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University of Massachusetts Amherst

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AN OCCUPATIONAL ROLE ANALYSIS OF INDIGENOUS NONPROFESSIONALS:
THEIR SUBJECTIVE EXPERIENCE AT WORK AND THEIR PERSPECTIVES ON
THE COMMUNITY MENTAL HEALTH MOVEMENT

A Dissertation Presented

By

HELEN A. LEKISCH

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 1979

Psychology Department

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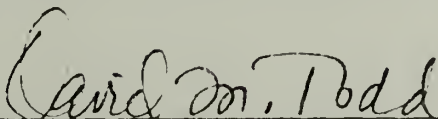
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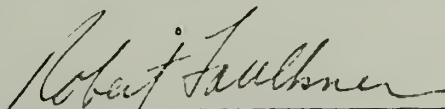
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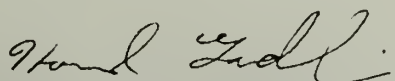
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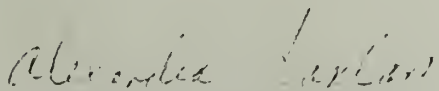
David M. Todd, Chairperson of Committee



Robert Faulkner, Member



Howard A. Gadlin, Member



Alexandra G. Kaplan, Member



Bonnie R. Strickland, Chairperson
Psychology Department

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I would also like to thank my committee for their time, support and enthusiasm. All four members have been active in making important contributions to the ideas in this study. Each committee member brought a unique perspective both to this research as well as to my overall graduate education. The sociology of work perspective, a critical theory perspective, a feminist perspective and a social systems perspective all informed my work, helped me gain crucial insights into the data, and are evident in the final product.

Finally, many friends and colleagues provided the support I needed in doing this work. I would especially like to thank Andrea Bakst, Joe Gabbert, Minna Genn, Sally Ives, Joel Levine, Jeff Lowell, Carol Simonson, and Susan Zlotlow. Finally, special thanks are due to my parents, Ruth and George Lekisch, for their encouragement and support.

ABSTRACT

An Occupational Role Analysis of Indigenous Nonprofessionals:
Their Subjective Experience at Work and Their Perspectives on
the Community Mental Health Movement

(September 1979)

Helen A. Lekisch, B.A., University of Rochester

M.S., University of Massachusetts, Ph.D., University of Massachusetts

Directed by: Professor David M. Todd

One of the acclaimed innovations of the community mental health movement has been the employment of indigenous nonprofessionals in mental health settings. In the 1960's and early 1970's, the community mental health literature included many studies and case examples suggesting the progressive and positive impact of using indigenous nonprofessionals as direct service providers. This literature suggests that nonprofessionals should feel useful to and respected by professionals; should make significant contributions in treatment planning and execution; and should have opportunities and encouragement for career advancement. Despite these assertions, there is a dearth of literature which asks nonprofessionals about their actual experience in their jobs.

The present study investigates the occupational role of the indigenous nonprofessional from his/her vantage point. The study adopts a critical theory perspective, locating these innovations and change efforts within the political and historical context in which they occurred. Drawing on a sociology of work perspective which articulates the phenomenology of the work situation, field observation, participant observa-

tion and structured interviews were conducted with sixteen indigenous nonprofessionals who work in both inpatient and outpatient departments of the community service of a large psychiatric hospital in an urban center.

Data reveal that there have been discrepancies between the design of jobs for nonprofessionals as described in the literature, and the actual implementation of these jobs as experienced by these workers. Whereas professionals tend to perceive nonprofessionals within the theoretical context provided by the community mental health literature, nonprofessionals see their jobs within the constraints and parameters of the civil service state bureaucracy. Divergent formulations of the job situation lead to staff conflict around patient care and division of labor. The juxtaposition of respondents' accounts of their jobs with the community mental health literature provides a sharp contrast with the programs described in the literature.

Features of these nonprofessionals' daily work life on a community service inpatient ward are described. Sitting with mental patients eight hours a day with no power or authority to initiate action but yet being required to respond to and control patient violence puts the non-professional in a reactive position which is subjectively experienced as both tedious and tension-producing. These exigencies of work life, exacerbated by differences in the distribution of power (depending upon the predominance of either the formal or informal organization of the ward), often leave these nonprofessionals feeling angry, impotent and exploited. In response, occupational culture becomes a series of collective actions designed to undermine the efficiency of the formal,

medical organization and prove the indispensibility of nonprofessionals (informal organization).

The consequences of the battling between professionals and nonprofessionals are analyzed from a structural point of view. Issues of classism, racism, and sexism are posited as underlying dynamics of organizational dysfunction. These deeply-rooted issues, compounded by ecological variables of the inpatient milieu, account for continual disruptions of work flow and impinge on patient care and staff relationships.

In discussing these findings, a critique of the function of professional literature is presented. It is suggested that professional literature may be biased in a direction which assuages liberal guilt by constructing an illusory world view, seeing nonprofessionals as more contented, as having more input into the organization and more opportunities for advancement than they do. In addition, looking at nonprofessionals' experience at work puts professionals in a more self-reflexive stance toward their own work phenomenology. It is suggested that human service professionals may be reluctant to become aware of their own frustrations at work.

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CHAPTER I

INTRODUCTION

Current analyses of the "nonprofessional movement" in community mental health include little reference to the actual experience of the people who have occupied these roles. These roles were designed to address a wide variety of perceived needs, many of which, if successful, should be reflected in the subjective work experience of the nonprofessionals themselves. The present study begins from the premise that the absence of data about such effects reflects systematic and self-serving biases in professionals' conception, implementation and evaluation of these innovations. The literature on nonprofessionals is reviewed critically from such a perspective. In addition, the present study reports research which does focus on the subjective experience of nonprofessionals. These data are used to further critique the existing literature and to suggest alternative analyses and directions for research and practice.

Conceptual Foundations of the Research

The idea of employing indigenous nonprofessionals as direct service providers represented an original and progressive innovation within the community mental health movement of the 1960's. Hailed as a "bold, new approach" (Chu & Trotter, 1974) in helping to abate problems in service delivery, especially to the poor, the deployment of indigenous nonprofessionals was also billed as a unique and exciting solution to the un-

employment problems of the poor. Consequently, there was a proliferation of services employing and serving the poor in the 1960's. New careers were created, new educational settings were established, and new agencies and storefronts were erected to accommodate and advance these reforms. Indeed, the use of nonprofessionals in community mental health centers seemed to be one of the more forward-looking innovations of the 1960's. It was a set of innovations which was consonant with the humanitarian-focused liberalism of the Kennedy and then Johnson administrations and which exemplified many of the principles which characterized both the Civil Rights Era and the War on Poverty (Cloward & Piven, 1975).

At least a decade later, it becomes instructive to assess the nature and evolution of these kinds of reforms. One important perspective to bring to bear on these innovations is a perspective which deals with the nature of change and reform themselves. The perspective adopted here is a combination of critical theory and the sociology of work (Lekisch, 1977, see Appendix A). Critical theory suggests that change ideas and strategies are best understood as emanating from a particular social and political context. The particular characteristics of the context often determine the very nature of ideas as well as the concrete course of their implementation. This perspective on change calls for a careful analysis of the ideas themselves and the context in which they are embedded. Within this, both the timing and form in which ideas emerge are seen, historically, to reflect the particular times. The actual enactment of reform is seen as being even more responsive and likely to express the economic and political order of the times (Chu &

Trotter, 1974).

In an even broader context, the vantage point taken here is illustrative of a sociology of knowledge framework, or more specifically, a sociology of social reform framework. This perspective begins with the notion that ideas reflect the culture in which they occur and then, through their implementation or "reification" as social reforms, serve dialectically to foster the perpetuation of that culture (Berger & Luckmann, 1966; Buss, 1975).

In looking at issues of reform and innovation in this light, it becomes important to put forth both a conceptual and empirical analysis of the ideological and operational aspects of change and its implementation. Within the present context, then, our task is to critically examine the literature dealing with the use of nonprofessionals, as this literature reflects the historical period in which it was written. Second, it would then be useful to gather empirical evidence which helps us analyze and evaluate the efficacy of such ostensibly innovative programs.

Thus, the first part of the inquiry entails a review of the literature on nonprofessionals. The review is explicitly critical, in that it seeks out evidence of any change-inhibiting or conservative themes underlying these supposed reforms. The second part of the thesis reports data about the actual subjective experience of indigenous nonprofessionals in their work roles. By using a sociology-of-work approach which describes the daily phenomenology of the work situation of the nonprofessional, we can hopefully build toward an assessment of the actual degree of innovation and reform which have accrued from these programs. By asking nonprofessionals how they see and understand the con-

text in which their jobs are embedded, i.e., the community mental health movement, we can hopefully obtain direct evidence about the real change value experienced as a result of these reforms.

Finally, a discussion and examination of the data will try to fit this perspective on change, itself, with nonprofessionals' experience and understanding of their work roles and of the community mental health movement. Thus, a theoretical analysis of the potentials for real change, both ideologically and pragmatically, will be applied to both the conceptual and operational aspects of the community mental health movement's employment of indigenous nonprofessionals as direct service providers. This theoretical analysis will draw on notions of change provided by Watzlawick, Weakland and Fisch (1974) as well as on more critical theory approaches to change and exploitation (e.g., Hook, 1955; Ratner, 1971; Leifer, 1969).

The present research applies a critical theory perspective to the historical developments of the community mental health movement as it evolved in the 1960's and 1970's. Within the context of community psychology and community mental health, this inquiry focuses more specifically on the employment of "indigenous nonprofessionals," or paraprofessionals, in direct service work with clients of the mental health system. General critiques of the exploitative nature of the community mental health movement have been articulately presented elsewhere (cf. Leifer, 1969; Hurvitz, 1973; Halleck, 1971; Szasz, 1971; Statman, 1970) and will not be discussed in this paper. Rather, this presentation will focus solely on the use of nonprofessionals within the community mental health movement.

Evolution of the Community Mental Health Movement and Its Employment of Indigenous Nonprofessionals

There is considerable literature tracing the history of the community mental health movement and its use of nonprofessionals for mental health manpower (cf. Riessman & Popper, 1968; Pearl & Riessman, 1965; Grosser, 1969; McGee & Pope, 1975; Matarazzo, 1970). Most of this literature traces the developments in community mental health back to Albee's (1959) report to the Commission on Mental Health Manpower Trends and to the report of the Joint Commission on Mental Illness and Health (1961). In summary, the findings of these commissions indicated 1) that there were vast numbers of people who needed mental health services who were not getting services; 2) that existing services could not nearly accommodate the great numbers of people needing help; 3) that the manpower available to service these clients was pitifully inadequate; and, finally, 4) that there was a need for prevention and early identification of mental health problems (Zax & Cowen, 1976).

As a consequence of these findings, several new programs, agencies and governmentally-funded offices (e.g., OEO created in 1964) were set up in the 1960's (Brager & Purcell, 1967). It should be noted that these programs were coming into being during the early and mid 1960's, in the midst of the civil rights era and the war on poverty (Goldenberg, 1973). This was a time when attempts were made to integrate minorities and disaffected citizens into the mainstream of the society.

Within the mental health fields, liberal innovators showed tremendous energy and imagination in designing progressive, if not radical programs, which would both provide necessary social services to the poor

and would abate a growing unemployment problem, especially among inner city poor and minorities (Reissman, Cohen & Pearl, 1964). The Manpower Development and Training Act (MDTA) of the early 1960's is an example of a large governmental measure undertaken to deal with these concerns (Grosser, 1969). Indeed, Hobbs (1964) considered the scope and nature of the change strategies of the community mental health movement to constitute a "revolution" in mental health history (cf. also Sobey, 1970).

Innovations in the use of nonprofessionals and paraprofessionals in community mental health took one of three paths. One type of utilization of nonprofessionals consisted of programs using college students as direct service volunteers to work with mental patients and others in need of human services (cf. Zax & Cowen, 1976). There is a plethora of literature describing these programs and developments from the mid-1960's to the present (Rappaport, 1977). Another trend in the use of nonprofessionals consisted of training and employing (or often only using as volunteers) educated middle-class persons, like housewives or retired persons, as mental health workers (cf. Rioch *et al.*, 1963). While this utilization of manpower has been very important, it is not of direct relevance to the present inquiry and will not be discussed further here.

The third type of nonprofessionals' usage in the mental health system consisted of employing "indigenous nonprofessionals," that is, those persons living in poor inner city communities who could well understand and represent the clientele of these communities (Reiff & Riessman, 1965). This last genre of innovations, which constitutes the thrust of the present inquiry, was perhaps the most radical and provocative of all

of the innovations using nonprofessionals (Steisel, 1972; Blau, 1969; Matarrazzo, 1970). These developments can be considered radical in that minority persons who had never before had a say in the provision of mental health services were now being given the opportunity to become integral parts of such organizations and to work directly with their own people.

Many rationales were developed to justify this utilization of nonprofessionals. Grosser (1969), for example, cites four reasons why indigenous nonprofessionals were used. First, he notes that the indigenous nonprofessional could serve as a "bridge" between the middle-class white professionals and the lower class minority clientele who very much needed mental health services (Hesse, 1977). Second, many jobs in the human service fields could now be provided to persons who might have otherwise remained unemployed (Riessman & Popper, 1968). Third, Grosser points out that the spirit of the times was to fulfill the democratic ideology of encouraging all persons to participate in government and human service. Fourth, Riessman (1965) has noted what he calls the "helper-therapy" principle, which says that the act of helping is itself therapeutic to the helper as well as to the client. Thus, one could economically help both therapist and client by using nonprofessional minority people (cf. also Mitchell, 1969; Brager, 1965; Hallowitz, 1969).

These kinds of programs, which used nonprofessionals in direct service roles in mental health agencies, seemed to address many important needs simultaneously: the unemployment problem, the need for more manpower, and the need for serving minority persons (Brager & Purcell,

1967).

On the surface, these kinds of innovations seem quite progressive and perhaps even commonsensical. In the mid and late 1960's, however, they met with considerable debate from those professionals in social work, clinical psychology and psychiatry (Hardcastle, 1971; Durlak, 1973; Bowhoutsos, 1970). Social workers in particular were threatened by the influx of nonprofessionals who were to do much of the same work which had formerly been the domain of social workers (Richen, 1969; Lowenberg, 1968). New roles were outlined for the professionals in such agencies to help the professionals feel less threatened. Not surprisingly, there is ample literature which deals with threats to the status, roles and professional identity of social workers and other professionals because of the entry of nonprofessionals in mental health settings (Levinson & Schiller, 1966). One should note here that the bulk of the literature deals with issues concerning the professionals rather than the nonprofessionals (Hardcastle, 1971; Dorr, Cowen & Kraus, 1973).

In general, the literature which deals with the use of indigenous nonprofessionals is centered around the following areas: 1) recruitment, selection and role definition for nonprofessionals; 2) training of nonprofessionals; 3) supervision of nonprofessionals; 4) the effectiveness of the programs using nonprofessionals; and 5) advancement and career opportunities.

Recruitment, Selection and Role Definition

Some of the literature on recruitment and selection looks at dif-

ferent ways of assessing whom to hire and who will work out well in the role of helper (Brager, 1965; Herbert et al., 1974). Other articles put forward manuals which show how to select appropriate indigenous nonprofessionals. Much of this literature (Grosser, 1969) suggests that one should hire nonprofessionals who can relate well with others, who are well known and liked in their own communities, who are not too politically radical or militant, and who are able to write and read rather well (typically having a high school education) (Riessman & Popper, 1968). Thus it appears that the type of indigenous nonprofessional who is recruited is the sort of person who is likely to blend in well with white middle-class professionals but who can also relate to his/her community of origin. This literature also suggests that when the indigenous nonprofessional moves into the mental health agency, he or she should not be given privy to dealing with issues of organizational structure, the distribution of power in the agency, long-range programming, grant-writing, or other administrative concerns. Rather, the indigenous nonprofessional should deal with some of the paperwork of the agency and with outreach to community residents (cf. Grosser, Henry, & Kelly, 1969).

One issue related to recruitment and selection which receives major attention in the literature is the role that the indigenous nonprofessional should play (Levinson & Schiller, 1966; Lowenberg, 1968; Lynch, Gardner, & Felzer, 1968; Alley & Blanton, 1976). The literature points out that the indigenous nonprofessional should be sufficiently identified with his or her own community so that he or she can adequately represent and relate to community residents. However, the nonprofessional should not be so identified with the community so as to undermine the

goals of the professionally-run agency by being too militant or contentious toward the agency. On the other hand, this literature indicates that the minority nonprofessional should not be so upwardly mobile as to be overly identified with the white middle-class professional. If he or she is, he or she will not want to deal with or relate to the problems of local community residents (Levinson & Schiller, 1966). Thus the literature suggests that one find an indigenous nonprofessional who can almost walk a tightrope between identifications with his/her community and desire for upward mobility and identification with the professional middle-class staff. The literature goes on to suggest that although one should build in steps for upward mobility, such indigenous nonprofessionals should not become too quickly overidentified with or absorbed by the white professional staff, because then they will not provide the necessary liaison to local residents (Grosser, 1969).

Perhaps it is already evident, drawing only on the literature about recruitment and selection of nonprofessionals, that the implicit tone of this literature is one which objectifies the indigenous nonprofessional, as if he or she were some tool or instrument which needs to be carefully shaped and molded by professionals before it or s/he will work properly in serving the needs of both the community and the professional staff. This underlying tone is rather flagrantly reflected by the very term "the use of nonprofessionals." The immediate question is: whose use? Judging from the objectifying and depersonalizing tone of the literature, and by the fact that the literature is written by professionals for other professionals, it would appear that the prime concern has been the professionals' use of nonprofessionals to do the direct service work

which has been both difficult and undesirable for the professionals.

On the one hand, the literature continually professes ways in which nonprofessional utilization is advantageous to the nonprofessional and his/her community and ways in which such utilization will help rectify all sorts of economic and social inequities in mental health service delivery and in access to employment possibilities. On the other hand, a closer reading of the literature shows ways in which nonprofessional utilization is beneficial for the professional mental health establishment. There seems to be an almost self-congratulatory quality to many of the papers written in the sixties. What is conveyed is the sense that such employment of nonprofessionals is almost an act of generosity on the part of professionals, not to mention a clear sign of the flexibility and progressiveness of professionals.

Once the reader of this literature has gotten through the elaborate rationales for how wonderful these innovations are for minorities and other poor people, the reader will note that the thrust of the literature then becomes centered around professionals' concerns with maintaining the upper hand within the agency, using nonprofessionals to do work which professionals do not really want to do, and preserving if not fostering professional integrity and identity (cf. Kaslow et al., 1972; Fishman et al., 1966; Riessman, 1965). Thus, while the manifest content of this literature appears to focus on the importance of nonprofessional involvement in mental health, the latent, but more substantive concern, seems to be on the conservation and preservation of professional power, status, and control (cf. Hallowitz & Riessman, 1967; Richan, 1969; Lowenberg, 1968; Lorber & Satow, 1977).

The literature goes on to recommend that one involve nonprofessionals in projects for which they must depend on the agency itself, so they will not be working for community residents and against the agency (Grosser, 1969). Thus, according to the literature, one must design jobs for which the professionals become the essential reference group, but not so much so that the nonprofessional loses his/her lower-class identifications. A careful balance must be achieved so that both agency and nonprofessional goals are consonant with each other, while at the same time allowing or encouraging the nonprofessional to remain identified with his/her community. This seems to imply that potential class differences and struggles are to be muted or camouflaged rather than acknowledged and worked through openly.

In fact, it is precisely the lower class status and "mentality" of the nonprofessional which makes him/her a good candidate for a job in a community mental health center in the first place. Such lower class characteristics are to be "used" and even preserved because they are of such value (as tools with which to reach the poor) to the white professional staff (cf. Pearl & Riessman, 1965). The inherent qualities which naturally seem to go with being poor and from a ghetto area are exactly what the middle class professionals do not have but need in order to be credible in alienated ghetto areas and communities. Thus, it is precisely those characteristics which have made indigenous residents disaffected from the society which now need to be almost cultivated and preserved intact. Their preservation, refinement and usage is to occur, according to this literature, under the direction of middle-class professionals and in settings run by middle-class professionals. The lit-

erature suggests that in the ideal situation, there is to be a meshing of inherent qualities of the indigenous poor with the psychiatric expertise of the white middle-class professional. However, it is the professionals who are to decide what proportions of the various (if not conflicting) attitudes and skills are to go together in which particular combinations to get the desired effect. Much of the literature consists of reports by various professionals on how they set up their particular programs. There seems to be quite a lot of comparing of how one professional coordinated his or her effort, as opposed to how a second professional organized his or hers (Riessman & Hollowitz, 1967; Willcox, 1970).

Training and Supervision

As noted above, there are also several articles which deal with the training of nonprofessionals, once they have been recruited and selected (Lynch & Gardner, 1970). These articles deal mainly with different designs for teaching social skills, empathy, reflection, and other qualities deemed necessary for doing direct clinical work. The thrust of this part of the literature is mainly on the kind of training program (e.g., weekend encounter groups, didactic material, and even community college courses and accreditation), rather than on the subjective experience of the nonprofessional in learning his/her new role (Kaslow et al., 1972; Lynch, Gardner, & Felzer, 1968). There is little attention paid to how these skills mesh with the vantage points and perspectives which inhere in the nonprofessional's "indigenous" background. Again, much of the emphasis here is on new roles for the professional in the training

of the nonprofessional (Shapiro, 1970; Moore, 1974; Herbert et al., 1974).

Another large percentage of the literature then goes on to talk about the supervision of nonprofessionals, once they have learned the basic skills (Karlsruher, 1976). Here again, the literature focuses on new tasks for the professionals rather than the personal experience, dilemmas, and concerns of the nonprofessional in performing his/her new job. Much of the writings deal with the relations between the nonprofessional and professional staff. Some of this literature indicates that professionals have quite a bit to learn from nonprofessionals as well as vice versa (Talbot et al., 1973). Unfortunately, however, the tone of this literature seems particularly patronizing and condescending toward the nonprofessional. For instance, it says that the nonprofessional can teach the professional some of the jargon of black people, that professionals can become sensitized to poor people's "inability" to delay gratification, and that professionals can begin to appreciate some of the immediate concerns for food and housing which preoccupy underprivileged persons. The tone of the literature almost suggests a bending-over-backwards in listening to the concerns and interests of the minority workers. There seems to be an attempt to be overly obsequious in seeking and obtaining the trust of the nonprofessional by the professional. Because the literature so clearly indicates that one should not put indigenous nonprofessionals in high organizational positions, it would appear that such attention to the concerns of indigenous nonprofessionals is more in spirit than it is in action.

What is important, within the present context, is to look at the

literature of the sixties as historical documents reflecting the implicit biases of the time. If one were to have read that literature when it first appeared, one would undoubtedly feel that the professionals who were writing it were very socially concerned, progressive and sincere liberal innovators. With the clarity of an historical perspective, the literature from the sixties appears now to be quite biased, condescending and perhaps quite exploitative. What comes across from this literature is that one should hire nonprofessionals who will not cause any trouble, who can be readily absorbed into the mental health system without totally losing their roots in the ghetto community. (Once they have lost their ties and identifications, they are seen to be of little usefulness to the mental health agency.) Thus, one is to hire the poor to deal with the concerns of other poor and disaffected peoples to whom white middle-class professionals cannot relate and to whom such professionals perhaps do not want to relate. This is not said explicitly, but is rather submerged under the assumption that white middle-class professionals cannot relate to poor minority persons.

To reiterate, it should be pointed out that the phrase "use of nonprofessionals" is used repeatedly in articles and books. It becomes increasingly clear that it is the professionals' use of nonprofessionals that is of concern in the literature. Indeed, if it were the nonprofessionals' use of nonprofessionals, the literature would be written by nonprofessionals rather than by professionals, and the literature would be oriented toward the use of professionals to work for nonprofessionals. Rather, however, the literature indicates that the use of indigenous nonprofessionals is, essentially, to help out the professionals. It

should also be noted that attempts are made to carefully engineer and control the degree to which nonprofessionals have power in the agency as well as their access to control of the organization.

With historical hindsight, one might argue that the entire nonprofessional movement was done in an almost backward fashion. For the sake of argument, let us propose another way in which nonprofessionals could have been brought into the mental health system. Rather than hire nonprofessionals who have no training in psychotherapy to do psychotherapy with their people, in agencies run by white middle-class professionals, why was it not considered more reasonable to build mental health centers in ghetto areas, have black nonprofessionals be administrators, and have white middle-class professionals carry out the direct service tasks of psychotherapy (cf., DeMoss, 1974)? Given that most social workers, psychiatrists, and clinical psychologists, along with nonprofessionals, have little or no training in administration, wouldn't it have been more logical to have trained therapists to do therapy and then allow the minority nonprofessionals actually to run the agency, given that they know best what their community needs?

This proposal is, of course, the opposite of what was actually done. However, it raises several important questions and elucidates many implicit biases. For instance, if the community mental health movement really wanted to bring community mental health to minorities and inner city poor, it might really have been more true to that goal to put such minority persons at the top of the hierarchy rather than at the bottom. Perhaps it was the white middle-class professionals who should have been working for the nonprofessional, rather than the other way

around. Hypothetically, perhaps the literature should really have been entitled "The use of professionals by inner city poor." However, the tone of the literature clearly implies that nonprofessionals are not equipped or responsible enough to run their own agencies (cf. Talbott et al., 1973).

Another bias inherent in this literature is the continual focus on issues affecting the professional in the incorporation of nonprofessionals into mental health centers. Surprisingly, there are very few articles which deal with the subjective experience of the nonprofessional, the vantage point of the nonprofessional, and the attitudes of the nonprofessional in these newly defined positions. Writings which do deal with nonprofessionals' outlooks come in the form of testimonials from nonprofessionals, who tell how great their jobs are (cf., Hines, 1973). Perhaps first-person accounts, of positive experiences as nonprofessionals, were more likely to get published in the 1960's, given the tremendous enthusiasm for these programs which seems to have predominated. One cannot know, with any real degree of accuracy, if nonprofessionals really were so satisfied, or whether those nonprofessionals who might have been contentious were screened out of such jobs, or whether only positive testimonials were printed. The critical orientation of the present review would lean towards interpretations based on the latter two explanations.

Effectiveness

The literature which does deal with nonprofessionals concerns itself almost solely with the effectiveness of the nonprofessional. In

other words, there are many studies which measure either therapeutic outcomes or outcomes of some community intervention which was carried out by the nonprofessional (though usually designed primarily by the professional staff) (cf., Karlsruher, 1974; Durlak, 1973; Gartner, 1971). While this is important information to obtain, it again sees the nonprofessional as a tool with which to achieve the end of helping community residents. It becomes increasingly apparent that the phrase "the use of nonprofessionals" is not accidental or simply an unfortunate choice of words in this literature.

The part of this literature which concentrates on measuring the effectiveness of nonprofessionals is again self-congratulatory, showing how well professionals can design programs to train nonprofessionals as therapists (cf., Lynch, Gardner, & Felzer, 1968; Riessman & Popper, 1968; Kaslow et al., 1972). The writings seem to imply that were it not for the expertise of the professional, the nonprofessional would be totally ineffective. It almost appears that the nonprofessional worker is not the author of his or her own experience and intervention, but it is rather the white middle-class professional who authors and engineers the tasks of the nonprofessional (Doyle, Foreman, & Wales, 1977). It is almost as if the professional is depicted as the "brains" of the operation, while the nonprofessional only carries out the "simple motor tasks" which the thinking part of the organization puts together (Herbert et al., 1974).

Even the small amount of literature which concerns itself with role dilemmas of the nonprofessional focuses mainly on how the nonprofessional becomes useless to the mental health center and to the professional

as the nonprofessional comes to feel identified with the aspirations of the middle-class staff (Levinson & Schiller, 1966). Also, articles on role dilemmas seem to quickly shift their focus to the new role dilemmas for social workers and other professionals because nonprofessionals seem to do just as good a job in direct service as the professionals (Bartels & Tyler, 1975). Many of these articles suggest that one needs to give the indigenous nonprofessional important sounding titles (Fine, 1968) and make them feel that they are doing something of great value and importance, where in fact they are doing much of the tedious paperwork and other "dirty" work for the agency (cf. Reiff & Riessman, 1965; Willcox, 1970).

Advancement and Career Opportunities: New Careers Programs

Aside from the literature on recruitment, selection, training, effectiveness, and supervision of nonprofessionals, there has been much written on the New Careers programs through which nonprofessionals originally got these kinds of jobs. When this literature was written in the mid-sixties, the thrust was toward creating an entirely new series of jobs, educational opportunities, and career ladders for people from poor backgrounds who had little education or potential for advancement (Pearl & Riessman, 1965; Matarazzo, 1971; Riessman & Popper, 1968).

One of the factors stressed in this literature was to provide a clearly spelled out series of rungs on New Careers ladders to give the nonprofessional the feeling of upward mobility and the desire to move up in organizations. One consequence of these New Careers programs and the variety of jobs within them has been the creation of community col-

leges and other brief training programs which give nonprofessionals some sort of credentials (or perhaps the illusion of credentials) in mental health fields. (The proliferation of community colleges also created jobs for the growing surplus of academicians.) Of course if one has "credentials" but still no power or agency control, the credentials really serve to mollify the nonprofessionals rather than to equip them with skills which will give them autonomy (McGee & Pope, 1975; True & Young, 1974).

Because of the advent of community colleges, one can now go to a one- or two-year training program (usually work-study) and come out with a degree of a "mental health technician" and thereby gain employment as a nonprofessional. Indeed, one of the hopes of the New Careers movement was to encourage education and employment. However, one should note that the number of newly created "rungs" on this newly created ladder seems to put the indigenous nonprofessional in a position where, no matter how many rungs s/he supposedly moves up, the actual effect is that s/he is walking in place.

Though one can change the title given to a nonprofessional every six months or so, this change in name may do nothing to bring the nonprofessional closer to actual control of the agency. To make an analogy, one could say that what economic inflation does to the value of money, these different titles and new rungs on the new career ladders have done to the worth, impact and value of the nonprofessional to the agency. While the nonprofessional can be given titles ranging from: subprofessional, nonprofessional, paraprofessional, mental health aide, mental health technician, to mental health assistant, his/her salary in-

creases are minimal and s/he acquires no more power in the changing of titles. Though s/he is given education about therapy and other intervention skills, s/he is rarely given training in grant-writing, organizational analysis, policy planning, the layout of relevant government agencies and other data which would ultimately give him/her more ability to run the agency without the professional staff (Ritzer, 1974). It almost appears that instead of the nonprofessional serving as a "bridge" between the local community residents and the white middle-class staff, it is really the white professional who serves as a one-way "bridge" between the nonprofessional direct service worker and the government agencies which dole out the power and the funding. Why the professional must remain as a go-between between the nonprofessional and the governmental agencies remains unclear and usually unquestioned.

While the New Careers programs have employed close to one million people over the last 12-15 years, most of these people remained employed at salaries under \$8000 and are still not much closer to autonomous control of their community agencies (Cloward & Piven, 1974). While they may be able to move up some newly laid-out career ladder, it appears that the pinnacle of their career ladder is perhaps the nadir of the white middle-class professional's career ladder. Thus, while a middle-class college graduate may take employment for a year or two as a nonprofessional before going on to graduate school, the nonprofessional may see the height of his/her career as achieving the position of nonprofessional or paraprofessional.

It should be noted that there is again much literature on educational babysteps and accreditation for the nonprofessional as well as on

the various steps on the career ladder. However, there is little attention paid to the subjective experience of the nonprofessional in moving "up" this supposed career ladder (True & Young, 1974; Matarazzo, 1971). In other words, we do not know how the nonprofessional sees and experiences what Riessman and other proponents of New Careers programs assume to be upward mobility. Because the nonprofessional becomes useless to the professional once s/he acquires middle-class values and hopes, it is not surprising that the career ladder available to the nonprofessional stops just at the point where the nonprofessional could be achieving professional credentials, salaries, and clout.

There is no doubt that the New Careers programs have addressed some of the problems of unemployment of the poor. The advent of community colleges and different educational degrees, at whatever low level, has also been helpful in "allowing" the poor to participate in servicing themselves. However, from a critical vantage point, the inherent biases and flaws in the New Careers programs and in the employment of indigenous nonprofessionals as mental health workers are rather flagrant. What becomes apparent is that real power to control the destiny of one's community has not typically been given to indigenous nonprofessionals or any other indigenous community representatives. They have been "used" by professionals to serve the needs of the professional staff and to carry out the work of liberal governmental programs and agencies (Grosser, 1969).

The potential for this kind of exploitative "use" of nonprofessionals was even noted in the early writings within this literature. Grosser, Henry, and Kelly (1969) write that the:

. . . use of nonprofessional personnel has been viewed as a device to accomplish professional reform; and even further, to relieve chronic unemployment, redistribute the national resources, and integrate those who are excluded from the political and social processes of the nation. This has evolved in a somewhat Parkinsonian manner from the enthusiasm and promise which have surrounded nonprofessional activity. The New Careers movement, as this phenomenon has been designated, has, in our view, inflated a useful and relevant, albeit limited strategy to the grandiose status of a social movement. The new careers hypothesis is analogous to the Horatio Alger mystique in suggesting that individual diligence and perseverance (in the current version with federal subsidies) will provide entry to the mainstream of society, ignoring the obvious fact that only social restructuring and economic reorganization will accomplish the objectives sought. In other words, change in the mainstream itself, rather than attempts to immerse the poor in it, is what is called for. The use of the nonprofessional can, if it is elevated to the status of a social movement, become a part of what Herbert Marcuse has called 'repressive tolerance'--that is, a device that provides a ventilating mechanism to the excluded minority in a system yet retains intact the institutions of the dominant elite. The service professionals having a proclivity for such roles, can avoid this pitfall by retaining a reasonable perspective regarding the scope and consequences of the use of nonprofessional personnel (p. 6) (cf. also Ryan, 1972) (my underlining).

Unfortunately, this kind of incisive caveat was not heeded very successfully. Rather the potential 'pitfalls' so articulately described above seemed to befall the nonprofessional and New Careers movements. It appears that while the inherently oppressive elements of the nonprofessional movement were known, they were somehow ignored in the name of progress and innovation (cf. also Ritzer, 1974).

Despite some awareness of the exploitative potential within the nonprofessional movement, the small amount of literature which deals with how nonprofessionals felt (in the mid-sixties) about their new jobs indicates that many felt very happy to now be a part of the human service fields. This is logical in view of the extreme segregation and dis-

crimination which dominated in the 1950's and early 1960's. This could also be explained by the fact that those nonprofessionals who were hired were those with ideologies consonant with those of the professional staff (cf. Poovathunkal, 1973; Bloom & Pared, 1977). It should be remembered that militants were expressly kept out of mental health agencies, and that professionals were in charge of recruitment and selection.

Despite these few articles discussing how nonprofessionals felt at their new jobs, there is still quite a dearth of literature dealing with the subjective experience of the nonprofessional mental health worker. Especially in the 1970's, when there has been increasing disillusionment with many of the liberal programs in the 1960's, it becomes important to now ask indigenous nonprofessionals who have been employed in these positions for some time how they experience their jobs and how they see the mental health system and the community mental health movement.

The Current Status of Nonprofessionals

Incorporation of indigenous nonprofessionals has now become an integral and commonplace part of mental health centers and other health service settings. In fact, a new occupational genre has been successfully created and accepted. No longer is it described as a threat for minority nonprofessionals to be on the staffs of such agencies. Currently, it is typical to find at least a few nonprofessionals on staffs in attempts to service the needs of minority residents within the catchment areas served by the particular agency. Because these positions have become so taken-for-granted, it is easy to overlook the occupational situ-

ation of the indigenous nonprofessional and to simply accept the literature of the past decade as providing an accurate and thorough account of all we need to know about nonprofessionals.

Ideally, if the reforms described in the literature were really effective, we might expect nonprofessionals to report the following kinds of experiences at work: an identification with both the community and the agency; a respect for professionals and a desire to emulate them; a sense of optimism about career advancement; enhanced self-esteem and competence due to role; a sense of being respected by professionals; and a sense of effectance in decision-making in patient/client care.

In reality there is almost no literature which sees the role, job and concerns of the nonprofessional from his or her vantage point. It is perhaps important, therefore, to focus an inquiry around these gaps in the literature. It is quite striking that the view from the nonprofessional's side has never been enunciated. Most of what is written discusses the concerns, usefulness and problems of nonprofessionals as they affect all the different professionals in mental health agencies. It is therefore important to give the floor, or the microphone, to the nonprofessional to get a first-hand account of how s/he feels in his/her position, how s/he sees the mental health system, how (or if) s/he sees the community mental health movement and its innovations. Given that s/he is both a primary deliverer and a recipient of the community mental health movement, s/he should be writing and contributing to this literature. The nonprofessional should really be the subject and not the object of study. Thus, the present study was designed to address these gaps. Having pointed out the kinds of biases which exist in the litera-

ture, the purpose of this study is to begin to provide a different vantage point and perspective, namely that of the nonprofessional, on the innovations which both use and service him/her.

Present Study: Goals and Objectives

The proposed study sought to accomplish the following goals: 1) to move toward a descriptive analysis of the occupational situation of the indigenous nonprofessional in mental health or other direct health service settings, from the vantage point of the nonprofessional; 2) to provide data which document the viewpoints and opinions that nonprofessionals have of the innovations which exemplify the community mental health movement; and 3) to provide data which allow us to examine discrepancies between program design and implementation and which highlight factors which contribute to and maintain those discrepancies.

In order to get at these issues, intensive structured interviews were done with 15 persons who were employed as indigenous nonprofessionals. An effort was made to interview minority persons who were native to the communities in which they were employed. The first part of the interview attempted to get at features of work, as constructed and experienced by the nonprofessional. In order to obtain these data, the framework provided by the sociology of work literature was applied. This perspective and its potential usefulness to clinical and community psychologists has been described in an earlier paper (Lekisch, 1977, see Appendix A). The sociology of work literature articulates the subjective experience of the worker as s/he goes about his/her daily interactions with clients and superiors. It takes a descriptive and

often a symbolic interactionist point of view (see Appendix A) which tries to articulate all the details which comprise the person's work life. Beyond that, this view extrapolates the possible impact on the evolution of the adult self and identity which grow out of these daily work dilemmas and interactions. It focuses on socialization into the work role, daily aspects of work, the kinds of interaction which affect workers, the risks and challenges in daily work life, the chances for mobility, and the way workers fudge or sabotage certain goals of the organization. One central thesis in this literature is that even the minute interactions at work cumulatively affect the individual self. An ongoing dialectic between the actor and the institution in which s/he works serves gradually and continuously to shape and transform the adult self as well as the social system. The extent to which we can elucidate these factors as they pertain to the indigenous nonprofessional formed a central objective of this study.

A second goal of this study was to obtain feedback from indigenous nonprofessionals about how they see the mental health system and how they understand community mental health innovations. In particular, an effort was made to get their impressions and opinions about the use of nonprofessionals in meeting the needs of minorities and other poor. By asking people who are in nonprofessional positions in mental health settings, we assumed that these persons have an especially important vantage point from which to understand the community mental health movement. Thus, several questions were focused around their perceptions of the community mental health movement, how they have seen it working over the past 10-15 years, in which directions they think it should move, and

how successful they think it has been in addressing the needs for which it has been designed. In turning our perspective around about 180 degrees from that of the typical nonprofessional literature, an attempt was made to let indigenous nonprofessionals evaluate the movements engineered by professionals rather than the other way around.

Third, we wanted to ask questions which touch on nonprofessionals' feelings of exploitation by the white middle-class establishment. Consequently, nonprofessionals were asked about the distribution of power and influence in the mental health system, the extent to which they feel they have the capacity to influence professionals and to direct the course of the agencies in which they work. We were also interested in nonprofessionals' perceptions of the possibility of career mobility in the mental health system (see interview guide in Appendix B) (cf. also Lorber & Satow, 1977).

The study should be viewed as a preliminary effort in presenting the perspectives of the nonprofessional. Because there are flagrant gaps and biases in the literature, studies oriented toward articulating the nonprofessional's vantage point, and studies which develop a more analytically critical understanding of community mental health innovations, can make important contributions to social science literature. In addition, an application of the descriptive approaches of the sociology of work perspective can offer insights into the nature of these jobs and their impact on both the role occupants and on the institutions.

CHAPTER II

DATA COLLECTION

Data were obtained when the writer did research and clinical work at a large teaching hospital and psychiatric institute in an urban center. Data were collected between January and July, 1978. Data were taken from field observation notes, formal tape-recorded interviews, participant-observation in inpatient and outpatient settings, and hours of informal conversation with nonprofessionals.

During the first three months of the data collection, the writer worked as a 'primary therapist' on a community service inpatient ward of this hospital. This community service serves a catchment area of approximately 50,000-60,000 people in this city. Over one-third of the patients are Spanish-speaking and more than a half are in the lowest socio-economic classes. As a primary therapist, one works with a team of psychiatric residents, nurses, social workers, occupational therapists, and indigenous nonprofessionals in determining and implementing appropriate patient care. For research purposes, this three-month period afforded the writer an opportunity to experience typically staff-staff and staff-patient interactions. Often it was difficult to have completely objective distance because of the writer's responsibility in direct service work on this ward. Field notes and observational data were collected during this time. In addition, the writer tried to develop good rapport with the

nonprofessionals who were to be interviewed.

The next phase of data collection began after the three-month inpatient rotation as primary therapist was completed. The author then compiled field notes from direct observation of interactions on this ward. Observations were made for an hour or more each day for a month. Because the field observation required the author to sit on the wards with the nonprofessionals, the author developed informal relationships with nonprofessionals, became a token member of their culture, and became privy to inside stories and perspectives. Informal contacts were further developed outside of the work situation at the nonprofessionals' local hangout (a bar across the street from the hospital).

Finally, structured interviews were done with fifteen nonprofessionals (see interview guide in Appendix B). There was considerable resistance to these interviews because they involved the use of a tape recorder and because they were conducted in the author's office within the hospital. This was significant because in the context of the formal interview, the nonprofessional was most likely to view the author as an unsympathetic, white, middle-class professional. Nonprofessionals became suspicious and self-conscious during these interviews. They were particularly distrustful of the use of the tape recorder. It was typical for them to ask who in the hospital administration had commissioned the author to do the study. More informal settings and contacts, in which the occupational role differentiation between author and nonprofessional was more muted, lent themselves to more comfort and more genuine self-disclosures. Interviews were conducted with workers from the inpatient ward and workers from the corresponding outpatient department

(OPD)

Participants and Their Representativeness

Taped interviews were conducted with thirteen indigenous nonprofessionals who worked in either the inpatient or outpatient department of the community service. Three additional workers were interviewed informally but were not taped. This included all day-shift workers on the inpatient ward and most outpatient workers. Of the total sixteen, there were nine men, seven women; two whites, five Hispanics, nine blacks. The two white workers differed from the others in that both were college educated and had taken the job to gain direct patient experience before going to social work school. Among black and Hispanic workers, there was a wide variation of educational status, age and years on the job. There seems to be no particular distribution of job experience or educational level which distinguishes between men and women in the study (see Table 1). While this is clearly a good sample from this particular setting, it is unclear how well these particular nonprofessionals typify others in this occupation. In addition, it is unclear how typical this particular institution is compared to other institutions employing nonprofessionals.

Two pieces of information may serve to clarify these ambiguities. First, there are features particular to this institution which color the data obtained. The institution is a prestigious, teaching hospital. This means that psychiatric residents, psychology interns, and social work students spend three to six months on the community service inpatient ward where the study was done. In other words, there are few per-

Table 1

<u>Sex</u>	<u>Race</u>	<u>Educational Level</u>	<u>Age</u>	<u>Years on Job</u>
Male	White	college	25	1 year
Male	Hispanic	high school	22	8 months
Male	Hispanic	college +	late 30's	5 years
Male	Black	high school	28	4 years
Male	Black	high school	26	6 years
Male	Black	high school	late 30's	10 years
Male	Black	some college	36	17 years
Male	Black	some college	41	21 years
Male	Black	high school	44	13 years
Female	White	college	25	1 year
Female	Hispanic	college	25	1 year
Female	Hispanic	high school/practical nurse in Puerto Rico	57	13 years
Female	Hispanic	high school +	58	12 years
Female	Black	high school	36	8 years
Female	Black	high school +	35	10 years
Female	Black	no diploma	36	16 years

manent staff besides the nonprofessionals. Students move through the community service ward or the outpatient department while nonprofessionals stay.

Because it is a teaching hospital, patients are sometimes used as examples of particular illnesses. Patients are interviewed publicly by senior psychiatrists because live presentations make good teaching devices. Though the "community service" ostensibly exists to provide inpatient services for disturbed members of the immediate community, it also exists to provide psychiatric residents with exposure to poor peoples' psychiatric problems. For psychiatric residents, this work experience is often their first exposure to illnesses they have studied in graduate or medical schools. It is also the first time, as young psychiatrists (psychologists), that they assume primary responsibility for patient care. Whereas psychiatric residents often see a particular patient not as an individual, but as an example of an interesting illness, the indigenous nonprofessional tends to see the patient as a person, rather than as a "diagnostic category." Thus, the purpose of this institution, i.e. that it is a teaching hospital, influences the nature of staff-staff and staff-patient interactions.

Second, not only is this an academically-oriented institution--it is also a prestigious one. This means that both the psychiatry residents who train and the senior faculty who teach at the institution are upper-middle class or upwardly mobile, Ivy-league educated, and often snobbish professionals. Not only do they just "pass through" the institution in training, but they consider their work on the "community service" ward to be the most menial part of their training program. The

stuffy and hierarchical attitudinal set that psychiatric residents and other trainees bring to the ward not only colors their experience but also impacts on and stimulates reactions in those nonprofessionals who have permanent positions there.

The extent to which these contextual variables influence this study became apparent when the author took a job in another state institution in the same northeastern city. This second institution serves inpatients but is neither academically-affiliated nor prestigious. In the second institution, both professional and nonprofessional staff are permanent employees. This serves as a great equalizer. Because this institution is not prestigious and because patient care, rather than student education, is its central purpose, there is a significantly less hierarchical division of labor on the ward.

The juxtaposition of the two institutions helped the author understand the extent to which the purpose of the first institution as a teaching hospital, as well as the academically prestigious nature of this institution, structurally affected work interactions within it. These structural variables are underlined here because they affect the nature of the data and the generalizability of the findings. These particular features of this institution may serve to highlight or exacerbate underlying role dilemmas and staff conflicts which may be more disguised or muted in other settings.

Role of Investigator

Early on in the process of data collection, it became clear to the researcher that gaining true entry into the occupational subculture of

the aide would be very difficult. Aides approached the researcher with suspicion and distrust, seeing her only as a white, middle-class professional who must necessarily represent the hospital and its interests. It took a concerted effort to develop meaningful ties with participants in the study. This came about gradually after the researcher spent considerable time socializing with aides outside of the work setting.

It appeared that the researcher had to pass certain "tests" to be allowed entry into aide culture. She had to prove that she was not an "uptight" elitist who only wanted to take something from aides without giving them anything in return. Aides seriously (and rightfully) questioned the researcher's motives. As a consequence of these concerns, and because it became obvious that the best way to learn about aides' subjective experiences was to spend time with them informally, the researcher often had lunch with aides in the bar across from the hospital, went to the bar with aides after work, and came into the hospital on Saturdays to simply sit around with aides and talk. The researcher's willingness to cross class and race lines proved, to whatever extent possible, that she wanted to be accepted by aides.

Over time, real friendships developed between participants in the study and the researcher. In fact, by the end of the six-month period of data collection, aides were actually coming to the researcher with stories and incidents. (Over time, data collection became a direct intervention with aides, sensitizing them to issues about the ward and their jobs.) This made it hard to know when to stop collecting data. The decision to stop was made when it became clear that stories were becoming repetitious, representing variations on themes rather than new

data.

Hence, the researcher's assessment was that true "inside" stories and perspectives were obtained. In time, aides became enthusiastic about the study. Most commented that they enjoyed the chance to talk and think about their jobs, even though some of the topics discussed made them sad or angry. Because the researcher was as accepted as possible into the aide culture, the data presented are seen as valid and representative, at least for this sample.

The researcher's efforts to become friends with aides and to become involved in aide culture were also viewed with suspicion by psychiatric residents, nurses, and other professional staff. To a small extent, the head nurse and chief psychiatrist on the ward saw the investigator as a bit of a rabble-rouser. For the researcher, it became difficult to balance the desire to be accepted by aides with the desire to be accepted by other professionals. Because the study was done during the researcher's internship, acceptance in professional spheres was also crucial. Shifting back and forth between these two goals was both trying and instructive. It sensitized the researcher to the experience of how the development of one's personal identity as a professional alters perceptions of others (e.g., nonprofessionals) and of self.

Data Analysis

Data consisted of hour-long taped interviews, field notes and many informal conversations and observations. Field notes were often not extensively detailed because the researcher could not record observations while sitting on the ward (this made aides and nursing staff too self-

conscious). Informal conversations were also not written up in detail because most of them took place at the bar.

However, as incidents began to occur with some regularity, it became possible to ask aides and other workers whether they felt these scenarios were characteristic of work interactions. Many of the researcher's perceptions and observations were then discussed at length with key informants and with a systems-oriented psychiatrist who consulted to all ward staff once a week. This psychiatrist felt that the researcher's analyses accurately portrayed the dynamics of the ward. Because support for the researcher's analysis of the data came from both this senior psychiatrist (who had formerly served as director of this community service) and from senior nonprofessionals who had worked in this setting for many years, the researcher felt confident that the data presentation accurately reflected aide culture, experience and staff interactions.

It took time and distance to extrapolate from the daily ward events to posit structural dynamics which influence staff conflict or collaboration. For instance, the impact of the teaching function of the institution only became apparent to the researcher when she worked at another state institution. This point of comparison allowed unarticulated impressions to become more sharply defined.

It also took time for the researcher to disengage from her marginal (but active) membership in the aide subculture to more objectively assess the aides' position in the organization. At points, the researcher became overidentified with the aides' perspectives. At these times, discussions with psychologists and psychiatrists (the former and

current directors of the community service) helped balance the researcher's observations.

Though time and distance helped the researcher to keep the data in perspective, it should be noted that much of the analyses were done shortly after the six-month period of data collection. Thus, data analysis involved an ongoing interactive process in which perceptions and formulations were checked out with hospital personnel, against raw data, and against informal observations in another institution. The continual checking out of the author's perceptions lends credence to the findings presented below.

Data Presentation

The following three chapters describe the occupational situation of the indigenous nonprofessional from three related vantage points. The first chapter adopts the sociological perspective (described in Appendix A) in order to explicate the particular goings-on which constitute work life. By focusing on the minute interactions which occur daily on a small inpatient ward, the nonprofessional's work phenomenology and culture are constructed and sets of collective action which enable the nonprofessional to deal with the inpatient environment are explained.

The next chapter locates the nonprofessional's job within the occupational context as it is perceived by the nonprofessional. The chapter juxtaposes the parameters which define and constrain the nonprofessional's job with the view presented by the community mental health literature, as outlined earlier. This comparison highlights discrepan-

cies between the promises of the literature (e.g., education and supervision; career mobility; "helper-therapy" principle) with the daily realities of work for the nonprofessional.

Finally, in the third data chapter, sets of collective action which occur on the ward are reframed within an organizational analysis of the worker's situation. By articulating the structural dynamics of the inpatient ward as an organization, we can understand how various actions become almost inevitable by-products of the social system.

It should be noted that in the data analysis which follows, direct quotations from participants in the study are presented in a way which tries to preserve their anonymity and confidentiality. It should also be mentioned that in the setting studied, the formal title given to indigenous nonprofessionals is "mental health therapy aide" (MHTA).

CHAPTER III

"WORKING THE WARD"

This chapter presents a detailed account of occupational life for the indigenous nonprofessional on the inpatient community service. The minute frustrations and satisfactions workers experience daily and the strategies that the occupational culture develops for dealing with such features of work may suggest explanations of why and how the organization functions and why and how it does not.

The Physical Ecology of the Inpatient Unit

The inpatient community service occupies one half of a floor of a 19-floor psychiatric institute. Only five patient floors are in operation in this 45-year-old building. The ward is a 20-bed unit which is mandated to serve people from the immediate catchment area. Often the "census", i.e., the number of patients on the ward, exceeds 20, and patients' beds are placed in corridors.

Entry onto the ward requires a key or an elevator. Elevator men are stationed in each of the three elevators which stop on the unit. Their function is to prevent patients from escaping. Such clearly defined boundaries and such explicit entry into the physical space makes the inpatient floor a tightly closed system. This has significant interactional consequences, in that events generated in such a system are likely to reverberate and escalate simply because there is no easy exit.

The ward is small and physically crowded, with little room for

privacy. There are male and female dormitories, each with ten beds. There is a small dining room which is also used for staff meetings. The television room also doubles as a conference room for staff. In this sense, the same physical space is shared by professional staff and patients. One area of the ward typically shared by patients and aides is called "center." "Center" is the dayroom, a large, institutional-looking space with chairs surrounding a ping-pong table. Aides and patients spend much of their day sitting in the center. This is the one space they share.

Around the corner from center is the nurses' station. It is a plastic-enclosed, oversized booth where nurses, aides, and doctors read and write patients' orders and charts. It is an enclosed space within an already encapsulated area. Perhaps part of the intensity of interaction in the nurses' station can be accounted for by its physical construction. The nurses' station is a "fishbowl" of sorts, because the plastic encasement allows patients and others outside the station to watch interactions within. The "nurses'" station, despite the sense of ownership expressed in its name, is a space shared by all staff, but from which patients are excluded.

Other spaces on the ward in which important interactions occur are seclusion rooms, treatment rooms, and offices. There are two seclusion rooms on the ward. Patients who are violent or out of control may be ushered, or literally dragged, into barren little rooms which are locked until a doctor orders them open. Seclusion rooms are spaces occupied only by patients--hence their name. Treatment rooms are places where doctors or nurses do medical examinations, and offices are where primary

therapists meet with patients and patients' families. Thus, the latter two spaces are shared by patients and professional staff. Often, aides are called into these spaces for technical assistance, protection or for translation. There is one private staff conference room. Finally, it should be noted that there is no explicitly delineated space which is only for aides.

Patients

Patients tend to be poor, seriously disturbed people who are admitted to the unit because of flagrantly psychotic or suicidal or homicidal behavior. Upon admission, they are often quite agitated or withdrawn, symptoms which subside, at least superficially, with psychotropic medication. Early in the patient's stay, doctors spend considerable effort in ascertaining an accurate diagnosis. The florid symptomatology and the push toward a diagnostic workup make the patient's first few days of great interest to psychiatric residents and other professionals-in-training.

If a patient is potentially violent or suicidal, s/he may be placed on a special status. "S.O." or "suicidal observation" means that the patient must be checked every fifteen minutes for any dangerous weapons or self-destructive gestures or hints. This is a task which aides do. "H.O." or "homicidal observation" means that the patient is potentially violent toward others and must be constantly observed by aides. "C.O." or "close observation" means that the patient must be watched closely. The patient must be in the presence of an aide at all times. Until a doctor has discontinued one of these orders, the patient must stay in

pajamas. S/he is not allowed his/her own clothes until s/he is acclimated to the ward.

Patients typically stay for no longer than two to three weeks. The expressed goal of the hospitalization is to "stabilize on medication" and to plan for immediate follow-up in the outpatient department. The flow of patient admissions and discharges is often based more on the availability of space (a bed) rather than on patient needs. For instance, as the weekend approaches, there is a push for doctors to discharge as many patients as possible to make room for admissions over the weekend. This is called "keeping the census down."

It is the rare exception for a patient not to be medicated. Most patients are on substantial doses of anti-psychotic drugs which leave them lethargic. Their drowsiness, compounded by the institutional environment of drab walls and poor ventilation, contribute to the daily work setting of the MHTA.

The majority of patients are black or Hispanic, reflecting the changing racial and ethnic composition of the surrounding catchment area. In recent years, there has been an influx of Hispanics into the community. The hospital staff has not substantially increased the number of Spanish-speaking workers, thus forcing the few Spanish-speaking employees to overextend themselves and creating basic problems in communication between staff and patient.

Chores

On the inpatient unit, MHTAs' tasks center around hour-to-hour and day-to-day chores with patients. The immediacy of how and when things

have to get done augments the intensity of an already intense situation.

There are certain things that an attendant, an MHTA, has to do when he hits the ward. Certain things you do every day like clockwork, almost like a prison guard. The security is to protect the patients, from themselves, . . . you gotta think safety all the time. People can hurt themselves.--Black male

At 7:30 A.M., aides get patients up for breakfast. At 7:45, the day shift receives an initial report from the night nurse. At 8:40, aides give a report on each patient to the professional staff. MHTAs spend much of their mornings escorting patients to different parts of the hospital for various tests (e.g., EEG, X-ray). At least one male aide must remain on the ward at all times. Aides must supervise patients' lunch at 11:30. Aides must make fifteen-minute checks on patients who are on S.O. or H.O. status. Patients have a rest hour from noon till 2 P.M., during which time aides take lunch breaks. When visitors come in the afternoon, aides must inspect incoming packages for dangerous items or drugs. MHTAs also assist in nursing functions of taking blood pressures, giving medications, and in social service functions like occupational and recreational therapy. Finally, they are required to write daily chart notes on patients.

"Eight Hours a Day"

Obviously, one of the central features of the aide's job is patient management, or simply being with patients "eight hours a day." Every participant in the study remarked about the tedium of observing patients for so many hours. Getting "off the ward" for lunch or to go to another part of the hospital becomes a welcome relief from the closed

off pressure cooker atmosphere of the ward.

Watching and sitting with patients all day is essentially a reactive position. Features of work are thus linked to events generated by patients. Handling patients well, dealing with trouble smoothly, are what constitute tests of competence for the MHTA:

You see, when you work the ward, when you're with that client eight hours a day, you establish a heavy relationship with the client. Now the doctor comes under another bag. The doctor comes in, sees this patient once a week. But you build a relationship when you're on that goddamn ward. You have to. You're with this person eight hours every day. You can't help it, particularly on a closed ward. Everything is locked, so everything they want to do, they have to have contact with you. Y'all try to make it easy for one another. Especially angry, fucked up patients. . . . I'd say, "We both here. I'm not mad with you, you're not mad with me. I don't want to hurt you, you don't want to hurt me. You may be pissed off with your doctor, whatever, we gonna be here. Why don't we make it easy for each other? I'm gonna help you all I can. You help me. . . . While you're here, let's try to make a go of it."--Black male

Being in such a reactive position is both suspenseful and exhausting. One is simultaneously "sitting on the edge of one's chair" waiting for a crisis, and bored by the soporific atmosphere of the drugged patients one is surrounded by. The everpresent co-existence of tension and tedium is one of the more debilitating features of the occupational situation of the MHTA.

The occupational culture of the aide modulates between too much tension and too much tedium so that aides can spring to action when necessary but not be too nervous without cause. When the ward is very calm, aides will reminisce about times of crisis. For instance, aides repeatedly tell stories about a suicide and a murder which occurred some

years ago on the ward. This lore keeps aides vigilant. It also reminds them that they have an important function.

Risks and Emergencies

If the patient's role in the system is to produce events, then the aide's primary role is to manage events. Aides' expertise is a function of managing events well. Events may be defined as any patient behavior or interaction that disturbs the quiet and equilibrium of the unit. Aides must return the disrupted ward back to order. Disruptions typically include: patients' assaulting other patients; patients' assaulting staff; patients' being self-destructive or destructive to property; or patients manifesting extremely bizarre and psychotic symptoms.

Patient violence becomes the arena around which aides come to life. In these situations, all staff rely on the aides. It is the one time during which they can do something which no one else is really equipped to do. Again, aides have ambivalent reactions to this. They feel special and sense the capacity for heroism when emergencies are handled well. They also feel "used" as bodies:

. . . .It was a different ball game on the wards. On the ward, a lot of them [doctors] wasn't really confronted with the outright violence that was there. It was frightening to them. . . . You see, being a "body" at the time, "strength," holding patients down, subdue the patient, I knew that I was being used for that.--Black male

Sometimes I feel that the only thing I'm here for is so when the clients go crazy, and start kicking and everything, I don't want to use a profanity, but to keep them from kicking the white people or any higher-ups. I don't think I'm serving any other purpose. In myself, I know I'm doing a job that they don't really even notice. . . . To them, I'm a big body--Black male

. . . Doctors knew that if you called one of them 'bad niggers' onto the floor that everything would be cool. Send for the goon squad. . . .--Black male

Because of this ambivalence, there is tremendous importance placed on how violence is handled. Because aides know that they are seen as "bodies" by professional staff, handling violence by "talking a patient down" rather than intimidating the patient physically is highly valued by aides. Somehow, such good verbal skills fly in the face of what other professional staff expect from aides.

Handling violence constitutes a public drama on the ward. As such, it becomes a public statement of the necessity and legitimacy of the aide. Though these data are primarily impressionistic and not empirical, it appears that patients tend to produce events more when more staff are present. (This impressionistic finding is in line with Melbin's (1969) finding that patient upsets are greater during the week when staff are around than on weekends.) If this is the case, then one can infer that the patient does not produce events at random and only in response to internal voices. Rather, events are produced in a social context. The patient may sense the aide's need for emergencies and may respond by getting out of control. Professionals' needs to demonstrate expertise may also contribute to patients' outbursts. It may also be possible that aides set off patients for the following reasons: in order to have something to react to; in order to display their competence to other staff; and in order to get back at professional staff by stimulating disruption, thereby making doctors and nurses uncomfortable. Events make aides feel needed:

When the ward became the community service, when you had all them niggers and them Puerto Ricans, them whities didn't know what to do. Them honkies went crazy. Some big black guy would tell the doctor, "I'll bust your motherfucking ass, you punk ass white boy. Who the fuck you think you are? You think you gonna give me that medicine? Let me see you give it to me, mothafucker." Doctor had to get an attendant.--Black male

Struggle for Legitimacy

If violence is dealt with in the presence of both professional and nonprofessional staff, there is often disagreement about how the patient should be handled. From the occupational vantage point of the MHTA, nurses and doctors are "booksmart" while aides are "streetwise." MHTAs contend that the book knowledge does not help professionals know what to do when a patient gets out of control. MHTAs feel they have a special area of expertise in these situations because of their tougher street background. However, the hierarchy of the ward mandates that aides have to take orders from nurses and doctors. This often produces intense conflict between aides and professional staff. From the aides' perspective, just as s/he has the chance to be heroic, s/he is told what to do. Aides are essentially given a double message--the informal organization of the ward puts them in the position of authority when a patient loses control. The formal organization of the unit puts them at the bottom of the hierarchy, in a position of no authority. Conflicting messages permeate the enactment of dramas around patients:

I felt that she needed to be in seclusion. Three of us felt that. But J. [nurse] didn't. J. says, "Well, let me do it this way." And you notice how everyone just walked off because we've dealt with this before. And what happened at the end was that the patient had to be secluded. It's like, "Do like I tell you. We'll try it my way. Then we'll go to your way."

But it must go my way first. . . ." But we're the ones who have to be in the front line. . . . I figure sometimes, "Why should I restrain the patient now?" when I knew that this is what it would come to but I wasn't listened to.--Black male

MHTAs feel called upon because of their expertise, but then, almost as quickly as they have been called upon, their expertise becomes undermined and denied. Sometimes it is hard for them to know whether they are doing dirty work or acting heroically.

Patient violence forces all staff to put their expertise to the test. It is a competitive drama, with all factions (doctors, nurses, aides) struggling for control, authority, and legitimacy.

We have people who've been working on this floor for years with this particular type of patient. It not like we just have ideas. We have plans! We've seen it! It's that simple. We've seen it into action. We're telling you it could work, but for some reason or another, I guess they feel we're overstepping them. . . . The majority of the MHTAs are black and the other staff is white. I don't think they like being told what to do by an MHTA who is black, that's what I think it has to do with. . . . It's really such a bad situation working where you're not heard. . . . Personally, I don't think they want to acknowledge that we are actually running the floor! As an MHTA, I work better with these people than these doctors who've gone to school for years.--Black male

Whereas professional staff have varied arenas for their displays of competence, the aide is limited to the drama around patient control. For aides, this is such an important part of the job that a substantial amount of time off the job (at the bar they spend time in) is spent analyzing and dissecting each situation. Attention is paid to how the patient was handled as well as to how the doctor or nurse was dealt with. From an occupational point of view, this suggests that the aide has more at stake in these dramas than do other staff. Greater sensi-

tivity to this feature of the aide's job on the part of professional staff would ease ward conflict and might enhance the potential for collaborative work relationships.

Professional staff's lack of appreciation of the importance of these dramas to aides may derive from sheer oversight or may be linked to feelings of being threatened by aides' competence with patients. Whatever the source of this competitive struggle around patients, there are numerous consequences which result from it. When the formal structure of the ward (medical hierarchy) clashes with the informal structure (in which aides are in command because of their strength and their closeness to patients), collective action, on the part of aides, is set in motion. The impact of aides' collective action on patient care, on the smooth functioning of the system, and on all staff's feelings of competence are enormous.

Collective Action

Collective action refers to the retaliatory stances and strategies developed by aides' occupational culture to deal with problematic others on the job. In this case, those "others" are professional staff (psychiatric residents and nurses). The occupational culture must establish ways of undermining the formal hierarchy of the organization. This is necessary in order for the aide to feel a sense of accomplishment and expertise in work with patients.

Collective action is also important in allowing the aide to feel some sense of control in a situation which is at least superficially structured so s/he has very little. Even when a patient becomes vio-

lent, thus calling for the aide's unique performance on the ward, his/her actions may be undermined by nurses and doctors. Just as the aide is in a reactive position vis a vis patients, the formal organization of the ward places the aide in a reactive stance toward professional staff. Any overt attack on doctors or nurses would only invoke negative sanctions from the larger system. The aide would get "written up" for "insubordination."

Consequently, management of professional staff by aides, expression of disagreement with policies of patient care, and displays of control on the ward all take more subtle (but no less dramatic) forms of expression. In this environment, collective action involves the sabotage of professionals' treatment plans with patients and the undermining of professionals' views of themselves as experts at work. Such acts of sabotage vindicate aides and give them a sense of control in response to a system where they ostensibly have none.

Aides spend considerable time discussing ways to retaliate. It is a central feature of occupational culture. In the bar they "hang out" in, aides continually speculate about ways to "get back" at nurses and doctors. The goal is to embarrass professionals, especially those "booksmart" doctors who act condescendingly to aides. Professionals can be embarrassed in front of their superiors, where their own performance is at stake, or in front of aides, where doctors or nurses get a lesson about who is "really" in charge on the ward. In this sense, collective action constitutes the aides' form of "disciplinary action" toward professionals. It is their collective response to charges against them of "insubordination."

Sabotage can be enacted individually or collectively, passively or actively. Even if it is played out individually, though, it is discussed by the group in the bar and is tacitly supported by others on the ward. Because performing acts of sabotage is an important way for an aide to display membership in the aide culture, it is likely that retaliatory acts will be discussed in detail.

Individual acts of sabotage which are passive in nature typically involve an exaggeration of the stereotyped role of the "dumb, lazy nigger."

Once Dr. A. B. called me up to his office and asked me to resign. He didn't like my attitude. It was poor. It wasn't "yowssum" enough. . . . It didn't matter if you were good with patients. You just had to follow orders. "Don't do no stopping and thinking now, just hold it." That head ain't for thinking. It was so easy to equate that is what this country thought and thinks about black people. We always had the big strong healthy body, but no brain.--Black male

The aide will innocently forget to do certain tasks or may act as if s/he simply is too stupid to understand the doctor:

Sometimes if I seen a patient really getting ready to blow, and I see a doctor around the corner, I'd go to the bathroom. I'd be pissing and flushing and wouldn't hear a thing. I'd come out, the patient would have the doctor by the throat and I'd say, "What's goin' on here?" Doctor would say, "Get him off of me!" and I'd say, "What's the matter?" "Pull him off of me!" "Okay, c'mon."--Black male

Or the aide may simply forget to give the doctor important feedback about a patient, thus making the doctor look foolish or putting the doctor in danger. One very effective way to do this is to "let" the patient elope (escape) from the hospital. On the surface, the aide makes

it look like s/he is simply too stupid to know better. In fact, sabotage like this is often well planned and choreographed:

. . . .Five years we worked together. And [he] and I were together for three years before that. We had some of the funniest times. . .we had some fun. . .but there were people we hated, supervisors, doctors. . .and they went on our list, our "fucking list."

(How did you fuck with people?)

We gave them no feedback about their patient, might let a patient elope. We'd sit back, watch that doctor run around, flipping through the chart trying to call the patient's mother. . . .

If a doctor look down his fucking nose at me and give me orders I'd say to myself, "I ain't gonna do none of that," and he'd be running around wondering why his patient wasn't getting better. Fuck the patient, and fuck the doctor too. Fuck both of you mothafuckers. He's pulling his hair out. . .the chief resident's in his ass. I knew damn well that when we took the patients to O.T., that's where they'd elope from. . . . But, we worked out a system where we could account for every patient on the ward. We made up a chart. . . .--Black male

Acts of sabotage which are individual and passive are more consistently enacted by female workers. (This applies, however, to black women in the study. The Hispanic women interviewed were unusual in their respect for doctors, their enthusiasm for their work and their lack of sabotage). For black women, most of this sabotage is directed towards female nursing staff and female doctors, rather than toward male professionals. These women are likely to "play dumb," to pretend they have not heard an instruction or do not understand it, or to call in sick frequently. They also show tacit support for some of the more aggressive acts of sabotage which are usually carried out by males.

Acts of sabotage which are collective and passive involve work boy-

cotts and slowdowns. Many workers will call in sick on a particular day. If the ward gets chaotic on that day, it will prove to professional staff that aides are indispensable. Another collective and passive type of sabotage involves getting stoned or drunk on the job. This is a way to quietly communicate disrespect or disdain toward the institution.

Individual acts of sabotage which are active in nature involve direct intimidation. The type of intimidation varies depending upon whether the targeted professional staff member is male or female. With men, there may be direct threat of violence, or, in rare cases, actual violence:

One time, a doctor was in a rush. . . . This old black kitchen lady was coming out of the kitchen. . . . He pushed right by her and almost knocked her over. . . and looked back at her with disdain. . . . Man, I was all over him before I knew it. . . . I pushed him up against the wall. . . . He came off the wall just as a reaction. . . . I broke his nose and fractured his cheekbone. . . . I was in court for three weeks. . . .--Black male

While this instance is highly unusual, its significance is that it becomes part of the lore of aides' occupational culture. Such a story can be called up to reinforce aides' feelings of control and strength, as well as to intimidate professionals.

On the ward, aides can get back at doctors through the patient, thus turning the patient him/herself into a weapon:

We had a patient in the seclusion room. Doctor said, "Open the door, I want to talk to him." I said, "I don't think you should open the door." He said, "I'll talk to him." I opened up the door, so he could walk right in, still with the key in the door. When he walked in, I locked it. I said, "Nah, it's

okay. . . . It's okay, he's alright. . . ." Shit, he tore his fuckin' shirt off. That doctor called up everybody, saying I locked him in a room with a patient. I just locked the door. . . . I didn't want the patient to run out. Ya know? Doctor was running around saying I locked him in there for fifteen minutes. . . . I was the only one on the ward so nobody could see. This patient was kicking his ass. He was running from one end of the room to the other. I laughed. I never laughed so much in my fuckin' life.--Black male

In this situation, the patient becomes the aide's "hitman."

With professional women, retaliation may be sexual in nature. On the ward, female staff literally need male staff for protection. This fact, compounded by societal stereotypes of the black man as more virile (cf. Stember, 1976), and even further compounded by the professional white woman's "liberal guilt" toward the poor people on the ward, render professional female staff easy marks for sexual retaliation. Though sincere relationships between male aides and female professionals are possible, in the present analysis such liaisons are seen as aides' assertions of power and control toward female professionals. (It is very rare for the reverse--for a white male physician to develop a relationship with a black female aide.) In other words, as a way of subverting the formal structure of the ward (the medical hierarchy in which doctors are superior to aides), the aide invokes the hierarchical structure of the larger (sexist) society, thereby placing himself in a superior position to women. From a functional perspective, a male aide's "coming on" to a professional woman serves to redistribute and equalize what was before an inequitable distribution of power.

When one aide who was "senior man" on the ward was transferred to another ward because of a power struggle with the head nurse, another

aide felt that the senior man should have taken the nurse to bed as a way of putting her in her place. That would have allowed him to "get over" on her and would have secured his position on the ward. An important consequence of sexual conquest is the equalization of the distribution of power in the system.

Interestingly, if women were to seduce men in this fashion, it would diminish their credibility in a system. Women would only become devalued. For these men, it is empowering.

(Where could you go on your merits?)

My merits got me in charge of the utility room. That's what my merits got me. My dick got me head attendant, weekends off, two-hour lunches, and can't nobody fuck with me. My dick and my brains, excuse me.

(What would it have accomplished for you to make love with an authority figure?)

No, you have to rephrase that. . . . What did it accomplish? . . . It put me head nigger on the ward. . . .

(Did you recognize early on that by going to bed with some of the women on the staff that that would do something for you?)

Yeah, but that wasn't brand new for me. In the street, it's a street maneuver also. . . . It's one of them things we use to get over. I didn't realize that it could even be there [in the hospital] too. And I thought this system was totally different. I didn't know that it was worse than mine. I didn't know that it was the lowest, slimiest shit that anybody could get into. . . . It was one of the weirdest, freakiest, craziest sexual shit I've ever witnessed or seen in my life. . . .

(How?)

Oh, the approaches made to me by male and female individually, or male and female together.

(How was that done?)

Generally at a party, had to be under some circumstances where people were drinking and juiced and it just came right out.

(And you were able to get some mileage out of that?)

"Mileage" was putting it lightly. I was able to get into a power position myself through that. The supervisor couldn't fuck with me too much because C.D. was too powerful. It kept the head doctor off me--he couldn't stand me. And when I fucked up, I always had her around to look out for me.--Black male

Thus, just as the patient can be used as a weapon to strike back at doctors or nurses, the penis also becomes a weapon for retaliation and the assertion of control. Even women who do not go to bed with aides can be "put in their place" through sexual flirtations and innuendoes. When the aide relates to a female professional only as a woman and ignores her other, and in this situation more relevant, status as doctor or nurse, the woman's ability to function is impaired. And again, this is highlighted by female staff's dependence on male aides' physical strength.

Female aides do not have a comparable sexual weapon available to them vis a vis male professional staff. But because the hierarchy of the ward is identical to that of the larger culture, they do not typically experience the same sense of degradation in being subordinate to white men. Their resentment is more directed toward white women in authority (e.g. head nurse). Much of their retaliation toward these white women is enacted vicariously by watching and gossiping about the sexual conquests of their black male counterparts. Female aides as well as male aides enjoy the balancing of power that results from a male aide's sexual conquest of a professional female.

Female aides also come to terms with their lack of power, authority and control by being less ego-involved in their jobs. Women typically

reported in interviews that their primary self-definitions derived from being wives and mothers. Though the men in the study also had other identities through "hustling on the street," males seemed to have more personal ego-involvement at stake in interactions on the ward. This difference may derive from the high value placed on physical strength on the inpatient unit, thus making the ward a male-dominated place. Females tended to try to disengage from struggle, while males tended to become more directly combative.

Acts of sabotage which are both active and collective call on a complex choreography within the overall hospital. Aides have many other collaborators throughout the institution. This fact is often ignored by professional staff, who do not understand the elaborate system of interconnections among all "workers" in the hospital. For instance, aides and elevator men (who control access to the ward) can collaborate in letting a patient escape. Aides will tell elevator men which doctors are irritating, so that elevator men can pass them by when they are in a rush:

What the doctors don't know is that when something happens between me and you, I talk to my friend on the elevator, and he'll pass you by, let the door close in your face. They'd come to us and say, "Who's that mothafucker?" They was a part of the system. We had to stick together. There was another whole system there. Because all of us was in the same boat.
--Black male

The choreography of collective action was epitomized at this institution by an ongoing crap game in the basement of the hospital:

When we wanted to control it, we controlled it all. . . . Somebody maintained that sheet, the other two could fuck around. "Okay, you stay here, 'cause we going downstairs to gamble with the Spanish boys." We had the biggest crap game going on in the kitchen. We used to have a big game going on down there. Next to the morgue, they had this big room. We got the key to that. By this time, we was friends with the security guards. I stumbled upon this room because a patient died and the supervisor gave me the keys to go downstairs. I saw that this room was empty. I took the key off the ring, put it in my pocket. . . . I went to 'housekeeping' and got the guy to give me chairs and a table, a rug for the floor, fixed that room up. And that rug, you could shoot dice all day and couldn't hear a thing. And we had some games, some as high as \$1500. Right there in [the hospital]. That went on for about five years. Everybody was gambling but it was hushed. All the kitchen help, the elevator men, maintenance men. . . .--Black male

Occupationally, this complex collective action serves to free aides (and other workers) from their feelings of impotence within the manifest structure and hierarchy of the institution. By creating a latent structure, contained within the obvious structure, aides can function within the same space without feeling vulnerable to the constraints imposed upon them. From a sociological perspective, the crap game is understood as a collective response designed to create control in a system in which the aide is explicitly denied control. This is done by creating a system within a system.

Sometimes it appears that professionals are unaware that this other group of people is an organized collective body. Undoubtedly, hospital administrators are more sensitive to the impact of this substructure. The dividing line between one organization and another is the time clock. It distinguishes between professional and nonprofessional and is the daily tangible representation of the parameters of the nonprofessional's work situation:

. . . . So I started pulling the plug out [of the time clock]. I didn't do it when I punched in, 'cause that meant I was there. I'd punch in, go down to the ward, let everybody see me, and then slide back up and pull the plug. I did that for about six months. Then they got tired of that, so they took the plug and put it inside this box. That's when I got my Crazy Glue. I'd drop a few drops of that stuff into the time clock. . . . I swear, that was the greatest invention--Black male.

In summary, collective action is viewed as an integral part of aides' occupational culture. It is motivated by the lack of control and power given the aide in planning and carrying out treatment with patients. It is a response to the rigidly hierarchical structure of the hospital ward, which simultaneously puts the aide in charge on the ward but then robs him/her of the sanction to execute that authority. The need for collective action is exacerbated by structural elements in the work situation, involving issues of race, sex, class and educational factors. The weave of these factors and their consequences are explicated in a discussion of organizational dynamics in Chapter V. In order to more fully understand these dynamics from the point of view of the aides, it is first important to appreciate the context within which they perceive their jobs: the state bureaucracy.

Table 2
Collective Action

	Individual	Collective (group)
Passive	playing stupid	not coming in to work
	withholding information about a patient	work slowdowns
	not being available to protect staff	drinking and getting stoned on the job (on the ward)
	using the patient as a weapon	
Active	physically threatening staff member	letting patients elope from hospital
	seduction of female professionals as sabotage	ongoing crap game in hospital basement
	penis as a weapon (equalization of power in the system)	tampering with the time clock
	purposely locking doctor in room with violent patient	

CHAPTER IV

TITLES AND TASKS

Titles

The indigenous nonprofessionals who participated in this study are all civil service employees of the state. Their occupational title within the state system is "mental health therapy aide" (MHTA). Their jobs must be understood within this large context of the state system. Though the community mental health literature may extrapolate their jobs from the state system in order to describe job opportunities for minority nonprofessionals, the workers themselves experience their occupational life as occurring within the state bureaucracy. This contextual discrepancy has important consequences for the present study. Whereas the published literature about nonprofessionals is located within the theoretical context of the community mental health movement, the work phenomenology of these nonprofessionals is located within the context of the large state civil service system.

The state system organizes all workers, from janitors to doctors, within a graded system of levels. Grades indicate salaries and job descriptions. Grades go from a grade 3, which is a janitorial position, to grades 35 and higher, which are occupied by senior hospital administrators. The typical MHTA is a grade 9. Salaries range from \$7,000 to \$12,000 (a grade 11 or 12). Advancement in the state system tends to be dependent on the availability of a "new line" and not on skill or dedi-

cation.

Often, advancement in the state system is impeded by bureaucratic "catch-22's." For example, participants reported that in order to move up in the system, from one grade to another, they must take a written examination. If they pass, their names then go on a list of workers who are applying for the next grade. A worker can only move up when a "line" is vacated. Thus, promotion is not only contingent upon performance but also upon line availability within the state system. One Hispanic woman, who had been on the job for 13 years, had only moved from a grade 7 to a grade 9.

However, within the specific institution, a worker can take on different functions without an elevation of his/her grade:

. . .They hired me 'cause I was big, that's the true fact about it. I came in on a Grade 4, which is really a cleaning item. . .but I worked as an MHTA. \$130 a week is a Grade 4. They promise you a lot of things that didn't come true--like promotions. . . .--Black male

A worker is likely to take on these tasks because they are more interesting and because s/he can be "written up" for "insubordination" if s/he refuses to obey a superior. Insubordination constitutes a built-in disciplinary action within the state system:

. . .I'm doing the shittiest work on the ward, I got no power, I punch a time clock, they treat you like shit. They so nice, but you step out of line, they cut your fuckin' throat. . . . I never experienced this type of white man before. I had met the white man on the street. But this white man didn't walk around with a gun. He walked around with a pencil. He taught me that "the pen was mightier than the sword." You see, in the street, it's sweet and short. Either you kill that motha-fucker or he kill you. But with the pencil, he can write shit down and destroy your whole family.

(How?)

Mess you up for life. You fuck up on the job, if you get fired from a state institute, it means that city, state and government isn't going to hire you. If private industry check you out, you are through. . . . A lot of times they say, "We don't want to fire you, we let you resign." But then you can't get unemployment. So you getting fucked, either way. When I started working there, any nurse could walk up and say to me, "Go home for the rest of the day, you're not doing this right," and you had to go and you got docked. . . .--
Black male

While the threat of "disciplinary action" constitutes a negative motivation for workers to take on different or extra tasks, workers do feel that additional tasks make their jobs more interesting:

From having no patients at all, because in those days paraprofessionals were not supposed to have their own patients. They were supposed to be used for translation, taking patients to welfare, making home visits. At this point, everybody has a caseload of 15-20 people and I have a caseload of 45.--
Hispanic male

However, workers begin to feel exploited very quickly. They are not swayed by changes in title unless such changes mean raises in salary. And they are only briefly flattered by changes in function which are offered without concomitant pay increases. For instance, these workers are aware that at some point in the 1960's, their titles were changed from "attendant" to MHTA. Historically, this change coincides with the growth of the community mental health movement. Apparently, these changes in title meant something different to professionals than it did to nonprofessionals:

That's just another way of saying janitor. . . the title don't means nothing. Only the money counts. . . . Like, you see a person walking around here, as a mental health worker or men-

tal hygiene therapist--that don't mean anything, 'cause you look like you be important, but you're only making \$9000 or \$10,000, which is no money at all. You can't hardly support your family on that. It's just a big fancy title but no money. You might work a few hours less, but it don't matter, 'cause with clients, it's hard not to get involved, because if you're any type of person, you have emotional feelings, and when you go home at night time, at the end of a day's work, your mind might be all messed up, and sometime, you might go home and don't even bother with your family because your job done messed your mind up so much. . .they don't realize this and you don't get paid for it. . . .--Black male

. . . .When I began, I was a "mental health worker" which was social service. When we moved down to [another floor], they changed it to "mental health therapy aide" which means attendant and I always had a personal thing about "attendants," thinking that attendants were the ones who was supposed to wipe everything that was dirty on a patient.--Hispanic male

MHTAs were not and are not snowed by the change in title (from attendant to MHTA) which was a by-product of the community mental health movement. Either they do not understand why the title of the job was changed or they are suspicious of the change, feeling that it was done to cool them out in some way. If anything, changes in titles or tasks without pay increases only breed resentment toward professionals:

The reason why I do things is 'cause I think of the patients and to hell with the system. They appreciate what I do. I say, "Alright, so they got a college education and they're a doctor, but half of them don't know their heads from their asses." And I do ten times the amount of work that they do, and they making goo-gobs of money and I'm not making shit!--Black female

I tell you, if I had the choice, if I had some say. . .instead of hiring 2-3 M.S.W.'s, why not hire 3-4 paraprofessionals who are bilingual, who will be doing exactly the same kind of work. . . . But they will take, what I call "a nice Jewish girl" who doesn't speak Spanish properly, who needs a translator. These people they will take. But they will not look for a Hispanic who knows exactly what is going on in the community, who

knows what's going on with the people. . . . So when it comes to the growth of a paraprofessional, they do the same work as an M.S.W. but do not get the money. No matter what you say, you will not be listened to. . . unless they want to get something from you. If they want to get something from you, then they'll listen to you. Not that they'll do anything, but they'll listen.--Hispanic male

Sometimes I don't think the clinic can run without me, but that don't put no money in my pocket.--Black male

The resentment is further exacerbated by the fact that white professionals do not understand the life circumstances of patients as well as MHTAs. Not only is the nonprofessional in a position where s/he feels exploited, but s/he must also watch his/her own people inadequately treated by so-called mental health professionals:

(Do professionals ever ask you to teach them?)

No. It's not even the point of teaching professionals. When they come on the job. . . this system couldn't even exist without the people like me. . . because this people treats mostly people from the community. . . most of these people have attitudes about life that we can deal with. I'm not downing you, but you don't even know what's going on with these people. You never really lived with them, you don't understand them and we can. We've lived with them, came from the same neighborhoods, and without us the system wouldn't even exist. In the old days, they'd just lock people away in the closet or control them with drugs, to a certain extent. But still, without the therapists, and when I say "therapists," I mean the lower class people who's not educated. At M. State, some of the doctors don't even come out onto the floors. A patient can go for six months without ever seeing a doctor. It's just like a prison, which is, I guess, what it's there for.--Black male

While the state system puts severe restraints on the workers' opportunity for advancement and on the tasks s/he is required to perform, there is some compensation for MHTAs in the fact that there is job se-

curity. Once a worker has been in the state system for ten years, s/he can receive half-pay upon retirement. Interviewees justified their remaining in these jobs on the basis of this job security.

(Why do people stay so long?)

When you're not trained to do anything, you need a gig. Job-wise, you're not digging a ditch. . .you're not outright as a floor-mopper. . .you set up some tricky values for yourself. . . but I was aware of the fact that whether I was a maintenance man, a garbage man. . . I was a garbage man in psychiatry, that's what an attendant is.--Black male

In addition, once a worker has gotten a "permanent line" (at whatever grade) in the state system, it is not easy to be fired. However, the worker can still be written up for insubordination or for coming to work late. The consequences for this are that the workers can be precipitously transferred to another ward or even to another institution in the state system:

(Who changed your title?)

Hm. Dr. X, who was the director of the clinic and the nurses on [the ward] wno ganged up in his office and said, "P doesn't work weekends." . . . So I was running the Spanish group and they all came in one day and interrupted my group and said, "Dr. X wants to see you immediately". . .so I came over to see him. . . . He said, "You have to work weekends, because your job description has been changed. You are now an attendant." I said, "Do I have a choice?" because at that time I was going to school, I had my own practice, and working weekends would be very bad for me. By the way, that was one of the things that caused the separation with my wife.--Hispanic male

During the author's stay on the inpatient floor, an MHTA who had been on the job for 13 years was transferred to another floor of the hospital. He had come into conflict with the head nurse. Even though he was considered to be the "head man" on the ward, knew most of the patients and was well-liked by them, the head nurse had him written up for drinking on the job. Even though it is well known that almost all MHTAs drink a lot, even during work, the nurse could invoke the formal structure of the state system to handle a worker whose power existed only within the informal system of the ward and the patients.

When Q. was here, they depended a lot on him. In fact, I recall that in a lot of meetings, they would ask if Q. was here, because there were things they weren't sure of. It was really simple. Q. had been in state service for many years. He's been working with these patients for years, since he's lived in this community. . . . And since we have the change of doctors so often, it makes it very impossible to work with some of these patients. They [doctors] have no idea. Whereas they see these patients for one or two months, we've been seeing these patients for the past three years, so I feel that I can voice a strong opinion about a patient whereas the doctor can't feel that. . . . But the doctor's going to do what he wants anyway. . . and I'll work with the patient the best way I know how.--Black male

Titles and tasks can be altered and reassigned with such serendipity that workers feel very little control over the course of their careers. The state system feels overwhelming and impenetrable. They recognize that they are cheap labor which is readily replaceable. When asked about the ability to strike or act back against the system, participants felt that this was not only futile but that it also put their jobs in jeopardy.

If workers focus their attention toward their superiors and to the

state system, they feel powerless, exploited and alienated. It is only when they turn themselves toward their clients and to the community that they experience satisfactions:

(Where do the satisfactions come from? The clients?)

Exactly. . . . I feel very, very, very, very good that out of those 45 people that I have, I don't think that I had more than seven admissions, and that to me is satisfaction. And whenever we have a patient that we feel is going to be needing a little more than just the 8 hours of the service, J. and I have extended our home phones so they can get in touch with us should they need us. And they do not abuse it. They call at an appropriate hour, usually no later than 10 P.M. And to me that's satisfaction. That's like an extra \$100 in my paycheck. . . . Incidentally I was criticized one time for being too friendly to the patients. . . no matter where we are, in the street or in the hospital, they don't treat us like staff, they treat us like persons, the people that help them. So they have a different kind of affection for us than they would have for a doctors.--Hispanic male

. . . .There's something that happens with the job. . .there's a bittersweetness to it. Being an attendant is not such a derogatory thing in some areas. It is a magnificent experience, you get to know yourself well. You come under many different types of pressures, more than the average type of person. You're confined to an area where people are mentally ill. Many strange things come at you, and you have to be able to cope, deal with it. . . .--Black male

(Do you end up doing work with patients out on the street?)

Sure. . .if we see them hanging out, or we see them doing something that might bring them back into the situation they were in--drugs, smoke, dust. . .you counsel them right there You allow them to reminisce about their last visit to the hospital. If that doesn't work, you can at least bring that information back to the hospital--"We can expect that patient to be coming back to the hospital, so we can begin working on a treatment plan right then. . . ." Sometimes we'll see someone on the outside and he'll say he hasn't been feeling too good, so we'll tell him to talk to someone, go over to OPD. . . . It's not like other jobs, eight hours and you're off. You see these patients quite a bit. You're always counseling them, talking to them, finding out how they're doing. It's like you're working around the clock.--Black male

If people in the community need help for welfare, they come to me. If people need for getting their residence, I write letters for them. That's the kind of work I was doing aside from helping people in their own private life. From no responsibilities to too many.--Hispanic male

One older Hispanic woman described herself as the "mother" of the outpatient service. She indicated that she loves her job. When asked about the lack of remuneration for her work, she insisted that this was not that important and that for her, the direct work with clients was what matters. This attitude was more common for female workers, especially older Puerto Rican workers, than for male workers. Typically, male MHTAs supplement their income from the institution by other jobs, hustling on the street, gambling, or, as three workers reported, by some form of private practice with clients.

In this hierarchy, the closest people to the patient is the paraprofessional because we are there, I mean, those people would invite us to their house just for a cup of coffee. And while we're there, over that cup of coffee, you'd be surprised how much help is given to those people, on the spot. Not on a formal thing, where they have to be tense because the professional is there. Over a cup of coffee, you saw so many problems.--Hispanic male

MHTAs enjoy their work with clients and tend to develop good working relationships easily. Though they are supposed to serve as a "bridge" between client and professional, MHTAs are often not taken seriously by professionals. A poignant example of this occupational dilemma was reported by an Hispanic worker. He is well known and highly regarded in his community as a spiritualist. Much of his direct service involves the use of exorcism and other "therapeutic techniques" of a spiritualist. Clearly, such beliefs are antithetical to modern psychi-

atric practice. The following vignette illustrates the kind of clash nonprofessionals can experience with professionals when trying to serve as a "bridge." It is presented in its entirety because it depicts the position the nonprofessional may be put in:

. . . .I was called by the doctor to do a translation. I debated whether I should go or not because I was on my own time [vacation]. . . . I look in the quiet room and there was this black man. . .and he was extremely crazy, as they call it, I could hardly recognize him. But they opened the door so I could do a translation and I recognized the man as someone I had done a spiritual reading for around 4-5 years before. And I had known this man to be very hyper. . . . So the minute he saw me he said--my nickname is P., everyone knows me as P.--so he said, "P., my God, I knew Santo _____ was gonna come and save me." St. _____ is a Cuban saint who he happens to be a devotee of, and so am I. . . .

So the doctor and the nurse are interviewing him but I'm there because I'm the translator. And they had given me a run-down on what a violent patient that was. Now this man, if anything, is not violent. . . . So what happens is that he says, "I feel my body shrinking; I feel like a little boy, like a child." Then he gave me a name.

Now I wanted to get out of there but I thought, "Now wait a minute, is my obligation to these people or to the patient?" I said, "I feel that this person is possessed by a spirit." And they look at me as if I was crazy. So the man makes some kind of movement. . .a contortion. . .so right away they send for the strait jacket. I said, "If you leave me alone with this man, I'll be able to get him out of that." To me, it's a cinch. It's something that I do everyday. . . . So I was in the room alone with this man.

How did I know that this man was possessed? Well, as a psychic I'm able to tell. But besides, the spirit, his voice was saying, "I'm a little boy, my name is so-and-so," and he gave me a whole run-down on who he was. Well, I had to give them a little run-down on Cuban culture before I was able to continue So I made a prayer and I commanded the spirit to leave his body and it only took about two minutes. And then I told the guy, "Do you know who I am?" and he said, "Yes, P." "Do you know where you are?" And he said, "No, I really don't." And I said, "You are in a nuthouse. You are in a crazy people's hospital. . . ."

I called the doctors back and they just looked and looked and didn't know what to say. But he was himself again. I told the doctor that my observation is that he does not need to be on any medication and that he needs to go home immediately. But he was put on 800 mg. of Thorazine, he was taken out of the quiet room. . . .

The man is still in my group, he has been taking medication for a year. . . . I don't think he should be taking medication, but I'm just the therapist [said sarcastically]. . . . Whenever I see a patient with spiritual problems, he should never take medication. But my word is not respected when it comes to that. So I find that they do decompensate after awhile. If they're not crazy, they become crazy. Do you know that the way I think of this man? As a "paranoid schizophrenic." This is the way I see him now. He doesn't come out of his house, he is beginning to hear voices. I find it very difficult to work with anyone who's medicated.--Hispanic male

It appears that often, the nonprofessional's "bridge" function is undermined by the nonprofessional's lack of credibility to professionals or by professionals' ignorance about exigencies of ghetto culture:

Let me give you an example [of not being listened to]. There's this woman [an outpatient]. She had her bed, and this is weird, too. . . she had her bed and each one of the legs of the bed, she had it in a can of water. And staff people, they talk about this, that it's real crazy and all, but I have heard that and seen that. A lot of times if people have roaches or mice and they don't want them crawling up on the bed, they put a can of water under the leg and put some bleach in there which will kill any mice or roaches that try to leap up the bed. I've seen plenty of people do that. . . . But I have been in a meeting where they didn't even listen to any of that.

(How did it feel that you weren't listened to?)

Well, it didn't make me that angry, 'cause I was just sitting back at that time thinking, "Boy, these sure are a bunch of dumb motherfuckers." I've seen them go off into their theories--man, in left field.--Black male

Aides know that patients view doctors and other professional staff as unable to understand. At times, the professional may be the last one

to obtain important information about a patient. The MHTA may sense this, but may also be left with the feeling that professionals do not understand:

I've spoken to many patients who've just come out of a session with a doctor and I would say, "How was the session?" And they'd say, "Oh, so-so. They're not doing anything for me." I'd say, "Well, did you tell them what you told me?" "No, they wouldn't understand." Sometimes they [patients] just don't trust them [doctors]. . . . There's a lot of games being played around the doctor. We're doing the treatment but we play dumb with the doctors. . . .--Black male

There's a lot of things that the aides take in that the doctors never really find out about. A lot of these clients, I'd say about 30% of them, when they go in to talk to the doctor, they find it like a game that they're playing. They just go in and, say, answer the questions, and just go along with the system but they don't really let themselves out, they don't really tell you what's happening. While I might be out there playing ping-pong with one of them and I learn a lot more than he [the doctor] learns in a whole session, because I guess they feel that I'm closer. Most of the patients know that this is a bullshit job. They know that we're just here to guard the place, not to really do treatment. They let themselves open more.--Black male

The MHTA is put in the difficult position that while not to report information to a professional may ultimately hurt a patient, to report information is a thankless task. Often, the aide's input is likely to be overlooked in planning treatment. In addition, many interviewees commented that they no longer attend staff meetings because they feel "stupid" not knowing what professional jargon means.

The general nature of the nonprofessional's job and the feelings about the job reported here are at considerable odds with the content and tone of the community mental health literature of the 1960's. There is surprisingly little convergence between the enthusiasm described in

those writings and the drudgery described by the workers in this study. These workers experienced some, but not many, of the joys of direct service work. Most felt the frustrations of coming into close contact with emotionally disturbed people from their own neighborhoods for whom they could do relatively little:

(What's the hardest thing you ever had to do to a patient?)

I had to put people in restraints, when I didn't want to. I had to lock people in rooms, when I didn't want to. I felt sorry for them, but it was best for them at that time. . . . Cleaning up dirty, shitty, stinky, licey, buggy people, saving people's lives. . . . I was with people when they died. It was all just a trip. . . . I couldn't say the hardest thing. It was hard when people went home. I was happy for them but I would miss them. That was hard.--Black male

Most did not experience encouragement from professionals for going on in school. Most described "inservice training" as infrequent and irrelevant. Practically no participant could describe exactly what the community mental health movement was or is about:

(Did anyone ever teach you basic terms about mental illness or psychology?)

No, never. I never learned the terms.

(How about the words 'community mental health'? Do you know anything about what that movement was about?)

No, I really don't. I know I work in community mental health.

(Do you vote in elections?)

Yes, sure I do. . . . I just know that I come to work and I go home. I don't know what's out there.--Black female

It is worth noting, especially in relation to the community mental health literature, that none of the MHTAs who worked on the community

service inpatient unit and came into daily contact with psychotic patients had ever had a basic explanation of schizophrenia or other psychoses, or any course in psychopathology. Aides often become "cooled out" of staff participation and treatment planning simply because they are afraid to ask what words mean.

Not being taken seriously by professionals, becoming emotionally drained by patients, not having a basic intellectual understanding of the mental health problems being confronted daily, finding salary increments difficult to get, living with the possibility of being transferred to another facility (thereby breaking up work friendships), and feeling unaccepted in the work environment necessarily leave the MHTA with little motivation and with little desire for involvement. Workers often become cynical about the organization and distrustful of professionals' motives:

Well, . . . I was the only paraprofessional on the staff there They was thinking of getting one other black person from the service, which made me feel very bad because they mentioned his name, they mentioned how much they did not want him, but at that time there was another black paraprofessional who had gone to the human rights commission because of some racial thing going on. So when I heard that they did not want this person but that they had to take him in because of what was going on, that made me scared. Not only did that make me scared but that sort of put me in a spot because I did not want to. . . . I always feel very uncomfortable when I'm surrounded by prejudiced people. And here was myself, the only paraprofessional, Hispanic. . . .--Hispanic male

Two very significant points help account for the discrepancies between the reports by MHTAs presented here and the thrust of the community mental health literature. First, variables which link the design and conceptualization of programs for indigenous nonprofessionals and

their pragmatic implementation are often omitted. The practical matter of where the nonprofessional's paycheck is to come from is often not dealt with in detail. This one fact puts enormous constraints on the nonprofessional's work situation. In the cases presented here, the missing variable is the state system.

Second, the overall parameters of these nonprofessionals' jobs are determined by the state civil service bureaucracy. Forces which are far outside the control of the MHTA, and even the hospital administrator, impinge on the MHTA's "career ladder." Institutional needs (e.g., which ward needs another strong male aide) and bureaucratic exigencies (e.g., the availability of a particular "line item") become the framework within which the MHTA constructs his/her work life. Being a "bridge" to clients is sometimes an added extra and sometimes an added burden.

The backdrop against which the professional views the nonprofessional is quite different and is often based on the parameters the professional applies to his/her own career. Many professionals feel a greater sense of autonomy from the state system. They feel more control over the course of their work lives. These factors may color the way in which the professional looks at the nonprofessional's work.

The professional may also have a different frame of reference from the nonprofessional, in that the professional's view may be drawn from the community mental health literature rather than from the state system. For example, the professional has likely read about programs using nonprofessionals prior to working in the community service. Consequently, s/he may see these particular nonprofessionals within that context rather than within the context in which nonprofessional experience their

jobs.

According to the findings presented here, the frame of reference described in the community mental health literature somewhat misrepresents the experience of nonprofessionals. One explanation for this is that the programs described in the literature may be the exception rather than the rule. It is conceivable that there were a relatively small number of programs in which nonprofessionals truly had careful selection and training and genuine encouragement for career advancement and that these programs were written about. Simultaneously, many minority workers may have gotten jobs bearing the same title but without the same concerns paid to personal development.

It is probable that the implementation of New Careers programs, as Reissman and others have described them, involved channeling large numbers of workers into the state system. The state's changing of the title of "attendant" to "MHTA" was simply an alteration of title and did not represent a bona fide change in function, status, or career opportunity. Here the gap between the design of a program and its actual implementation is so large that it creates divergent ways of understanding nonprofessionals and their job experience.

A concrete example of these discrepant vantage points will clarify the point. An article which exemplifies the nature and tone of the community mental health literature of the 1960's is entitled "Community Psychiatry Welcomes the Nonprofessional" (Shachnow & Matorin, 1969). The article reports about a "family aide program" in which three minority women were used in helping patients return to the community. This

study was done in a comparable place to where the current study was carried out. Two of the aides in the 1969 study also participated here.

First, it should be noted that the 1969 study describes a project using only three workers. Out of the total number of nonprofessionals in the setting, these three represent only a small minority. In that study, three workers were given intensive supervision, a modicum of training about mental health problems, and much support from hospital administration. What happened to all other nonprofessionals during the time this project was being carried out? Possibly their experience was akin to what has been described here.

The juxtaposition of the 1969 article to the reports of the nonprofessionals interviewed in this study is illustrative of the discrepancies between how professionals see nonprofessionals and how nonprofessionals feel. Much of the 1969 report stands in opposition to the present study:

The impact of severe emotional illness can be jarring to any new staff member. The aides in particular, lacking a professional or even middle-class sophistication, find mental illness especially frightening and incomprehensible. Aides do not have the educational tools on which other team members might rely to gain emotional distance. Therefore, the aides feel diffuse anxiety in the first months as they attempt to grapple with their perceptions of and reactions to 'crazy' behavior (Shachnow & Matroin, 1969, p. 8).

Our family aides. . . alleviate the language problem by translating for clinical interviews and conferences. Second, out of their appreciation for culturally different life styles, family patterns, values and beliefs, they are able to augment the sensitivity and understanding of professional staff. Similarly, they can convey the staff's interest and recommendations in a manner meaningful to the patient and family.

The aides' cultural closeness as well as more informal relationships with patients are a third asset. Regarded as

friends, the aides have often been first among the staff to hear the most significant details of a patient's background. Finally, aides' on-the-spot observations of patients outside the hospital may help staff to identify or crystallize a problem which the patient could not articulate (Shachnow & Matorin, 1969, pp. 4-5).

Compare this rosy picture with what a respondent reported in 1978:

I started work during the fall of 1973. At that time I was ready to leave the job a week later because my duties were to bring a newspaper and read it unless I was called. Mental health worker. They never told me what I was supposed to do, except to bring something to read, stay in your office and we'll call you. They called me twice in the week for translation. . . .

(Do they ever ask you to teach them about your culture?)

The few times that I was asked, I felt a touch of sarcasm there. . . . A couple of people asked me to write a paper on Spiritualism and give a seminar on it. But I felt that if other people were paid for it, I didn't think I should just be extending my services for nothing.

J. and Mrs. M. and I have developed our own "on call" system for the Spanish community. But we always have to be on call because of translations. If no Spanish-speaking person is on call, that automatically places one of us on call. But our own rotation was not accepted. That's why I say we have no power, no voice. We are to do what we're told to do and that's it.

. . . And I was told, "You have to draw a line with the patients. Don't allow them to be that friendly." Now by "that friendly" they mean that the patient will hug us. That's out, professionals don't do that. . . . I have a little game I run with them, whenever we do something which they do not understand, I say, "It's cultural,". . . because they don't know what's cultural and what's not.--Hispanic male

What the 1969 article reports as an exciting duty for nonprofessionals, i.e., translating, is considered to be a kind of dirty work to the non-professional. Further, what is described as professionals' openness to Hispanic culture is not necessarily perceived as such by workers.

It should be noted that two of the three aides who were described in the 1969 article were working in community service in 1978 and were interviewed for this study. Both of them are older women who were the only people in the study to speak positively about their jobs. Evidently, the attention paid to them because of the Family Aide Program had a lasting effect on their feelings about their jobs. However, one piece of follow-up should be mentioned. One of these women revealed in an interview that although she has worked at the job for over 12 years, she has been on three different payrolls, not all of them state payrolls. Consequently, she is not eligible for half-pay upon retirement. In putting the 1969 study in line with this one, it becomes apparent that this worker was initially paid from a research grant and was then shifted to another source of funding. Unfortunately, professionals did not take into account what these payroll shifts would mean for this woman's retirement. Presumably, this oversight is not due to insensitivity on the part of professionals. Rather, it is probably due to professionals' viewing the family aide's job in the context of community mental health programs and not in the context of the aide's basic livelihood. This particular aide felt that there was so much red tape involved in getting her situation straightened out and that the administration simply would not care enough that it was futile to pursue.

The 1969 article is misleading, especially in an historical perspective. It takes three workers out of context and described a program which was atypical in that community service. How many other nonprofessionals were welcomed? It leads the reader to believe that such a program was the norm rather than an isolated event, that possibly all aides

got supervision and were as appreciated as were these three women. According to the data collected in this study, community psychiatry has not "welcomed" the nonprofessional. Perhaps community psychiatry has begrudgingly allowed the nonprofessional in the back door and has bureaucratically structured the situation so that the nonprofessional cannot do much more than stay in his/her place.

Thus, if one accepts the first-hand accounts of these nonprofessionals, it becomes apparent that the same set of events, i.e., the employment of indigenous nonprofessionals, was constructed and experienced differently by the two different groups. One level of analysis explains this discrepancy in a pragmatic way, stressing the gap between the design and implementation of programs, focusing on the availability of funding (i.e., the state), and assuming simple misunderstandings between professionals and nonprofessionals. A more critical analysis locates these discrepancies within structural issues of class, race, sex, and the role of professionals. Chapter V will focus on how these issues emerge within the immediate context of the ward as a social system.

C H A P T E R V

THE STRUCTURE OF ORGANIZATIONAL DYSFUNCTION

The efforts of the aides to come to terms with their roles, within the context of the state civil service system, have profound consequences for the provision of good patient care, as well as for the way all staff members feel about themselves and their jobs. These consequences are expressed through the dynamics of the ward. Though aides spend so much time and energy calculating retaliatory efforts, and though these efforts do serve to give aides a certain power, these preoccupations do not make aides feel especially good about themselves. Collective action is a negative form of power and as such does not affirmatively enhance workers' self-concepts. In addition, these sorts of sabotage negatively impact on professional staff. They function less effectively with patients and their sense of adequacy as proficient workers is compromised. Given that many of the professional staff are in training in this inpatient setting, their professional self-concepts are in the formative stages, and they are thus more vulnerable to the effects of undermining acts of sabotage.

None of this bodes well for the patient. Sometimes it appears that s/he is only a pawn in some other struggle rather than an individual in severe personal distress. From a sociological perspective, it is interesting to note how patients intuit staff dynamics and play into them, becoming disruptive when many staff are around and well-behaved when

staff are not in conflict. From a psychiatric point of view, however, putting the patient last or exploiting the patient to fight staff power struggles is the antithesis of responsible patient care.

Because the costs to individuals and to the overall functioning of the system are great, it becomes important to analyze why these staff struggles exist and why they unfold as they do. Are the dilemmas and interactions described here unique to this institution and to this group of people? Or are there more universal elements underlying this situation which motivate and influence actors' behavior?

It is suggested here that certain structural features of this work environment are unintentionally arranged in such a way as to provoke and sustain profound conflicts and differences between groups of people. This chapter outlines the underlying and more universal issues which may account for the continual disruption of organizational functioning.

Discrepancy between the Formal and Informal Organization

The inpatient community service contains two different and competing organizational gestalts. One is based on a formal medical hierarchy, with doctors, psychologists, social workers, nurses and aides occupying descending positions on the ladder. This hierarchy is based on formal educational credentials given different valence in the society.

However, the inpatient ward is, in itself, a different society, which values some skills more than others. Often, the skills valued by the ward society are not those valued by the educational hierarchy of the larger culture. It is out of these different values that the informal organization emerges.

Within the informal organization, or within the ward society, the aides are the most valuable members. If the primary objective on the ward is patient control, then those members who can create an easy rapport with patients, who can communicate with patients, and who can subdue patients with physical force when required must necessarily be viewed as leaders. Aides are also on the ward more than other staff, know the patients far better than other staff, and have been on the job longer than other staff. If physical strength and accessibility to patients are the criteria used, rather than formal educational factors, then aides should occupy the top position. Within this system, aides are the professionals and doctors are the nonprofessionals. Aides see the situation in precisely this way, claiming that everyone relies on them but no one gives them the proper credit or remuneration.

Thus, this tightly closed system contains two competing organizations, each positing different values for members, and locating members in different niches in the hierarchies. What becomes problematic is that at some points, the formal organization is invoked, while at others, the informal organization is called into play. When there is violence on the ward, the informal organization moves into the foreground. If this organization stays in the foreground for any length of time, thus challenging the validity of the formal system, then the formal organization will be mobilized. Doctors will give orders, nurses will write up aides for insubordination, or aides will be transferred to other wards. In order to maintain a sort of homeostasis, neither system can allow the other to stay emergent for long. However, the constant shifting of emergent and submerged organizations, at least without

acknowledgment of this systemic pattern, is disruptive to the cohesive functioning of the ward.

Ownership and Territoriality

A second structural issue in the work environment is the question of territoriality. To whom does the ward belong? Whose 'turf' is it? Within the formal system, it belongs to the doctors and nurses. The doctors make the explicit rules (give orders) and the nurses enforce these rules. Yet the doctors only spend small amounts of time on the ward. During the course of the work day, they enter and exit many times. They only work on the ward for six months and then go elsewhere. Most nurses do not stay at this job for very long.

Only aides and patients stay for long periods of time. Patients are discharged and readmitted, leaving and re-entering over the years. Aides stay--eight hours a day. What they describe as their burden becomes their claim. They feel that the ward is their turf. Professional staff are often seen as intrusive outsiders. They are natives--others are tourists.

The ward is their territory, their turf, but they do not own it. Two metaphors are striking at this point. Like the colonial state or the plantation,¹ they work the land but do not own it. The metaphors are not mere coincidence, since they imply a particular racial composition of the factions in the ward society. Most professional staff (especially doctors) are white, while most MHTAs are black or Hispanic.

¹I am grateful to one of the participants for the suggestion of this metaphor.

Further, most aides are physically strong and intimidating (one of the requisites of the job), while most professionals are "booksmart", cerebrally strong people. The splits between brawn and brain, workership and ownership, which are built into the ward structure call to mind supposedly archaic images like the plantation.

The set-up of the ward simulates obsolete structures of colonial states or plantation life. It is quite possible that, whether consciously or not, these structural variables subtly incite aides to disruptive forms of collective action and may explain why workers act as they do. If one accepts the notion that systemic and structural variables impact on people and influence them to act in certain ways, then one must at least consider the impact of this type of ward structure on the workers within it.

The Battle Lines

The conflicting organizational systems, the ambiguities over territoriality and ownership, and the divergent racial compositions of professionals and nonprofessionals are structural factors which, taken together, polarize roles and functions and lend themselves more to battle than to collaborative work relationships.

In fact, the battle lines become the clearest divisions within the entire system. There are professionals and nonprofessionals; temporaries and lifers; students and workers; majority (whites) and minorities (blacks and Hispanics); formally educated ("booksmart") and not formally educated ("streetwise"); middle-class and poor; "brains" and "brawn." Microcosmically, this tiny ward contains within it a hyperbole of the

most volatile elements of the society in general. Profound and explosive cultural conflicts are cloaked within different opinions about patient care and are acted out through various strategies of sabotage and disciplinary action. Indeed, given these structural constraints, the potential for conflict is overdetermined. Consider an example on the ward in which some of these elements come together around historically pertinent events:

During the sixties, we'd get a lot of blacks from the bus rides, from the south. A lot of cases of organic brain damage, from getting hit in the head--from nightsticks from the police. A lot of people got brain damage from that. We got many of them, right there at [the hospital]. We had two black guys who got beat up bad by the police--a lot of brain damage. This one guy, he wouldn't take his medication and the doctor said he got to take his medication and he just slumped down to the floor and just lay limp. Doctor said, "Take him down to the seclusion room." I said, "Take him your mothafucking self." I walked away. I did not touch him. I walked away and sat down. . . . "Insubordination" again!--Black male

Battles and Battlegrounds

Though the structure of the ward involves an interplay of issues of race, sex, class and education, from the aides' vantage point, one central issue is overriding. For them, the crucial battle centers around competing definitions of manhood and masculinity. Female aides participate in this battle vicariously, by giving tacit support to male aides' conquests. There is almost a sense of caricature in this. Who is more of a man--the streetwise, physical black nonprofessional or the book-smart, cerebral white professional? Perhaps this issue is so prominent because, within the formal organization, aides have little control or authority but are yet required to be physical and strong, that is,

hyper-masculine, at least by traditional standards.

Struggles for control, dominance, authority and territoriality are traditionally "masculine" struggles, in an archaic historical sense as well as currently. These struggles are particularly poignant for minority males, who are simultaneously seen in our society as both emasculated and hyper-masculine (Stember, 1976; Wallace, 1979; Kovel, 1970). Males in this study appear to behave with some sensitivity to these issues. Though they are in subordinate positions, or perhaps because they are in subordinate positions, they become intent on proving to themselves and to professionals that they are the "better" men.

The battlegrounds where they show that they are "better" men are interpersonal ones. Patients become one battleground, while relationships with female staff become another. For instance, "talking a patient down" in front of a professional, rather than using physical force, is an attempt to show the professional that the aide can play the professional's game too. Aides compete with highly educated doctors by demonstrating different treatment approaches with patients. Aides want to work one way, doctors another. In this way, the patient becomes the battleground for the negotiation of other issues, the medium for the communication of deeper concerns. The aide wants to show that all the "booksmart" education and all of the formal power granted to the professional by the formal organization is not "real" power or "smarts." The aides see the professional's power as ascribed power, while they see their own as achieved, or earned. In traditional sex-role terms, ascribed power carries with it less of a sense of "virility" than does achieved power.

By competing for and winning the affections of female staff, male aides communicate to professionals that they are preferred as men--as sexual partners. The higher-up the woman is in the formal hierarchy, and the more in demand she is by professional men, the more appealing she becomes to the nonprofessional male. To possess such a woman is a conquest and a testimony to the aide's appeal as a man. "Making it" with the female professional equalizes the distribution of power in the system, thus serving a homeostatic function.

The sexual competition is heightened by its interracial implications. According to Stember (1976) and Wallace (1979), the conquest of the majority race's woman by the minority male is a sign of power, strength and masculinity. The way aides in the present study discussed, sought out, and exploited these kinds of sexual "conquests" supports this notion.

This analysis positions men and men's issues at the center of organizational dynamics and struggles. Though female aides experience power struggles and feel that their competence and expertise are often undermined by professionals, it is posited here that the underlying issue is a "masculine" one--masculine, in the traditional, stereotypic, "macho" sense. Female aides in this study tacitly encourage male aides in their sexual exploits. If sexual conquests serve to redistribute power in the system, then bringing down the white professional woman from her "high horse" allows the minority nonprofessional woman to feel more power. Unfortunately for both sets of women (professional and nonprofessional; white and minority), struggles in this work environment (and probably other work environments) are so masculinity-oriented that

there is little opportunity for camaraderie or solidarity across different groups of women.

The Casualties

The impact of this drama on patients, professionals, aides and on the institution as a whole is enormous. The underlying structure of the ward kindles what are often dormant but explosive issues. It is a structure destined to be dysfunctional. Quite simply, it is set up in a way that brings out the worst in intergroup relations.

Not every worker or patient is affected by these dynamics. Not all of these issues operate all of the time. These dynamics may be set in motion by personality clashes, individual patient variables, the number of patients on the ward, as well as by individual affections between workers. It is suggested here, however, that these organizational dynamics are at the root of the system and can be triggered at any time.

Because of these dynamics, patients may receive mixed messages about their care in the hospital. A therapeutic relationship with a doctor may be undermined if an aide dislikes that particular doctor. The rapport a patient has with an aide may be undermined if a doctor orders an aide to place the patient in the seclusion room or orders additional medication. For patients whose ego boundaries are fragile and poorly defined, sensing staff conflict and becoming incited to lose control may aggravate a patient's psychosis. Finally, sensing staff tension and disharmony may affect the patient's capacity to form a trusting relationship with hospital personnel and may diminish the patient's feeling of safety and security in the hospital.

Both professional and nonprofessional draw on this work environment to develop and enhance adult identity. The adult self is shaped at work by the daily, minute interactions which make up occupational culture (see Appendix A). It appears that the struggles which absorb the energies of workers on this ward may serve to detract from a positive sense of the self at work. Professionals may have other outlets, but for the aides whose work lives are confined to this ward, the consequences over time can take quite a toll:

. . . .Anytime you come to a job and you got to drink a fifth of liquor and smoke a joint to start your day, each and every day, and everybody drank! Poor A. drinks like a fish now! J. drinks like a fish! E. drinks like a fish! I drink like a fish! When you're constantly reminded that you're not shit! And something 24 hours a day is telling you that. . . .--Black male

In addition, the sexual exploitation of professional women may have consequences for the development of their careers, their identities and their self-respect as professionals.

For the institution, the impact of these undercurrents is that the basic task of the institution is not accomplished well. Empirically speaking, these tensions become confounding variables which interfere in efforts to design and implement the best patient care possible. It becomes difficult to ascertain what factors are helping or hurting patients. In addition, hospital administrators are forced to spend time and effort mediating staff conflicts, transferring aides from one ward to another, confronting workers with "disciplinary actions" and replacing destroyed property. On a daily basis, administrators are forced to treat overt symptoms of the system rather than extricate underlying,

causative factors.

In summary, there are two competing systems of the organization, function and relative significance of staff on the ward. Often, the formal and informal organizations are at cross-purposes with each other. While the formal hierarchy dominates in theory and during periods of relative calm on the ward, the informal hierarchy is mobilized during times of patient crisis. The dual organization of the ward leads to conflicts around issues of ownership and territoriality. The potential for staff tension and organizational dysfunction is further overdetermined by the polarization of roles around race, education and class dimensions. Though surface disagreements may center around treatment of patients and competition for the affections of female staff, the underlying battle, analytically speaking, centers around competing definitions of masculinity. In a caricature of the larger society, the organizational structure of the ward pits the middle-class, white, educated, cerebral male against the poor, minority, street-educated, physical male. Both nonprofessional and professional women may be disregarded or abused, or may become pawns in these struggles. The consequences of these battles are seen here as negative for all elements of the system, both individually and institutionally.

CHAPTER VI
DISCUSSION AND IMPLICATIONS

Subjective Experience of the Nonprofessional

Field research and interview data from participants in this psychiatric institution reveal that these indigenous nonprofessionals perceive and experience their jobs differently from the way such positions are described in the community mental health literature.

Whether in the outpatient department of this community service, or on the inpatient ward, the aide's job is simultaneously menial and pivotal for the organization. Aides must shift back and forth between just sitting with patients (without actively initiating treatment plans) and springing to action when patients lose control on the ward or are in crisis out in the community. Much of the time aides feel exploited by professional staff for their having to take on undesirable, difficult clients, translations, errands, and other dirty work. They feel that professional staff are either insensitive to or exploit aides' emotional ties with patients. If they are a "bridge," it appears to be more in the literal sense of an object that is walked over to get to something else, rather than something that connects things. In this regard, the imagery of a "bridge" as a passive object may not be mere coincidence.

From the point of view of these MHTAs, the parameters of their jobs are imposed by the state civil service system. Within these constraints,

upward mobility is difficult and often dependent upon bureaucratic circumstances rather than contingent upon impressive work performance. Overt protest is also difficult because of the threat of disciplinary action by the state.

Though the lack of power is experienced by aides who work in the outpatient department, it is experienced more intensely within the inpatient ward. The inpatient ward is a closed system with clear boundaries. In such a pressure cooker atmosphere, occupational life is characterized by continual exposure to severely disturbed mental patients. The aide's position in relation to patients is primarily reactive. The aide is thus dependent on the behavioral productions of patients to demonstrate competence at the job. Displays of expertise revolve around controlling patient violence, especially in the presence of professional staff. It appears that aides can orchestrate disruption in patients at certain times so that aides' indispensability can be made apparent to all staff. Staff conflicts result from professionals' interference with aides' demonstrations of competence, thus triggering a set of collective actions from aides.

Nonprofessionals' Views of Community Mental Health Movement

The juxtaposition of the reports from these indigenous nonprofessionals with the way such nonprofessionals are depicted in the literature reveals many discrepancies between the design and implementation of this set of community mental health innovations (cf. Lorber & Satow, 1977). The stated goals of the integration of nonprofessionals into community mental health agencies and the goal of establishing genuinely

"new careers" have not been met in the situation studied here. The kinds of subjective reports one might anticipate, given the way the literature reads, were not obtained from these nonprofessionals.

Ritzer (1974) articulates some of the reasons why these "innovations" have failed to be innovative in practice. He argues that the failure of New Careers programs is due to professionals': withholding of information from nonprofessionals; making decisions of impact without consulting or informing aides; failure to acknowledge aides' contributions and value; not treating aides as colleagues; and failure to support changes within the agency. Further, Ritzer attributes program failure to the propensity to give only dirty work to nonprofessionals, to the overwork and underpay of aides, and to training and supervision which is so middle-class in orientation that it is of little value to aides.

Ritzer states his case very strongly:

. . . .Lacking a meaningful job, he [the nonprofessional] soon found that he did not have a career. . . . In fact, Reissman's provision of the ultimate option of becoming a professional can only be regarded as a cruel joke. . .the professionals were clearly not going to supervise their own demise (Ritzer, 1974, p. 223).

The data from this study support Ritzer's assertions. The dual system of organization on the inpatient ward and its consequences for patient care and staff relationships suggest that some professionals in this study are threatened by aides' competence. The exclusion of aides from staff decision-making, often because nonprofessionals have simply never been taught the psychiatric jargon professionals use, further un-

underscores the unspoken message that nonprofessionals should "stay in their place." Similarly, a recent study by Lorber and Satow (1977) reports that in a community mental health center, nonprofessionals are assigned the most undesirable cases, again reinforcing a hierarchical system with minority aides at the bottom. Rather than becoming coopted by or overly ingratiating to professionals, aides in this study tend to become alienated and depressed and begin to view their jobs as being as mundane as any other line of mental labor. While they feel guilty vis a vis patients in taking such a resigned stance, it may be the only available way of coming to terms with their occupational situation.

Again, these findings of nonprofessionals' subjective experience at work are at variance with what one would expect from a reading of the community mental health literature about indigenous nonprofessionals. The literature suggests that nonprofessionals should feel useful to and respected by the organization, should make significant contributions to treatment planning and execution, and should have opportunities and encouragement for career advancement.

It would be unfair to generalize the findings obtained here to all institutions and agencies which have employed indigenous nonprofessionals. Hopefully, other institutions, perhaps those which are more financially autonomous and which are independent of large state civil service bureaucracies, have met with greater success.

The Latent Function of Professional Literature

The findings of this study represent a check of the innovative programs so enthusiastically described in the literature of the late 1960's

and early 1970's. These data were collected in 1978. It has only been about ten years since programs for nonprofessionals have been in operation. In this short period of time, important discrepancies between the literature and the direct experience of (at least these) nonprofessionals have emerged. How can we account for the gaps between the first-hand reports of these aides and the professional publications in the community mental health literature?

In understanding these gaps, it is important to analyze the function of both innovative change efforts and of professional literature. According to Piven and Cloward (1977):

The widely heralded federal programs for the ghettos in the 1960's were neither designed nor funded in a way that made it possible for them to have substantial impact on poverty or on the traumas of ghetto life. But the publicity attached to the programs--the din and the blare about a 'war on poverty' and the development of 'model cities'--did much to appease the liberal sympathizers with urban blacks (underlining mine) (p. 31).

The publications of the 1960's, the "din and blare," appeases our liberal guilt by allowing us to construct a particular view of the people these programs were supposedly designed to help. Indeed, professional literature presents a selected account of how these innovations were operationalized. The particular account permits us to feel that we have made changes in the system when in fact we have not. In this sense, the literature becomes a propaganda medium which pacifies us and allows us to feel complacent rather than stimulating us to challenge the status quo. At the extreme, the literature actually coopts us, encouraging us (professionals) to participate in and endorse the illusion of

a progressive and socially activist community mental health system.

The vantage point constructed by the literature not only assuages our guilt but also creates a distorted and biased view of minority non-professionals in community mental health settings. It gives us a lens through which to understand what nonprofessionals are doing in the mental health setting and how they must feel about it. Beyond being distorted, this is presumptuous. The findings of this study attest to the fact that what these nonprofessionals experience at work is different from what we (professionals) think they experience.

If our change efforts are sincere, then it is advisable to begin with a reassessment of the function of our own professional writings and publications. We need to check out our constructions of situations with the people we are writing about. Otherwise, we risk operating out of perspectives which are fundamentally incompatible with daily realities. As with the dual organization of the inpatient ward described in this study, we run the risk of creating and perpetuating dysfunctional work environments. What Chu and Trotter (1974) describe as a "minuet of mutual deception" (p. 202) exists both between professional and nonprofessional and between the actual realities and the published constructions of those realities.

It also behooves us to locate our change efforts within our own social and historical context so that we have a backdrop against which to evaluate innovations. Levine and Levine (1970) note that one of the important consequences of an ahistorical view has been for psychologists to herald their change efforts as new when, in major ways, they are recreations of past endeavors. Reppucci and Saunders (1977) caution that,

"The prevailing social context is a powerful determinant of how history is written. . . Changing social contexts offer new insights and alter old views." This study supports this view and advocates for the integration of these caveats in both the design and implementation of social change efforts and in our reading of professional literature.

Professional literature not only provides a lens through which we view nonprofessionals, but also provides us with a view of ourselves as professionals. These perspectives exist in relation to one another, and so changes in one would undoubtedly bring about changes in the other. For instance, if we are willing to accept the idea that much of what nonprofessionals do is "dirty work," what does this imply about what we (professionals) do? Perhaps some of the resistance in looking more phenomenologically at the experience of the nonprofessional derives from our reluctance in looking at the experience of the professional.

One possible explanation for this reluctance to examine our own roles may be that over a longer span of years, perhaps since the 1950's, the human service fields have been portrayed in the literature as rather glamorous. Perhaps the importance, desirability and impact of human service occupations have been overinflated. Possibly we have seen ourselves as doing more or better than we actually do. Somehow it appears that the human service fields may have been "hyped" or publicized to be more than they are. Indeed, the proliferation of mental health and other human service related jobs since World War II also must be located within a social and historical context. With the emergence of psychology and sociology as "sciences" over the last thirty years, there has perhaps been premature and naive optimism for the potential of such

disciplines to solve societal problems (Cloward & Piven, 1975; Goldenberg, 1971).

In articulating the subjective experience of the nonprofessional at work, we are challenged with the task of explicating our own experience as professionals. In so doing, we are confronted with any discrepancies between what our own professional positions were said to offer and what our actual phenomenology is. The speculation offered here is that gaps between design and implementation are to be found not only in the programs we erect for others (e.g. nonprofessionals), but also in the jobs and programs we create for ourselves. The professional literature which we publish and consume may serve, because of the distorted view it creates, to keep us from insights about ourselves and may reinforce the naive optimism that we are actual agents of social change.

Recommendations

The position advocated in this paper is that real changes in structure require a self-reflexive stance in which one sees one's own ideas, and the reification of one's ideas (i.e., publications, literature, jobs, programs) within a social and historical context. In order to move outside of one's frame of reference, which is what Watzlawick, Weakland and Fisch (1974) argue is necessary for real (or Type II) change, one must see problems and their solutions against an historical backdrop. On a broad, conceptual level, it is suggested that social reform strategists adopt this stance as an important priority in examining the programs they create.

Practically speaking, the findings of this study suggest certain

pragmatic recommendations. First, this sort of research can be utilized by the organization to help conceptualize and rework staff relationships. Issues of racism, sexism and classism are woven into the fabric of the organization and affect even the minutia of occupational life and work relationships. A clearer assessment of the impact of these issues is crucial for making structural changes in the work environment.

Second, professionals can use this material to begin to learn from nonprofessionals. One set of recommendations is for professionals to acknowledge that nonprofessionals are also "experts" who have much to teach, particularly to professionals who want to work in community mental health settings. An actual example of a course designed for professionals by a nonprofessional is included here in Appendix C. The course outline was drawn up by one of the participants in this study. Courses like this should be sanctioned by the institution. This can only happen, however, if nonprofessionals are paid for sharing their knowledge and expertise (cf. also, Assertive Black. . .Puzzled White: A Black Perspective on Assertive Behavior, by Donald Cheek, as another example of a teaching tool).

Aides could be formally asked to teach psychiatric residents, psychology interns, and social workers what they know about the community. Professionals-in-training could, in turn, teach nonprofessionals about psychopathology. The two sets of knowledge, both of which are crucially important to good service delivery, could be shared rather than kept private. Minority nonprofessionals often have a different, but no less valid, vantage point on mental health problems and treatment. A synthesis of both vantage points would facilitate a critical evaluation of our

own biases and distortions, might improve work relations, and might improve the quality of patient care.

The Use of the Sociology of Work Perspective

The sociology of work perspective allows for an analysis which synthesizes both individual and organizational frames of reference. It is useful in explicating the impact of institutions on individuals, as well as the impact of individuals on institutions. In evaluating the implementation of a set of programs, like the employment of indigenous nonprofessionals in mental health settings, this perspective facilitates a construction of the situation from the actor's purview--from the inside out. This is an especially helpful methodology in the case of the nonprofessional, because so much attention can be directed toward assessing the effect of these jobs on the workers themselves. This descriptive approach creates an experiential understanding of the phenomenology of work. It allows for identification with the actor, thus minimizing the possibility of objectifying the subject of study. More broadly, and of relevance to a goal of the community mental health movement, this perspective allows us to see the impact of work on the mental health of the individual actor, and, in turn, the impact of the individual's mental health on the functioning of the institution.

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APPENDICES

Appendix A is a summary overview which describes the perspective taken in the sociology of work. It is included here because it provided the conceptual backdrop used in understanding the subjective work experience of the indigenous nonprofessionals who participated in this study. The chapter was written by the author in 1977 as a prelude to the present inquiry.

Appendix B is the general interview guide used in this study.

Appendix C is an example of the type of didactic course which could be used to teach professionals about indigenous nonprofessionals' and patients' attitudes towards mental health professionals. This course guide was written by one of the nonprofessionals in the present study and is printed here with his permission.

APPENDIX A

The Sociology of Work PerspectiveOverview

The sociology of occupations and professions comes out of a different academic tradition from either industrial sociology or psychology. It stems from the so-called Chicago School of urban sociology, which, founded by Robert Park, developed in the 1930's and 1940's. While the focus of industrial sociology grew out of the Hawthorne discovery of the relationship between the informal social system created by workers themselves and the managerially designed work organization, the sociology of work took a qualitatively different vantage point on the person-at-work.

The Chicago School of urban sociology tried to articulate every conceivable aspect of urban life (Berger, 1964). The underlying notion was that no human activity or job was too insignificant or mundane for the sociologist to examine. The study of occupations was initially a by-product of this overriding concern with the details of urban life, especially urban low-life. Thus, the occupations which were first studied were the more socially disreputable ones--like the janitor, the thief, and the hobo. In these early studies, the emphasis was on the social worlds created by these occupations.

One thesis which still pervades the literature in the sociology of work is that there is a coherent and intelligible culture that emerges out of each occupation. This culture is created through social interac-

action (Goffman, 1959) by the actors themselves. Eventually, the culture comes to take on a life of its own, and then this reified set of norms and explanations acts back on the actor. In acting-back, the (occupational) culture dictates how the actor should talk, think, relate and feel. It is through this dialectical process, as it unfolds through time, that both the social self and the culture are formed and transformed (Berger & Luckmann, 1966).

In elucidating this dialectical process, the sociologist must understand both the occupational culture as it is created and reified, and the person as s/he, in turn, shapes and is shaped by that culture. This suggests a complicated set of tasks in the study of occupations and professions. Sociologists have primarily focused on the impact of structures on people. The researcher must describe the occupational situation in detail. S/he must then explicate the process by which (i.e., how) the person learns to participate in that situation as the situation dictates, that is, how the novice becomes socialized. A second task is to describe how the actor, having him/herself become changed in the socialization process, then comes to maintain and foster the occupational culture and perspective. A third task is to understand the steps or stages that the individual passes through during the course of his/her work life. Movements through critical junctures, or turning points, mark significant moments in the "career" of the person and often formalize, by making public, dramatic changes within the self.

The emphasis on the unfolding of this social dialectic through time illustrates the impact of a few important theoretical influences. The primary notion that the "self" is social and is formed throughout life

in interaction with "significant" and "generalized others" comes from a synthesis of both Cooley and Mead. In sociology, these ideas have been further developed by the symbolic interactionists (e.g., Blumer, Goffman). These authors bring to life the notions of a social self, shaped in interaction, through the use of a dramaturgical metaphor. The language of the stage is borrowed to describe the implicit, everyday qualities of face-to-face interaction. The "taken-for-granted" characteristics of daily encounters are minutely articulated, because it is out of such interactions that the self continually evolves. The life-long process by which identities are formed and transformed has also been well-developed by Anselm Strauss (1969).

The idea that the self continually evolves is another fundamental assumption in the sociological perspective. Such a position clearly has important potential for a comprehensive understanding of the adult person through the life course. Howard Becker describes personal change in adult life as deriving, in part, from two related processes: the process of situational adjustment and the process of commitment. According to Becker, the process of situational adjustment suggests an explanation of change, while the process of commitment suggests an explanation of stability. "One way of looking at the process of becoming an adult is to view it as a process of gradually acquiring, through the operation of all these mechanisms, a variety of commitments which constrain one to follow a consistent pattern of behavior in many areas of life" (1964, p. 51). Thus, Becker suggests that we look at the sequences and combinations of the small units of adjustment which produce the larger units of role learning (also cf. Brim, 1966). Further, he

says that we should look to the characteristics of the situation for the explanation of why people change as they do. Finally, we need to understand the perspectives of the person as a result of situational adjustment and commitment.

According to sociologists in this field, these processes of adult change, as affected by the social structure of work, can be best studied by careful qualitative field research, participant-observations, and interviews which bring to light the properties of the work situation as well as the subjective experience of the individual. A number of studies, of many seemingly different walks of life, have been researched in this fashion. Since the 1940's, this work has been most heavily influenced by Everett Hughes (Berger, 1964). Much of the literature in this area comes by Hughes' students, and it has been his conceptual clarity which has sculpted the direction of this research (cf. Hughes, 1958).

It is the hallmark of the thought and personal style of Everett C. Hughes to unerringly detect mind-jolting similarities among species of social life which seem at first glance wholly disparate and unrelated, if not outrightly far-fetched. This gift for comparative thinking in depth, for seeing around the conventional symbols and adornments by which men try to distinguish their stations and achievements from those of their fellow men, is everywhere evident in Hughes' writing, most especially in his lifelong preoccupation with the life of work: ergo, the intriguing, almost inexhaustibly provocative comparisons of the janitor and the physician, the prostitute and the psychiatrist, the jazz musician and the lawyer (Davis, 1966, p. 236).

In summary, the sociology of work entails the descriptive explication and comparative analysis of individuals in various work situations. Assuming the notion of a social self formed in interaction, it adopts a

symbolic interactionist perspective in which interactions are understood as constructing the social self. In turn, the collective constructions of both "selves" and situations, as they are made public through face-to-face interaction, become reified into social structure or culture. The culture then acts back on the person to further shape him/her.

"Work as social interaction is the central theme of the sociological and social psychological study of work" (Hughes, 1958, p. 68). The way this process unfolds at work has a lot to say about how adults change and grow through their lives. The sociology of work is, in essence, the study of the processes of personal change in adult life.

The rest of this section illustrates the kind of perspectives which emerge from this treatment of work. In presenting examples, the literature is divided into three stages of this personal change process. Thus examples are drawn from the following areas:

- 1) the shaping of the self at work: career socialization
- 2) the maintenance of the self at work: occupational culture; meanings and myths; work relationships; commitment
- 3) the transitions of the self at work: the concept of career; turning points; status passages; movement; the concept of failure.

The following subsections illustrate the developmental or evolutionary nature of changes in the adult self as a function of work. While change is a continuous process, and while elements of it can be punctuated at many points, we have somewhat arbitrarily divided cumulative changes into three blocks. Within each block or category (shaping, maintenance, transitions) are a series of mini-phases or stages, which contribute, in concert, to continual alterations of the self and of so-

cial structures. Even the category of "maintenance" paradoxically involves mechanisms of change and adaptation. In any case, the three divisions are used to help organize the sociological literature developmentally. Within each subsection are concepts which are typically used by sociologists to depict various features of work and its impact on the social self. Note that most of the concepts in some way underscore structural and relational aspects of work, dictates about normative behavior and action, and a sense of process or personal evolution through interaction. These qualities of the concepts exemplify the sociological perspective.

The Shaping of the Self at Work

Sociological researchers typically begin their investigation into understanding the interplay of the self and work by looking at the processes of socialization, both formal and informal. The formal structures of career socialization, typified by training programs and professional schools, provide the backdrop against which an informal peer culture develops. The institutional structure, and the reified rites of passage which accompany it, necessitate the need for role-initiates, or novices, to band together in order to understand and get some control over the dramatic changes experienced within the self. This forms the nucleus of the informal student culture. The individual and his/her rather malleable identity, move back and forth between the expectations of the institution and the peer group, thus weaving a new sense of who s/he is. The impact of this process is intense and often produces a profound sense of role confusion within the individual. The confusion

persists until the novice has sufficiently internalized the role demands of the institution and can perform the role without dissonance. The student, or informal culture, helps in reducing the dissonance which inhibits both internalization and demonstration of role competence.

The transformations of the self which inhere in this process are monumental. Professional socialization is undoubtedly one of the more intensive change processes in the society. Indeed, it almost seems that various hurdles or initiation rites are designed to unhinge the individual from his/her former conceptions of him/herself, the job to be done, and the clientele to be worked with. Goffman (1961) and Brim (1966) have even compared career socialization in general, and professional training in particular, to socialization procedures in total institutions, like mental hospitals, prisons, or the military (cf. Dornbusch, 1955). The newcomer is stripped of the trappings of his/her former identity, is not permitted much contact with former reference groups, loses any former status, and is often given a new uniform to wear (e.g. nurses and medical students). The novice becomes increasingly unable to retain the former sense of self that was maintained and confirmed by now unavailable others. The changing of reference groups, both in terms of superiors and peers, creates a change in one's personal experience of oneself.

While socialization procedures as dramatic as what has been described are most explicitly observable in professional training, sociologists contend that some variation on these themes occur in any occupational situation. Whether one observes the janitor (cf., Gold, 1950) or the physician (cf., Becker & Geer, 1961; Preiss, 1968; Hall, 1948),

one sees the novice picking up implicit and explicit cues from newly significant others. Such cues demand different actions and attitudes and in time transform the self.

Though these processes go on in all occupations and professions, sociologists have directed most of their research efforts to the professions, because these processes are often concrete and formalized in such training institutions. One very illustrative example of these socializing processes comes from the work of Fred Davis (1966) in his study of student nurses. His work typifies the perspective on work and the self taken by sociologists.

Through participant-observation and interviews with nursing students, Davis depicts six stages through which the individual goes in the process of becoming a nurse. According to Davis, "becoming" involves subjective experiences and formulations which transform the individual over time. The subjective experience is so dramatic in its impact that Davis adopts the metaphor of "doctrinal conversion." Something so profound is altered within the individual that the world, especially the world of nursing, is seen, understood and responded to differently. Above all, there is a shift in the individual's cognitive framework. Hughes (1958) describes this shift as "a passing through the mirror so that one looks out on the world from behind it" (p. 119). Davis unravels this personal drama of "conversion" or "passing through the mirror" through a stage or phase analysis of nursing socialization.

According to Davis, the newcomer enters nursing school with an "initial innocence" with regard to what nursing is all about. Such naivete derives from the popular conceptions or "lay imagery" of nurses

as tender, loving caregivers who have specific skills and techniques through which patients are made comfortable and well. However, the initial experience of the student in nursing school does not support this lay imagery of the field. Instead, the student finds that she (Davis uses the female pronoun) learns few actual skills and that the faculty does not reinforce popular notions of the field. Furthermore, the caring relationship which the student envisioned becomes replaced by a rationally manipulated set of interactions with patients in which nurses come to see their own interventions in a highly objectified, premeditated way. The stage of initial innocence is characterized by feelings of worry, disappointment and frustration because nursing school is so different from what was expected. At this point, students feel very alone in this experience, as if other students must surely feel more competent and adequate.

It is only in the second stage, called "labelled recognition of incongruity," that students begin to put together a collective definition of their problem. A student culture emerges to cope with the most commonly expressed concern that nursing school is not at all what was expected. Davis notes that this is the most problematic stage for students during the whole of their nursing career. Students typically begin to wonder if they have chosen the right field. The collective admission of incongruities between students' own initial expectations and those which faculty direct at them forms the basis of the incipient student culture. As this culture solidifies, the main goal then becomes searching for ways to reduce the dissonance. Note that the finding that student culture emerges in order to deal with originally individually-

felt concerns supports the notion of a socially-mediated self.

The development of a student culture to deal with incongruities leads to the third stage, which Davis calls "psyching out." This is a term used by students to designate a role performance geared toward pleasing the faculty. Davis' interviewees note that a sense of moral discomfort and ego alienation accompanies these role performances because they are so calculated. Psyching out, which is really an orientation, then leads to the next stage, "role simulation," in which the student carries out the necessary actions and stances. Davis notes that while role simulation is not distinguished temporally from psyching out, its enactment does usher in a set of internally-experienced changes. Role simulation refers to "that genre of highly self-conscious manipulative behavior of students which aims at constructing institutionally valued performance of a particular role" (Davis, 1968, p. 246). Role simulation is distinguished from the ordinary enactment of social roles by the qualities of self-consciousness, ego-alienation, and play-acting which the actor experiences.

Davis further distinguishes two kinds of psychological dissonance which inhere in role simulation. The first is that occurring between the actor and him/herself and is felt as ego-alienation. The second is between the actor and others. From a dramaturgical point of view, whether the actor convinces him/herself of the sincerity of his/her performance may be less important than whether s/he convinces him/her audience. It is this factor in interactions which eventually leads to personal change. "The paradoxical thing about this kind of role simulation is that the more successful the actor is at it, the less he feels

he is simulating, the more he gains the conviction that his performances are authentic. . . . This transformation occurs by virtue of the actor's ability to adopt toward himself the favorable responses which his performances of the new role elicit from others" (Davis, 1968, p. 247). Thus, the sense of ego-alienation is dispelled by the external, and then internalized reinforcement of one's performance. In time, the actor becomes his/her performance.

Davis describes two more stages, those of "provisional" and finally "stable internalization." Provisional internalization is characterized by episodic failure at integrating the cognitions, perceptions and role orientation which the student is trying to demonstrate. In this fifth stage, there is still some dissonance and some persistent attachment to former perspectives, performances and identities. Davis finds that in order for stable internalization to occur, two intervening phenomena happen: professional rhetoric and jargon are adopted; and positive and negative reference models of the professional nurse emerge within the student group.

Through these processes, the student begins to ignore parts of the self's past which might now bely that which the self has become. Though the self is still malleable to further socialization by other institutions, by the end of nursing school, important features of a professional self have been formed, internalized and enacted. The entire self feels and looks radically different. This metamorphosis, occurring within an institutionally controlled environment, exemplifies what career socialization entails and what consequences it has for the individual.

Davis's work typifies the descriptive, yet analytical approach taken by sociologists. One can note in this work the dual focus on the institution and the person, as well as the dynamics which emerge from their interplay. The synthesis of these two forces (i.e., institution and individual) is the development of student culture. Becker and Geer, (1961) in research on medical students, note the same phenomenon. The student culture provides a way of dealing collectively with subjective experience, though both individual and culture are themselves transformed in the process. It is through the vehicle of student culture that the individual becomes able to incorporate institutional norms and to allow him/herself to be changed. And it is via the reception the individual receives from others for his/her performance that the self begins to experience itself as different.

The sequence of publicly shared and privately experienced events is not only applicable to nurses. Similar if not identical processes of socialization have been observed in medical students (cf., Becker & Geer, 1961; Coombs & Vincent, 1971; Preiss, 1968), in clinical psychology graduate students (Clark, 1973), in teachers (Lortie, 1969), in the military (Dornbusch, 1955), and in the career of the mental patient (Scheff, 1966; Goffman, 1961). Undoubtedly, similar studies could be carried out with other occupational and professional groups as well. What is important to note here, in the sociological literature, is the descriptive articulation of the subjective experience of change as a function of institutional demands and occupational culture. This sociological literature offers considerable insight into the pliability of adult identity and the nature of personal change in adult life.

Wheeler (1966) has distinguished between different kinds of socialization situations provided by different institutions. For instance, entry into an institution may be serial (one person at a time) or in groups (classes). Communication channels may be either open or closed between people in different classes or statuses. A comparison of the effects of different socialization strategies on personal change might provide important links to literature on organizational development.

The Maintenance of the Self at Work

Having become socialized, either through explicit training or through a more implicit process of learning the ropes while on the job, the individual becomes not only "situationally adjusted," as Becker describes, but also "committed" (Becker, 1964). According to Becker, the process of commitment suggests an explanation of stability. Indeed, the person, in both his/her actions and identity, must be maintained, if not reinforced at work.

In any job, the self is maintained through the performance of specific tasks and through the enactment of roles vis a vis important others. Central concepts used by sociologists in discussing this maintenance process include explicating features of work, work roles and relationships, and occupational culture. An occupational culture, complete with myths, meanings, attitudes and perspectives, grows out of a synthesis of the task and the relational aspects of work. It is this culture, internalized within the person and projected and reified outside of the person, that most fundamentally maintains the self at work.

More concretely, sociologists use the term features of work to re-

fer to aspects of the work situation which arise normatively, or in daily interaction on the job. Some of these features involve tasks while others involve particular kinds of interactions with important others. For instance, in a classic sociological study on apartment-building janitors, Gold (1950) notes that one of the main tasks with which the janitors must deal routinely is that of taking care of other people's garbage. The questions for the sociologist are: what is this like for the janitor? What mechanisms does the janitor use in order to be able to deal with the objectively unpleasant and demeaning task of looking at, smelling and disposing of other people's garbage?

Focusing on the janitor's routine of dealing with tenants' garbage may appear, initially, to be mundane and inconsequential as part of a descriptive analysis. And yet, it is a task like garbage-removal which happens to make up the daily work of the janitor. Thus, the sociologist essentially describes the obvious in order to draw out the work culture within an occupation. In fact, Gold (1950) extrapolates from this particular feature of the janitor's work and posits that in all occupations and professions, some feature of the job involves what he labels dirty work. Sociologists can now apply this more general concept to any number of work situations. The physician must deal with blood; the secretary must make coffee for the boss, and the undertaker must deal with dead bodies. Because the sociology of occupations and professions is a comparative field, the purpose of studying janitors is to be able to draw out qualities of their work situation which are really not so different from those of more glorified or prestigious professions (cf. Hughes, 1958).

According to Gold (1950), the way the janitor deals with the considerable amount of dirty work in his job is by figuring out his tenants and the nature of their lives by what they dispose of in their garbage. In other words, the janitor maintains his integrity and some sense of control by getting to know details about his tenants which tenants would not ordinarily expose publicly. In this way, the janitor one-ups his tenant. The comparative notion of "dirty work" is especially applicable to low-status occupations, in which one person does a service for another which the latter finds beneath his dignity to do for himself.

As with the example of the janitor's dirty work, one observes that most features of the work situation, in one way or another, imply or involve relationships with other people. These others typically demand or receive a service. Most commonly, there is face-to-face interaction with these others. Sociologists refer to this almost ubiquitous feature of work as client work (cf. Faulkner, 1976; Becker, 1951; Stanton, 1970; Davis, 1959; Friedson, 1960, 1962; Bigus, 1972).

Generally speaking, the concept of client work means that the actor must answer to, or produce some service or product for, an other whose judgment the actor does not respect. Becker's (1951) classic study on the professional dance musician and his audience portrays this relational dilemma. In order for the dance musician to make money, he must play for audiences who, according to the musician, do not understand or appreciate the esoteric music the musician would really like to play. The musician has to play music he finds trite or simplistic in order to cater to his audience. In order that his integrity does not feel prostituted, and in order to feel some sense of control, dance-musicians

tend to put down their audiences, to isolate themselves within their own sub-culture, and to evolve a cynical stance toward those they serve. The janitor handles his dirty work by figuring out his tenants; the dance-musician maintains integrity and meaning in his work by demeaning his clients.

The idea that persons in a number of occupations and professions essentially mock the clients whom they serve has been found in a plethora of sociological investigations. Some of these studies have dealt with cab-drivers (Davis, 1959), milkmen (Bigus, 1972), philanthropic volunteers (Stanton, 1973), Hollywood film composers (Faulkner, 1976), and nurses (Katz, 1968). Clearly, the notion of client work, of a deliberate and collective "psyching out" of the recipients of one's services, is a concept with broad applicability. Thus, this very common feature or dilemma of work becomes a higher-order, more abstract construct which can be used to make sense out of any occupation, and not only the specific ones which have been carefully studied. Again, the comparative nature of the constructs provided by sociologists allows one to look at actors in any work situation, and to understand and predict their behavior as well as the meanings attributed to their behavior.

The collective attribution of meaning which role occupants give to aspects of their daily work forms the groundwork of occupational culture. In any occupation, there are shared meanings about the nature of one's work which imbue the role occupants with a sense of integrity and usefulness. Within the professions, this may be more explicitly enunciated in a code of ethics or through an oath or vow that bestows legitimacy, or even sanctity, upon one's work. Even the janitor finds inte-

grity in his work by noting that he is the "guardian" of his building, that he has autonomy in his work hours, and that he is responsible for property and people.

Often one's sense of meaning in work derives from the risks inherent in the job and in the emergencies encountered at work. Sociologically speaking, risks and emergencies are the crucial counterpart of routines. Meanings may be derived from routine situations, but they are tested and solidified through risks and emergencies. For the janitor, emergencies typically involve fires, flooding and other breakdowns in apartments. Here again, dealing with an emergency involves more client work. According to Gold, janitors may try to make themselves look very heroic to their tenants by allowing a busted pipe or flood to get just catastrophic enough for tenants to see the janitor's intervention as a real rescue. Thus, handling an emergency may not be enough. In addition, timing the handling of an emergency may be a significant part of both client work and may enhance the actor's sense of himself in his job. Undoubtedly, this is true in many lines of work and may be especially relevant in jobs where emergencies are actually routine, as with firemen, physicians, and policemen. Indeed, what is an emergency to one's clients may in some sense be routine to the actor, though the actors often do not let on that this is the case.

One feature of work which lies somewhere in between routines and emergencies is mistakes at work. Clearly, neither routines nor emergencies are consistently handled smoothly. In every occupation or profession, mistakes are made. Thus, the actor needs a way of dealing with, acknowledging, or covering up mistakes. Part of occupational culture

among co-workers, and part of client work, entails fudging about one's mistakes. The recipient of one's services is not to know that a mistake has been made or that an accident has happened. In medical practice, for instance, nurses are often called on to cover up for doctors or even to falsely admit that they were responsible for the mistake (e.g., the death of a patient). Nurses' taking the blame for a mistake they have not even made illustrates both norms of professional culture of medicine and the notion of dirty work.

The idea of fudging is akin to the concept of role simulation referred to by Davis in describing the play-acting of nursing students. Throughout the course of one's work life, one is called upon to do tasks which one does not feel competent to do (cf., The Peter Principle). Consequently, people are continually pretending that they know what they are doing when they in fact do not. To borrow from Goffman (1959), the actor must manage the impression his/her audience has of his/her competence. Indeed, the sense of ego-alienation experienced in socialization of the self at work really continues in smaller ways through the purposeful portrayal of confidence and proficiency. In this way, the self is further maintained and defined at work.

Independent of the status or prestige accorded to a job, it becomes clear through a comparative exploration of work that people find meaning, pride, control and integrity in most lines of work (cf., Turkel, 1972). It appears that there is both a shared and a more private cognitive process which defines and interprets tasks and interactions in ways which render work meaningful. Much of this evolves out of an occupational culture which shapes and defines interactions with clients or

superiors. Interactions are timed and controlled in order for the actor to get respect for his/her work. It is this omnipresent dynamic, unfolding in interaction, which preserves and enhances the self.

The jargon used in the sociology of work provides a language which delineates aspects of the work situation which might otherwise be simply taken-for-granted. In fact, it is precisely the taken-for-granted that the sociological perspective attempts to frame. The descriptive analysis of daily occurrences, of situations with which the individual will deal thousands of times, is the "stuff" of which this area in sociology is made. It is also these continually reoccurring encounters and activities which stabilize and add character to the adult self. As the self is maintained, so it is always in process and in flux. Perhaps because the self is so continually in a process of change in childhood and youth, the shift toward maintenance of the self in adult years is paradoxically a change. To achieve or perceive a consistent identity, which is reinforced through occupational tasks, interactions, and culture, is itself a form of change.

Transitions of the Self at Work

The individual undergoes a transforming socialization process as s/he enters his/her particular work world. Work identity (a substantial part of adult identity) is then maintained and reinforced by an occupational culture which defines tasks and interactions in self-preserving and work-enhancing ways. Yet the work world has impact even beyond these factors. Work provides the individual with an historical, biographical perspective on life. From such an historical perspective, the

individual views work in terms of career. One envisions statuses to be held in the future, and one looks back at positions formerly occupied. The longitudinal view of the self allows the individual to understand change within a context of personal continuity (Strauss, 1969).

Hughes (1958) defines career as "the sequence of passage through objective statuses and the moving perspective in which the person sees his life as a whole and interprets the meaning of his various attributes, actions and the things which happen to him" (p. 63). This moving perspective is punctuated by critical junctures and turning points which shift and modify the course of one's career. Such turning points serve to insure both the stability and preservation of work organizations as well as to carve paths of personal change and accommodation for the individual.

The vocabularies of all societies cut and order the flow of time. . . and when a society divides time into conventional units, it thereby succeeds in introducing periodicities, repetitions, routines and high points into the lives of its members. . . . Turn this statement of institutional action into a statement of identity and you would say that people are sanctioned to be different during different periods (Strauss, 1969, p. 124).

Thus, "transitions" of the self at work deal with those institutional markings which create transformations of identity as well as the career contingencies which influence the nature and direction of such transformations. As Strauss notes, there are sanctions, if not demands for behavioral, attitudinal and associational changes as a function of movement through different positions and statuses. Within this framework, the sociological view of careers focuses on the following ques-

tions: what factors determine individual movement and change? What are the various directions of change at work? How do both the individual and the institution deal with and legitimize various movements and sequences?

Factors which influence the course of careers have been called career contingencies. Perhaps surprisingly, many career contingencies have little to do with actual job skills or knowledge. Instead, ethnic and religious background, social memberships and affiliations and other informal factors have been shown to be decisive in determining career mobility (Dalton, 1951). Sociologically speaking, it may be more important for the actor to display socially valued behaviors than to be completely competent at the job (cf., Chinoy on assembly-line workers, 1964; also cf., Shibutani, 1955). In actuality, getting ahead may be contingent upon belonging to the "right" church, club or political party, or wearing the right clothes, and so on.

Mobility may also be contingent upon having sponsors or mentors who help the individual enact the finer, more subtle aspects of socialization, membership displays, and task performance. The impact of sponsorship on career advancement has been the focus of much sociological analysis. Strauss adopts the metaphor of coaching to depict the nature of this important relationship. "Because the sequence of steps are in some measure obscure. . . someone must stand prepared to predict, indicate and explain the signs" (Strauss, 1969, p. 111). Like a coach helping an athlete with the minute nuances of style, form and strategy, there are those in any occupation or profession who serve an analogous function. One especially important role the coach can play is to sen-

sitize the neophyte to the delicacies of timing and pacing in attempts to move up.

Those who are new to a position often commit the indelicate error of taking formal promotion or certification much too literally, when actually there exist intervening informal stages that must be traversed before full prerogatives of position are attained. This passage may involve tests of loyalty as well as the simple accumulation of information and skill (Strauss, 1969, p. 104).

It is the coach, or mentor, who tests the individual and cues him/her into the subtleties of the position. Clearly, having a coach can make a tremendous difference in how and when one moves up in the work place (cf. Hall, 1948; Becker & Strauss, 1956).

Another career contingency which has received attention in the literature is age. Faulkner (1974), in a comparative study of symphony musicians and hockey players, has shown age to be a critical variable for understanding "both the objective features of career status passage and subjective change in the mobility motivation and occupational outlook of individuals" (p. 132). Faulkner finds that the meanings given by participants to their mobility experiences change as the individual ages. There is a kind of 'coming to terms' with one's career limitations. This is particularly dramatic in fields in which mental acuity or physical fitness are required, as with scientists, astronauts, athletes (Weinberg & Arond, 1952), or fashion models. Several authors note (Becker & Geer, 1961; Davis, 1966; Strauss, 1969) that 'coming of age' at work means becoming more realistic about mobility chances. "Being 'realistic' is a stance that is the mark of occupational adulthood" (Faulkner, 1974, p. 169). Thus, aging produces internal changes about

aspirations and goals. It also leads to a continual revision of one's personal sense of history. The self is repeatedly reconstructed to accommodate new developments.

Each person's particular contingencies serve to push and pull the actor in one path or another. Depending upon what contingencies are in the individual's favor, s/he can move up or down within an organization. One can also move "horizontally" to a similar position within a different organization. Or, one can simply move out. How positions are vacated and filled has been the focus of considerable descriptive research (cf., Becker & Strauss, 1956; Caplow & McGee, 1958).

Attention has also been directed toward an understanding of how both the institution and the person cope with failure at work. Obviously, not everybody moves up the career ladder or plays by all the appropriate rules. There are those who, either because of ineptitude or more likely deviance from implicit norms, become "frozen" at one level or get routed out of the organization. Goffman (1952) provides a useful conceptualization of how failures are dealt with. Borrowing from jargon of the criminal world, he suggests that in all spheres of interaction, there are occasions where a "mark" (jargon for sucker, a person who has been taken in by a con) must be "cooled out." In essence, the "cooler" has the job of handling persons whose expectations and self-conceptions have been built up and then shattered. This is undoubtedly commonplace in work situations.

Goffman's focus is primarily on the interactive components of cooling the mark out. For instance, some common strategies entail: allowing the mark to blow up in order to save face, giving the mark another

chance, or giving the mark another position as a consolation. Caplow and McGee (1958) describe how this process operates in academia. When a faculty member does not get tenure, s/he must reorder his/her values and priorities to incorporate this objective failure. S/he may decide, for example, that teaching is really more interesting and valuable than research and that working at a small college is preferable to being at a large university (cf., Strauss, 1969).

Failure at work poignantly illustrates the subjective reevaluation of goals, motivations and meanings. The organization also must facilitate and legitimize the acquisition of more realistic career outlooks. Aside from the process of cooling the mark out, the organization provides other alternatives for its immobile members. One common role is to become a coach and to derive vicarious satisfaction from others' advances. Sometimes the organization shows special veneration to those who have remained constant over many years. Having an historical, long-term perspective on the organization can give value to a person who has become "frozen" at one level. In addition, Becker (1964) points out that the individual may be able to look to side benefits or investments which derive from staying in one place. This is probably one of the payoffs or consolations that institutions offer to persons who have remained in immobile positions.

It is clear that mobility aspirations become modified by the nature of the movements one is able to effect at work. With every objective, external shift, there are subjective, internally experienced reassessments of one's self and perspectives. When one moves up, one must learn to be different. As one displays these new behaviors, one again experi-

ences changes within the self. Indeed, the process of "role simulation" described earlier is re-enacted time and time again over the course of one's career. When one moves out of one work setting, one must be re-socialized yet another time. And when one fails at work, both the individual and the institution must accommodate. It is out of these ongoing subjective cognitive processes of attribution, dissonance reduction and rationalization that a sense of personal continuity and integrity is maintained. It is because transitions at work have such dramatic impact on the self that the individual must go through such mental acrobatics. This profound personal impact also explains why the institution carefully times and paces the recruitment and replacement of its members and allows members periods of adjustment to new statuses.

Though the sociological literature addresses the issue of personal change in adult life, the individual inner workings of this process still remain somewhat elusive.

It is a sociological commonplace to assert that man actively conceptualizes his work biography, and thereby comes to know the working constitution of the setting in which his career is located. Yet the problem of how this is temporally achieved is seldom posed. It seems as obvious matter that personal change occurs during crucial marking points in occupational lives. It seems equally obvious that the selection and sorting processes within organizational sets will affect the manner and degree to which incumbents align success aspiration with actual accomplishments. But the very obviousness of these phenomena should motivate close inspection of them (Faulkner, 1974, pp. 168-169) (underlining mine).

Thus, the sociological perspective tries to make explicit on a comparative and universal level what seems to go on implicitly on a private, individual level.

This overview of the sociology of work literature presents a particular perspective on the individual in adult life. The perspective assumes that the self is formed and altered in interaction. Normative behavior is demanded by institutions and impersonal social structures, but it is made enactable via the creation and participation in (occupational) culture. The specific focus here has been on work institutions as they affect and are affected by individuals. One key feature of this literature is the emphasis on internal cognitive maps and formulations in both producing and understanding change. Work institutions and occupational outlooks are internalized within the persons, and then projected and reified outside the person as objectified, external reality, paradoxically producing both change and consistency simultaneously (Berger & Luckmann, 1966). It is the elucidation of this dialectic which makes the sociological perspective both objectively and subjectively incisive, meaningful, sensitive and unique in contemporary social science.

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APPENDIX B
INTERVIEW GUIDE

I. Demographic Information

Sex
Age
Educational level
Salary
How long at this job
Other nonprofessional jobs
Race
Political orientation
Voted in last election?

II. Occupational Information

A. The organization/agency

how many people work here?
how many are professionals?
how many are nonprofessionals?
what tasks are you supposed to perform?
what is your job description?
what tasks do professionals perform?
what are the objectives, purposes of the agency?
description of hierarchy, division of labor within organization
(formal layout)

B. Entry of individual into organization

how did you hear about job?
what did you have to do to apply for it and get it?
who interviewed you?
what did they want to know about you? what did they seem to be
looking for in a nonprofessional worker?
how were you prepared for your work? describe
what kind of training did you have?
who did the training?
once you started working here, whom did you find most helpful
in showing you how things really work around here?
what discrepancies, if any, did you find between the formal and
informal ways of operating here?
what were the first few weeks on the job like for you? de-
scribe
how do you recall the job affecting you personally, your self-
concept, your view of yourself?

C. Daily features of work life: Interactions

describe what you typically do during the course of a day--what did you do yesterday?

describe a typical interaction with a client

describe a typical interaction with a professional staff member

describe a typical interaction with another nonprofessional

describe the kind of situation which would lead to conflict with: a client, professional staff member, nonprofessional staff member

with whom are you most closely identified here?

with whom would you be most likely to share something personal?

to whom would you be likely to go if you had some work-related difficulty or crisis? give examples.

how is what you do similar to and different from what the professional staff do here?

with whom do you feel you have more in common--the clients or the professional staff?

who do you think would understand you better as a person--your clients or the professional staff?

describe an occasion where you made a "mistake" at work. what happened? what did you do? who could you be honest with on the staff?

what discrepancies, if any, have you found between what you were told you'd be doing on the job and what you actually do? describe

what changes do you see or feel in yourself which you think are related to your work here?

what is your role when a client and a professional staff member come into conflict?

with whom do you identify? give examples

has this job affected your values, opinions, political attitudes, ambitions? How? describe.

how do you think the clientele of this agency view you? do you think you understand and identify with them?

how do you think the professional staff view you? do they think you understand and identify with them?

how do professional staff treat you? describe interactions

describe how crises and emergencies get handled.

who does what, and who gets credit?

what power do you feel you have to change things?

describe supervision, inservice training, consultation:

who does it, when, how often?

what does it entail?

what are the interactions like?

how helpful is it?

what aspirations do you have for a career in this field?

what are your expectations for advancement?

how do people move up in this system? describe.

what are the differences, if any, between how professionals move up vs. how nonprofessionals move up?

do you feel that your pay is commensurate with the work you do?
is the professionals' pay commensurate with what they do?

III. Provision of Services to Community; Views of the Community Mental Health Movement; Feelings of Cooptation

A. Provision of services to community

from your work in this agency, how would you evaluate the services provided to the people of this community?

do you think the agency accomplished the goals it sets out to?

is it servicing the people who need services? why or why not?

is it providing appropriate and relevant services?

how do you think the community residents who are supposed to be using this agency feel about it? what sort of reputation does it have?

does the community see this place as one which can be supportive and helpful to them?

do you feel that the professionals and the other administrators of the agency have the same goals and objectives as the community residents? how are they the same or different?

how often are community residents consulted about the goals and operations of this agency?

how often are your opinions asked?

what happens to suggestions you make about how the agency should be run?

what changes do you think should be made in the organization, division of labor, distribution of power in this agency?

how is power distributed at present in this agency?

how different did you think this agency would be from how you now see it operating?

how do professional staff talk about community residents?

how well do you think professional staff understand community residents?

B. Feelings of exploitation

how much power do you have in this agency?

what happens to suggestions you voice to the professional staff?

how much do you think you have influenced the professional staff here?

what impact have you had on them?

what purposes has the employment of minority nonprofessionals served, in your opinion?

who has benefitted most, and how?

is yours a "community-controlled" agency?

where does the funding of this agency come from?

what contact do you have with funding sources?

what contact do professional staff have with funding sources?

what happens to you if you find yourself defending the views of

do you feel that your pay is commensurate with the work you do?
 is the professionals' pay commensurate with what they do?

III. Provision of Services to Community; Views of the Community Mental Health Movement; Feelings of Cooptation

A. Provision of services to community

from your work in this agency, how would you evaluate the services provided to the people of this community?

do you think the agency accomplished the goals it sets out to?

is it servicing the people who need services? why or why not?

is it providing appropriate and relevant services?

how do you think the community residents who are supposed to be using this agency feel about it? what sort of reputation does it have?

does the community see this place as one which can be supportive and helpful to them?

do you feel that the professionals and the other administrators of the agency have the same goals and objectives as the community residents? how are they the same or different?

how often are community residents consulted about the goals and operations of this agency?

how often are your opinions asked?

what happens to suggestions you make about how the agency should be run?

what changes do you think should be made in the organization, division of labor, distribution of power in this agency?

how is power distributed at present in this agency?

how different did you think this agency would be from how you now see it operating?

how do professional staff talk about community residents?

how well do you think professional staff understand community residents?

B. Feelings of exploitation

how much power do you have in this agency?

what happens to suggestions you voice to the professional staff?

how much do you think you have influenced the professional staff here?

what impact have you had on them?

what purposes has the employment of minority nonprofessionals served, in your opinion?

who has benefitted most, and how?

is yours a "community-controlled" agency?

where does the funding of this agency come from?

what contact do you have with funding sources?

what contact do professional staff have with funding sources?

what happens to you if you find yourself defending the views of

APPENDIX C

INTRODUCTORY COURSE FOR WHITE PROFESSIONALS WORKING IN COMMUNITY
MENTAL HEALTH CENTERS IN BLACK AND HISPANIC COMMUNITIES

This course is designed to aid the white professional in better understanding and communicating with patients in community mental health centers in the black and hispanic community; to alleviate some of the fears, myths and misconceptions that most white professionals bring with them to the black and hispanic community; to expose the white professional to many support systems in the community of which he or she is not aware and to give the white professional a deeper insight into the patients that they are treating and their environment.

Course Outline

- I. Who Came Before You?
 - A. welfare and social security workers
 - B. police department
 - C. crime organizations
 1. numbers bankers
 2. drugs
 3. prostitution
 - D. white research teams
 - E. white churches
 - F. white landlords
 - G. white storeowners
 - H. white bar owners
 - I. Police Athletic League counselors (PAL)
- II. What Are You Doing Here?
 - A. What does the community think you are doing here?
 1. "Gettin' into my business"
 2. "Gotta be police"
 - B. How do you see yourself?
- III. Communication
 - A. The do's and don't's
 - B. What are we talking about?
 - C. Interpretation of speech (one language versus another)
- IV. Guilt, Fear and "I Never Did a Thing"
- V. Daytime Field Trip into the Community
- VI. Feedback from Students on Field Trip

VII. White Professional's Personal Racism

- A. Discussion of personal problems students perceive for themselves in black and hispanic community
- B. Problems of white man
- C. Problems of white woman

Class Instructor--Black MHTA*

*This course outline was put together by one of the participants interviewed in this study.

