension

Institution → Role → Expectations

Social System

Individual → Personality → Need-dispositions

Social behaviour

Therefore, role theory offers an excellent theoretical framework for
the study of social workers, social activism, and community mental
health centers.

Chapter two will provide: a review of the literature on role
and role conflict, an application of role theory to social workers,
and conclude with a presentation and discussion of the investigator's
hypotheses.

Literature Review of Role Theory

Numerous reviews of the literature on role have identified
the different ways role has been conceptualized (Neiman & Hughes,
1951; Gross et al., 1958; Biddle & Thomas, 1966; Robin, 1966; Morris, 1971). Most of these reviews have indicated that the perspective on role that Anthropologist Ralph Linton (1936, 1945) developed is the most utilitarian and definitive.

Linton was the first social scientist to combine culture, social structure, and the behavior of individuals through the concept of role. This was accomplished, in part, by his initial differentiation between status and role.

A status, as distinct from the individual who may occupy it, is simply a collection of rights and duties...a role represents the dynamic aspect of status. The individual is socially assigned to a status and occupies it with relation to other statuses. When he puts the rights and duties which constitute the status into effect, he is performing a role (Linton, 1936:113-14).

In this definition, status is a reference to location in a social structure and role is perceived as an expression of status. Linton later redefined role to refer to expectations and behavior when he wrote The Cultural Background of Personality:

Role thus indicates the attitudes, values and behavior ascribed by the society to any and all persons occupying this status (Linton, 1945:77).

Linton's approach to role defines role as a set of expectations for behavior applied to occupants of positions in a social structure but his conceptualization of role is only the first of many presented in role literature.

Parsons (1951) has provided a theoretical work which unites the perspective of Linton with Mead (1934), who attempted to link the functioning of social order with that of individual characteristics and personality so it might be possible to examine "that strategic
area where individual BEHAVIOR become social CONDUCT" (Nadel, 1957). According to Parsons, role is "that organized sector of an actor's orientation which constitutes and defines his participation in an interactive process. It involves a set of complementary expectations concerning his own actions and those of others with whom he interacts" (Parsons, 1951). Status, however, refers to the actor's position within an institution, that is within a system of roles. Role is, therefore, the "processual aspect" and status the "positional aspect" of an actor's participation in a social system.

This initial distinction between status (or position) and role is significant. As a structural or relational concept, status can be defined only in terms of an organized system of norms or role expectations. This was implicit in the Gross et al., (1958) observation that one can never have a position without expectations or behavioral patterns and Sarbin (1954) made a similar statement when he wrote that "a position in a social structure is equivalent to an organized system of role expectations."

Gross et al., (1958) selected three categories for the various definitions of role that are presented in the literature. Typified by Linton's approach to role and including definitions which equate it with or define it to include normative cultural patterns, the first category of definitions places emphasis on evaluative standards rather than behavior. Also included in this "normative cultural pattern category" are the works of Newcomb (1951), Znaniecki (1940), Bennett & Tumin (1948), Rose (1951), and Komarovsky (1946).

The second category of major role definitions that Gross et al., delineates are those where "a role is treated as an individual's
definition of his situation with reference to his and others' social positions" (1958:13). This approach to role does not isolate position in the social structure and treats evaluative standards and actual behavior in an interactional framework. Sargent's statement is given as an example of the definitions included in this category:

...a person's role is a pattern or type of social behavior which seems situationally appropriate to him in terms of the demands and expectations of those in his group (Sargent, 1951:36).

Sargent perceives roles as having "ingredients of cultural, of personal, and of situational determination but never is a role "wholly cultural, wholly personal, or wholly situational" (1951:359).

A third category cited by Gross et al., emphasizes definitions which deal with role as "the behavior of actors occupying social positions" (1958:14). A role defined in this manner refers to what actors actually do as position occupants. Davis' definition of role fits into this category:

How an individual actually performs in a given position, as distinct from how he is supposed to perform, we call his role. The role, then, is the manner in which a person actually carries out the requirements of his position (Davis, 1949:90).

Robin (1966) describes three approaches to role that differ from the Gross et al., categorization in terms of the phenomena investigated and conceptual clarity. The first category noted by Robin is one developed by Sarbin (1954), Rosenberg (1962), Davis (1949), and Sherif (1948). The basic ingredients of this position have been identified by Sarbin:

The writer would regard a position in a social structure as a set of acquired anticipatory reactions. This
is to say, the person learns (a) to expect or anticipate certain actions from other persons and (b) that others have expectations of him.... In other words, a position is a cognitive organization of expectations, a shorthand term for a concept embracing expected actions of persons enacting specified roles.... A role is a patterned sequence of learned actions or deeds performed by a person in an interaction situation (Sarbin, 1954:225).

According to Sarbin's definition, role is behavior and expectations that create the position. Robin asserts that by failing to isolate position, as a sociological concept, these theorists are not able to treat role in the abstract by separating the personality system of the actor from the structural demands, conflicts, and ambiguities of the role per se (1966:141). It is Robin's conclusion that this approach to role "...confuses structure with norms and expectations with behavior" (1966:146).

The second category that Robin delineates is the one established by Linton. Position or status is conceived as a structural unit in this conceptualization and the definition of a particular position is in terms of other positions in a social structure.

The third approach that Robin describes considers the concept of role-set which has its origins in the works of Merton (1957) and Bates (1955). Merton explains the concept of role-set in his sociological classic, Social Theory and Social Structure:

...We must note that a particular social status involves not a single associated role, but an array of associated roles.... This fact of structure can be registered by a distinctive term, role-set, by which I mean that a complement of role relationships which persons have by virtue of occupying a particular social status (Merton, 1957:369).

Robin explains the difficulty with the third approach by

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noting that it would analyze the various roles an occupant of a position would be expected to perform in a variety of social structures but fail to consider the unique character of each position in each social structure.

Biddle and Thomas (1966), in addition to reviewing the literature on role, provide an extensive classification scheme to order the various role phenomena. They note that the ordering of concepts of role have usually received less attention than the classificatory concepts, but that ordering the concepts are important because they are among some of the central ideas in the hypotheses and theories of role:

Concepts for variables, like those for classification and properties, may be used for descriptive or theoretical purposes, but unlike these other types of concepts, the ordering ideas are particularly well suited to interpretation, explanation, and prediction (1966:62).

In a discussion of role theory, Levinson (1959) commented on the structural difficulties in what he termed the unitary conception of role. Such a conception (originating from the writing of Linton) had, according to Levinson, at least three specific meanings:

1. Role may be defined as the structurally given demands (norms, expectations, taboos, responsibilities and the like) associated with a given social position. Role is, in this sense, something outside the given individual, a set of pressures and facilitations that channel, guide, impede, and support his functioning in the organization.

2. Role may be defined as the member's orientation or conception of the part he is to play in the organization. It is, so to say, his inner definition of what someone in his social position is supposed to think and do about it. Mead (1934) is probably the
main source of this view of social role as an aspect of the person, and it is commonly used in analyses of occupational roles.

3. Role is commonly defined as the actions of the individual members--actions seen in terms of their relevance for the social structure (that is, seen in relation to the prevailing norms). In this sense, role refers to the ways in which members of a position act (with or without conscious intention) in accord with or in violation of a given set of organizational norms. Here, as in (2), role is defined as a characteristic of the actor rather than of his normative environment (1959:172).

The unitary conception of role, Levinson stated, assumed a high degree of congruence among the three role aspects and although one could expect some congruence it was unrealistic to expect a 1:1 relationship; he, therefore, recommended that the three role concepts be redefined and renamed as role-demands, role-conception, and role-performance.

Role Conflict

Role-demands, or role expectations, may comprise, as Gross et al., (1958) have observed, either predictive or normative criteria; they will also have a degree of consensus, and be external to the individual incumbent of the specific status. Levinson stated that they are "the situational pressures that confront" the incumbent, and may have "manifold sources." Gross et al., (1958), in a similar context, made reference to role segmentation, and the "multiple expectations" that may hold for the incumbent of a specific position. Merton (1957), expanding on Linton's terminology, described such multiple expectations as "role-sets." Recognizing that each social status involves not a
single associated role, but a number of roles, Merton defined role-set as "that complement of role relationships which persons have by virtue of occupying a particular social status" (Morris, 1971:398).

A network of role expectations, a number of which are in conflict, is, as many role analysts have commented, a structural basis for conflict; but as with so many concepts in role theory, the term "role conflict" has itself been subjected to a variety of meanings. Four major aspects of role conflict have been discussed in the literature, and Morris (1971) has described them as the following:

1. **Inter-role conflict**- Sarbin (1954) suggested that "role conflicts occur when a person occupies two or more positions simultaneously and when role expectations of one are incompatible with the role expectations of the other." Such conflict is more properly designated role-role conflict, as Musgrove (1967) has suggested.

2. **Intra-sender conflict**- Kahn et al., (1964) have proposed that this term be used for those conflicts which are derived from the contradictory expectations of a single member of the role set.

3. **Intra-role conflict**- The pattern of role relationships and the accompanying expectations which an individual has by virtue of occupying a single position has been termed a role set. That such role-sets engender, through conflicting, even incompatible role expectations, role strain upon the incumbent has been well documented (Parsons, 1951; Seeman, 1953; Gross et al., 1958; Kahn, 1964).

4. **Self-role conflicts**- Discrepancies between patterns of expectations attaching to a role, and the patterns of need-dispositions characteristic of the incumbents of the role result, according to Getzels (1968), in self-role conflict. "Absolute congruence," he writes, "between expectations and needs, and along expectations in a role set and among needs in a personality is not found in reality. Consequently, there is inevitably a greater or lesser amount of conflict for the individual and strain in the institution." ... Levinson (1959) speaks of such a
situation in terms of "role dilemmas or problematic issues," while Goffman (1961) assigns the term "role distance" to signify the extent to which a person must play roles that contradict his self-image... (Morris, 1971:398-99).

It is important to note that while many authors (Merton, 1957; Secord & Backman, 1974; Ivey & Robin, 1966) have chosen to treat role conflict as conceptually independent or role strain, Morris (1971) presents role strain as a dimension of role conflict which he terms intra-role conflict. Also considered under this intra-role conflict categorization is Goode's (1960) definition of role strain which he described as coming about through: contradictory or conflicting demands from different roles; inconsistent or competing requirements for the same role; conformity to unpleasurable role demands; and over-demanding role obligations. According to Goode, an individual can select from two primary sets of techniques for role strain reduction: those which will determine whether he enters or leaves the role, and those which constitute a role bargain (Goode, 1960:486).

Additional studies on role conflict of particular relevance to the current investigation are Ivey and Robin (1966) and Parsons (1966). Both of these studies can be related directly to the role conflict experienced by the social worker in the community mental health movement.

Ivey and Robin (1966) define role conflict as any "situation in which there is systematic difficulty involved in assuming, maintaining a role, or functioning in a role situation" (1966:30). They cite the basic sources of role conflict as:
1. Situations in which legitimate role definers disagree about the normative content of a role.

2. The agreed upon expectations for a role cannot all be fulfilled by the role incumbents because they are competing or conflicting.

3. The role in interaction with the social system:
   (a) A type of "functional" role conflict occurs when the normative prescriptions of a role are not sufficient to allow the role taker to perform the functions expected of his role in the larger social system in which it is situated; or (b) Role conflict also arises because of the multiplicity of roles an individual assumes.

4. Role conflict stemming from the interaction of the individual and his role, e.g., a situation where the role definers' demands exceed the limits of the role taker's capacity (1966:30-31).

Ivey and Robin indicate in their article, "Role Theory, Role Conflict, and Counseling," that role theory clearly points to the significance of interpersonal and interprofessional relationship if the counselor is to be effective in a work setting and that while the counselor may define his role accurately according to professional standards, it is important that he communicate that definition of role to those with whom he works. If the counselor, according to Ivey and Robin, fails to communicate his perception of role or does not understand others' perceptions of his role, his chances for successful performance in the counseling role are limited.

Parsons' study of role conflict, "Role Conflict and the Genesis of Deviance," focuses on it as something restricted to conflicting sets of legitimized role expectations such that complete fulfillment of both is realistically impossible. Parsons (1966) identified the following sources of role conflict:

1. Differential interpretation of the range of behaviors that are congruent with a norm.
2. Multiple role conflict or conflict among expectations attached to different roles.

3. Situationally inappropriate role performance, e.g., deviant motivation.

4. Changes in any part of ego's role network may induce role conflict.

5. Malintegration of the social system so that cultural and group expectations are incompatible or simultaneous membership in more than one group may require decisions among alternatives.

Parsons indicates that conflict can be beneficial to the social system as a source of motivation leading to social change.

Application of Role Theory to Social Workers

The literature on social work roles is, in general, not based on empirical research. Barker and Briggs (1968) classified most of the literature into the following types: descriptive, prescriptive, informal observations, and theoretical. Regardless of type, Berg et al. (1972) has noted that the social work literature on roles is centered on comparisons of MSWs with non-MSWs--with a primary focus on how to allocate social work staff with optimum efficiency.

Two previous sociological studies that have examined social work role relations in mental health are those of Rushing (1964) and Zander, Cohen, and Statland (1957). Rushing dealt with such problems as low prestige, roles that were not clearly defined, and conflicts between social workers and others regarding demarcation of social work responsibilities. A single setting, a department of psychiatry in a university teaching hospital, was selected for the study. The professions represented in the study were: social work, nursing,
recreation, clinical psychology, and psychiatry. Eight staff social workers comprised the investigator's sample of social workers. His hypothesis was that mental health organizations are a complex of related social roles and divisions of labor. Rushing's findings indicated that psychiatrists and social workers frequently disagreed on the social worker's role, and that tensions were most obvious when rules for professional interaction were ambiguous.

Zander's study investigated the role relationships between psychiatrists, clinical psychologists, and social workers. The data for this study were obtained by means of individual interviews with 156 psychiatrists, 165 clinical psychologists, and 159 psychiatric social workers. The respondents were active in large metropolitan areas and were engaged in work which provided opportunity for interaction with members of the other two professions.

Zander reports that nine out of ten of the social workers interviewed were women, whereas the other two groups were predominantly male. His conclusion, which he credits in part to the influence of sex and role on interrole behavior, is that: "The impression one derives is that the members of this profession want far more responsibility even though they readily accept their status as an ancillary group to psychiatry."

The present research is concerned with whether or not the social worker can juxtapose the two roles of social activist and professional care-giver in his work at the community mental health center. An investigation of these two roles relies on the definition of role as it was established by Linton (1945), i.e., a position or
status conceived as a structural unit that is defined in terms of other positions in a social structure. This definition is important because role theory literature suggests that an individual's position in a system of social relationships will largely determine his role enactment.

If the social worker cannot successfully maintain the two roles of social activist and professional care-giver simultaneously then it might be assumed that he would experience role conflict.

Hypotheses Development

Examining the intraprofessional differences of social activism among social workers and the effect of social activism on social work professionalism, the hypotheses have been divided into four categories. The first two are based on independent variables relating to the organizational characteristics of the CMHC and the personal characteristics of the social workers employed by the community mental health centers. The third category focuses on three independent variables based on cognitive characteristics of CMHC social workers, community mental health ideology, the community mental health center as an organization based on a social service/medical model continuum, and the three dimensions of felt professionalism. The fourth category will provide an exploration of the degree to which boundarylessness or boundary busting exists in the perceived roles of the social workers employed by community mental health centers.

Social activism was measured through the utilization of the Community Mental Health Worker Role Inventory (CMHWRI). This research
instrument consisted of a series of vignettes formulated from nine community arenas that were illustrative of situations that a community mental health worker might encounter. The arenas of community functioning were represented on a gradient of increasing activism. In each situation, the respondent was requested to answer in terms of what he thought would be the expectations of his community mental health center as well as how he would respond as a professional, without regard for organizational constraints. Recognizing that a role is not assumed or endorsed in isolation or without the possibility of conflict, Wagenfeld and Robin introduced role discrepancy as a third dimension of social activism. What an individual does as a member of an organization is, in part, a reflection of organizational policy and may bear only an approximate correspondence to what one would do if permitted to follow personal or professional inclinations. Role discrepancy, measured by the difference in the CMHC and personal/professional activism scores, provides a method of calculating the differences between the "real" (CMHC activism) and "ideal" (personal/professional activism) roles. Therefore, each hypothesis in the first three categories are tested for community mental health center activism, personal/professional activism, and role discrepancy. Such a format allows the personal, psychological, and organizational sources of real and ideal activism to be investigated.

The final category of hypotheses focuses on boundary busting in the role of the Community Mental Health Center social worker. Boundary busting, the fourth dimension of social activism to be examined, can be defined as the willingness of the social worker to
become involved with organizations that might be considered outside the domain of community mental health centers in an effort to benefit CMHC clients.

**Category I--Organizational Characteristics**

Auspices of a community mental health center was defined as the applicant for the grant that established the center. Within the context of the current study, it has been possible to identify four types of auspices: Public/Governmental; Agency/Board; University; and Hospital. Auspices of the CMHC can differ in their social histories as well as their organizational commitment to social activism or the maintenance of the status quo.

Government auspices (state mental hospitals), university auspices, and hospital auspices, for example, all predate community mental health centers and reflect an intramural orientation while agency/board auspices are frequently newly developed organizations explicitly created to reflect community concerns in the provisions of health care. It is, therefore, hypothesized that social workers would perceive a CMHC under agency/board auspices as having a strong orientation toward social activism, that social workers employed by CMHCS with an agency/board auspices would be more activistic than other social workers, and that social workers employed by such a CMHC would experience less role discrepancy.

**Hypothesis IA:** Social workers will perceive CMHCs with an agency/Board auspices as more supportive of activism than CMHCs under other auspices.

**Hypothesis IB:** Social workers employed in a CMHC under agency/board auspices will have a higher level of
personal/professional activism than social workers employed at CMHCs under other auspices.

Hypothesis 1C: Social workers employed at a CMHC under agency/board auspices will have less role discrepancy than social workers at CMHCs under other auspices.

Organizational complexity was a variable which dealt with the center on the basis of its components. A single agency was considered one component. The primary concern here was with whether the social worker was from a single agency or multiple agency program, and if the latter, which kind of agency was the dominant force. A multiple agency program might be dominated by a medical (psychiatric) model or a social service model. If a program was under medical dominance, for example, one could expect numerous types of organizations involved: voluntary and public general hospitals, psychiatric clinics, state hospitals, and medical schools or universities. It is hypothesized that social workers will perceive more CMHC activism in a center with less organizational complexity, be more activist in a center with limited organizational complexity, and experience less role discrepancy than their colleagues in CMHCs with greater organizational complexity. This series of hypotheses is based on the work of Kahn et al., (1964) on organizational stress. According to Kahn et al., "the role expectations held by members of a role set--the prescriptions and proscriptions associated with a particular position--are determined by the broader organizational context."

Hypothesis 2A: Social workers will perceive more CMHC activism in a center with less organization complexity than in a CMHC with greater organizational complexity.

Hypothesis 2B: Social workers employed by a CMHC with less organizational complexity will have a higher
level of personal/professional activism than those social workers in a CMHC with greater organizational complexity.

**Hypothesis 2C:** Social workers employed by a CMHC with less organizational complexity will experience less role discrepancy than social workers in a CMHC with greater organizational complexity.

The issue of accountability in the functioning of community mental health centers and the planning of services is complex. The actual community involvement and input varies greatly from community mental health center to community mental health center, and the segments of the community represented is also subject to vast variation. Most community mental health boards have a preponderance of middle class professionals and representatives of the community power structure. The minority group populations of the catchment area usually represent the groups with the most urgent mental health needs. Consideration of accountability, then, must be taken into account as to whether the board is essentially advisory and the source of power resides elsewhere or whether minority groups are represented adequately on the board. This can be viewed in terms of "local" vs. "governmental" authority and an "elite" vs. "indigenous" control. Therefore, it can be hypothesized that the nature of accountability required of a community mental health center would have an effect on CMHC activism, the personal/professional activism of the social workers, and role discrepancy. The hypotheses dealing with CMHC accountability suggest that CMHCs that are accountable to community mental health boards with indigenous representation and controlled by the community will be perceived by social workers as more oriented toward activism, that social workers employed by such CMHCs will have a stronger orientation...
toward personal/professional activism, and that they (the social workers) will experience less role discrepancy. Such hypotheses can be justified on the assumption that CMHCs accountable to community mental health boards with indigenous representation and controlled by the community would be more responsive to the needs of the people in its catchment area, therefore, more activistic than CMHCs that were accountable "governmental" authority and "elite" control.

Hypothesis 3A: Social workers will perceive CMHC activism as greater in CMHCs that are accountable to community mental health boards with indigenous representation that are controlled locally than in a CMHC with different accountability.

Hypothesis 3B: Social workers employed by CMHCs accountable to community mental health boards with indigenous representation that are controlled locally will have a higher level of personal/professional activism than social workers employed by CMHCs with different accountability.

Hypothesis 3C: Social workers employed by CMHCs accountable to community mental health boards with indigenous representation that are controlled locally will have less role discrepancy than social workers employed by CMHCs with different accountability.

Category II--Personal Characteristics of Social Workers

It is thought that the age of the social worker will be directly related to his level of social activism. Even though the community mental health movement is recent in origin, it has been in existence long enough to affect the professional socialization of the most recent cohorts of social workers. Therefore, the youngest social workers, more influenced in a formative professional stage, should have higher levels of social activism in matters relating to community mental health than their older counterparts for whom it
represents at least in part, a professional resocialization.

Hypothesis 4A: Younger social workers will perceive lower levels of CMHC activism than older social workers.

Hypothesis 4B: Younger social workers will have a higher level of personal/professional activism than older social workers.

Hypothesis 4C: Younger social workers will experience more role discrepancy than older social workers.

Research indicates that social workers frequently begin their careers with a strong orientation toward social activism that is gradually eroded through on-the-job experiences resulting in "burnout syndrome," a term that has come to be associated with an extreme form of job-related stress and exhaustion (Reid et al., 1977). Malach (1976) describes one of the major signs of burnout for the social worker as "the transformation of a person with original thought and creativity on the job into a mechanical, petty bureaucrat" (Maslach, 1976:18). The length of agency tenure is, therefore, hypothesized to effect the social worker's perception of CMHC activism, the level of the social worker's personal/professional activism, and the resulting role discrepancy in a negative manner.

Hypothesis 5A: The longer the period of time that a social worker has been employed by a CMHC the lower the perception of CMHC activism.

Hypothesis 5B: The longer the period of time that a social worker has been employed by a CMHC the lower the level of personal/professional activism.

Hypothesis 5C: The longer the period of time that a social worker has been employed by a CMHC the lower the discrepancy.

Although higher education often serves as a conservatizing force, it is hypothesized that the nature of social work education

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(Henry et al., 1971; Hughes et al., 1973) will serve as a motivating force toward social activism. Profiling the social work graduate students of the 1960s, Gurin and Williams (Hughes et al., 1973) have characterized them as "children of their decade," noting that:

They seem to believe more firmly than did their predecessors that the most important changes in the condition of the poor, the sick, and the oppressed will come about as the result of societal and institutional restructuring rather than induced changes in the character, behavior, or feelings of the individual victims of the system. And they feel more strongly than have professionals in the past that the proper aim of their efforts must be a change in the condition imposed upon the poor and the disadvantaged (Hughes et al., 1973:219).

It is therefore hypothesized that the higher the social worker's educational level the more likely he is to perceive CMHC activism as low, have a high level of personal/professional activism, and a high level of role discrepancy.

Hypothesis 6A: The higher the level of the social worker's education the less likely he is to perceive CMHC activism as high.

Hypothesis 6B: The higher the social worker's level of education the higher the level of personal/professional activism.

Hypothesis 6C: The higher the social worker's level of education the greater the role discrepancy.

The final series of hypotheses in category two deal with the variation in social worker perception of CMHC activism, personal/professional activism, and role discrepancy as it relates to the type of service (direct/indirect) performed by the worker in the CMHC. One of the distinctive features of the CMHC is the requirement that it provides the five essential services of inpatient and
outpatient care, partial hospitalization, emergency treatment, and consultation and education. The first four have been characterized as direct services, while the latter is considered to be an indirect service. Direct services are primarily intramural, while indirect services are carried out in the community. Given this, it is reasoned that the individual involved in consultation and education would have greater opportunity to be involved in the community aspect of community mental health than someone essentially concerned with inpatient care, therefore the social worker in indirect service will adopt the higher level of activism. Implicit in the current study's hypotheses is the assumption that indirect service will spur social activism and create a greater role discrepancy between perceived CMHC activism and personal/professional activism for the social worker spending a greater proportion of time in indirect as opposed to direct service.

Hypothesis 7A: The higher the proportion of time spent by social workers in indirect service the lower the perception of CMHC activism.

Hypothesis 7B: The higher the proportion of time spent by social workers in indirect service the higher the level of personal/professional activism.

Hypothesis 7C: The higher the proportion of time spent by social workers in indirect service the greater the role of discrepancy.

Category III--Cognitive Characteristics of Social Workers

Three cognitive variables considered to be significant in the current investigation are: community mental health ideology, organizational perception (social service agency/medical facility
continuum), and professionalism. Ideology was selected as a variable because of its importance in the field of mental health in general and more specifically in the area of community mental health. Wagenfeld (1972) has suggested that the mental health field and psychiatry have tended to foster the growth and proliferation of ideologies. He notes that numerous treatment ideologies--from psychoanalysis to community mental health--have occupied prominent positions in the mental health field and that the ideological nature of these positions has been facilitated by the paucity of knowledge concerning the etiology of mental disorders. This conclusion is in congruence with the more general arguments of Geertz (1964) and Marx (1969). Geertz has described ideologies as functioning "...to render otherwise incomprehensible situations meaningful, to so construe them as to make it possible to act purposefully within them" while Marx has indicated that ideologies represent shared cultural meanings that permit purposeful social action in circumstances of uncertainty. An ideology, for a professional, is a guide for conduct or action in the face of uncertain or incomplete commands of reality. It is Marx's observation that the significance of ideologies in a professional arena is inversely related to the extent to which the content of the field and the problems confronting its practitioners have been completely understood. He has suggested that three criteria apply to fields that are most likely to create ideologies: (1) newness or rapid expansion; (2) a premium on a particularistic, subjective, or intuitive approach to the application of knowledge; and (3) a moral or ethical aura surrounding the subject matter (Robin & Wagenfeld, 1976). Also,
Friedson (1970a, 1971) argues that professional ideologies represent attempts at professional dominance and autonomy through claiming access to special knowledge and adjudicating territorial disputes among competing interest groups.

As might be expected, a movement that has grown as large and as rapidly as community mental health, has developed a distinct ideology. Baker and Schulberg (1967) were among the first to consider the question of ideology and community mental health. They saw the emergence of the community mental health center as a collectivity which had an organizational basis of community held beliefs which acted to "redefine social action in the treatment of mental illness" (Baker & Schulberg, 1967:216).

The ideology of community mental health, as defined by Baker and Schulberg and utilized in the current investigation, encompassed the perspective that the etiology and treatment of mental disorders resided in the community. Accordingly, they formulated and tested a Community Mental Health Ideology Scale measuring five conceptual areas:

1. **A population focus**--the view that the mental health specialist should be responsible, not only for individual patients with whom he has contracted for treatment, but for the entire population of both identified and unidentified potentially sick members in his community.

2. **Primary prevention**--the concept of lowering the rate of new cases of mental disorder in a population by counteracting harmful forces before they have had a chance to produce illness.

3. **Social treatment goals**--the belief that the primary goal of treatment is, not to reconstruct the mental patient's personality, but rather to help him achieve social adjustment in an ordinary life situation as...
soon as possible.

4. **Comprehensive continuity of care**—the view that there should be a *continuity of professional responsibility* as the patient moves from one program to another in an integrated network of caregiving services.

5. **Total community involvement**—the belief that the mental health specialist is only one member of a group of community agents caring for the mentally ill and that he can extend his effectiveness by working with and through other people (Baker & Schulberg, 1967:217).

Baker and Schulberg thought it necessary to delineate and measure the ideology of community mental health because the ideology of the community mental health worker is important in shaping his behavior as a change agent. If the worker considered it acceptable to alter the life circumstances of those individuals living in poverty, then the worker would have to adopt the role of change agent and would become involved in various modes of social action. The ideological assumption that social conditions are etiologically associated with mental disorder is in part the basis of the social activist role.

The adoption of the community mental health ideology by community mental health workers is not uniform. Baker and Schulberg (1967) have noted considerable variation in ideology endorsement among the members of the disciplines involved in community mental health and recent research by J. Marx (1969), Langston (1970), Mangum and Mitchell (1973), Del Gaudio et al., (1975), Penn, Baker, and Schulberg (1976), and Wagenfeld and Robin (forthcoming) reiterate this finding. The hypotheses in this study will explore the effects of commitment to community mental health ideology on the social activism of the community mental health social worker. Implicit in these hypotheses is the assumption that the greater the social
worker's support of community mental health ideology and the higher the level of personal/professional activism the less likely the social worker is to perceive the level of CMHC activism as adequate. Research by Wagenfeld, Robin, and Jones (1974) has found that ideological commitment to community mental health is strongest among social workers and psychologists and that medical training seems to be associated with lesser commitment to community mental health as an ideology. Therefore, it might be expected that social workers would perceive CMHC activism as inadequate—especially in those cases where CMHCs had psychiatrists as directors.¹

Hypothesis 8A: The greater the social worker's support of community mental health ideology the higher the perceived level of CMHC activism.

Hypothesis 8B: The greater the social worker's support of community mental health ideology the higher the level of personal/professional activism.

Hypothesis 8C: The greater the social worker's support of community mental health ideology the higher the role discrepancy.

A second possible cognitive effect relates to the organizational perception of the social worker. A major point of controversy in the 1960's emanated from what community mental health "ought" to be. The medical model was severely attacked and different public health and social service alternatives were suggested. Research by Wagenfeld and Robin (1978) has shown that CMHC staff members view

¹Eleven of the 20 CMHC directors in the Wagenfeld & Robin research study are psychiatrists, 5 are psychologists, 2 are social workers, while there is one sociologist and one hospital administrator.
their centers differently. Some consider them to be similar to social service agencies while others see them as similar to medical facilities. Looking at the perception of the CMHC on the social service agency/medical facility continuum, it is hypothesized that the social worker's perception of the CMHC as a medical mode of organization will serve as a conservatizing force while the social service agency model will provide a liberal influence. A basis for this hypothesis, the medical model as a conservatizing force and the social service agency model as a liberal influence, can be found in numerous sources relating to the sociology of medicine (Freidson, 1970a, 1970b, 1975; Illich, 1976; Waitzkin & Waterman, 1974) and social welfare (Briar & Miller, 1971; Reid & Epstein, 1972; Bailey & Brake, 1975; Cox et al., 1974). It is further hypothesized that the social worker will perceive less role discrepancy in a CMHC based on a social service agency model than in a CMHC based on a medical facility model because of this liberal influence.

**Hypothesis 9A:** The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility model the higher the perceived level of CMHC activism.

**Hypothesis 9B:** The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility model the higher the level of personal/professional activism.

**Hypothesis 9C:** The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility model the lower the role discrepancy.

The final nine hypotheses in category three deal with social activism as it related to the felt professionalism of social workers.
as viewed in three ways. First, the adherence to "stated professional standards" when placed in opposition to client needs. Second, the adherence to professional standards when placed in opposition to agency policy. Third, the adherence to professional standards when placed in opposition to community expectations. These three variations of professionalism, independently measured, are conceived to be antithetical to community mental health ideology. Since such ideology is both novel and disputed (Wagenfeld, Robin, & Jones, 1974; Robin & Wagenfeld, 1976), a high adherence to the professional peer group standards of behavior should prevent the acceptance of an innovative and socially activistic perspective on mental health treatment.

Hypothesis 10A: The greater the social worker's tendency to opt for client needs when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 10B: The greater the social worker's tendency to opt for client needs when placed in opposition to "stated professional standards" the greater the social worker's level of personal/professional activism.

Hypothesis 10C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's level of personal/professional activism when opting for clients needs as opposed to "stated professional standards" the less role discrepancy.

Hypothesis 11A: The greater the social worker's tendency to opt for agency policy when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 11B: The greater the social worker's tendency to opt for agency policy when placed in opposition to "stated professional standards" the greater the social worker's level of personal/professional activism.

Hypothesis 11C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's...
worker's level of personal/professional activism when opting for agency policy as opposed to "stated professional standards" the less role discrepancy.

Hypothesis 12A: The greater the social worker's tendency to opt for community expectations when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 12B: The greater the social worker's tendency to opt for community expectations when placed in opposition to "stated professional standards" the greater the social worker's level of CMHC activism.

Hypothesis 12C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's level of personal/professional activism when opting for community expectations as opposed to "stated professional standards" the less role discrepancy.

Category IV--Boundary Busting in the Role of the Social Worker

Dinitz and Beran (1971) have commented that community mental health has developed an extremely expansive view of its scope and jurisdiction. The definition of a "case" has been extended to include a number of problematic situations not considered legitimate by the traditional psychiatric mental health system. Additionally, if the community is perceived as being affiliated with the origin of mental disorder, however defined, then "therapeutic intervention" is appropriate. This has been identified by Dinitz and Beran as the "boundary busting" nature of community mental health.

Wagenfeld and Robin's 1976 study of boundary busting in the role of the community mental health worker found that social workers and psychologists were the greatest boundary busters among mental health professionals. They noted, however, that social workers and psychologists as well as their colleagues in community mental health
were more likely to view consensus situations\(^1\) as appropriate and dissensus situations\(^2\) as inappropriate for boundary busting. The researchers cited their data as providing evidence of "powerful and persistent forces within the community mental health movement blunting the presence and incorporation of boundarylessness in practice."

Prior research on social worker boundary busting by Epstein (1968, 1970a, 1970b) has resulted in the proposition that "the greater the institutional involvement of social workers in a problem area, the more conservative will be their perceptions of effective social action strategies for social workers..." Epstein suggests that the conservatism he found among social workers might be more a product of individual desire for professional status, organizational variables, and status characteristics that social workers bring to the job rather than a response to a relatively homogeneous and organized professional community.

In order to test the boundary busting propensity of the social workers employed at community mental health centers the nine arenas of community functioning, as presented in nine issue consensus and nine issue dissensus vignettes, were divided into high and low

\(^1\) A consensus situation has been defined by Warren (1971:12) as one where "there is (a) basic agreement as to the way an issue should be resolved, or (b) the likelihood of reaching such basic agreement once the issue is fully considered."

\(^2\) A dissensus situation has been defined by Warren (1971:13) as one where "important parties to the situation either (a) refuse to recognize the issue or (b) oppose the change agent's proposal."
involvement categories. The high involvement category was composed of responses to vignettes on matters where social workers had traditionally had frequent involvement (Briar & Miller, 1971; Reid & Epstein, 1972; Ferguson, 1975) while the second category, low involvement, was composed of responses to vignettes on matters where social worker participation has often been discouraged by social service agencies, therefore his category represents low involvement.

Utilizing the framework described in the preceding paragraph, it is hypothesized that social workers at community mental health centers will more frequently break boundaries in arenas of low involvement (Epstein, 1968, 1970a, 1970b) and that they will be more likely to break boundaries in these arenas if it involves a consensus situation (Wagenfeld & Robin, 1976).

Hypothesis 13A: Social workers will exhibit a higher level of boundary busting in arenas of low involvement than in arenas of high involvement.

Hypothesis 13B: Social workers will exhibit a higher level of boundary busting in arenas of low involvement if the arena is characterized by a consensus situation as opposed to a dissensus situation.

Summary

This chapter began with a review of the literature on role and role conflict. Particular attention was given to the perspective on role developed by Anthropologist Ralph Linton (1936, 1945) and the categorization of roles as presented by Gross et al., (1958) and Robin (1966). Role conflict, like so many of the concepts in role theory has been subjected to a number of definitions. Four major
aspects of role conflict have been discussed in the literature, and Morris (1971) has described them as the following: inter-role conflict, intra-sender conflict, intra-role conflict, and self-role conflicts.

The third section of chapter two dealt with the application of role theory to social workers. The literature on social work roles is, in general, not based on empirical research. Social work literature on roles is centered on comparisons of MSWs with non-MSWs--with a primary focus on how to allocate social work staff with optimum efficiency. Rushing (1964) and Zander, Cohen, and Stateland (1957) have conducted sociological studies that have examined social work role relations in mental health services.

Examining the intraprofessional differences of social activism among social workers and the effect of social activism on social work professionalism, thirty-eight hypotheses have been divided into four categories. The first two categories are based on independent variables relating to the organizational and personal characteristics of the social workers employed by the community mental health centers. The third category focuses on three independent variables relating to social worker cognitions of: community mental health ideology, the community mental health center as an organization based on a social service/medical model continuum, and the three dimensions of felt professionalism. The fourth category, boundary busting in the role of the social worker, departs from the format established in the first three categories and explores the specific community arenas most likely to become the targets of social activism by the social worker.
CHAPTER III

RESEARCH METHODS

Introduction

The purpose of this chapter is to present the methodological aspects of the research in four sections. The first section provides a description of the sample selection. The second section explains the methodology involved in the data collection. The third section offers a description of the construction and measurement of variables in the study. The fourth section focuses on the statistical techniques utilized in analyzing the collected data.

Sampling

The data analyzed in this dissertation originated as the result of a larger study designed by Wagenfeld and Robin to investigate the emerging roles of community mental health workers.¹ A sample of 20 community mental health centers was selected to represent the universe of 200 operating centers which existed in 1969.

The sampling procedure logic involved several factors. The community mental health centers were selected on the basis of six

¹Much of the material in this section and the following sections of the present chapter were paraphrased from Chapter III of Emerging Roles of Community Mental Health Workers (Wagenfeld & Robin, 1978).
variables. Three of the variables dealt with the characteristics of the catchment area and three with the organizational structure of the center.

The three variables dealing with catchment area characteristics were: socioeconomic status, ethnicity, and demographic complexity. Socioeconomic status, the first variable differentiating CMHC's, was defined by using the poverty/nonpoverty criteria delineated by DHEW (Federal Register, 1971). Poverty and nonpoverty specifications were formulated by ranking catchment areas in terms of the proportion of families living at or below a specified income level.

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

The final variable identifying the characteristics of the catchment area was demographic complexity. Demographic complexity is a reference guide to the nature and location of the population in the catchment area, e.g., rural, urban, and inner city. The Community Mental Health Center Support Branch, NIMH (USDHEW, 1973) issued a Mental Health Center Directory which identified rural catchment areas as all catchment areas in which 50 percent of the population lived in communities of 2,500 or less. Inner city and urban designations of catchment areas were also taken from the Community Mental Health Center Support Branch data which were based on the self-reporting of centers. Wagenfeld and Robin made two further demographic
distinctions: urban-mixed and rural-mixed. Centers whose catchment areas encompassed a variety of types of communities and an urban center was referred to as urban-mixed. Likewise, catchment areas that did not have an urban area were labeled rural-mixed. Each center in the population of CMHC's was designated as either inner city, urban, urban-mixed, rural-mixed, or rural.

The three variables relating to the organizational characteristics of the centers were auspices, organizational complexity, and accountability. The auspices of the community mental health center were defined as the applicant for the grant that established the center. Utilizing data from the Community Mental Health Center Support Branch, it was possible to identify four types of auspices: Public/Governmental; Agency/Board; University; and Hospital. All centers in the population could be placed in one of the four categories.

Organizational complexity was a variable which dealt with the center on the basis of its components. A single agency providing all services was considered one component. Wagenfeld and Robin were primarily concerned with whether the mental health worker was from a single agency or multiple agency program. Using data from the Community Mental Health Support Branch, centers were classified as: a single agency center, a center with two or three components, a center of four to six components, or a center comprised of seven or more components.

Accountability, the final variable, was formulated as a reference to the location of the locus of responsibility to which the center was answerable. A designation on local, distant, or mixed
locus of accountability was given to each center. The information concerning the locus of accountability was provided by Technical Systems Associates and Community Change, Inc.

A model was developed on the basis of the intersect of the variables that described the catchment area and the organizational characteristics of the centers. Every variable was represented in the selection of centers but not all possible intersects of the six variables were present because some combinations of the six variables do not exist in the population, e.g., 40-79 percent white, urban-mixed, and poverty.

In summary, the twenty community mental health centers selected for the Wagenfeld and Robin research represent the intersect of the major catchment area and organizational characteristics of the population of functioning centers. The sample of centers is also representative of all geographical areas of the United States.

Data Collection

Two major elements were utilized to develop a typology of community mental health centers: the various demographic and socio-economic characteristics of the catchment area and the organization of the center. After the particular characteristics of the centers were designated, several centers with each set of specified characteristics were randomly selected from the population of functioning centers.

Following a series of adjustments based on such contingencies as recent center reorganization, a newly appointed director, or
refusal of a director to cooperate, the sample of twenty centers was selected. Six centers were eliminated during the process of selection; but in no instance were all the centers with a specific set of characteristics unobtainable. Two centers with uncooperative directors were randomly replaced with centers from the same category.

Directors of selected centers were notified by letter regarding the nature of the research, requesting their assistance, explaining the nature of the cooperation needed, and apprising them that they would be contacted by telephone. The telephone contact secured permission to: collect data from the staff and about the center; and to interview the director of the center. A letter was also sent to each staff member describing the nature of the research and asking for the worker's cooperation in completing a questionnaire that would be distributed.

After the director of a center was interviewed, packets containing a cover letter, questionnaire, a response reporting postcard, and a self-addressed stamped envelope were distributed to the workers. Upon completion the questionnaire and response cards were mailed directly to the researchers.

Employing a method developed by Robin (1965), the distribution and collection of each questionnaire was accompanied by a minimum of two and a maximum of five contacts with the potential respondent. Prior to the mailing of the questionnaire, a prequestionnaire letter was sent to the respondent which explained the request to assist in the research. The second contact with the potential respondent consisted of the questionnaire and a cover letter which reminded the
respondent of the previous communication and thanked him for his help in such a way that the commitment of the respondent appeared to be taken for granted. The first follow-up letter, the third contact with the potential respondent, consisted of a brief letter, on letterhead stationery, that reminded the individual of his lack of response and the significance of it to the research. The fact that he received a stamped envelope "for his convenience" was also mentioned in this first follow-up letter. The second follow-up letter, the fourth contact, was accompanied by another copy of the questionnaire with another stamped self-addressed envelope. The letter emphasized the mailing of a second questionnaire and envelope "in case you have misplaced the original questionnaire and stamped envelope we sent to you." The third and final follow-up letter also contained a reference to the stamped self-addressed envelopes the subject had received and invited the subject to "get in touch with" the researchers or their staff for another questionnaire if his copies had been misplaced.

Using a process formulated by Glock and Stark (1966), the respondent was requested to mail a postcard to the researchers once the questionnaire had been completed and returned. The postcard was a means of insuring anonymity to the respondent. The questionnaires were without any identification. When the researchers received the postcard they removed the respondent's name from the list of those scheduled to receive further follow-up. As a result of the methodology utilized in the collection of completed questionnaires, 889 community mental health workers responded to the survey. Extensive data cleaning and cross-checking procedures indicated that although
the entire sample had provided usable data on the independent and intervening variables, not all the respondents completed all eighteen of the vignettes needed to provide data on the dependent variable, social activism. Therefore, to have equated activism scores of respondents who completed only a few of the vignettes with those who had completed all would have resulted in a misinterpretation. A common research procedure for handling missing data is the insertion of the respondent's or the group's mean. Given the large number of responses for which this would have been necessary and the "leveling" effect it would have produced, it was decided that this would be an unwarranted measure. Tallying the number of respondents by the number of vignettes filled out, it was found that 67 percent had completed sixteen or more of the vignettes. Establishing a cutting point of sixteen-plus for the calculation of the several dependent variable scores seemed to be a logical research decision since it permitted the retention of the greatest number of cases and introduced the minimum amount of misinterpretation into the scores. This culling resulted in an N of 595 workers. Circumstances such as this always involve a problem as to whether those who completed the questionnaire were markedly different than those who did not. Two gross bases on which the two samples could be compared were by community mental health center and occupational or professional affiliation of the respondents. A comparison of percent contributions of each of the twenty CMHCs to the total sample reveals no appreciable differences. A further comparison of occupational or professional affiliation shows that the relative proportions in the two samples were essentially equal.
Measurement of Variables

Assignment of individual workers to the characteristics of their centers used in the sampling provided measurement of six variables relating to the catchment area and organizational characteristics of the community mental health center. These six variables were: socioeconomic status of catchment area, ethnicity of catchment area, demographic complexity of catchment area, center auspices, organizational complexity, and locus of control.

A series of variables were measured through single items on the questionnaire (see appendix). The component with which the worker was affiliated was asked directly of the worker (item 1). Years at the center, sex and age were secured through items 3, 4, and 5. Professional affiliation was asked directly in item 5, with cross-validation items "Title of your position at CMHC" (#2), and "highest degree earned" (#7) as auxiliary data. Professional affiliation was categorized as: Psychiatrist, Psychologist, Social Worker, Nurse, Educational/Counseling, Rehabilitation Worker, Medical (physician, not psychiatrist), Paraprofessional, and Other. Item 9 of the questionnaire provided worker assessment of their time expended in administration, direct and indirect services. Question 11 provided a cross-validation for those workers reporting administrative duties.

The community mental health worker's perception of the organization of his center and of centers in general was measured by juxtaposing medical facilities and social service agencies as two distinctive modes of center organization. Workers were requested
to place a check mark on a ten point continuum with social service agency at the end designated 1 and medical facility at the end marked 10. The worker's view of CMHC's in general was established by asking for an X on the same continuum (item 48).

Three summated scales were utilized to measure variables. Professionalism of the respondents was measured by a scale adapted from the one developed by Billingsley (1964) and later employed by Epstein (1968, 1970a, 1970b). The purpose of this scale was to provide a single professionalism score. Using the "stated professional standards" endorsement as an index of professionalism, Billingsley placed professional standards in opposition to client needs, agency policy, and community expectations (see items 1, 2, and 3 on page 2 of the questionnaire in appendix). The scale, as used in this research consisted of three Likert-type items scored on a four point scale ranging from "absolutely must" to "absolutely should not." These items failed to scale when combined. Wagenfeld and Robin, however, felt justified in using respondent scores on each item as a measure of professionalism in different circumstances, with possible different relationships to worker role--particularly in regard to different types of centers. They were aware of the methodological difficulties involved when employing one-item scales to measure complex phenomena and the epistemological weakness of this post hoc revision. Therefore, this researcher will use these measures equivocally in analysis.

The Baker-Schulberg Community Mental Health Ideology Scale (Baker & Schulberg, 1967) was used for the measurement of community mental health ideology. The scale comprised 38 items scored on a
seven point Likert Scale. A strong adherence to community mental health ideology was indicated by a high score. This scale was found to have a corrected split-half reliability coefficient of .95, a Cronbach Alpha (Kuder-Richardson Formula 20) of .94, and a test-retest reliability of .92 (Baker & Schulberg, 1967). For the present sample the scale had a corrected split-half reliability of .90.

The Community Mental Health Ideology Scale has five dimensions. The first dimension, Population Focus, has been defined as: "The mental health specialist should be responsible, not only for individual patients with whom he has contracted for treatment, but for the entire population of both identified potentially sick members in his community." Primary Prevention, the second dimension has been defined as "the concept of lowering the rate of new cases of mental disorders in a population by counteracting harmful forces before they have had a chance to produce illness." "Social Treatment Goals" according to Baker and Schulberg should evolve from "the belief that the primary goal of treatment is, not to reconstruct the mental patient's personality, but rather to help him achieve social adjustment in an ordinary life situation as soon as possible." Comprehensive Continuity of Care, the fourth dimension of the community mental health ideology scale, takes the view that "there should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of caregiving services." The fifth and final dimension, Total Community Involvement, focuses on the belief that "the mental health specialist is only one member of a group of community agents caring for the mentally ill and that
he can extend his effectiveness by working with and through other people" (Baker & Schulberg, 1967:217).

The Baker-Schulberg Community Mental Health Ideology Scale has been used successfully in a number of studies. Findings have indicated consistent differences among individuals from different disciplines, mental health organizations and components of mental health organizations (Baker & Schulberg, 1967; Marx, 1969; Langston, 1970; Howard & Baker, 1971; Poovathamkal, 1973; Del Gaudio et al., 1975; Penn, Baker, & Schulberg, 1976; Wagenfeld & Robin, 1978).

Warren (1965) delineated three types of issues around which social change can take place at the community level: consensus, difference, and dissensus. Although, change is possible through either issue difference or issue dissensus, Warren considers issue consensus as the most successful path for community change. He defines issue difference and issue dissensus as degrees of divergence from the consensus model. Difference is defined as a situation where there is a good possibility that consensus can be reached, but there is--at the present time--no agreement that an issue exists. In issue dissensus, little chance of consensus exists or offers opposition to the change agent's proposal for solution. Wagenfeld and Robin have noted that it is important to recognize that the substantive nature of the lack of issue consensus in both the difference and dissensus situations may be identical. The two are differentiated by the potential for achieving consensus: where it is reasonably high, it is described as difference, where it is remote, it is termed dissensus.
Guided by the work of Roland Warren (1965) which provided a basic framework for understanding the nature of change agent roles at the community level, Wagenfeld and Robin developed the Community Mental Health Worker Role Inventory (CMHWRI) to measure the social activism of community mental health workers. This was achieved by asking the workers to respond to a series of 18 vignettes. The vignettes were developed from a content analysis of the community mental literature. Themes of community mental health situations and needs were taken from the literature and vignettes created to reflect these themes. Each vignette focuses on an issue, the possibility of worker involvement, and a set of responses that include possible worker behaviors (see questionnaire, pages 8-17 in appendix).

The vignettes were designated to sample nine arenas of community life: economic, political, police, family, medical, school, community (organization), housing. Two vignettes were constructed for each of the nine areas. One vignette was a consensus vignette in which the need for problem resolution was agreed upon by everyone involved. The other vignette was a dissensus vignette in which the existence of a problem or the need for its resolution was denied by one of the parties involved. Therefore, the inventory consisted of nine consensus and nine dissensus vignettes.

Each vignette had five possible responses. The "exclusion response," the first response, stated that the issue was irrelevant to mental health and the respondent would not become involved. Two of the remaining four responses were "enabler" responses (Warren, 1965). These responses emphasized behaviors which were conciliatory.
and in which the worker acted as consultant and catalyst for problem resolution. Two responses to each of the bignettes were "contestant" responses in which worker behavior was depicted as involving political, legal, social, or physical actions directed toward at least one of the parties to force a solution to the problem.

A second method of dividing the four substantive responses to the vignettes was developed using Epstein's (1968) distinction between institutional and non-institutional resolution of issues. Two of the four responses to each vignette were "institutional" responses which proposed that worker behaviors use and remain within the established social structures relevant to the issue contained in the vignette. The other two responses were "non-institutional" in that they suggested behavior outside the usual structural arrangements associated with the issue of the vignette.

These two dimensions are used in the response categories simultaneously and in combination. For each of the bignettes, the four substantive responses include one enabler-institutional (EI) response, one enabler-non-institutional response (EN), one contestant-institutional response (CI), and one contestant non-institutional response (CN). These responses are ranked 1-4, in the above order, and their selection by the respondent used as a measure of role activism. These categories of substantive responses were put in random order after each vignette and not categorically identified to the respondent.
TABLE 3.1. Typology of Social Action Strategies

<table>
<thead>
<tr>
<th>Consensus</th>
<th>Institutionalized</th>
<th>Non-institutionalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Conduct studies of housing or welfare needs and make recommendations through expert testimony.</td>
<td>3. Communicate with public officials through letters, personal contacts and so forth.</td>
</tr>
<tr>
<td>2.</td>
<td>Bring together interested groups and agencies to discuss the problem and coordinate efforts to plan a program based on the agreement of all participants.</td>
<td>4. Provide direct services—e.g., counseling, homemaker services—to demonstrate their value to ameliorating the problem.</td>
</tr>
<tr>
<td>5.</td>
<td>Inform low-income tenants or welfare recipients of their rights and encourage them to file complaints through official housing or welfare agencies.</td>
<td>7. Offer support to community action groups that request help in organizing strikes and protest demonstrations at official housing and welfare agencies.</td>
</tr>
<tr>
<td>6.</td>
<td>Openly campaign for political candidates or work through political parties that favor proposed reforms.</td>
<td>8. Actively organize low-income people to conduct strikes and protest demonstrations at official housing and welfare agencies.</td>
</tr>
</tbody>
</table>

The designation of vignettes as consensus or dissensus and or responses as EI, EN, CI, or CN were initially made by the senior researchers. The inventory was then submitted to a six member panel of sociologists and social workers. The items and responses were revised until the theoretical identifications were accomplished with no more than one error per item or response.

The respondents were asked to select as many responses to each vignette as they thought they could endorse. This procedure was adopted in an effort to avoid an unrealistic "forced-choice"
situation.

Each worker was asked to respond twice to each vignette. First, the worker was requested to respond, "from the perspective of what you perceive that your CMHC would expect of you in these situations?" (CMHC expectations) and second, "what you think best to do as a community mental health worker" (personal/professional expectations). This resulted in two views of the workers' role.

Worker role activism was measured by the summation of values from all chosen substantive answer categories, over eighteen vignettes, which were indicated as preferred (marked with a plus [+]). As previously noted, these values ranged from 1 to 4 for each vignette. If the respondent did not place a plus next to any category but placed a check next to one category, this response was considered as a preferred response. The absence of a plus when checks were placed next to more than one category rendered the datum unusable for the calculation of this score. As with the prior scores, two activism scores were calculated for each worker: one for the CMHC role and one for the personal/professional role. The CMHWRI functioned as a summated scale for the development of the activism scores. Accordingly, the connected split-half reliability was calculated for the CMHC and personal/professional activism scores; the reliability for the first was .88 and the second, .90.

Social worker activism was also measured by dividing the nine arenas of community functioning as presented in the nine issue consensus and nine issue dissensus vignettes into two categories. The first category was composed of responses to the vignettes on
matters of family, medical care, schools, and welfare issues; all areas where social workers have traditionally had high involvement (Briar & Miller, 1971; Reid & Epstein, 1972; Ferguson, 1975). The second category is composed of responses to the vignettes on matters regarding the police, housing, economics, politics, and the community; areas where social worker participation has frequently been discouraged by social service agencies, therefore, this category represents low involvement.

Role discrepancy was measured by the differences in the CMHC and personal/professional activism scores. This difference was summed over eighteen vignettes and the discrepancy scores were calculated by subtracting the CMHC activism score from the personal/professional activism score.

Finally, two role exclusion scores were developed. For each vignette, the worker had the option of selecting a response which indicated that the respondent thought the situation depicted in the vignette was irrelevant to the interests of a community mental health worker and that avoidance or no role behavior was proper. This measured the perceived scope or extent of the worker's role and revealed what the worker perceived as the appropriate domain of community mental health. The number of times this vignette response was selected by the worker when responding as he thought his center defined his role constituted the Community Mental Health Role Exclusion Score. The number of times this was selected from a Personal/Professional Role Exclusion Score.
A major pretest was conducted following the development of
the questionnaire. Two centers excluded from subsequent sample
selection, separated geographically, and with differing model
characteristics were chosen. All data collection procedures and
questionnaire instructions were evaluated in this pretest. The
reliability of all summated scales were examined and further item
analysis and scale refinement were accomplished.

Statistical Analysis

Analysis of variance will be used in the initial testing of
thirty-six of the thirty-eight hypotheses. The one-way analysis of
variance makes basically the same assumptions as the test for differ-
ences between means. Interval measurements are assumed. It is assumed
that the observations are independent. The samples should be indepen-
dent simple random samples from normally distributed populations and
the sample variances are assumed to be homogeneous. It has a known
sampling distribution--the F-distribution. The F-distribution, like
the chi-square distribution and the t-distribution, is actually a
collection of related sampling distributions rather than a single
distribution. Therefore, the F table is constructed with degrees of
freedom to represent individual distribution from the collection.
The F-distributions are such that the critical region appears only
in the right tail. If the two variances that form the ratio are equal,
then F will equal 1. The F values in the critical region will always
be greater than 1. The larger the F values, the farther they are
into the right tail of the distribution (Loether & McTavish, 1974).
Chi-square analysis will be used to test the two boundary busting hypotheses.

A set of stepwise regression analyses will be conducted for each dependent variable; this will determine the relationship of the independent variables to the dependent variables. Stepwise regression analysis will also make it possible to determine: the extent to which the set of independent variables predict each dependent variable; and which independent variables account for the variance in each dependent variable and with what strength. In summary, stepwise regression analysis will permit the investigator to consider what independent variables are most likely to predict what the CMHC social worker perceives to be organizational (CMHC) activism, his/her personal/professional activism, and the role discrepancy between the two.

Summary

The data analyzed in this dissertation originated as the result of a larger study designed by Wagenfeld and Robin to investigate the emerging roles of community mental health workers. A sample of 20 community mental health centers was selected to represent the universe of 200 operating centers.

The procedural logic of sampling involved several factors. The community mental health centers were selected on the basis of six variables. Three of the variables dealt with the characteristics of the catchment area: socio-economic status, ethnicity, and demographic complexity. Three variables dealt with the organizational
characteristics of the center: auspices, organization complexity, and accountability.

Employing a procedure for securing returns to mailed questionnaires developed by Robin (1965) and a process formulated by Glock and Stark (1966) to ensure the anonymity of the respondents, data was collected on 889 (56% rate of return) community mental health workers. A culling of the data resulted in an N of 595 community mental health workers, 140 of these were social workers.

The dependent variables in this study are those relating to social activism: CMHC activism, Personal/Professional activism, role discrepancy (the statistical variation between CMHC activism and personal/professional activism) and boundary busting (personal/professional role exclusion). The independent variables are: age of respondent, respondent's level of education, organizational complexity, auspices, accountability, agency tenure at CMHC, the proportion of time spent in indirect service, client-professionalism conflict, agency-professionalism conflict, community-professionalism conflict, community mental health ideology, and CMHC orientation (social service agency-medical facility continuum).

Analysis of variance will be used in the initial testing of thirty-six of the thirty-eight hypotheses and a stepwise regression analysis will be conducted for each dependent variable tested in these hypotheses. A chi-square analysis will be used for the two boundary busting hypotheses.
CHAPTER IV

FINDINGS

Introduction

The purpose of the present chapter is twofold. First, a descriptive profile of the hundred and forty social workers that comprise the sample for this investigation: how are they distributed in terms of catchment area and organizational characteristics and what are they like in terms of personal and professional characteristics? Second, a testing of the thirty-eight hypotheses contained in the following four categories: organizational characteristics of CMHCs, personal characteristics of social workers, cognitive characteristics affecting social activism, and boundary busting in the role of the social worker.

Profile of the Social Workers

Catchment area characteristics were demographic complexity, ethnicity, and socioeconomic status. The social workers were employed in four inner-city centers, two urban centers, six urban-mixed centers, five rural-mixed centers, and three rural centers. Forty-seven of the social workers (33.6%) were employed in CMHCs serving inner-city catchment areas, while the balance was distributed in the following fashion: 9 (6.4%) in urban, 38 (27.1%) in urban-mixed, 17 (12.1%)
in rural, and 29 (30.7%) in rural-mixed.

Poverty and nonpoverty specifications were formulated by ranking catchment areas in terms of the proportion of families living at or below a specified income level. Seventy-three of the social workers (52.1%) worked in poverty catchment areas while 67 (47.9%) worked in nonpoverty catchment areas.

Catchment areas were delineated on the basis of ethnicity. Centers were, therefore, classified as having 0-39%, 40-79%, or 80-100% while population in their catchment area. Seventy-two social workers (51.4%) worked in catchment areas having 40-70% white population and 68 (48.6%) worked in catchment areas having 80-100% white population.

Organizational characteristics of the centers were designated as auspices, organizational complexity, and accountability. The auspices of the community mental health center was defined as the applicant for the grant that established the center. Utilizing data from the Community Mental Health Center Support Branch, it was possible to identify four types of auspices: Public/Government; Agency/Board; University; and Hospital. All twenty centers in the population could be placed in one of the four categories and Table 4.1 indicates the distribution of social workers by center auspices.

Organizational complexity dealt with the center on the basis of its components. A single agency providing all services was considered one component. Centers were classified as: a single agency center, a center with two or three components, a center comprised of four to six components, or a center with seven or more components.
Table 4.1 shows the distribution of social workers by organization complexity.

TABLE 4.1.--Social Worker Distribution by Organizational Characteristics of Community Mental Health Centers

<table>
<thead>
<tr>
<th>Organizational Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auspices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public/Governmental</td>
<td>70</td>
<td>50.0</td>
</tr>
<tr>
<td>Agency/Board</td>
<td>32</td>
<td>22.9</td>
</tr>
<tr>
<td>University</td>
<td>7</td>
<td>5.0</td>
</tr>
<tr>
<td>Hospital</td>
<td>31</td>
<td>22.1</td>
</tr>
<tr>
<td><strong>No. of Components</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Agency</td>
<td>37</td>
<td>26.4</td>
</tr>
<tr>
<td>2-3 Agencies</td>
<td>37</td>
<td>26.4</td>
</tr>
<tr>
<td>4-6 Agencies</td>
<td>54</td>
<td>38.6</td>
</tr>
<tr>
<td>7+ Agencies</td>
<td>12</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distant</td>
<td>54</td>
<td>38.6</td>
</tr>
<tr>
<td>Local</td>
<td>51</td>
<td>36.4</td>
</tr>
<tr>
<td>Mixed</td>
<td>35</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Accountability was formulated as a reference to the location of the locus of responsibility to which the center was answerable. A designation of local, distant, or mixed locus of accountability was given to each center. Fifty-four social workers (38.6%) worked in centers with distance accountability, 51 (36.4%) in centers with local accountability, and 35 (25.0%) in centers with mixed accountability.

The personal characteristics of the social workers are described in Table 4.2; this table indicates the distribution of
social workers by: the social worker's sex, age, level of education, agency tenure, and proportion of time spent in indirect service.

TABLE 4.2.--Personal Characteristics of the Social Workers

<table>
<thead>
<tr>
<th>Personal Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>55</td>
<td>39.3</td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
<td>59.3</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 34</td>
<td>92</td>
<td>65.7</td>
</tr>
<tr>
<td>35-44</td>
<td>23</td>
<td>16.4</td>
</tr>
<tr>
<td>45+</td>
<td>25</td>
<td>17.9</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Education</td>
<td>25</td>
<td>17.9</td>
</tr>
<tr>
<td>Graduate Education</td>
<td>115</td>
<td>82.1</td>
</tr>
<tr>
<td>Agency Tenure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year or less</td>
<td>53</td>
<td>37.9</td>
</tr>
<tr>
<td>2-4 years</td>
<td>59</td>
<td>42.1</td>
</tr>
<tr>
<td>5-21 years</td>
<td>28</td>
<td>20.0</td>
</tr>
<tr>
<td>Percentage Spent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10</td>
<td>55</td>
<td>39.3</td>
</tr>
<tr>
<td>11-20</td>
<td>49</td>
<td>35.0</td>
</tr>
<tr>
<td>21-30</td>
<td>36</td>
<td>25.7</td>
</tr>
</tbody>
</table>

Category I--Organizational Characteristics

Auspices of a community mental health center was defined as the applicant for the grant that established the center. Within the context of the current investigation, it was possible to identify four types of auspices: Public/Governmental, Agency/Board, University,
and Hospital. Since auspices of a CMHC differ in their social histories, it was postulated that their organizational commitment to social activism or the maintenance of the status quo could differ as well. Agency/board auspice was believed to be the most activist because it had been explicitly created to reflect community concerns in the provision of health care. The first set of hypotheses in this category, organizational characteristics, therefore, dealt with social activism as it related to agency/board auspices of community mental health centers.

Hypothesis 1A: Social workers will perceive CMHCs with agency/board auspices as more supportive of activism than CMHCs under other auspices.

Hypothesis 1B: Social workers employed in a CMHC under agency/board auspices will have a higher level of personal/professional activism than social workers employed at CMHCs under other auspices.

Hypothesis 1C: Social workers employed at a CMHC under agency/board auspices will have less role discrepancy than social workers at CMHCs under other auspices.

None of these hypotheses proved to be statistically significant at the .05 level and were rejected (see Table 4.3)

Organizational complexity was a variable which dealt with the community mental health center on the basis of its components. A single agency was considered one component. The primary concern here was that whether the social worker was from a single agency or a multiple agency program, and if the latter, which kind of agency was the dominant force and how did this affect social activism.

Hypothesis 2A: Social workers will perceive more CMHC activism in a center with less organizational complexity than in a CMHC with greater organizational complexity.

Hypothesis 2B: Social workers employed by a CMHC with
less organizational complexity will have a higher level of personal/professional activism than those social workers in a CMHC with greater organizational complexity.

Hypothesis 2C: Social workers employed by a CMHC with less organizational complexity will experience less role discrepancy than social workers in a CMHC with greater organizational complexity.

Hypothesis 2A is statistically significant (.0432) and the researcher, therefore, fails to reject it. Hypotheses 2B and 2C are not statistically significant and are therefore rejected (see Table 4.3).

The issue of authority and accountability in the functioning of community mental health centers and the planning of services is complex. The actual community involvement and input varies greatly from community mental health center to community mental health center, and the segments of the community represented is also subject to vast differentiation. The hypotheses focusing on CMHC accountability suggest that the kind of accountability will affect social activism.

Hypothesis 3A: Social workers will perceive CMHC activism as greater in CMHCs that are accountable to community mental health boards with indigenous representation that are controlled locally than in a CMHC with different accountability.

Hypothesis 3B: Social workers employed by CMHCs accountable to community mental health boards with indigenous representation that are controlled locally will have a higher level of personal/professional activism than social workers employed by CMHCs with different accountability.

Hypothesis 3C: Social workers employed by CMHCs accountable to community mental health boards with indigenous representation that are controlled locally will have less role discrepancy than social workers employed by CMHCs with different accountability.

Hypotheses 3A and 3C were found to be statistically significant (see Table 4.3), although not in the manner predicted. The Scheffe procedure
TABLE 4.3.--CMHC Activism, Personal/Professional Activism, and Role Discrepancy of CMHC Social Workers by Organizational Characteristics of the CMHC

<table>
<thead>
<tr>
<th>Organizational Characteristics of CMHC</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>( \bar{X} )</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Auspices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public/Government</td>
<td>70</td>
<td>35.09</td>
<td>8.72</td>
</tr>
<tr>
<td>Agency/Board</td>
<td>32</td>
<td>47.88</td>
<td>6.39</td>
</tr>
<tr>
<td>University</td>
<td>7</td>
<td>39.00</td>
<td>7.28</td>
</tr>
<tr>
<td>Hospital</td>
<td>31</td>
<td>39.10</td>
<td>10.31</td>
</tr>
<tr>
<td><strong>F = 1.99</strong></td>
<td></td>
<td>F = 1.21</td>
<td></td>
</tr>
<tr>
<td><strong>P = .12</strong></td>
<td></td>
<td>P = .31</td>
<td></td>
</tr>
<tr>
<td><strong>Organizational Complexity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Agency</td>
<td>37</td>
<td>40.11</td>
<td>9.37</td>
</tr>
<tr>
<td>2-3 Agencies</td>
<td>37</td>
<td>36.54</td>
<td>8.96</td>
</tr>
<tr>
<td>4-6 Agencies</td>
<td>54</td>
<td>35.28</td>
<td>7.88</td>
</tr>
<tr>
<td>7+ Agencies</td>
<td>12</td>
<td>34.33</td>
<td>6.77</td>
</tr>
<tr>
<td><strong>F = 2.79</strong></td>
<td></td>
<td>F = 1.95</td>
<td></td>
</tr>
<tr>
<td><strong>P = .04</strong></td>
<td></td>
<td>P = .12</td>
<td></td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distant</td>
<td>54</td>
<td>35.46</td>
<td>9.17</td>
</tr>
<tr>
<td>Local</td>
<td>51</td>
<td>35.90</td>
<td>6.82</td>
</tr>
<tr>
<td>Mixed</td>
<td>35</td>
<td>40.20</td>
<td>9.60</td>
</tr>
<tr>
<td><strong>F = 3.75</strong></td>
<td></td>
<td>F = 1.63</td>
<td></td>
</tr>
<tr>
<td><strong>P = .03</strong></td>
<td></td>
<td>P = .20</td>
<td></td>
</tr>
</tbody>
</table>

for testing any and all possible comparisons between means was used as a statistical analysis of the data tested in Hypotheses 3A and 3C. The results of the Scheffe test indicated that social workers perceived CMHC activism as greater in CMHCs that had "distant" accountability rather than "local" accountability (significant at the 5% level) and that social workers employed by CMHCs accountable to community mental...
health boards that were controlled locally did have less role discrepancy than social workers employed by CMHCs with "mixed" accountability (significant at the 5% level). Hypothesis 3B was not found to be statistically significant and was rejected.

A correlation matrix containing the three organizational characteristics variables and the three dependent variables is presented in Table 4.4.

TABLE 4.4.--Correlation Matrix for Organizational Characteristics Variables

<table>
<thead>
<tr>
<th></th>
<th>Auspices</th>
<th>Organ. Complex.</th>
<th>Acct. Activism</th>
<th>CMHC Activism</th>
<th>Per/Pro Activism</th>
<th>Role Disc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auspices</td>
<td>-0.14</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountability</td>
<td>-0.58*</td>
<td>-0.30*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC Activism</td>
<td>0.19*</td>
<td>-0.23*</td>
<td>-0.14</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal/Prof.</td>
<td>-0.03</td>
<td>-0.16*</td>
<td>0.15</td>
<td>0.28*</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Activism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role Discrepancy</td>
<td>-0.14</td>
<td>-0.00</td>
<td>0.23*</td>
<td>-0.44*</td>
<td>0.53*</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Significant at the .05 level

The correlation matrix reveals: significant negative correlations of auspices with accountability and CMHC activism; significant negative correlations of organizational complexity with accountability, CMHC activism, and personal/professional activism; a significant positive correlation between CMHC activism and personal/professional activism; a significant negative correlation between CMHC activism and role discrepancy; and a significant positive correlation between personal/professional activism and role discrepancy.
Category II--Personal Characteristics of Social Workers

It was hypothesized that the age of the social worker would be directly related to his level of social activism. The community mental health movement has been in existence long enough to affect the professional socialization of the most recent cohorts of social workers. Therefore, the youngest social workers, more influenced in a formative professional stage, should have higher levels of social activism in matters relating to community mental health than their older colleagues for whom it represents at least in part, a professional resocialization.

Hypothesis 4A: Younger social workers will perceive lower levels of CMHC activism than older social workers.

Hypothesis 4B: Younger social workers will have a higher level of personal/professional activism than older social workers.

Hypothesis 4C: Younger social workers will experience more role discrepancy than older social workers.

None of these hypotheses proved to be statistically significant at the .05 level and were rejected (see Table 4.4).

Hypotheses 5A, 5B, and 5C dealt with the effect that agency tenure (years employed at a CMHC) had on social activism. These hypotheses were formulated to explore the existence of the "burnout syndrome" and its effect on social workers at community mental health centers.

Hypotheses 5A: The longer the period of time that a social worker has been employed by a CMHC the lower the perception of CMHC activism.

Hypothesis 5B: The longer the period of time that a social worker has been employed by a CMHC the lower the level of personal/professional activism.
### TABLE 4.5.--CMHC Activism, Personal/Professional Activism, and Role Discrepancy of CMHC Social Workers by Personal Characteristics

<table>
<thead>
<tr>
<th>Personal Characteristics of Social Workers</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 34</td>
<td>92</td>
<td>36.14</td>
<td>8.36</td>
</tr>
<tr>
<td>35-44</td>
<td>23</td>
<td>36.43</td>
<td>8.84</td>
</tr>
<tr>
<td>45+</td>
<td>25</td>
<td>39.60</td>
<td>9.39</td>
</tr>
<tr>
<td>F = 1.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Tenure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 or less</td>
<td>53</td>
<td>36.60</td>
<td>8.86</td>
</tr>
<tr>
<td>2-4</td>
<td>59</td>
<td>35.32</td>
<td>7.72</td>
</tr>
<tr>
<td>5-21</td>
<td>28</td>
<td>40.32</td>
<td>9.54</td>
</tr>
<tr>
<td>F = 3.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Education</td>
<td>25</td>
<td>33.96</td>
<td>8.64</td>
</tr>
<tr>
<td>Graduate Education</td>
<td>115</td>
<td>37.43</td>
<td>8.59</td>
</tr>
<tr>
<td>t = 1.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Spent: Indirect Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10</td>
<td>55</td>
<td>35.95</td>
<td>7.96</td>
</tr>
<tr>
<td>11-20</td>
<td>49</td>
<td>37.71</td>
<td>9.54</td>
</tr>
<tr>
<td>21-30</td>
<td>36</td>
<td>36.89</td>
<td>8.59</td>
</tr>
<tr>
<td>F = .54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypotheses 5A and 5C are statistically significant at the .05 level. Hypothesis 5C is not statistically significant and is therefore rejected (see Table 4.5).
Although higher education frequently serves as a conservatizing force, it was hypothesized that the nature of social work education would serve as a motivating force toward social activism.

Hypothesis 6A: The higher the social worker's level of education the less likely he is to perceive CMHC activism as high.

Hypothesis 6B: The higher the social worker's level of education the higher the level of personal/professional activism.

Hypothesis 6C: The higher the social worker's level of education the greater the role discrepancy.

Hypothesis 6A was found to be significant at the .05 level of a one-tailed t-test while hypotheses 6B and 6C were not found to be statistically significant (see Table 4.5).

The final series of hypotheses in category two focus on the variation in social worker perception of CMHC activism, personal/professional activism, and role discrepancy as it relates to the type of service (direct/indirect) performed by the worker in the CMHC. Direct services are essentially intramural while indirect services are carried out in the community. Given this, it was reasoned that the social worker involved in the community aspect of community mental health would adopt the higher level of activism.

Hypothesis 7A: The higher the proportion of time spent by social workers in indirect service the lower the perception of CMHC activism.

Hypothesis 7B: The higher the proportion of time spent by social workers in indirect service the higher the level of personal/professional activism.

Hypothesis 7C: The higher the proportion of time spent by social workers in indirect service the greater the role discrepancy.
Hypothesis 7B is statistically significant at the .05 level. Hypotheses 7A and 7C are not statistically significant and are therefore rejected (see Table 4.5).

A correlation matrix containing four personal characteristic variables and the three dependent variables is presented in Table 4.5. It indicates: a significant positive correlation of age with tenure; significant negative correlations of age with education and percent of time spent in indirect service; significant negative correlations of tenure with education, personal/professional activism, and role discrepancy; a significant negative correlation of CMHC activism with role discrepancy; and a significant positive correlation of personal/professional activism with role discrepancy.

TABLE 4.6.--Correlation Matrix for Personal Characteristics of Social Workers

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Tenure</th>
<th>Education</th>
<th>% Spent Indirect Serv</th>
<th>CMHC Activism</th>
<th>Per/Pro Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tenure</td>
<td>0.36*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-0.22*</td>
<td>-0.16*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Spent:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect Serv</td>
<td>-0.16*</td>
<td>-0.05</td>
<td>-0.04</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC Activism</td>
<td>0.14</td>
<td>0.12</td>
<td>-0.15</td>
<td>0.05</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal/Prof. Activism</td>
<td>-0.01</td>
<td>-0.17*</td>
<td>-0.13</td>
<td>0.15</td>
<td>0.28*</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Role Discrepancy</td>
<td>-0.11</td>
<td>-0.22*</td>
<td>-0.00</td>
<td>0.05</td>
<td>0.44*</td>
<td>0.53*</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Significant at the .05 level
Category III--Cognitive Characteristics Affecting Social Activism

The ideology of community mental health, as defined by Baker and Schulberg and utilized in the current investigation, encompassed the perspective that the etiology and treatment of mental disorders resided in the community. The adoption of the community mental health ideology by community mental health workers is not uniform. Baker and Schulberg (1967) have noted considerable variation in ideology endorsement among the members of the disciplines involved in community mental health and recent research by J. Marx (1969), Del Gaudio et al., (1975), Penn, Baker, and Schulberg (1976), and Wagenfeld and Robin (1978) reiterate this finding. The hypotheses in this study explored the effect of commitment to community mental health ideology on the social activism of the community mental health social worker.

Hypothesis 8A: The greater the social worker's support of community mental health ideology the lower the perceived level of CMHC activism.

Hypothesis 8B: The greater the social worker's support of community mental health ideology the higher the level of personal/professional activism.

Hypothesis 8C: The greater the social worker's support of community mental health ideology the higher the role discrepancy.

Hypothesis 8B was the only hypothesis in the ideology series to prove statistically significant (see Table 4.6).

Some CMHC staff members consider their center to be similar to a social service agency while others consider their CMHC as similar to a medical facility. Considering the perception of the CMHC on the social service agency/medical facility continuum, it was hypothesized
that the social worker's perception of the CMHC as a medical mode of organization would serve as a conservatizing force and the social service agency model as a liberal force.

Hypothesis 9A: The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility model the higher the perceived level of CMHC activism.

Hypothesis 9B: The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility model the higher the level of personal/professional activism.

Hypothesis 9C: The greater the social worker's organizational perception of the CMHC as based on a social service agency model as opposed to a medical facility the lower the role discrepancy.

None of these hypotheses proved to be statistically significant.

The final nine hypotheses in category three dealt with social activism as it related to the professionalism of social workers as viewed in three ways. First, the adherence to "stated professional standards" when placed in opposition to client needs. Second, the adherence to professional standards when placed in opposition to agency policy. Third, the adherence to professional standards when placed in opposition to community expectations.

Hypothesis 10A: The greater the social worker's tendency to opt for client needs when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 10B: The greater the social worker's tendency to opt for client needs when placed in opposition to "stated professional standards" the greater the social worker's level of personal/professional activism.

Hypothesis 10C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's
level of personal/professional activism when opting for clients needs as opposed to "stated professional standards" the less role discrepancy.

Hypothesis 11A: The greater the social worker's tendency to opt for agency policy when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 11B: The greater the social worker's tendency to opt for agency policy when placed in opposition to "stated professional standards" the greater the social worker's level of personal/professional activism.

Hypothesis 11C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's level of personal/professional activism when opting for agency policy as opposed to "stated professional standards" the less role discrepancy.

Hypothesis 12A: The greater the social worker's tendency to opt for community expectations when placed in opposition to "stated professional standards" the greater the social worker's perceived level of CMHC activism.

Hypothesis 12B: The greater the social worker's tendency to opt for community expectations when placed in opposition to "stated professional standards" the greater the social worker's level of CMHC activism.

Hypothesis 12C: The greater the social worker's perceived level of CMHC activism and the greater the social worker's level of personal/professional activism when opting for community expectations as opposed to "stated professional standards" the less role discrepancy.

Eight of the nine hypotheses proved to be statistically insignificant at the .05 level; however, Hypothesis 10C was statistically significant (see Tables 4.7A, 4.7B, and 4.7C).

A correlation matrix containing the cognitive characteristics and the three dependent variables is presented in Table 4.8. A study of the matrix shows: significant positive correlations of ideology with CMHC activism and personal/professional activism; significant positive correlations of client-professionalism conflict with agency-
TABLE 4.7.--CMHC Activism, Personal/Professional Activism, and Role Discrepancy of CMHC Social Workers by Cognitive Characteristics

<table>
<thead>
<tr>
<th>Intervening Variables</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Ideology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>128-206</td>
<td>36</td>
<td>33.92</td>
<td>8.49</td>
</tr>
<tr>
<td>207-226</td>
<td>37</td>
<td>37.38</td>
<td>9.07</td>
</tr>
<tr>
<td>227-242</td>
<td>36</td>
<td>38.11</td>
<td>6.91</td>
</tr>
<tr>
<td>244-261</td>
<td>31</td>
<td>37.97</td>
<td>9.80</td>
</tr>
<tr>
<td>F = 1.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| CMHC Orientation     |    |     |    |    |     |    |    |     |    |
| Social Service/       |    |     |    |    |     |    |    |     |    |
| Medical Facility      |    |     |    |    |     |    |    |     |    |
| 1-5 Social Service    | 60 | 36.78| 8.96| 45.77| 10.47| 6.25| 5.92 |
| 6-10 Medical Facility | 75 | 36.51| 8.62| 45.47| 8.77 | 6.91| 5.60 |
| F = .03               |    |     |    | F = .03 |    |     | F = .44 |
| P = .86               |    |     |    | P = .86 |    |     | P = .51 |

TABLE 4.7A.--Client-Professionalism Conflict

"A community mental health worker should meet the needs of his clients, even if this requires violating stated professional standards."

<table>
<thead>
<tr>
<th>Cognitive Characteristics</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Response:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Not</td>
<td>11</td>
<td>37.09</td>
<td>9.60</td>
</tr>
<tr>
<td>Probably Should</td>
<td>41</td>
<td>35.85</td>
<td>7.48</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>61</td>
<td>37.57</td>
<td>9.69</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>24</td>
<td>35.38</td>
<td>7.59</td>
</tr>
<tr>
<td>F = .52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .67</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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TABLE 4.7B.--Agency-Professionalism Conflict

"A community mental health worker should carry out agency policy, even if this requires violating stated professional standards."

<table>
<thead>
<tr>
<th>Cognitive Characteristics</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Response:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Not</td>
<td>1</td>
<td>36.00</td>
<td>--</td>
</tr>
<tr>
<td>Probably Should</td>
<td>20</td>
<td>37.15</td>
<td>8.15</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>78</td>
<td>36.91</td>
<td>8.58</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>38</td>
<td>35.82</td>
<td>9.39</td>
</tr>
<tr>
<td>F = .1614</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .9222</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 4.7C.--Community-Professionalism Conflict

"A community mental health worker should act according to professional standards, even if this requires violating community expectations."

<table>
<thead>
<tr>
<th>Cognitive Characteristics</th>
<th>CMHC Role Activism</th>
<th>Personal/Professional Role Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Response:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Must</td>
<td>9</td>
<td>39.89</td>
<td>7.70</td>
</tr>
<tr>
<td>Probably Should</td>
<td>35</td>
<td>36.17</td>
<td>9.51</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>64</td>
<td>37.06</td>
<td>8.37</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>27</td>
<td>35.59</td>
<td>8.88</td>
</tr>
<tr>
<td>F = .62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P = .60</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

professionalism conflict and community-professionalism conflict; negative significant correlations of client-professionalism conflict with personal/professional activism and role discrepancy; a significant

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TABLE 4.8--Correlation Matrix for Cognitive Characteristics Affecting Social Activism

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideology</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC Orientation</td>
<td>-0.03</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client - Prof.</td>
<td>-0.08</td>
<td>-0.11</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency - Prof.</td>
<td>0.13</td>
<td>0.05</td>
<td>0.22*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community - Prof.</td>
<td>-0.11</td>
<td>-0.03</td>
<td>0.38*</td>
<td>0.31</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC Activism</td>
<td>0.20*</td>
<td>-0.01</td>
<td>-0.02</td>
<td>-0.04</td>
<td>-0.08</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Personal/Prof.</td>
<td>0.31*</td>
<td>-0.02</td>
<td>-0.18*</td>
<td>-0.00</td>
<td>-0.14</td>
<td>0.30*</td>
<td>1.00</td>
</tr>
<tr>
<td>Role Discrepancy</td>
<td>0.00</td>
<td>0.05</td>
<td>-0.22*</td>
<td>-0.08</td>
<td>-0.01</td>
<td>-0.43</td>
<td>0.51*</td>
</tr>
</tbody>
</table>

*Significant at the .05 level

positive correlation of CMHC activism with personal/professional activism; a significant negative correlation of CMHC activism and role discrepancy; and a significant positive correlation of personal/professional activism with role discrepancy.

Category IV--Boundary Busting in the Role of the Social Worker

Wagenfeld and Robin's 1975 study of boundary busting in the role of the community mental health worker found that social workers and psychologists were the greatest boundary busters among mental health professionals. They also found that in both personal/professional and CMHC perceived community mental health worker role definitions, the greatest boundary busting was prescribed in centers that were rural, governed by agency/board mechanisms, in consensus situations and in

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the medical and welfare arenas of community life. The least boundary busting, according to Wagenfeld and Robin, was found among centers that were rural-mixed, governed by public/governmental sources, in dissensus situations and in the political arena of community life.

Combining the information from the Wagenfeld and Robin study with Epstein's work on social worker boundary busting (1968, 1970a, 1970b) which suggested that social worker boundary busting was influenced by the institutional involvement of social workers in the problem area, the present researcher formulated the following two hypotheses to determine the effect of high and low involvement community arenas, and consensus and dissensus situations on social worker boundary busting.

**Hypothesis 13A**: Social workers will exhibit a higher level of boundary busting in arenas of low involvement than in arenas of high involvement.

**Hypothesis 13B**: Social workers will exhibit a higher level of boundary busting in arenas of low involvement if the arena is characterized by a consensus situation as opposed to a dissensus situation.

Social workers exhibited a higher level of boundary busting in arenas of high involvement than in arenas of low involvement, therefore Hypothesis 13A must be rejected. Social workers did exhibit a higher level of boundary busting in arenas of low involvement that involved a consensus situation rather than a dissensus situation, but statistical testing did not prove significant. Hypothesis 13B is therefore rejected (see Table 4.9).

Table 4.10 presents the classification of the vignettes into high and low involvement arenas, and consensus and dissensus situations.

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### TABLE 4.9. — Chi-Square Analysis of Social Worker Boundary Busting Behavior

<table>
<thead>
<tr>
<th></th>
<th>Exclusion Scores</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consensus Situations</td>
<td>Dissensus Situations</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>High Involvement Arenas</td>
<td>23</td>
<td>51</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Low Involvement Arenas</td>
<td>49</td>
<td>103</td>
<td>152</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>72</td>
<td>154</td>
<td>226</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 4.10. — Classification of Vignettes*

<table>
<thead>
<tr>
<th></th>
<th>Exclusion Scores</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consensus Situations</td>
<td>Dissensus Situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Involvement Arenas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>4</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Care</td>
<td>3</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td>10</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare Issues</td>
<td>6</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74 (7%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Involvement Arenas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>3</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>10</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economics</td>
<td>9</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Politics</td>
<td>17</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>10</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>162 (11%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td><strong>72 (6%)</strong></td>
<td><strong>154 (12%)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Each number given in the two columns of exclusion scores represents the number of social workers (out of a possible 140) that excluded that particular vignette as not being within the domain of community mental health. Seventy-four is the total number of exclusion scores (out of a possible 1120) for the high involvement arenas while 162 is the total number of exclusion scores (out of a possible 1400) for the low involvement arenas. Seventy-two and 154 represent the totaled exclusion scores for consensus and dissensus situation vignettes respectively (out of a possible 1260).
Table 4.11 gives the response of social workers not willing to bust particular community arena boundaries regardless of a consensus or dissensus situation.

TABLE 4.11.--Distribution of Exclusion Scores: Responses of Social Workers Not Willing to Bust Particular Community Arena Boundaries*

<table>
<thead>
<tr>
<th>Community Arena</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Involvement Arenas</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare Issues</td>
<td>14</td>
<td>5.0</td>
</tr>
<tr>
<td>Medical Care</td>
<td>15</td>
<td>5.4</td>
</tr>
<tr>
<td>Family</td>
<td>21</td>
<td>7.5</td>
</tr>
<tr>
<td>Schools</td>
<td>24</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Low Involvement Arenas</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>21</td>
<td>7.5</td>
</tr>
<tr>
<td>Economics</td>
<td>22</td>
<td>7.9</td>
</tr>
<tr>
<td>Police</td>
<td>26</td>
<td>9.3</td>
</tr>
<tr>
<td>Community</td>
<td>36</td>
<td>13.0</td>
</tr>
<tr>
<td>Political</td>
<td>47</td>
<td>17.0</td>
</tr>
</tbody>
</table>

*Numbers and percentages are based on 280 responses for each arena because each community arena is composed of two vignettes and the number of social worker respondents is 140.

Regression Analysis

A concluding step in the statistical analysis of the data would appear to be a series of stepwise multiple regression analyses of the independent variables with each of the dependent variables that permit such an analysis. The order of analysis will be to first consider CMHC activism by predictor variables, followed by a consideration of personal/professional activism and role discrepancy by

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predictor variables.

TABLE 4.12.--Stepwise Multiple Regression for Social Workers: CMHC Activism by Predictor Variables

<table>
<thead>
<tr>
<th>Added Variable</th>
<th>Increment In Variance</th>
<th>Significance of Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>F</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------</td>
<td>----</td>
</tr>
<tr>
<td>Organizational Complexity</td>
<td>.23</td>
<td>7.65</td>
</tr>
<tr>
<td>Accountability</td>
<td>.31</td>
<td>7.03</td>
</tr>
<tr>
<td>Geographic Complexity: Rural</td>
<td>.34</td>
<td>3.44</td>
</tr>
<tr>
<td>Geographic Complexity: Inner</td>
<td>.38</td>
<td>4.60</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>.42</td>
<td>4.11</td>
</tr>
</tbody>
</table>

R = 42  \( R^2 = .17 \)  F = 5.69  p = .0001

Organizational complexity, accountability, and ethnicity are all inversely related to CMHC activism while working in a rural area or the inner city are both positively and significantly associated with organizational activism.

TABLE 4.13.--Stepwise Multiple Regression for Social Workers: Personal/Professional Activism by Predictor Variables

<table>
<thead>
<tr>
<th>Added Variable</th>
<th>Increment In Variance</th>
<th>Significance of Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>F</td>
</tr>
<tr>
<td>CMHC Ideology</td>
<td>.30</td>
<td>13.96</td>
</tr>
<tr>
<td>Urban-Mixed</td>
<td>.37</td>
<td>6.56</td>
</tr>
<tr>
<td>Agency Tenure</td>
<td>.41</td>
<td>5.99</td>
</tr>
<tr>
<td>Inner City</td>
<td>.44</td>
<td>4.19</td>
</tr>
</tbody>
</table>

R = .44  \( R^2 = .19 \)  F = 8.17  p = .0001

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Working in an urban-mixed area and agency tenure are both inversely related to personal/professional activism while CMHC ideology and working in the inner city are both positively related.

### TABLE 4.14.--Stepwise Multiple Regression for Social Workers: Role Discrepancy by Predictor Variables

<table>
<thead>
<tr>
<th>Added Variance</th>
<th>R</th>
<th>Increment In Variance</th>
<th>F</th>
<th>Prob.</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>.23</td>
<td>--</td>
<td>7.68</td>
<td>.01</td>
<td>-1.31</td>
</tr>
<tr>
<td>Accountability</td>
<td>.31</td>
<td>.08</td>
<td>6.19</td>
<td>.01</td>
<td>.03</td>
</tr>
<tr>
<td>Agency Tenure</td>
<td>.34</td>
<td>.03</td>
<td>3.27</td>
<td>.07</td>
<td>-1.33</td>
</tr>
<tr>
<td>Socioeconomic Status of</td>
<td>.36</td>
<td>.02</td>
<td>2.30</td>
<td>.13</td>
<td>1.47</td>
</tr>
<tr>
<td>Catchment Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R = .36  \( R^2 = .13 \)  \( F = 5.04 \)  \( p = .0008 \)

Opting for client needs over "stated professional standards" and agency tenure are inversely related to role discrepancy between CMHC activism and personal/professional activism while agency accountability and socioeconomic status of the catchment area are positively related.

**Summary**

The first section of this chapter provided a profile of the 140 social workers that comprised the sample for the current investigation. These social workers were described by their distribution according to the catchment area characteristics of the CMHC, the organizational characteristics of their CMHC, and their
own personal characteristics. Two summary tables (4.15 and 4.16) indicate the results of the statistical testing of the thirty-eight hypotheses investigated in this study.

Category I, Organizational Characteristics, reviewed the nine hypotheses which dealt with the effect of CMHC auspices, CMHC organizational complexity, and CMHC accountability on CMHC activism, personal/professional activism, and the role discrepancy between CMHC activism and personal/professional activism. Three of these hypotheses proved to be statistically significant (see Table 4.15).

Category II, Personal Characteristics of Social Workers, reviewed twelve hypotheses. These hypotheses dealt with the effect of age, agency tenure, level of education, and percentage of time spent in indirect service on CMHC activism, personal/professional activism, and the role discrepancy between CMHC activism and personal/professional activism. Three of these hypotheses proved to be statistically significant (see Table 4.15).

Category III, Cognitive Characteristics Affecting Social Activism, reviewed fifteen hypotheses which dealt with the effect of CMHC ideology, CMHC orientation, client-professionalism conflict, agency-professionalism conflict, and community-professionalism conflict on CMHC activism, personal/professionalism activism, and the role discrepancy between the two. Two of these hypotheses proved statistically significant (see Table 4.15).

Category IV, Boundary Busting in the Role of the Social Worker, reviewed two hypotheses which dealt with the effect of high
and low involvement community arenas and consensus and dissensus situations on social worker boundary busting. The first hypothesis was rejected and the second failed to be rejected (see Table 4.16).

Using the variables that have proven to be significant in a one-way analysis of variance, three sets of stepwise regressions were used to determine the predictor variables for CMHC activism, personal/professional activism, and role discrepancy.

Table 14.17 provides a comparison of mean community mental health center activism scores, personal/professional activism scores, and role discrepancy scores by independent variables. It can be noted that the personal/professional activism mean is greater than the community mental health center activism mean for all but two dependent variables. Such findings would suggest that community mental health center social workers consider themselves to be more activistic than the community mental health centers where they were employed.
TABLE 4.15.--Social Workers, Social Activism, and the Community Mental Health Center: A Summary Table

<table>
<thead>
<tr>
<th>Personal/C M H C Professional Role</th>
<th>CMHC Activism</th>
<th>Personal/Professional Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Characteristics of CMHC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auspices</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Organizational Complexity</td>
<td>+S</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Accountability</td>
<td>+S</td>
<td>NS</td>
<td>+S</td>
</tr>
<tr>
<td><strong>Personal Characteristics of CMHC Social Workers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Agency Tenure</td>
<td>+S</td>
<td>NS</td>
<td>+S</td>
</tr>
<tr>
<td>% Time Spent: Indirect Services</td>
<td>+S</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Cognitive Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC Ideology</td>
<td>NS</td>
<td>+S</td>
<td>NS</td>
</tr>
<tr>
<td>CMHC Orientation: Social Service/Medical Facility</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Client-Professionalism Conflict</td>
<td>NS</td>
<td>NS</td>
<td>+S</td>
</tr>
<tr>
<td>Agency-Professionalism Conflict</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Community-Professionalism Conflict</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

S = Significant at .05 level
NS = Not Significant at .05 level

+ = Positive Association

TABLE 4.16.--Social Workers, Boundary Busting, and the Community Mental Health Center: A Summary Table

<table>
<thead>
<tr>
<th>Exclusion Scores</th>
<th>Consensus Situations</th>
<th>Dissensus Situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Involvement Arenas</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Low Involvement Arenas</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

NS = Chi-square not significant at .05 level

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TABLE 4.17.—Mean Community Mental Health Center Activism Scores, Personal/Professional Activism Scores, and Role Discrepancy Scores by Independent Variables

<table>
<thead>
<tr>
<th>Independent Variables by Category</th>
<th>CMHC Activism</th>
<th>Personal/Professional Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Characteristics of CMHCS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Auspices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public/Government</td>
<td>35.09</td>
<td>45.80</td>
<td>7.34</td>
</tr>
<tr>
<td>Agency/Board</td>
<td>47.88</td>
<td>45.84</td>
<td>5.72</td>
</tr>
<tr>
<td>University</td>
<td>39.00</td>
<td>38.86</td>
<td>6.57</td>
</tr>
<tr>
<td>Hospital</td>
<td>39.10</td>
<td>45.81</td>
<td>5.32</td>
</tr>
<tr>
<td><strong>Organizational Complexity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Agency</td>
<td>40.11</td>
<td>48.43</td>
<td>6.81</td>
</tr>
<tr>
<td>2-3 Agencies</td>
<td>36.54</td>
<td>44.08</td>
<td>5.60</td>
</tr>
<tr>
<td>4-6 Agencies</td>
<td>35.28</td>
<td>45.04</td>
<td>7.07</td>
</tr>
<tr>
<td>7+ Agencies</td>
<td>34.33</td>
<td>42.50</td>
<td>5.58</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distant</td>
<td>35.46</td>
<td>47.26</td>
<td>8.11</td>
</tr>
<tr>
<td>Local</td>
<td>35.90</td>
<td>44.14</td>
<td>5.37</td>
</tr>
<tr>
<td>Mixed</td>
<td>40.20</td>
<td>44.63</td>
<td>5.60</td>
</tr>
<tr>
<td><strong>Personal Characteristics of Social Workers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 34</td>
<td>36.14</td>
<td>45.80</td>
<td>7.00</td>
</tr>
<tr>
<td>35-44</td>
<td>36.43</td>
<td>43.00</td>
<td>5.44</td>
</tr>
<tr>
<td>45+</td>
<td>39.60</td>
<td>46.48</td>
<td>5.56</td>
</tr>
<tr>
<td><strong>Agency Tenure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year or less</td>
<td>36.60</td>
<td>47.30</td>
<td>7.83</td>
</tr>
<tr>
<td>2-4</td>
<td>35.32</td>
<td>44.92</td>
<td>6.27</td>
</tr>
<tr>
<td>5-21</td>
<td>40.32</td>
<td>43.34</td>
<td>4.39</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Education</td>
<td>33.96</td>
<td>42.48</td>
<td>6.44</td>
</tr>
<tr>
<td>Graduate Education</td>
<td>37.43</td>
<td>46.03</td>
<td>6.50</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Independent Variables by Category</th>
<th>CMHC Activism</th>
<th>Personal/Professional Activism</th>
<th>Role Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of Time Spent:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10</td>
<td>35.95</td>
<td>42.73</td>
<td>5.67</td>
</tr>
<tr>
<td>11-20</td>
<td>37.71</td>
<td>48.33</td>
<td>7.65</td>
</tr>
<tr>
<td>21-30</td>
<td>36.89</td>
<td>45.75</td>
<td>6.14</td>
</tr>
<tr>
<td><strong>Cognitive Characteristics of Social Workers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ideology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>128-206</td>
<td>33.92</td>
<td>40.33</td>
<td>6.61</td>
</tr>
<tr>
<td>207-226</td>
<td>37.38</td>
<td>46.41</td>
<td>6.14</td>
</tr>
<tr>
<td>227-242</td>
<td>38.11</td>
<td>46.75</td>
<td>6.28</td>
</tr>
<tr>
<td>244-261</td>
<td>37.97</td>
<td>48.81</td>
<td>7.00</td>
</tr>
<tr>
<td><strong>CMHC Orientation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Service/</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Service</td>
<td>36.78</td>
<td>45.77</td>
<td>6.25</td>
</tr>
<tr>
<td>Medical Facility</td>
<td>36.51</td>
<td>45.47</td>
<td>6.91</td>
</tr>
<tr>
<td><strong>Client-Professional Conflict</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Must</td>
<td>37.09</td>
<td>46.91</td>
<td>9.55</td>
</tr>
<tr>
<td>Probably Should</td>
<td>35.85</td>
<td>48.39</td>
<td>8.20</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>37.57</td>
<td>44.28</td>
<td>5.26</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>35.38</td>
<td>42.83</td>
<td>5.71</td>
</tr>
<tr>
<td><strong>Agency-Professionalism Conflict</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Must</td>
<td>36.00</td>
<td>38.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Probably Should</td>
<td>37.15</td>
<td>44.55</td>
<td>5.65</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>36.91</td>
<td>46.37</td>
<td>6.69</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>35.82</td>
<td>44.29</td>
<td>6.92</td>
</tr>
<tr>
<td><strong>Community Professionalism Conflict</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely Must</td>
<td>39.89</td>
<td>45.67</td>
<td>5.11</td>
</tr>
<tr>
<td>Probably Should</td>
<td>36.17</td>
<td>47.43</td>
<td>7.03</td>
</tr>
<tr>
<td>Probably Should Not</td>
<td>37.06</td>
<td>45.34</td>
<td>6.61</td>
</tr>
<tr>
<td>Absolutely Must Not</td>
<td>35.59</td>
<td>42.74</td>
<td>5.89</td>
</tr>
</tbody>
</table>

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CHAPTER V

INTERPRETATIONS AND IMPLICATIONS

Introduction

This chapter is concerned with a discussion of the present study's findings and as assessment of their relevance to: social workers employed in community mental health centers, the relationship of social worker activism to social worker professionalism, theoretical implications of the findings, and theoretical revisions as they pertain to a delineation of the limitations of the investigation and suggestions for future research.

Chapter five is presented in four sections; these are: summary and implication of the study, areas for future research, limitations of the study and concluding remarks.

Summary and Implications of the Study

The Community Mental Health Centers Act, like numerous other works of federal legislation, carried with it an ideology regarding social policies. The operationalization of this ideology, however, varied immensely according to the occupations or professions of the individuals staffing the community mental health centers.

Among the professionals staffing the center, social workers
gained a reputation for social activism. Social activism in the role of the community mental health center social worker can be seen in four ways. First is the perception of the role by the worker as a set of expectations sanctioned by the worker's community mental health center (CMHC role activism). Second is the worker's definition of his/her role, independent of organizational influence (personal/professional activism). Third, the role discrepancy between CMHC activism and personal/professional activism, therefore determining the degree of variance between organizational and personal/professional activism. Finally, social activism can be seen in the boundary busting activity of the social worker; that is, the willingness of the social worker to become involved in activities and institutions not considered within the domain of community mental health.

Role theory is an important conceptual tool in this study because it provides an intermediary concept between the individual and society. Role can be defined as the expected behavior of those occupying a particular social position (Linton, 1936; Gross et al., 1967; Jackson, 1972). Within the framework of this particular perspective, the definition of position is an analytical category based upon the conceptualization of the social structure of which the position is the basic component (Robin, 1974). Therefore, the position of role under investigation is that of the community mental health worker and social structure of the community mental health center.

As previously noted, in the second chapter, the literature
on social worker roles has not been based upon empirical research but rather on descriptive, prescriptive, informal observation, and theoretical data. Most of this literature has centered on comparisons of MSWs with nonMSWs. The current research is concerned with an analysis of the social worker role, as social activist within the context of the community mental health center, and how this relates to the conceptualization of social worker professionalism.

In order to examine the intraprofessional differences of social activism among social workers employed by community mental health centers and the effect of social activism on social work professionalism, four categories of hypotheses were developed. The first two were based on independent variables relating to the organizational characteristics of the community mental health centers and the personal characteristics of the social workers. The third category focused on independent variables related to cognitive characteristics: community mental health ideology, the community mental health center as an organization based on a social service/medical model continuum, and the three dimensions of professionalism. The fourth category provided an exploration of the degree to which boundarylessness or boundary busting existed in the perceived roles of the social worker.

The organizational characteristics of the community mental health center were: organizational auspices, organizational complexity, and organizational accountability. Each one of these organizational characteristic variables was evaluated for their effect on organizational activism (CMHC activism), personal/professional activism, and
personal/professional activism.

Organizational auspices was shown to have no statistically significant relationship to social activism as represented in the three dependent variables. Such a finding makes it impossible, on the basis of the present research, to expect that the auspices of community mental health centers that differ in their social histories will also differ in their commitment to social activism (as perceived by social workers).

Organizational complexity, a variable that dealt with the community mental health center on the basis of its size (number of components), only has statistical significance when related to organizational activism. The results of the data analysis indicated that social workers thought that there was more organizational activism in centers with less organizational complexity (fewer agencies combined under an umbrella organization) than in centers with greater organizational complexity.

Organization accountability was a variable formulated as a reference to the locus of responsibility to which the community mental health center was answerable. The data regarding this variable revealed that social workers perceived CMHC activism as greater in those community mental health centers accountable to community mental health boards that had "distant" accountability—an indication, perhaps, that community mental health boards serve as a conservatizing force in the development of community mental health policy. Analysis of the data also indicated that social
workers employed by community mental health centers accountable to boards that were controlled locally had the least role discrepancy between organizational activism and their own personal/professional activism. A lack of such role discrepancy would suggest that a locally controlled board might be perceived by social workers as having a better knowledge of the problems confronting the community than those boards that had distant or mixed accountability.

It is significant that two of the three hypotheses that failed to be rejected in the first category of hypotheses dealt directly with organizational activism while the third hypothesis dealt indirectly with organizational activism. Clearly, social workers see organizational characteristics of community mental health centers as effecting organizational activism, and not having a strong impact on their own personal/professional activism. It can be suggested that CMHC social workers either feel that CMHC organizational characteristics can be effectively circumvented in their personal/professional activism or that these characteristics are not directly applicable to their roles as CMHC social workers.

The second category of hypotheses represented four independent variables dealing with the personal characteristics of CMHC social workers. These variables were: the age of the social worker, agency tenure of the social worker, social worker's level of education, and the percentage of time spent in indirect service. Like the variables in category one, three also were tested to determine their relationship to three dependent variables: CMHC activism, personal/
professional activism, and role discrepancy.

Age, the first independent variable in category two, did not prove to be statistically significant in its effect on the dependent variables. It had been expected that younger social workers--trained more recently under curricula reflective of heightened interest in community mental health--would have higher expectations of organizational activism and possess a higher level of personal/professional activism than older social workers, therefore, being subjected to more role discrepancy than that experienced by older social workers.

A second variable in the category of personal characteristics of social workers is agency tenure. Research has shown that social workers often start their careers in human service with a strong orientation toward social activism and that this energetic persuasion is continuously eroded through on-the-job experience resulting in "burnout syndrome," a term that is associated with an extreme form of job-related stress and exhaustion. It was, therefore, hypothesized that the longer the social worker had been employed by the community mental health center the lower his/her professional activism, and the less resultant role discrepancy. The data confirm the hypotheses regarding agency tenure, organization activism, and role discrepancy but does not prove statistically significant for the hypothesis on agency tenure and personal/professional activism.

Education, the third variable in the category of personal characteristics of social workers, proved to be statistically
significant when correlated with organizational activism and role discrepancy. Social workers with a graduate education were found to have a higher level of personal/professional activism, perceive a higher level of organizational activism, and experience more role discrepancy than social workers with only an undergraduate education.

The fourth variable in the personal characteristics of social workers category is the proportion of time spent in indirect services. It was hypothesized that the amount of time spent in indirect services would effect the perception of organizational activism, the level of personal/professional activism, and the degree of role discrepancy. The proportion of time spent in indirect service did effect personal/professional activism. Social workers spending less than 10 percent of their time in indirect services had lower levels of personal/professional activism than those spending between 11 and 30 percent of their time in indirect services (30 percent being the maximum amount of time that any community mental health social worker spent in indirect services). Such findings suggest that the time spent in indirect services, i.e., consultation and education regarding community mental health matters, might serve as an impetus toward social activism. Social workers having the opportunity to spend approximately a sixth to a third of their community mental health center work involved in consultation and community education programs might find such time as a valuable respite from the more crisis oriented activities of direct service duties, i.e., inpatient and outpatient care, partial hospitalization,
and emergency treatment. Indirect service might be a deterrent to social worker burnout in the community mental health setting.

Category III, Cognitive Characteristics Affecting Social Activism, focused on the relationship of community mental health ideology, community mental health center orientation (social service agency vs. medical facility model), client-professionalism conflict, agency-professionalism conflict, and community professionalism conflict to CMHC activism, personal/professional activism, and role discrepancy.

Previous research has indicated that each profession develops its own characteristic set of concepts, value priorities, and practices which represent that profession's distinctive ideology (McLeod & Meyers, 1967). Baker and Schulberg developed a Community Mental Health Ideology Scale which "discriminates between the professional groups known to be highly oriented to this ideology and random samples of mental health professionals" (1967:216). Analysis of the current data on the relationship between community mental health ideology and activism suggests that the greater the social worker's support of community mental health ideology the higher the level of personal/professional activism.

The fact that community mental health ideology is related to the social worker's personal/professional level of activism presents some interesting considerations in regard to social work in general and social workers employed at community mental health centers in particular. Social work has long claimed a dual
orientation to both client and community needs and services, yet the field of social work has continually been at the point of coming apart because of the conflicting micro verses macro ideological commitments that such a dual orientation demands. Community mental health centers provide the opportunity for social workers to activate this dual orientation and process micro and macro ideological commitments into a functional reality.

Community Mental Health Center Orientation was a variable that dealt with how the social worker viewed his community mental health center, i.e., as a social service agency or a medical facility. Sixty social workers considered their centers to be similar to social service agencies while 75 saw them as similar to medical facilities. Looking at the perception of the community mental health center on the social service agency/medical facility continuum, it was hypothesized that the social worker's perception of the center as a medical model of organization would serve as a conservatizing force while the social service agency model would provide a liberal influence. However, the three community mental health center orientation hypotheses did not prove to be statistically significant.

The final nine hypotheses in category three dealt with social activism as it related to the professionalism of social workers as defined in three ways. First, the adherence to "stated professional standards" when placed in opposition to client needs. Second, the adherence to professional standards when placed in opposition to agency policy. Third, the adherence to professional
standards when placed in opposition to community expectations. Eight of the nine professionalism conflict hypotheses did not prove to be statistically significant. The hypothesis that failed to be rejected in this category concerned the client-professionalism conflict and role discrepancy; the data testing this hypothesis showed that social workers experienced more role discrepancy when violating professional standards to meet the needs of the client. The fact that this hypothesis proved significant points to one of the possible causes of social worker burnout--the role conflict experienced by social workers in attempting to meet the demands of organizational activism as well as their own personal/professional activism.

The fourth category, Boundary Busting in the Role of the Social Worker, contains two hypotheses. Based on the work of Epstein (1968, 1970a, 1970b) and Wagenfeld and Robin (1976), these hypotheses suggested that: social workers would exhibit more personal/professional activism in arenas of community involvement where they had limited institutional involvement; and the kind of situation, consensus or dissensus, as well as the level of involvement would determine social worker activism. The data on social worker boundary busting revealed that social workers exhibited a higher level of boundary busting in arenas of high involvement than in arenas of low involvement, a result that ran contrary to Epstein's theorization that the greater the institutional involvement of social workers in a problem area, the more conservative will be their
perceptions of effective social action strategies for social workers. The data also indicated that social workers have a higher level of boundary busting in an arena characterized by a consensus situation rather than a dissensus situation; a factor that held constant for arenas of high involvement as well.

Social workers are most likely to bust boundaries in areas relating to welfare issues and medical care and least likely to bust boundaries in the political arena. The reluctance of social workers to become involved in political situations is more clearly understood when one realizes the sanctions, including loss of job, that can be imposed upon a social worker who should he/she choose to be politically active. A number of social service agencies inform social workers at the time of job application that public political activity is forbidden.

A parsimonious and logical concluding step in the analysis of the data would appear to be a series of stepwise multiple regression analyses of the independent and intervening variables with each of the dependent variables that permit such analysis.\(^1\) The order of the analysis is to consider the predictive power of the independent variables and the intervening variables\(^2\) with three of the dependent

\(^1\)Multiple regression techniques were not used in the analysis of the material pertaining to boundary busting behavior because of the different format used for these two hypotheses.

\(^2\)Included in this analysis are variables relating to characteristics of the catchment area: geographical complexity, ethnicity, and socioeconomic character (poverty vs. nonpoverty). These variables were included to give a more complete presentation of the factors affecting CMHC activism, personal/professional activism, and role discrepancy.
variables.

Organizational complexity, accountability, and ethnicity were all found to be inversely related to CMHC activism, while working in a rural area or in the inner city were found to be both positively and significantly associated with organizational activism. Therefore, social workers perceived more organizational activism in community mental health centers that had a smaller number of components,\(^1\) diversified accountability,\(^2\) a predominantly white catchment area, and were located either in the inner city or rural areas.

Working in an urban mixed area\(^3\) and agency tenure were both inversely related to the personal/professional activism of the social worker while community mental health ideology and working in the inner city were found to be positively related. An urban mixed catchment area and agency tenure longevity are, thus, seen as negatively affecting the social worker's personal/professional activism while adherence to community mental health ideology and working in the inner city are likely to increase the personal/professional activism of the CMHC social worker.

Role discrepancy between CMHC activism and personal/professional activism was found to be inversely related to the CMHC

\(^1\)"Number of Components" refers to the number of affiliate or component agencies joined together to provide the federally mandated mental health services.

\(^2\)"Diversified accountability" refers to both "local" and "distant" accountability.

\(^3\)"Urban mixed area" is a term used to define a catchment area that includes both urban and rural regions.
social worker selecting client needs over "stated professional standards" and agency tenure while agency accountability and socio-economic status of the catchment area increased role discrepancy. Such findings suggest that the social worker in the community mental health center is subject to role conflict. "Role conflict," according to Ivey and Robin, "occurs in a situation in which there is systematic difficulty involved in assuming, maintaining a role, or functioning in a role situation" (1966:30). These two researchers have indicated that role theory points to the significance of interpersonal and interprofessional relationships if the counselor is to be effective in a work setting and that while a counselor may define his role accurately according to professional standards, it is important that he communicate his perception of role to those with whom he works. Ivey and Robin note that if the counselor fails to communicate his perception of role or does not understand others' perception of role, his chances for successful performance in the counseling role are limited. Transfering this information to the current data and the role of the CMHC social worker, one begins to comprehend the problem. Reference to the vagueness of the social work role can be found in the report of the Joint Commission on Mental Illness and Mental Health, Action for Mental Health (1961):

The prospects are not so bright in relieving the shortage of social workers. Part of the problem is the lack of clear cut and favorable definition of the social worker's role as the public sees him and as he sees himself.... The social worker, who is the key figure in any clinic or hospital proposing to provide competent care of mental patients, presents a rather vague image in the mind of many people (1961).
Although the years since the publication of *Action for Mental Health* have effectively eradicated the shortage of social workers, social work's identity crisis has continued. Recently, Cooper (1977) labeled social work "a dissenting profession" and noted:

> We ask ourselves repeatedly: Who are we? How are we? who values us? Where do we belong? What can we contribute that is distinctive? Where are we going? How can we shape our direction? And still the essential nature of our profession remains elusive. We do not work in the same settings, we perform many different tasks, we use a vast array of different tools and interventions, we are seen differently by others and influenced heavily by these perceptions, we use many theories and not always the same ones, while some among us even resist the idea that any theory is particularly useful. At times, we question whether we are a profession at all, let alone one profession. Crazy patchwork quilt or evolving, discernible design. Even the professional labels we attach vary: BS, BSW, MSW, MSSW, DSS, DSW, Ph.D., ACSW, LCSW, RSW (Cooper, 1977:360).

At the core of the problem centering on the clear delineation of the social worker role is the question of whether social workers are professionals, semi-professionals, or nonprofessionals, and how these categorizations relate to the social activism that has always been an integral part of American social work. Those critics and social analysts that refuse to consider social work as a profession claim that social workers lack the necessary detachment to function as professionals while those that label social workers as semi-professionals state that social workers have shorter periods of required education and training, less legitimated status, less established right to privileged communication, less of a specialized body of knowledge, and less autonomy from supervision or social control
than the "professions." Finally, those individuals that credit social work as a profession do so with the qualification that social work is a profession in the process of emerging.

Areas for Future Research

Suggestions for future research are closely related to the major conclusions and implications of this study. Some of the issues cited in this study remain unanswerable because of the inherent problems of the data; therefore, it is important that they be discussed here as suggestions for future research. These suggestions are presented under the following five subheadings: social worker activism and social worker professionalism; community mental health ideology and community mental health center directorship; social worker burnout and the community mental health center; educational preparation for social work in community mental health centers; and social workers with other mental health professionals at the community mental health center.

Social Worker Activism and Social Worker Professionalism

The results of this research have shown that there still needs to be a clarification of the social worker's role in the field of community mental health in general and the community mental health center in particular. The present study was concerned with whether or not the social worker could juxtapose the two roles of social activist and professional care-giver in his/her work at the community mental health center. Although the study was successful in establishing
the extent of social worker activism and role discrepancy within the context of the community mental health center, it failed to adequately relate this social activism to social worker professionalism, thus underscoring the necessity for a new research instrument to measure social worker professionalism.

This investigator's review of the literature relating to social worker activism and social worker professionalism revealed few empirical attempts to explore the relationship of the two, even though social activism is frequently cited as a hinderance to the professionalism of social work. Future research must consider whether social activism and social worker professionalism are antithetical or inseparable if there is ever to be a concise delineation of the dimensions of the social worker's role in both community mental health and American society.

Community Mental Health Ideology and Community Mental Health Center Directorship

Additional research should look at whether or not the social workers that adopt and accept the community mental health ideology differ significantly from social workers that do not, in their delivery of community mental health center services. The findings from the present study reveal a statistically significant relationship between the adoption of the community mental health ideology and personal/professional activism, but more research is needed to establish just how much activism is implemented, e.g., quality and effectiveness of service provided, and their service delivery priorities.
Consideration also should be given to the possibility of more social workers as directors of community mental health centers. As a group, directors have not received much study, despite the significant role they play in the delivery mental health services. Directors are primarily drawn from the three major professional disciplines in mental health: psychiatry, psychology, and social work. A few directors come from other related fields such as sociology, rehabilitation, hospital administration, and nursing. The present study included 11 community mental health center directors that were psychiatrists, 5 psychologists, 2 social workers, 1 sociologist, and 1 hospital administrator.

Research by Musto (1975), Robin and Wagenfeld (1977), and Sharfstein (1978) has given evidence that psychiatrists have fallen short of providing effective leadership as directors of community mental health centers. Data gathered by Robin and Wagenfeld (1977) revealed that psychiatrists in community mental health centers manifest low levels of organizational and personal/professional activism:

Although psychiatrists have been instrumental in the development of community mental health, they are not the leaders in the application of ideology within CMHCs--the organizational repositories of the ideology. Compared to their co-workers in community mental health centers, they can be seen as a conservatizing influence in realizing the mandate of putting "community" into community mental health...to the extent that the community mental health movement demands attention to the community origins of mental illness, primary prevention, and the assumptions of responsibility for mental health of the entire catchment area, then the ideological stance of psychiatrists in non-supportive (1977:39-40).
Social workers exhibit high levels of organizational and personal/professional activism as well as a strong commitment to community mental health ideology. Therefore, the available data support the proposition that social workers have the appropriate qualifications for leadership positions in community mental health centers.¹

Social Worker Burnout and the Community Mental Health Center

As previously noted, in the third chapter, social workers often start their careers with a strong orientation toward social activism that is slowly eroded through on-the-job experience resulting in "burnout syndrome," a term that is associated with an extreme form of job-related stress and exhaustion. The length of agency tenure was hypothesized to affect the social worker's perception of CMHC activism, the level of the social worker's personal professional activism, and the resulting role discrepancy in a negative manner. Agency tenure was found to have a negative correlation with personal/professional activism and role discrepancy. Having found some evidence that social workers in community mental health centers might be victims of the burnout syndrome, additional study needs to focus on why burnout would occur in a community mental health center, who (personality profile) would be the most likely candidate for

¹Since the collection and analysis of the data for this dissertation, social workers have begun to actualize their micro and macro ideological commitments in the community mental health field. "The Report of the Task Panel on Mental Health Personnel" submitted

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burnout, what coping mechanisms could be developed by community mental health center social workers to avoid burnout, and what programs could be instituted by community mental health center social workers to help prevent burnout among their colleagues.

Freudenberger (1975), Maslach (1977), and Reid et al. (1977) have all credited burnout as being an occupational hazard of social work that has been largely ignored. Reid writes:

Although much has been written regarding the way things "ought to go," there has been little attention paid to some of the pitfalls awaiting the social worker in a helping relationship. Factors leading to these pitfalls include the worker's own problems, his personal life, client hostility, cultural factors, the difficulty of maintaining a sense of objectivity in any intimate human relationship, unrealistic expectations of the client, and an unwarranted acceptance of responsibility by the worker for the success of the intervention (1977:4).

Schools of social work need to develop a curriculum that confronts the high rate of burnout among social workers so that the number of MSWs leaving social work after only a few years of work experience can be lessened. The rewards of such a revised curriculum are bound to be great for community mental health centers which according to the most recent statistics available employ 6,752 social workers.¹

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¹This statistic is based on the number of full time social workers employed by community mental health centers in 1976.
Educational Preparation for Social Work in Community Mental Health Centers

Although social forces converged during the decade of the 1960's to underscore the relevancy of social action in all areas of social work education, there are a number of ways that social work education can be made more relevant to students preparing for social work in community mental health centers. While the present research study did not have the data available to confront the issue of educational preparation for social work in community mental health centers, a recent CSWE report of the Community Mental Health Practice-Education Project (1978) addressed this topic. According to Harm, editor of the report, the following are some of the major themes regarding social work education and community mental health agencies.¹

- The interface between social work education and community mental health agency practice
- Factors external to both systems, mental health practice and social work education: funding, governmental policies, political forces, socio-economic changes in service areas, and variance in personnel needs
- Insufficient differentiation between the roles and functions of the various educational levels of social work personnel
- Collaborative effort of both social work education and community mental health practice to provide continuing education

¹ Community mental health agencies was defined by this study as: community mental health centers, state hospitals, VA hospitals, residential treatment centers, private psychiatric hospitals, Day Care programs, outpatient clinics, emergency services, community care alternatives, community health centers, social service centers, and co-ordinating agencies.

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-Curriculum development in social work education programs to deal with the expanding focus of community mental health practice

-Identification of those mechanisms pertaining to social work practice in community mental health agencies that will strengthen the social work professional in his/her functioning and the total profession in its contributions and identity in the field.

The existence of community mental health centers and the growing number of social workers practicing in the community mental health field with its broad range of competencies and its demand for a combination of community service and clinical skill, make it mandatory that additional research be directed in the area of social work education.

Social Workers and Other Mental Health Professionals at the Community Mental Health Center

The focus of this study has been on the social worker at the community mental health center but social workers are not the only mental health professionals employed by community mental health centers. According to recent statistics,¹ social workers provide 19 percent of total patient care at community mental health centers while psychiatrists provide 6 percent, other physicians less than one percent, psychologists 13 percent, registered nurses 13 percent, and other mental health professionals with academic degrees greater than or equal to B.A.'s, 18 percent. It is, therefore, necessary that additional research

¹This is a 1976 statistic taken from Task Panel Reports Submitted to the President's Commission on Mental Health, Vol. II (1978:485).
in community mental health deal with the quality of relationships between mental health professionals at community mental health centers, i.e., the hierarchy of authority, the designation of service delivery, and the priority of service delivery.

There is a tendency, that has been cited by the President's Commission (1978), for the qualified mental health professionals to congregate in the urban areas of the wealthier states. Rural areas show a scarcity of mental health professionals, and those who work there are frequently less highly trained than those who work in the cities. Although researchers have clearly documented the maldistribution of mental health personnel, future research needs to consider what effects this maldistribution has on service delivery and service priorities among mental health personnel. The current study found that social workers in rural areas perceived the activism of their community mental health center as high while social workers in a catchment area of both urban and rural regions had a low level of personal/professional activism.

While this study has attempted to establish the dimensions and degrees of social activism for community mental health center social workers, future research should be directed to the social activism of other mental health professionals working in community mental health centers. Community mental health centers have been part of this nation's mental health care delivery system for almost 15 years, received $1.5 billion in federal funding, and been responsible for a number of important mental health services, but there are serious problems that remain in the delivery of mental
health care services.

Limitations of the Study

The major limitations of the present research analysis are seen as evolving from the following: the definition of the personal/professional activism variable, the adaptation of the Billingsley Scale of Professionalism, the two boundary busting hypotheses, and the nature of the data upon which the current research is based.

A dependent variable purportedly measuring social worker activism should not have been presented to the social workers surveyed as both personal and professional in nature; inherent in a variable defined in such a manner is the assumption that the individual's role as a social worker is the same as when he/she is not involved directly in social work, i.e., a non-social work role. Such an assumption goes directly against one of the most basic tenets of role theory, which is that each individual has many roles and the nature and content of these roles is dependent, in part, on the audience present. While an argument can be advanced that certain kinds of people seem to be attracted to certain jobs or professions,¹ it seems reasonable to conclude that personal and professional perspectives and mandates might have a tendency to conflict at various times.

A second concern, which has already been indirectly noted, is that

¹William Henry, John Sims, and Lee Spray (1971) have conducted research to determine the similarities and dissimilarities of people in the four professions that combine to create what they term the "fifth profession," psychotherapy. In addition, numerous studies have been done within the area of sociology of occupations and professions that have attempted to describe the characteristics of individuals attracted to particular jobs or professions.
the personal/professional activism variable denies the researcher
the opportunity to analyze, in any meaningful way, the role conflict
between personal activism and professional activism. A separate
analysis of personal activism and professional activism would have
provided a valuable and logical addition to the analysis of organi-
zational activism and the role discrepancy between not only organi-
zational activism and professional activism but the role discrepancy
between professional activism and personal activism.

Professionalism of the social worker was measured by a
scale adapted from one developed by Billingsley (1964). This scale
proved to be an even weaker instrument of measure than anticipated
and did not yield information that could significantly contribute
knowledge concerning social worker professionalism and social activism.
Any future researcher desiring an empirical measurement of social
worker professionalism will have to select from some of the other
professionalism scales available, i.e., Wilensky (1964), or design
a new research instrument.

No serious attempt to assess the relationship of social
worker professionalism to social activism should omit the boundary
busting activities of the social workers surveyed. This study
incorporated boundary busting into the research design by formulating
two boundary busting hypotheses. The results of these two tested
hypotheses were that social workers exhibited a higher level of
boundary busting in arenas of high involvement than in arenas of low
involvement, and in arenas of low involvement involving a consensus
situation as opposed to a dissensus situation. The reason as to why
social workers responded as they did can only be left to speculation. It can, for example, be suggested that social workers exhibited a high level of boundary busting in arenas of high involvement because they were better acquainted with the nature of those arenas and, therefore, better able to effectively bust identified boundaries. This rationale, however, would not be accepted by Epstein, who noted in a 1968 study that:

the greater the institutional involvement of social workers in a problem area, the more conservative will be their perceptions of effective social action strategies for social workers as well as for other politically active groups (1968:106).

Epstein's findings, which dealt with the perceived efficacy of actions suggested a pattern of differentiation of political roles for different social classes as well as different problem areas; and he viewed the tendency to regard conservative strategies as most effective for low income people in areas where social workers were institutionally involved as possibly translating into actions that would reduce the militancy of politically active low income groups. The findings from the current study could provide the basis for exactly the opposite forecast.

The different findings of the two studied can be traced, in part, to several differences in the two research designs and methodologies. First, Epstein surveyed 1,020 members of the New York City Chapter of the National Association of Social Workers while the present study surveyed 140 social workers employed at twenty community mental health centers located throughout the United States. Epstein's findings may be more of a reflection on how social workers function
within the bureaucracy of New York City than any information that can be generalized into a commentary on social workers throughout the country. Second, Epstein limited his study to the fields of housing and welfare reform while the current study considered the following community arenas: welfare issues, medical care, family, schooling, housing, economics, police, community, and political. Finally, the present study deals only with community mental health social workers while Epstein surveyed members of the New York City Chapter of NASW and did not limit himself to a particular kind of social work or agency.

A final limitation of the study which is pervasive throughout the dissertation is the lack of some basic information on the CMHC social workers that might have clarified several issues surrounding social worker activism and social worker professionalism. Such an omission can be cited as one of the common difficulties encountered by researchers engaged in a secondary analysis of a data set.

Information unavailable in the current data set that would have been beneficial to the present analysis includes the following: distribution of social workers in the twenty community mental health centers surveyed; the particular graduate school where the social worker received his/her MSW and the area of specialization in the graduate curriculum; method of social worker recruitment employed by the various community mental health centers; if the community mental health center was the first choice of employment for the social worker; and whether the social workers felt that their work at the community mental health center was appropriate for their level of
expertise. Further information was also needed to determine whether the boundary busting activity of social workers in community mental health centers is directly related to the social workers' conceptualization of professionalism or social activism, or both.

Concluding Remarks

The data collection for the Wagenfeld and Robin study, "Emerging Roles of Community Mental Health Workers," was done in the early 1970's. Since that time, the number of operational community mental health centers has increased from 200 to 590, the number of social workers employed in community mental health centers has grown from 1,989 to 6,752, and federal health legislation (the 1974 Health Planning & Health Resource Act and the proposed 1979 Mental Health Systems Act) has been introduced and is likely to have significant implications for social workers and social work in relation to mental health. Wittman has noted:

It is certain that singular contributions will be demanded of social workers in health planning and resource development. As never before, knowledge about and skill in short and long range planning will be at a premium. Hard issues of multi-institutional integration will need to be faced. Mental health and health services will be forced into congruence as never before (Sobey, 1977:76).

The passage of time since the initiation of this study, the numerical growth of community mental health centers and social workers employed by community mental health centers, and recent health legislation, should serve to alert the reader that what has been written here focuses on the CMHC social workers in the past, not the
present. However, the fact remains that the CMHC social worker has yet to identify and clarify his/her particular role as a mental health professional within the context of the community mental health center and reconcile the social work professional role with the social activism role.

It was the consensus at a major conference on social work education in community mental health, "that social work has a key role to play in community mental health that stresses rehabilitation, health promotion, and primary prevention," but there was considerable feeling at the conference that social work had too readily adopted the traditional medical-psychiatric treatment model and as a result has relegated itself to "a secondary or auxiliary role in most mental health programs" (McPheeters, 1975:87-91). Such findings suggest that social workers are still suffering from what Gilbert (1977) has termed the "Flexner syndrom," i.e., professional insecurity based on an idea presented by Flexner in 1915 when he observed that because social workers have so many roles in so many settings, social work is "not so much a separate profession as an endeavor to supplement certain existing professions..." (Flexner, 1915:908).

This study has attempted to investigate the role of the social worker as social activist within the community mental health center and the effect of this activism on social work professionalism. Although methodological difficulties have clouded some of the findings of this work, making interpretation tenuous, it is hoped that future researchers will feel compelled to initiate study of some of the issues presented.
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APPENDIX

COMMUNITY MENTAL HEALTH WORKER SURVEY
COMMUNITY MENTAL HEALTH WORKER SURVEY

1. Are you attached to a particular component or service of the CMHC (e.g. inpatient, 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__

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
Absolutely should not

2. Carry out agency policy, even if this requires violating stated professional standards.

Absolutely must
Probably should
Absolutely should not

3. Act according to professional standards, even if this requires violating community expectations.

Absolutely must
Probably should
Absolutely should not

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 feelings about 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.

AA 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

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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 influence 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.

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

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

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

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

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

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

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.
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 A A D DD DDD

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

AAA A 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 A A D DD DDD

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

AAA A A D DD DDD

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

AAA A A D DD DDD

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.

AAA A A D DD DDD

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

AAA A A D DD DDD

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

AAA A A D DD DDD

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

AAA A A D DD DDD

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

AAA A A D DD DDD

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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.

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

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

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.

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 other, 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>I would do nothing, since this is not part of my job as a community mental health worker.</td>
<td></td>
</tr>
<tr>
<td>I would advise and help to organize a protest, work stoppage or demonstrations.</td>
<td></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></td>
</tr>
<tr>
<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>
<td></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>

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.

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.

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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 representatives.

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 the 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.
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.

**CMHC**

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.**

**CMHC**

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

---

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CMHC

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.

CMHC

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

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.

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

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 side, your participation has been requested.
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 the system is successful. Parents have claimed that it should be changed since it perpetuates social inequality and have asked you to enter the situation.

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.

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.

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.
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 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.

CMHC

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.

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.

CMHC

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.

It has been proposed that a free medical clinic be provided for those who do not have access to the usual medicine 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.

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 decisionmakers 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

PERSONAL-
PROFESSIONAL

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.

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.

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

The majority of residents in your catchment area live in seriously dilapidated houses and tenements. Numerous instances of fires due to faculty 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 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 occasions experiences.

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!