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AUTONOMY OF ORGANIZATIONAL PARTICIPANTS:

A CASE STUDY OF A PSYCHIATRIC HOSPITAL

by

Ivan Foltin

A Thesis

Submitted to the Faculty of Graduate Studies  
through the  
Department of Sociology and Anthropology  
in Partial Fulfillment of the Requirements for  
the Degree of Master of Arts at  
the University of Windsor

Windsor  
1975

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## Abstract

The autonomy of organizational participants is cast in the literature variously as the independent, intervening and dependent variable. Correlational studies and especially experiments show conclusively that work-related satisfaction increases with autonomy, under ordinary circumstances. Productivity does not respond consistently to variations of autonomy or work-related satisfaction.

Autonomy as the intervening and dependent variable is studied mainly in the context of professionalism, conceived of as a motivational syndrome prominently featuring the desire for autonomy. Correlational studies show a congruence between the professional motivation and actual autonomy. As organizations are said to have a built-in tendency to restrict the participants' autonomy, speculative explanations of the above findings deal mainly with the power processes resulting in the professionals' autonomy. The mechanism involved need not be surmised, however. It can be investigated directly. This research represents such an investigation.

In the psychiatric hospital, the basic motivational syndrome leads to conflicting tendencies. The outcome is that autonomy exceeds what the staff consider optimal levels, as the desire for autonomy prevails over the need for treatment coordination. Of the major power resources involved, legal provisions binding on the hospital personnel are the primary autonomy-restricting factor, aided by vulnerability

to the potential fluctuation of the demand for a profession's or an individual's services. Interprofessional competition further reduces resistance to autonomy restrictions. Resources serving to increase individual autonomy prominently include technological uncertainty, an absence of criteria of therapeutic effectiveness, and the availability of alternative sources of clients. The hospital's dual authority structure contributes to increased autonomy by separating the holders of legal authority from the holders of ordinary administrative authority.

The findings can serve as instructions for the manipulation of similar organizations, perhaps with the objective of increasing organizational effectiveness, assuming that the relationship between autonomy and effectiveness can be clarified.

## Acknowledgments

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## INTRODUCTION

The material presented in this thesis covers some aspects of three areas of sociology that are of abiding interest to this writer. Two of these concern theoretical problems of model-building and testing, and the necessary characteristics of the data required in testing of causal models. Essentially, the discussion will concern the question of what does, and reasonably should, pass as a valid process of theory testing and therefore as validated theories-models (causal models in particular). Secondly, we shall examine the question of what reasonably should pass as data, or facts that could be justifiably used in building and testing of models. These two broadly theoretical issues will be discussed relative to the substantive area of interest, namely, the autonomy of members of a particular formal organization (a psychiatric hospital), with special emphasis on the consequences of the various limitations to which the researcher had been subject.

The problem of employees' autonomy in formal organizations was selected because of the impression that it offers one of the most fruitful conceptualizations of formal organizations as autonomy structures. No doubt, the autonomy perspective does not exhaust all conceptual avenues when dealing with formal organizations. Other perspectives, such as those dealing with technology, power, authority and exchange have also proven useful. But viewing organizations as autonomy structures appears to be a major indispensable tool when describing the state of, and changes in, organizations. This research seems to indicate that the various issues interpretable as involving individual and group autonomy are indeed salient in the psychiatric hospital studied. Such

a finding tends to support the claims of autonomy's importance as one of the crucial variables to be employed in causal models of organizational and individual functioning (c.f., especially Blumberg, 1968).

While the autonomy structures appear to be crucial aspects of formal organizations, the organizations themselves are perhaps the most fascinating aspect of social life. Inasmuch as the social order is one of the primary topics of sociological inquiry, organizations can be seen as representing some of the most complex instances of ongoing order. As such, they are among the most important inquiry subjects.

In descriptive terms, "organization" will be understood to comprise the answer to the question of "who does what, when and how" concerning a specific set of mutually articulated activities. "Autonomy", on the other hand, refers to an actor's or a group's "freedom from influence" (Dill, 1958:411). For the sake of clarity, autonomy must always be seen in reference to the actor's freedom relative to specific others and specific decisions or activities. The primary objective of the research reported here is to explicate as much as possible the existing state of affairs within an organization from the viewpoint of individual and group autonomy. In addition, an attempt is made to identify tendencies towards change, the mechanisms leading to changes, and the limitations and obstacles to these various tendencies.

Among the various approaches to the study of social life in general and formal organizations in particular are experimentation and correlational analysis. For reasons to be discussed, neither of these approaches has been selected for the present study. This writer shares the widely held conviction that experimentation is the ideal approach

because it circumvents a number of difficulties faced by correlational analysis, but experimentation with the organization studied in this instance (a psychiatric hospital) was obviously not feasible. Correlational analysis has not been adopted as it seems that the logic of correlational analysis leaves certain problems unsolved, with the strong possibility that the goals ordinarily set in science for that type of analysis are unattainable (for an extended discussion of this view see Appendix A). Consequently, the decision was made to limit this study to things that could be accomplished without experimentation and correlational analysis and yet lead to valid statements about the behaviors and processes taking place in the organization studied. This basically means enquiry into the methods used by participants to manage their organizational environment. More specifically, the focus will be on the organizational members' aspirations, on the pressures and restrictions to which the organizational environment subjects the members, and on the coping techniques at the members' disposal, both those actually used and potentially available. The detailed case study method which was adopted seems to be the most appropriate tool for the study of these problems.

A similar approach to the study of social behavior appears, for example, in the work of Goffman (1959), where the actor is seen as solving technical problems of conveying and testing motives and of establishing and perpetuating stable, concerted activities. On a more analytical level, the problems of producing and maintaining the social world are dealt with in the phenomenologically - oriented sociologies (c.f., Garfinkel, 1967; Douglas, 1970). The importance of detailed attention to the ways in which organizations begin, develop, sustain

themselves and change is recognized also by more macroscopically-oriented sociologists (c.f., Heydebrand, 1973:5-8).

Many aspects of the behavioural techniques used by participants in organizational settings have been described in commonsense terms, such as in the work of Roy (1954) and the "human relations" literature, starting with the Hawthorne studies (Roethlisberger and Dickson, 1939) and later especially the work of Whyte and others (1955). Among the research particularly relevant to the present topic one should mention the studies of "goldbricking" in industry (e.g., Collins et al, 1946, Roy, 1952) which describe some of the methods used by industrial workers to maintain a measure of autonomy. Similarly, Scheff (1961) described various methods used for the same purpose by hospital attendants. Other works supplying useful insights into these problems are those of Gouldner (1954) and Gayles (1958) with their emphasis on methods utilizing primarily collective action.

Of course, there are numerous other case studies or organizations dealing more or less directly with individual autonomy in a similar manner. One characteristic of this literature is the apparent difficulty of pulling the research results together into generalizing statements, and thus moving beyond a number of disjointed observations about the ways in which organizational members maintain or alter their autonomy. A certain modest measure of success in that direction has been achieved in the literature dealing with power and authority. It will be argued that the question of the methods used by organizational members to develop specific autonomy structures can be reasonably viewed from the perspective of power and authority processes. Consequently, the lists and categorizations of power resources (Mechanic, 1962) and authority

resources (Peabody, 1962) that are at the disposal of organizational members will be useful in our present endeavor.

In sum, the intended focus on autonomy results from the conviction that autonomy is one of the crucial aspects of organizational structure and functioning, and that its understanding is necessary both for descriptions and causal models dealing with organizations. Partly because of the writer's predilections and partly because of either the nonfeasibility or inefficacy of alternative methodologies, including problems in obtaining data with characteristics necessitated by those methodologies, the approach selected here derives from organizational characteristics as social accomplishments. Accordingly, the emphasis in this detailed case study of a mental hospital will be on the discovery of the commonsense methods used by organizational participants to achieve their sundry objectives, especially those connected with the maintenance and alteration of the existing characteristics of individual and group autonomy. The primary elements involved in these behaviors are power resources and their use.

The inquiry into the mechanisms underlying organizational autonomy structures is linked to other important foci of interest in the literature on organizations. With respect to some of those interests, this linkage is due to the fact that an examination of the autonomy - underlying mechanisms necessarily produces sets of instructions useful in manipulating the autonomy levels of organizational participants. The ability successfully and consistently to manipulate the organization's autonomy structure is crucial where the causal relationships between autonomy and other variables are concerned, variables such as work-related satisfaction and productivity. The literature on these causal



relationships will be examined because, aside from providing information useful for the immediate interests of the present research, such an examination places the present research into a broader perspective. This perspective tends to emphasize the potential uses of the present findings, and the limitations placed on those uses by the inadequacies of the current knowledge of the causal relationships in question.

The following chapter (Chapter One) contains a review of the literature dealing with autonomy, including experiments, correlational studies and case analyses. A theoretical discussion of the problems of causal inference from correlational data appears in Appendix A. Appendix B contains a discussion of the problem of measurement as it relates to autonomy. The literature on autonomy as well as the current approach should be seen in the light of the material found in these Appendices. Chapters Two and Three contain a discussion of the theory and methodology directly relevant to the present research. In the subsequent chapters, the research findings are presented.

CHAPTER I

A Review of Literature on Autonomy  
in Organizations: Methods, Findings  
and Explanatory Techniques.

In this chapter, an account will be given of the approaches found in the research literature dealing with individual autonomy in formal organizations. Emphasis will be placed on the concerns evidenced in these researches, on the methodologies used, and kind of data gathered, with the view of placing the current research project in relation to other work in the area. At the outset, it is best to elaborate somewhat on the meaning of the term "autonomy" and on the nature of the relevant more specific derivatives such as "work autonomy".

A note on the concept of "autonomy"

A definition that coincides with the general usage in the literature proposes that "autonomy" refers to "freedom from influence" (Dill, 1958:411). It will be argued later that it is impossible to measure total individual autonomy, or total group autonomy, for that matter. At this point the truth of that proposition will be taken for granted, with the consequence that it is always necessary to speak of autonomy with respect to specific others and specific behaviors and decisions. One may attend to the constraints offered by the organizational environment, as Dill did in the above cited paper (1958). The alternative will be emphasized in the following inasmuch as the present research interests have that orientation, i.e., an orientation towards internal organizational autonomy, covering the relations among people conventionally recognized as members of the organization.

Needless to say, the exogenous infringements on the internal affairs of the organization cannot be neglected entirely in research such as the one to be reported here, to wit, research that makes no firm a priori decisions as to the variables whose bearing on internal individual autonomy (or vice versa) is to be examined. This is

especially the case in an organization such as the mental hospital studied which corresponds to what has been referred to as an "heteronomous professional organization" (Scott, 1965), in which externally imposed (such as legislative) constraints and structuring play an important role. In fact, in anticipation of the report on findings it can be said that external regulations had a crucial impact on some of the key aspects of autonomy in the mental hospital in question.

Thus, the main focus of interest is individual freedom from influence with respect to other members of the organization. Basically, we can speak of influence on "what" is to be done on the one hand and "how and when" it is to be done on the other. A distinction cross-cutting these two categories will separate "work" from other behaviors. This distinction should be one of the important symbolic devices used by the organizational members in orienting their behavior and one serving as the grounds for evaluating the appropriateness of the individual's autonomy, and of the attempts at changing that autonomy, among other matters. It should be pointed out that it need not always be quite unambiguous into which category (work vs. other) an item of behavior or decision-making belongs, as the categorization depends on the organizational members' notions, and consensus there need not obtain. Similarly, there may be ambiguity as to whether an issue refers to an objective ("what" should be done) or to a method (how and when something ought to be done).

The things that are to be done (the "what") appear to have an important place in individual autonomy in organizations such as the mental hospital where "each patient is different", (as this researcher has been assured repeatedly) and where both the appropriate techno-

logy and the desired characteristics of the "product" are fairly ambiguous. The work of these organizations is often carried out by the individual alone in the absence of even fairly loose requirements for either the sequencing of operations or the state of the "product" at various stages in the process. Under such circumstances, it is technologically possible for each individual to set the objectives of his work autonomously. This type of decision figures conspicuously in writings on professionalism. Indeed, the emphasis on autonomy in the terms outlined above (concerning the objectives) forms a part of perhaps all definitional treatments of professionalism (e.g., Hall, 1968:93). The current research indicates that the autonomy in terms of the setting of objectives was important in the organization studied, save for the most general formulation of such objectives (that patients be cured, for example).

In contrast to professional organizations with the above characteristics, industrial enterprises with their greater interdependence among various phases of work, more clearcut sequencing of operations (e.g., the assembly line); and more definite criteria for product evaluation, as well as greater uniformity of "raw materials" and more definite technologies seem to lend themselves to a greater emphasis on participation in decision making than on outright individual autonomy, or group autonomy (cf., the review of literature on participation and autonomy in industry by Blumberg, 1968). The difference, however, is one of varying degrees only as issues of all kinds can be found in perhaps any organization.

#### "Participation" and "Supervision Style"

In general, individual work autonomy can be of interest as

a causal, intervening or dependent variable. There is fairly extensive literature in existence dealing with individual autonomy as the causal (independent) variable. It consists of reports on experiments with increasing or occasionally decreasing individual work autonomy, reports of natural occurrences where individual autonomy somehow came to increase or decrease, and reports of correlational studies conceptualizing work autonomy as the independent variable. For the most part, the objective had been to find the effects of autonomy in terms of labour productivity and some indices of work satisfaction such as labour turnover.

A measure of vagueness exists in this literature because of the variety of conceptualizations used. Researchers speak of "autonomy", "participation in decision-making", and "supervision style". Examination of the usage shows that the latter two concepts involve individual and/or group autonomy to varying degrees, depending on the circumstances. While supervision style in all research studies contains an element of the autonomy granted the subordinates, there seems to be more ambiguity as far as "participation" is concerned. A brief comment, therefore on the writings dealing with participation in decision-making is in order.

First it should be noted that the terms "participation" and "autonomy" are quite often used in the literature with a rather excessive faith in their interchangeability (e.g., Blumberg, 1968:ch.5). However, greater participation in decision-making need not mean greater autonomy, nor does it reflect that aspect of supervision style which deals with the degree of autonomy allowed the subordinates. Whether or not participation in decisions is to be taken as an avenue towards,

or a manifestation of, autonomy depends on the terms of the participation. Participation, although real enough, certainly was not a vehicle towards worker autonomy in the experiment with "overcoming resistance to change" (Coch and French, 1948) or with worker input into decisions concerning the setting of production goals (Lawrence and Smith, 1955; for a cynical view of the character of the supposedly democratizing changes introduced in these experiments see Gomberg, 1966).

Since autonomy is here distinguished from democracy or other collective decision-making rules as well as from heteronomy, the literature dealing strictly with participative decision-making is not of direct relevance here. That is to say, the areas in which a person (or a group) can behave on his own discretion in various ways (within certain limits, of course) is of interest rather than situations where outsiders have to be involved in the decision. Still, under certain circumstances, such as when outsiders can be outvoted or if they only have the right to be heard from, "autonomy" would nevertheless be the correct conceptualization of the situation, in the final analysis. The existing studies of participation rarely fall into that category, however, with the exception of studies of worker-managed enterprises (e.g., Adizes, 1971 on the Yugoslav system and Rozner, 1969 on Israeli Kibbutzim). But worker-managed enterprises would seem to present a situation radically different from those to be found in other studies of autonomy and therefore, it does not seem advisable to incorporate that type of autonomy into the present considerations.

One of the often-used conceptualizations of supervision style distinguishes between "close" and "general" supervision (Katz et al., 1950). In this instance the supervisory style is to a large extent

understood as the reverse of individual or group autonomy although the characteristics of the "style" do not all necessarily have a direct bearing on autonomy. For example, merely because a supervisor checks "upon the employees more frequently", which is taken as one dimension of close supervision (Katz and Kahn, 1953:617), does not mean that autonomy is thereby unavoidably curtailed. Closer monitoring does not logically involve lesser amounts of autonomy. It cannot be said, therefore, that the researcher operating with the above conception of supervision style makes it quite clear what can be said of the consequences of autonomy.

#### Autonomy as the Independent Variable in Correlational Studies

Insofar as the measures used reflect individual autonomy, it is relevant here that the bulk of the evidence in correlational studies suggests that general supervision is associated with higher work satisfaction (Weschler et al., 1952; Baumgartel, 1956; Wickert, 1952; Ross and Zander, 1957; Morse, 1953). The exceptions are rare. In one study, no relationship had been found between supervision style and some indices of work satisfaction for large groups of manual workers (Katz, 1963:82), but it appears that in this case the measure of "style" was further away from "autonomy" than in other researches.

A correlational study which actually found a slightly negative relationship between general supervision and job satisfaction was reported by Morse (1953:128 ff) for large groups of clerical workers. This finding led to further research wherein the conclusion was made that the relationship between supervision style and satisfaction is mediated by the supervisor's influence with higher management. With such influence decreasing, the otherwise positive relationship between



general supervision style and satisfaction will be negative (Pelz, 1952).

Another refinement sees the subjects' personality as intervening between supervision style and satisfaction. It seems that controlling for personality (authoritarianism) does differentiate among groups that manifest the same relationship between "style" and "satisfaction", but to varying degrees (Vroom, 1960).

A different conceptualization of supervision style than the one used in the abovementioned studies appears in the work of Fleishman and Harris (1962) who came to differentiate supervisory style along the dimensions of "consideration" for the subordinates and "initiation of structure". The latter can be seen as reflecting the existing subordinate autonomy to a considerable extent, because most of the items (questions) making up the scale of "initiation of structure" refer clearly to the subordinate's autonomy in various respects (for scale construction, see Fleishman, 1957). The findings indicate a generally negative relationship between initiation of structure and indices of satisfaction (grievance rate, turnover), except under special conditions: when the supervisors scored low on "consideration", the relationship in question was positive, i.e., the higher the score on "initiating structure," the higher the job satisfaction.

In addition to work satisfaction, morale and the like, most of the research mentioned so far has also dealt with the effects of supervision style and thus, to a certain degree, the effects of autonomy on productivity of labour. As far as correlational data are concerned the evidence on this point seems to be mixed. Kahn (1956) for example, showed that in the studies of railroad workers and clerical workers, "general" as opposed to "close" supervision was related to productivity

(and the concept of "general" supervision contains an autonomy dimension with a higher degree of autonomy than is the case for "close" supervision).

But the evidence supporting the proposition that autonomy will lead to higher productivity does not go uncontroverted in correlational studies, even though there has been some disregard of this contrary evidence in generalizations drawing on the research literature (e.g., Likert, 1961). Thus, Argyle et al (1958) failed to find a relationship between autonomy, as reflected in supervisory methods, and productivity. Similarly, supervisory style was found unrelated to productivity in another study by Fleishman et al (1955) and the authors propose that, depending on the degree to which the schedules faced by supervisors are demanding, a greater degree of "initiation of structure" (which entails lower autonomy) may actually result in higher productivity (Fleishman et al. 1955:99).

Another conclusion that emerged from these findings was that the correlation between supervision style and productivity will depend on whether we are speaking of production or non-production departments (Fleishman et al., 1955:103). These varying productivity correlates of supervision style contrast with the style's relationship to satisfaction, which is invariably the same - less initiation of structure is accompanied by higher satisfaction. The observations from these studies were used to infer a still more general explanation by Dubin (1965) who suggested that the relationship between supervision style and productivity will depend on the technology involved, which was differentiated, following Woodward (1958), into "unit", "batch", and "mass" technologies. High "initiation of structure" was said to be

compatible with mass technology (Dubin, 1965:38).

The correlational analyses inquire into the characteristics of organizations that can be assumed to have achieved a more or less steady state of routine operation. The evidence seems to suggest that, in terms of the relationship between autonomy, or supervision style reflecting the autonomy of the subjects on the one hand and job satisfaction and productivity on the other hand, job satisfaction is more often directly correlated with autonomy than is productivity, with only infrequent and relatively small exceptions having to do with personality and the supervisor's influence with higher management, as has been noted.

The relationship between autonomy and productivity is more complicated. The reports indicate that steady states can develop, depending on the circumstances such as time pressures and technology, such that the relationship in question varies in its character (direct or inverse), or else appears to be absent, such as in the study of supervisory behavior (style) and the effectiveness of middle management personnel reported by Fleishman and Peters (1962). Of course, two characteristics of the researches in question should not be disregarded, namely, that they concern only autonomy levels found in a natural state in ongoing organizations and that, therefore, all the variations of autonomy (highest and lowest levels found) were presumably within culturally tolerable and conventional limits. Secondly the differences always involved relative comparisons of group or individuals in single organizations which are again likely to have been within customary limits. Consequently, these studies do not necessarily indicate the equilibrium which will be reached by organizations subjected to

experimental manipulation of autonomy. Some other reasons why correlational data need not be good predictors of experimental results are outlined in Appendix A.

#### Autonomy as the Independent Variable in Experiments and Quasi-Experiments

There are a number of accounts in the literature of events and processes in organizations that involved some changes in autonomy. In most cases, however, the changes in autonomy were only a fraction of the events described and there are, therefore, difficulties with unravelling the causal links involved. An example of a rather complex process, a part of which can be interpreted as erosion of workers' autonomy which resulted in lowered productivity, dissatisfaction and finally a wildcat strike has been described by Gouldner (1954:68 ff). To estimate the consequences of decreased worker autonomy would be a difficult if not impossible task as managerial and technological changes in the whole pattern of labour - management relations, and worker autonomy had been only one aspect of it, although not an unimportant one.

Some of the literature dealing with such complex, non-experimental cases will be discussed later. At this point, attention will be confined to experiments and "natural experiments" where a change of autonomy is more clearly the starting point, although some difficulties are to be found in most of the reports to be reviewed. For example, Babchuck and Goode (1951) report the results of changes in the structure of a workgroup carried out by a group of salesmen in a department store. The changes included an increase in the group's autonomy relative to the management and the adoption of radically new internal group arrangements. The result was higher

job satisfaction and higher productivity. However, it cannot be said what the contributions of the two changes respectively were.

Experimental studies and some reports of natural experiments deal with more simply conceived variables than do the correlational studies and also tend to examine simpler causal models (i.e., models consisting of fewer variables). The results of these experiments are somewhat more consistent than those of correlational studies. Thus, there is the report by Strauss (1955) on a group of workers in a toy factory who were given control over the speed of the conveyor belt with the result that job satisfaction and productivity increased considerably. When this increase of autonomy was subsequently revoked by the management because of the dissatisfaction of workers in other departments whose wages fell behind those of the group in question, satisfaction of that group plummeted and three-quarters of the group's members quit shortly thereafter.

A series of experiments with worker participation in decision-making, provides further data conforming to those previously discussed. In these experiments, increased worker autonomy and participation resulted in higher work satisfaction, lower turnover and higher productivity, both under unchanging conditions of production (Lawrence and Smith, 1955) and in situations involving changes in job content (Coch and French, 1948). Although it has been suggested that perhaps the "participation" or greater worker autonomy lacked real substance and was rather a more or less clever manipulation in the worst spirit of "human relations" (Gomberg, 1966), it would appear that certain decision-making functions were indeed transferred to the workers who made suggestions on the job re-design that had previously been carried out solely by the management. The mere fact that the management

would hardly have been willing to implement any and all conceivable suggestions does not mean that the workers acquired no new latitude in decision making. On the other hand, there were strong overtones in these experiments of changes in the atmosphere and in the "courtesy" elements in the plants. These often consisted of apprising workers of proposed changes and soliciting or at least listening to their comments. Insofar as these behaviors connote changes in the social status characteristics of the participants, as would appear to be the case, it must be noted that the consequences of autonomy changes alone were contaminated in these experiments.

There is apparently only one exception in the literature to the otherwise consistent findings of experimental studies. The exception concerns an experiment in participation in a Norwegian factory (French et al., 1960). The authors suggest that the cultural characteristics of the organizational participants matter, that higher autonomy or participation in decision-making are not necessarily seen as appropriate or desirable by the prospective recipient of higher autonomy and that, therefore, the response usually found need not always result. In the Norwegian factory, for example, increased participation resulted in somewhat higher satisfaction and more favourable worker attitudes towards the management, but there were no changes in productivity at all. The explanation offered drew on the findings in the literature on restrictions of output in industry suggesting that workers develop and by and large adhere to a traditional norm of what constitutes a "fair day's work" (cf., Mathewson, 1931; Roy 1952), and that this norm prevented productivity increases.

In the above studies the causal variable was a rather complex mixture of changes in supervisory demeanor and the routines followed

in decision making, involving especially consultations with the people affected by the decisions, as well as increases of worker autonomy that were rather vague with respect to their content and extent. More satisfactory from the viewpoint of studying the effects of autonomy increases and decreases was a study by Morse and Reimer (1956), as the changes apparently involved reasonably definite areas of work as well as non-work autonomy. The experiment consisted of increasing the autonomy of several highly similar sections of a large office and decreasing the autonomy of several other sections in the same office. The resulting work satisfaction varied directly with autonomy. Productivity, however, increased in sections of either type and, in fact, slightly more on the average in sections with decreased autonomy than in those with increased autonomy (14 and 10 per cent respectively; Morse and Reimer, 1956:128). This indicates that, under some circumstances, even a decrease in autonomy can improve productivity.

The results of experiments and of natural experiments show, then, consistent results in terms of the relationship between autonomy and work satisfaction (or morale, as a broader concept), but a somewhat problematic relationship between autonomy and productivity. Correlational data are still more ambiguous as not even the relationship between autonomy and satisfaction appears consistently. It would seem, therefore, that since undisturbed organizational systems can exist without manifesting the relationships indicated by experiments, the very act of manipulating individual or group autonomy is significant to the organization members.

#### The Limitations of the Reviewed Evidence

From the viewpoint of the definitions of "causal model"

and "proof" discussed in Appendix A, the proposition that an increase in autonomy will result in increased work satisfaction appears to have been adequately demonstrated as correct in the experiments, while the correlational studies indicated that the effects of the change need not persist indefinitely. The adequacy of the proof can be argued on the grounds that we can, without undue difficulty, recognize a change in autonomy as well as a change in satisfaction in terms of turnover, for example, or the relative satisfaction as expressed by the subjects. It is also possible to increase and probably also decrease (though with more difficulties, perhaps) individual or group autonomy. Thus, the proposition in question offers operational guidelines for achieving certain objectives and testing has shown the consistent success of the manipulation.

A limitation on the generality of the proof stems from the observation that in none of the experiments has the new level of autonomy exceeded what ordinarily would be recognized as a point beyond which the subjects would lack the competence to assume the decision-making role entailed by the new (higher) level of autonomy granted them. On the assumption that a certain level of performance will be required after the autonomy has been increased, too much autonomy in the above sense might adversely affect work satisfaction by making adequate performance too difficult. Naturally, there may be other reasons why the replication of the experiments might disappoint these expectations, but it appears that, using common sense as a guide, replications have met with full success so far. The theories, therefore, proposing that an increase in work satisfaction will be achieved by increasing work and non-work autonomy, are sound within what has been recognized as realistic and reasonable limits.



The theoretical rationales used in the research studies cited use the notion that autonomy is psychologically satisfying as well as socially valued, with the latter perhaps as a consequence of the former (e.g., Blumberg, 1958:129-131). Thus, the theory involved is very simple and of itself has few entailments. Nevertheless, it can be used as one of the considerations in any project involving people such that some of the causal manipulations or their consequences (outcomes) involve what could be interpreted as changes in autonomy. It should be noted, however, that the usefulness of the propositions in question is hindered by the nature of the data used to test it. More specifically, because of the inadequacies in the measuring techniques the precision of predictions is seriously impaired.

The theory proposes that work satisfaction is a function of autonomy. Ideally, one should be able to specify this function within a coordinate system. Unfortunately, the measurement techniques are so inadequate as to offer no prospect of doing so whatever. The measurement problems are discussed in greater detail in Appendix B. The views expressed there suggest, in brief, that when measuring abstract variables (such as autonomy) that have peculiar historically and circumstantially bounded manifestations, certain requirements will go unfulfilled. Firstly, it will not be known whether the measure is correlated with the true value of the abstract variable, thus making generalizations questionable. Secondly, even correlations among measures made up of a number of items are suspect, unless the items form a Guttman scale, which is not the case for autonomy (cf. Engel, 1970:16). Thirdly, unless a Guttman scale is used it is impossible to know from the score on a scale what the actual social

situation is like even if that concerns the same situation from which the score was derived. For different situations, it is impossible to infer the state of affairs corresponding to a score even on a Guttman scale. All that can be managed is a simple statement of more or less autonomy in specific instances. But for that purpose a literal description is quite adequate. Other measurement would be superfluous. For these reasons, the decision has been made to confine the contemplated research to a literal description of autonomy.

#### Autonomy as the Intervening Variable

Up to this point, the literature conceiving of autonomy as the independent (causal) variable has been examined. A less extensive body of literature treats autonomy as the intermediate and/or dependent variable. In view of the usual approaches to causal theories it would seem peculiar to use the separation between theories using autonomy as independent and dependent variable, i.e., when it is specified a priori that autonomy is either the cause or the effect. After all, the decision about which is the cause and which is the effect is one of the perennial problems in correlational analysis. Autonomy had been cast as the independent variable in all of the correlational studies reviewed so far. It must be conceded that no evidence had been offered there of that particular causal direction. Yet, it is obvious that in any of those cases the existing level of autonomy may have been the consequence of the presumably dependent variables. That is precisely the contention based on an "experimental object lesson in ambiguity of correlational data" provided by Lowin and Craig (1968) who conducted an experiment where performance (productivity) was experimentally manipulated, i.e., cast as the

cause and it was found that leadership style, including its autonomy-granting component varied accordingly. The writers used these findings to criticize the assumption that autonomy is the independent variable in the relationship with productivity.

Now, this criticism is largely sound, in that it shows that the state of affairs found in correlational studies may have been the result of independent manipulation of productivity rather than of autonomy. In experimental studies the variable that is being manipulated is the causal variable irrespective of the possibility of conducting experiments where the originally dependent variable itself is manipulated.

Because of the problems the researchers studying the effects of autonomy had set out to solve, only the conception of autonomy as the independent variable made sense. Not only was the question there one of influencing satisfaction and productivity but autonomy was the only one of these three variables that the researchers were in any position to manipulate at will. Productivity could not have been manipulated directly; to manipulate it, another causal model would have been needed. Granting that a causal model is the answer to a practical question about the achievement of some objective, it was quite legitimate to disregard the possible reciprocal relationship between the variables.

Ordinarily, autonomy as an intervening or dependent variable is studied either as the effect of some other variables or as the historical result of activities, events, power struggles and the like. Of course, the latter can be recast into conventional causal theories employing variables and the manipulation of variable values. The causal-variable models deal mostly with motivation and bureaucratiza-

tion as the causal variables. Because the motivational aspect used is almost invariably "professionalism" (even though professionalism is said to have a "structural" component - a professional association, etc. - in addition to the attitudes/motivations, cf., Wilensky, 1964; Caplow, 1954:139; Hall, 1968), quite often the dependent variable will be "alienation" and the like. The general principle underlying this relationship is that bureaucratically restricted autonomy and other characteristics of bureaucratic organization will frustrate the realization of the various motivational components of professionalism, thereby leading to feelings of alienation in the individual.

Speculative writings had postulated the conflict between professional motivation and the bureaucratic organizational environment. These expectations were borne out both by anecdotal and to a certain extent by statistical evidence. Among the theoretical writings one might mention Gross et al. (1958), Thompson (1961), and Scott (1966). Especially Scott's paper is a reasonably complete as well concise statement of the conceivable reasons for conflict between the professionals' attitudes (motives) and the realities, requirements and limitations of larger (bureaucratic) organizations. That this literature is relevant here is due to the fact that the concept and measurement of bureaucracy used logically implies (as distinct from causing) differing levels of professionals' autonomy, (e.g., measures of bureaucracy used by Hall, 1967 and 1968). Only occasionally is an index of "bureaucratization" employed that uses no elements that could be directly reinterpreted as referring to autonomy (e.g., the number of levels in the hierarchy in Engel, 1970).

With the exception of case studies and anecdotal evidence, the testing of the above propositions generally takes the form of

measuring the "attitudinal component", and sometimes also the "structural component" of professionalism (see Hall, 1968, for a discussion of both) on the one hand and measuring the degree of bureaucratization on the other, using a varying number of dimensions of bureaucracy. Occasionally, the "bureaucratic orientation" (attitudinal) of the respondents (Sorensen and Sorensen, 1974), or the supervisory style (Scott, 1965) will be used as the autonomy limiting factor.

It might be noted that the measures used, insofar as they purport to measure abstract concepts, suffer from all of the measurement deficiencies discussed earlier. Only with respect to some of the measures of the dimensions subsumed under the general concept does this not apply. For example, one of the dimensions may be the extent to which the organization is governed by written rules. If nothing more is intended than that the number of rules on the books is to be measured (Engel, 1970:14; Hall, 1967:463), validity is no problem. The theoretical worth of such a measure is somewhat suspect, however, since the relationship between the single count of rules and the actual functioning of the organization in terms of the use of the written rules is far from non-problematic as the rules may be neglected or used discriminately (see, for example, Strauss et al., 1963, on the use of formal rules in psychiatric hospitals).

A number of studies have come to the conclusion that, indeed, higher restrictions on the professionals' autonomy are correlated with dissatisfaction and the like and that the stronger the motivation (professionalization), the higher the dissatisfaction, in a variety of settings, including social work agencies (Scott, 1965), industry (Miller, 1967), the military (Daniels, 1969), nurses and physicians in hospitals (Ben-David, 1958; Corwin, 1961), and public accounting

agencies (Sorensen and Sorensen, 1974). These studies differ only slightly from those reviewed earlier which used autonomy as the independent variable. There are some differences in the research interests in that productivity was quite neglected where professionalization was used. This shift in interest occasions cynicism, considering that the studies have been conducted by professionals, even though it must be admitted that in professional organizations measurement of productivity is likely to be much more difficult than in industry. Otherwise, the difference mainly rests in normally casting motivation as the independent variable whereas in the industrial studies motivation has been used as a "human nature" condition which one merely took into account because it could not be avoided.

The findings of the above-cited literature on professionalization are neither particularly interesting nor enlightening as they merely belabor the commonsense platitude that, if people cannot realize their wishes, they may well be or become dissatisfied. Neither is it a particularly notable advancement of knowledge to observe that things like that occur in a variety of organizational and occupational settings.

#### Autonomy as the Dependent Variable.

There is another group of studies dealing with professionalization and autonomy, in which autonomy (or bureaucratization) is not seen as a more or less independently changing variable which, for example, combines with certain motivations to produce alienation, but rather as the end result of a process of realization of the given motivation. This result will not only depend on the circumstances but is also causally dependent on the motivation to a large extent. This orientation brings us closer to the interests that informed

the selection of the research to be reported later in this thesis. There the topic also concerns autonomy as the result of organizational members' motivation and activities, given the overall conditions under which the process takes place.

Of the studies expressing these concerns, several correlational analyses will be discussed first. These studies present, in several forms, data on the relationship between professionalism and individual autonomy in larger organizations that are, as a whole, and for various reasons and to various degrees, bureaucratized. The strictly correlational studies present evidence for the less than astounding proposition, one that has been offered as the conclusion or finding by one writer, that apparently "the nature of the occupational groups (in terms of professional attitudes) in an organization affects the organizational structure." (Hall, 1968:104). In one of these studies Hall (1967) dealt with the "degree of bureaucratization" which, in terms of the measures used was in some respects the antithesis of professionalism and especially of professional autonomy. According to the findings, professionals were not significantly more likely to find themselves encumbered by bureaucratic rules (or, conversely, low autonomy) if they worked in professional departments of larger organizations than if they worked in independent organizations composed largely of professionals.

Apparently, then, professionals in large bureaucracies can isolate themselves from their bureaucratic organizational environment and work under conditions not particularly antithetical to their attitudes as professionals, or under conditions not unlike those found in organizations composed almost exclusively of professionals.

A later study by the same author (Hall, 1968) of a number of organizations suggests that although on the average professionals in larger organizations will find their autonomy as indicated by some indices of bureaucratization, significantly lower than professionals in independent professional organizations (such as law firms), a wide range of situations will be encountered in the larger organizations, depending on the circumstances. In some cases, the professionals' autonomy may be fairly high while in other cases the professionals apparently may be unsuccessful in their (hypothetical) attempts to increase their autonomy.

In a study examining the relationship between overall degree of bureaucratization in an organization and several aspects of professional autonomy (Engel, 1970), it was found that no appreciable correlation existed between the two variables, not even when a variety of controls were used. The measure of bureaucratization consisted of the number of hierarchical levels and the number of rules, regulations and forms to be filled out existing in the organization. Since especially the latter index can be seen as unequivocally referring to issues of individual autonomy, it seems to indicate that the professionals in the organization either neglect the rules, etc., or that these rules are not applicable to them. Under those circumstances, therefore, the professionals need not feel their autonomy is low (autonomy in Engel's study was measured by asking the respondents to evaluate their own degree of freedom in various respects, rather than by using indicators of autonomy).

Needless to say, to a certain extent these findings may be the artifacts of the measurement procedures but it does not seem



surprising that professionals should be able to realize some of their goals even within large organizations. Indeed, there are indications that perhaps professionalism (as a motivational syndrome) encounters lesser resistance and influences bureaucratic organizations to a greater degree than would seem indicated by the above studies. This conclusion emerges from a longitudinal study of the managers in a service organization (Haga et al., 1974), where it was reported that subordinates were allowed great latitude in choosing the ways to do their jobs according to their inclinations. Various individuals in supposedly identical jobs came to perform these jobs in a great variety of ways without coming into conflict with their supervisors who accepted the ways in which individuals behaved without attempting to impose uniformity on the organization. The researchers were able to show that the end results were largely congruent with the initial attitudes, i.e., the routine that developed in the organization studied by Haga et al. (1974) was consistent with the ways in which the respondents had envisioned their jobs when the organization was being established, even though there were wide differences among the individual views.

Thus, organizations may have enough flexibility to accommodate a broad spectrum of attitudes by allowing these attitudes to be translated into corresponding behaviors. But this flexibility is not necessarily automatic. Various processes may be involved in the development of the situations described in the above-cited studies.

#### Autonomy in "Descriptive" Studies

The contrast between the last of the studies mentioned

(Haga et al., 1974) and the correlational studies using autonomy as an intervening or dependent variable is important because of the differences in the approaches to explanations. It had been proposed that a causal explanation specifies a set of variables and the way of accomplishing certain objectives in terms of the altered values of some of these variables (effects) through manipulation of other (causes). The expectations are the logical entailments of some basic premises employed in the theory - explanation. If no actual manipulation is performed in a given situation by the researcher, the explanation of a state of affairs consists of identifying the causal relationships that came into play in the process between a specified departure point and the end result - the situation to be explained.

Ordinarily, it is impossible to use only experimentally tested causal models in explanations since there are very few available. In respect to autonomy levels as the end products of organizational events there is, to this writer's knowledge, only Lowin's and Craig's (1968) study showing that experimentally manipulated performance can influence the autonomy level granted subordinates. This paucity of experimentally tested propositions does not mean, however, that the various explanations found in correlational studies cannot be valid. But more importantly, neither does it mean that other methods of finding valid explanations are unavailable.

Given the use of certain types of premises and explanatory techniques, explanations may be shown adequate without special experimental testing, with the necessary non-experimental empirical support. In general terms, explanations based on such support can

be found in detailed case studies, usually referred to as "descriptive" studies. This term is something of a misnomer, however, because explanation is a prominent part of studies of that kind. And while the explanations in "descriptive" studies often differ in principle from those used in experiments, frequently they are identical with explanations found in correlational studies. Indeed, the latter draw on "descriptive" studies as a source of explanations.

The Haga et al. (1974) study is one example of an informative "descriptive study", although it paid insufficient attention to the explanatory detail. Of the great number of other "descriptive" studies which analyzed the behavior and the commonsense reasoning that led to various organizational arrangements (or structure, including the structure of autonomy) one should mention as examples the various studies of "goldbricking" in industry (e.g., Collins et al., 1946; Roy, 1952) which deal precisely with the techniques of maintenance of a certain level of autonomy by industrial workers. Similarly, Scheff (1961) described the techniques used by mental hospital attendants to control certain aspects of organizational functioning, as did Sykes (1961) with respect to the relationship between prison inmates and guards. In either case, one party to the relationship maintained or augmented a degree of discretionary control over its affairs in the face of attempts to curtail that control.

Various other writings using a similar methodology touch upon the issue of individual or group autonomy in organizations as one of their concerns. Most notable here is the work of Gouldner (1954), Dalton (1959) and Sayles (1958). These writers dealt extensively with various processes in formal organizations that resulted, among other things, in changes of the autonomy structure,

or in perpetuation of that structure in spite of attempts at changing it. In these processes, the actors were seen to use a number of resources to further their objectives and a number of resources to further their objectives and a number of methods, including collective action, covert activities, etc. However, the findings reported in the "descriptive" case studies are rather difficult to incorporate into a coherent theoretical whole. At best, they seem to make possible an ad hoc list of resources used by organizational members to promote some of their interests. Therefore, these findings will not be discussed in greater detail at this point. A theoretical approach that appears somewhat to bind the findings of the various case studies together is one focussing on power and authority. Those two perspectives will be discussed in the next chapter. There, more attention will be devoted to the relevant research findings. At this point, attention will be given to the fundamental premises on which the explanations found in the research reviewed so far are based.

#### On the explanatory techniques in the reviewed literature

Without exception, the explanations employed in the reviewed research postulated a certain motivational make-up of the "actors". This psychological variable was in some studies merely taken for granted, while in other explicit attention was given to the "authoritarianism" of the actors. In the last series of reviewed studies, the motivational syndrome referred to as "professionalism" was used. In some of those studies the dependent variable was also psychological, such as satisfaction or alienation. In these cases individual or group autonomy were seen as conditions who characteristics could

apparently vary more or less independently of the psychological factors. Accordingly, autonomy was not cast as causally dependent on the subjects' motivation and satisfaction. The assumption seemed to be that the autonomy level of organizational members is fully at the discretion of the management, or that the bureaucratic nature of the organization is somehow causally prior to the members' motivations. Neither the research built on these assumptions, nor the almost exclusively psychological explanations used therein are of particular interest at this point. The class of research and explanations that is relevant has the common feature of viewing the social relationships or some elements of the social structure as the dependent variable or outcome. Autonomy is one of such structural outcomes. Although the explanations in these studies also start with or at least imply motivations of some kind, operation with psychological variables alone is generally deemed insufficient, perhaps because it is obvious that the state of affairs is not, or at least is not recognized as, or assumed to be, a simple unproblematic realization of the actors' motives. The path between the motives and the existing social structure is seen as more or less complicated and obscure.

This path is generally portrayed as being influenced by the plurality of existing motives, by technical problems, social skills and social resources, non-social resources, etc. To wit, the explanations refer to the activities of the actors. The behavior that assumedly occurred and that explains the given state of affairs is basically seen as commonsensically rational, i.e. as involving ordinary motives, ordinary knowledge of means-ends relationships, and ordinary decision-making criteria. Thus, the explanations generally operate with notions not incomprehensible to laymen. Of course, reference here is not made to broadly theoretical

writings on organizations but only to those concerned with various more specific matters, such as professionalization, or to the speculative rationales found in research reports where they are used to generate and modify hypotheses and interpret findings.

The explanations offered may be more or less simple, at least in principle, and contain more or less broad inferences. In the researches where the conclusion has been made that professionals in organizations do not necessarily find their autonomy inordinately restricted and incompatible with their aspirations as professionals, extensive speculation is offered to account for that state of affairs (Hall, 1967 and 1968; Engel, 1970). The same general approach to explanation is used in all of the correlational studies cited so far, as the speculation there relies heavily on the reasons organizational participants may have had for their behavior, the resources used by the participants (as individuals or variously grouped) to pursue their ends, the pressures of interests, objectives and circumstances, etc. A very similar approach is taken in other research reports explaining findings about the relationships among various aspects of the organizational role structure such as size, hierarchy, division of labor, centralization, administration ratio, etc. (e.g. Blau et al., 1966; Indik, 1964; Blau, 1968; and countless others).

There are two points to be made about the explanatory techniques used in the above-cited writings. Firstly, while they all have the common feature of operating with a body of (assumed) ordinary human motives and with knowledge of the commonsense rationality is outlined above, they also are extremely opportunistic and erratic, showing little systematic reliance on any particular theoretical framework designed for use in explaining organizational behavior. With respect to this first point it should be

emphasized again that it holds not so much for the theories from which hypotheses are derived but rather for the ex post facto explanations of findings which, as a rule, are unlikely to support the original hypotheses. In the attempt to explain the findings use is often made of ad hoc ideas that appear to serve the purpose.

The second, and crucial point is that a large portion of the speculations comprising the explanations of findings is potentially testable by detailed in-depth studies. That is to say, the correlations allegedly explained by the speculations are not the only available tests of the explanations' validity, nor is it necessary to test these explanations by correlationally testing other hypotheses entailed by the same theories. Neither is it always necessary to test these explanations experimentally.

As has been noted, case studies are sometimes condescendingly labelled as "descriptive" since the information thus gathered appears to be far removed from large-scale generalizations, social laws, and the like. Now, it is admittedly a defect if large-scale generalizations cannot be drawn on the basis of the available material. However, this possible drawback seems to be outweighed by the potential of the detailed case studies to test (establish as facts) what in large-scale correlational analyses are merely speculations about the processes responsible for the situations reflected by the data. Generally speaking, this possibility exists insofar as the speculations involve commonsensically rational behavior, since detailed studies can establish the facts of that behavior from observations and interviews, describing the things that happened and how they are viewed, talked about and reacted to. And explanations employing commonsense rationality can be seen as sociologically legitimate and adequate because an account of the reasons for behavior may be accepted as its explanation.

Furthermore, knowledge of commonsense rationality can certainly serve as a basis for interference in the natural course of affairs, thereby opening the possibility of further, this time experimental testing, as against simple learning of facts about the commonsense rationality. Parenthetically, in anticipation of a future argument, it should be said that commonsense rationality can hardly be studied apart from actual social action which means, in essence, quasi-experiments (or "natural" experiments).



## Chapter II

### Formulation of Research Objectives and the Theoretical Foundation

### A general formulation of research objectives

The research reported in this thesis has the objective of explicating the mechanisms responsible for the particular autonomy structure found in the organization studied (a psychiatric hospital). It has been suggested in the preceding chapter that correlational analysis suffers from certain crucial inadequacies stemming from problems with causal inference and data validity, and was therefore not adopted for this project. One of the alternative approaches is experimentation. But since experimentation with the studied organization was obviously not feasible, a methodology was chosen that does not require experimental testing and one which can often be substituted, as has been shown in the preceding chapter, for correlational analyses. To a considerable extent, the study of commonsense rationality<sup>28</sup> fulfills that condition, as it relies on natural quasi-experiments and often results in the same sort of explanations as those used in correlational studies.

An explanation drawing on commonsense rationality is adequate, of course, only if certain limited purposes are to be served. For some purposes other forms of explanation may have to be sought, e.g., those referring to psychological functioning, social-structural pressures and functions, etc. While attention is rarely paid to the precise limitations on the questions to which explanations are answers, as mostly the problem is formulated as searching for explanations without specifying the sort of objectives the explanations

ought to enable us to achieve, the limits of explanations detailing the characteristics of the commonsense functioning are not very difficult to appreciate. Since a general formulation of such limits is unavailable, they will have to be discerned in each instance separately. Basically, the question always concerns the things that can be accomplished by a manipulator, given the knowledge comprised by the explanation, including the premises and the variables contained therein.

The desirable characteristics of the data and the data-gathering methods are described in Chapter III. This chapter concentrates on the theoretical considerations involved in the study of the mechanisms responsible for the existing autonomy structure. The central theoretical perspective to be used draws on the notions of "power" and to a lesser extent, "authority". The individual autonomy will be largely seen as the resultant of power processes in the organization as they are based on the utilization of a variety of resources by organizational participants. As examples of resources we can mention expertise, the legal framework, formal position, and social relations.

The theoretical writings on power contain what is, in effect, a number of propositions testable in detailed case studies. The current research effort is such a test, in a sense, with the possibility of extending the knowledge of power processes contained in the theoretical formulations. Of course, the fact that a case study is used places

various limitations on the kind of testing that can be carried out. It largely has to be confined to finding instances (or an absence) of processes suggested by theoretical studies and perhaps identifying instances of new ones.

The emphasis on the study of commonsense rationality distinguishes especially ethnomethodology (cf., Garfinkel, 1967; Manning, 1970; Zimmerman and Pollner, 1970) and recently phenomenological sociology (for a general discussion of the application of phenomenology to the study of formal organizations see Jehenson, 1973). Although these two similar theoretical approaches to the study of social life can be profitably used to sensitize the researcher to the tentative and problematic nature of social structures in general and organizational structures in particular (see especially Manning, 1970), the existing research informed by these two approaches has yet to demonstrate its superiority to ordinary sensitive descriptions. The existing work (e.g., Jehenson, 1973) has not produced results appreciably different from or superior to those achieved elsewhere in the literature. For example, the usual assumption of relative rigidity, explicitness and clarity of organizational structure in correlational studies which is made suspect by ethnomethodology on theoretical grounds has been challenged by conventionally-oriented researchers following detailed case analyses. Instances of this can be found in

the previously cited study of the influence of professionalism on role (job) content by Haga et al. (1974: 131-2), or in the somewhat generalized conclusions about organizational processes based on a detailed study of the "negotiated order" in psychiatric hospitals (Strauss, et al., 1963), including the negotiated autonomy levels (although the employees' methods described were often underhanded, indirect and would probably qualify more as power struggles than negotiations).

In the following, then, the theoretical foundation will be discussed which served to orient the research effort to be reported here. In broadest terms, this theory will consist of the "power" and "authority" perspectives which rely largely on the material gathered in the above-mentioned and similar case studies. The basic explanatory premise will consist of viewing behavior as commonsensically rational and the autonomy structure as the product of such behavior.

#### The conception of "organization"

The first point to be discussed concerns the conception of the organization to be adopted, as that conception defines the scope of interest in addition to orienting, to some extent, the research effort and informing the analysis. The boundaries of the organization will be seen in a perfectly commonsense manner. The reasons for this largely is the fact that even though there have been a number of very

elaborate attempts (Smith, 1972) in the literature to define the organizational boundary "analytically", ". . . ultimately, the commonsense boundaries of organization are accepted . . ." (Georgiou, 1973: 305). This is so because the analytical criteria for identifying organizational boundaries are extremely difficult to operationalize, if operationalization in principle is at all possible. Thus, starting with a core of people who are obviously ( or by arbitrary definition) members, the relationships of others to the core members can be described and certain types of relationships can be selected to distinguish members. In an organization such as the mental hospital the relationships of various people to any selected core are of different types and the arbitrariness of the boundary becomes apparent from descriptions of those relationships.

The organization thus identified will not be said to have a "goal" since, in this writer's view, the imputation of a goal (in ontological sense) to the organization is not an analytically effective device but only a cumbersome reification, or at best a step demonstrating too much deference to the managerial perspective. (for a similar view see Cyert and March, 1963: 28; and Burns, 1967: 122-123). Of course, it is not suggested here that this perspective is suitable for all conceivable purposes, but only for the currently contemplated type of analysis.

From the present viewpoint, the only useful conception

of organizational goal is one that places it ". . . in the category of cultural objects which members use to make their actions accountable". (Silverman, 1970: 6). Accordingly, members may confront each other with certain conceptions of the organization's goal, or outsiders may confront members singly or collectively, with some "goal" conceptions. In either case, the ways in which the notion of organizational "goal" is defined, used and dealt with will be the interesting issue, with the expectation that any formulation of that goal can be deferred to, rejected, amended, etc.

The organization itself is defined here as consisting of the relationships among members as manifested in members' activities (obviously, "relationship" is an inference, not a phenomenon). It is recognized that not all aspects of members' mutual relationships need be identified by them as belonging within the organization, i.e., as being relationships among members as members. Nor is it proposed that all aspects of members' relationships are organizationally relevant as for example, in terms of their impact on the work that is carried out in the organization, or the autonomy structure characterizing the work processes. The question of relevance cannot be decided a priori, however; it is an empirical question and will be treated as such.

The dynamics of the organization will be seen as

deriving from the private goals of the members, goals they pursue through their membership in the organization, that is, through their relationships with other members (as well as outsiders, of course, but that is of secondary importance now).

The approach outlined above is largely consistent with several available treatments of the subject which conclude that understanding organizational behavior requires above all reference to the autonomous (self-willed) actor, such as can be found in Katz and Kahn (1966: 15-16), in the incentive - contribution theory of Clark and Wilson (1961), or the exchange theory of Blau (1964: 18-25), as well as the earlier quoted work of Georgiou (1973) and Silverman (1970), and lately in White's (1974) work interpreting organizations as resource utilizing coalitions of commonsensically rational actors pursuing their several and sundry objectives through their memberships in the organization.

For our current purposes a slightly paraphrased version of the following conception of a mental hospital is eminently suitable. Thus, it has been written that

"A hospital can be visualized as a professionalized locale - a geographical site where persons drawn from different professions come together to carry out their respective purposes". (Strauss et al., 1963: 150).

This conception accords well with the one expressed here earlier, with the exception that "a set of relationships"



ought to be substituted for "a geographical site", as spatial considerations have no bearing on our conception of organization, regardless of the impact they may have on organizational functioning. The notion of "professionalized locale" is quite suitable for our purposes as well. The members of the mental hospital studied on whom the research focused were self-professed professionals, a self-identification the researcher found went undisputed by any of the encountered members.

A specification of the meaning of "autonomy"

Having identified the organizational boundaries, defined the overall meaning of the term "organization" and postulated the basic source of organizational dynamics, attention can be turned to autonomy, which is the one aspect of the relationships among members of particular interest here. A definition of individual and group autonomy has been discussed at the beginning of the preceding chapter. The discussion here is pertinent for the following material. It need not be repeated here, beyond the basic statement of what is to be understood by "autonomy" and some clarifications. Thus, following Dill, "autonomy" will refer to "freedom from influence" (1958: 411) or control, i.e., individuals or groups are autonomous with respect to specific behaviors and specific other individuals to the extent that the content of the behaviors is not effectively controlled by the other individuals.

The qualification entered by the use of the term "effectively" is as necessary as it is potentially troublesome, because while one has to distinguish between nominal and factual control or influence, these concepts involve matters of degree and the problem of seeing through appearances where especially the latter task can pose difficulties. Since these difficulties do not seem to be susceptible to solution in principle, the adequacy, of evidence in regard to each particular autonomy issue will have to be judged on its own merits.

One entailment of the above definition of autonomy that had not been discussed specifically earlier concerns the organizational positions of the individuals involved in the (autonomy) relationships, i.e., the relationships involving one party's control over or influence on some decisions of the other party to the relationship. Apparently without exception, the question of autonomy in formal organizations is seen in the literature as involving only superior - subordinate relationships and furthermore, only the subordinates autonomy is discussed. However, even a brief look at the relationships among the staff of a mental hospital would show that formal hierarchical authority relationships are merely a minority of the relationships where individual autonomy becomes a contested issue. Therefore, it is not proposed here to confine attention to formal authority relationship. Further,

influence or control need not flow only from superiors to subordinates but also vice versa. Accordingly, each of the sides to a relationship should be examined for autonomy as well as control.

When the structure of autonomy in the organization or the autonomy in a single relationship changes, the changes may be the results of deliberate effort aimed at altering the autonomy structure or they may be the unexpected consequences of otherwise motivated activities. Similarly, maintenance of the status quo in terms of autonomy can be either intentional or inadvertent. In either case, the relationships can be legitimately interpreted from the viewpoint of autonomy. Such an approach (neglecting the intentionality) is advisable also because differentiation between intended and unintended consequences requires that the motives of the parties involved be ascertained, which is an exceedingly difficult proposition. Of course, to decide whether or not a party to a relationship was influenced by the other in making a decision can be rather difficult as well. The strategy chosen for dealing with those difficulties will be discussed later in the section on methodology.

#### The power and authority perspectives on autonomy

As had been suggested in the preceding chapter, because of deference to certain measurement problems, autonomy will be discussed issue by issue rather than in

some overall terms. The task will be to explain the characteristics of the instances of autonomy observed. The basic form of the explanations that will be looked for has been discussed already: the focus will be on the mechanisms of commonsensically rational ordinary behavior as it results in an organizational autonomy structure. A description of such behavior will be accepted as the explanation of the resulting autonomy. Since the basic interest is in explaining processes leading to various states of affairs, it is well to concentrate on changes in the organization or on actively contested autonomy issues. It would seem that under such circumstances the mechanisms responsible for a state of affairs surface and become re-searchable. Past processes are largely lost to the researcher and explanations of at present routine situations that developed in the past are, therefore, unavoidably highly speculative.

Changes in the organization's autonomy structure can be expected to involve a measure of conflict. Furthermore, even in the absence of appreciable conflict, it would seem that some resources have to be available and utilized if change is to be brought about because, presumably, change does not arise from nothing. Since here we are speaking of conflict and the use of resources to achieve various objectives, the relevant theoretical perspective ought to use notions such as power, control, influence and authority. Conflict and the use of resources to achieve objectives are

central to the various treatments of power found in the literature.

The context of "power"

It seems that no distinction need be made between power, control, and influence or at least that the concept of power as it is encountered in the literature is sufficient (that the three terms are used synonymously is argued by Tannenbaum, 1968: 5). A distinction is often made by various writers between power and authority which sees authority as a special sub-type of power. However, that distinction is rarely drawn in a way that would make it useful for the present purposes. Therefore, authority will be discussed only briefly.

The views to be expressed in the following include the proposition that a formal definition of power is not all that important and that almost any of those found in the literature would do, although various re-statements of the definitions may facilitate the research endeavors, depending on the specific research orientation involved. Another and a more important point will concern the sources of power. It seems that theorizing as well as research concerning power as an interpersonal process boils down to the problem of what are the resources used by the participants in that process and how these resources are used in social life, resources being the various things under the individual's control, i.e., things the individual can, or

presumably can, manipulate or refer to at will, under specific conditions. A further crucial point in power relationships would seem to be whether or not the individual is in a position to use the resources at hand. That question can be sometimes reduced to a problem of control over resources only when the notion of resources is rather stretched (e.g., the moral willingness to use certain resources, or the time one has can be both interpreted as resources).

That a fully satisfactory formal definition of power is not necessary to a competent treatment of power-related topics has been demonstrated by Mechanic who dealt imaginatively with the "sources of power of lower participants in complex organizations", even though he defined power as ". . . any force that results in behavior that would not have occurred if the force had not been present". (1962:351) Obviously, "force" needs defining no less than "power", especially if physical force is only an unimportant part of the intended meaning.

Similar objections can be raised to Etzioni's definition suggesting that ". . . power is an actor's ability to induce or influence another actor to carry out his directives or any other norms he supports". (1961a: 4) This definition also relies on the reader's commonsense intuitive understanding of the terms that comprise it, takes it for granted that the meanings of "ability" and "influence" are

clear and that instances of influence, for example, can be recognized without further elaboration of the definition. However, as will be argued presently, "influence" as well as "power" are inferences and some rules are necessary to show how those inferences are to be made. It is these rules that effectively constitute the definition of power.<sup>29</sup>

The definitions of power poured in the literature are largely compatible with Etzioni's definition (e.g., Taubenbaum, 1968; Dahl, 1957; Cartwright, 1965). The entity of which power is an attribute is variously conceptualized but the degree of real as against apparent conflict among those conceptualizations may not be great. In the above definition by Etzioni (1961a: 4) power is apparently an attribute of the actor, but since it was recognized that an actor's power over different others may well vary, Etzioni's conception is compatible with Emerson's who asserted that ". . . power is property of the social relation; it is not an attribute of the actor". (1962: 32). It is fairly clear that the differences in formulations are for practical purposes inconsequential: if an actor's power over others varies, it varies from relationship to relationship. A somewhat different view was expressed by Mechanic who suggested that power is to be defined as

". . . a force rather than a relationship because it appears that much of what we mean by power is encompassed by the normative framework of an organization, and thus any analysis of power must take into consideration the power of norms as well as persons". (1962: 351).

Clearly, Mechanic speaks of power in a somewhat different sense than Etzioni did. Aside from the likelihood that power of norms, etc., depends on those who use it and those against whom it is used, it may be argued that it is inadvisable to lump together the "power of norms" and thus the power individuals derive from the use of those norms with power based on other types of resources, as is sometimes done, and this irrespective of whether norms are used as sources of power opportunistically or not. This point will be discussed further later on.

Whether power is seen as a conditional attribute of persons, or of relationships, norms, or other resources, the above definitions are compatible with the intuitive commonsense understanding and conventional usage of that concept and do not add to it appreciably. For our current purposes a restatement of these definitions is useful even though it does not mean an improvement on the above formulations in terms of obviating reliance on commonsense intuitive understanding of the terms used in definitions. It should, however, facilitate certain types of research, such as the one to be reported herein.

Thus, "power" is a generic term serving to signify our perception of a fundamental similarity among a great number of apparently diverse behaviors. These behaviors may involve a strictly physical manipulation of other actors but that class of manipulations is irrelevant here; the



term "coercion" can be reserved for such behaviors. Apart from coercion, the behaviors linked together by the term "power" apparently all involve the free-willed (autonomous) actor in situations of choice. The actor contemplating a course of action is faced with a set of presumed, possible, probable, certain, contingent, etc., consequences and obstacles. Some of these consequences and obstacles are the results of free-willed actions, or under the free control of other actors with the possibility of certain actions. The actions involved may or may not be performed by the others directly in response to the actor's choice of behavior.

One focus in the literature on power relationships and processes seems to be on the consequences of the above outlined contingencies for the actor's choice. It should be also noted that some of the possible consequences may have no realistic foundation but, insofar as they are suspected by the actor, they are consequential for his choice. Another focus derives from the class of consequences not anticipated by the actor. These consequences do not influence the choice but only the outcome of behavior following the choice.

Given the preceding, an actor is said to have power over another insofar as he can or does manipulate or have free control over something consequential for the other's choice or for the outcome of the other's activities.

Anything of that nature and subject to an actor's autonomous (at will) manipulation or control will be referred to as a resource. Where resources are consciously used to influence others' choices, the situation can be converted into an episode of exchange: the actor may comply with the directives of another in exchange for being allowed to achieve some personal objectives. Alternatively, an actor may reduce some of his requirements or give up some rights or prerogatives in order to be allowed to achieve some of his objectives (cf., Marcus and House, 1973, on exchange between supervisors and subordinates). If the viewpoint of the actor over whom power is exercised is adopted under such circumstances, we can speak of dependence. As Emerson noted, "power resides implicitly in the other's dependency". (1962: 32).

One subtype of occasions that are sometimes classified under "power" and which is not included in the above definition involves instances when an actor complies with the wishes of another even though there is no apparent, or even factual, resource the other actor could manipulate, nor is there anything that could be interpreted technically as an obstacle to the actor's realization of the alternative choices. Giving a stranger the time of day may be an example of such an occurrence, although it is not to be assumed that it can be encountered only in trivial matters. Behaviors of that type can be seen as conforming to various norms of

conduct voluntarily followed by actors. To some extent, behavior according to such norms is what Mechanic had in mind when he referred to the "power of norms" (1962: 351; c.f., the earlier quotation). Other examples of norms that can be function in the same manner are "friendship", "kinship", or, in organizational contexts, position in the hierarchy, etc., although there may be very few instances where non-compliance with the norms would assuredly be without adverse consequences for the actor.<sup>30</sup>

The instances of "power of norms" seem fundamentally to differ from those comprised by the definition of "power" used here because of the differences in terms of the appropriate explanations. Thus, the mechanism of choice envisioned in our definition and the corresponding explanation of power is nonexistent where a norm is followed apparently for its own sake. That is to say, compliance with the norm of say, friendship, is not necessarily a means to an end; behavior according to that norm may be a goal per se, and insofar as that is the case no means - ends relationships that could be manipulated by other actors exist. Instances of "power of norms" will be noted in the research itself as they may have a bearing on the organizational autonomy structure, but only secondarily. Behaviors falling within the definition of power proper will be of primary interest.

It is obvious that the definition used here only provides vague guidelines for categorizing certain behaviors

as incidents of power - the use of resources, intentional or inadvertent, to affect choices or outcomes. It does not suggest how to recognize such occurrences, i.e., how to infer from the phenomena observed that the specified underlying process has taken place. The problems with that inference will be discussed in the context of methodology later. At this point, the relationship between the concepts of "power" and "authority" should be commented upon.

A note on "authority"

As has been noted earlier, "authority" is ordinarily considered a subtype of power. The literature contains a number of more or less lucid definitions of authority attempting to separate it conceptually from power. The success of these attempts is often limited. It hardly helps, for example, if no elaboration is offered, as if none were needed, of the statement that "authority is institutionalized power" (Mechanic, 1962: 350). The formulations of other writers appear similar, but that is only an assumption, considering the vagueness of the various definitions. Thus, authority as the "formal right to exercise control" (Tannenbaum, 1968: 5) may have been intended to be close to "institutionalization". Some writers suggest, however, that the various intended meanings found in the literature are not congruent enough:

"there is no consensus today in the management literature as to how the term "authority" should be used". (Simon, 1957: XXXiv).

The same conclusion was reached by Peabody (1962: 319).

The notion that authority is separated from other kinds of power by being invested with legitimacy or right appears routinely in the writings on the subject (see Blau, 1964: 208-209). However, where definitions and speculative analyses are concerned, the problem of viewpoint is often neglected as if authority were an inalienable and immutable attribute of a person, position, and the like. At best, the viewpoint of a very ambiguously defined plurality of people is referred to (Blau, 1964: 208-212).

It can be argued, then, that if an actor acknowledges another's right to make a decision or give an order and complies voluntarily, the situation is tantamount to what has been previously termed "power of norms", with the formal position functioning as a norm. Otherwise, the situation corresponds to the current concept of power and is distinguished only on the basis of the resources used in such power relations, if at all. Thus, when Simon speaks of the sanctions pertaining to the authority of position, such as ". . . a) the power to hire and fire, b) power to promote and demote, and e) incentive rewards (1957a: 104), it is clear that "authority" may be referring there to the position-holder's relationship with someone other than the person (a subordinate) being hired, demoted or rewarded. From the viewpoint of the subordinate there may be nothing legitimate about the treatment received or the objectives

pursued by the superior through the above sanctions. Furthermore, even if a subordinate agrees in general terms that a superior has a certain authority, it is well to realize that authority per se is never exercised; only episodes of the exercise of authority occur and the subordinate may refuse to recognize any such episode as a proper exercise of authority.

It would seem, then, that when we focus on instances of the use of authority and specific relationships, the distinction that follows from the definition of authority as "legitimate power" or the "formal right to control" is one between "power of norms" and "power" as these terms were defined here. The usage in the literature is more complicated because attention for the purposes of definition is sometimes given to the "sources of authority". Thus, Peabody concluded that great ambiguity obtains in the definitions of authority, but contended that there

"... seems to be considerable agreement . . . on an important facet of the . . . problem, namely, identification of the bases of authority . . ." (1962: 319).

Peabody identified four broad categories under which bases of authority (not defined apart from its bases) could be classified. The categories were a) authority of legitimacy (social approval), b) authority of position including the sanctions pertaining thereto, c) authority of competence, d) authority of person, including leadership skills.

(Peabody, 1962: 320). It appears that each of these "sources of authority" can exhibit what has been termed here the "power of norms". Equally well, however, each of those sources can be used as a power source in a relationship where the other party would not comply because of those resources alone: the actor possessed of the resource may elicit the support of and various acts by third parties and thus induce compliance. Peabody's approach lumps together these two processes under the label of "authority". The rationale offered earlier for distinguishing "power" and "power of norms" rested on the proposition that they rely on generically different explanations of behavioral episodes. It seems preferable to follow that course rather than to create a category of resources more or less arbitrarily and label behaviors based on them "authority", as Peabody did.<sup>31</sup>

Thus, the difficulties with the definition of authority appear to be due to inattention to specific instances of behavior and specific relationships. Once the suggested focus is adopted, the problem seems solvable. It is well to keep in mind, however, that the solution is based on the behavior of a homunculus, a "model actor" whose situation and motivation are postulated. The transition to actual actors in social situations is likely to uncover considerably less clearcut cases.

## The Resources in Power Processes

Insofar as they are interested in studying the motivated, commonsensically rational actor, the writings on power and autonomy have two basic thrusts. One centres on the role of motivation, the other on power resources. The results of the former consist of more or less perceptive and exhaustive observations of the human motives current among the members of society. The second focus results in similar sets of observations detailing the resources used in the pursuit of the motive fulfillment. Motivation and resources have been placed into a single scheme by Emerson who started with the proposition that an actor has power over another insofar as he can facilitate or hamper the other's goal achievement (1962: 32). To alter the power relation with another person, an actor is said to have two alternatives: a) to change his motivation, or b) to develop alternative ways of goal achievement (Emerson, 1962: 35). It seems that another method should be added, namely, that the actor can discover or develop additional resources to be used in the power relationship.

More or less explicitly, the above processes are used in the literature dealing with power as well as in the literature dealing with autonomy within frameworks similar to the one to be employed in the present research (as described earlier in this chapter). Otherwise, the advancements that are made seem to consist of expanding the lists of re-



sources used by organizational members and of findings concerning motivation of the members in various settings. The motivation obviously of interest here is the desire to have greater autonomy or to reduce someone else's autonomy. In broader terms, the motivational syndrome referred to as "professionalism" is relevant because desire for autonomy is an important part of that syndrome. Otherwise motivated activities can also lead to albeit unintended changes of autonomy. However, no general statements about the motivations that can have such consequences exists.

As far as resources are concerned, there are no general rules that would make it possible to deduce them for particular situations. Both common sense experience and organizational research do, however, contain an extensive repertoire of resources. The reports on those resources, whether generalized or specific, can be used to alert the researcher to the various possibilities when studying new organizations.

Attempts at categorizing the resources used by members of organizations are an obvious source. Thus, Peabody lists as resources the belief in the legitimacy of formal position and the requirements made by position holders, laws and ordinances, formal organizational rules and regulations, formal organizational position of individuals, technical competence and experience, promotions, financial rewards (Peabody, 1962: 322 and 326). Marcus and House (1973)

conceived of interpersonal style of behavior as a resource (listening to suggestions, giving praise, non-maintenance of social distance, etc.), as well as performance above the lowest levels that would be tolerated, initiative, and information. In a generalization drawn from various case studies of organizations, Mechanic (1962: 352) distinguished three main types of resources: information about the organization (persons, procedures, etc.); access to persons in and out of the organization; control over "instrumentalities" such as equipment, machines, money, etc. Further, Mechanic listed expertise, effort, organizational rules and coalitions, i.e., any type of concerted collective action (Mechanic, 1962: 357-361; see also Whyte, 1955 and Sayles, 1958). Among other resources mentioned in the literature is the non-routine, unpredictable character of an individual's or a group's work, and the lack of clear technical requirements (Goldner, 1970: 110).

In the context of the psychiatric hospital, Scheff (1961) showed how individuals (attendants) can use their ability and willingness to perform duties legally consigned to others (physicians) as a power resource and a bargaining device. In the same setting, Strauss (1963) emphasized the ways in which participants make use of the complicated nature of the organization's work. Since inadequate performance in complicated settings is extremely difficult to document, the relative impunity of members can be used by them as a power resource.

Needless to say, the above list of resources is far from complete. Sabotage and troublemaking in general can obviously be used as a resource. Studies of goldbricking and other unauthorized practices (Roy, 1952 and 1954) show how lack of observability can be used as a resource by individuals or groups. There is no reason to believe that other resources have not or will not be found. None of those cited is the invention of social scientists. Although it may be possible to devise categories that would cover all the observed resources, there are no rules for inventing new ones and thus their discovery is a task for research as an open-ended fact finding enterprise rather than a procedure aimed at testing finite entailments of a deductive theory.

The theoretical preparation has thus been completed. We have discussed the reasons for the selection of the general approach, the approach itself, and the basic research focus. The latter consists largely of emphasis on the power process underlying the autonomy structure as it emerges from the plurality of motivations of organizational participants and the use of various resources. The next chapter deals with the research methodology.

Chapter III

The Research Methodology

Our research methodology has to resolve essentially two problems. One is the problem of the description of autonomy and the other the description of behaviors that result in the given autonomy structure. Both of these problems involve the question of the reliability of fact - finding which will be of principal concern in the following.

The problem of the description of autonomy

The type of behaviors that are relevant were discussed earlier as largely belonging under the heading of "power relations". Although a definition of autonomy has also been discussed, we have largely neglected the problem of arriving at a description of autonomy. A note on that methodological problem is in order now.

Assuming that the data gathered are valid, i.e., that they are correct descriptions of facts, observing a routinely operating organization will have resulted in a description of behaviors. However, it will not necessarily result in a description of autonomy. Basically, the reason is that whereas "autonomy" implies certain limits, observed routine behavior merely falls within those limits, without making it possible to identify them. Thus, many reasons may be responsible for an actor's behavior and (the lack of) autonomy is only one of them. To ascertain the extent of an actor's autonomy it is necessary to determine whether or not it is the limits on the actor's autonomy that are responsible for the given behavior. We can speak of these

limits as the tolerances afforded by the actor's environment, under the given conditions (cf., the discussion of power).

There seems to be only one way of ascertaining what these tolerances are, namely, to observe behaviors that appear to reach the limiting tolerance levels. That such levels have been reached should be apparent, presumably, from certain responses by the actor's environment. A description of the limits of an actor's autonomy is then an account of the incidents where the tolerances have been strained. Whereas the above relies on actual behavior, there is the alternative of asking the actors to estimate the limits on their autonomy. It is questionable, however, whether such speculation is of much value. There may be a wide gap between the estimated potential and the limits that would be found if the actor attempted to behave according to his estimates. This is not to say, of course, that the estimates are inconsequential for the actor's behavior, but only that the above problem concerned the actual limits.

#### Inference and the validity of data

To provide the needed information, in addition to organizational artifacts such as forms and manuals, the data that had to be gathered in the course of the research concerned the organizational members' motivation and their actual behavior. Each of these two areas requires a different methodological approach because behavior (both verbal

and non-verbal) is subject to direct observation while motivation is either reported to the researcher by the respondent or is stated in the course of interactions observed by the research, or is inferred from the observation of various behaviors.

The problems of inference need not be attended to here as the grounds for each important inference will be presented in the report on findings thus making it possible for the reader to judge each instance on its merits. That approach is advisable since there seem to be no general rules for making inferences about motives and intentions. The inferences that appear in the literature employ the implicit commonsense methods used in everyday life. These methods involve examining all kinds of behaviors against the presumed motivation. However, it is impossible to state a principle that would suggest when the fit is such as to warrant a firm conclusion (cf., Lindzey, 1958).

It should be noted that the literature dealing with field research and the inferences made in its course presents the researcher making tentative conclusions (inferences), getting more data and re-evaluating the original conclusions, but such a description obviously does not deal with the grounds for inferences themselves. They are largely taken to be self-evident, apparently in the light of "what everybody knows", or "what a competent researcher knows" (cf., Strauss et al., 1964: 19-2); Schwartz and Schwartz, 1955; Becker, 1958).

Essentially the same holds for the selection of observations (from the universe of observations) relevant to the theoretical problem at hand. It can only be assumed that the researcher did indeed discern and record the relevant data as they were encountered. Of course, the relevance of what is reported can be judged by the reader. The problematic and unsolvable question is whether or not the observations that went unrecorded were indeed irrelevant to the problem at hand, as deemed by the researcher.

There are presumably certain types of information that do not require inferences to be made in the process of conveying that information or which involve only inferences that we ordinarily assume are made with such reliability as to enable us to disregard them. The methods used to obtain such information were observation and interviewing. The validity of the data obtained by these methods involves several problems. For one thing, it is important to know to what extent the information received consists of "uninterpreted facts". Two points need to be considered there. One of them is the requirement that only the respondents' first-hand experiences be taken seriously. The other point consists of the requirement that the data be limited to information which poses little problems as to the actual empirical referents of the respondent's statements.<sup>32</sup>

It seems that much of the criticisms of data collection methods and the achieved validity (e.g., Phillips, 1971 and 1973) refers in the final analysis to the lack of



knowledge on the part of the researcher of the methods the respondent used to arrive at the formulations communicated in the interview. For example, if a relationship is described as "close cooperation", it is difficult to say what, if anything, the researcher has learned from that description because of the vagueness of each of the terms used. In contrast, the statement "I asked Dr. N. what to do" presents no such difficulties. Every effort was made by the researcher to elicit information of the latter type, i.e., information describing precisely what was said or done, even though considerable resistance to that effort was encountered. Not only did the respondents seem to prefer to speak in vague non-committal generalities, but terms such as "close cooperation" are routine and accepted as adequate in everyday speech and the respondents apparently found the transition to exact and relatively detailed descriptions difficult. It is also possible that in spite of the researcher's attempts at explaining the insistence on first-hand detail, the respondents did not appreciate the reasons involved, which may have been responsible for some of the reluctance to oblige the researcher.

#### Organizational rules and the validity of data

In the context of describing the autonomy structure of the organization, care must be taken not to confound an account of (formal and informal) professional or organizational rules, as rendered by the respondents, with the

description of autonomy or of behavior in general. That actual behavior may not follow the rules and roles is an obvious possibility, but it is of only minor importance. A more fundamental question concerns the problem of correspondence between rules and behavior, even if all concerned would agree that the given behavior conformed to the rule.

Thus, the organizational participants face the problem of determining whether or not specific behaviors, given the various practical contingencies under which rules are to be applied, are indeed behaviors according to a rule. After all, rules are likely to be general rather than operational statements and the correspondence between rules and the appropriate behavior may be rather obscure.

Some studies indicate that the fit between rules and behavior is managed in ways that are less than predictable from the rules themselves (Zimmerman and Wieder, 1970: 291-293; Zimmerman, 1970). It is therefore imperative that not rules per se be collected as data, but rather literal descriptions of behaviors (whether or not they are said to conform to the rules). This means that only actual activities can be of interest. If no behavior according to a rule occurred, the rule must be considered non-existent. That is not to say, that, over time, rules may not be revived or forgotten opportunistically by organizational members (cf., Straus et al., 1963: 150). It is only that

"dormant" rules do not describe the organization's functioning.

The literal descriptions which, by themselves, are not the result of interpretations, can then be used by the researcher to formulate the rules - in - use by generalizing from the actual behaviors. Further, the rules obtained through such generalizations can be compared to the rules ostensibly and putatively used by the organizational participants.

#### The role of the researcher

One of the basic methodological questions in case studies is whether or not the research enterprise is disguised from the subjects. In the present case, the researcher did not seem to have much choice in the matter, for various reasons. From the beginning, all staff members were informed that the researcher was a student gathering material for his thesis on the organization of a mental hospital. The only elaboration that was ever offered consisted of saying that the research goal is to obtain a detailed description of "who does what", with emphasis on specifics. To the researcher's knowledge, only one patient ever inquired about the researcher. The inquiry was made to the researcher personally and the same explanation was supplied as that given to the staff.

To what extent the explanation proffered was taken seriously is difficult to tell. Occasionally it was clear

that some of the staff believed the research "really" was oriented towards finding out "what was wrong" with the hospital, apparently because that was a research interest that made easily appreciated sense as either being oriented towards something useful or congruent with the usual sociological interests. A disclaimer was made whenever that belief was encountered, but with doubtful success.

Although not being an employee of the organization and being overtly engaged in studying it is bound to present problems, on balance this approach need not be inferior to the opposite alternative. As Dalton (1959: 216-217) noted, if the researcher is ostensibly an ordinary employee of the organization, he faces rather difficult problems in justifying his inquisitiveness and other departures from ordinary employee behavior. On the other hand, there is the obvious drawback of an outside researcher, namely, that the organizational members may have too much control over the information they release. It can only be hoped that they will find it too difficult to sustain concerted performances, thereby making it possible to cross-check the information received.

#### Bias in interviewing and observation

As far as observation was concerned, no evidence of performances staged for the researcher's benefit (or detriment) were detected. Interviewing poses essentially the same problem, to wit, that in addition to the requirement

of obtaining information consisting of "uninterpreted data", the researcher has to decide whether or not the respondents are simply lying in their interview statements.

The problem of lying is often discussed in the literature which includes compilations of clues the researcher could use to infer that the respondent is deliberately misrepresenting the facts (e.g., Dean and Whyte, 1958). This literature shows, however, that the clues and the techniques for their detection are the ordinary commonsense techniques used daily for the same purpose, albeit couched in a different (more obscure) terminology. Basically, these techniques consist of detecting the respondents' possible motives for lying and then assuming that, because of the motives, lying is likely to have occurred. Otherwise, inaccuracies can be sometimes detected by cross-checking the information received, either against the answers of other respondents or by asking the same but somewhat re-phrased question several times and checking for consistency.

While the first of the above alternatives was used extensively, the second was avoided, and apparently with good reason. Since most of the respondents (social workers and psychologists) are familiar with the technique in question, not only could its effectiveness have been limited but it may also have been found offensive if detected by the respondents, as its use implies that the respondent's veracity is being doubted. In one case the researcher,

having failed to make adequate notes in an initial interview, returned again to ask a few questions. Even though the actual reason was given, the respondent expressed the suspicion that the researcher's real purpose was to check the earlier answers. Since the respondent appeared to represent that possibility it seemed advisable to dispense with the technique in question.

Besides the points discussed so far, the literature on interviewing was somewhat useful, although it appears to rely exclusively on ordinary social skills as the resources the researcher can draw on. The basic proposition seems to be that an interview is an instance of social interaction much like any other interaction and that it requires comparable judgement and behavior to be successful, i.e., to take place, be sustained for the desirable period of time and to produce the desired results (cf., Argyris, 1952; Kahn and Cannel, 1957).

Another data - gathering problem also discussed in the literature on interviewing and participant observation may be posed by the research site's vernacular. Familiarity with the vernacular is necessary both for the purposes of observation and interviewing (cf., Becker and Geer, 1957). It seemed that in the hospital studied the linguistic peculiarities (from the researcher's viewpoint) were confined to some psychiatric terminology and various acronyms standing for the hospital's departments and programs, or outside agencies.

### The relative importance of data-gathering techniques

Because of circumstances to be described later, most of the hospital staff's work with patients could not be observed, with the exception of occasional impromptu encounters and staff interventions with patients that occurred while the researcher happened to be present. These occasions may be referred to as "informal treatment". Most of the work with patients takes place on formally instituted occasions behind closed doors where the researcher did not have access. Consequently, the data on the staff's work with patients were obtained mostly from interviews. The interaction among the staff was observed both at formal staff meetings and informally during the time the researcher spent on the hospital premises.

However, the direct observations could provide only a smaller part of the information needed. Therefore, the bulk of the data on interaction among the staff was also obtained in informal conversations and formal interviews. The formal interviews were distinguished by an explicit statement by the researcher which designated some conversations and formal interviews. The formal interviews were distinguished by an explicit statement by the researcher which designated some conversations as data gathering occasions, usually by prior appointment with the staff members. The interviews were conducted in the staff offices and only once was more than one respondent present.

Informal talks took place with varying numbers of the staff members at any one time, and on a variety of occasions. On such occasions, no effort was made by the researcher to channel the conversation into directions that were of interest to the research and it was never made explicit whether or not the things that transpired there "counted" towards the data gathering enterprise. The staff members apparently did not consider those situations ambiguous or important enough to enquire into the researcher's intentions.

Notes were kept on all observations thought relevant to the research topic. In the case of informal occasions, notes were made after the researcher left the scene, which was done as frequently as the circumstances warranted and made possible. Essentially the same procedure was followed when the researcher attended staff meetings. Only the briefest notes were made during the meetings, as the extent of the relevant material encountered was sufficiently small to make it possible to defer recording the observations until after the meetings.

In formal interviews the researcher took as detailed notes as possible while maintaining some semblance of a continuous conversation. More or less extensive additions to the notes were made after the interviews. This method worked reasonably well and only on a few occasions did the researcher find it necessary to re-interview the respondents



about points already covered because of forgetting the original answers.

Although a list of more or less detailed topics had been prepared for each interview, the lists were not followed if it appeared that some more promising directions offered themselves. The initial interview plan always focused on the characteristics of the work-flow directly involved with patients, i.e., the things the interviewed staff members did with patients and the relationships among the staff relative to that work. This especially meant the dependence of one staff member's activities on another staff member's requests or work with the same patient. Both because of time limitations and the strategy of following promising leads, each interview covered a somewhat different area of the members' activities.

#### The progression of the research

The research evolved in two stages. In the initial stage the heads of the various departments involved with adult psychiatric patients were interviewed in order to gain a general picture of the organization which could be used to plan the subsequent more intensive investigation and to obtain permissions to interview the staff. In the second stage, intensive interviews were conducted with the staff, supplemented by attendance at selected meetings and other observations.

Altogether, twenty-four staff members were inter-

viewed. Because of the staff's work schedules, each respondent was interviewed on at least two and on the average, three occasions. The average total interviewing time per staff member approached one hour and a half. The researcher attended a total of eleven staff meetings of several kinds over a nine week period. The interviews were conducted throughout that period.

The majority of the staff working directly with psychiatric patients were interviewed, with the exception of the nursing staff. Thus, in addition to the heads of departments and administrators, included were psychiatrists, psychologists, social workers, occupational and recreational therapists and nurses not involved with in-patients. Supporting staff such as maintenance or food services were not included. More detailed information on the interviewed staff will be provided in the description of the mental hospital studied.

A final point that should be mentioned concerns the way the hospital was initially approached. The first contact (by a member of the researcher's thesis committee) was made with the Director of the general hospital of which the mental hospital studied is a part. The research requirements were then discussed by the researcher with the administrative head of the Department of Adult Psychiatry which is referred to here as the "psychiatric hospital". The administrator wrote formal letters of introduction to

the heads of the various functional departments involved, such as social work, whereupon the department heads were contacted for the initial interviews and permissions to interview other staff. It appears that this approach was a reasonable one. Only one department head expressed the view that he should have been approached directly rather than through the administrator. Otherwise, the chosen approach was apparently considered appropriate.

This chapter and the one preceding it have presented the methodological and theoretical foundations on which this research in a psychiatric hospital is based. The following chapter presents the findings of this study.

CHAPTER IV

THE RESEARCH FINDINGS

## The Research Site and the Unit of Analysis

The hospital in which the research was conducted is one of several general hospitals in a medium-sized industrial city in South-western Ontario. It will be referred to here by the fictitious name of Windsor Hospital. In the last several years, the hospital has grown rapidly and recently underwent a reorganization that seems to have been a response to the growth. A particularly rapid expansion has been experienced by some 'professional' departments, such as Social Work and Psychology. For example, the Department of Psychological Services had only three members (two with Ph.D.'s) in 1969, while having twelve members in 1974 (five with Ph.D.'s), in addition to four 'interns' (Ph.D. student trainees), and three outside consultants. Only within the past year does the hospital seem to have reached a plateau as the growth has been relatively small. A reorganization which took place several months before the start of this research may mark a period of consolidation.

The part of the hospital singled out for attention approximates what is officially known as the Department of Adult Psychiatry, and will be referred to in the following as the 'psychiatric hospital'. That the unit selected for study only approximates a formally designated part of the organization is due to the fact that the current research interests required that the unit to be studied be separated from the rest of the organization on the basis of characteristics somewhat different from those that are used in the formal organizational chart.

The difficulties with the direct use of the formal structure arise largely because of the double lines of authority found in hospitals (cf., Smith, 1955; Coser, 1958; Main and Rapoport, 1962), which is also

a formal feature of the Windsor Hospital, and also because of, at times, rather complex personnel assignments and task structure. The formal organizational chart of the hospital (produced by a hospital executive) appears in Figure 1. It will be shown later how the unit of analysis defined in the following fits into the formal chart.

Work with patients is presumably the principal reason for the mental hospital's existence and the chief preoccupation of the hospital staff. Work-related autonomy is the main topic of interest here. It seems therefore reasonable for our purposes to define operationally the unit of analysis by starting with the patients, as well as those additional persons which the research showed had considerable impact on various aspects of work autonomy.

The category of 'psychiatric patient' is operationally relatively well-defined for most cases. That is not to say anything, of course, about the quality of diagnosis or similar matters. A patient becomes a patient through certain easily recognizable clerical acts. A degree of ambiguity exists where discharges of patients are concerned. The reason is that while a clerical act creates a patient,<sup>33</sup> the staff recognize a de facto lapse of the patient status when the (ex) patient stops attending therapeutic occasions for a loosely specified period of time (ca. several weeks). There a clerical act only confirms the recognized change of status. This ambiguity concentrates in the category of 'out-patients'. A more definite category is comprised of 'in-patients' as they lose the patient status by a clerical act only.

The in-patients can serve to identify one part of the organizational unit studied. They remain in the hospital overnight and stay on three physically separate wards. There is the 'controlled access'

Windsor Hospital Organizational Chart, May 1974.  
(adopted from official hospital chart)

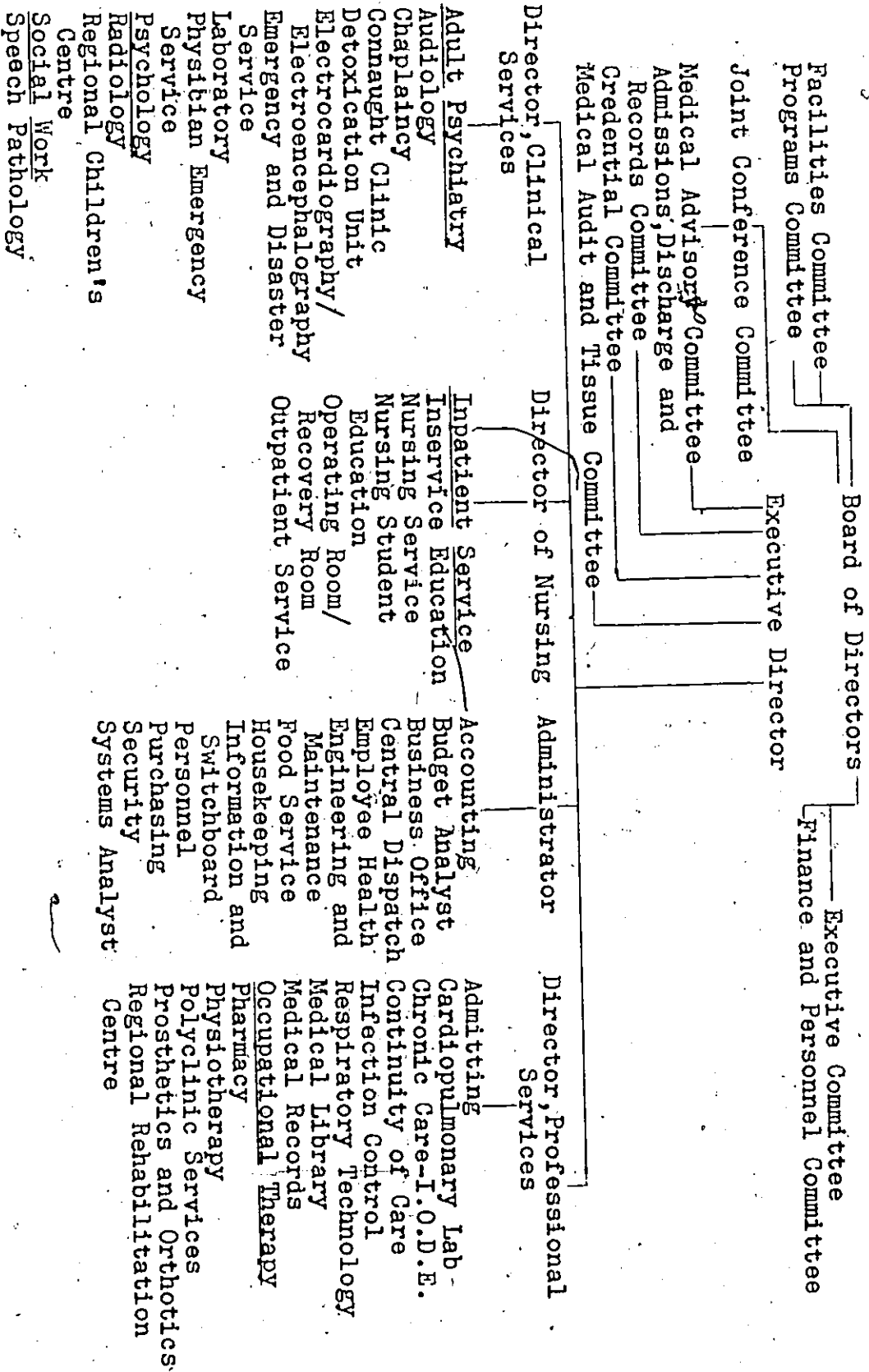
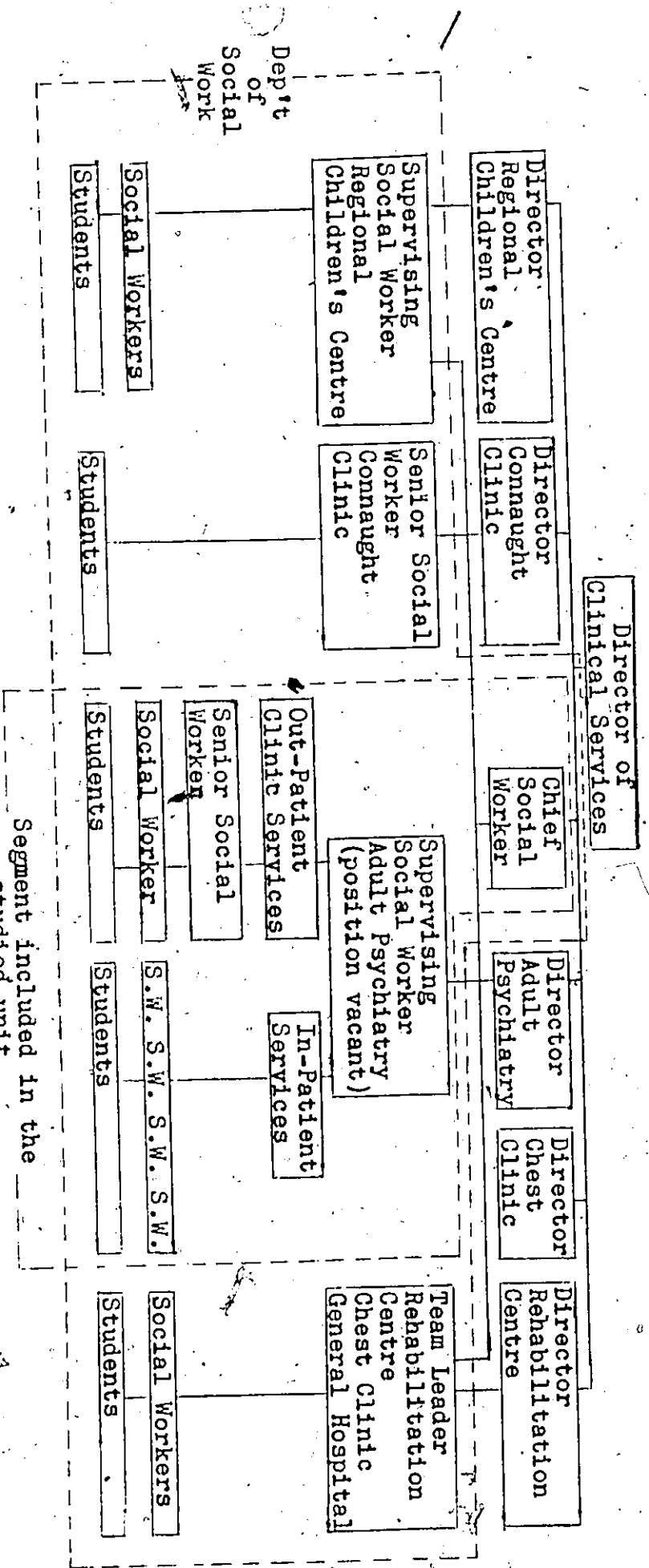


Figure 1.

Windsor Hospital Organization Chart, the Department of Social Work.  
(adapted from the Department of Social Work Manual)

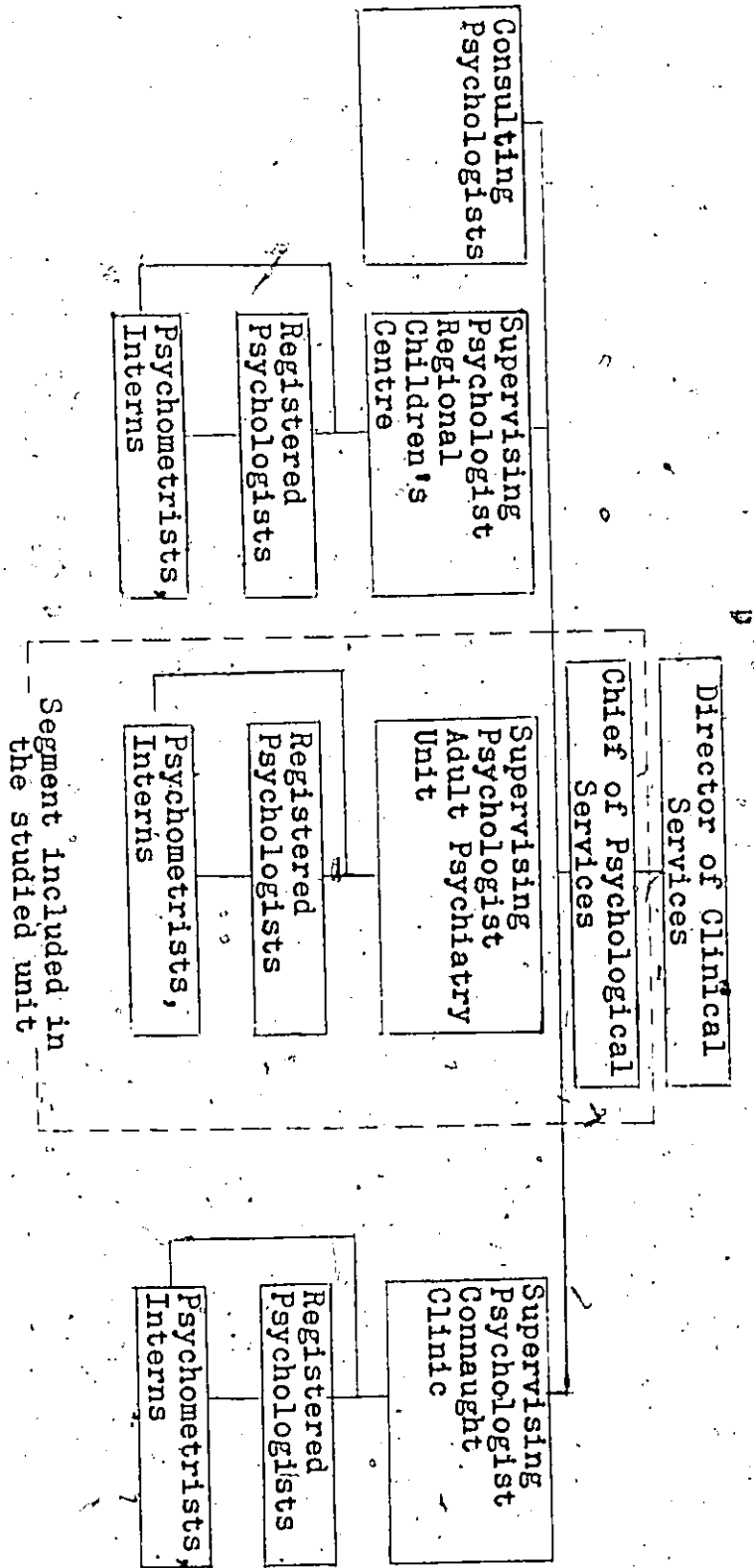
Figure 2.



S.W. - Social Worker  
No student social workers were working in the hospital during the research period.

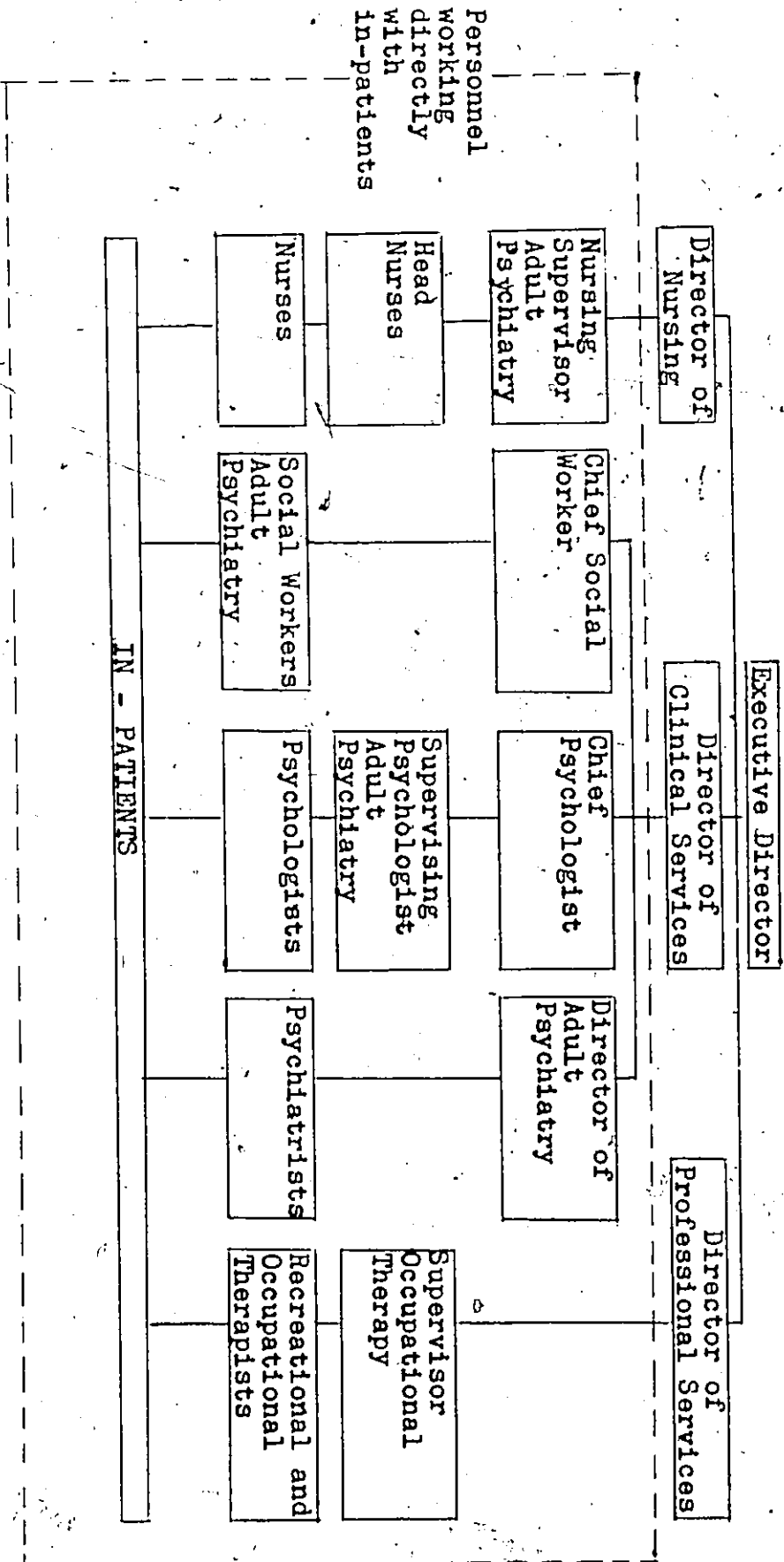


Organizational Chart, the Department of Psychological Services.  
Source: Department of Psychological Services Manual.



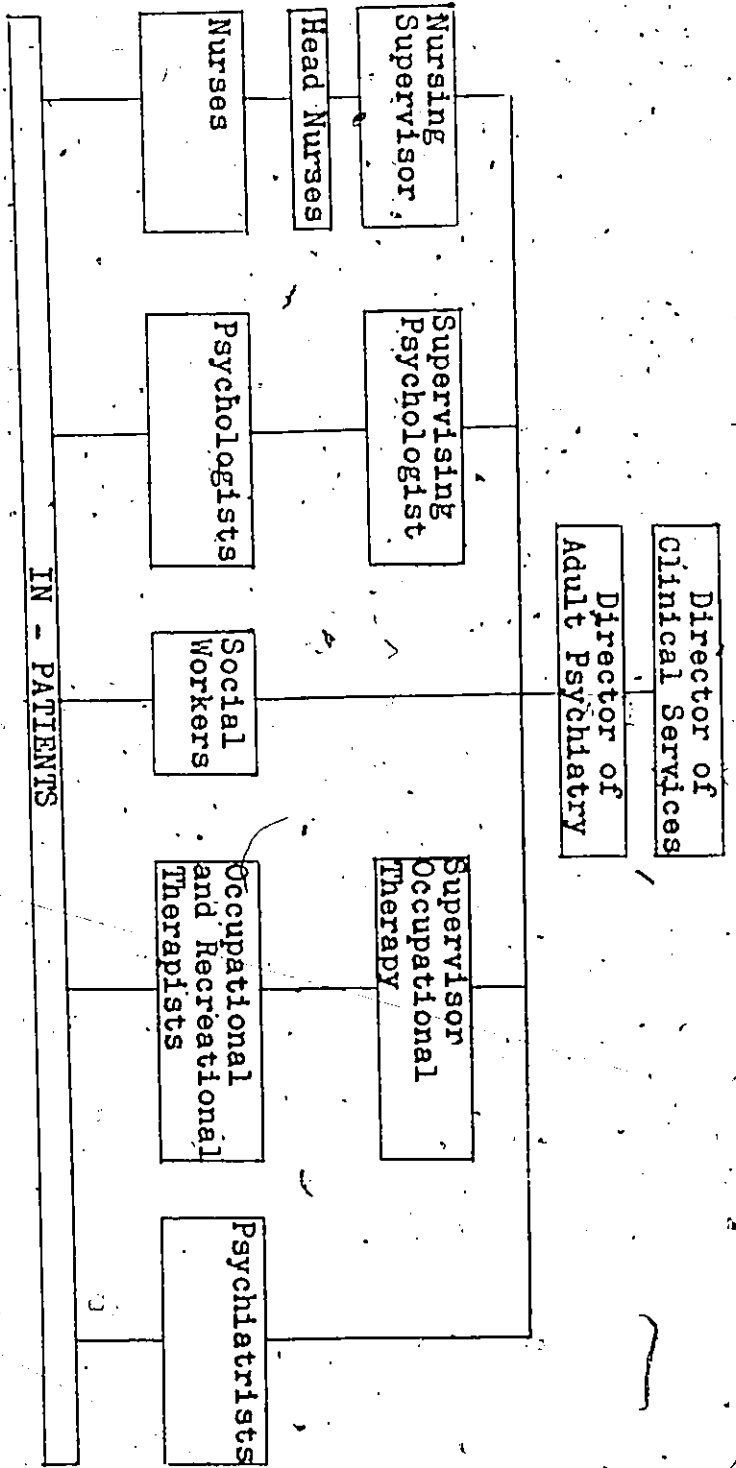
The personnel working with in-patients and their immediate superiors. The functional authority lines are indicated.

Figure 4.



The clinical formal authority structure within the in-patient unit.

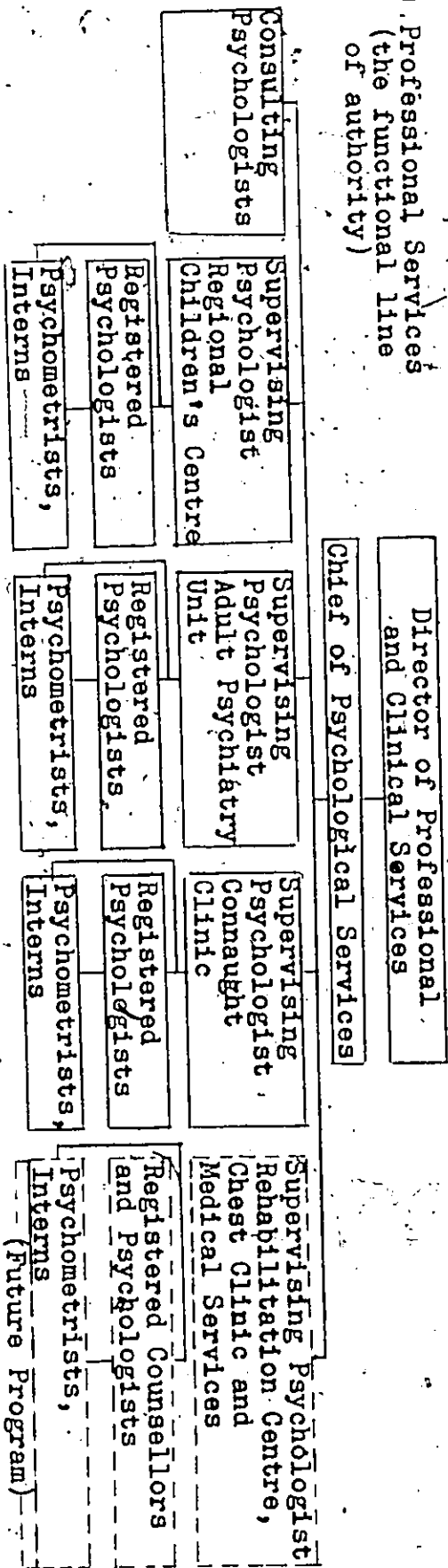
Figure 5.



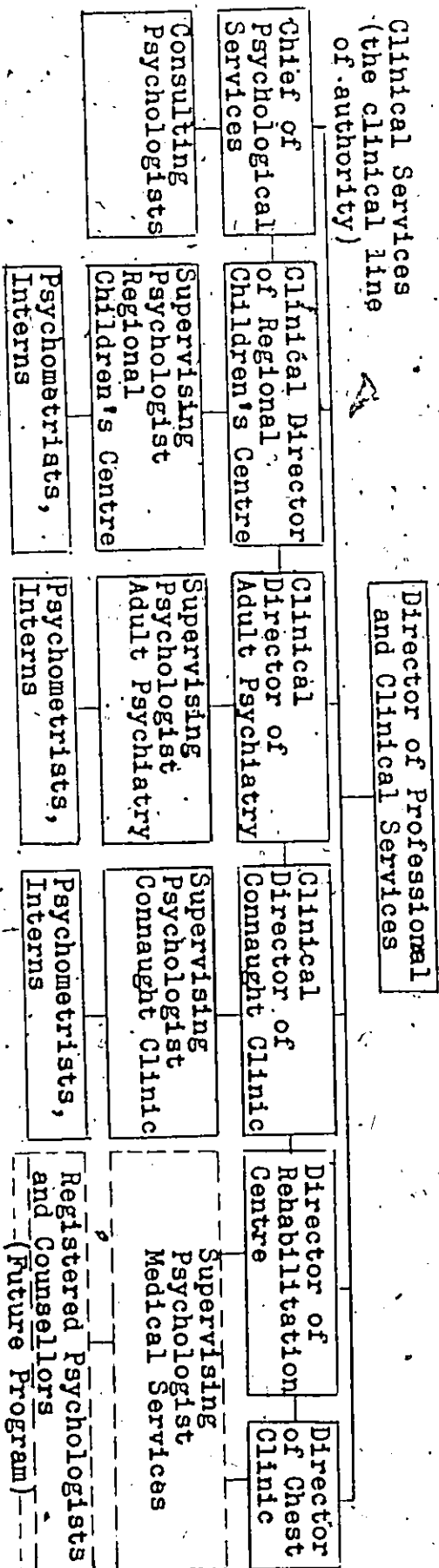
Organizational Charts with respect to the Department of Psychological Services, prior to the latest re-organization. Source: the Department of Psychological Services Manual.

Figure 6.

a) Professional Services (the functional line of authority)



b) Clinical Services (the clinical line of authority)



(locked) ward with 29 beds, for 'acute' cases and two other wards with 26 and 24 beds respectively. The staff who come into therapeutic contact with the in-patients formally belong in several occupational categories. Thus, there is the category of nurses which includes registered nurses (RN), registered nursing assistants (RNA), and attendants. Other categories are occupational therapists (OT), recreational therapists (RT), social workers (SW), psychologists, and psychiatrists. Of course, other (ancillary) occupations may come into direct contact with in-patients, such as maintenance personnel or food service personnel, but these are not designated by the staff as therapeutic contacts, i.e. they are not a part of the principal work and work-flow of the organization. Since the linkage between the ancillary occupations and those listed above was expected (and found) to be weak, attention was restricted to the latter.

Each of the occupational categories mentioned represents a functional department within the hospital. The formal organizational charts of two of these departments (adopted from the departmental manuals) appear in Figures 2 and 3. The individuals working with psychiatric patients form a sub-category of each of the functional departments.

Thus, starting with the folk categories<sup>34</sup> of 'psychiatric in-patient' and 'therapeutic work', we can designate a group of employees with reasonably definite boundaries. Some persons who are not employees of the hospital may also come into therapeutic contact with patients (e.g., vocational therapists or volunteers) but during the research period such contacts were few and not at all systematic. It should be also noted that most psychiatrists are not employees of the hospital.

Those to be identified as members have a special formal status consisting of 'admitting privileges'.<sup>35</sup>

The group of positions comprising our unit of analysis and containing the segments of various functional departments appears in Figure 4. The lines there correspond to formal authority relationships. All position-holders below the level of the Director of Nursing, the Director of Clinical Services and the Director of Professional Services work at least occasionally with in-patients. In some cases (e.g., the nursing supervisor) such work seems not to be a formally designated part of the position-holder's duties.

Another formal line of authority cuts across those shown in Figure 4. The way this line of authority is expressed in formal organizational charts can also be seen in Figures 2 and 6.<sup>36</sup> Most of the present unit of analysis shown from the perspective of the second line of authority appears in Figure 5. The positions described by identical terms in the various Figures are the same and refer to the same position-holders. Two persons working occasionally with in-patients (the Chief Psychologist and the Chief Social Worker) are not formally subordinate to the Director of Adult Psychiatry.

It should be noted that the authority relations shown in Figure 5 are not always said to obtain without qualifications. For example, when asked to name his subordinates, the Director of Adult Psychiatry said, "... the five M.D.s (psychiatrists) are the only ones that are really subordinate to me." Presumably, the reference was to some sort of difference between the formal authority relations in Figure 4 and those in Figure 5.<sup>37</sup> This difference will be explored later.

There is also another set of authority relationships existing between individual psychiatrists and other staff members. Because of various legislative provisions, psychiatrists claim certain authority over all staff working with in-patients. These relationships will be attended to later and need not be schematically represented here.

There are approximately 44 nurses working with psychiatric in-patients. Because of circumstances to be described in more detail later, the Nursing Supervisor was the only one interviewed among those belonging to the functional division of 'nurses' as shown in Figure 4.<sup>38</sup> Otherwise, all those in supervisory or higher positions shown in Figure 4 were interviewed, with the exception of the Executive Director. As far as the members at the lowest organizational level are concerned, among those interviewed were two of the four psychologists, three of the four social workers, two of the five psychiatrists, and one of the two recreational therapists. There is one part-time occupational therapist and one unqualified assistant. Neither was interviewed, because of the absence of the former during the research period, and because the latter was a deviant case, not having the ordinary appropriate occupational credentials possessed by the rest of the staff in the psychiatric hospital.

Another part of the studied unit consists of the Out-Patient department. Later on it will be useful for our purposes to distinguish between two categories of 'out-patients'. At this point let it suffice to say that the department deals with what can be referred to as the 'formal out-patient'.

A person acquires the 'out-patient' status by being referred to the out-patient program<sup>39</sup> by a psychiatrist with admitting privileges,

whereupon a file on the patient is started by the two nurses in the Out-Patient Department. Thus identified, out-patients then participate several times a week in various activities organized by out-patient and other personnel and receive several types of services. The total number of out-patients formally in the program is approximately 45. The number that actually come to the hospital on any given day fluctuated between ten and thirty during the research period.

The formal chart of the Out Patient Department appears in Figure 7, showing the 'clinical', rather than 'functional' structure of the department. The various occupations involved there belong functionally to the same departments as the identical occupations in the in-patient unit. The Head of the Out-Patient Program is a part-time salaried position occupied by one of the psychiatrists with admitting privileges in the in-patient unit. All of the persons occupying the positions shown in Figure 7 were interviewed. Each position corresponds to one person only, working either full-time or part-time in the Out-Patient Department.

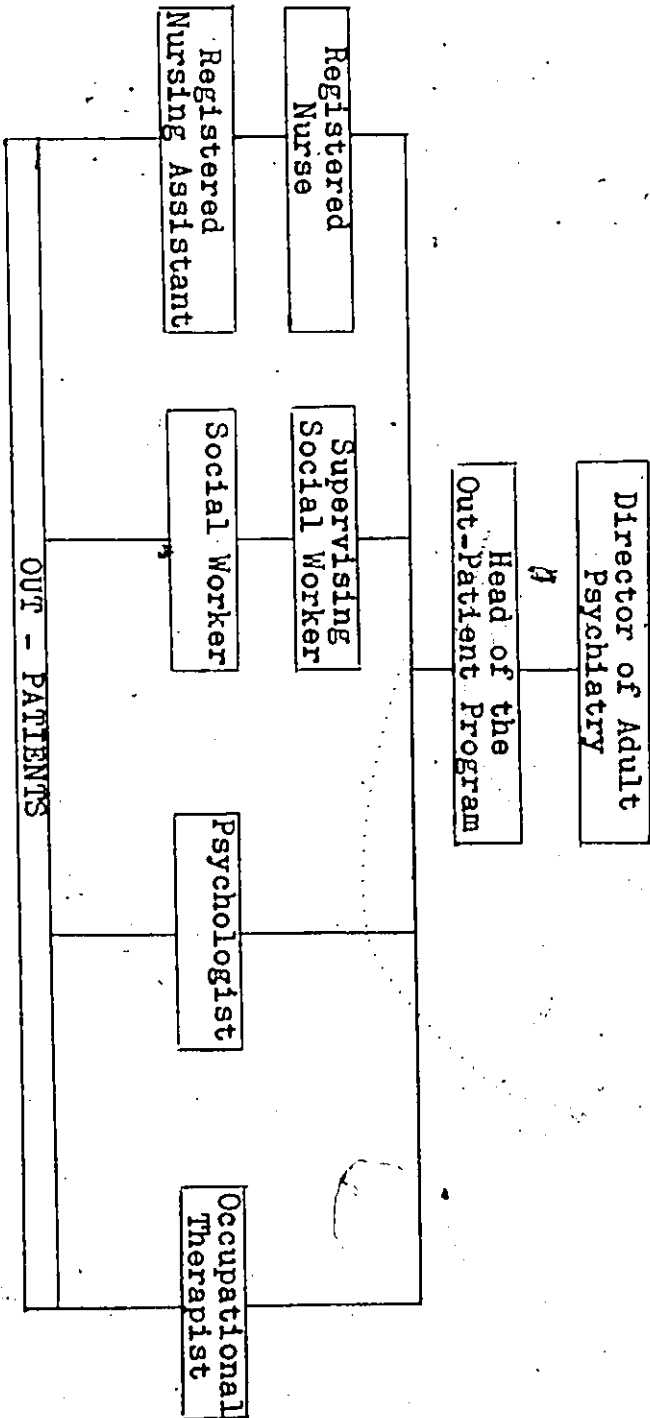
Various employees of the hospital not formally belonging in the Out-Patient Department work occasionally with the out-patients. Some of these involvements were found to be of minor importance, however, and there is no need to include such personnel in the unit studied. The few important regular contacts between out-patients and staff not formally belonging to the Out-Patient Department involved staff previously included in the in-patient unit.

Thus, in terms of the formal positions involved, the unit of analysis consists of a combination of the structures shown in Figure 4 and Figure 7, with the exception of the Executive Director. As has been



Figure 7.

The 'clinical' authority structure of the Out-Patient Program (Department).  
Source: Respondents' verbal statements and functional departments' manuals.



All positions shown may work directly with out-patients. Such work is the principal activity of those below the level of the Head of the Out-Patient Program.

noted, because of certain difficulties to be discussed later, in-patient nurses were omitted from interviewing and therefore, from most of the analysis to follow.

The situation is somewhat more complicated when, instead of focusing on positions, attention is given to actual persons and their work assignments. Since a chart showing the formal positions of individuals and the type of patients they work with would be too involved and difficult to read, the individual assignments are described in Note 40.

## The Plan of Analysis

It has been suggested earlier that, in discussing autonomy, attention has to be given to specific relationships. To a certain limited extent generalizations can be made about the relations between certain categories of organizational members, such as psychologists and social workers. With this in mind, the analysis will focus on each of the following sets of relationships in turn:

(a) The relationships among the members shown in Figure 8. This level (to be referred to as the 'department head level') includes those in the formally highest positions in the analyzed unit.

(b) The relationships within each of the functional departments, with the exception of nurses.

(c) The relationships within the Out-Patient Department (Figure 7).

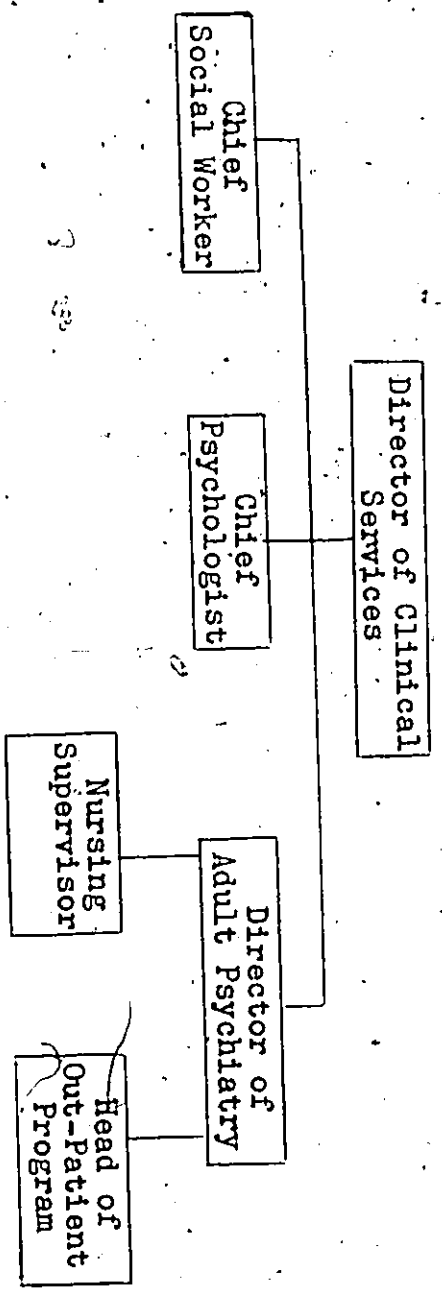
(d) The relationships within the In-Patient Department (Figure 5).

### 1. Autonomy at the 'Department Head Level'

Because of the methodological requirements set out earlier in terms of the desired characteristics of data and because of the emphasis on the limits of autonomy rather than on a mere description of routinely-made decisions and routine activities, little information is available on the autonomy structure at the Department Head Level (Figure 8). Few of the interactions involved were subject to observation by the researcher and the respondents were quite determined to speak in generalities whose reliability could not be estimated. In such general terms, some of the Department Heads feel that the Director of Clinical Services had too much influence over various financial decisions, such as those concerning

Figure 8.

The Department Head level of the analyzed unit.



staffing and equipment acquisition, and that these decisions were presumably made without due consideration of the therapeutic needs of the patients and the 'professional needs' of the staff. Needless to say, this is a quite common complaint in hospitals (cf., Perrow, 1963).

Another aspect of the autonomy of the Heads of functional departments concerns the control they have over their own departments' personnel. The dual authority structure would suggest that a degree of control be held by both the functional and the clinical department Heads and overstepping some limits of the control would automatically mean infringements upon another department Head's autonomy. With respect to that possibility it appears that in some cases the tendency is to desire and exercise less control than would be easily tolerated by others. From rather general comments made by the respondents it appears that the Heads of Psychology and Social Work would concede more control over the members of their departments to the Director of Adult Psychiatry and to the Head of the Out-Patient Program than the latter two can or care to assume. The opposite trend appears to be the case with the Nursing Supervisor.

There is some evidence to support the above generalization. In one case, certain procedural innovations were being introduced in the out-patient department which concerned among others the psychologists working with out-patients. Because of a disagreement between the Head of the Out-Patient Program and some of these Psychologists, the Chief of Psychological Services was called upon to influence his subordinates and resolve the matter. Although the Chief Psychologist agreed that the proposed changes were desirable, he expressed unwillingness to intervene in the matter and opined that the problems concerned clinical procedures

and should be resolved by the Director of Adult Psychiatry. Thus, the Chief of Psychological Services (Chief Psychologist in the following) would abandon some of the decision-making discretion over what in the interpretations current in the hospital was his area of the staff's work.

The mechanism responsible for the above state of affairs seems to consist of two elements. First, the Chief Psychologist was faced with forcing a decision upon his staff that had been publicly rejected by one of the psychologists, and such behavior would not be in the best spirit of professional collegiality. It could have jeopardized the relations within the Department of Psychological Services and create dissatisfaction because of decreasing the psychologists' autonomy (to wit, the initial conflict arose over an expression of the psychologists' attempted autonomy). Furthermore, since the moot decision in question had been opposed publicly, its acceptance would mean giving in to the pressure of the psychologist who requested the Chief Psychologist's involvement. And accepting the authority of psychiatrists, irrespective of their precise organizational position, are disliked by psychologists and some other staff alike. Indeed, some respondents stated openly that their respect for the Heads of functional departments varies directly with the opposition these department Heads show against the demands of the psychiatrists.

That the two clinical directors involved did not try particularly to assert authority seems to be due mainly to the possibility that such an attempt may have been rather time-consuming. All psychiatrists see private patients (including the Director of Adult Psychiatry) and time spent on other activities is, therefore, not only relatively non-productive in terms of patient care but downright counterproductive in terms of the psychiatrists' incomes.<sup>41</sup>

Therefore, the Head of the Out-Patient Program, instead of asserting his authority and attempting to argue the legitimacy of the decision in question (which might involve various forums and a number of occasions) relied instead on what he called 'public opinion pressure', i.e. on the pressure to be exerted, presumably, by the rest of the staff of the Out-Patient Program who all agreed that the contemplated procedural changes were desirable. Thus, the change could be implemented without a time expenditure on the part of the psychiatrists involved and without the Chief Psychologist's initiative in acceding to a psychiatrist's wishes.

The reliance on 'public opinion' incidentally increases the staff autonomy by making their course of action discretionary, as against a situation where the Heads of 'clinical' departments would make the decision and put it through by their own initiative.

The above incident indicated a tendency by some department Heads to concede to others some of their departments' autonomy. The opposite situation can be illustrated by the circumstances surrounding the researcher's attempts to have access to direct observation of some of the staff's activities. The organizational events in question constitute a study of hospital rule-use made possible by the trouble caused by the researcher's presence and requests. In effect, Garfinkel's (1967: 37) advice was followed, suggesting that to study social structures it is well for the researcher to cause trouble, for in the process of repairing the routine appearance of social life and accommodating new eventualities to the rules presumably in use, the underlying structure of these rules is revealed. Of course, the trouble was caused inadvertently, by the very presence of the researcher and his apparently inconspicuous requests.

The rule in question concerned the conditions of allowing outsiders to be present on the psychiatric wards. Such a rule should consist of a formulation of the prerogatives of one or several positions to authorize or deny such access. Inquiries into the formal terms of that rule found that the Director of Clinical Services claims the prerogative in question for the Executive Director and for himself as the intervening link in the line of authority. The Director of Adult Psychiatry claims the prerogative for himself as well. As a practical matter however, neither of these two position-holders ventured to overrule the opposition to the researcher's presence on the wards, expressed by others (the Executive Director was not involved).

The problem was handled differently by the two parties claiming authority over it. The Director of Adult Psychiatry granted his permission to the researcher but left the matter at the discretion of a Head Nurse on one of the wards who then refused the researcher access to the ward while suggesting that a permission from the administration (i.e., the Director of Clinical Services) was necessary if the access were to be granted. The Director of Clinical Services originally promised the researcher access to the wards but several days later the researcher was informed that the promise could not be kept after all. Since the Director of Clinical Services refused to discuss the circumstances surrounding the matter, it can only be surmised that the end result was brought about by opposition from certain quarters, most likely from the Nursing Supervisor who was the only staff member to express to the researcher opposition to his presence on the wards.<sup>42</sup> The reason given was that the researcher's presence might upset the patients.



Thus, the researcher's case was for practical purposes judged not to fall under the general rule that only persons with legitimate business on the ward and not presenting a significant potential detriment to the patients are to have access to it (which was the formulation of the Director of Clinical Services). Furthermore, the position-holders who formally are to determine individual cases' conformity to the rule apparently cannot do so strictly on their own but have to obtain the consent of at least some other members. Insofar as the formal rule specifies the area of decision-making autonomy of some position-holders, the successful opposition to their initial evaluation of the researcher's case signifies an encroachment on this autonomy and, conversely, an increase in the autonomy of the people working on the wards who thus increase their control over the conditions of their work.

The rule concerning outsiders' access to the ward is obviously very vague and no guidelines exist for its application. Presumably under the provisions of the rule, various outsiders are regularly granted access. This most notably includes student nurses and social workers. These two categories of outsiders are connected with occupational groups within the hospital, which may account for the difference in the treatment accorded the student nurses and social workers against the researcher. It may be that in a case where no inside interest group supports the outsider, the matter is not pressed by those presumably with the necessary authority even if only not very extensive opposition is encountered.<sup>43</sup>

What appears to be a similar pattern was encountered when the researcher requested to be allowed to attend case conferences. While the Director of Adult Psychiatry expressed a willingness on his part to grant

the request, he claimed no authority to do so inasmuch as a policy had been formulated some time ago not to allow outsiders to attend the case conferences. Reportedly, this policy had been adopted at the insistence of 'the nurses' who 'feel on display when outsiders are present and therefore object to it'. Consequently, the nurses' permission was necessary. It was denied by the Nursing Supervisor on the grounds that the researcher's presence at case conferences would jeopardize the confidentiality of the matters discussed there. No other nurses were involved in that decision. Thus, while the Director of Adult Psychiatry did not claim authority over an area of decision-making, this authority was in effect taken over by another position-holder.

In the out-patient program the permission to attend case conferences was denied by the Head of that program, on the grounds of protecting the confidentiality of the patients' matters discussed there. That decision was reportedly only announced in the case conference, not discussed. On the other hand, permission was granted the researcher to attend 'staff meetings' in the out-patient programs, i.e., meetings at which specific patients were not discussed. No opposition to the researcher's presence at these and other staff meetings was encountered whatever.<sup>44</sup>

The mechanism responsible for the apparent shift of actual decision-making power towards the Nursing Supervisor in matters concerning the researcher is not quite clear. To a certain extent, it may be due to the negligible importance of those issues to some of the other participants. Since the rationale for the decisions in question concerned confidentiality of the problems discussed in case conferences, position-holders who could oppose those decisions could be called upon to defend

their positions, thus losing time over an unimportant matter. Of course, one cannot tell beforehand which issues will be judged unimportant, especially since at occasion a supposedly unimportant issue may be treated as a 'matter of principle' and thereby, in effect, acquire importance.<sup>45</sup>

The available data suggests, then, that there are to a certain extent conflicting tendencies on the 'Department Head level' where the extent of individual control over various matters is concerned. In most cases, there is an absence of the tendency to acquire more direct control over various issues. Especially interesting is the willingness of the Chief Psychologist to concede a degree of control over his staff to the 'clinical' authority line. This may be an example of what, according to some sources, is a relatively recent trend in the authority relations in psychiatric hospitals, a trend towards greater emphasis on the 'clinical' authority (Berkanovic and Vander Haegen, 1974).

It should be emphasized, however, that as far as the current distribution of control between the Director of Adult Psychiatry and the Heads of functional departments is concerned, an incomparably greater amount of control seems to be exercised by the latter. Some respondents expressed this difference in terms of a lack of leadership on the part of the Director of Adult Psychiatry, but a similar conclusion seems to be dictated by the fact that several respondents could think of no contacts with the Director, nor of any requirements placed on them by the Director. The staff activities ('programs') seem to be established almost exclusively under the umbrella of the functional departments.

Some encroachment on the autonomy of functional departments seems to be in the form of 'public opinion' mentioned earlier which is

based on the desire of the participants to command a degree of respect by others. Another reduction of the functional departments' autonomy is due to the special legal status of the psychiatrists (with M.D. degrees) which will be elaborated upon later. At this point it need only be noted that the last of the above sources of limitations on the functional departments' autonomy does not arise from the psychiatrists' formal positions in the hospital (such as that of the Director of Adult Psychiatry) but from their legal status as physicians with admitting privileges, among other things.

## Autonomy Relations within Functional Departments

This section deals with the restrictions on individual autonomy imposed by the individual's superior(s) within the functional departments. Because of lack of data, the psychiatrists are excluded from this discussion. The department of Occupational Therapy will be considered briefly, followed by the departments of Social Work and Psychological Services.

### 2. The Department of Occupational Therapy

This department's functional line of authority is shown in Figure 4. In broad outline, the limits on the autonomy of the department members relative to the Director of Professional Services are said to consist of the requirement that programs of work with patients be in existence, that the department's work not arouse criticism from the Director of Adult Psychiatry and other quarters,<sup>46</sup> and that a record of individual activities be kept. This record has to contain the patient's names, the type of activity, and the time spent at it. Similar records have to be kept by members of other departments. As in all other cases, no audits of these records are made. They are considered valid for the statistical purposes for which they are kept.

The requirement that programs be in existence is fulfilled when the occupational therapist is able to outline a plan for patients' activities and has available the necessary paraphernalia. Supervision by the Director of Professional Services is sporadic, having been described by one respondent by saying that the Director 'walks through, maybe once a month, and asks how things are going'. In areas not directly related to the work with patients the Supervisor reports few con-

tacts with the Director, such as for permission to advertise a position in the newspapers (the hiring decision itself will reportedly be made by the Supervisor). The above points mostly involve fairly specific areas and limits on autonomy of departmental members. Reportedly, no opposition to these limits exist. They are accepted as a matter of convention.

Only one of the already mentioned limitations on the department members' autonomy is rather vague and needs further attention. It concerns the requirement that the department's work not draw criticism from other hospital staff. Presumably, the higher placed participants in the department's functional hierarchy would, or could attempt to, limit the lower participants' autonomy so as to remove the sources of outsiders' criticism. As a practical matter, however, no instances of such a nature were reported.

To account for this apparent absence of conflicting views of the department's work, several things have to be considered. First, the department's work is largely marginal from the viewpoint of other staff. On several occasions, its role was expressed by psychologists and social workers as 'giving the patients something to do'. The 'things to do' consist of arts and crafts in which patients can engage during specified time periods. Patients are referred to the department by other staff, and other treatment takes precedence in cases of conflicting time schedules. (Only patients thus referred can be accepted.) The department can, presumably, refuse to accept 'unsuitable' patients but no attempt to act on this claimed privilege was recalled by the respondents where in-patients were concerned.

The occupational therapists receive few instructions when

the patients are referred to them. The only reported type consists of a cautioning that certain topics of conversation might upset the patients. These warnings are reportedly heeded, apparently because the ability to maintain a smoothly running operation seems to be recognized as a sign of competence.<sup>47</sup> Thus, the activities of occupational therapists are considered marginal to the therapeutic activities taking place within the hospital. Consequently, the routine operation of the department, restricted to what are conventional activities for occupational therapy<sup>48</sup> engenders no appreciable controversy. This is not to say, of course, that the rhetoric of occupational therapy conceives of the field in such inconsequential terms, but only that the conventional activities performed by occupational therapists are innocuous and, in the opinion of other professions, 'cannot do any harm'. Therefore, occupational therapy does not have to be specially articulated with other therapeutic activities, with the consequence that there is no appreciable tendency on the part of other professions to modify the work done by occupational therapists of their own accord, as a result of their training.

There were no indications that the occupational therapists ventured in their work beyond the 'uncontroversial' activities. The patients are brought to them during scheduled times if no other therapy interferes and during thus delimited periods of time the occupational therapists' activities seem to be subject to no pressure to take a different course than they would take anyway. In the absence of outside pressures, the intra-departmental hierarchy which could interfere in an individual's work in order to modify it somehow appears not to pursue ends contrary to the lower participants' voluntary behavior.<sup>49</sup> This situation largely applies both to the occupational and recreational

therapists in the department, with some slight differences for the latter.

The work and the circumstances of recreational therapists are quite similar in relevant respects to those of occupational therapists. The work activities include the conducting of exercises, games and social activities, such as dances, for in-patients. These activities are scheduled so as not to conflict with therapeutic activities. Patients can participate without having been referred to the program by other hospital staff. The recreational therapists can exclude patients from the activities if they disturb the proceedings.

Similarly as occupational therapy, recreational therapy is considered marginal by other professions. Reportedly, few instructions about the work to be done with patients are received and these are complied with (such as giving a patient exercises for the back). No instance of a disagreement on the proper type of exercises was reported. Otherwise, the smooth conduct of recreational therapy work requires that accidents involving bodily harm or disturbances do not occur. That objective is shared by all members of the department.

As far as the 'functional' line of authority is concerned, then, no actual conflict of interest was found where work with patients is concerned. Some pressures in the area of work were reported as coming from outside the department but they were not supported by the Supervisor or the Director of Professional Services. Thus, it was reported that some psychologists attempted to induce the recreational therapists to organize competitive games for patients. The recreational therapists refused to do so and since the functional hierarchy did not



actively support the psychologists, the matter was dropped.<sup>50</sup>

A similar incident was reported concerning the scheduling of recreational activities, when several nurses suggested that some activities should be scheduled on weekends when the patients have nothing to do. The occupational therapists were opposed to the proposal and received the support of the occupational therapy supervisor. Once again, the therapists were successful as the proposal was not pursued beyond the level of suggestion in meetings.

Only in one respect do the recreational therapists enjoy less control over their work than they would desire, namely, in the scheduling of the gymnasium. By an earlier administrative decision, basic control over the gymnasium schedule is in the hands of the Director of the Rehabilitation Centre (cf., Figure 1, 2). The problem was brought up at meetings but without success, as the lower participants were unable to influence those who are in the position to change the rule in question.

In sum, there are some administrative restrictions on the members of the Department of Occupational and Recreational Therapy, but these restrictions are minor and meet with little opposition while being considered a reasonable and conventional facet of a hospital's operation. Where work with patients is concerned, the marginality of this department's work in terms of its therapeutic function seems to leave little room for conflicting views and consequent restrictions on the staff's autonomy. The staff of the department are given control over a segment of the patients' time during which they perform activities compatible with their training.

This segmentation of the patients' time and the relatively low level of articulation of the activities of different professional groups seems to be made possible by the character of the technology involved, especially in terms of the high level of uncertainty concerning the casual models employed and the difficulty in estimating the efficacy of various therapeutic activities, and especially of sets of such activities.

Of course, the degree of isolation of the activities of the different professions involved may vary. According to a respondent familiar with the situation in some other institutions of a similar nature, the psychiatric section of Windsor Hospital shows a particularly low level of inter-professional contacts and consultation. This may be an aspect of the already noted tendency towards emphasis on the authority within functional departments. Furthermore, according to Coser (1958: 259-261), the level of inter-professional consultations and articulation of activities is directly related to the degree of concern with therapeutic success. Insofar as that proposition is correct, it would seem that emphasis on therapeutic success is not compatible with emphasis on functional authority lines. The latter can be expected, then, to fulfil other functions.

The above matters will be more fully discussed later in the context of interdepartmental relations. At this point it will suffice to suggest that the alternative function in question appears to be the improvement of the status, influence and autonomy of the various professions relative to the psychiatrists, or that, as one respondent put it, the members of various professions 'flock together for protection'. At any rate, the result seems to be that each profession performs the

therapeutic activities traditionally within its sphere according to individual judgment, and is wary only of 'incidents'.

The overall planning of a patient's therapy goes only slightly beyond putting a patient through a set of routine existing programs. The contrasting possibility would involve the existence of a binding plan of treatment for each patient. Currently, each therapist has the tendency and opportunity to make his own assessment and act accordingly.<sup>51</sup> Of course, this can be done only after the individual acquired a patient. The control over patients will be presented as a central power source in the hospital. In the case of occupational and recreational therapy there is no shortage of patients, however. Perhaps because of the innocuousness of the department's routine work and the department's lower status, the individuals who can control the flow of patients to the departments seem not to be interested in utilizing that resource.

### 3. The Department of Social Work

The segment of the department to be examined consists of the Chief Social Worker and six social workers. Four of them worked with in-patients and two with out-patients. One social worker in each of these categories held only a temporary position and left the hospital at the end of the research period.

The work social workers carry out consists of researching and writing 'social histories' of patients (i.e. records of the patients' past and present circumstances), personal counselling, family counselling, referrals of patients to other agencies or organizations, running therapy groups, participation in case conferences, staff meetings and informal consultations, producing progress reports, and keeping a statistical record of their activities. The latter consists of recording the

patient's name and the type of activity performed.

Although formally one social worker in each of the in-patient and the out-patient unit is designated as 'supervisor', there seemed to be no substance accompanying that designation. Therefore, the autonomy relations concern mainly those between the Chief Social Worker and each individual member.

The individual social workers desire to be well thought of by their colleagues. They seek support from others for various issues where the operation of 'public opinion' is useful, such as in proposals for changes in the programs. Consequently, certain limits on individual autonomy can be expected to exist because of the dependence on this support. No evidence was found, however, of individual behavior being under, or being adjusted to colleague pressure, except indirectly. Some differences among individuals can be found,<sup>52</sup> but they seem to be fully tolerated. Insofar as individual social workers' behavior does not accord with what they would recognize as the ideal state,<sup>53</sup> the discrepancy would seem to be due to limits imposed by organizational participants other than fellow social workers. Some of the discrepancies between the actual state of affairs and the professional ideology will be discussed in the following.

The relations between social workers and the Chief Social Worker can be best reviewed if the issues involved in these relationships are dichotomized into two categories. First, there are issues involving only the above two parties and, secondly, there are situations concerning the support given by the Chief Social Worker to his subordinates in their attempts to assert a degree of autonomy, mainly with respect to the psychiatrists.

There are few concrete restrictions on social workers' autonomy falling into the first of the above categories. They consist of the requirements that statistical records of the individual's activities be kept, and that the social workers keep the customary working hours. Exceptions have to be authorized by the Chief Social Worker. Of course, a certain amount of rule-breaking in this respect may exist, as strict control would not be feasible. More importantly, social workers have to continue the existing programs of group therapy. It should be noted that no wish to discontinue existing groups was reported by the social workers.

Another formal restriction is that social workers have to be available to work with specified types of patients. In the out-patient department that simply means work with formal out-patients, upon the request of the Head of the Out-Patient Program or other out-patient staff. In the In-Patient Department a social worker may be assigned a specific number of beds on a given ward or may be assigned to a specific ward as a whole. Requests for social work involvement may come from psychiatrists or occasionally from other staff. The social workers have also other sources of patients, which means that they are not fully bound by the present arrangement. The present arrangement seems to meet with the approval of those concerned, perhaps because it largely guarantees each social worker an exclusive supply of patients. Some negative consequences of this arrangement will be noted later when inter-professional relations are considered.

The above points refer to the fairly general rules governing personnel assignment and basic activities, as these rules actually function. Because of other characteristics of the situation, these rules are

even less restrictive than might appear initially. For one thing, there is no specific requirement concerning the caseload a social worker has to carry. Although the Chief Social Worker suggested that the caseloads are about the same, they were reported to vary between 15 and 25 in the in-patient department, and up to 32 in the out-patient department. The two types of patients may not be strictly comparable, of course, and because the in-patient department social worker with the caseload of 25 runs no therapy groups, the actual workloads may be quite similar.

In the absence of a required caseload, then, only the (presumed) uniformity of workloads has to be maintained. According to the Chief Social Worker, those with apparently lower workloads would be judged not to perform adequately. Thus, the effective rule governing the size of workloads is that apparent uniformity be maintained. Probing did not uncover any reasonably concrete criteria for judging the workload, however. Irrespective of how vague the standards are, because of the criterion of uniformity the social workers as a group can, to a certain extent, establish the workload standards and not be bound fully by the number of beds assigned to them. This situation also gives rise to indirect limits on individual autonomy. Since social workers in effect establish the standards, they exercise pressure on their colleagues to maintain certain outward signs of performance.

Further comments on the types of performance evaluation will be made later, in the context of discussing the Chief Social Worker's support of the social workers' tendency towards autonomy relative to other professions. At this point the final type of issue internal to the Department of Social Work should be mentioned. It concerns the

control social workers have over the establishment of new or modified programs and assignments.

During the researcher's presence in the hospital, there was an attempt to modify a part of the out-patient program. The initiative seemed to be entirely that of the social workers involved. However, the changes tended to routinize and extend the social work involvement in the patient career<sup>54</sup> and thus were consistent with the apparent objectives of the Chief Social Worker.

Another change involved the assignment of additional duties to the social workers, namely, being on call to the emergency department of the hospital. The change was to consist of an extension of the social work role there<sup>55</sup> and of making the previously haphazard personnel assignments patterned by rotating the responsibility for the emergency service among the social workers in the psychiatric hospital. Neither the extension of their responsibilities, nor the method of assigning the responsibility (rotation) met with any opposition from the social workers who thus passively accepted the Chief Social Worker's initiative.<sup>56</sup> It will be argued later that these changes were highly functional (in the sense of being useful) from the viewpoint of the social workers, which may account for the lack of opposition on their part.

The last item to be noted concerns a social worker's intention to start a new therapy group. Reportedly, the initiative as well as the planning of the group's focus and activities were those of the social worker concerned. The implementation requires the approval of the Chief Social Worker, which was reportedly given with enthusiasm.

Thus, all of the changes in the basic outlines of the social workers' work activities that were in the process of implementation during the research period involved an extension of the role of social work within the hospital. This factor may have been crucial to the lack of conflict accompanying the changes as well as to the direction of initiative, given the concerns the social workers appeared to have. The source of these concerns seems to be in the relationship between social workers and other staff members, most notably the psychiatrists. Because of the relative non-involvement of psychiatrists with the out-patients,<sup>57</sup> the mechanism is slightly different in each of the two departments (in-patient and out-patient), although the situation in each has repercussions for the other.

As has been noted, the psychiatrists are private practitioners, with exclusive hospital admission privileges and legally sanctioned control over patients. Because of their legal liability, the psychiatrists claim control over the character of the therapeutic and other activities performed by the hospital staff with the psychiatrists' patients. From the reports of various respondents it appears that the control is rather erratic, in the sense that the psychiatrists assert their authority at some occasions only and with respect to specific interventions in the patients' treatments by the hospital staff, rather than in a more generalized or systematic manner by setting broad outlines of the staff therapeutic activities.<sup>58</sup> Accordingly, most of the time the social workers appear to be able to let their own judgment guide their work as the psychiatrists cannot possibly attend to all the details of other professions' work. Occasionally, however, a situation arises when a psychiatrist will assert his authority to make the binding interpretation of a patient's problem and prescribe the social worker's action.



If a social worker disagrees with the psychiatrist's view, ideally he should follow his own judgment. On the level of principle, all social workers (including the Chief Social Worker) propose that they as professionals should do so. As a practical matter, however, the social workers reported that they defer to the psychiatrists' judgments. This deference appears to be to a considerable degree due to the fact that the opposite would not receive the support of the Chief Social Worker. As one respondent put it, if a psychiatrist wants something, the Chief Social Worker 'considers it an order'. Thus, the Chief Social Worker contributes to the maintenance of restrictions on social worker autonomy).

It should be also noted that the way of dealing with the specific instances of intervention with patients is not the only substantive area where the same situation existed. Similar circumstances surrounded the issue of the rules governing the control over the disciplining of patients. There again, the Chief Social Worker reportedly failed to oppose the psychiatrists and agreed with an attempt to limit the discretion of the social workers.<sup>59</sup>

The above pressure is not the only reason for the limitations on the discretion social workers use. Other reasons will be noted in the section on inter-professional relations. Only the mechanism apparently responsible for the above described tendencies will be analyzed here.

The key observation seems to be that the Chief Social Worker pursues a policy of expansion of the department<sup>60</sup> and that the social

work involvement in the psychiatric hospital may have reached a saturation point.<sup>61</sup>

Consequently, an atmosphere favorable to the department is necessary, and from that viewpoint it seems requisite that the psychiatrists should not have trouble with social workers. Such cuts could idle the social workers to a certain extent and make it more difficult to argue that new positions be created.

Thus, even though the Chief Social Worker is probably aware of the dissatisfaction engendered by his support of the restrictions on the social workers' autonomy, the objectives pursued by the Chief Social Worker place him in a position of weakness with respect to the psychiatrists. It can be only assumed, of course, that were it not for this weakness, a different attitude would be adopted. It should also be emphasized that, to a degree, this situation is due to the character of the technology used. The technology is sufficiently vague to allow the psychiatrists either to avail themselves of the social work services, or not to do so, as social work intervention is not an essential part of the therapeutic process in any clearly identifiable sense.<sup>62</sup>

In the light of the above argument, and considering that the social workers would prefer a situation where they are not periodically faced with the psychiatrists' authority, the newly established programs discussed earlier seem to further the social workers' interests. To wit, each of these programs tends to provide social workers with patients who are not under the control of psychiatrists, at least where the social workers' contacts with these patients are concerned.

Consistent with the above analysis of the situation is the set of criteria social workers believe are used by the Chief Social Worker to evaluate their performance. In addition to the view that one criterion was the familiarity with their cases social workers display in case conferences, two other criteria appeared prominently. First, there is the initiative social workers display in volunteering to 'look into things' rather than limiting themselves to attending to unsolicited referrals. Secondly, some respondents suggested that the main, if not the only criterion used was how satisfied the psychiatrists are with the social workers.

The latter criterion seems not quite congruent with the proposition that was encountered, namely, that the quality of individual performance ought to be judged by fellow social workers who are presumably the only ones with the necessary competence where 'the family and the community' are concerned (as the domain of social work was defined by a respondent). It seems, however, that psychiatrists' satisfaction was judged to depend more on the subordination of social workers (i.e., fulfilling requests) than on the quality of their specialized work which would be extremely difficult and time-consuming for the psychiatrists to evaluate in any case.

The ideology of social work appears remarkably tolerant of relatively close supervision of junior social workers by senior social workers. According to Scott, there is a sanctioned pattern of 'tutorial supervision' (1965: 71) distinguishing the profession of social work. The same pattern seems to persist to some extent at Windsor Hospital. Thus, all social workers agreed that the Chief Social Worker has the

right at any time to examine minutely his subordinates' work, and to ask them to justify every action they took, or any failure to take action, in a particular case. It was not proposed that the suggestions the Chief Social Worker may make should be binding, nor was any report made of the Chief Social Worker attempting to make such suggestions, except in the support of psychiatrists. The formulations of the superiors' rights were found to be different among the psychologists. There it was only suggested that the Chief Psychologist had the right to read the reports produced by individual psychologists.

The above ideology notwithstanding, the current practice in the Social Work Department contains no elements of the close supervision pattern. None of the social workers interviewed could recall an instance of being called upon to account for his handling of a case by the Chief Social Worker. Therefore, performances in case conferences are the only occasions for direct evaluation of the quality of work by the Chief Social Worker. But since the Chief Social Worker is not familiar with other social workers' cases, the judgment of members of other professions seems to be the only workable source of evaluation.

The only performance criterion enforced directly by the Chief Social Worker concerns the statistical records social workers have to turn in. One of the purposes of these records is to account for the social worker's time. That this purpose is achieved is a proposition hinging on the assumption that the activities recorded did actually require the time conventionally allocated for them. For example, if the record shows an interview with a patient, the entry is

regarded as accounting for one hour.

How exactly social workers deal with this convention is not clear, except that they respect it in the statistical reports. Since no checks on the reliability of the reporting are made, it is possible that, as a practical matter, social workers behave in greater or lesser disregard of the time standards while reporting in conformity with them. Thus, although the standards would tend to limit seriously the social workers' autonomy by removing their discretion over the time to be allocated to single episodes of various work activities, it is well possible that the standards do not actually function in that manner.

That the time allocation conventions are not always considered reasonable or appropriate is indicated by the case of a social worker the researcher was told about. The case is a part of the organizational folklore from the recent past. Thus, a social worker was reported to have recorded 17 interviews for a single day, which is the conventional equivalent of 17 hours of work. For our purposes this may be taken to indicate that the standard does not reflect everyone's views on time requirements. However, it should be noted also that the case was related as an instance of organizationally incompetent behavior, a faux pas a competent person would not commit. Aside from the above problem, it is also possible that the statistical records may contain fabrications since, as has been noted, no checks of these records are made. In the final analysis, then, the records need not appreciably reduce individual autonomy, except to the extent that they have to be produced.

Finally, two areas of decision-making should be mentioned with respect to which social workers are subject to no restrictions.

These areas are important for the relations between social workers and other professions that will be discussed in greater detail later on. First, there are no restrictions on the amount of time to be spent working with a patient, either in terms of frequency of contacts or the total amount of time involved. Secondly, social workers may follow up discharged patients even though these ex-patients are not registered nor participate in formal out-patient programs. Also, there is no limit on the length of time over which these 'informal out-patients' can be followed (given counselling, etc.). The especially important point about the informal out-patients is that work with these patients is not subject to the psychiatrists' control. Social work involvement in such cases is a private arrangement between the ex-patient and the social worker.<sup>63</sup>

To summarize the most important points, it seems that the restrictions placed on social workers directly by the Chief Social Worker are rather trivial and minimal. There was no indication of an inclination or an attempt to impose restrictions whose factual contents would not be highly suspect. In terms of program development, the interests of the whole department seemed to coincide.

Limits on individual autonomy that conflict with the social workers' orientations obtain in the area of relationships between social workers and psychiatrists. The psychiatrists claim the authority to have their treatment instructions carried out even if they are at variance with the social workers' views. The Chief Social Worker supports the psychiatrists, possibly because of the influence psychiatrists have on the availability of patients for social work intervention

and on the staffing of the Department of Social Work. It should be noted that the Director of Adult Psychiatry was not found to have any greater or difficult pattern of relationships with social workers than other psychiatrists.

The arrangements within the department entail quite definite limits on the sources of patients to which the social workers have access. In effect, each social worker is limited to an exclusive set of sources. It seems, however, that the situation coincides with the interests of those involved, perhaps because it eliminates a potential conflict or uncertainty area. Since performance standards are extremely vague, the influence exercised over individuals by their colleagues/as a group need not be great even though the setting of standards seems to be controlled to some degree by the social workers themselves.

The restrictions placed on the social workers' autonomy by the other professions involved were quite vague. They were made possible by the social workers' desire to be well thought of by others. Consequently, the social workers do not always insist on making and following an independent assessment of a patients' situation when asked to intervene, as would be dictated by their professional ideology. However, these relations were highly individual and defy generalization beyond the above statement. The Chief Social Worker was reported not to interfere in these relationships.

There were no reports of any profession encroaching on another profession's field of competence. Because of their training, inclination and presumed expertise, each profession tends to restrict itself to activities traditionally within its purview. There are occasional

disagreements regarding specific treatments, but in such instances individual autonomy suffers apparently only if the psychiatrists become involved. Otherwise, each individual uses the time he spends with the patient or in family intervention according to his own judgement.

#### 4. The Department of Psychological Services

The studied segment of this department is shown from different perspectives in Figure 3, 4 and 5. The 'psychologist' in the Out-Patient Department (Figure 7) is formally a part-time position held by the Supervising Psychologist in Figure 5. Including the Chief of Psychological Services, <sup>64</sup> five Psychologists are involved.

Two aspects of the psychologists' intra-departmental autonomy can be distinguished. We shall discuss, firstly, autonomy with respect to therapeutic work and, secondly, autonomy relative to assignments, administrative procedures, and intra-departmental control over the relationships with other professions.

On the part of the Chief Psychologist and the Supervising Psychologist, supervision of therapeutic work reportedly consists of observing the psychologists' performance in case-conferences and occasionally reading test reports. Indirectly, the observations and views of other participants may come to the Chief Psychologist's and the Supervisor's attention. In practice, then, there is no appreciable difference in the form of the supervision of therapeutic work between



the departments of psychology and social work, except for the more frequent attendance of the Chief Social Worker in case - conferences and other meetings.

In terms of the principles enunciated by the respondents, however, there is a notable difference. Thus, the Chief Psychologist does not claim the right to examine a psychologist's patient to assess the situation and the adequacy of the therapy, whereas the Chief Social Worker does. The rationale underlying this position ostensibly is that the examination would "undermine the relationship between the therapist and the patient". This reason may well be specious to a large extent, even though the possibility of undermining the relationship in question need not be denied. Aside from the possibility that the senior psychologists prefer to perform therapy rather than engage in close supervision, it seems likely that close supervision would meet with resentment no one cares to engender.

The psychologists show considerable interest in the affairs of the psychiatrists and aspire to the same status. Accordingly, there is an incentive to approximate the position of the psychiatrists whose therapeutic work is not subject to any supervision whatever, save for the fact that they do develop a reputation among the staff and that they are subject to certain legal liabilities. On the other hand, the psychologists follow the academic model in that various members of the department will periodically conduct seminars in which research or cases may be discussed. Furthermore,

the department members are encouraged to publish.

Thus, perhaps the best way of pointing out the difference between the supervision ideologies of the departments of social work and psychology is to suggest that the psychologists are given control over the occasions at which their competence will be judged, and over the material to be used to judge that competence. As has been suggested, however, in practice the difference is not in the kind of supervision and control over individual therapeutic work, but only in the frequency of observation of performance in case conferences. It should be emphasized that the preceding involves no authoritative interference by the Supervisor or the Chief Psychologist in their subordinates' therapeutic work. No such interference reportedly occurs, whether based on the discussions in case conferences or on otherwise obtained information about patients. The input by senior psychologists has the status of suggestions only.

The quality of work is judged in a quite nebulous manner and the best that can be done to describe the criteria used is to say that the other professionals involved must gain the impression that a psychologist's patients improve or at least do not deteriorate, that the patients have a favorable attitude towards the psychologist, and that disruptive incidents or extreme behavior of some kind do not occur. Of course, it is not suggested that such incidents would not be tolerated at all but only that they must be kept to an acceptable level. It is not at all clear, however, what that

level is and no instances of performance judged substandard were reported.

The quantity of the work carried out by psychologists is regulated by similar conventions as that of social workers. The psychologists compile monthly reports of their activities, which include group and individual therapy, diagnostic assessments and more or less formal consultations with other staff. The reports which serve to account for the psychologists' time amount to a loose quota system in which each activity has a conventional time equivalent. This need not seriously restrict the psychologists, since no examination of the validity of the reports is made. More importantly, no specific rules apply to the amount of time to be spent with individual patients. Although extremes would supposedly not be tolerated, the limits were left unspecified. Thus, the case-load seems to be governed by a loose convention that somehow developed among the psychologists themselves and is maintained spontaneously.

The only two specific rules that restrict the psychologists are that, firstly, written reports of diagnostic assessments be produced and, secondly, that therapy group sessions be attended. The therapy group sessions are a regularly scheduled part of the hospital therapy program and non-attendance would be easily noticed. On the other hand, the work done in therapy groups and in the process of producing diagnostic assessments is at the discretion of the psychologists, within the broad limits mentioned earlier (e.g., that

no extreme behaviors occur). It is within the psychologists' discretion what type of testing to use in the process of producing a diagnostic report. The referring agent, such as a psychiatrist, can request the use of specific diagnostic devices but these requests are not binding on the psychologists.

No written reports on group or individual therapy sessions have to be produced. Verbal reports on patient progress may be made in case conferences or informally. While in-patient attendance in therapy group sessions can be assured by the nurses, the out-patient attendance cannot be controlled. It was proposed as a part of the already mentioned changes in the out-patient program advocated by some of the staff and by the Head of the Out-Patient Department that the psychologists start regularly reporting out-patient attendance and progress in therapy groups. At the end of the research period this change has not been instituted, however. The Chief Psychologist refused to dictate to the psychologists, suggesting that the matter should be handled by the 'clinical' authority line.

In general, then, the restrictions placed on the psychologists' therapeutic and related work by their department are quite vague in a number of respects. Essentially, the character of the work is at the psychologists' discretion and its quantity is subject to very flexible regulations, partly because of an absence of checks on the reliability of reporting. The exceptions exist in the area of attendance

in group sessions and production of diagnostic reports. Once a psychologist starts running a group or accepts a diagnostic assignment, he is required to attend sessions and to produce the diagnostic assessment report.

No attempt has been reported or observed to increase the control over the psychologists' work by any members of the department. To a certain extent, this may be due to the difficulties such attempts would encounter because of a high level of technological uncertainty. It seems likely, however, that more important in this respect is the lack of interest on the part of the higher placed participants in exercising greater control, and an unwillingness to engender dissatisfaction with, and opposition to greater restrictions.<sup>66</sup>

For example, even though the reporting of out-patient attendance in therapy groups presents no technical problems, the Chief Psychologist did not impose a decision on his subordinates, one of whom contended that "group attendance is good and it is not necessary to report it". It has been already noted that, for the implementation of this and other changes, the Head of the Out-Patient Program tended to rely on the pressure of "public opinion" rather than on the higher-placed psychologists.

Some of the characteristics of the psychologists' autonomy noted so far arouse the dissatisfaction of various other staff members, especially the psychiatrists. One of these characteristics is the psychologists' ability to decide on their own what type of testing to do and what instruments

to use in producing diagnostic assessments. Because of their inability to receive the desired services from the psychologists, some staff members turn to outside agencies in order to get the desired type of testing done.

A similar situation exists with respect to individual and group therapy, except that in that case the staff cannot use outside agencies. The psychologists can decide what kind of therapy to perform, and whether or not to accept a patient for therapy since, as one respondent suggested, "the personal variable is very important". Neither of these characteristics of the psychologists' autonomy is always approved of by other staff because of two of their consequences. Firstly, the other staff members either have to defer to the psychologists' views of appropriate therapy, or have to search for someone willing to perform the desired therapy. Secondly, some patients are difficult to place and "just drift around, without anybody doing anything with them", as a staff member critical of the psychologists contended.

Where patient assignments to psychologists are concerned, one rule presumably limits the psychologists' choice, namely, that in-patients be given priority over other patients.<sup>67</sup> But, given the psychologists' control over acceptance of patients for therapy, this rule is largely meaningless since the prospective patient can be easily declared unsuitable. Furthermore, as one respondent remarked, it is quite easy to discourage patients from attending group sessions, and it can be done so subtly as to make documentation impossible.

The only exception exists where assessments are concerned. In that respect, in-patients are apparently actually given priority, as the rule specifies, but in the manner described earlier.

As far as the issues described in the preceding are concerned, various staff members would prefer reducing the psychologists' autonomy. The senior psychologists do not support that tendency, however. Whereas in the case of the social workers the pressure mounted by the psychiatrists meets with a degree of success, the same cannot be said in the case of the leadership of the Department of Psychological Services. This is not to say that less extreme accommodations between individual psychologists and other staff (including the psychiatrists) do not exist. The character of these relationships varies. Any concessions the psychologists make in such relationships are the result of individual initiative, however, rather than being a response to pressure from within the department. An attempt to account for this state of affairs will be made after two additional areas of the psychologists' autonomy have been discussed. They concern decisions about individual therapeutic specializations, and decisions concerning personnel assignments.

The work performed by psychologists can be categorized into a number of treatment and assessment techniques. Each psychologist specializes in some of these techniques. On the level of principle, there is no interference with individual inclinations in this respect. Individuals will not be asked

to acquire new techniques not used by other members of the department, even if such a broadening of the department's therapeutic repertory is seen as desirable. The gaps in the repertory are sought to be filled by the acquisition of new staff, rather than by influencing or controlling the content of the competencies the staff develop.

It can only be surmised that individuals will seek on their own to develop skills assuring them of a degree of demand for their services and a certain exclusiveness limiting the competition for patients. Insofar as this mechanism is working, however, it is working with a degree of imperfection.<sup>68</sup> It appears that because of the alternative sources of patients, some of whom are not controlled by other hospital staff, and because of the indeterminacy of the technology,<sup>69</sup> the psychologists need not be particularly responsive to the nature of the demand for their services. The higher-level members of the department do not provide an alternative source of pressure.

In addition to the therapeutic orientation, the establishment of treatment programs which essentially consist of permanent, regularly scheduled therapeutic groups, is also the result of individual initiative, compatible with the psychologists' training and orientation.

Two observed episodes of decisions dealing with personnel assignment show a similar pattern of individual autonomy. In one case, the Head of the Out-Patient Program requested that a full-time psychologist be assigned to the



Program when the Program was given funds for another half-time position. The Supervising Psychologist offered two part-time psychologists. There was no intervention in this disagreement by the Chief Psychologist, even though it was requested as the decision was to be made by the Department of Psychological Services. Consequently, the Supervising Psychologist was allowed to make his own decision.

The other case concerns the existing half-time assignment to the Out-Patient Program. Reportedly, the psychologist involved had been ordered some time ago by the Chief Psychologist to be available to the Program during specified time periods. This directive was never carried out, save for the regularly scheduled therapy group session. The rest of the allotted time was given to the Program haphazardly, and possibly not to the full extent. Apparently, no attempt was made by the Psychology Department to enforce the directive in question.

In sum, then, the department enforces a standard of performance which is necessarily quite vague because of the inadequacy of the technology involved. The psychologists have to 'account for their time' by means of monthly statistical reports that are presumed to reflect the work activities. Furthermore, commitments in terms of cases accepted for assessment have to be honoured, as well as the continuing commitment to run therapy groups.

These restrictions seem to be accepted by the psychologists and it is unlikely that they could be removed, since

The removal would mean a fairly serious dislocation of the current hospital routine and thus would be likely to engender opposition from various quarters. A somewhat peculiar in this respect is the statistical reporting. It seems to be required because it is the only thing the department and the hospital administration can use in lieu of evidence of work and performance of the hospital functions, as no other reporting channels exist.

In several respects, other staff would prefer to restrict the psychologists' autonomy but receive little or no support in that direction from the psychology department's hierarchy. In some respects, the lack of support is due to the ideological orientation of the senior psychologists who are opposed to the imposition of greater restrictions on the psychologists. In other instances, even though the Chief Psychologist, for example, may agree that a certain restriction is desirable, it will be suggested that the matter should be negotiated between the 'clinical' superiors and the psychologists. In the contested cases that were either observed or reported, however, the clinical superiors were unsuccessful in influencing the psychologists.

Along the clinical lines, changes can be brought about apparently only by persuasion and through the influence of 'clinical' position-holders on overall staffing and budget decisions. Other staff can contribute by the pressure of 'public opinion' and through their control over the flow of referrals to psychologists. These potential power sources

are either not used, or used ineffectively, to induce the Chief Psychologist and the Supervising Psychologist to restrict their subordinates' autonomy, perhaps by using some disciplining measures or the power of dismissal.

The explanation of this situation seems to involve several considerations. Firstly, the current ideology in the field of mental health manifested in the hospital is strongly treatment-oriented, rather than custodial. Treatment methods such as chemotherapy or electric shock, therapy are done by the psychiatrists and the nursing staff and occupy only a small portion of the patients' time. If the basic therapeutic orientation is to be realized, psychotherapy must play a major part in the hospital treatment program.

The psychologists have by far the most impressive credentials for the purposes of psychotherapy, all of them being at least advanced doctoral students (in comparison, the psychiatrists are holders of Master's degrees in psychology at best). Consequently, the treatment ideal makes it difficult to cut down on the complement of psychologists or to risk losing some of the more competent ones who would be difficult to replace. Similarly, it is difficult not to refer patients to psychologists as a means of inducing the psychologists to be more responsive to the requests of other staff members. Such practice would deprive the patients of presumably beneficial treatment and, since treatment is discussed in case conferences, it is impossible to disguise that practice.

Thus, even though less use may be made of the psychologists' services than could be the case (as one respondent reported), the difference seems to be inconsequential, especially considering the already mentioned alternative sources of patients and the virtual absence of any criteria specifying the conditions under which a psychologist's involvement with a patient is justified.

Another relevant consideration is that their relatively high educational levels confer a status on the psychologists making them considerably less vulnerable to 'public opinion' than other professions (not including the psychiatrists), and less vulnerable in any public controversy over the issues involved, as it is well possible to present all of these issues as turning around the patients' best interests.

Complementary to the above are several sources of weakness on the part of the 'opposition' which undermine its ability to mobilize the potential power resources. Except for the psychiatrists, each profession involved aspires to a somewhat greater degree of autonomy than it currently enjoys. Therefore, the occasional frustrations caused by psychologists seem to be mitigated in their effect by the desire to emulate the psychologists. The result is a clearly visible degree of ambivalence in the staff's attitude towards restrictions of autonomy. Furthermore, since the ambitions of other professions are oriented towards greater independence from the psychiatrists, it is not a united front that confronts the psychologists.

Finally, the technology involved is sufficiently ambiguous to make it very difficult if not impossible to specify efficiency requirements, or to require particular sequencing of specific operations, or to necessitate clearly certain types of information or cooperation. Consequently, the autonomy evidenced by the psychologists amounts only to an inconvenience to other professions. Of course, the situation may be detrimental to the patients' progress, but that would be extremely difficult to document. Otherwise, the psychologists' autonomy is largely irrelevant as the other staff can nevertheless work with patients or produce conventionally acceptable evidence of work without any difficulties or consequences. This may help to account for the relative lack of serious interest in undertaking the potentially time consuming process of placing greater restrictions on the psychologists, together with the fact that the enforcement of more restrictive rules may well be rather difficult.<sup>70</sup>

The preceding discussion referred to the position of the Department of Psychology as a whole. The attempts at restricting the psychologists' autonomy need not involve the whole department or go through the Chief Psychologist; they can take place between individual staff members. The characteristics of these relationships will be discussed in a later section.

## Autonomy within the Clinical Departments

### 5. The Out-Patient Department

In terms of the work with patients, the principal activities of the staff shown in Figure 7 can be briefly described as follows. The Head of the Out-Patient Program participates in case conferences and staff meetings. At these and some informal occasions the Head takes part in formulating the treatment process for individual patients and in developing the repertory and character of therapeutic and related activities carried out by the department's staff. The occupational therapist runs regularly scheduled 'assessment and observation group' sessions and may perform some of the conventional occupational therapy activities mentioned earlier. The psychologist runs a therapy group composed exclusively of out-patients and may perform individual therapy and testing. Out-patients also participate in therapy groups run by other psychologists who may perform other therapy or testing as well. The Supervising Social Worker conducts another out-patient therapy group, in addition to the other conventional social work activities mentioned earlier. The other social worker, who works only part-time in the out-patient program, takes part in the occupational therapist's assessment group, in addition to carry a small case load.

The nurses' work is considerably more vague in some respects. Aside from keeping the patients' records, the registered nurse seems to be largely in control of the patients' movement among the rest of the staff and engages occasionally in informal impromptu therapy. The registered nursing assistant organizes and supervises outings for the patients (such as bowling), participates in the group run by the psychologist and has a rather vague input into the movement of patients through the Program.

The patient's career begins by a referral from one of a variety of outside sources, through one of the psychiatrists with admitting privileges. The referral need not consist of anything more than a telephone call from the psychiatrist advising that the patient is being sent to the program. Initially, the patient is almost automatically sent to the assessment group. After a period of time of no set duration, the patient is sent to the social worker's group and, if there is a vacancy, to one of the psychologists' groups. The patients can at any time participate in the outings and may be referred to other activities, such as occupational or recreational therapy. At any time in the process, the patient may receive various types of social work services and be subjected to psychological therapy.

Since no statistics on that point are kept, it is not known for how long the average patient stays in the program. No rule governs the length of stay. Formally, the patient can be discharged only by a psychiatrist. It appears, however, that in most cases the patients simply stop coming,

as was the case with the six discharges that occurred during the research period.

#### Autonomy in Individual Therapeutic Work

The following discussion is to be seen in the light of the proposition subscribed to by the hospital personnel, namely, that both communication and coordination are important as there is always only one correct diagnosis and treatment (i.e., two different diagnoses or treatment approaches cannot be correct and equally effective at the same time).

To some extent, the characteristics of the occupational therapists' autonomy in areas other than the out-patient assessment group have been discussed already. The elaboration that is necessary concerns some features of the situation peculiar to the Out-Patient Department. The staff in the Out-Patient Department seem not to have any control over the character of the occupational therapist's therapeutic work. Some very broad objectives are usually formulated by the referring staff member, or in the case conference, before the therapist gets involved with a patient, but there are apparently no further limitations. Nor does it seem that the occupational therapist is compelled to accept any specific patients, or a specific number of patients, for therapy. Presumably, the occupational therapist has to demonstrate a degree of initiative and some willingness to accept suggestions for occupational therapy involvement made by other staff in case conferences, but the respondents were



quite unable to make it even slightly clear what an acceptable level of performance in this respect would be.

The occupational therapist can apparently refuse to accept any patient on the grounds that the patient is unsuitable, would not benefit from occupational therapy activities, or that there are no openings in the program. These claims can be sustained easily, partly because, as one respondent put it, 'no one has the time to check on anyone else'. Still more importantly, however, the reason seems to be that a norm developed in the Out-Patient Department to the effect that claims made by an individual about his sphere of competence or workload not be challenged by other staff. This norm was described as 'professional courtesy' and, although it is not approved of without reservation by all of those involved, it is reportedly adhered to so as to maintain a friendly atmosphere in the department.

The Head of the department avoids exerting pressure in this as well as other cases, apparently because it would be rather time consuming to demonstrate clearly the validity of claims in these areas. Accordingly, when a staff member suggested at one occasion that the Head take more initiative, the response was that the staff are 'all professionals' and that the Head's role was only that of a catalyst. Consequently, the occupational therapist is in control of the patient flow to the Occupational Therapy Department, subject only to the necessity of acquiring a sufficient number of patients. The acquisition of patients reportedly poses no

problems, even though a formal referral to the department is necessary before a patient can be accepted. The nodding agreement of a case conference is adequate as a formal referral and it is reportedly never refused should the occupational therapist, or any other staff member, volunteer to get involved with a patient.

Formally, only the therapy specified by the referrals should be performed, but in the case of out-patients this rule is substantially disregarded. Any change made by the therapist can be easily justified as being in the interests of the patient's improvement, and as has been noted already, patients' improvement and interests are the primary justification symbol in the hospital.

The preceding referred to the conditions of work other than the running of the assessment group. The group is a formal part of the out-patient program and constitutes an area of relatively greater restrictions on the occupational therapist's autonomy than is found in other types of the therapist's work. Of the three basic aspects of group functioning, i.e., allowing patients into group, the conduct of the sessions, and discharges from the group, the occupational therapist seems to have substantial control only over the conduct of group sessions. Still, there was no attempt reported at changing the current format described as a 'discussion group'. The control exercised by the occupational therapist over the group content, may be only illusory, then, as it has not been tested.

The other two aspects of group functioning are controlled by the registered nurse. This situation seems not to be challenged by the occupational therapist but rather is accepted as a reasonable part of the functioning of the out-patient program. It would be difficult to speculate about the possibility of the occupational therapist's acquiring greater control, for example, over the admission of patients to the group. There is some indication, however, that such an attempt would be unsuccessful. The ability to acquire that control seems to be directly dependent on the individual's status. Thus, all psychologists control admissions into their groups, but not all social workers do. Since something has to be done with all patients, it is unlikely that the situation could be changed by an individual at the bottom of the prestige hierarchy. The patients that cannot be placed elsewhere will have to remain in the care of the low-prestige staff such as the occupational therapists and nurses. It is notable, however, that this situation exists only in an area where compliance is easily observable, as is the case with regularly scheduled group sessions, and if only minimal objectives are set, such as 'observation and maintenance'. Such minimal objectives make it difficult to argue that they can not be attained under the given conditions of work, or with respect to specific patients.

The position of the social workers in the Out-Patient Department is largely similar to that of the occupational therapist. For example, the Supervising Social Worker does not

control admissions of patients into his therapy group.

In this case, however, the intention was stated by the social worker to assume control over admissions. Still, no attempt actually to do so was made by the time this research ended. As far as the conduct of group activities is concerned, the social worker seems to have almost complete autonomy, within rather vague limits similar to those described earlier for the psychologists, i.e., the activities must be congruous with ordinary social and therapeutic conventions and the patients should not be upset.

In terms of the therapeutic models used by individuals (e.g., relaxation therapy, aversion therapy), no respondents showed any desire to venture beyond the set of models traditionally associated with their fields. (Because of legal regulations, such attempts would certainly be unsuccessful where chemotherapy and electric shock therapy are concerned, as they can be administered by psychiatrists only.) The only more specific restriction was found in a related area. Thus, the social worker was directed by the Head of the department to provide justification for a funding request to be sent to the administration. <sup>71</sup> Of course, the effective source of this restriction is in the policy of the hospital administration, rather than within the Out-Patient Department itself.

As far as other types of social work involvement with patients are concerned, only the general restrictions described earlier seem to apply, with one important exception.

This exception stems from the very low involvement of the psychiatrists with out-patients.<sup>72</sup> Consequently, the most significant part of the restrictions on the social workers' autonomy, compared to the In-Patient Department, is absent. Since the involvement in the program by the Head of the Out-Patient Department is restricted to attending case conferences and staff meetings, his familiarity with patients is low. Therefore, the Head reported that he interferes only if the other staff cannot agree on a course of action.

On the occasions when a psychiatrist gives explicit instructions, the social workers comply because otherwise 'they would lose the patient', as well as because of the other reasons described earlier. Only one such incident was reported during the whole research period. Even this single case could have been avoided, however, as it was an inadvertent result of the social worker's initiative. In this case, social worker initiated the consultation with the psychiatrist during which the instructions were received. The lesson derived from that incident was that consultations with psychiatrists should be used judiciously if the social worker is to maintain control over his handling of cases. It is implicit, of course, that the social workers are not obligated to consult the psychiatrists before intervening in the case where the out-patients are concerned. In fact, the staff find it difficult to reach the psychiatrists, possibly because consultation with other staff is an activity for which the psychiatrists are not remunerated.

This consideration seems to be especially salient where the out-patient staff is concerned as the out-patients suffer from relatively minor disorders only and, as a rule, receive no medication which is the psychiatrists' primary area of concern.

In relationships to staff members other than the psychiatrists, the social workers seem to maintain almost complete independence in all aspects of their therapeutic interventions. The indeterminacy of the technology involved means that various interpretations of each problem are possible and that it is extremely difficult to check the validity of the documentation used. Furthermore, each staff member forms an interpretation of the given problem on the basis of a somewhat different body of data based on the personal contacts with the patient, etc. Consequently, it is possible to document the justifiability of quite divergent interventions. Coupled with the already mentioned norm of 'professional courtesy' which tends to discourage interference in the work of others, the situation seems to have been adequately described by a respondent who suggested that 'everybody does whatever they want'.

The possibility of intervention by the Head of the program where disagreements occur is reduced also as a result of the way disagreements are handled. It appears that, possibly in order to preserve amicable relationships within the department, discussions of patients are either avoided or carefully handled so as not to make differences of opinion

particularly noticeable. In the several informal conversations that were observed, no strong views were expressed and, indeed, the observer gained the impression of a remarkable congruence in the views of the various staff members involved. It was, therefore, surprising to find in subsequent interviews that one party to the discussion felt that the other party had 'a completely different interpretation' of the given problem. <sup>73</sup> Furthermore, the contemplated course of action were not formulated with specificity. It was, therefore, possible to present subsequent actions as congruent with the spirit of the discussion, and thus to maintain autonomous control over the choice of action.

Another aspect of social workers' activities consists of non-therapeutic work, i.e., the production of 'social histories' and assessments. Referral for such work will apparently be accepted according to the current state of the social worker's workload and the need to account for a certain number of work hours. The only restriction in this respect seems to be that the histories and assessments be produced, once the referral is accepted. The process of their production is completely under the social worker's control. As will be observed more fully later, what exactly is an adequate product and the form in which it reaches the referring agent is largely under the social worker's control as well. The reasons for this seem to be the same as those underlying other characteristics of out-patient staff autonomy.

There is no substantial difference between the psychologist formally included in the Out-Patient Department and those in the In-Patient Department in terms of their relationships to the rest of the out-patient staff. The psychologists have control over the content of their therapeutic work, as well as over the acceptance of patients for treatment. One peculiarity exists in the area of acceptance of patients for group therapy. Although formally the psychologists insist on having the right to screen and refuse prospective patients, as a practical matter this right is not exercised with respect to out-patients. As openings in therapy groups occur, they are filled quite automatically with out-patients referred by the registered nurse. The referrals specify the group into which a patient is to be admitted, and are reportedly invariably honoured. This situation contrasts interestingly with the handling of in-patient referrals from psychiatrists and will be elaborated on later.

With respect to therapeutic work not involving groups, the situation described earlier in the section on the Psychology Department holds for the psychologists' involvement with out-patients. This means that the psychologists have relatively greater autonomy than the rest of the out-patient staff since they are immune to the occasional restrictions imposed on other staff by the psychiatrists.

The main areas of work of the two nurses differ considerably. The role of the registered nursing assistant (RNA)



is marginal in the department and there seems to be no appreciable interest in it by the department's staff. Control over the RNA seems to be exercised by the Nursing Supervisor rather than the out-patient staff.<sup>74</sup> This holds for the outings (accessible to all out-patients) organized by the RNA, and apparently for various other not systematically occurring occasions, such as the researcher's presence. Because of inadequate opportunities to interview the RNA, no more information is available. It is not known, for example, whether the participation in the psychologist's therapy group is the result of the RNA's own initiative or not. It seems likely, however, that the participation in the therapy group is in the RNA's interest since there seemed to be no alternative sources of work available.<sup>75</sup>

The registered nurse's (RN) work consists mainly of keeping patients' records and partially controlling the patients' movement among therapists. The record-keeping involves entering information received from the out-patient staff and sources in the patients' charts. As a practical matter, only the psychiatrists' orders and information received in writing are recorded. Since various discussions about the patients' career are made in case conferences, the RN's influence over these matters is somewhat limited, but still major with respect to deciding when the patients should leave the 'assessment group', whether or not social work involvement should be sought, and to which psychologist's therapy group the patient should be sent. Of course,

the implementation of the RN's decisions depends on the already described control the other staff have over accepting patients and over the work they actually perform.

The take-over of some of the RN's decision-making functions by others in the Out-Patient Department may well be the only area of influence on the RN by the out-patient staff. In other respects, restrictions on the RN's autonomy appear to be either self-imposed<sup>76</sup> or imposed by the Nursing Supervisor. In one instance, for example, the Head of the department made a request of the RN who flatly refused. However, when the Nursing Supervisor suggested that the RN should comply with the request, compliance was immediate. This example tends to point out again the predominance of control by the functional departments which is based on the fact that sanctions can be exercised only through the Heads of functional departments. Control over patients in this instance is not a very significant factor as the RN does not engage in formal therapy.

#### Autonomy and the Articulation of Roles

Certain aspects of role articulation have been described by implication in the preceding, such as the consequences of individual control over the acceptance of patients for treatment and over the content of therapeutic activities. In this section two areas of role articulation will be focused upon more explicitly, namely, the flow of information about patients and the design and articulation of therapeutic and other

activities into individual patient careers and into the overall out-patient program.

### The Information Flow

Since therapeutic intervention should presumably depend on the information about patients possessed by the staff, certain mechanisms for generating, collecting, storing and retrieving information can be expected to exist. The existing mechanism consists of collecting formal patient evaluation material such as social histories and diagnostic assessments, and of verbal exchanges of information, either informal or in case conferences. As has been noted, the production of formal evaluation material is discretionary. It need not be requested by the staff already involved with the patient, which means at least the RN. Nor does a request for formal evaluation necessarily mean that it will be produced, at least in the sense of exactly what will be produced and how soon. It seems that the only action that is invariably taken is some kind of contact between the patient and the evaluator, followed by a report which may be quite informal.

All formal evaluations can be made at any stage of the patients' careers. Other information is handled verbally and it seems that to some extent the RN functions as the repository of the information. No particular rules apply to day-to-day reporting of developments, however, and the handling of reporting is apparently highly idiosyncratic.

One regularity that can be detected suggests that high-status staff report very little or not at all while low-status staff report and discuss cases more frequently. The RN who is the only staff member available to gather information has a relatively low status and cannot induce others, with the exception of the occupational therapist, to report to her. Communication among the other therapists is reportedly virtually non-existent outside of case conferences.

Since no first-hand information is available about case conferences, it is not quite clear how the case conference functions as a communication device. In general terms, the respondents suggested that case conferences provide some increase in the flow of information, in spite of the rather limited amount of time available per patient (less than four minutes a week). At any rate, no particular rules apply to the characteristics or to the flow of information in case conferences, nor is the information received binding on its recipients in terms of their therapeutic activities. Since individual therapeutic work is not checked and the staff do not necessarily report back to the conference, the individual therapist retains control over compliance with the discussion in case conferences, even when explicit suggestions for action are made.

#### Therapy Coordination and Program Development

It follows from the observations made up to this point that individual staff members are not bound by some overall design for patients' careers, aside from the mere physical

presence of patients in the assessment group, the social worker's group and in the outings organized by the RNA. The conceptualization of the problem at hand and the direction of therapeutic efforts and other intervention is largely the result of each therapist's autonomous decision. An element of predictability in the work to be done with a patient obtains by virtue of the existence of more or less broad therapeutic orientations characterizing individual therapists. That is to say, if a therapist becomes involved with a patient, it is likely that the subsequent interventions will fall within some broad treatment model espoused by the therapist. However, there is no centralized decision-making point which would set out a plan of treatment. Whether or not a patient will follow any staff member's notion of an appropriate career in terms of either the therapists involved or the therapeutic orientations used is open to question and, where someone's idea of an appropriate career is realized, it is realized fortuitously.

The repertory of therapeutic orientations in existence is controlled by the individual staff members in that changes seem to result only from individual initiative. The limits on changes that would be tolerated are quite obscure and there seems to be no reason to believe that they would go beyond the general characteristics of "good therapeutic work" mentioned earlier, except perhaps that changes have to be supported by some kind of therapeutic theory if they are to be accepted. This, however, holds only for formal

proposals made in case conferences and staff meetings. The actual therapeutic work need not coincide with the proposed orientation since no examination of actual work takes place. In the absence of individual initiative the program does not change unless new therapists are added. Some function is initially set for the newcomer (such as individual therapy for the newly added half-time psychologist), but this function is likely to be modified in the long run, as a result of the new staff member's initiative.

Some attention has already been given to certain changes that were in the process of implementation during the research period. These changes tended to affect the department's autonomy structure with respect to the information generation and flow, as well as with respect to the design of patient careers. The changes were proposed by the social workers and received the explicit support of the Head of the Out-Patient Department and most of the other staff in the department.

Based on the observation that feedback about patients was inadequate and that 'no one knows what is happening', it was proposed that a written report on each therapy group session (including those led by psychologists not belonging to the out-patient staff) should be made and given to the RN. As has been noted earlier, the out-patient psychologist refused to do so. The mechanism relied upon to implement the changes in spite of the opposition was the pressure of 'public opinion'. The outcome of this situation is not known

and it can only be observed that the initiators of the proposals in question expressed the view that success could be reasonably expected only in inducing the psychologists to report patient attendance in group sessions.

The second part of the proposed changes concerned the gathering of information about patients for the purposes of assessment and therapy planning at the time the patients enter the program. This part of the proposal was accepted and seems certain to be implemented. For practical purposes, the proposal was to make social work involvement automatic. On the one hand, this would tend to reduce the RN's influence on patients' careers both because a part of the career would become non-discretionary and because the information gathered through the social work assessment was to be used in treatment planning. The proposal was not opposed by the RN, because she claims no special expertise in assessments. Given the ideology of the hospital, presumed expertise in doing assessments is a potent resource to be used in promoting various organizational arrangements.

From the viewpoint of the social workers, the proposal might initially seem to be counterproductive if the desire for greater autonomy is assumed, since they were to lose discretion over accepting cases for assessment. If the implications of automatic social work involvement are examined, however, the opposite conclusion emerges. Perhaps most importantly, automatic referral of patients to social work reduces the dependence on other hospital staff that

previously had discretionary control over referrals. Correspondingly, the susceptibility to the pressures from other staff members is reduced. Furthermore, the knowledge of patients that presumably is developed in the process of producing assessments should add weight to the views the social workers might express in case conferences and thus reduce the likelihood of their being saddled with undesirable therapeutic assignments. Since all patients were to be processed by the social workers, the social workers would be in a position to select at will patients for any further attention, as well as the type of attention the patients should receive.

#### The Sources of the Autonomy Structure

It does not seem likely that other changes in the Out-Patient Department's autonomy structure will follow as a result of the implementation of the described proposals. The main reason for this seems to be that the social workers will be in no position to demand or check upon compliance with the conclusions drawn in assessments. Only psychiatrists seem to be able to do so, to a certain extent, as a result of their special legal relationships with patients. To change other characteristics of the autonomy structure than those already mentioned, other requirements would have to be met. These requirements consist of the removal of the conditions responsible for the current state of affairs. As far as the psychologists are concerned, some of these



conditions are connected with the organization of their work in the In-Patient Department which will be analyzed in the next section. Otherwise, the essentially voluntaristic nature of the departmental functioning stems from several sources, namely,

a) an absence of any noticeable criteria for identifying 'problems deserving attention',<sup>78</sup> whether internally or externally imposed;

b) the indeterminacy of the technology involved and an absence of any criteria of effectiveness, or procedures for the evaluation of effectiveness;

c) the non-involvement of the psychiatrists with their special relationships to patients, which seems to be the only resource potentially capable of lessening the functional departments' autonomy, given the preceding two conditions.

It has been suggested that interference by the Head of the Department can be largely avoided by not allowing disagreements to surface. Perhaps because resolving disagreements according to the merits of the problem at hand would be rather time consuming, the Head does not seek involvement in those matters. Furthermore, the disorders characterizing out-patients are relatively minor as compared to in-patients and hardly ever require the treatments in which the psychiatrists specialize. The psychiatrists' interest seems to be somewhat greater where former in-patients are concerned.

To influence the behavior of other staff without involving the department Head would be rather difficult and time consuming for any staff member since no one has the authority to exercise sanctions. To bring about compliance with restrictions it would be necessary to involve the Heads of functional departments and to produce conclusive arguments with the inadequate tools offered by the available technology. An additional incentive to avoid conflicts and attempts to restrict other staff's autonomy is the desire to maintain amicable relationships in the department and to prevent infighting for the same reason, it is necessary to avoid soliciting the involvement of the department Head as well as the involvement of the Heads of functional departments.

That the situation as we find it has developed as a response to the problem of the department's functioning can also be seen as a result of the performance criteria in use. Individually, the only reasonably concrete performance requirement is that a certain number of hours be accounted for by the staff. All other criteria are vague, especially in the Out-Patient Department, and refer to only broad issues of therapeutic style (compliance with psychiatrists' directives which may be sufficiently specific is a performance criterion only marginally in evidence in the Out-Patient Department). These performance criteria can be fulfilled with no more than nominal restrictions on individual autonomy, since the checking of various claims about

performance would be technically difficult as well as time consuming, in addition to leading to resentment.

It is important to note that the existing 'criteria of performance' are in no way equivalent to criteria of therapeutic effectiveness. No such criteria exist, whether in terms of individual or collective effectiveness.<sup>80</sup>

In the absence of effectiveness criteria, no one involved with the program is dependent on its effectiveness. Therefore, there would seem to be a lack of incentive to overcome the obstacles to the lowering of the staff autonomy. This assumes, of course, that greater and more definitely organized information flow as well as centralized planning of therapeutic intervention by the various staff members would lead to higher effectiveness. The true merits of the matter are irrelevant, however, as the important point is that such a relationship between the program's functioning and therapeutic effectiveness is believed by the staff to exist.

#### 6. The In-Patient Department

The unit under consideration is shown in Figure 5. As has been noted earlier, the nurses and the occupational therapists will be largely excluded from the discussion because very few data are available on the former and because of the marginality of the latter relative to the primary therapeutic process in the hospital.

Most of the characteristics of the in-patient staff's work and autonomy have been discussed already in the section

dealing with functional departments. Only a brief recapitulation is needed here. More attention will be given to another aspect of the unit's functioning, namely, the structure of work assignments and the co-ordination of therapeutic interventions. Most importantly, however, additional observations will be made about the mechanism underlying the existing structure of individual autonomy, and about the tendencies towards change.

The parties involved in shaping the autonomy structure are social workers, psychologists and psychiatrists. It is not necessary to attend separately to the relationships between the non-medical staff and the Head of the Adult Psychiatry. As has been noted earlier, no evidence was found of a difference between these relationships on the one hand, and the relationships between the psychiatrists and the other staff on the other hand. <sup>81</sup> It seems that basically the same mechanism underlies each of these two types of relationships, possibly because there is no difference between the sanctions the Head and the other psychiatrists can exercise over other staff. In either case, all sanctions that do not derive directly from the psychiatrist's control over patients have to be mediated by the Heads of functional departments. Greater influence over the hospital's funding decisions might be an additional source of power for the Head of Adult Psychiatry but no data suggesting that this potential resource is being used were encountered. Of course, the Head's responsibility for

a semblance of order and harmony in the department may lead to attempts not to engender dissatisfaction. This would necessitate restraint in restricting other staff's autonomy, as autonomy seems to command strong feelings on the part of all involved.

The in-patient staff deal with two types of patients. In addition to regular in-patients, the staff may have continued contacts with patients after their discharge. Such patients were previously termed 'informal out-patients'. The relevant point about the informal out-patients is that no restrictions are placed on the staff's work with these patients by either the psychiatrists or by members of other functional departments. While only the psychiatrists exercise appreciable control over the staff's work with in-patients, this control lapses when the patients are discharged. The patients then can seek therapeutic intervention on their own and the intervention need not be coordinated.

The hospital staff apparently have no control over the psychiatrists' work. At least in one respect, however, there seems to be a unanimous desire to decrease the psychiatrists' autonomy. Thus, the staff would like to be consulted about, or at least apprised of, patient discharges. The staff's complaints notwithstanding, the psychiatrists did not allow themselves to be bound by any rule in this matter. Although plans for discharges may become known to psychologists and social workers, such occurrences are

normally accidental. Thus, while the staff are able to maintain a degree of autonomy greater than the degree the psychiatrists would prefer (as will be shown in the following), their resources are insufficient to effect a desired reduction of the psychiatrists' autonomy.

The relationship between psychologists and social workers is characterized by full autonomy of each of the parties involved, with respect to inpatients and informal out-patients alike. An exception exists in the handling of informal out-patients, to the effect that, if a referral is made from one department to the other, only such intervention will take place as is mutually acceptable. <sup>82</sup> Otherwise, the relationship is characterized by a peculiar symbolic feature in the area of the handling of referrals. While patients may be referred to individual social workers who will accept such referrals, the psychologists will not, as a rule, accept such patients but rather will insist that the referrals be made to the Psychology Department. One of the psychologists then distributes the referrals among the members of the Psychology Department. As will be shown later, this practice is useful in frustrating the psychiatrists' attempts at reducing the psychologists' autonomy. Aimed at the social workers, however, this practice seems to be a status-connotative expression of autonomy, akin to that observed by Whyte (1948:69-78) among restaurant employees. There, the waitress is obliged to write down the customers' orders instead of relaying them verbally, and the cook will take these orders

'at will', thus glossing over the fact of having lower-status employees initiate action for him. Of course, this parallel holds only if the referring agent knows beforehand which psychologist will get the referral. Because of the specialization among the psychologists, there is often only one possible referral destination. The formal referral channel makes no difference for the patients' careers, which is a fact well known to the referring agent who are familiar with the specializations of individual psychologists. In relation to the social workers, then, this procedure seems to be a mechanism for the symbolic expression of social status differentials.

The terms of the relationship between social workers and psychologists where in-patients are concerned follow directly from the relationships between each of those professions and the psychiatrists. As will be shown in the following, the psychiatrists control the patients as well as the staff's accountability, thus pre-empting direct influence between the two professions in question, except for an alleged concern each profession has for its reputation. The consequences of this concern are too vague for our purposes, however, and may well not go beyond 'good manners'.

Since the psychiatrists do not control informal out-patients, there is a possibility of a different set of relationships developing between psychologists and social workers, one characterized by a lower degree of autonomy

either on the part of the members of one or both of these departments. For example, the requested intervention might be invariably carried out, regardless of which party is the referring agent. However, there seems to be no incentive to move in that direction. Thus, the technology is too uncertain to allow sufficiently clearcut and conclusive arguments, thereby making compliance unnecessary. There is a total absence of effectiveness criteria which could induce individuals to accept instructions from presumably or demonstrably more competent practitioners, and each department promotes the claim of its exclusive and unrivaled competence in its field. Perhaps equally importantly, the patients are not in a sufficiently short supply to lead individuals to comply with the requests of the referring agent in spite of disagreeing with the referral's proposal for intervention. The two professions can thus function autonomously, in accordance with their professional ideologies. Reportedly, the same holds for the nurses in their relationship to psychologists and social workers where in-patients are concerned. Since each of the three professions acquires in-patient clients through the psychiatrists and irrespective of each other, a degree of coordination of treatment approaches can, as a rule, be assured only by the psychiatrists. In the absence of directives from the psychiatrists, coordination can, and reportedly usually does, break down. Of course, even given the psychiatrists' involvement, the coordination and planning of patient careers is limited



by the autonomy of each profession with respect to the psychiatrists. The characteristics of this autonomy are described in the following.

The relationship between the psychiatrists and other staff in terms of the staff's autonomy in their work with in-patients can be analyzed best if two aspects of that work are considered separately. Firstly, there is the staff members' control over the acceptance of assignments, i.e., whether or not they have to accept a patient referred to them and to carry out the intervention specified in the referral. Secondly, there is the question of the extent to which the staff can assume initiative, once a patient has been referred to them, by instituting new treatments or by making further referrals.

Although the professional ideology espoused by the social workers dictates the contrary, referrals by psychiatrists are apparently invariably accepted and the terms of the referrals followed, at least to the extent that compliance can be reliably and relatively easily checked. For reasons to be discussed, there is rarely any temptation on a social worker's part not to accept a referral. Disagreements over the merits of the proposed social work intervention occur, but the psychiatrists' instructions are carried out. The mechanism underlying this situation wherein the social workers' autonomy ambitions are held in check seems to be threefold.

Firstly, the supply of patients is relatively low and thus the social workers occasionally solicit referrals so as to maintain adequate workloads. Non-compliance with the terms of referrals might lead to the loss of clients, lower success rates of at present invariably successful referral-soliciting, and perhaps the discontinuation of the case-history compiling assignments which are at present 'virtually automatic' for newly admitted patients. All of these things are under the control of the psychiatrists and make expressions of autonomy rather risky for the social workers.

The second source of restrictions on the social workers is in the policy of the Chief Social Worker who encourages compliance with the psychiatrists' instructions and, reportedly, uses the psychiatrists' satisfaction with the behavior of social workers as the primary tool for performance evaluation. It has been suggested already that this attitude seems to be dictated by the expansionist policy of the department, which could be frustrated by psychiatrists dissatisfied with the department's work. Since the psychiatrists are the primary consumers of the social work services, the need for satisfying the nature of the existing 'market demands' is indicated. And compliance with the psychiatrists' instructions is definitely in demand.

Facilitating the effect of the preceding two items is an administrative feature of the Department of Social Work. Thus, social workers are assigned either to specific beds or to a specific ward as a whole. This situation makes it

extremely easy to identify the source of non-compliance as there is never any question as to which social worker should take on an assignment. The psychiatrists can always approach the appropriate social worker. Direct sanctions, as well as complaints to the Chief Social Worker can be specific rather than being mostly aimed at the whole Department of Social Work, which would be the case if the previously mentioned assignment system used by the Psychology Department were used.

The existing assignment system thus makes individual social workers more vulnerable to the sanctions at the psychiatrists' disposal. Nevertheless, it is only beginning to be criticized by the social workers, and the criticism concerns so far only some secondary aspects of the system.<sup>84</sup> Perhaps one reason that the system has not been re-examined is that, by focusing attention on individual social workers and by making them relatively more individually vulnerable to the psychiatrists, the performance of the department can more easily be kept in line with the requirements dictated by the policy of departmental expansion. Under the alternative assignment system, more performance problems would have to be solved intradepartmentally.

The second aspect of the social workers' autonomy concerns the limits on their initiative in instituting new treatment for patients already referred to them. In principle, the psychiatrists insist that every new treatment has to be approved by them. As a practical matter, however, because control is time-consuming, it is possible only where the change

of treatment is easily noticeable. A review of several cases showed that, with rare exceptions, only referrals of patients by the social workers to other therapists are cleared with the psychiatrists.

A special category of therapeutic decisions consists of disciplining, and granting passes to patients. For a time, the decisions in these matters were handled by the social workers on one of the wards. This practice was discontinued because of the opposition by a majority of the psychiatrists. This turn of events may seem a little surprising since the psychiatrists, pressed for time, could be expected to want to delegate the chore of signing passes and withholding patients' privileges to someone else. In fact, in the psychiatric hospital studied by Scheff (1961) it was precisely the threat of not relieving the psychiatrists of small decision-making duties that provided the attendants with a major power resource.

Several considerations are necessary to account for the situation at Windsor Hospital. Thus, the social workers attempted to acquire the formal right over the granting of passes and disciplining, removing the delegation of those powers from the discretion of the psychiatrists. Since the additional discretionary control over patients represented by those rights is highly prized by the hospital staff, the psychiatrists were faced with the loss of a potent bargaining resource. Perhaps even more importantly, the psychiatrists were not confronted with a unified front of hospital

employees determined either to acquire the formal right in question or not to assume any of the decision-making chores at all. Had that been the case, the outcome may have been different. As it is, the psychiatrists routinely empower various staff members (nurses, social workers and psychologists) to make the decisions with respect to specific patients.

As a result, various diadic accommodations seem to occur wherein the control over patients is exchanged for certain concessions, such as more willing cooperation. Increased control over patients is thus exchanged for reduction of autonomy in other areas. In this instance, then, the failure of the attempt to increase the staff autonomy from the psychiatrists resulted from the existence of several mutually independent functional departments competing for a valued item - the control over a set of therapeutic decisions.

The psychologists are relatively more autonomous with respect to the psychiatrists than are the social workers. This is especially the case where the acceptance of patients for treatment or diagnosis and compliance with instructions for therapy are concerned, although the mechanism of exchange noted above is responsible for various departures from the prevalent practice. Ordinarily, patients have to be referred to the department as a whole. A psychologist then screens the patient and assigns him to one of the in-patient psychologists. These assignments can be refused since the psychologists can claim personal incompatibility with patients. This claim is honoured by the department and is used

to neutralize the pressure from psychiatrists dissatisfied with the rejection of patients. The rejections are possible also because this type of referrals is not the only source of work for psychologists who can fill their schedule automatically from other, already mentioned sources. <sup>85</sup>

The centralized handling of assignments seems to be an efficient autonomy-protecting device because it shields individuals from the pressure the psychiatrists could exercise because of their control over patients. Under the current system, the psychiatrists cannot very well control the flow of patients towards individual psychologists. A reduction of that flow is possible only as a result of a reduction in the total number of referrals to the Psychology Department. This would necessitate the cooperation of most of the psychiatrists which is a rather proposition since, firstly, there is ~~no~~ full agreement on the desirable state of affairs and, secondly and more importantly, psychotherapy seems to be crucial to the concept of treatment held by all concerned. It would be difficult, therefore, to deprive a significant portion of the patients of the most important part of their treatment.

With respect to therapeutic decisions made after a referral has been accepted, the psychologists are in the same position as social workers. In principle, no new therapy can be instituted without the approval of the patient's psychiatrist. In practice this includes only further referrals to other therapists since other changes in the therapeutic

orientation are considerably more difficult and time consuming to monitor and it is more difficult to argue that a change in the therapeutic approach really took place, or that unauthorized treatment took place. Of course, when the earlier mentioned changes occur, the psychologists gain control over the changes in treatment, disciplining of patients and the granting of passes.

The current situation falls short of the ideals desired by each of the professions involved. Psychologists and social workers alike expressed dissatisfaction with the inaccessibility of the psychiatrists who prefer to spend their time dealing with patients rather than in consultations. In spite of periodic complaints, it seems unlikely that the psychiatrists will allow themselves to be bound to greater accessibility on a regular basis, since such activity is currently producing no income for them and there is no apparent resource the other professions could use to change the current situation.

The social workers generally seem to compare their position with that of the psychologists and would like to achieve the same level of autonomy, in addition to gaining control over patient disciplining and passes, an issue over which they suffered the recent setback. The psychologists would also like to acquire greater control over the patients, but they approach the issue differently than the social workers. While the latter seek greater control over patients by bringing about a change in the hospital policy,

the psychologists are oriented towards achieving legislative changes which would empower them to authorize hospital admissions and discharges, now an exclusive right of the psychiatrists. This difference in ambition seems to have the same basic source as the different levels of autonomy possessed by the two groups. The social workers have lower educational levels, are considered less competent and their work is considered more marginal and dispensable to the therapeutic process.

The current level of independence of social workers and especially of psychologists is considered too high by the psychiatrists. One of them suggested, for example, that instead of the present arrangement, social workers and psychologists should be assigned to individual psychiatrists. Needless to say, under such circumstances the psychiatrists would be in a position fully to control the flow of patients to the other two professions. Furthermore, the psychiatrists would be incomparably better informed about the way the other professions allocate their time and, therefore, would be in a position to influence the character of the time allocation. At present, the absence of these two conditions is a source of the other professions' autonomy from the psychiatrists.

It seems rather unlikely that the above changes could be successfully implemented without lowering the educational standards of the hospital psychologists and social workers, thus presumably lowering the staff's 'professional'



pretensions and the desire to achieve greater autonomy.

The attachment of the present staff to at least the current levels of autonomy is rather strong and further restrictions on autonomy would probably not be tolerated by the majority of the in-patient staff. Such was the case following the recent setback suffered by the social workers, which resulted in the resignation of one of the social workers. Because assignments to individual psychiatrists would interfere with the psychologists' tendency to specialize in only a few treatment techniques, there would be an additional incentive to resist changes in the current arrangements.

Finally, the difference between the Out-Patient Department and the In-Patient Department should be underlined. It largely consists of the considerably greater centralized control over the character of therapeutic interventions found in the In-Patient Department. This greater control is almost entirely due to the psychiatrists' involvement with in-patients. On the other hand, since the psychiatrists restrict themselves to working with patients, no difference can be found between the two clinical departments in the area of the development of therapeutic programs and the repertory of therapeutic techniques. Those matters remain at the discretion of individuals, with some vague input from the Heads of functional departments and with some concern by individuals for the demand for various services.

## Summary of Research Findings

The basic conception of the psychiatric hospital used in this study was that of a 'professionalized locale', i.e., a set of relationships in which 'persons drawn from different professions come together to carry out their respective purposes'. (cf., Strauss et al., 1963:150).

Accordingly, the hospital structure in general, and the structure of individual autonomy in particular, were seen as the resultant of the interplay of individual motives on the one hand and of the commonsense use of various power resources at the individuals' disposal on the other hand.

In a broad outline, the motives with which the analysis operated were conventional ones. They consist of the need for employment and income, the desire to work in one's field of specialization, altruistic concern for the patients' welfare, the desire to achieve good therapeutic results as evidence of one's competence, and the motivational syndrome referred to as 'professionalization'. For our purposes it was sufficient to think of the latter as being comprised of the desire for autonomy based, among other things, on the proposition that the practitioner's field requires special knowledge not possessed by non-specialists. Various practices were found to be invested with symbolism connotative of the organizational members' autonomous professional status, thus being drawn into the motivational syndrome.

Because of the nature of the hospital work, the technological uncertainty, and the variety of therapeutic orientations, the basic motivations give rise to conflicting tendencies. On the one hand, the hospital staff agree that proper diagnosis and treatment require consultation and cooperation. However, it is often very difficult, nay, impossible to reach an agreement on those matters. Aside from the time-consuming nature of negotiations, which circumstance some participants find, of necessity, particularly unpalatable, the professions' claims to esoteric knowledge militate against the acceptance of other professions' views. Even within the professions, the ideology mostly encourages the therapist to make his own judgement the final arbiter of the merits of different views. Since the technology does not offer sufficiently clear rules of documentation, the precept that only one diagnosis and treatment approach is correct in any given case tends to be disregarded. Cooperation and the attendant restrictions on autonomy based on professional ideology thus tend to dissolve, aided perhaps by the fact that the decisions are not even ostensibly always based on the merits of the situation alone. The use of legal rules or of presumed competence to circumvent extended arguments discourages cooperation as well as consultations since it bases compliance on something other than the demonstrable merits of the cases.

Contributing to the tendency towards the fragmentation of not only therapeutic interventions in single cases,

but also in the development of therapeutic repertoires, is the existence of only weak effectiveness criteria. While demonstrable competence of some staff members might encourage compliance because of the 'authority of competence', there does not seem to be enough evidence to substantiate claims to such authority. Conversely, the sources or even the existence of failures are difficult to detect because of the plurality of therapists involved, the fragmentation of therapeutic approaches and the technological uncertainty. The need on the part of individuals to avoid failures is thus reduced. The need or desire to heed the advice of presumably competent others is diminished correspondingly. On the other hand, there is the desire to put one's own skills to the test.

Even in the absence of criteria of individual effectiveness, there might be greater efforts made, especially by higher-placed participants, to assure compliance, coordination and cooperation, if some meaningful collective effectiveness criteria were in existence. The absence of such criteria means the absence of another potential incentive to restrict the participants' autonomy. It is obvious that the data available to the hospital employees, such as the patients' average length of stay in the hospital, are inadequate. There is no necessary relationship between the above variable and therapeutic effectiveness, given the high level of technological uncertainty (cf., Fisher et al., 1973:57-64) and the fact that the identification of 'problems deserving

attention' (such as hospitalization, etc.) is at the therapists' discretion.

Thus, under the given circumstances, the basic motivations of the hospital staff tend to produce a loosely bound collection of autonomous practitioners. Such is largely the result in the Out-Patient Department in which both the elements of the therapeutic program and the interventions in individual cases are substantially the results of autonomous behavior. With occasional exceptions, only the very basic administrative restrictions were found to apply there. The resources on which these restrictions are founded derive ultimately from what may be referred to as legal and administrative authority. The 'legal authority' refers to the legislatively established relationship between psychiatrists and patients, granting the psychiatrists the exclusive right of admitting and discharging patients to and from the hospital and investing them with primary responsibility for treatment. 'Administrative authority', on the other hand, refers to a subtype of power comprised of control over hiring, promotions and funding.

Legal and administrative authority serve to counteract, in some respects, the tendencies following from the basic motivational syndrome. Because of the marginal involvement of the psychiatrists in the Out-Patient Department, the countervailing effect of legal authority there is minor. To some extent, administrative authority was found to be used to reduce staff members' autonomy in response to

the psychiatrists' control over the patients and thus over the demand for the services of other professions. The psychiatrists' non-involvement in the Out-Patient Department led thus also to a diminished use of administrative authority there.

Because of the involvement of the psychiatrists, the autonomy structure in the In-Patient Department differs considerably from that in the Out-Patient Department. The difference consists largely of the reduced level of autonomy the hospital staff have with respect to the therapeutic work with the majority of their patients. In comparison with the Out-Patient Department, the autonomy relations among the staff other than the psychiatrists are not appreciably affected. With minor qualifications only, the staff members remain mutually autonomous. Neither were other aspects of the staff's work, such as program and skill development, altered as a result of the involvement of the psychiatrists.

That the impact of the psychiatrists' involvement is limited and varies among the different professions seems to be due to the use by the involved parties of a variety of resources. Foremost on the list of the resources facilitating greater autonomy is the nature of the technology, which makes control of either procedures or of results rather difficult and time consuming in many instances. A further incentive not to exercise stricter control stems from the great vagueness of effectiveness criteria. This vagueness makes effectiveness less consequential and low coordination

of the therapeutic effort more easily acceptable. As a consequence, time can be spent on other than control activities. Another important resource used to augment the participants' autonomy is the plurality of sources of patients, which reduces the staff's dependence on patients controlled by the psychiatrists.

Apart from the heretofore mentioned resources, a variety of less important resources and weaknesses account for the variations in the different professions' autonomy. Among these is the centrality of a profession's work relative to the prevalent therapeutic concepts. Such centrality can be used to enhance the profession's autonomy by making it relatively difficult to use certain power resources, such as the ability to deprive that profession of patients, to reduce that autonomy. It is not to be assumed, however, that the importance of a profession's work is necessarily conducive to greater autonomy. As has been noted, occupational therapists enjoy a level of autonomy that is in some important respects, particularly in their work with patients, as high as the autonomy possessed by the psychologists. The autonomy of the occupational therapists, however, is the result of the neglect of a therapeutically marginal occupation.

Certain administrative arrangements can also promote the acquisition of greater autonomy, by shielding individuals from the power holders and making collective opposition easier. On the other hand, some departmental policies, such as the pursuit of departmental expansion, require greater

sensitivity to the nature of the demand for the profession's services and may thus undermine the profession members' autonomy aspirations. A degree of modification of the prevalent autonomy structure is achieved by subtle diadic negotiations and bargaining. Of interest in this research were the exchanges of enhanced autonomy for improved cooperation made mainly between the psychiatrists and other staff. It seemed that the competition among the various groups for increased autonomy was responsible for the failure to make the higher level of autonomy a formal right of the staff, i.e., an item not subject to bargaining. This point to the division of the hospital staff into mutually autonomous functional departments as a source of weakness of organizational participants in the face of a centralized control over some valued resources.

On the level of the psychiatric hospital as a whole, an important reason for the relative weakness of control seems to be the fact that all psychiatrists are engaged in private practice, in some cases in addition to their hospital appointments. As a result, the psychiatrists tend not to spend their own time monitoring the performance or work patterns of the hospital staff, thus lacking information that could be used to reduce further the staff's autonomy, in accordance with the psychiatrists' stated desires. The time pressures under which the psychiatrists apparently work also seems to encourage their entry into various diadic accommodative relationships with other staff and thus to reduce the



possibility and effectiveness of collective action by the psychiatrists as an interest group.

Chapter V

Conclusion

In general terms, the situation in the hospital studied resembles quite strongly the situations in other, similarly staffed psychiatric hospitals reported in the literature (esp. Strauss et al., 1964; Coser, 1963; Zander et al., 1957), insofar as those reports focus on the same aspects of organizational functioning as this research. It appears that the cultural and institutional settings which are to a large degree common to North American psychiatric hospitals, aided by the existent communication networks which connect the personnel of various hospitals, result fairly predictably in similar patterns of functioning. The changes over time, if any, are apparently too subtle to be gauged from the available data, as the above-cited studies are not specific enough and focus rather on more generalized observations about status differentials and power processes. Although the findings of this research were presented in a more detailed manner and identify a considerably greater variety of power resources than the above studies of psychiatric hospitals, all of the resources identified here can be subsumed under the general resource headings listed in the earlier-cited literature on power processes (e.g., Mechanic, 1962; Peabody, 1962; Simon, 1957a; Strauss et al., 1963; Scott, 1965; Goldner, 1970). Since the power resources identified here do not seem to have properties peculiar to psychiatric hospitals, it is also likely that they have been detected in other types of

organizations in largely the same specific form.

Assuming, then, that the present findings constitute a body of data applicable to some extent to diverse types of organizations and especially to psychiatric hospitals existing in similar social and legal environments as the Windsor Hospital, we can examine the relationship of these findings to some broader sociological and social concerns. The fundamental consideration in this context is the proposition that sociology as a science, has essentially the same primary objective as do other sciences as well as conventional social endeavors, namely, the control over the phenomena we encounter. Control is pursued through the development of more or less complex and inclusive theories and propositions that function as instructions for the manipulation of phenomena (cf., Meehan, 1968:21-31, and Note 1). The findings of this study conform to the above programmatic statement in that they make a degree of control over phenomena possible both by themselves and potentially as a part of more broadly conceived approaches, in combination with other theories and propositions.

The approach to power resources used in this study started with the conception of the free-willed, motivated actor behaving on the basis of his motives, and his common-sense knowledge of social life and various means-ends relationships in situations of choice. This conception is conventionally recognized in the sociological literature as an often adequate basis for explaining social life in terms of the underlying causal mechanisms. In the present case,

the attention centred on the identification of the means used by organizational participants, deliberately or inadvertently, to maintain and alter the characteristics of the organization's autonomy structure. If successful, this endeavor should result in a set of instructions for the manipulation of the autonomy structure, both by organizational members and by outsiders. The basic elements in these instructions are the free-willed direct control by the manipulator over various aspects of behavior and over resources, and the consequent control over, and the ability to alter, the existing choice structure of the organizational participants.

Of course, the identification of power resources is an inference process and the efficacy of the instructions in question will depend on the quality of the inferences involved (e.g., that something is indeed used as a power resource). It was one of the concerns in reporting the research findings to provide the reader with a sufficient amount of literal descriptions and descriptions involving only minimal degrees of interpretation to make it possible to judge the quality of the inferences made. The achievement of satisfactory results (i.e., workable sets of instructions for controlling the autonomy structure), given that the underlying assumptions about the dynamics of the actors' behavior are correct, also depends on the adequacy of the descriptions of autonomy, the adequacy of the description of the power resources involved, and the quality of the instructions for the direct manipulation of those resources. It has been

argued elsewhere in this thesis that not all measurement methods are adequate in that respect because of the difficulties involved in moving from abstract descriptions such as variable values to the substantive features of actual situations. Few such difficulties should be encountered with the present material if the instructions for interference in the organization embodied in the findings were to be carried out. The effectiveness of such interference should depend almost exclusively on the quality of the causal propositions involved, rather than on the descriptions.

Granted, then, that we have causal propositions of a general type that is considered valid (involving motivated behavior) and workable instructions for their applications to specific objectives, it is possible to proceed to manipulate the organization's autonomy structure. Given the ordinary interests evidenced in the sociological literature as well as what seem to be the practical concerns of the lay users of organizations, manipulation of autonomy per se would be a pointless exercise. The ability to manipulate autonomy is useful in the context of broader objectives, generally falling under the heading of organizational effectiveness.

There are several approaches to the problem of organizational effectiveness (cf., Price, 1972). The most prominent one conceives of effectiveness as "...the degree to which a social system (an organization) achieves its goals."

(Etzioni, 1964:8). Of course, the organization per se does not have goals; various actors have more or less definite goals

in mind both for themselves and for the organization. This gives rise to difficulties with goal-identification on the one hand (cf., Price, 1972a:101) and to rather complex conceptions of organizational effectiveness incorporating the plurality of viewpoints, and consequently a great variety of ways in which organizations can be seen as effective or ineffective, by members and outsiders alike (cf., Ghorpade, 1971). The broad approaches to effectiveness allow us, among other things, to see the degree of organizational members' autonomy as a direct element of the organization's effectiveness: if autonomy is the goal of an actor whose viewpoint is considered relevant, then the existing autonomy can be seen as an element of organizational effectiveness. This situation is not particularly interesting, however, because, taken in isolation, it presents no particular technical problems. After all, autonomy can be increased directly (i.e., it does not have to be caused to increase) and easily. Of the various other elements of effectiveness that can conceivably be affected through the manipulation of autonomy, very little is known about all but two of such elements, namely, work-related satisfaction and productivity. Consequently, only these two elements will be attended to in the following.

The available literature on the relationships among autonomy, work-related satisfaction, and productivity has been examined earlier in this thesis. It was found that work-related satisfaction increases quite reliably with autonomy, especially where actual variation of autonomy is concerned.

Similarly, the present research suggests clearly that the same pattern obtains in the psychiatric hospital studied: although greater autonomy is not invariably regarded as an unmixed blessing, on balance higher autonomy is preferred and sought after by all concerned.

The literature offers conflicting evidence about the relationship between autonomy and productivity. Empirical studies do not provide data that would make it possible to account for the conflicting results by narrowing down the range of conditions under which the relationship should be positive, for example. The efforts to do so remain on the level of speculation (cf., Dubin, 1965). If, then, the ability to manipulate the organizational autonomy structure is to be put to use in affecting the productivity aspect of organizational effectiveness, an extensive area of uncertainty has to be removed. This area involves not only the relationship between autonomy and productivity, but also the relationship between work-related satisfaction and productivity. As the review of literature on that subject showed, the evidence so far is contradictory and the relationship remains to be elucidated.

Even though the current hospital lore has it that lesser autonomy, as manifested in improved coordination of therapeutic interventions and other things, would enhance therapeutic effectiveness, such is not necessarily the case, as there is no clear evidence to that effect (cf., Fisher et al., 1973:32-33; Glasser, 1965:48). Unfortunately, then,



the same holds for the relationship between autonomy and productivity in the psychiatric hospital as does in other organizations, namely, that the relationship is still obscure and needs to be investigated further. The same applies to the relationship between work-related satisfaction and therapeutic effectiveness in psychiatric hospitals.

The theoretical formulations dealing with autonomy suggest that, as a minimum, the above basic triad of autonomy, work-related satisfaction and productivity has to be considered to provide meaningful conclusions, at least because improvements in organizational performance due to increases in productivity may be offset by increased turnover, for example, due to impaired work-related satisfaction. To guard against that possibility if autonomy is decreased in the pursuit of higher organizational effectiveness, however, not only the directions and conditions of the above causal relationships have to be clarified. To predict the net outcomes of conflicting influences, the measurement techniques used must meet what at present are far too exacting criteria. The inadequacy of the currently available measurement techniques makes it impossible to move beyond the specification of causal directions, even insofar as the empirical evidence is consistent.

Thus, if we restrict ourselves to the above three-variable model, and propose to consider autonomy as the ultimate independent variable inasmuch as it is the only one of these three variables that can be more or less

readily directly manipulated either by higher-placed organizational members or by outsiders, at least two directions for future research are indicated, in addition to the attention to the problems of measurement. They focus on the relationship between work-related satisfaction (manipulated through autonomy and possibly other variables) and productivity on the one hand, and the relationship between autonomy and productivity on the other hand. The possible orientations towards the changes in autonomy consist of increasing and decreasing the participants' autonomy, and of rearranging the organization's autonomy structure. It seems, however, that only the latter two would present appreciable technical problems to which the present research is relevant.

There are some empirical findings as well as theoretical formulations (Dubin, 1965), suggesting that the technology involved should play a large part in differentiating among different patterns of relationships among the three variables discussed here. Since the character of the technology used in the psychiatric hospital studied has been emphasized as one of the crucial factors responsible for the dynamics of the existing autonomy structure, it would probably be advisable to confine attention to psychiatric hospitals and similar organizations rather than to deal with organizations using disparate technologies. It is also important to note that whereas ordinarily productivity is not considered to present particularly great measurement problems, it seems

that no sufficiently unambiguous measures of therapeutic effectiveness are available. To no small extent, this is due to the intricate problems involved in the conception of mental illness itself (cf., Szasz, 1961; Glasser, 1965:42-50; Mowrer, 1965). Even if simplified measures of therapeutic effectiveness are adopted, such as hospital re-admission rates, the potentially complicated nature of patients' careers, with a number of possible systematic biases in the treatment accorded the patients at different stages in their careers, makes the design of systems for the evaluation of therapeutic effectiveness due to the organizational autonomy structures a rather intricate matter.

Thus, the present research can be seen as only one of the initial building blocks necessary for the solution of considerably more complex problems. It is not being suggested, of course, that the limited set of problems dealt with in this research need be considered conclusively solved. Painstaking as this research was, it is nevertheless open to question whether or not it offers findings adequate for the various conceivable purposes to which these findings may be put. Some power resources may have gone unnoticed, some choices available to the organizational participants may have been misinterpreted. As has been observed previously, the adequacy of causal propositions and instructions for the manipulation of phenomena can hardly be determined conclusively without actual manipulation, in the final analysis.

Appendices.

## Appendix A

### On Causal Inference from Correlational Data

As far as the testing of causal propositions is concerned, the pure experiment is, of course, the ideal method. It offers, at least in theory, a constant situation with only the selected causal variable changing. Thus, it can be employed to ascertain the effects of a variable on a specified situation, or to search for the cause - impetus which, combined with a set of specified stable conditions will produce the desired effect. The effects of several simultaneously changing causal variables could also be studied, although it is difficult to unscramble the roles of the individual variables involved, unless the process can be broken down into discrete steps involving only single variable changes.

The experiment can be used to specify at least the initial segment of a causal chain and provides a clear definition of 'conditions' and 'cause', to the effect that 'conditions' are the variables held constant (of course, it need not always be perfectly clear what exactly these variables were in any actual case). The experiment is based on instructions embodied

in a theory.<sup>1</sup> If the desired effect can be routinely achieved by the experimenter, and if all the entailments (deducible propositions) of the theory have been borne out in such experiments, the theory can be termed adequately supported or 'proven'.

While theories that have some additional experimentally confirmed entailments are to be preferred over less extensive theories, it does not follow that the discovery of such a more inclusive theory constitutes a refutation of the initial theory. Given the definition of 'proof' offered above, the initial, less inclusive theory remains adequately supported and useful for practical purposes. This means, in effect, that we have to distinguish carefully between the assertion that a theory is 'proven' on the one hand, and 'true' on the other hand. The former does not imply the latter and, in this writer's view, the question of the criteria for declaring a theory 'true' is superfluous and indeed unsound, because the issue of 'proof' as defined above is the only conceivable operational goal for the testing of causal theories, as we can never preclude the possibility of discovering a still more inclusive theory.<sup>2</sup>

The basic advantage of the above formulations is that they specify precisely the objectives involved in theory - testing by providing for a finite set of requirements (i.e., a clearly specified set of experiments), which is not the case in some other formulations of conventional theory - testing procedures, most importantly in the correlational model to be discussed. The definition of 'cause' used above accords well

with that developed in Simon's (1953) early work with sets of linear equations, where he also distinguished between causes and conditions and noted that testing must involve experimental manipulation of the variables involved.

In contrast with the experiment, observation of social processes or, in effect, of uncontrolled natural experiments seems merely to exacerbate the technical problems involved in recognizing the proper sets of conditions and in disentangling the effects of different causal variables changing and having an impact simultaneously (this is to be distinguished from mutual causation among such variables); observation of such natural experiments does not appear fundamentally to alter the process of theory validation. Instances of use of that method can be found, for example, in the literature of the early 1950's when, however, the distinction became blurred between observation of natural experiments involving attention to the process itself and simple enumeration of the conditions accompanying a phenomenon.

In the writings on the method of analytic induction it was argued that there is no difference in principle between analytic induction and 'enumerative induction', i.e., correlational analysis (Robinson, 1951). The objections that were raised pointed to the difference between statistical and causal questions (Lindesmith, 1952:492), but did not provide an adequate argument to show why correlational (statistical) data could not be used to infer causal relationships or to test causal theories. Yet, Lindesmith's own work on opiate

addiction (1947) used distinctly the 'natural experiment' approach rather than simple enumeration of conditions. The criticisms of that work (e.g., Turner, 1953) show neither that the causal structure proposed was improperly set up (given the present definition of theory, cf. footnote 1) nor that it had been improperly tested but only that it answered a mere fraction of the questions that might conceivably be asked about its subject matter. At any rate, the view came to prevail, at least in practice, expressed by Robinson who did "...not regard 'causal analysis'...as being logically different from the 'statistical' approach..." (1952:494).

It seems that in later research not much attention has been paid to the problem of testing causal propositions by correlational data, even though not all of the problems involved have gone unnoticed. Blalock (1964) dealt extensively with cross-sectional data but basically concluded that the problems can be neglected and causal analysis performed nevertheless. At one point, having noted that only in experimental situations is there usually no ambiguity as to which is the independent and which is dependent variable (p. 36), he suggests that

"One way of dodging the problem of causality is to deal only with covariation and the notion of prediction. Thus one can ask how well we can predict from X to Y, or vice versa, while completely begging the question of the causal relationship between the two." (p. 38)

Having the opportunity to dodge the issue, it is in order to ask what would be lost by neglecting causal analysis. And the answer is, it seems, that we would have to abandon the



objective of producing, controlling and using the phenomena we explain. While actuarial methods have their uses (generally, they consist of the user's adjustment to the phenomena covered), causal models offer the additional ability to control phenomena. And whereas control is not necessarily the sole objective of science (viz., astronomy), Meehan (1968:7-29) is correct that control is the usual goal in the physical sciences and no less worthy of attention in the social sciences. The question is, of course, whether or not the correlational (non-experimental and non-quasi-experimental) approach is indeed incapable of testing causal theories as defined here. The position taken here suggests that correlational analysis cannot serve as a substitute for experimental and quasi-experimental testing, in spite of the usual practice in the literature where correlational findings are routinely presented as tests of causal formulations, with only rare exceptions when the tentativeness of such a procedure is acknowledged, but neglected for all practical purposes nevertheless (e.g., Pugh et al., 1969:112 et passim).

The first proposition to be examined is that correlational testing of causal theories, as currently conceived, does not have an objective that would be at least in principle attainable. Instead, it foresees a perpetual process, while not necessarily coming closer to the correct causal explanation, nor achieving any other particular objective. According to one rendition of that approach, which seems to be a reasonably representative statement of the current ideas on the subject,

theory testing is a process whereby alternative explanations of a phenomenon (a case, event<sup>4</sup>) are subjected to hypothesis-testing such that in each step some of them are eliminated. This process culminates in the 'crucial experiment' which is

"...a description of a set of observations which will decide between two alternative theories, both of which according to present knowledge are quite likely." (Stinchcombe, 1968:25).

There are a number of problems with this proposition, the least of which concerns the vagueness of the term 'likely'. If this term connotes 'plausibility', we are left without any explicit criteria for judging it. All we can rely on is the familiar vague feeling that a theory 'sounds right'. But, as we are dealing with a new theory rather than a mere application of one or several old ones (already tested), it is quite meaningless to speak of such intuitive impressions. In applications it might make sense merely to feel that an application has been put together properly if the available rules are not quite definite, but with new knowledge such a criterion is singularly without any foundation: all theories compatible with the available data (as stipulated by Stinchcombe) are equally plausible. If, on the other hand, 'likely' is to be understood as 'probable' in the sense that a fraction could express the probability that the given theory is true, it is again fairly obvious that the task is hopeless. That a theory is true is a unique event and there is no known way of assigning a probability to unique events.

Therefore, the notion of the 'crucial experiment' is founded on a misconception, as there is no reason to believe

that we can in any meaningful fashion differentiate among competing theories as long as all of them are compatible with the known data. At this point it is not particularly important that what Stinchcombe referred to as (crucial) 'experiment' is not necessarily an experiment at all; it may be just another correlation. A more important point is that the theory-testing is aimed at learning the 'truth' about nature, so to say, rather than at deciding the practical adequacy of theories in terms of their contribution to our ability to manage phenomena. The result is that we could never act on the basis of theories tested under Stinchcombe's program because it lacks any definition of a theory's adequacy. The idea of the 'crucial experiment' is one attempt to provide closure to the whole process but, as it rests on the notion of a theory's likelihood, which has been shown wanting, in actual fact we always have a body of (correlational) data and an infinite set of theories congruent with those data (cf., Stinchcombe, 1968:20). This situation exists at any point in the testing process, quite irrespective of the number of hypotheses that have been tested and the number of theories that may have been rejected previously.

Now, it may be possible to construct deductive theories that would have no entailments beyond those supported by currently available data (this would not mean, of course, that such theories would be causally correct). Were that the objective, it would be operational, i.e., there would be no question about its achievement in any particular case.

Since the objective is different, however, and since it is always possible that some other theory, consistent with the available data but having additional entailments is 'true' after all, there is no alternative to the pursuit of further 'support' for our models (and there seems to be a potentially infinite amount of data abroad). This might not seem to be a particularly worthless or counterproductive idea, were it not for one circumstance peculiar to correlational testing of causal theories. Thus, additional testing and therefore what is routinely referred to as 'further support' or, in one version, making a theory 'more credible', 'much more credible', or even 'very much more credible'. (Stinchcombe, 1968:25), is not guaranteed at all to make theories approximate the truth closer and closer.

The preceding is a rarely appreciated proposition, and one whose merits can best be illustrated by an example where the correct explanation of the events of interest is known. Meehan (1968:45) provided such an example, in which the driver of an automobile uses a rule to decide on his behavior (say, giving or not giving the right-of-way to other vehicles) when crossing intersections. Any rule is here sufficient, including tossing a coin to make the decision, or the knowledge of the correct causal explanation in any real-life situation, dealing with any subject whatever. Having set up the example, Meehan asks:

"...does it follow that no explanation of D's (driver's) behavior would be possible unless the description included the information required by the rule that D actually followed? Curiously

enough, that is not the case. It would be possible ...to produce an explanation of his driving behavior that made no reference to the terms of D's actual rule of driving, yet accounted for his behavior quite adequately." (Meehan, 1968:45).

Thus, we have instances of behavior about which we know that they are determined by identical causes and, knowing the rule the driver uses, his behavior can be experimentally altered or predicted. However, should we use the deductive type of explanation, the illusion of having arrived at the correct explanation could be maintained while actually the explanation would be incorrect. Yet, there are present all the ingredients required by Stinchcombe (1968:10-30): there is an unlimited number of occasions for testing our hypotheses of the driver's behavior and, concurrently, the amount of data available increases with each intersection crossed. Nevertheless, the explanations we come up with could just as well become more and more outlandish and come to include more and more irrelevant variables. There is no reason to expect that the theories would become 'more credible', as Stinchcombe would lead us to believe. If, on the other hand, an attempt at interference in the events were made in the form of manipulating some of the variables suggested by the theories designed to explain the driver's behavior, there would be no guarantee of success either. However, at least the illusion of approaching the true explanation would not be entertained. Each failure of manipulation would merely refute an explanation and another one would have to be tried at the next occurrence of the event studied.

Only under very special circumstances does Stinchcombe's version of the 'deductive paradigm'<sup>5</sup> lead to the correct explanation. This exception is the rather peculiar situation when it is either known or postulated that the correct explanation has to be one of a finite number of explicitly<sup>6</sup> formulated possibilities.

The preceding dealt with rather broad questions. There are a number of less general reasons why a theory or a simple proposition about the relationship between two variables, if validated through correlations, may fail to be supported in experimental testing and thus fail as a causal theory or proposition. As has been noted earlier, if there is to be any point to constructing causal theories, they must enable us to do something more than a mere correlation would, i.e., they must enable us to manipulate phenomena. All that correlations make possible is passive adjustment (cf., Meehan, 1968:19). Further, it should be pointed out that testing (by correlation) more and more implications (entailments) of theories, perhaps implications involving new variables, is quite useless if we cannot test conclusively various small causal segments of such theories. That a number of additional entailments of a theory are supported by correlations has no particular bearing on the validity of any single causal link proposed by the theory.

Let us examine, then, the problems encountered when the situation to be explained is complicated because it involves a number of variables and there is no clear indication of

the causal direction. The first of these two complications basically raises the problem of spuriousness. If a theory implies a correlation and the 'path' of causality, only the former can be tested from cross-sectional data, while the character of the causal link (direct or indirect) can be only refuted from correlational data, but not confirmed. At best, the confirmation of a direct link is based on the failure to discover the variable that would remove (or reduce) the initial correlation.

The solutions offered most frequently to the problem of spuriousness are essentially non-answers. Consider, e.g., the following recipe furnished by Labovitz and Hagedorn:

"A nonspurious relation is defined as an association between two variables that cannot be explained by a third variable. Stated otherwise, if the effects of all relevant variables are eliminated and the relation between the independent and dependent variables is maintained, then the relation is nonspurious."  
(Labovitz and Hagedorn, 1971:7)

Although the above is undoubtedly correct, it suffers from a certain technical difficulty, to wit, that while only the correct theory can indicate which are the 'relevant' variables, prior to proof it is unknown which theory is correct. Thus, Labovitz and Hagedorn propose that the theory in question has to be at the same time both tested and already proven. If we don't have a proven theory, and if the theory that is being tested is incorrect, we might choose 'irrelevant variables' and erroneously conclude that the given relationship is nonspurious. Since we cannot have a theory

that is already proven and in the process of being proven at the same time, it follows that the discovery of spuriousness by correlational analysis is unavoidably fortuitous.

It might be noted that the situation is quite different when examining the spuriousness of relationships in the light of theories considered valid, as Rosenberg (1968:28-33) does using several examples (while giving the erroneous impression that he is discussing the testing of new theories). There the question only is how to piece together the given spurious correlation on the basis of accepted theories in such a manner as to make it logically predictable. In our case the situation is different, as we are trying to test a theory in the first instance.

What we have, then, is a reliance on accidental discovery of spuriousness, whereas in experimental testing the spuriousness of any given relationship would immediately manifest itself. It is also apparent that should an error be made concerning any one causal link, the deductive theory will be incorrect and unusable quite irrespective of any additional 'successful' hypothesis - testing. It follows, then, that mounting correlational support does not guarantee that a theory will become more correct.

A problem analogous to spurious correlation involves the so-called 'spurious non-correlation' (cf., Rosenberg, 1968:93) which refers to the situation where a correlation between two variables appears only after introducing a suitable control variable. The control variable can be integrated



into the causal network, or else, it can be said to distinguish different kinds of cases. The latter interpretation might be preferable if the control variable is something we can not change, e.g., the place of birth.

The proposition that there is no relationship between two variables may be an integral part of a deductive theory. Therefore, it has to be found true before the theory can be said to have received support. Needless to say, it is difficult if not impossible to find instances in the literature where the absence of a correlation has been subjected to testing, unless the theory predicted the presence of a relationship rather than its absence. In either case, the discovery of a suitable control variable is necessarily accidental. In contrast, experimental testing would show immediately that the theory, regardless of whether it predicted a correlation or the lack of it, 'works' for some cases while not for others, or that it does not work at all (the former would be reflected in correlations under proper controls where for some cases a correlation would exist while not for others). Although it might be difficult to find the characteristics that distinguish the two types of cases (i.e., the control variables), it would be at least clear that two or more kinds of cases exist in the population originally thought to be homogeneous.

Another potentially problematic area involves the causal status of the cases referred to in correlational analysis as the 'percentage of variance explained'. Apparently without

exception, it is assumed in the literature that the cases falling within the correlation are causally identical. It is easy to see, however, that such is not necessarily the case. Should the sample contain what can be referred to as 'things of different kinds', several possibilities exist.

Thus, a portion of the cases within the correlation may actually be instances of a spurious correlation, or the direction of causality may be reversed, as compared to other cases. Only experimentation offers a reasonably systematic and routine way of discovering things of that nature.

Correlational analysis can perform the same task only accidentally, if one happens to control for the proper variable.

Some of the routine assumptions made by users of correlational analysis would seem to reduce the chances of these discoveries even further. The assumptions in question concern the homogeneity of the cases, events, etc., contained in the samples.

'Homogeneity' refers to the proposition that a theory should apply to all the cases that were assembled in order to test that theory.

It should be noted that for some purposes it is necessary to assume that all the test cases are essentially the same. Such is generally the case when one of the variables we are dealing with cannot be returned to its previous value. Human experience is one example and the germination of seeds another. To effect experimental treatment, the manipulation has to be applied to different specimens if it is to be applied to presumably identical things. And of course, in properly

constructed experiments of this kind the characteristics distinguishing the kind of thing we are dealing with are not cast as the cause. Something variable (e.g., the amount of fertilizer) must be used as the cause. Experimentation might show that the original assumption of sameness had been incorrect after all (e.g., the fertilizer may have no effect, or adverse effect, on some seeds). In the absence of experimentation it seems impossible to separate cases of apparently different kinds. As long as nothing is changing, there will not be the necessary crack in the appearance of the data. And cross-sectional data do not change, i.e., the statistical manipulation does not alter variable values for single cases.

The recognition that there is no particular reason to assume causal identity of cases assembled on the basis of some a priori, perhaps commonsense, criteria informs the notion of 'limiting the universal' which appears in the work drawing on analytic induction. The essential point there is the practice of starting with single cases and building them into categories because of the applicability of apparently common explanations to these observed quasi-experiments (e.g., Robinson, 1951:814). Similarly, Meehan (1968:25-28) contends that starting with single cases is the routine practice in the natural sciences.

Another reason why causal inferences from correlational data may be problematic is that in sociology we cannot necessarily transform the correlational statement into an experiment starting with identical cases, which is an operation

that ordinarily can be performed in agronomy, for example. Thus, let us say that we have a correlation between income and another variable. To transform this relationship into an experiment, the income of a low-income person would be increased. But since it is clear that this does not necessarily replicate the process which a high-income person had gone through, it cannot be said that the experimental treatment was applied to the 'same kind of thing' as the now high-income person had once been. In other words, the correlation between income and another variable cannot be used as a transcription of a pre-treatment versus post-treatment situation because the high-income person is not a case of a low-income person after the experimental treatment took place. In contrast, each plant had once been a seed, presumably just like any other seed. This makes the transformation of a correlational proposition into an experiment possible under certain conditions, to wit, if we can legitimately speak of pre-treatment and post-treatment categories within the sample. Although this condition can be fulfilled in sociology, as it is in the statistical analysis of experiments involving control groups, it seems to be quite neglected in ordinary cross-sectional studies.

This brings us to the final point concerning correlational testing of causal theories, one focusing upon the 'unvarying variables' used in such testing. The departure point will be the observation that, in correlations, instead of changing the value of a variable and observing the consequences,

another case (or many cases) with a different value of the given variable is selected and the 'effects' of the 'change' observed. This shortcut is the source of most of the difficulties with correlational theory testing discussed so far. One difficulty that has been mentioned briefly involves the question of causal direction. As Blalock (1964:41) noted, even if a causal relationship between two variables is actually unidirectional, the selection of cases with different values of either of the two variables will 'produce effects', while in experiments with the same cases that reciprocity would not be found.

A further complication appears when we are dealing with 'variables' whose values for single cases cannot be altered. Then not only is the causal direction neglected but the illusion is created that, for example, 'race' is manipulated, while it obviously is not. And since it cannot be manipulated, it is pointless to use it as an independent variable in causal (in contrast to actuarial) models. But the above is a trifling example of an easily avoidable error. More serious objections to substituting 'shifting' of cases for the 'changes' of the values of the variables involves the proposition that the former does not take into account what might be called the 'systematic change' and the 'history of changes' involved in true manipulation of variable values. Either of these two shortcomings may well render correlationally tested propositions at least seriously myopic and potentially quite unusable.

The 'history of changes' can be illustrated by a simple example involving a change of the socio-economic status or, to select something more easily managed, a change of a person's income. This change might be conducted in a great number of cases to control (hopefully) for the effects of accidental causes. Now, it seems highly unlikely, given both our commonsense knowledge of the way things work and various reports of the results of social mobility, that the changed sub-sample would resemble the sub-sample which had the given, say, higher income all along, in terms of the distribution on several 'dependent' variables. The simplest proposition that would have to be considered is that personal histories matter and that the act of altering a person's status is consequential beyond the change itself, so to say.

Of course, the preceding is a trivial example, but it can serve as an illustration. Another one can be drawn from the studies of work autonomy. Usually, we find a certain positive correlation between employee autonomy and work satisfaction, in a variety of settings. Although the variables in most of this research are 'supervision style' and 'morale', their meanings are akin to autonomy and satisfaction, the latter two being almost invariably used as dimensions subsumed under the more inclusive variables (e.g., Weschler et al., 1952; Vroom, 1960; Katz, 1963). One possible flaw in all these studies is that the difference between satisfaction levels is invariably given for two (or more) groups of employees who know of the other group(s) that have different autonomy

levels. Therefore, no propositions can be made concerning the levels of satisfaction as related to autonomy in situations where no 'invidious comparisons' can be made by the employees.<sup>11</sup> It may well be that the notions of relative deprivations and the reference group theory would have to be introduced to achieve more satisfactory explanations. At any rate, even if these refinements are not introduced, as is the case in the above mentioned studies, the correlations reported there can be used as the departure point in experiments.

Experience with experiments shows that, indeed, increases in autonomy do result in improved job satisfaction, among other things (e.g., the natural experiment in the toy factory, reported in Whyte, 1955:90-96; and the experiment conducted by Coch and French, 1948). In one of these studies, autonomy was not only increased in some, but also was actually experimentally decreased in other treatment groups (Morse and Reimer, 1956). Here the expected results were achieved as well: a decrease in autonomy resulted in lowered satisfaction. But, in all these instances a simple one-way change was involved. There is nothing in the correlational evidence to suggest that if the changes were cyclical, the state of satisfaction at the end of the cycle (i.e., with the same autonomy as originally) should be any different from its state at the beginning. The available reports on increases of employee autonomy that were later revoked by the management (Whyte, 1955:90-96; Drucker, 1962:299-300) indicate

that this practice may lead to drastic dissatisfaction and job quitting (by more than fifty per cent of the affected workers, in one case).

The presentation so far has dealt with the 'history of changes' only. The earlier comment on relative deprivation and reference groups may serve to indicate some of the possible problems involved in 'systemic change'. To a certain extent, laboratory experiments are deficient on this count just as correlational analysis is, because the changes produced in experiments lead nowhere else, i.e., there are no repercussions in some larger system, not to mention the differences in the subjects' outlook and the forces that infringe on them in the laboratory and outside. The former deficiency is more important, because there are no prospects of controlling for things of that nature and experience shows that they are important. The repercussions of the experiment in the larger system of the factory led to the revoking of autonomy concessions in the above cited incident. A similar situation might exist when putting into effect findings based solely on laboratory research.

When correlational studies are used to plan programs of organizational change or to test theories, there is not only the absence of any warning about the repercussions of the proposed changes in the environment and possible feedback, but also no information on the consequences of actual changes of variable values within the isolated causal model itself. The essential point is that the experimental change of



a variable's value automatically alters the overall system, while mere 'shifting' has no such consequences. And if the increase in one case were to be compensated for by a decrease in another case, one would have to anticipate the consequences of changes in relative deprivation and of various alternations in the pattern of the system's characteristics. Therefore, the 'evidence' gained from 'shifting' would be useless from the viewpoint of practical applications of theories tested by means of that methodology.

Thus, correlational analysis unavoidably neglects at least two consequential areas: relative deprivation and the change of the system. Examples of either are easy to come by. For instance, should one attempt to achieve a certain objective by increasing the income or the value of any other variable characteristic of the members of a group, the situation would change by dint of that interference. Therefore, the information on the correlation between the independent and dependent variables may be useless. After all, that information concerned a different sort of situation, one in which a different pattern of relative deprivation obtained, possibly along with a host of other different relationships. Another example can be drawn from this writer's earlier research, in which a positive correlation had been found between the grades students received in a subject and the likelihood of their selecting that subject as their 'major'. This relationship existed for students not originally intending to major in the given field. It can be suspected that should a department

desire to increase enrollment by giving more students higher grades, success would not be inevitable, even though there is nothing in the initial data to suggest otherwise. But then, the increasing frequency of higher grades would bring about a somewhat altered situation, one for which data were not available. A study of other departments with higher proportions of higher grades might shed some light on this question if it could be assumed that the cases (departments) had been initially identical, as earlier discussion suggests. And that is a rather intricate question.

In conclusion, it is proposed that the problems of testing causal theories (as defined here) from correlational data are manifold, that most of them can be solved only fortuitously (e.g., spurious correlations) and even then one cannot know that a solution has been reached until experiments are performed. Other problems, stemming from 'systemic changes', seem to be insurmountable. The only exception is correlational analysis of data that constitute the records of natural experiments, on condition that the processes can be assumed to have started with identical cases. Of course, natural experiments may still leave unanswered the question of how to manipulate experimentally the phenomena (causes) that change naturally in these quasi-experiments. Otherwise, correlational analysis is suitable for the investigation of conditions under which a causal theory will be applicable (or, more precisely, has been found applicable), as that procedure involves purely statistical questions rather than causal propositions.

The reasons for the scarcity of experimental studies in sociology are not difficult to appreciate. Meddling in the social life is not a trivial matter and is likely to be regarded with suspicion, even by sociologists themselves. Aside from laboratory studies of small groups, only rarely does it happen that the sociologist's interests coincide with those of laymen and even then the experimental subjects are not always given choice. Such is the case with some of the experimental research on work autonomy where it is the management's approval that is crucial.

It is somewhat more difficult to understand the trend away from the study of natural events as experiments, unless the reason is that it is incomparably easier to gather data for correlational studies. Furthermore, the problems with causal inference from correlational data seem to be glossed over in much of the literature, even though scattered throughout the literature we could find an awareness of perhaps all of the problems discussed heretofore. The ordinary practice largely seems to neglect them, except that 'mounting support' is claimed for theories rather than 'proof'. But it is open to question whether the things conventionally recognized as 'support' actually constitute support. It has been argued here that such is not the case, because of several reasons, deriving from the proposition that the 'truth' of a theory is a unique event rather than a statistical expression, and from the observation that the quantity of 'support' is no substitute for the demonstration of the validity of even

a single causal link.

It has also been suggested that the goal usually set for theories and theory testing is inappropriate as it involves no notion of a theory's adequacy. And while it is clear that no theory need be 'true' in an ontological sense, it is possible to specify conditions of a theory's 'proof', i.e., a stage of testing declared adequate for the purpose at hand. The theories thus obtained may be crude and allow only minimal control over phenomena, but they may work nevertheless, just as the innumerable commonsense theories that enable people to manage their everyday lives do. At any rate, if it is assumed that there are ways, as yet unknown, of controlling phenomena, then the limits on the extent of these theories are set, in the final analysis, only by the ambition of the investigator, in terms of the kind and number of phenomena that are to be controlled.

## Appendix B

### On Problems of Measurement and Scaling

To specify a function relating two variables, such as autonomy and work satisfaction, each variable would have to be measured on an interval scale, and in terms of the total autonomy possessed by an individual, or a group, depending on the social entity of interest. As it is, neither of these two conditions can be fulfilled.

The researcher has two possibilities when measuring autonomy. One is to use various indicators and assign arbitrary points on a scale to these indicators. The other is the equivalent of using an attitudinal scale, i.e., asking the respondents, although not necessarily in so many words, how high their autonomy is. The basic problem with all instances of the latter method is that it shifts the problem of measurement from the researcher (who often could not solve it in the first place) on the respondents who then use unspecified operations that result in the response that, say, their autonomy is four on a five point scale. What can be obtained by this method is, at best, the respondent's judgement in terms of more or less, and relative to the reference groups selected for comparison.<sup>19</sup> After all, there is no reason to expect that

the respondents have solved the problem of measuring total autonomy better than the researcher has.

Thus, measuring autonomy by questions asking the respondents to estimate their level of autonomy can result in the most primitive relative values only, and consistency should be found only among people familiar with each other's situation, since only then is there a reason to expect that the same referents will have been chosen in answering the questions. It should be noted that we are not focusing here on 'perceived autonomy', even though it may be important in explaining behavior. The present interest is in a technical measurement problem, irrespective of the variable's theoretical import. The reviewed research uses the alternative method of measuring autonomy, one drawing on various indicators of that concept. This type of measurement ordinarily has to resolve the problem of validity, i.e., whether or not an instrument actually measures the concepts it is said to measure.

There is no definitive method that could be used for the purposes of determining the validity of instruments designed to measure abstract concepts that have varied and diverse historically specific manifestations (cf., Peak, 1953:283-292). This concerns not only the fact that measures relying on historically specific items do not produce what Blumer (1956) referred to as 'generic' (not historically limited) variables. It concerns also the validity of measurement within specific historical contexts which relies on various specific items

as indicators of the total concept.

In the case of autonomy it can be argued that in most cases it is fairly easy to determine whether or not an item of behavior involves autonomy. It is, therefore, not a question of whether or not the items comprising a scale actually refer to things interpretable as instances of autonomy. Rather, the problem consists in determining if the scores obtained by the instrument are correlated with the true scores on total autonomy. Obviously, that question is unanswerable as the measurement of total autonomy is the problem the scale is intended to overcome in the first place. It is therefore inevitable that comparisons be confined to the autonomy individuals have in specific areas (e.g., deciding when to have a coffee break) or to increases or decreases of autonomy in specific areas such as when the right to control the conveyor belt's speed is granted the workers. If a more complicated measurement is attempted, serious doubt is cast on the justifiability of the conclusions that may be drawn.

Individual or group autonomy consists of autonomies in all areas of behavior, or at least those recognized as belonging within the organization, if intraorganizational autonomy is measured. It seems hardly practical to enumerate all areas of autonomy and therefore, the research focus always is on only a few behaviors. In either case, however, in combining these items into a score, problems are encountered that are, at present, probably insurmountable. They involve

the absence of criteria for deciding the equivalencies or weights to be assigned to the single instances of autonomy that are to be combined. Thus, while it may be that a person's autonomy over the time when to have coffee breaks is equivalent to another person's autonomy over the same thing, it is not clear how the weight of that item compares with other items, and the decision on that point is quite arbitrary (see also Cicourel, 1964:14-29, for a discussion of these matters).

In implicit recognition of these problems the existing studies dealing with autonomy used closely matched items to derive the scores. Of course, in experiments the problem had been less acute as only the matter of more or less autonomy was involved and an increase (or decrease) of autonomy on a single item (such as coffee breaks) can be assumed to increase (decrease) overall autonomy, if there appear to be no other changes.

In correlational studies, the conclusions are mostly reported in terms of correlations and statistical significance. Occasionally, however, some of the more preposterous statements are made because of an apparent obliviousness to the measurement limitations. Thus, it has been 'shown' that the relationship between turnover and 'structuring of activities' (an item relying mostly on autonomy) is positive and curvilinear, producing a convex curve (Fleishman and Harris, 1962). Since all the problems with measuring autonomy noted above applied (see Fleishman, 1957, for the scale



construction), the curvilinearity may be much more the function<sup>21</sup> of the measurement procedure than of actual fact.

Furthermore, unless the items used to derive the scores form a Guttman scale (cf., Stouffer, Guttman et al., 1950:195 ff.) even the proposition that a correlation between the items used to measure the two abstract concepts exists is shaky; because of the arbitrariness of the assignment of weights, if the items do not form a Guttman scale, the correlation itself may be an artifact.<sup>22</sup> There is still less reason to assert that the phenomena corresponding to the abstract concepts per se are correlated, in the sense that, say, autonomy is correlated with satisfaction rather than merely that the scores obtained by the instruments are correlated.<sup>23</sup>

A problem directly related to the preceding difficulties concerns retracing one's steps, i.e., going back from scores to actual items (behaviors). If the items form a Guttman scale, it is possible to know the actual items from the score on the scale, but only if the retracing goes back to the same or identical case. If the cases (and, therefore, the items) are substantively different (e.g., there are no coffee breaks in the new case and therefore no substantive item corresponding to the given score on the scale) it is impossible to tell what situation would qualify as equivalent to that particular score on the scale. It is obvious that this retracing of measurement is vital in applications of the theory if any degree of precision is to be achieved, precision being

essential when several causal theories are applicable such that they specify contradictory changes in the dependent variable. For example, the question might arise of whether granting subordinates control over the time of their coffee breaks will offset the adverse impact on satisfaction of some other change. Given the currently attainable accuracy of data, that question is unanswerable as satisfaction cannot be expressed as a function of (increases in) autonomy beyond saying that a given increase in autonomy will result in an increase in satisfaction of unspecified and in any actual case perhaps insufficient magnitude. The impossibility of inferring the substantive situation from scores of the variable corresponding to it stems from the fact that, given the interpretive nature of concepts such as autonomy, we are necessarily dealing with instances of autonomy that are different from other instances (whereas an instance of 'length' is for measurement purposes identical with any other instance of 'length').

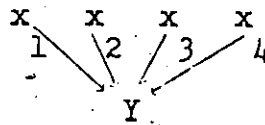
The shortcomings of the measuring techniques that have been noted show that the various limitations on the generalizability of both experimental and correlational findings are due not only to the research design as was argued earlier, but also due to the problems with measurement and indeed, that the research designs were limited because of those measurement problems. Also because of these problems, it appears questionable whether or not any advance is made when scores on

autonomy scales are substituted for simple accounts of the substantive state of affairs in the organizations studied.

It has been argued that the best that measurement can do is to speak of more or less autonomy and even that only under rather limited conditions. But for that purpose and under the conditions that allow confidence in the results, measurement instruments other than simple descriptive accounts are superfluous, as a statement about 'more or less autonomy' can be managed quite easily without any special instruments. An additional advantage is that the problem of retracing the measurement is circumvented if no scaling is used and there is no question as to what the researcher is talking about in terms of the actual situation that is being studied.

Notes

- 1 - 'Theory' is here defined in terms identical with the definition of explanation provided by Meehan:  
"...explanation is the application of a logical system to a description."(1968:31), where "...systems are logical structures, sets of variables and the rules governing their interactions."(1968:31). Thus, "...an explanation is an instrument that suggests ways in which man might in principle intervene in an empirical situation to alter the course of events."(1968:21). An experiment has the advantage of making it easier to determine that a description does indeed correspond sufficiently well to the given empirical situation.
  
- 2 - This agrees somewhat with Blalock's insistence that "Since these (causal) models do not refer to reality itself and a number of alternative models may yield the same predictions, we can never actually establish a given model."(Blalock, 1964:173). However, if we speak of a causal model tested in experiments rather than regression analysis, it is doubtful that we can produce models that would employ the same concepts and have the same entailments and yet be different. If such models cannot be produced, then one of those actually available will always be more inclusive than the rest and therefore preferable.
  
- 3 - The distinction between causes and conditions is not always made. For example, one formulation has it that "...the cause of a phenomenon is that complex of conditions, ...without which the phenomenon cannot occur and in the presence of which it never fails to occur..." (Lindesmith, 1952:492). This definition requires neither experimental manipulation of variable values, nor the monitoring of natural events as quasi-experiments. But such a formulation, a part of the 'analytic induction' approach, makes it impossible to advance beyond a model such as the following:



The causal structure derived from experiments (and therefore correct) may be considerably different. And indeed, the research work of some exponents of analytic induction (e.g., Cressey, 1953; Lindesmith, 1947) shows emphasis on quasi-experiments. The problems involved in bridging the gap between experimentally tested models and models derived from correlational analysis will be the main topic of discussion in this appendix. The problem is precisely one of advancing beyond a model such as that illustrated above. In another technique of causal

analysis, employing sets of simultaneous linear equations, the overall problem is much the same. A reading of Simon (1953) would show that, without selecting a causal variable and manipulating its value experimentally, the regression model amounts to nothing more than a hypothesis, as neither the causal ordering nor the appropriateness of the selection of variables can be tested otherwise. The same conclusion has been reached by Hilton (1972).

- 4- Strictly speaking, a phenomenon is something directly apprehensible by the senses. Therefore 'autonomy', for example, would not be a phenomenon. For the present purposes, the content of the term 'phenomenon' may be stretched to include abstract concepts such as autonomy, for descriptive purposes; for explanatory purposes such as when autonomy is said to be a cause of something else, it will be referred to as 'noumenon', i.e., the underlying cause of phenomena.
- 5- The term 'deductive paradigm' is borrowed from Meehan (1968) and refers to the combination of deductive theories and correlational testing where ordinarily the validity of theories is judged on the basis of correspondence between deductions from the theory and static data in a process that tends to incorporate into the theory more and more variables in order to accommodate newly found correlations.
- 6- The most interesting example of this situation seems to be offered by the commonsense techniques of motive - inference. It appears that the problem of inferring a person's motives is approached with a more or less extensive repertoire of motives which are tried out against the data, perhaps in an order informed by some notion of the likelihood that the various motives will be found present (cf., one report of such indicators in Henslin, 1968). To deal with the failures that may occur, one or several residual categories may be developed so that no one will fail to be categorized eventually. One such residual category may be 'mental illness', although of course persons with various successfully ascertained motivations may be classified into the same overall category, even though on somewhat different grounds.  
The preceding is akin to Scheff's (1963:438 et passim) concept of 'residual deviance'. It is noteworthy that, in commonsense reasoning, categorizing a person as 'mentally ill' does constitute a proper explanation of behavior, so it seems: the person behaves in the given motivationally incomprehensible manner because he is mentally ill. Thus, the repertoire of motives at hand is always sufficient to 'explain' any conceivable behavior. Finding the proper explanation involves the elimination

of various possible motives or causes until only one remains. In cases of this kind we can even speak of the likelihood that an explanation is true as, for example, the fraction of one over the number of remaining possibilities.

- 7- It should be noted that other devices used to deal with the problem of causal inference (see, e.g., Stinchcombe, 1968:32-37, for a list of these devices) such as time priority cannot substitute for the testing of spuriousness. To declare that a piece of evidence supports the theory it is necessary that the several conditions (time priority, spuriousness, etc.) do not indicate the contrary conclusion.
- 8- Rosenberg (1968:93) stresses the fact that in correlational analysis we can never be sure that a correlation is not spurious, etc. He does not propose to do anything about it, however, and merely falls into the trap of looking for infinite increments of support while not ever being sure of it for any practical purpose - such as trying to manipulate phenomena. Rosenberg, similarly as Stinchcombe, speaks of enhanced 'confidence' in the theory as more and more tests fail to discover, e.g., a control variable that would remove a correlation. While one can understand the feeling Rosenberg refers to, the fact remains that the theory either is or is not correct and therefore feelings of confidence are pointless, unless we are speaking of mere applications of 'proven' theories.
- 9- It would seem that this does not hold only when a peculiar conception of 'causal model' is adopted, one that is, incidentally, directly testable from correlations alone. For example, given identical conditions, corn may yield more than wheat. To bring about (cause?) higher yield, it would do to switch to growing corn. But this is patently a different kind of 'causal' model than those of interest here, as it depends on a mere reformulation of ordinary adjustment to phenomena.
- 10- Blalock (1964:42) used the term 'shifting' to refer to the substitution of different cases and 'change' to actual manipulation of the value a variable has in a single case. This usage will be followed hereafter.
- 11- The groups that were compared were engaged in tasks as similar as possible, and correctly so. What was perhaps unintentional was the familiarity of all subjects with the happenings in other groups. While it is in principle possible to prevent an experimental group's members from knowing of the experimental treatment of other groups, there seems to be no way of avoiding awareness by group members of a change in their relative

status compared to their environment, nor is it possible to produce a change in autonomy such that the act of change would have no significance for the subjects. The latter is a point that has to be considered in experimental studies. Correlational studies employing 'shifting' offer no information on the effects of those two characteristics of actual manipulation of autonomy and therefore make the application of their findings problematic.

12- ° Sometimes it is difficult to tell with precision what the measures used in the various studies had been because only conclusions are reported and the measurement procedure is given short shrift. Such is the case in Katz's (1963) review of various researches. It appears from that report that emphasis in measuring supervision style was given to workers' participation in decision making in the form of consultations between foremen and the workers, rather than to the extent of the subordinates' autonomy.

13- It should be also pointed out that higher work satisfaction or morale had not been found related to productivity in correlational studies (Kahn, 1956:43 ff.). Although the evidence from experiments is different, it cannot be said that experimentally induced satisfaction causes higher productivity since the causal variable actually manipulated is work autonomy or participation in decision making, and satisfaction there rose together with productivity, e.g., in the experiment in a toy factory reported by Strauss (1955).

From the viewpoint of causal models, it is not necessarily to the point to cast satisfaction, morale, and the like, as causal variables since their values cannot be directly manipulated. Some other variable is always manipulated, such as income, autonomy, etc. Unless higher satisfaction per se is the goal, rather than some other variable presumably causally dependent on satisfaction, the use of satisfaction and similar (non-manipulable) variables in causal models may well be pointless (see also note 14).

14- The reviewed studies deal with relative levels of actual autonomy, assuming that measurement was reasonably accurate and without systematic biases. Other studies have examined the relationship between the adequacy of the autonomy as perceived by the subjects themselves and some indices of job satisfaction, most notably turnover (Wickert, 1951; Ross and Zander, 1957), and the feeling that the individual's autonomy was inadequate was found positively correlated with turnover.

In keeping with the discussion of causal explanations (Appendix A), as well as with the interest in autonomy



per se as a causal variable, these studies can be disregarded because the variable cast there as the cause is not subject to manipulation, and therefore the knowledge of its correlates (or even true effects, for that matter) is, from the viewpoint of causal explanations, pointless. It can only be used as a condition, or a theoretically intermediate step, but not as the cause, as only variables subject to manipulation can be used that way.

- 15- Still, the nature of the experimental changes is not clarified in the reports on this experiment beyond saying that "work methods, ... and personnel matters, such as recess periods, the handling of tardiness..." (Morse and Reimer, 1956:122) were left at the employees' discretion. However, the employees did not "have complete autonomy and were subject to some of the same rules... as other employees." (Katz, 1954:105). Thus, all that can be said is that autonomy was increased and decreased. Nevertheless, it at least appears that these changes were not contaminated by changes in other conspicuous factors, as none were reported.
- 16- Of course, the lowered satisfaction and the higher turnover that might possibly result could offset at least partially the gains of productivity in situations where autonomy is decreased. No data are available on that point.
- 17- This is again a causal proposition, based on ordinary experience. The solution to any problem (the goal to be achieved) may necessitate the use of a number of such small-scale causal propositions. Of course, in this case only work autonomy is affected, not non-work autonomy.
- 18- Since the relationship between autonomy and productivity is rather ambiguous, it will not be considered in the discussion of measurement (Appendix B). It has been suggested that supervisory pressure for production results in higher productivity (Dubin, 1965:27) and perhaps that proposition could be used in conjunction with increases of autonomy to improve productivity and satisfaction with some reliability. However, Dubin's proposition is based on correlational data and, at any rate, is not quite relevant to the matter at hand.
- 19- This can be expected if the respondents have identical jobs and the differences in autonomy are simple, i.e., concern identical items, such as control over coffee breaks. Otherwise, the judgement may be based on an item of autonomy that has become an issue in the organization while disregarding differences on other points and thus bearing no necessary relationship to total autonomy.

It might be noted parenthetically that some of the conflicting results in correlational studies may have been due to the selection of indicators of autonomy with low saliency to the respondents.

- 20- Ordinarily, measurement problems are seen as the researcher's problems where he has to overcome 'bias', 'response set', lies, etc. (for an exhaustive account of these problems see Phillips, 1971 and 1973). Just as likely, however, the researcher's question confronts the respondent with a staggering measurement problem.

That the solutions reached by the respondents are often astoundingly inadequate has been documented by, for example, Schuman and Duncan (1974), although still in a context of viewing the (attitude) measurement involved as a researcher's problem. They provide a number of examples of attitude surveys where different wordings of what rather obviously is the same question produce widely different response distributions.

More importantly, however, response distributions will vary if the respondents are offered two scales on which to measure their attitude, one of them being a collapsed version of the other, even though the collapsing seems perfectly logical and as such should not affect the response distribution. In one reported case, the combined proportion of responses in two uncollapsed categories was 61% higher than the proportion of cases falling into the collapsed category when the respondents measured their attitude on the collapsed scale (Schuman and Duncan, 1974:247). While in responding to differently worded questions respondents may read the questions differently even if the researchers do not, the results from collapsing the scales suggest that in tackling the measurement of his attitude (or an abstract notion such as autonomy) the respondent's selection of measurement criteria is rather unreliable.

- 21- Depending on the way in which items are placed on the scale, i.e., on the weights assigned to them, the values of autonomy for individual cases can vary and it is quite easy to rework a convex curve into a concave one.

- 22- The relevant characteristic of the Guttman scale is that if a person answers positively a question on the scale, we know a positive answer had been given to all questions falling lower on the scale. In adding up items to derive an autonomy score an arrangement like that means that the question of equivalency and weights of items has been largely circumvented: we are never faced with deciding whether being autonomous in respect to item "A" is more than being autonomous on item "B", because all respondents autonomous in "B" are autonomous in "A" as well, and it can be assumed that "A and B" give higher

autonomy than "A" alone. The situation for the next higher item on the scale is analogous. None of the reviewed studies (nor any other, to this writer's knowledge) measured autonomy on a Guttman scale. The problem that remains is, of course, that Guttman's is only an ordinal scale and therefore curvilinearity may still be only an artifact of the measurement procedure. At any rate, the only reported attempt at measuring autonomy on a Guttman scale failed, leading to the conclusion that "...autonomy does not lend itself to Guttman - scaling techniques." (Engel, 1970:16).

- 23- There is no particular reason to believe that scales using indicators of general concepts such as single behaviors or specific views will adequately measure abstract concepts, even if they form Guttman scales (cf., Peak, 1953:283). Irrespective of the type of scaling, however, there is evidence that even extremely meticulous measurement may fail. If the selected indicators are adequate, then two groups of indicators of the same concept should produce values of the variable for the same cases that are correlated. Pennings (1973) examined in that manner a number of measures of organizational structure, comparing the instruments used by Hage and Aiken (1967), and Pugh et al. (1968). The scores for the same organizations obtained by the different instruments were uncorrelated, calling "into question the assumption that different instruments tap identical structural concepts." (Pennings, 1973:702).
- 24- A similar view can be found in Yuchtman (1968) who argued that whereas ordinarily performance (productivity) is assumed to be the effect of management practices, especially in terms of the strategies of control used, this causal direction may not be the one responsible for the current state of the organization but rather that it may have been caused by performance, or modified as a consequence of performance, giving thus rise to the correlation between control strategy and productivity.
- 25- Another point concerns the reciprocal causation itself. It can be argued that although reciprocal causation may correctly describe a relationship between two variables in terms of its potential, it is not necessarily warranted to employ it in explanations. Since any situation is the product of a history of events, the correct explanation depends on that history rather than on the potential relationships among the variables. And in any given case, in the course of the relevant history only one of a pair of variables may have been independently manipulated. Therefore, only the one - way causal relationship may be relevant for the explanation in both correlational studies and experiments. (By 'independent manipulation' of a variable in a system

we mean manipulation that did not result from a prior manipulation of some other variable within the system.)

- 26- Of course, motivation, attitudes and other psychological characteristics can be seen as being influenced by the social structure (roles, relationships, positions). Explanation of any long-term social process probably could not do without considering things such as changes in motives and attitudes due to experiences with the social structure. Such processes will be considered and made use of in the research report later on. At this point, attention is being restricted to the one-way relationship between motives and the resulting social relationships in order to keep the following discussion simple.
- 27- More precisely, it is an assumed knowledge of common-sense rationality, since in conventional research, examples of which have been cited, commonsense rationality itself is never the research topic. Its knowledge is taken for granted by the researchers and used as a resource in explanations. This is partially what has been referred to as the practice in sociology of using that which is to be studied as a resource for the study (Bittner, 1965:232; Manning, 1970:244).  
As was noted earlier, by 'commonsense rationality' we mean simply the ordinary motives, ordinary knowledge of means - ends relationships, and ordinary decision-making criteria characteristic of social behavior.
- 28- The things referred to as 'commonsense' rationality' are outlined in Note 27.
- 29- To a certain extent, this parallels Cicourel's (1964: 159-163) discussion of reports on experiments with social cohesion that manifest great reliance on unspecified commonsense knowledge in terms of the theoretical propositions underlying the ways of manipulating cohesion, and of the actual operational content corresponding to the descriptive terms used in the said reports.
- 30- The discussion here resembles somewhat certain aspects of Etzioni's compliance theory (1961a:3-67), where 'moral involvement' in organizations is said to result in willing compliance ('normative compliance') with a superior's requests or directives irrespective of the potential for non-compliance (1961a:7-9). The motivation for compliance is crucial in our as well as Etzioni's treatment. Behaviors taken to be instances of the 'power of norms' or of 'normative compliance' seem to have the common feature that there is apparently no reason for the given behavior other than that a particular norm is invoked or that request is made by a particular person, or one in a particular status, office, etc.

- 31- The question of what resources should be subsumed under authority is one of the points of contention (cf., Simon, 1957; Bierstedt, 1954; Presthus, 1960). Peabody (1962) overstates the degree of consensus considerably.
- 32- Various writers, notably the ethnomethodologists, maintain that no description of interaction is, strictly speaking, literal. If nothing else, unspecified background knowledge is necessary to understand descriptions properly (see Wilson, 1970:70-76). It seems, however, that certain 'background expectancies and inferences' are effectively standardized to such an extent as to justify their neglect and make apparent literal description of interaction possible.
- 33- Exceptions are very short-lived and happen in emergency cases when a person may receive some treatment before being formally admitted, i.e., made a patient.
- 34- The term 'folk category' refers to the results of activity - categorizing or person - categorizing done by hospital employees.
- 35- Formally, no admissions to the mental hospital should be made unless authorized by a psychiatrist with 'admitting privileges'. In practice, however, some exceptions are reportedly made. As far as the In-Patient Department is concerned, the Director of Adult Psychiatry is the only psychiatrist who is a hospital employee. Two other psychiatrists have salaried appointments in the Out-Patient Department to be described later. In this respect, the situation at Windsor Hospital differs from that found in the U.S. psychiatric hospitals studied by Strauss (1963), Scheff (1961), and Jehenson (1973) whose work deals with similar matters as this thesis. In those U.S. hospitals, the psychiatrists are mostly interns, residents, or administrators.
- 36- Before the recent reorganization, the dual authority structure in the Western Hospital was conceived along the lines indicated in Figure 6 for the Department of Psychological Services. The two lines came together under the Director of Clinical and Professional Services. The Clinical Services were the rough equivalent of the 'line' in industrial organizations (or the structure shown here in Figure 5), and the Professional Services the equivalent of 'staff' or 'functional departments' (cf., Dalton, 1950) along the lines shown also in Figure 4. The reorganization, the results of which are shown in Figure 1, consisted partly of the separation of Clinical Services from Professional Services. But Figure 1

shows clearly that this split was made along different lines that those nominally following from the distinction between 'staff' and 'line', since the two authority lines shown in Figure 6, for example, ended up both in the Department of Clinical Services. Thus, when the pre-reform terminology is compared with the current one, there is clear inconsistency of usage in evidence because the previously 'professional' substructure now belongs under 'clinical' services.

37- Similarly, the Nursing Supervisor said that she was only 'indirectly responsible' to the Director of Adult Psychiatry. The heavy emphasis on the 'functional' line of responsibility in hospitals has been commented upon in the literature. It has been suggested that the alternative line of responsibility has for practical purposes sometimes disappeared (Creditor, 1972:125). The shift towards greater emphasis upon functional authority seems to continue in some respects at Windsor Hospital. Thus, the Director of Professional Services told the researcher of a plan to consolidate into a single functional department the occupational therapists employed at the hospital who are at present the only occupational group without a single departmental structure.

On the other hand, in other hospitals there are signs of the beginnings of the opposite trend. Thus, one respondent suggested that the functional line of authority is being de-emphasized at another psychiatric hospital in Ontario. The literature reports at least one case study of a similar shift in a U.S. psychiatric hospital (Berkanovic and Vander Haegen, 1974).

38- Basically, the reasons for this consisted of the researcher's failure to obtain access to the in-patient wards where nurses could be interviewed, as the nurses could not be called off the wards for interviews. Neither was it possible to attend the case conferences at which some nurses participate, which could have served as a partial source of data.

Case conferences are formal occasions at which the patients' progress and treatment programs are discussed. The conferences are held twice a week with only some of the staff attending both meetings. All personnel working with in-patients attend, with the exception of nurses, among whom only head nurses and registered nurses do. The case conferences held in the Out-Patient Department are attended by all of the personnel working there, and by the Chief Social Worker and the Nursing Supervisor.

39- There are three different out-patient programs dealing with psychiatric patients. In two of them

the involvement of the hospital personnel is minimal, by a temporarily employed social worker and a psychiatrist in one case, and a single nurse and a psychiatrist in the other case. Attention here is restricted to the largest of the out-patient programs. In all three cases, the psychiatrists hold part-time salaried positions in the Out-Patient Department.

40- It has been noted that the Head of the Out-Patient Program is a part-time position held by a psychiatrist with admitting privileges. The Social Worker in Figure 7 worked part-time only in the studied out-patient program. The Psychologist in Figure 7 is the Supervising Psychologist in Figure 4. The Occupational Therapist in Figure 7 is the Occupational Therapy Supervisor in Figure 4. Furthermore, all of the psychologists in Figure 4 work with out-patients more or less regularly, while not being formally members of the out-patient department. Similarly, all psychiatrists may have patients in the out-patient program. The recreational therapists in Figure 4 also work often with out-patients.

41- All of the psychiatrists have offices at the hospital and see private patients, sometimes in addition to their duties as hospital employees. Some psychologists and social workers are opposed to this arrangement and would prefer the psychiatrists to have the same status 'as everyone else'. This desire is at least partially motivated by problems to be discussed later. At this point it is only to be noted that the present arrangement seems to be largely responsible for the autonomy the various professions enjoy. Similarly as in Scheff's (1963) case study, the psychiatrists allow others more autonomy than they would because of time considerations. Thus, the opposition to the psychiatrists' special status is to some extent counterproductive from the viewpoint of other staff's autonomy.

42- As has been noted, a Head Nurse also refused to admit the researcher to the ward but she expressed a willingness to follow the administration's decision.

43- The opposition to the researcher's presence on the wards was probably restricted to one staff member (the Nursing Supervisor). According to the Director of Adult Psychiatry, the head nurses were not opposed to it, given the administration's permission. The ostensive reason for the Nursing Supervisor's position has been given already, to wit, that patients might be upset by the researcher's presence. Although that may very well have been the case, another possible motivation emerges from two interviews with the Nursing Supervisor who on one occasion pointed out that the hospital staff knew

very little about the researcher's interests. Furthermore, to point out a difference between student social workers or nurses on the one hand, and the researcher on the other hand, the Nursing Supervisor noted that the hospital staff had control over the students, but not over the researcher. This presumed lack of control and knowledge of the researcher's motives may have been responsible for the stand the Nursing Supervisor took.

- 44- In addition to the Out-Patient Department staff meetings, several meetings of the Department of Social Work were attended. These two types of meetings were the only ones held during the research period, in addition to the case conferences and some higher-level administrative meetings.
- 45- For example, in one instance the Head of the Out-Patient Program asserted his authority to control the out-patient staff's contacts with journalists. Contrary to the Nursing Supervisor's claim, the Head asserted that the control belonged to him. The matter was said to be a minor one but was not neglected so as to make the situation clear and precluded the possibility that later on the Head of the Out-Patient Program might be forced to argue about the control over more important things.
- 46- According to the Director of Professional Services, other parties (including the Director of Adult Psychiatry) can only complain and express disapproval of the department's work, but cannot apply any disciplinary measures. Disciplining is said to be the exclusive prerogative of the Director of Professional Services.
- 47- 'Incidents' departing from the 'routine care of patients' must be reported to the nursing staff or the patients' physician. Of course, the above definition of 'incident' (contained on the official incident reporting form) is vague and it is not known how it is actually employed. It is clear that at least physical injuries would not escape attention.
- 48- In addition to arts and crafts, there is the 'relaxation therapy' which consists of teaching patients how to relax and various assessments, such as of 'manual dexterity'.
- 49- Of course, research of this type necessarily neglects the more subtle of influence processes. The participants engage in a great number of informal conversations in the course of which individuals' behavior may be influenced in the desirable directions without it being necessarily made clear that a person would not be allowed to pursue a certain course of action. At any rate, their reported work behavior appears to be perceived by the respondents as spontaneous.



- 50- It must be understood that the psychologists' attempt only consisted of suggestions made on various occasions. Once the proposals were rejected, in what was described as a quite informal manner, by the occupational therapists, the task of putting the proposals into practice would become arduous. It would involve convincing several people in the hierarchy and potentially prolonged arguments. This situation is similar to the one already described in the Out-Patient Department where the Head relied on 'public opinion' instead of pursuing other routes. In the present case, the public opinion did not materialize.
- 51- The already mentioned case conferences are formally intended to provide the coordination of treatment. The extent to which the coordination goes beyond making suggestions and referring the patients to different professions is doubtful. The data on that point are very sketchy and will be discussed further on. In the case of the department of occupational therapy, however, it is fairly certain that the planning emerging from case conferences rarely goes beyond simply referring the patients to occupational therapy.
- 52- Most importantly, the differences exist in the frequencies and patterns of consultation and cooperation with other professions or the Chief Social Worker. Of other important differences one might mention the primary therapeutic orientation. Some social workers stress the social causes of patients' problems more than others. Finally, as will be discussed later on, different sources of patients are used to various degrees by different individuals. These differences per se need not lead to conflict since each case is assigned to only one social worker. Thus, mutual accommodation on a daily basis need be minimal only.
- 53- There is substantial agreement on the very general terms of the 'professional code'. In more specific areas differences can be found. For example, some social workers are more willing than others to defer to the authority claimed by psychiatrists, and junior social workers are more willing to accept close supervision from the Chief Social Worker.
- 54- Other professions were to be affected by these changes as well, but from the viewpoint of social work the crucial point was that every out-patient would be automatically referred to a social worker upon entering the program. Previously, the referral to social work was discretionary.

- 55- The Chief Social Worker intended to publicize the Department of Social Work among the Emergency personnel and to solicit, through persuasion, a higher frequency of referrals of patients to social work by the Emergency Staff.
- 56- The changes outlined above were proposed by the Chief Social Worker in a staff meeting and approved without appreciable comment, although discussion was invited.
- 57- While in-patients may be seen daily by their psychiatrist making the rounds, out-patients are reportedly not seen by the psychiatrists more often than once in a month or two, unless a crisis situation develops. The Head of the Out-Patient Program comes to the Out-Patient Department (housed in a separate building) only for case conferences and staff meetings where his patients are discussed, but that does not involve direct contact with the patients. No other psychiatrist attended out-patient case conferences during the research period.
- 58- From various comments and discussions of treatments observed, one broad generalization seems to be applicable to the treatment approach used, namely, that proper treatment consist of maintaining a very non-restrictive and non-punitive setting in which the staff's attention, affection, care and concern are given the patients almost without conditions. Indeed, when the staff on one of the wards decided 'not to put up any longer' with a patient who appears to have cynically manipulated the staff members and played them against each other, the new approach was referred to as 'withdrawal of treatment' (for an account of similar episodes with extensive comment see Fisher et al., 1973:45-64).  
Apart from the above rather general characteristic of treatment, the proper intervention in any given case can apparently depend on such a number of contingencies and inconclusive interpretations that to insist on rigid application of generalized instructions would not be feasible. Consequently, the specific activities to be performed under particular conditions acquire a prominent place in inter-professional consultations.
- 59- While the psychiatrists see other patients (in-patients) only briefly and not necessarily daily, social workers and nurses can spend most of their time on the wards working with patients. Under such circumstances, some of the staff would want to have greater control over various decisions that make it possible to manipulate patients. These decisions concern basically the barring of patients from activities routinely permitted other patients (removal of privileges) and permitting the patients

to leave the hospital grounds (granting of 'passes').

For a time, and until several months before the beginning of this research, some social workers made such decisions. In the confrontation with psychiatrists following the attempt to put a stop to that practice, a social worker resigned. Since then, the situation reverted to the original arrangement under which removal of privileges, granting of passes, as well as all other possible disciplining of patients has to be approved by the psychiatrists, with some informal exceptions only.

- 60- This conclusion emerges from the topics of discussion and the arguments presented in staff meetings, as well as from an explicit statement of the Chief Social Worker's current objectives, the foremost of which is the creation of a new full-time permanent position in the out-patient department.
- 61- Two observations lead to this conclusion. Firstly, a social worker stated openly that no more social workers are needed in the in-patient section, even though there is a position open there. Secondly, the already-mentioned extension of the social workers' duties to include increased Emergency Department duties was accepted without any suggestion that it might strain the staff's time resources. On the other hand, the criteria for identifying the problems that should be attended to are extremely vague and flexible in the field of mental health (cf., Fisher et al., 1973:ch.4).
- 62- A similar situation seems to exist where psychologists are concerned. A psychiatrist reported that because it is difficult to get the psychologists to do various things according to the requests without encountering trouble, he uses the psychologists' services 'much less than he would otherwise'.
- 63- This work is done by social workers in their capacity as hospital employees. The hospital is reimbursed for these services through a special arrangement not involving the patient's hospital insurance.
- 64- The Chief Psychologist and the Supervising Psychologist are holders of Ph.D. degrees and 'registered' clinical psychologists. Another psychologist was awarded the Ph.D. while this study was in progress. The 'registration' refers to a certain legal status of the practitioner. Apparently the only clearcut consequence of this status relevant here is that the reports on patients produced by non-registered psychologists ('psychometrists') have to be signed by a registered psychologist. The corresponding status differences are quite subtle.

- 65- For example, the psychologists are strongly in favor of being granted admission privileges, and would prefer to have their relationships with patients considered fully confidential, equally as the psychiatrists. Occasionally, a few remarks can be heard concerning the relative worth of the M.D. and the Ph.D. degrees, with the psychologists maintaining that the Ph.D. is 'better'.
- 66- It appears that the relative tranquility of the department and a very low turnover are a source of satisfaction to the Chief Psychologist, and the relatively high autonomy of the department's members is seen as the prerequisite for that state of affairs.
- 67- This means formal out-patients from the Out-Patient Department and patients referred to the psychologists by outside agencies.
- 68- The department is currently searching for a new psychologist to provide heretofore missing skills. Members of other professions turn sometimes to outside agencies to get the needed testing done. In one case, a staff member reported using outside agencies with the majority of his patients since no one in the Department of Psychological Services was willing to perform the desired testing.
- 69- The most relevant point here is that it is very difficult to say whether or not too much time is being spent with a patient. It is therefore possible to absorb some fluctuations in the supply of patients.
- 70- One aspect of the psychologists' autonomy had been reportedly challenged some time ago. A conference of the staff and the administrators was called to determine whether or not it was incumbent upon the psychologists to inform the psychiatrists about everything in-patients might do or say. It was resolved that according to the legislation governing those matters, the psychiatrists had the right to be informed of everything, thus denying the psychologists control over one aspect of their relationships with patients.  
The decision in question is obviously almost unenforceable and thus the conference decision was largely futile. Voluntary compliance does not seem very likely inasmuch as the psychologists' position (as it emerges from the interviews) is that they would comply only if satisfied that a patient might commit suicide.
- 71- The request concerned a series of motion pictures to be shown in group sessions. Apparently, the assertion that the films had a therapeutic value, and perhaps some elaboration, would constitute a sufficient justification.

- 72- Reportedly, the out-patients will be seen by a psychiatrist not more often than once in a month or two, and only very briefly. As a rule, instructions are given to the out-patient staff only rarely.
- 73- Of course, this concerns only discussions outside of case conferences. There were numerous indications, however, that case-conferences are handled in a very similar manner. This situation contrasts with that reported in Strauss et al. case study which found the staff of a psychiatric hospital disagreeing "to the point of apoplexy about how to implement patients' getting better" (1963:154). At Windsor Hospital disagreements are commonplace but quite subdued, as a rule.
- 74- This occurs mostly in case conferences and staff meetings which the Nursing Supervisor invariably attends.
- 75- The RNA was interviewed only once and relatively briefly. When the researcher asked for another interview, the RNA declined saying that the Nursing Supervisor 'indicated to me' that the researcher should be referred to the Nursing Supervisor for information. No difficulties were encountered where the registered nurse (RN) was concerned and it is quite likely that the RN chose to ignore the Nursing Supervisor's wishes. This situation is consistent with the earlier suggested pattern of autonomy depending on the individual's primarily educational status.
- 76- The RN reported that when psychological testing is needed she would ask a psychiatrist to make the request. It is doubtful whether it is actually necessary to enlist the psychiatrists' authority to get testing done, although it may be helpful. At any rate, this practice is not resorted to by the social workers in the Out-Patient Department. In many respects, the nurses placed much more emphasis on 'following the channels' than other staff did. Their inability to get results on their own may be the reason to some extent, but simple traditionalism seems to be even more important.
- 77- This holds invariably for the psychologists, while for other staff there are some exceptions where the Program Head's private patients are concerned. More will be said about this point later.
- 78- In effect, a referral of a patient to the program and/or the patient's desire or willingness to attend the program identify a 'problem deserving attention'. The staff narrow down the problem identification according to their biases and inclinations (e.g., as a 'family

problem') and proceed accordingly. Since each therapist's competence in his own field is generally held to be superior to that of members of other disciplines, there is a tendency to allow everyone to identify problems on their own.

- 79- The only exception exists in areas such as being late for work or therapy group sessions. Regulations concerning those things are enforced by Department Heads at the request of members of other departments.
- 80- Needless to say, evaluation of therapeutic effectiveness is a rather difficult matter, especially where relatively complex patient careers are concerned, such as in the present case. According to one source, no such large scale therapeutic models have ever been evaluated (Fisher et al., 1973:32-33). The out-patient program does not compile statistics on any aspects of its functioning other than the current number of patients in the program. Of course, data such as the average length of patient stay in the program would contribute nothing to the evaluation of the program's effectiveness and somewhat more suitable data such as re-admission rates are out of the program's reach.
- 81- If there are any restrictions placed on the psychiatrists by the Head of the Adult Psychiatry, they went unnoticed. There is also lack of data on the relationships among psychiatrists, which therefore will not be considered separately.
- 82- That is to say, if a social worker refers an informal out-patient to a psychologist, the psychologist need not perform the requested therapy but neither will he perform any other therapy, so as not to 'take over' a patient. This convention, apparently designed to reduce conflict, would not apply if the patient himself initiated the contact with the psychologist (and vice versa).
- 83- This is to be seen in contrast with the handling of informal out-patients where the referring agent, such as a social worker, exercises some control. Where in-patients are concerned, only the psychiatrists have such control.
- 84- It is a source of irritation to some social workers that the psychiatrists merely 'pick up the phone and tell you what they want' whereas they have to send written referrals to the Psychology Department. It seems not to be fully appreciated that the psychologists can insist on written referrals from the psychiatrists because it is presumably not known beforehand which psychologist will end up accepting the referral (which is the case occasionally). Without such a rationale the practice would become

an undisguised status symbol and perhaps difficult to maintain.

- 85- This situation leads to some peculiarities in the uses of the autonomy held by the psychologists. For example, it was reported that patients referred for group therapy by the RN in the out-patient department are never screened nor rejected, and the RN's recommendations for group placement are always followed. In contrast, patients referred by the psychiatrists are invariably screened and sometimes refused because of being 'too psychotic' or otherwise unsuitable. While this may be the case, the screening of patients may also be seen as a status expression aimed at the psychiatrists. The status difference between the psychologists and the nurses is too great to require this type of expression.

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