This study was conducted by members of the staff of the Research Center for Group Dynamics of the Institute for Social Research at the University of Michigan.

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Alvin Zander
Arthur R. Cohen
Ezra Stotland
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... from Chapter One
ROLE RELATIONS
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ROLE RELATIONS
in the
MENTAL HEALTH PROFESSIONS

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RESEARCH CENTER FOR GROUP DYNAMICS
INSTITUTE FOR SOCIAL RESEARCH
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1957
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PREFACE

This report is the result of a study of intergroup attitudes and behavior among the members of three professional groups, and of the conditions which appear to determine these feelings. The reasons for making this investigation were both practical and theoretical. The practical interest arose out of our awareness that social welfare and medical agencies, among others, have found it efficient to use staff teams composed of persons from various occupations in order to conduct their professional work. The fact, however, that the team members often belong to different professions means that they bring different points of view to the co-operative endeavor. The problem, then, was to describe the nature of the feelings and difficulties that a cross-disciplinary group needs to face if it is to maintain itself as a team.

The theoretical concern had its origin in the widely accepted notion that a person's role determines the quality of his relations with those in other roles. There is little understanding of the dynamics of this process. We have tried to develop an approach to an explanation for it.

The relations among the professions of psychiatry, clinical psychology, and psychiatric social work were chosen for study. A majority of mental health agencies employ persons from each of these three fields, and encourage them to work together closely.

Because our purposes were both practical and theoretical, we have tried to write for persons who may have either or both types of interests. We hope that practitioners in these and other professions will obtain insights concerning the causes of problems in interprofessional relations. We hope also that social scientists and other students of group relations will find here useful ideas and explanations concerning the effect of a role upon the occupant's behavior, or ideas which may stimulate further research on these problems.

The opening chapter contains a brief description of these three professions and of the expectations members have both for themselves and for members of the other two groups. The next chapter is a description of our approach to the study of role relations. This is followed by an account of the methods used in obtaining the data, and the following five chapters present the interrole attitudes in various types of relationships. The final pages offer a summary of the findings.
and an interpretation of the results, as well as a number of conclusions concerning role relations under specified conditions.

This study is the product of the work of many people. Bernard Hymovitch carried a major responsibility in planning the project, supervising the data collection, and suggesting analysis methods. Coding and statistical treatment of the data were done by Jay Gould, Jacob Hurwitz, Julian Morrissette, Otto Riedl, and Robert Zajonc. Charles Cannell served as a consultant in the construction of the interview and supervised the interviewing staff. Jane Corfield did much of the typing and retyping. To all these persons we owe deep gratitude.

We are most grateful to Dorwin Cartwright for his wise and careful criticisms of the manuscript and to Ian Ross for his advice on statistical methods and the effective use of tabulation machinery.

Arthur Cohen was a member of the staff at the Research Center for Group Dynamics while this study was being done. He moved to his present post at Yale University while the manuscript was being completed.

The work on this project was financed by grant-in-aid (M-325(c)) from the Institute of Mental Health of the National Institutes of Health, Public Health Service. That organization, and others whose help we acknowledge, cannot be held accountable for the content of this report. Such responsibility belongs to the authors alone.

A. Z.
A. R. C.
E. S.

Ann Arbor, Michigan
April, 1956
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CHAPTER 1

INTERGROUP RELATIONS AMONG PROFESSIONS

Co-operation among professional persons is at once the easiest and most difficult of relationships to achieve.

It is the easiest because service to others is always a part of the standards of professional bodies, and members place great value upon these standards. Because of this fact it is easy for persons from different professions to join hands in a shared purpose.

It is the most difficult because, in order to have true co-operation there must be trust and understanding among those who would work together. The members of various professions bring their own points of view, social positions, and skills to the collaborative relation. These differences may hinder the development of confidence and mutual agreement.

In our society teamwork among the members of different professions has been productive and has brought about much that is prized in our way of life. It is used in many places. In the planning and building of an airplane, for example, there is joint effort among many persons who possess discrete abilities and knowledge. Medical groups use the combined services of persons from a variety of fields. Co-operation is found among representatives of different disciplines in universities, planning commissions, community councils, and factories.

Because of the widespread use of teams composed of interdependent roles in the various institutions of our democratic society, it is of the utmost importance to know how they work together and what factors produce harmony or tension among them. A democracy is strong if the groups and organizations within it function effectively. Teamwork is a precious source of energy.

Why is it that feelings between some of the members of two professional groups may be strongly favorable, while quite different attitudes develop between other members of the same two groups? The research reported here is an attempt to explain the causes of these differences. It is primarily concerned with the beliefs which the members of different occupations have about each other and with the way in which a
member's role and social position serve to influence his feelings. Simply stated, this is a study of role relations.

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Published Views on the Relations among the Mental Health Professions

Psychiatrists, psychologists, and psychiatric social workers have been keenly concerned about the scope of each role as well as the most effective means of collaboration. More than fifty articles about such problems have been published since the war.

The themes of these articles provide useful clues to the nature of currently unsettled issues in role relations. The writings indicate that each profession has certain expectations among its members concerning their own behavior and the behavior of those in other professions. But these attitudes are not always acceptable to everyone concerned. The growth and change in expectations can be clearly seen in the historical development of psychiatry, psychiatric social work, and clinical psychology.

Changes in the field of mental health have been rapid in the last fifty years. Up to that time care of the mentally ill was the major activity—the treatment consisting primarily of surveillance of psychotics isolated in asylums. As the mental health movement progressed through knowledge of dynamic psychology, improvements in psychotherapy, and the growth of social welfare agencies, there arose increased interest in the problems of childhood and in prevention of mental illness. In accordance with these developments a number of clinics, hospitals, and other agencies appeared along with new professions to staff them. In a relatively brief span the field of mental hygiene grew from one in which there were almost no specialists, to a broad area requiring many. Activities ranging from the care and therapy of the extremely sick to the development of preventive practices conducive to the growth of healthy personalities utilize many types of personnel. These specialists
include teachers, guidance counsellors, ministers, personnel officers, group workers, psychiatric nurses, and others alongside the psychiatrists, clinical psychologists, and psychiatric social workers. Although our central concern is with the relations among the last three groups, it is likely that much of what we learn concerning their interrelationships may be applied to other occupations.

During this rapid development, it has been necessary for psychiatrists, psychologists, and psychiatric social workers to develop new perceptions of their professional roles. The early psychiatrist was a medical doctor with the task of watching over the physical health of sanitarium inmates. Medical knowledge offered little to encourage the hope that these patients would recover or even improve. Recent advances in the understanding of psychiatric illness have broadened and complicated the range of the psychiatrist's functions. He can now expect improvement in many who are mentally sick, and thus may be engaged in psychiatric diagnosis, differential diagnosis, and psychotherapy in any of a variety of settings, including private practice. Although activities in hospitals still take a large share of his efforts, a psychiatrist may also work in schools, social agencies, clinics, and in industry. In addition, ancillary professions have been developed to assist him. Because of these assistants, many psychiatrists have had to develop supervisory and administrative skills. A recent study has shown that 80 per cent of mental hygiene clinics and hospitals have psychiatrists as their directors (23).

As the work and usefulness of the psychiatrist grew, adjunct professions also broadened the scope of their services. The clinical psychologist shortly before 1920 was usually to be found working in a mental hospital or other institution, where his functions consisted almost entirely of administering psychometric measures intended to determine intelligence or aptitude. Shortly after the development of child guidance clinics in the late twenties, and the creation of tools intended to measure personality characteristics, psychologists began to appear in a greater variety of places. Working on the staffs of schools, hospitals, clinics, and in industry, they were concerned primarily with measurement and selection. The psychologist, however, was trained in an academic department rather than a professional school and he brought to his job the frame of reference typical of a scientist and research man rather than a practitioner. It was natural, then, that he offered, as a unique contribution, research on the development of better measurement methods and the testing of hypotheses which were derived from
personality theories. It has been emphasized by some (11, 21, 23, 37) that the early experimental training which stressed objectivity made psychologists impatient with psychiatric speculation and therapy. Since World War II, however, a change has occurred: Many clinical psychologists have become dissatisfied with their function as diagnostic technicians and now aspire to engage in some part of the therapeutic process. They have been encouraged in these hopes by the demands of the military for more persons who could help carry the patient load and by a definition of the role of the clinical psychologist made by the Veteran's Administration which included psychotherapy as one of his expected functions (12, 16). More recently a joint committee of the American Psychological Association and the American Psychiatric Association (8) as well as a resolution by the Group for the Advancement of Psychiatry (7) have recognized that the psychologist should be allowed to practice some types of therapy under the supervision of a psychiatrist. Thus, the psychologist's sanctioned responsibilities have increased greatly in recent years and the profession is in a new stage of development as to standards, ethics, methods, and training. At a Conference on Graduate Training in Clinical Psychology held at Boulder, Colorado in 1949 a formal resolution was approved describing the social needs which can be currently met, to some extent, by trained clinical psychologists (21, p. 21). It reads:

The basic needs of our society for the services of clinical psychologists are of two major kinds:

a. Professional services to:

(1) Individuals through corrective and remedial work as well as diagnostic and therapeutic practices.
(2) Groups and social institutions needing positive mental hygiene programs in the interest of better community health.
(3) Students in training, members of other professions, and the public through systematic education and general dissemination of information.

b. Research contributions designed to:

(1) Develop better understanding of human behavior.
(2) Improve the accuracy and reliability of diagnostic procedures.
(3) Develop more efficient methods of treatment.
Develop methods of promoting mental hygiene and preventing maladjustment.

Although these are the services clinical psychologists by and large aspire to provide, it is unlikely that at present many are willing or able to do them all. As may be seen in later pages, there is still a good deal of discussion as to what a psychologist should do and should not do. The role of the clinical psychologist is in the stage of "becoming" and expanding.

During this burgeoning in the field of mental health, general social work also became established as a profession. The origins and traditions of this large field stem from social welfare activities, which in turn grew out of a long heritage of efforts to help the less fortunate. During the period we are describing, universities started to provide professional training for social workers. As the broader interests in mental hygiene developed and were supported by social agencies, and as hospitals began to move into psychotherapeutic endeavors, social work came to see the need for the specialty known as psychiatric social work. Social workers brought skills in interviewing to the mental hygiene agencies and an interest in the impact of the social environment on the patient. Services to the mentally sick forced the social work profession to develop training programs with a strong psychiatric orientation. Today psychiatric social workers serve in a variety of hospitals and clinics devoted to therapy. They are also staff members in family and child counseling agencies which benefit from their insight and skill. Currently, the typical functions provided by the psychiatric social worker are conducting intake interviews with patients, writing case histories, helping patients adjust to the treatment situation, making use of the resources available to patients, and performing therapeutic casework either with the patients or with those who are close to the sick persons (3, 9, 28).

There are unsettled issues among psychiatric social workers concerning the functions they should perform. The impression one derives is that the members of this profession wish for more responsibility even though they readily accept their status as an ancillary group to psychiatry. Doubtless the professional aspirations of the clinical psychologists will call for adjustments by both psychologists and social workers if they are to work most effectively with one another; but the direction of a potential change has not yet become clear.

Despite differences in the histories of these three professions they collectively seek to serve similar needs for society. Each still retains unique functions, yet they overlap considerably in the procedures they
use and the activities they perform. It would be expected, then, that
their close interaction would develop feelings of interdependence and
that members of the three professions would work together closely. The
notion of the psychotherapeutic "clinical team" began to grow before
World War II and since that time has increased in popularity. In a
study by Krugman, 97 per cent out of a total of 240 psychiatric
organizations employing staff members from all three professions stated
that they were using these groups in a "co-ordinated service." One of
the recurrent themes in the literature about these professions is that
each needs the other.

**Expressions of Mutual Interdependence**

The following quotation from a published speech by a psychiatrist
to a group of clinical psychologists exemplifies widely held opinion
concerning the need for professional collaboration: "In diagnosis and
treatment no one profession is completely independent, i.e., unsuper-
vised and individual. There are only degrees of competence which have
a loose relationship to degrees of independence." (18) Another typical
statement reads: "Neither the case worker nor the psychiatrist, as at
present trained, is equipped technically to deal with the whole range
of the problem." (1) It is quite common to find descriptions of the
various ways in which a psychiatrist is dependent upon colleagues from
other professions for gathering necessary information and for helping
the patient who comes to him with a complaint (1, 13, 18, 35).

The members of the ancillary professions have also stressed the need
for collaboration among professions. Psychologists have emphasized
the fact that there are too many sick people for the members of any
one profession to handle alone (21, 37, 39). A report of the American
Psychological Association, Committee on Clinical Psychology, which
met with a similar committee from the American Psychiatric Associa-
tion included the following:

Both professions recognize their mutual dependence, and a full
medical and psychological diagnosis should be made of each
patient, using the skill for which each group has been specially
trained... Counseling and the therapy of "mild psychoneuroses"
requires the highest degree of competence and should be handled
by co-operation among the medical, psychological and social points
of view. In the administration of community clinics, counseling
facilities, etc. neither group has priority, and the present diversity
of practice is satisfactory (8).
It is quite clear that there is strong sentiment favoring co-operation among the three professions. Recognition of this need has led to a variety of practices in various agencies. These procedures have been described by Krugman after examination of current trends in the use and co-ordination of the professional services provided by the three professions in 327 mental hygiene organizations. He found that five different concepts of co-ordination were being employed, ranging from simple availability but separate functioning of each of the groups to relatively complex and complete sharing of all clinical functions by the members of all professions. Data describing the typical duties of each profession also illustrate overlapping in the services provided by the three (23).

The expressed need for interdependence, we may assume, is being implemented in many institutions concerned with mental health. However, this mood of co-operation does not always mean that firm agreement has been reached as to the ways in which psychiatrists, clinical psychologists, and psychiatric social workers should relate to one another.

What Others Should and Should Not Do

A role is the product of many expectations concerning the functions that a given person will carry out. Although there is considerable expression of opinion about the interdependence of these three professions, there is still much confusion as to who should do what, and what the occupants of a given role must not do. Much of the writing about the relations among these roles has concerned the appropriateness of certain functions for a given group. Let us concentrate for a moment on what the members of one group say about the other groups.

Almost all the writings about the appropriateness of various functions to one or another group are by psychiatrists, who apparently recognize that their expectations for the psychologist's and social worker's role often differ from the perceptions of those in the ancillary professions. One psychiatrist writes:

As long as the clinical psychologist feels that he has a special competence in the areas of research, and in the giving of various examinations which make a contribution to diagnosis, there is not much conflict with psychiatry. It is only when the psychologist begins to think more seriously of therapy, particularly in private practice, that questions and opposition arise (18).
He goes on to quote from a letter he received from a professional colleague which reads:

"This problem is not related only to psychologists—there are others in the so-called ancillary services who have been taking on more and more responsibilities which are clearly in the realm of treatment. Perhaps we have erred in not defining limits so that the training of ancillary workers will include such limits just as it does in the training of the nurse in her relationship to the doctor and to the patient in terms of her role in treatment."

The medical doctor, of course, has a broader training in the sources of disease, and also has a broader legal sanction for treating sick persons. This raises a problem for many psychiatrists which is also discussed in the above article:

... The psychologist should be warned of the tremendous responsibility he is asking for in order that he may know that the responsibility for the health of the community rests with the physician and that he is asking for a part in usurping his role, not in assisting in it... The turning over of the psyche to the psychologist is separating the psyche from the soma. In medical schools we teach that the mind cannot be separated from the body... Now comes a group which proposes to divorce the mind from the body—to say that one who has never seen the healing process in action in other parts of the body is qualified to work with healing the mind as though it existed in free space. Psychopathology is a branch of clinical pathology and the physician is still the only one who should be trusted with it.

It is apparent that the psychiatrists are concerned with the proper limitation and boundaries for the clinical psychologist’s role. Many, as noted earlier, are eager and ready for more help from psychologists but are not certain as to what these services should be. Some have tried to specify them. One psychiatrist suggests that the psychologists deal with “reality” problems but not with problems requiring deeper therapy. Another suggestion is that psychologists work with personality problems within the normal range, educational disabilities, and minor psychoneurotic conditions without important somatic components. It also emphasized that the psychologist’s most important contributions will be research efforts, and that psychologists are now ready to make early diagnosis which would have been impossible just a few years ago.
It appears that pressures and counterpressures are at work among the psychiatrists concerning the best expectations of the psychologist's role (2, 16, 28).

In regard to social workers there is much less discussion but what there is deals with similar issues. Should social workers do therapy? Yes, say some, but others warn that the social worker and psychiatrist must not try to substitute for one another; both are necessary when the patient is admitted to the clinic (1, 2, 3).

Since more and more psychiatrists are engaging in private practice, some psychologists have wondered what the psychiatrist's eventual role in a clinical team may be. A psychologist speculates that the day may not be far off when psychiatrists will serve only as consultants to social workers and clinical psychologists (37). However, a psychiatrist counters that psychiatrists are an important part of co-ordinated services and that they should never anticipate the day when they will have only a consultant role for others (1).

Within any one institution many of these problems are apparently resolved among the persons involved. It is often asserted that these issues are not so prominent at the local level as they may be at the policy level. Usually, good working relations seem to develop among these teams, even though maximum capacities of all members are not always utilized.

What the Members Wish for Themselves

The proper functions for a given profession are not always clear to its members. Take therapy as an example. A psychologist has declared that it is unwise for members of his profession to engage in therapy since it spoils their ability to do unbiased research. Others have advocated that psychologists do therapy primarily because it helps in broadening their research competence. Still others say psychologists should do some therapy but not to the detriment of their more useful efforts in diagnosis and research. Young summarizes the question when he asks, “In what specific areas of human conflict can the psychologist expect to work independently of medicine and in what areas should he seek the collaboration of the medical man?” (12, 37, 38, 48).

Kelly, a psychologist, discusses the difficulty in arriving at clear-cut answers to such a question and says in part:

The exact roles that all clinical psychologists should play in relation to members of the psychiatric profession cannot, of course,
be defined. Local circumstances, variations in training and competence, and even conditions of employment pre-determine relationships in specific settings. In general, however, the Boulder Conference felt that a collaborative role, rather than one in which the profession is clearly subservient to the other although the two are working intimately together, was in the best interests of the patient. A collaborative role has two necessary implications: (1) equality of status is recognized, but (2) it is recognized in the context of differing fields of competence and responsibility. Joint discussion of the patient from admission to final disposition results in a more rounded view of the patient's problems and is conducive to better treatment. The collaborative role is extensively practiced within the medical profession when referrals are made from one physician to another. Here, there are commonly accepted procedures in which the question of status rarely enters, since there is explicit recognition of the limitations on both sides (21, p. 145).

Psychologists state that they wish to do more than routine and uninterpretive testing. They feel that they have a contribution to make toward diagnosis and they wish to be more than technicians. Some feel that psychologists have much to offer beyond therapeutic efforts and indeed they assume that few psychologists expect therapy to be their major contribution when compared to their potential services in research and diagnosis (28, 37).

Social workers are also concerned with the role definition issue. One endorses the notion that psychiatric social workers, when doing therapy, engage only in a unique type of treatment called attitude therapy. Another holds that social workers are ready to do therapy and not only in a psychiatric setting. However, caution is also expressed. For example, it is suggested that the social workers avoid a therapeutic relationship with a patient and work instead only to prepare the patient for relationship with the psychotherapist and to determine whether the person is one who should undergo therapy. Therapy, then, seems to be a strongly attractive function for both of the adjunct professions and an area in which differences of opinion exist concerning the propriety of this function for all groups (9, 15, 33).

The psychiatrists have differences of opinion concerning the nature of their own role. One has warned his psychiatric colleagues that they assume a grave risk, both from the ethical and legal points of view, when they attempt to supervise the therapeutic services of a lay person.
In other respects, though, psychiatrists have indicated that they can benefit from the knowledge and skills of the related professions. It is said, for instance, that too few psychiatrists know the role of a clinical psychologist and thus fail to make good use of him, and that psychiatrists should do much more research than they have been doing up to this time (13, 16, 27).

Each of the three professions, then, has had critical and appraising statements made by its own members concerning the profession's objectives in relation to other fields. Undoubtedly, many more issues have yet to be resolved, but these cited will show the lively interest these professional groups have developed as to the appropriate relationships to which they can aspire and the functions each group can assume as its own.

Who Should Have the Authority?

About half of the articles reviewed make some reference to who should have the final "say." All of these without exception assume that the psychiatrist is the person with the greater authority and that this power should be his. All authors recognize his as the final responsibility although they differ concerning the source of his power, that is whether it derives from his legal right to practice medicine, from the fact that he knows more, from the fact that he is better trained, and so on. All in all, however, the writers clearly recognize his right to greater influence and do not question it, even though they may desire greater influence for themselves.

Expressions of Attitudes and Feelings

Most of the writings on the relations among these professions have been stated in objective problem-solving terms. On occasion, however, feelings are explicitly mentioned which indicate that the interactions among them can be accompanied by strain. Conditions under which these attitudes are more friendly or less friendly are described in the later chapters of this book. It will be interesting then to note what affects may be seen in some of the published writing.

There are a variety of references to difficulties in communication and to emotional stresses between psychologists and psychiatrists. A psychologist, for example, states that psychiatrists and psychologists question each other's competence because of their differences in training. Another writes that there has been "too much heat and confusion of issues, blindness and recrimination, readiness to generalize concerning
the other...” He adds that psychologists tend to be arrogant concerning their research ability, and that psychiatrists tend to parade their status before psychologists who are sensitive concerning their profession because it is new (36, 37).

A psychiatrist and a psychologist writing in collaboration have noted indications of emotion in the role relations and state that the psychologist creates suspicion in the mind of a psychiatrist if he suggests that the psychiatrist does not have primary responsibility for treating patients. It is also asserted in this article that fear sometimes develops among these groups out of ignorance of each other’s functions. Criticism by each group toward the other generates ill will. Psychiatrists blame psychologists for dogmatism and the use of “mystifying” language in their psychometric reports.

Another writer, a psychiatrist, objects to “bargain basement physicians” and adds, “…misunderstanding behind the charges that physicians hold some culpable monopoly and that medicine is a vested interest should not blind psychiatrists to the fact that not all ancillary medical workers have achieved the inner pride and self-respect that one associates with professional life. It may be that personal problems of status and prestige have contributed to the present unrest within the ancillary specialties and to many of the proposals designed to extend their jurisdiction into medical areas.” Finally, a letter from a psychiatrist reads: “The whole subject bores me. I first encountered it in Europe in connection with lay analysis and now again in this country in the form of clinical psychology. Anyone who wishes to treat sick people should get a medical degree.” (14, 18, 27, 29)

Before we leave this topic, it is of value to look at feelings expressed about psychologists by psychiatric social workers: “(1) The psychologist’s attitude is too often similar to his attitude toward a laboratory subject; (2) the psychologist on the mental health team is likely to play the role of the critic and thus create tensions in the team relationship; and (3) the broad field encompassed by the training program of the clinical psychologist creates the risk that he will be trained as a second-rate psychiatrist or second-rate social worker.” (21, p. 151) No “strong” comments were found concerning the psychologist’s reactions to social workers.

These writings are not a representative sample of the attitudes expressed among these groups. In fact, most articles clearly indicate that the problem of role relations is one which needs clear-headed effort rather than emotional interaction.
Procedures for Maintaining Good Relations

One final theme deserves discussion. Many writers make suggestions about procedures which would allow the three groups to work together smoothly. Most of these proposals concern changes in training practices. A psychiatrist for instance suggests that social workers be given more psychiatric training. Others describe a course at the Winter V. A. Hospital in which psychologists and psychiatric social workers examined the "terms" used by each other and found that communication and understanding was improved. Some advocate that training be given the three professions jointly, at some points at least, so that they may learn to work together as a team. Finally, the suggestion is offered that good will is needed on both sides of the psychologist-psychiatrist relationship, because the two professions have perhaps been too concerned with their own needs rather than those of the patient. (3, 8, 10, 37)

Chapter Summary

This chapter has reviewed the published statements of psychiatrists, clinical psychologists, and psychiatric social workers concerning the relations among these three groups. They indicate that this trio of professions has developed strong values concerning interdependence but that there are still unsolved issues concerning who should do what, how they might best collaborate, and how best to acquire or maintain professional status. These matters are of vital concern among them and strong opinions have arisen. We are ready now for a consideration of the factors which may be crucial in determining the nature of the interactions among persons in various professional groups.
CHAPTER 2

AN APPROACH TO THE STUDY OF
ROLE RELATIONS

We have seen that members of the mental health professions show concern about interprofessional relations. Some go further and speculate about the causes of intergroup amity or strain. The purpose of this study is to develop a fuller understanding of the reasons for good or bad relations. How do we approach this task? We need, first, to have some basic definitions and some general ideas about what sorts of conditions cause smooth or stressful role relations. Second, we require an explanation as to why these conditions lead to specified consequences. Finally, we must have some way of indicating the presence of ease or discomfort in role relations.

This chapter begins with a definition of the terms role, role prescription, professional aspirations, and security. It continues with a discussion of the importance of security in determining attitudes and behavior between professional groups. This discussion is expanded, after a delineation of various prescribed role relationships, by an explanation of how a person's location in one of the relationships may determine his degree of security and may lead to certain feelings and actions toward others. A number of interrole attitudes and behaviors are next presented as the ways in which the quality of relations may be characterized. Finally, the use of this theoretical approach is illustrated by a discussion of interrole behavior among persons with different degrees of authority.

The approach proposed here was developed only in part before the study began. It was modified and enlarged during the analysis of the data in order that it might best explain the results obtained. What is now presented is the revised statement. It is further expanded in Chapter 9.

Roles and Role Prescriptions

In order to discuss the nature and causes of relations among persons in these professions, it is helpful to employ certain terms which allow us to deal with the primary characteristics of their professional positions.

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These terms are now set forth. Our decisions about the most appropriate concepts were strongly influenced by the writings of Theodore Newcomb.

We begin with the assumption that a person's profession specifies his role. In its most general sense a role is a set of behaviors which an individual is expected to perform. The more restricted meaning we have given the term is that a professional role includes a limited set of behaviors concerning, for example, task functions, responsibility relations, and normative relationships which are expected of an individual by relevant others. These expectations of a role occupant may be called prescriptions for the role. There may be many prescriptions for various kinds of roles. The three just mentioned occur often. Let us examine them further.

An individual who takes a given role has certain task functions prescribed for him. These are the work contributions he is expected to make while a member of that role. The three professions studied each contain a number of task functions. For example, a psychiatrist may do therapy, diagnosing, supervising, teaching, and so on. A clinical psychologist may administer tests, do research, or conduct therapy. A psychiatric social worker may write case histories, meet with community groups, or assure the patient's family. Each person in his role is expected by himself, his colleagues, and those in remaining roles, to perform specific professional activities which are here designated as task functions.

If one knows the title of the role occupied by a given person, it is possible to anticipate the sort of functions the individual will typically perform. This can only be a rough approximation, of course, since different persons within the same profession will do somewhat dissimilar things. To illustrate, it is not unusual to find some psychologists doing psychotherapy, a task function considered by some to be solely in the province of psychiatrists. Social workers may also engage in therapy. Then too, there are psychiatrists who do research, or who administer psychological tests-duties which are often thought to be the unique functions of psychologists. Generally speaking, however, the different occupants of a given role engage in fairly similar functions. Because the task functions are the most visible aspects of a role, they may come to be seen as the "property" or the prerogatives of persons in the profession and to be highly valued by them.

A person in a specific role has particular responsibility relations prescribed for him. These responsibility relations specify what degree
of authority he has over others or what accountability he may expect from them; as well as how much authority others have over him and the accountability he has to them. When one participates in a given task function it is usually stated explicitly or implicitly that he is to have contacts with designated other persons in the process of fulfilling this obligation. These requirements may ask that he work in collaboration with other persons, may demand that he report the results of his efforts to a superior, or may require that he supervise the efforts of others. Whatever the duty, once a person assumes a given function there are concomitant expectations as to how he is to relate himself to specified others.

As examples, a psychologist is requested to obtain test results which are to be reported to the psychiatrist and specifically not to the patient. A social worker is asked to obtain certain information from the patient's relatives and to report to them certain facts which the therapist feels the family should know. She subsequently describes the results of her interview to the psychiatrist or to her social work supervisor, or to both, depending upon the responsibility-relation requirements which accompany that function. As a further illustration, a psychiatrist has the right to give advice to, or request consultation from, a social worker, but he does not have the authority to determine her working hours and wage scale since such matters are for other persons to decide.

It should be emphasized that if a person changes the nature of his functions within his role, by that fact he will change his responsibility relations with others. A social worker, for example, may have quite different relations with psychologists when performing diagnosis and therapy functions than she has when making visits to a patient's family.

Two important points are contained in the discussion of role prescriptions, thus far. The first is that roles interlock. The prescriptions for each role are described in relation to the prescriptions for other roles. They specify not only what the person must do as an occupant of the role, but also how he must relate to others. Role prescriptions, therefore, prescribe certain role relationships. This distinction is significant for the purposes of this study.

The second point is that professional role prescriptions are the product of group pressures. These pressures originate among the members of the profession as a whole and have a strong impact upon the persons in that role. Being a member of a profession, and acting professionally, then, implies that a person is also a member of a group and that he is conforming to group standards developed by the
organization. He must perform some of the approved task functions and assume some of the appropriate responsibility relations in order to occupy the role and in order to win acceptance from his colleagues.

A person occupying a particular role often has specific beliefs prescribed for him which concern the nature of his relationships with other persons. These prescribed evaluations are distinct from responsibility relations. Though an accurate label is difficult to select, they will be called *normative relationships*. They may concern evaluations a role occupant is expected to make about himself, in comparison to those in other roles on, for example, his comparative knowledge, skills, or training. Or, they may describe a belief about his own quality of performance in comparison with the quality of other's efforts on these same functions.

Social workers may feel that they are better than psychologists in working with a patient's family but are not more skilled in measuring aspects of a person's personality; psychiatrists may believe that they are more adept in therapy than are psychologists, but are not so able in conducting research; or, social workers may feel that they can get information from a patient more efficiently than psychiatrists, but are not more proficient in conducting therapy. Conformity to these group pressures would not be mandatory in order for an individual to occupy a role; but acceptance by colleagues may very well be based upon his adherence to them.

**Group Aspirations**

A profession, like most groups, has goals. These goals are states which the members wish to reach in the future. More accurately stated, a group goal is some mutually valued state of affairs which exerts influence over the members so as to activate and steer their behavior toward it.

It is difficult to say exactly what the content of these aspirations may be at any given time since they change as knowledge is increased, as professional experience and wisdom is collected and codified, and as the means for greater professional service are made available by society. Therefore a fully accurate description of the goals for any profession cannot be given. Nevertheless, it will be helpful to offer a description of these aspirations in terms which will be useful in explaining later results.

The psychiatric social worker aspires to make herself maximally useful to psychiatrists. She accepts and supports the therapeutic goals
of psychiatry and views herself as a person who contributes to that profession by reducing the load on psychiatrists. As the profession has grown in experience and wisdom the psychiatric social worker has been requesting and winning more autonomy in these efforts. Thus, she aspires to increase the usefulness of her profession in the future by enlarging the number of her task functions, and by performing these under the general supervision of psychiatrists.

The clinical psychologist also hopes to increase the usefulness of his profession by engaging in activities which are not now widely available to him. He, like the social worker, does not aspire to duplicate the functions of the psychiatrist. Unlike the social worker, however, he aims to engage in professional functions such as research, diagnosis, and some types of counseling or therapy which are important for the broad goals of mental hygiene, but without psychiatric supervision. He desires, in short, a given area of professional autonomy, while admitting that some of his functions should be supervised by psychiatrists. For a variety of reasons the urgency of this desire for autonomy is usually much stronger among clinical psychologists than among social workers.

The psychiatrist, in contrast to the other two, aspires to supervise the activities of the ancillary professions and to make more effective use of their assistance. He is ordinarily given this responsibility and his greater authority is usually accepted by occupants of the adjunct roles. In many instances he is ready to share some of his responsibility with assistants and otherwise to enlarge their area of autonomy. In this matter the psychiatrist must act cautiously within the limitations of medical ethics in order to protect himself and his profession, since he is usually held responsible for medical activities within any agency under his supervision.

A professional group desires to have all of its members participate in the functions most valued by it. We shall assume that the needs of each individual member, insofar as career aspirations are concerned, are similar to those of his professional group.

Security in Interrole Relations

A person may perceive that his professional needs, like any others, are being gratified or frustrated. An individual is secure if he perceives that he is able to satisfy important needs and he is insecure if he is blocked in the achievement of these aspirations. Limiting the definition of security to interrole situations, it can be formulated: Security is that state in which a person feels that the needs he aspires to gratify can
or will be satisfied in a given relationship with others. Broadly speaking we may think of a person in role A as being either secure or insecure in his relations with members of role B.

In this study security is used as a construct which helps to explain why it is that certain relationships among the members of different roles are associated with given interrole attitudes and behavior. No direct measure of security is employed. Instead, it is postulated that various affective reactions between persons such as liking, esteem, conflict, rivalry, solicitousness, and so on are associated with the presence of security or insecurity as defined. It is the nature of these affective reactions which this study seeks to describe and explain.

We assume that, in general, security in role relations is accompanied by positive and accepting attitudes, while insecurity is related to negative and rejecting feelings. There are exceptions, however, to this point, as will be noted in a moment.

Average Interrole Feelings and Attitudes

In the light of the discussion thus far, how will each of these professional groups feel toward the other two?

Psychiatrists, it is assumed, are more secure in any relationship between their profession and the ancillary professions. They are more secure because their role prescriptions tend to give them greater freedom to meet their professional aspirations in a relationship with subordinates, than is available to the ancillary groups. They are more free to fulfill their own needs because (a) the psychiatrists' task functions are such that the adjunct groups contribute to their accomplishment, (b) their responsibility relations generally require that the adjunct groups be subordinates, and (c) the psychiatrists' normative relationships usually allow them to evaluate their profession more favorably than others.

Because they are more secure, psychiatrists will perceive that they have the support and admiration of the other two professions and they will feel friendly toward them.

Psychologists and social workers, in contrast, are less secure in any relationship between their professions and psychiatrists. They are less secure because their role prescriptions make them dependent upon psychiatrists for gratifying their professional ambitions. Their task functions, responsibility relations, and normative relationships make it highly probable that, when interacting with psychiatrists, they cannot easily move toward satisfaction of professional aspirations without the help or permission of psychiatrists.
Because they are less secure, and because they are in a dependent relationship, members of the ancillary professions will be eager to win good will from psychiatrists so that they will use their authority in a helpful fashion. Psychologists and psychiatric social workers will be more inclined to accept and admire psychiatrists than to reject them because such behavior will increase the probability of developing positive feelings among psychiatrists toward the adjunct professions.

**Individual Patterns of Role Behavior**

Although the pattern of behavior among members of any one profession is generally similar, it is also true that no two persons will interpret their roles in exactly the same way. It follows, therefore, that interrole feelings and behaviors among individual members of separate professions can be different from the group averages just described.

In a specific working situation—a particular clinic or hospital—role prescriptions may be influenced by unusual conditions. Because of this fact, the way that a particular member of one profession in that setting relates to a particular member of another profession will also be affected. As an illustration, even though the professional role of psychiatry has superior status to the professional role of social worker, the prescribed role relations may be determined by the fact, for example, that the social worker is a highly experienced supervisor while the psychiatrist is a young, lower-status member of the staff. Or again, in a specific work environment an individual may develop notions about his relative knowledge and skill or the amount of influence he should rightly have which are different from his professional group's prescriptions. These make relations for that individual, with an individual in another role, quite different from the average relations between his profession and the other.

Assuming that there are individual differences in the way that persons interpret their roles, we may ask, why might these lead to differences in interrole attitudes and behavior?

To explain this phenomenon we must first recall that role prescriptions describe a person's expected relations with others. The role occupant is required to perform his activities relative to others in certain ways. Because of the interlocking of role prescriptions, individual X who differs from individual Y in his performance of the same role, is also differing from Y in the nature of his relationships with other persons. These relationships are dimensional in character; that is, a person may be high or low on a dimension of his relationship with those in another role.
A person's location in a prescribed relationship refers to the position he perceives himself to have in it in respect to those in another role. A social worker in respect to psychiatrists may perceive herself to have much or little power, few or many contacts with them, and much or little ability. Social workers may have differences of opinion concerning, for example, the degrees of power they have to influence psychiatrists. The social workers may then be said to have different locations on the power relationship dimension in respect to psychiatrists.

The location of a person in a prescribed relationship affects his security. A person may perceive that his location is such that he probably will be able to meet his needs. In that instance he would be secure. A person who sees that his location is such that his needs are likely to be frustrated, will be less secure. To illustrate, let us assume that a social worker desires greater freedom to interpret the results of interviews with incoming patients and to suggest to psychiatrists the courses of therapeutic treatment. She is more secure if she evaluates her diagnostic skill as high in reference to psychiatrists (high location). She is less secure if she perceives that her diagnostic ability is low (low location).

For any type of relationship between roles it is possible, in principle, to designate which locations provide the greater security. This task will be attempted in Chapter 9.

Some Prescribed Role Relationships

There are many ways in which the members of one role may be related to those in another as a result of their role prescriptions. Certain prescribed relationships were chosen for this study because (a) preliminary study had led us to believe they are usually included in the prescriptions for these three roles, (b) they covered a variety of dimensions, and (c) persons in any one role appeared to occupy different locations on them.

The list of prescribed relationships selected for this study follows:

1. Perceived relative power to influence.—the ability to influence others which a person attributes to himself.
2. Acceptance of relative power to influence.—the degree to which a person accepts the amount of power he has in relation to members of another group. More exactly, it describes the degree to which he desires greater or less influence in relations with others.
3. Frequency of professional contacts.—the amount of face-to-face interaction a person has with those in other roles.
4. Professional knowledge and skills.—a comparative judgment concerning the degree of services, information, or resources a person can provide for others, in contrast to what they may give to him.

5. Satisfaction from providing advice for those in other professions.—the amount of satisfaction a person has as a result of being asked to advise another.

Information was obtained from the professional persons interviewed concerning two other matters pertinent to role relationships. These cannot be considered prescribed relationships; however, they may often determine the nature of the role prescriptions, and certainly affect the quality of interrole attitudes.

The relative prestige of each person within his own profession was determined. Members of a profession may vary in respect to the offices they hold, their titles, their salaries, their professional recognition, their training, and so on. Those who are high in these characteristics are high in prestige. It is assumed that persons who are high in prestige more strongly identify with their profession because they have derived many satisfactions from membership in that group.

The satisfaction of each person concerning interrole relations was obtained. This is a global measure describing the degree of satisfaction a person in one role feels concerning his relations with those in another profession. It is an indication of the person's evaluation of his locations in his various prescribed relationships.

The prescribed relationships plus prestige and satisfaction are described as independent variables in this study; we consider them to cause interrole attitudes and behavior.

**Interrole Attitudes and Behavior**

The person who perceives himself to be in a location which creates need frustration, will be likely, we assume, to behave in such a way that greater gratification and security results for him. What he will do in order to maximize security will be determined by his professional objectives and the opportunities available to act in his own behalf.

Because of their strong desire for increased usefulness to society, we may expect that psychologists when insecure will display feelings and intentions which indicate that their need for independent action is frustrated. Psychiatrists might behave in a manner which helps them to maintain their superior status. Social workers may engage in actions which guarantee that they are appreciated and that their services are effectively used by psychiatrists.
While some acts or feelings may be instrumental in the ways just described, we must not overlook the possibility that other acts or feelings may not indicate that the person wishes he could change degree of need fulfillment. These would be likely to occur when action seems impossible for him.

It is possible to be somewhat more specific about the reasons for certain interrole attitudes and behavior. In order for a person to increase the possibilities of professional need gratification he must act at some level of awareness upon the origin of the deprivation. Though he may attempt to do so, it is not easy for him to shift his location to a more favorable site. It is more feasible for him to try to increase the effectiveness of influences which are favorable to need satisfaction, or to decrease effectiveness of forces which are detrimental to need gratification. He may act upon his environment, including other persons, or seek to convince himself of the others' favor toward him, in order to make the state of affairs strongly positive and weakly negative. He will be most secure when he views relations with others as facilitative to need satisfaction. A number of examples are listed within each of the following categories of action.

Security-maximizing attitudes and behaviors which indicate that the person wishes:

1. To see others as facilitative to need satisfaction—sees no conflict of interests in relations with them; sees them as helpful advisors; attributes helpful stereotypes to them.

2. To increase the effectiveness of need facilitating behavior from others—attributes friendly stereotypes to them; praises them; seeks advice from them; desires many contacts with them; admires them; values their help; communicates to protect good relations.

3. To see others as weak in their attempts to hinder—sees them as troubled by conflict of interests; sees them as incompetent and not respected; attributes negative stereotypes to them.

4. To decrease the effectiveness of hindering behavior from others—encroaches upon their prerogatives; avoids contacts with them; prefers own group to theirs; freely communicates hostile feelings.

An illustration of the approach described thus far is now presented by an examination of the interrole behavior among persons with different degrees of power.
Interrole Attitudes and Behavior Associated with Perceived Relative Power to Influence

Perceived relative power is the ability of A to influence B, or to determine B’s fate, as A perceives the situation. Person A may also feel that B has some amount of power over A. Thus the resultant amount of relative power A attributes to himself in relations with B is the degree to which he believes he can successfully influence B, less the amount to which he believes that B can influence him.

Some persons in role A may perceive that their power is great in relations with persons in role B while others may feel that it is relatively small. Those in role A who believe that their power is great will feel that they can determine what persons in role B think and do. Persons in role A who see that their power is small, on the contrary, will feel that they can have few such effects on persons in role B. For the sake of brevity, the simpler term power will be used hereafter. It should be understood, however, that it refers to perceived relative power.

It is possible for a person to have more power in some functions than in others. For example, a psychologist may feel that he has greater power to influence psychiatrists while he is conducting research with them, or when he is interpreting the results of psychometric tests, than when he is suggesting therapeutic procedures. The total amount of a person’s power in any relationship is the sum of the separate amounts in each of his task functions. In the discussion of results, we shall examine how the power varies depending upon the functions being performed.

It may be assumed that a person with high perceived power will attribute to himself a greater probability of fulfilling his aspirations than one who has little power. He has greater control over his own fate through his ability to influence others, and a stronger likelihood, therefore, of ensuring that events will occur as he wishes. Thus, in accordance with earlier suppositions, he is likely to be secure in his relations with members of the other profession. In contrast, a person who is low in power is likely to be subject to the impulses and wishes of more powerful persons. He, therefore, would assign a lower probability to the possibility of fulfilling his aspirations and would be less secure in this relationship.

In general, when a person is high in power he will react toward those in another role in a fashion which helps him to maintain a high power position. If he is low in power, his interrole perceptions and behavior
will represent his desire to protect himself against any unpleasant consequences of his position. These actions and attitudes are the phenomena which describe the quality of the relations. Which phenomena will occur under different conditions of power?

A member of a given profession will seek to meet his needs in interrole relations according to the means which are available to him. The members of a major profession and those in ancillary groups have quite different procedures at hand for accomplishing this purpose.

Psychiatrists ordinarily have role prescriptions which demand that they guide the efforts of clinical psychologists and psychiatric social workers. It is important to them to maintain this higher place.

A psychiatrist who attributes high power to himself is likely to perceive that the members of the ancillary groups respect him and like him, and seek to make a good impression on him. He will believe this because his high power provides him security. He will be ready and willing to associate with the members of the adjunct profession since when he does so he is usually in a superior position, and frequent contacts satisfy rather than threaten his desires.

In contrast, a psychiatrist who sees himself as low in power will feel that he is in a relationship which is unusual and threatening to him. He may show his feelings by stating that the members of the ancillary groups do not respect or admire him, and by fearing that the other professions are attempting to perform functions which are ordinarily reserved for psychiatrists. Furthermore, he will be eager to avoid persons in the adjunct professions and will be less ready to communicate with them, since by avoiding interactions he will maintain his professional stature.

In Table 1 a number of tentative predictions are made concerning the nature of interrole attitudes or behaviors of a psychiatrist who is either high or low in power. Column (a) predicts the reactions of one who is high in power and column (b) indicates the nature of interrole behavior which may be expected from one who is low in power. The entries in this table may be considered to be testable hypotheses concerning the effects of power positions for psychiatrists.

Now let us turn our attention to a consideration of the interrole attitudes of persons in the ancillary professions in their relations with psychiatrists. We must remember that the adjunct groups are by tradition assistants whenever they interact with psychiatrists. An individual in one of the ancillary roles who finds himself relatively higher than his colleagues in respect to influence on psychiatrists is eager
Tentative Predictions Concerning Interrole Attitudes and Behavior Directed toward Members of Roles who are Expected to be Lower in Power

<table>
<thead>
<tr>
<th>Class of interrole attitude or behavior</th>
<th>Persons who have high power who belong to a group which is usually powerful</th>
<th>Persons who have low power who belong to a group which is usually powerful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed toward persons in less powerful roles</td>
<td>Directed toward persons in less powerful roles</td>
<td></td>
</tr>
<tr>
<td>Admiration and esteem directed toward other level</td>
<td>Mild respect for other level, willing to work or associate with them</td>
<td>Does not admire or respect other level, avoids associating or working with members of other role</td>
</tr>
<tr>
<td>Desire for admiration and esteem from those on other level</td>
<td>Much desire to be valued by lower level</td>
<td>Little desire for admiration or esteem from members of other role</td>
</tr>
<tr>
<td>Perceived amount of admiration and esteem received from those on other level</td>
<td>High perceptions of being esteemed by those on lower level</td>
<td>Believes he is not admired or valued by members of other level</td>
</tr>
<tr>
<td>Solicitousness: received and given</td>
<td>No effort to win favor of lower level, perceives those on other level as striving to win his favor</td>
<td>Is willing to win approval for self from other level, perceives no effort by other group to win his favor</td>
</tr>
<tr>
<td>Encroaching or conflict: received or given</td>
<td>No perception that lower level is encroaching on own functions</td>
<td>Is willing to encroach on other-role functions and views others as attempting to invade own</td>
</tr>
<tr>
<td>Stereotypes concerning other level</td>
<td>Stereotypes favorable concerning lower level</td>
<td>Stereotypes unfavorable to members of other role</td>
</tr>
<tr>
<td>Type of communication to other level</td>
<td>Communication to lower level is infrequent but permissive, not inhibited about discussing own adequacy or that of persons addressed.</td>
<td>Communication infrequent, cautious about deflating self or members of other role when communicating</td>
</tr>
</tbody>
</table>

To maintain this power in order that he may continue to move toward his professional aspirations. An efficient way for him to do this is to avoid contacts with psychiatrists so that he cannot be placed in an assistant position and thus lose his power. We may expect, therefore, that the person in an ancillary profession who sees himself as being relatively high in power for a member of his profession will want few contacts with psychiatrists and will have little desire to talk with them.
His desire for independence and autonomy will be further apparent in his greater attachment to, and positive evaluation of, his own profession rather than psychiatry. The assurance he obtains from his relatively high power will also cause him to have little concern about winning the good will of psychiatrists or in making a good impression upon them.

An individual in either of the assisting professions who attributes low power to himself in his relations with psychiatrists may be expected to be insecure for reasons given. His power position provides him with little freedom to meet his own needs so he must depend upon developing good relations with psychiatrists in order to do so. It is anticipated, therefore, that the ancillary professional member with low power will reveal much concern with being liked and respected by those with greater power. He will also seek to make a favorable impression upon psychiatrists in order that the greater power possessed by superiors will be used in a supporting and rewarding manner rather than a depriving one. Furthermore, he will want much interaction with the higher-power persons and will be eager to talk with them in order to have ample opportunity to win from these superiors protective and rewarding actions.

A number of tentative predictions are listed in Table 2. These describe the interrole behavior of ancillary group members high in power and low in power. They are a set of testable hypotheses concerning the effect of power positions on role attitudes directed upward in a hierarchy.

Thus far, the interrole reactions have been examined among those who are ordinarily at quite different power levels. What about the interrole attitudes of persons in groups which are usually at a peer level? Clinical psychologists and psychiatric social workers may, for the present, be considered to be peers. It has been assumed that each of these two groups has developed strong professional needs. However, neither professional body can be of much help or hindrance to the other in fulfilling these desires because of the prescribed equality and the lack of interdependence of their activities. We may anticipate then that one who perceives himself to be high in power in his relations with the members of the other ancillary group, will act very little differently toward them than a person who is low in power. Because the power relationship between these two professions has little effect in determining the probability of fulfilling professional needs, it has little effect upon the degree of security in role relations, and thus small effect in controlling the interrole attitudes and behavior.
Table 2

Tentative Predictions Concerning Interrole Attitudes and Behavior Directed toward Members of Roles who are Expected to be Higher in Power

<table>
<thead>
<tr>
<th>Class of interrole attitude or behavior</th>
<th>(a) Persons who have high power and who belong to a group which is ordinarily low in power</th>
<th>(b) Persons who have low power and who belong to a group which is ordinarily low in power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed toward persons in roles which are usually powerful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admiration and esteem directed toward other levels</td>
<td>Does not admire or respect highs, avoids working or associating with them</td>
<td>High respect for higher-level persons, eager to work and associate with them</td>
</tr>
<tr>
<td>Desire for admiration and esteem from other level</td>
<td>Has little desire for admiration or esteem from members of other role</td>
<td>Strong desire for admiration and esteem from higher level</td>
</tr>
<tr>
<td>Perceived amount of admiration and esteem received from those on lower level</td>
<td>Believes he is not admired or valued by highs</td>
<td>Very little perception of being esteemed by those on higher level</td>
</tr>
<tr>
<td>Solicitiveness: received and given</td>
<td>No attempts to win favor for self from highs and no perception of highs attempting to be solicitous</td>
<td>Makes many attempts to win favor of higher level</td>
</tr>
<tr>
<td>Encroaching or conflict: received or given</td>
<td>Is willing to encroach on highs' functions and views them as fearing encroachment</td>
<td>No intention to encroach on functions of higher level, no perception that they are encroaching</td>
</tr>
<tr>
<td>Stereotypes concerning other level</td>
<td>Stereotypes unfavorable concerning highs</td>
<td>Stereotypes favorable concerning upper level</td>
</tr>
<tr>
<td>Type of communication to other level</td>
<td>Communication infrequent, not cautious about deflating self or highs when communicating</td>
<td>Communication to upper level is frequent, not inhibited in talking about selves or those on upper level—in positive vein</td>
</tr>
</tbody>
</table>

Independent and Dependent Variables

In what follows, the information provided by a respondent concerning his relations with the members of another role will be divided into two broad categories: independent and dependent variables.

Independent variables are the prescribed role relationships plus prestige and satisfaction with relations. Variations in the relationships are described by the different locations of the professional persons. The
dependent variables are the interrole attitudes and behaviors just described.

CHAPTER SUMMARY

The purpose of this chapter has been to propose how and why it is that the attributes of the role a person occupies may have an important bearing on the affective interaction he has with persons in a role different from his own.

A professional role was defined as a limited set of behaviors concerning task functions, responsibility relations, and comparative evaluations which are expected of an individual by relevant others. These expectations for the role occupant are the role prescriptions. They state not only what the person must do but also how he must relate to others. These are considered to be independent variables.

It was assumed that the members of these three professions are attempting to fulfill professional needs. An individual is secure if he has a relationship with other persons which promises to allow him to fulfill these aspirations, and he is insecure if he is unable or unlikely to gratify these important desires. The interrole attitudes and behaviors which an individual directs toward the members of another profession are either indications of his degree of security or signs that he is attempting, in this relationship, to maximize security by increasing the probabilities of need gratification.

The attitudes or stated behaviors which a person in a given location chooses to use are determined by the means available to him in his relations with the relevant role group, and by whatever he sees as helpful in achieving security in role relations. The nature of various affective reactions which may occur in interrole relations were described. These are dependent variables.

A series of predictions was made for persons who are high in power, or low in power, which described the type of behavior they might use toward those who are in a role different from their own.

We are now ready to consider the methods which were used in obtaining and treating the data. The discussion on methods will be followed by chapters describing the results regarding the nature of the affective interactions among professional groups and the situations associated with variations in these responses.
CHAPTER 3

HOW THE DATA WERE OBTAINED
AND TREATED

The data for this study were obtained by means of individual interviews with 156 psychiatrists, 165 clinical psychologists, and 159 psychiatric social workers. The respondents were active in large metropolitan areas and were engaged in work which provided opportunity for interaction with members of the other two professions. The interview called, in most questions, for selection from among fixed alternatives, such as indicating a position on a rating scale. It also contained some open questions and some requests for objective facts. On the whole, however, it was designed to obtain quantitative data on predetermined questions rather than free responses in the respondent's terms.

The data fall into three broad classifications: (a) independent variables including prescribed role relationships plus prestige and satisfaction, (b) dependent variables including interrole attitudes and behaviors, and (c) social structure information.

Each respondent was asked to reply concerning his relations with members of an entire professional group. An individual from occupation A was asked to describe his relations with members of occupation B. He was asked not to consider specific individuals in occupation B; rather, he was to consider group B as a whole. This procedure allowed a maximum of phantasy and projection concerning the members of another profession, thus reducing the effects of inhibitions or modesty which might arise in discussing feelings about specific associates. It also tended to exclude from conscious consideration the personality characteristics of any particular associates, making the respondent's answers correspond more closely to his stereotyped notions about members of the other profession.

Professional Persons Interviewed

Candidates were selected for interview who had a maximum opportunity for interaction with those in the other two professions. This meant that the sample had to be drawn from persons connected with clinics,
welfare agencies, hospitals, or other institutions which employ members of all three professions.

Sampling from a wide variety of institutions ensured that the results would be applicable to any setting in which members of these three professions collaborate. Since such organizations are most often situated in cities or the surrounding metropolitan areas, it was decided to limit the sample to people in six large cities. One other factor made it important that the interviews be conducted in cities: relatively few mental health workers are found outside the large centers of population.

Boston, Chicago, Los Angeles, New York, Pittsburgh, and St. Louis were selected on the basis of probability sample procedures from among the largest metropolitan areas in the United States. Within these cities the persons available for interview were chosen from complete lists of all members of the three professions living there. Potential interviewees had to fulfill certain minimum requirements, so that all participants would be representative of their respective professions. The psychiatrists had all completed a psychiatric residency and were members of the American Psychiatric Association. The clinical psychologists had earned a Ph. D. degree and were members of the American Psychological Association. The psychiatric social workers were members of the American Association of Psychiatric Social Workers.

All those selected were associated on at least a part-time basis with some institution doing work in the field of mental hygiene. The representativeness of the sample was guaranteed by using a procedure which allowed every individual on the original lists an equal probability of being selected for interview. When it was not possible to obtain an interview with a chosen person, an alternate was taken from a reserve list of people who met the requirements. Further information about the persons who were interviewed will be found in the Appendix.

The Interviewing Procedure

The interview began with factual questions about the respondent's training, experience, society memberships, and present place of employment. Then the interviewer handed the respondent a sheet containing a series of graphic rating scales. For many of the questions, the respondent was asked to choose the point, on a specific scale, which best described his feelings in response to a given question. To illustrate, the psychiatric social workers were asked:

"To what extent have you the authority to determine any psychologist's work in relation to family and community contacts
about patients? Please make your reply in terms of scale number two."

Following this they were asked:

"To what extent does any psychologist have the authority to determine the work you do in relation to family and community contacts about patients? Please choose your reply from scale number two."

Then this question was raised:

"To what extent should you [determine their work in this area]?")"

and this was followed by a question concerning the degree to which psychologists should have this right. In answer to such questions the respondent made the most appropriate choice on a 7-point rating scale ranging from "a very great extent" (at point 1) to "not at all" (at point 7).

This closely-structured method may have reduced the richness of the data in a number of ways since the respondent was often asked to reply in the investigator's terms rather than to express himself freely. Such a loss, however, was balanced by the fact that the objectives of the study were more likely to be realized by obtaining specific quantitative data from every respondent. On occasion, open questions were also used where it was considered desirable to have an elaboration or an explanation of a given rating.

The interview situation was difficult not only because the schedule was long but also because the persons being studied were themselves skilled in interviewing. It was necessary that able and experienced persons do the job. The supervisors of the field interviewing staff for the Survey Research Center at the University of Michigan were employed. All interviewers were intensively trained and were allowed to practice using the questionnaire before beginning the data collection.

The independent variables, that is, the prescribed role relationships plus prestige and satisfaction, were discussed in the previous chapter. The methods employed in the measurement of each will be briefly described.

1. Perceived Relative Power to Influence. Each person was asked to describe his perception of the amount of authority he had to determine the nature of the work done by the members of the other professions. Since the amount of power an individual possesses in relation to occupants of other roles may vary according to the task function, a series of questions was posed concerning the respondent's perception of his
authority over others in varied functions such as therapy, diagnosis, case-history writing, and community contacts. In addition, each respondent stated his perception of the degree to which the members of the other professions could determine his activities in these task functions.

In order, then, to determine the respondent’s power position in respect to a given professional group in each of these functional areas, a discrepancy was calculated between the amount of authority which the respondent perceived himself to have over another group and the amount of authority which he perceived them to have over him. The size of this discrepancy was considered to represent the amount of authority, or power, that the respondent finally perceived himself to have in relation to members of the other profession in that particular function.

In addition, a total power score was derived for each role relationship which combined the discrepancy results of all the relevant task functions. This procedure is described in the Appendix. It should be mentioned, however, that total power scores were computed for a given role relationship only for such combinations of task functions as had both theoretical and statistical reasonableness. To illustrate, a psychologist’s power position in relation to psychiatrists is composed of his discrepancy scores in the areas of diagnosis, therapy, and the freedom to choose patients, while the social worker’s power location in regard to psychiatrists is represented by her power in the areas of diagnosis, therapy, case-history writing, and community contacts. (Measures were also made of the degree to which individuals actually “exercised” their power. This figure correlated so closely with perceived power that exercise of power was dropped from the analysis).

2. Acceptance of Relative Power to Influence. This dimension specifies the degree to which the respondent accepts the amount of power he has in relation to members of another group. A person whose location is at the low extreme on this dimension wishes for more power over the other group than he now has, while a respondent at the other extreme on this dimension may be ready to give up some of the power he already possesses. A midpoint location indicates a willingness to maintain the status quo. To determine an individual’s location on this dimension his perceived power relationship with those in another group was first obtained in the manner described above. In addition, he was asked two questions: “How much authority should you have in relation to others?” and, “How much authority should they have over you?”
These "should" question were asked concerning each of the functions considered in determining the power location. A discrepancy was computed for each of the pairs of "should" responses. Finally, the difference was calculated between the discrepancy for power and the one for "should." This figure represents the respondent's feelings of acceptance of his power relationship with the specific other group, based on the amount of power he presently perceives himself to have. A combination of the results for each function yielded a total score.

3. **Frequency of Professional Contacts.** The amount of professional contact each person perceived himself to have with members of the other two professions was determined by asking the respondent to specify on a 7-point scale (from "daily" to "a few times a year") the degree of interaction he has with others. His perception of how much contact with him the members of the other two professions might claim was not considered meaningful and therefore was not sought.

4. **Professional Knowledge and Skills.** The respondent was asked to indicate the degree to which he perceives himself to have knowledge and skills in various task functions from which persons in the other two professions could benefit, and the degree to which he believes they have knowledge and ability from which he (the respondent) could profit. The discrepancy between his attribution of this characteristic to himself and to others indicated the individual's perceived comparative amount of knowledge and skill.

5. **Satisfaction Due to Providing Counsel for Others.** The respondent was asked to state the amount of satisfaction he feels concerning the frequency with which members of the other professions come to him for advice. The perceived actual frequency of advice-giving was also determined.

6. **Satisfaction with Interrole Relations.** This is a measure of the amount of satisfaction each respondent expressed concerning his past and current prescribed relations with the members of the other professions. The point chosen on a rating scale represented the individual's degree of satisfaction.

7. **Prestige in Own Profession.** The degree of the respondent's prestige within the prestige hierarchy of his own profession was computed on the basis of objective data. For such separate items of information as income, training, membership in professional societies, offices held, age, title, size of organization in which he works, and so on, the respondent's prestige was determined by means of a weighting process described in the Appendix.
Measuring the Dependent Variable Data

Methods for the measurement of certain interpersonal feelings and actions will be briefly described. They are further discussed in the Appendix.

1. *Attitudes of admiration and esteem: given, received, desired.* A measure of such private feelings is often difficult to obtain directly because professional respondents are likely to view affective factors as irrelevant to a professional relationship, and thus feel inhibited in their responses. It was necessary, therefore, to use both direct and indirect questions concerning potential relations with members of another profession on a hypothetical community committee, evaluations of potential contributions to such a group, desire for leisure-time contacts, attribution of stereotypes to the members of the other occupations, and similar questions.

2. *Attitudes indicating either the use or receipt of solicitous behavior.* In exploring such feelings, questions like the following were used: “To what extent do you find it necessary to soft-soap or flatter X's occasionally?” “To what extent do X's strive for your approval?” In addition, the attribution of stereotypes, the selection of preferred communication topics, and reasons for contacts with those in other professions were relevant as indicators of the respondent's desire to win good will for himself.

3. *Attitudes indicating either the use or receipt of encroachment or hostility.* By means of both direct and indirect questions, measures were taken of the respondent's efforts to decrease the influence that those in other professions have over him, the energy spent in competing with others, the degree to which he aspires to take over functions which are usually assigned to another role, and so on. These data give indications of readiness to encroach upon other groups or enter into rivalrous relations with them. In addition, the respondent was asked the degree to which members of other occupations were behaving in this manner toward his own group.

4. *Stereotypes about other groups.* In order to determine the respondent's stereotypes concerning those in another profession, a list of thirteen characteristics relevant to this professional environment was used. These traits included such items as well-trained, scientific, striving, and competent. The respondent characterized his own and the other groups in terms of these stereotypes.

5. *Disposition to communicate with others.* Each respondent was
asked about his disposition to talk to members of his own and of the other professional groups about eleven different conversational topics. It was assumed that professional people would either want to discuss these subjects or would wish to avoid them because they affect interpersonal relations. Some typical subjects were: own failures, own successes, interpersonal complaints, the other group's professional successes, and shop-talk. In the analysis of the data obtained, each subject of conversation was examined in terms of the respondent's readiness to discuss it, and an over-all measure of willingness to communicate was computed by averaging the degree for each of the eleven topics.

Social Structure Data

The information obtained in this section of the interview describes the unique society of the mental health professions and the roles which have evolved within this society. The questions yielded a variety of objective data about the institution in which the respondent was employed: the organization, the professions of those in various positions on the staff of the institution, the numbers of persons from various professions employed there, and so on.

In addition this part of the interview included questions about the functions of the respondent, the functions of his co-workers, the type of knowledge and skills which he felt to be unique to his profession, and those which he felt to be unique to the other professions. Open-ended questions elicited the reasons that the respondent felt relations to be satisfactory or otherwise.

Treatment of the Data

The first phase in the analysis of the data was to determine the average responses of each professional group concerning the other two groups on each of the interrole attitudes and behaviors (dependent variables). To determine whether these averages were different from one another to a significant degree, the averages were compared by the use of a critical ratio test. The degree of statistical significance for the difference between averages is expressed in terms of the value of \( p \). This value indicates the degree of probability that the results could have been due to chance. For example, a \( p \) value of .05 means that the statistical comparison made between two averages could be a result of chance no more than one time in twenty.

The next stage in the analysis was an examination of the way in
which the respondents' locations on the various independent variables correlated with the particular interrole attitudes and behaviors they demonstrated toward persons in the other roles. The size of the correlation indicates the degree of association there is between a given position on a relationship dimension and the tendency to react to the other groups in a specific fashion. Correlations, we must remember, indicate only the degree to which the results on two measures vary in a similar fashion. They do not prove that one variable is the cause of another. In order to interpret the data provided by correlations, however, we shall assume that the independent variables are the causes and the dependent variables are the effects.

Correlations are designated by the letter *r*. After each correlation the reader will find a *p* value. In the case of correlations, the value of *p* indicates the probability that a correlation of this size would occur by chance in a population of the size being considered. In this study an *r* of about .18 is significant at the .05 level of confidence and an *r* of .36 is significant at the .001 level. It is apparent that relatively small correlations can be acceptable at the .05 level which is the usual standard. An interpretation of results based upon small correlations, however, means that much of the variance in the relationship between the two variables is left unexplained. It was decided to use low correlations if significant in the interpretation of findings, on the assumption that they are suitable leads for evaluating and developing theory.

Because we shall be emphasizing those correlations and critical ratios which have *p* values of .05 or better in the discussion of the results, it is obvious that five out of every one hundred significant correlations and critical ratios would tend to be chance occurrences and therefore might have no important psychological meaning. All significant correlations and critical ratios have been included in the results, only those few being omitted which clearly did not fit the general pattern of results or were contradictory to the greater number of statistical tests.

On occasion statistical significance had to be examined by the use of *t* tests or chi-square. The reader who is not familiar with these procedures will find them described in any textbook on statistics. The *p* values are also given for these so that the reader may judge for himself what degree of confidence he may have in the findings.

**Chapter Summary**

This chapter has described the procedures used in gathering and analyzing the data. The data were obtained by means of individual
interviews with approximately 160 members of each of the three professional groups. The respondents were active in large metropolitan areas and were engaged in work which provided an opportunity for interaction of all three groups. The interview method primarily depended upon highly structured questions. The method used for obtaining quantitative data on a number of variables has been described. A more detailed discussion of the methods is available in the Appendix.
CHAPTER 4

RELATIONS BETWEEN PSYCHIATRIC SOCIAL WORKERS AND PSYCHIATRISTS

In recent years the professions of psychiatric social work and psychiatry have become increasingly interdependent as a result of the cross-disciplinary co-operation now common in therapeutic agencies. Social workers reduce the burden of the psychiatrist's work. For example, a social worker may gather data from the patient, prepare him for sessions with the psychiatrist, do some therapy herself, or consult the sick person and his family on matters concerned with the treatment procedure. In addition, the social worker provides help to the community by conducting educational activities or by contributing psychiatric insights to agency programs which would otherwise require a psychiatrist. All of these activities lighten the demands on the doctor. The social worker assumes the status of an ancillary worker, since psychiatrists either explicitly or implicitly sanction her professional activities. It is clear that the members of the two professions need each other, but for quite different reasons. The psychiatrist wants and needs the social worker's help; the social worker depends on the psychiatrist for such things as aid in the definition of her task functions and social sanctioning. We may anticipate, then, that the average responses in these two groups will indicate an awareness of a difference in functions and prerogatives in relations with each other.

We shall review first the average attitudes and behaviors which members of these two professional groups express toward one another. After that relations among persons in the two groups will be examined as they are influenced by the positions that the individuals occupy on various relationship dimensions.

Comparing Some Perceptions that Social Workers and Psychiatrists Have about Each Other

Social workers are more eager than are psychiatrists for acceptance by the other group. Members of the assisting profession express a stronger desire to be liked and respected by psychiatrists, and wish for more contacts with them, than the psychiatrists want from social
workers. This fact may be seen in Table 3. (This table, and others which report mean scores, is read in the following fashion: The first column lists the content of the questions asked of each respondent. The next column to the right contains the average responses made by psychiatrists concerning social workers on a 7-point rating scale. The third column contains the average answers of social workers concerning psychiatrists. The final column gives the \( p \) value of the difference between the averages. The lower the \( p \) value, the less is the probability that the difference between the means was due to chance.)

**Table 3**
Comparing the Mean Desire for Supportive Relations with Members of the Other Profession as Stated by Psychiatrists and Social Workers

<table>
<thead>
<tr>
<th>Nature of desire</th>
<th>Mean rating made by:</th>
<th>( p ) value of diff. between means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists re social workers</td>
<td>Social Workers re psychiatrists</td>
</tr>
<tr>
<td>Desire to be respected</td>
<td>3.99</td>
<td>4.28</td>
</tr>
<tr>
<td>Desire for professional contacts</td>
<td>4.82</td>
<td>5.31</td>
</tr>
<tr>
<td>Desire to be liked</td>
<td>2.90</td>
<td>3.38</td>
</tr>
<tr>
<td>Desire for leisure-time contacts</td>
<td>3.04</td>
<td>3.72</td>
</tr>
</tbody>
</table>

The greater desire on the part of social workers for building accepting relationships is also apparent in the topics social workers are disposed to discuss with psychiatrists. As is shown in Table 4, social workers are more ready than psychiatrists to talk about: their own profession's inadequacies; their personal successes; their failures; and light conversation. Psychiatrists are not so willing to talk about those personal matters to social workers. They are more disposed to complain about the behavior of social workers and to comment on their failures. Apparently social workers are ready to converse with psychiatrists about personal achievements, and failures as well. They have much to gain from reporting successes since this is a way of obtaining admiration. The willingness to discuss their inadequacies, however, is not an obvious means of winning respect; but this readiness to talk about shortcomings may be understood if it is assumed that social workers perceive a psychiatrist as an instructive superior who will help them to improve their skills when a need for this is shown. It is likely too, that social workers perceive that they can maintain comfortable relations by discussing those matters which are not a threat to psychiatrists.

The psychiatrists, on the contrary, have little to gain by reporting their own failures. Furthermore, there is small motivation for convincing
TABLE 4
Comparing the Mean Desire for Communication with Members of the Other Profession as Stated by Psychiatrists and Social Workers

<table>
<thead>
<tr>
<th>Topic</th>
<th>Mean desire to talk shown by:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists to Social Workers</td>
<td>Social Workers to Psychiatrists</td>
<td>p value of diff. between means</td>
<td></td>
</tr>
<tr>
<td>My profession's inadequacies</td>
<td>2.26</td>
<td>2.54</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>My personal successes</td>
<td>2.23</td>
<td>2.59</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>My personal failures</td>
<td>2.30</td>
<td>2.87</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Complaints about the other's behavior</td>
<td>2.05</td>
<td>1.78</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>Other's failures</td>
<td>2.52</td>
<td>1.89</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Light Conversation</td>
<td>2.48</td>
<td>2.68</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

Social workers that their group is superior by describing personal successes.

Psychiatric social workers have great respect for psychiatrists and for their professional functions. In fact, they value psychiatry more than their own profession and many wish they were psychiatrists rather than social workers.

Social workers are content that their income should be less than that of psychiatrists. Thus, 91 per cent of social workers feel that they should be paid less than psychiatrists, and an equal proportion of psychiatrists agree that their own salaries should be greater than the earnings of social workers.

Of the psychiatrists, 29 per cent stated that they utilize the special resources provided by social workers, and an equal proportion of social workers perceive that psychiatrists are in fact interested in obtaining such help. In contrast, 41 per cent of the social workers state that they attempt to profit from the knowledge that psychiatrists possess, and 50 per cent of the psychiatrists feel that social workers actually do so.

A social worker is more attracted to the psychiatric profession "were she given the opportunity to begin (her) career over again," than is a psychiatrist interested in social work. Thirty-nine per cent of the social workers say they would prefer to be psychiatrists if they had the chance; whereas, 100 per cent of the psychiatrists prefer their own field over social work.

In response to a query which asked "What profession might make the best contribution to a community committee concerned with mental health problems?" social workers ranked psychiatrists higher than they were placed by the other group. Psychiatrists were given a mean rank.
of 2.84 (lower number = higher rank) by social workers whereas social workers were assigned an average rank of 3.78. The difference between these two is significant at the .001 level of confidence. In addition psychiatrists were stereotyped as more insightful (4.70) and scientific (5.32) than were the social workers (4.14 and 2.95 respectively.)

The members of the two professions have a clear comprehension of the functions included in one another's roles (See Table 44). The respondents were asked what kind of knowledge or skills their own profession has from which the other group could benefit, and what information the other group has which the respondent's group values. The two are in close agreement (i.e. no significant differences in number of persons stating each) that psychiatrists can provide information about: neurology, psychopathology, psychological theory, clinical skills, therapeutic skills, and diagnostic methods. Both agree that the social worker has the special functions of providing: knowledge of the patient's family, knowledge and use of community resources, and understanding of the influence of environmental factors in mental health. Although a number of other functions are mentioned, they are discussed less often. Only in the area of the social worker's skill in interviewing is there a significant difference between the expectations of these two professions. Of the social workers 30 per cent see this as a unique ability that they possess, while only 12 per cent of the psychiatrists attribute this skill to them. The difference between these two is significant at the .001 level of confidence.

It was earlier stated that psychiatrists make somewhat less use of the knowledge and skill possessed by social workers, than the other way about. The reasons given by both psychiatrists and social workers for failing to use the resources of those in the other field again indicate the social worker's high respect for the psychiatrist. The reasons given divide into two types: (a) situational or impersonal reasons such as lack of time, lack of opportunity, and physical separation; and (b) interpersonal relations, reasons referring to status conflicts, insecurity, defensiveness, or other attitudinal barriers to ready communication and co-operation.

When explaining why psychiatrists do not seek to profit more from the knowledge and skill of social workers, the majority in both groups perceive that situational matters keep them from having such contacts. Among the psychiatrists, 73 per cent, and of the social workers 60 per cent, of the replies are in the situational category. Only 27 per cent of the psychiatrists' answers refer to the difficulties in interpersonal
relations while 40 per cent of the social workers’ responses are of that type.

In discussing why social workers do not use the knowledge of psychiatrists, the reasons are emotionally toned. The failure of a social worker to use a psychiatrist’s knowledge and skill is unusual behavior. It is seen by the respondents to be due more to problems in interpersonal relations than to situational matters. Sixty per cent of the psychiatrists’ responses refer to interpersonal difficulties and an equal proportion of social workers so respond. About 40 per cent of the replies in each group point to situational reasons.

**Summary**

In general, the average responses fit fairly well the type of feelings that might be anticipated from groups with a difference in status. Social workers are eager to be liked and respected by psychiatrists and place great value on the profession of psychiatry. Psychiatrists also, of course, wish to be valued by social workers, but not so much, and the profession of social work has very little attraction for them as a career. Each group has quite clear perceptions of the other’s functions. Both agree on why it is that one profession fails to benefit from the ability and wisdom of the other. These average responses suggest that the members of the two professions are clear concerning their position in relation to each other, have accepted this placement as proper, and hold attitudes which maximize the possibility that the two groups will supplement each other well.

Let us accept this condition of “good relations” as a base line or average assumption and examine how the location an individual has on various relationship dimensions affects the nature of the affective interactions with members of another group. For the sake of simplicity in presentation, the findings concerning the social worker’s perception of her relations with psychiatrists will first be described and this will then be followed by a description of the psychiatrist’s view of his relations with social workers.

**Perceived Position on Independent Variables of Psychiatric Social Workers in Relation to Psychiatrists**

**Perceived Relative Power to Influence**

*More than half of the social workers state that psychiatrists have the greater power in relations between the two groups.* Social workers
attribute somewhat less power to themselves when performing what we may term their traditional duties (case histories and community contacts) than when engaging in the functions of diagnosis and therapy. Sixty one per cent of the social workers believe that psychiatrists have the greater power in regard to case-history writing or making community contacts, 32 per cent state that both groups are equal in these activities, and 7 per cent say that social workers have higher power. When performing the functions of diagnosis and therapy, 55 per cent of social workers believe that both groups are equal, and 21 per cent feel that they have more influence than psychiatrists.

Those social workers who have the most power are eager to avoid contact with psychiatrists. A social worker who perceives herself to have strong power in relation to psychiatrists when performing her traditional responsibilities is different in that respect from the majority of her colleagues. Although there may be sources of uneasiness in this unusual location, there are also obvious satisfactions and advantages in such a high station. One way to maintain this position is to avoid interaction with psychiatrists since most of the collaborative activities a social worker has with the members of the other profession place her in a subordinate position. This is apparent in the following results.

The greater power a social worker attributes to herself in relation to psychiatrists, the less does she wish to have professional contacts with them \((r = -0.41, p < .001)\). (The letter \(r\) indicates that the figure following is the result of determining the coefficient of correlation between the two measures. The \(p\) again indicates the degree of probability that the correlation was a chance occurrence). It is not only job-related contacts she wishes to avoid, however. The more power a social worker perceives herself to have, the less does she tend to want leisure-time contacts with psychiatrists \((r = -0.22, p < .01)\). This preference for keeping her distance appears to be reflected in the measure of her readiness to talk to psychiatrists. The greater her power, the less is she likely to converse with psychiatrists regardless of the topic \((r = -0.22, p < .01)\). These correlations are stronger when performing case-history writing and community contact functions than when doing diagnosis and therapy. Perhaps the social worker’s confidence in herself is greater when she perceives herself to have high power in the traditional functions usually included in her role.

It was noted earlier that social workers as a group are eager to be liked by psychiatrists. Results seem to indicate that the social worker who assigns high power to herself does not feel the same way as the
average member. The social worker who feels that she has much power has less desire to be liked by psychiatrists \((r = -0.26, p = 0.01)\), and feels that she would not "get along" with them \((r = -0.18, p = 0.05)\).

The social worker who believes that she has considerable influence upon psychiatrists, then, is somewhat less interested in building accepting relationships with them than the one who perceives herself to have little power.

**Acceptance of Power Position**

*Almost half of the social workers feel that their power should be greater than it now is in their relations with psychiatrists.* In respect to the case-history and community contact functions, 49 per cent say that the social worker should have more power than she now has, 23 per cent believe that her power should remain as it is, and 28 per cent state that she should have less power than she now possesses. The proportions in the various responses are roughly similar in regard to the diagnosis and therapy functions.

The characteristics of the social workers who want more power in one set of functions are somewhat different from the characteristics of those who want more power in the other set of functions. The reason for these differences, it is believed, is that the two types of function generate unlike relations between social workers and psychiatrists.

While performing the functions of case-history writing and making community contacts, the social workers who most desire an increase of power are those who have the least perceived power and the most frequent contacts with psychiatrists. The correlation between the desire for greater power and the present degree of power is \(-0.39\), which is significant at the .001 level. The relations between contact frequency and desire for influence is \(0.30 (p = 0.01)\).

The social workers who wish for more power in regard to diagnostic and therapeutic activities tend to be those with most prestige \((r = 0.25, p = 0.01)\), and tend to feel satisfied concerning the frequency with which psychiatrists come to them for advice \((r = 0.21, p = 0.01)\).

*The social worker with a strong desire for more power tends to be sensitive about the respect she receives from psychiatrists.* The more a social worker feels that she should have greater influence upon psychiatrists the stronger is her wish to be respected by them \((r = 0.21, p = 0.02)\) and the more she feels that psychiatrists do in fact respect her \((r = 0.32, p = 0.01)\). An interesting sidelight is the finding that the more a social worker wishes for influence, the less is she willing to talk to
psychiatrists about any mistake she may have made on the job \((r = -0.24, p < .01)\). It seems probable that the ambitious social worker is alert to the need for respect from psychiatrists because such an accepting relationship is likely to increase her chances of obtaining more influence.

**Frequency of Professional Contacts**

*Social workers tend to have frequent professional contacts with psychiatrists.* Their responses separate into three broad categories: 62 per cent state that they have daily contacts with psychiatrists, 18 per cent state that contacts occur once at least a week, and 20 per cent state that contacts occur monthly or less often.

*Social workers having the highest status have the fewest contacts with psychiatrists.* When a social worker works with a psychiatrist she is usually in an assisting capacity. It would be expected, therefore, that the most powerful social workers, as well is those with the most prestige, would seldom have contacts with psychiatrists since they are less likely to want to be assistants. Thus, the more power the social worker attributes to herself, the less contacts she has with psychiatrists \((r = -0.29, p < .01)\); and the more prestige she has, the fewer contacts she has with them \((r = -0.21, p < .01)\).

*The more contacts a social worker has with psychiatrists, the more she feels accepted by them and comfortable with them.* The correlation between frequency of contact and the belief that psychiatrists like the respondent is 0.46 \((p < .001)\). The greater the contact, the more the social worker also tends to feel that she is respected by psychiatrists \((r = 0.26, p < .01)\).

Frequent professional contacts lead to cordial relations. The more frequent the contacts, the greater is the social worker's satisfaction with professional relations \((r = 0.21)\), the more she wants future professional contacts \((r = 0.84)\), the more she seeks leisure-time contacts \((r = 0.40)\), the more she feels that she would "get along" with psychiatrists \((r = 0.22)\), and the more she is ready to communicate with them \((r = 0.21)\). Frequent professional contacts apparently help social workers to build positive relations with psychiatrists, as social workers view the matter.

**Professional Knowledge and Skills**

*Fifty per cent of the social workers say that psychiatrists have more knowledge and skills than themselves,* 41 per cent state that both groups
have equal knowledge and skills, and 9 per cent believe that social workers have more.

Those with the most favorable opinions of their own competence tend to be sensitive to the need to appear competent and to feel that they are esteemed by psychiatrists. The higher the social worker's perceived knowledge and skill the more she is likely to feel that psychiatrists respect her \((r = .24, p .01)\). The topics which she is willing to discuss with psychiatrists indicate that she is ready to foster this favorable perception. A social worker who values highly her own knowledge and skills is more willing to talk to psychiatrists about the quality of social work training \((r = .18, p .05)\) and her personal successes \((r = .19, p .05)\), but is quite unwilling to talk about any mistakes she may have made \((r = -.25, p .01)\). Finally, she hopes to improve her status by attempts to decrease the power of psychiatrists; the greater her knowledge and skill, the more willing is she to admit to such attempts \((r = .21, p .01)\).

**Satisfaction with Interrole Relations**

Most of the social workers (over 80 per cent) express strong satisfaction concerning their professional relations with psychiatrists. The degree of satisfaction in each of the two major sets of functions is shown in Table 5.

**Table 5**

<table>
<thead>
<tr>
<th>Social work functions</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and therapy</td>
<td>7 %</td>
<td>10 %</td>
<td>83 %</td>
</tr>
<tr>
<td>Case histories and community contacts</td>
<td>16 %</td>
<td>0 %</td>
<td>84 %</td>
</tr>
</tbody>
</table>

Those social workers who are generally satisfied concerning their experiences with psychiatrists in the past express favorable attitudes and describe potentially rewarding interactions with psychiatrists. Correlations between satisfaction of social workers in professional relations with psychiatrists and attitudes toward psychiatrists may be seen in Table 6.

These correlations also indicate that those who are least satisfied with the nature of their past experience with psychiatrists are most likely to express negative feelings. The more satisfied the social worker
Correlations Between Satisfaction of Social Workers in Relation to Psychiatrists and Certain Attitudes toward Them

<table>
<thead>
<tr>
<th>The greater the satisfaction of the social worker —</th>
<th>Functional areas</th>
<th>Social history &amp; community contact r</th>
<th>Value of p</th>
<th>Diag. and therapy r</th>
<th>Value of p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The less they perceive psychiatrists as trying to keep PSW's income down.</td>
<td></td>
<td>-.27</td>
<td>.01</td>
<td>.27</td>
<td>.01</td>
</tr>
<tr>
<td>The more they feel psychiatrists like PSW's.</td>
<td></td>
<td>.28</td>
<td>.01</td>
<td>.36</td>
<td>.001</td>
</tr>
<tr>
<td>The less they stereotype psychiatrists as &quot;threatening.&quot;</td>
<td></td>
<td>-.19</td>
<td>.05</td>
<td>-.19</td>
<td>.05</td>
</tr>
<tr>
<td>The more they feel psychiatrists respect PSW's.</td>
<td></td>
<td>.22</td>
<td>.01</td>
<td>.26</td>
<td>.01</td>
</tr>
<tr>
<td>The less they seek to &quot;curry favor&quot; with psychiatrists.</td>
<td></td>
<td>-.20</td>
<td>.02</td>
<td>-.23</td>
<td>.01</td>
</tr>
</tbody>
</table>

is concerning the nature of her relations with psychiatrists (while engaging in case-history writing or community contacts), the more she wishes for frequent professional contacts with psychiatrists, and for leisure-time contacts as well. These two correlations are .32 and .27 respectively; both are significant at better than the .01 level of confidence.

*Feelings of satisfaction concerning social workers' relations with psychiatrists appear to make communication more free and easy.* The greater the satisfaction they feel with the relationship the more disposed they are to converse (on nine out of eleven possible topics) with psychiatrists. (The correlations all fall in the range from .20 to .25 and are significant at the .02 level or better.) This same trend appears in the summated score on readiness to talk to psychiatrists, the correlation being .27 which is significant at the .01 level of confidence. Indeed, when highly satisfied with professional relations, social workers are more disposed to talk to psychiatrists than to their own group (*r* = .21, *p* .01).

We have reported earlier that it is the psychiatric social workers with the most power who attempt to create distance between themselves and psychiatrists by avoiding contact with them. Presumably these are social work supervisors, or perhaps they are members of the profession who have earned power because of competent performance. In addition, it has been noted that those describing unsatisfactory relations with psychiatrists also try to avoid contacts with them and are less dependent on them. Thus, it may be expected that the social
workers who are most independent, most distant from psychiatrists, and least “friendly” toward them would be those who are simultaneously high in power and low in satisfaction concerning their relations with psychiatrists.

It may be seen in the following analysis that it is the powerful but dissatisfied social worker who has unfavorable interrole attitudes, and tendencies to behave in ways which are least conducive to smooth relations between the two professions. Her power contributes a feeling that autonomy is possible (or necessary) for her. Her dissatisfaction stimulates her to express hostile feelings toward the other group. She has little interest in winning the approval of psychiatrists, feels that she cannot “get along” with them, has little desire to be liked, and reports overt attempts to decrease the power of the superior group.

The social workers interviewed were divided into four types: high in power and high in satisfaction; high in power and low in satisfaction; low in power and low in satisfaction; low in power and high in satisfaction. The second group were separated and their responses compared to replies made by the other three groups. In the following tabulation it is clear that the group which is high in power and low in satisfaction is strikingly different from the others in their relations with psychiatrists.

Social workers high in power and low in satisfaction in regard to psychiatrists report:

Less that they curry favor with psychiatrists (than do those who are low in both respects).
More that they attempt to decrease the power possessed by psychiatrists (than do those who are high in both respects).
Less that they would “get along” with psychiatrists on a hypothetical committee (than do all other social workers).
Less that they are willing to communicate about their own personal successes to psychiatrists (than do all the rest of the social workers).
Less that they would have light conversation with psychiatrists (than do those who are high in both respects).
More that they would disagree with psychiatrists (than do those who are high in both respects).
Less that they are eager to talk about the inadequacies of their own profession (than do all the rest of the social workers).

All of these comparisons are significant at the .05 level of confidence or better.
Satisfaction from Providing Advice for Others

Data were obtained concerning the degree to which each respondent used the resources that members of the other profession had to "offer him." These findings were reported previously. They indicated that 41 per cent of the social workers feel they utilize the knowledge and skills of psychiatrists, but only 29 per cent report that psychiatrists turn to them for counsel.

Immediately after the above information was obtained the interviewee was asked about "the degree of satisfaction he felt with the frequency that the other members came to him for advice." In answering this question, it should be noted, the person is indicating his satisfaction with the extent to which others come to him in what may be considered a dependent relationship.

The degree of this special type of satisfaction among social workers is as follows: Twenty four per cent say that they have very little satisfaction with the degree to which they serve as counselors, 14 per cent state that their satisfaction is medium, and 62 per cent claim very high satisfaction in this respect. Whatever the frequency with which psychiatrists actually seek the advice of social workers, it is clear that two-thirds of the social workers are content with this aspect of their relations.

The knowledge of a social worker that psychiatrists have come to her for help has a positive effect on her behavior. She acts like a person with confidence and power. There is a correlation of .21 (p .01) between the degree of her satisfaction in this respect and her willingness to mention personal mistakes that a psychiatrist has made. Furthermore, the more satisfied she is with the degree to which psychiatrists come to her for help, the stronger the tendency to tell a psychiatrist about behavior on his part which displeases her personally or makes her uncomfortable. The correlation between satisfaction and readiness to point out such faults is .18 (p .05). Indeed, the more she is satisfied with the psychiatrist's assumption of a dependent position in seeking advice, the more she feels free to communicate to psychiatrists regardless of the topic (r = .20, p .02). Finally the more that a social worker is satisfied with the extent to which psychiatrists have sought her help, the more she is likely to attribute to psychiatrists the stereotype of "striving" (r = .21, p .02). It appears that a social worker who has been asked for advice in the past by psychiatrists feels quite secure and free in her relations with them.

The poise of the social worker under these conditions is reflected in
other ways. The greater the social worker's gratification with the degree to which psychiatrists seek her counsel, the less does she state that she is attempting to encroach on the prerogatives of psychiatrists \( r = -0.19, p < 0.02 \), the less does she envy the income of psychiatrists \( r = -0.20, p < 0.02 \), and the less does she say that psychiatrists are trying to hold down the income of social workers \( r = -0.18, p < 0.05 \).

Lastly, it is fruitful to note the reverse of these correlations, since they indicate a possible source of rivalry and conflict. Envious feelings and suspicions about psychiatrists' motives are more likely to arise, it appears, among those social workers who are dissatisfied concerning the degree to which psychiatrists use the resources of the psychiatric social worker.

### Prestige in Own Profession

*A social worker having much prestige wishes for less contact with psychiatrists and is comparatively unconcerned about the nature of the impression she makes upon them.* Correlations between prestige and attitudes may be seen in Table 7.

#### TABLE 7

<table>
<thead>
<tr>
<th>The greater the prestige of the social worker</th>
<th>( r )</th>
<th>Value of ( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>The less the desire for leisure time with psychiatrists</td>
<td>-0.27</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less the desire for professional contact with psychiatrists</td>
<td>-0.27</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less the wish to be liked by psychiatrists</td>
<td>-0.19</td>
<td>&lt;0.02</td>
</tr>
<tr>
<td>The less the attempts to curry favor with psychiatrists</td>
<td>-0.26</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less striving for recognition from psychiatrists</td>
<td>-0.23</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less competing with psychologists for approval of psychiatrists</td>
<td>-0.32</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less encroaching upon psychiatrists' functions</td>
<td>-0.27</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>The less the desire to talk to psychiatrists</td>
<td>-0.22</td>
<td>&lt;0.02</td>
</tr>
<tr>
<td>The less the wish for light conversation with psychiatrists</td>
<td>-0.22</td>
<td>&lt;0.02</td>
</tr>
</tbody>
</table>

It is apparent that the higher the prestige of the social worker, the less she desires to spend leisure time with psychiatrists and the fewer number of professional contacts and conversations she wants with them. Also, the higher her prestige, the less does she feel that she is attempting to curry favor with psychiatrists, striving for recognition from them, or competing with psychologists for the approval of psychiatrists. And finally, the higher a social worker's status within her own profession the less eager does she feel to be liked by psychiatrists.
In the light of the above results, it may be expected that the high-status social worker would be more likely to feel dissatisfied concerning her relations with psychiatrists. It is as though the source of greater satisfaction for her does not stem from psychiatrists but from the persons within her own profession. The results are in accord with this expectation. The higher the prestige of the social worker, the greater is her dissatisfaction ($r = -0.54$, $p = 0.001$) when writing case histories or making community contacts. The same trend is apparent when doing diagnosis or therapy. Here the correlation between prestige of the social worker and her satisfaction is $-0.33$ ($p = 0.01$). It seems quite clear that a highly valued member of the social work profession is more likely to be dissatisfied concerning the nature of the relationships she has with psychiatrists.

**Summary of Social Workers' Attitudes toward Psychiatrists**

A dominant theme in the average relations between psychiatric social workers and psychiatrists is one of satisfying, close, and comfortable interactions. Many factors contribute to this situation, but of primary importance is the clear delineation of functions of the two groups and the well-defined integration of their professional activities. A high proportion of social workers tend to accept the superior power of psychiatrists; and thus their security is enhanced by working with the higher-power persons in a well-ordered set of functions.

The social workers who are most satisfied and at ease with psychiatrists have positions most typical of their traditional place in the hierarchy of the mental health professions. That is, the social workers having the least power to influence psychiatrists, and the least prestige within the social work profession most often feel that satisfactory relations exist between themselves and psychiatrists. They are also likely to have the most frequent contacts with psychiatrists and to want more contacts with them.

In contrast, the social workers who are most dissatisfied concerning relations with psychiatrists, and who are least comfortable in relations with them, are those who are most independent. These are the social workers who attribute high power to themselves, who have much prestige in their own profession, and who have little direct contact with psychiatrists. A number of these persons may be social work supervisors. In any case, it is quite apparent that they have risen above most of the members of their group in several important respects and are free to behave and react differently toward psychiatrists than the social workers.
worker low in prestige and power. Perhaps their needs for higher status have been strongly aroused; or perhaps they view themselves as persons with a superior position, and act in a manner which will protect this perception of themselves. This notion of superiority seems most likely since the social workers who are most dissatisfied concerning relations with psychiatrists tend to want autonomy, as shown by their desire to avoid contacts with psychiatrists.

In short, a crucial basis of the social workers' satisfaction in relations with psychiatrists is the acceptance of their traditional position as helpers and assistants.

**PERCEIVED POSITION ON INDEPENDENT VARIABLES OF PSYCHIATRISTS IN RELATION TO PSYCHIATRIC SOCIAL WORKERS**

**Perceived Relative Power to Influence**

In the review of the role relations literature contained in Chapter 1 it was observed that the psychiatrist is usually the responsible supervisor in therapeutic activities. The data show that psychiatrists accept this responsibility. About 80 per cent of the psychiatrists feel that they have greater power when they compare their own influence to that possessed by social workers. Furthermore, less than one per cent of the psychiatrists believe that social workers have any power over them at all. The rest of the psychiatrists feel that the power of the two groups is about equal. This was true in all functional areas.

It is clearly part of the mores of the medical profession that ancillary groups have been developed to assist the doctors. Psychiatrists, in the light of this role expectation, think of themselves as the persons who primarily make the decisions, give the instructions, and carry the weight of the responsibility in treating sick people. One would anticipate, therefore, that a psychiatrist who attributes high power to himself would be comfortable in his relations with the members of the adjunct professions.

The ease in this relationship is apparent in the fact that the more power a psychiatrist perceives himself to have the greater is his tendency to feel that social workers both respect and like him. The correlation between power and respect is .21 and that for liking is .29. Both correlations have significance levels of better than .02.

The relative security of a psychiatrist with high power is also shown in his belief that social workers seek to win his favor. The more power
the psychiatrist attributes to himself the more he feels that social workers are striving for his profession's approval and recognition. The correlation between these two variables is .28 (p .01). In addition, the greater his perception of his own power, the more likely is he to say that social workers attempt to curry favor with psychiatrists (r = .19, p .02).

Given the fact that the psychiatrist who assigns high power to himself feels confident of the social workers' esteem and their efforts to win good will, it is reasonable to assume that he welcomes continued and frequent collaboration with them. The more power a psychiatrist has, the stronger is his desire for more professional (but not leisure-time) contacts with social workers. The correlation between these two is .33 and the p value is .01. Likewise, the greater the psychiatrist's power the more he would prefer to talk with a social worker on any topic in preference to talking with a member of his profession (r = .22, p .01). Finally, it is interesting to observe that the more power a psychiatrist attributes to himself, the more professional contact he regularly has with social workers. The correlation between power and the frequency of professional contact is .37 (p .001). It may be remembered that among social workers it is those with the least power who have the greatest number of professional contacts with psychiatrists. Thus, the most powerful psychiatrists and the least powerful social workers are most often in a working relationship.

A reasonable conclusion is that powerful psychiatrists like to talk to social workers and like to work with them because the psychiatrists are comfortable and confident in this relationship.

Acceptance of Power Position

The psychiatrists on the whole have no strong need to increase their influence over social workers. When asked how much power they should have, in comparison to the amount social workers should have, their replies fall into three categories: 38 per cent say that they should have more power than they now have and social workers less, 39 per cent feel that their own should remain as it is, and 23 per cent state that social workers should have more than they now have and themselves less.

The psychiatrists who say that they are ready to give social workers more influence (and thus reduce their own) tend to be those who already attribute most power to themselves. The correlation between readiness to share power and the amount of power presently possessed by psychiatrists is .57 (p .001). Apparently when psychiatrists perceive
themselves as having considerable power, they feel that they can afford to allow some increase in the power of the ancillary group. This interpretation is consistent with the finding that it is the members of the psychiatric profession with more prestige who are willing to state that social workers should have more power \((r = .20, p .02)\).

Of the other interrole attitudes and behaviors toward social workers which were correlated with the measure concerning the desire for greater power, none reach statistical significance. Those psychiatrists with a strong desire for power are hardly different in their attitudes toward social workers from those who are willing to reduce their own power. Seemingly, a psychiatrist's evaluation of his power position does not greatly modify his attitudes toward social workers.

**Frequency of Professional Contacts**

*A majority of the psychiatrists have very frequent professional contacts with social workers.* Sixty-two per cent say that they see social workers every day, 18 per cent see them a few times a week, and 20 per cent seldom see social workers.

It has been mentioned that the more powerful psychiatrists have the most frequent contacts with social workers, and that their interactions are relaxed and comfortable. *The psychiatrists who meet with social workers most often feel friendly toward them.* Thus, the more professional contacts a psychiatrist has with social workers, the more does he believe he could "get along" with them as members of the same committee \((r = .27, p .01)\), the more does he desire further professional contacts with the social workers \((r = .83, p .001)\), and the more would

<table>
<thead>
<tr>
<th>Correlations between Frequency of Professional Contact which Psychiatrists Claim to Have with Social Workers and Certain Attitudes Toward the Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more contact a psychiatrist has with social workers —</td>
</tr>
<tr>
<td>The more he believes that social workers respect psychiatrists</td>
</tr>
<tr>
<td>The more he believes that social workers like psychiatrists</td>
</tr>
<tr>
<td>The more he believes that social workers curry favor with psychiatrists</td>
</tr>
<tr>
<td>The more he believes that social workers strive to win the approval of psychiatrists</td>
</tr>
<tr>
<td>The more he feels it necessary to discourage social workers from attempts at currying favor</td>
</tr>
<tr>
<td>The less he stereotypes social workers as &quot;threatening&quot;</td>
</tr>
<tr>
<td>The less he stereotypes social workers as &quot;striving&quot;</td>
</tr>
</tbody>
</table>

55
he welcome further leisure-time contacts \((r = .35, p .001)\). He is also more ready to communicate to social workers when his contacts with members of that profession are frequent. (Table 43-C.)

The psychiatrist’s ease in his contacts with social workers is also demonstrated by his feeling that social workers like and respect him and by his belief that they seek to win his approval. The seven correlations listed in Table 8 illustrate these attitudes. It is worthy of recall that social workers also feel comfortable in frequent interactions with psychiatrists. Apparently frequent contact among the members of these two professions enhances positive feelings and behavior.

**Professional Knowledge and Skills**

Sixty-nine per cent of the psychiatrists state that their own professional knowledge and skill is greater than that possessed by social workers. Twenty-eight per cent report that they are about equal to social workers in this respect, and three per cent feel that social workers have more knowledge and skills than they do.

It is the less confident psychiatrist who is most ready to minimize the competence of social workers. The less power a psychiatrist attributes to himself the greater is the likelihood that he will rate the social workers’ knowledge and skills as low \((r = .26, p .01)\). Also, the less a psychiatrist is satisfied about social workers’ use of his advice, the lower does he place their competence. The correlation between satisfaction and the amount of knowledge and skills attributed to social workers is .25 \((p .01)\).

To the psychiatrist the fact that social workers are seen as highly capable is not a threat. He welcomes frequent contacts with social workers when he believes that they are able people. The correlation between the amount of knowledge and skills attributed to social workers and the willingness to have professional as well as leisure-time contacts with them are both .29 \((p .01)\). This readiness for interaction with social workers is also apparent in the area of communication. A psychiatrist who values highly the competence of social workers would prefer to talk to them than to members of his own profession, regardless of the topic. The correlation here is .30 \((p .01)\).

**Satisfaction with Interrole Relations**

It was reported earlier that social workers are highly satisfied concerning their relations with psychiatrists. Here it will be seen that this
is a mutual perception among the members of the two groups, and that many favorable attitudes accompany these feelings of satisfaction.

Among the psychiatrists 90 per cent stated that they were highly satisfied concerning relations with social workers. Only 2 per cent expressed feelings bordering on dissatisfaction, and the other 8 per cent had intermediate degrees of satisfaction.

A recurrent theme in the relations among the members of these professions is that psychiatrists are likely to be most positive toward social workers when expectations of being the higher-level group are fulfilled. Here again, the same phenomenon appears. The more power a psychiatrist attributes to himself, the greater is the likelihood that he will express high satisfaction concerning relations with social workers. The correlation between power and satisfaction is .34, which is significant at the .01 level of confidence. Another manifestation of the notion that satisfaction is greatest when status is high may be seen in the correlation between satisfaction with the degree to which others come for advice and general satisfaction with relations \( (r = .47, p .001) \).

Psychiatrists, when their satisfaction with interrole relations is high, have favorable feelings about social workers. When highly satisfied they believe that they can “get along” with social workers, they wish to spend leisure time with them, and they feel admired by them. In addition, satisfied psychiatrists are desirous of working with social workers and are ready to talk to them even in preference to their own group. The correlations between degree of satisfaction and these various measures are listed in Table 9.

Satisfaction is likely to be greater when relations are such that the

| Correlations between the Amount of Satisfaction Expressed by Psychiatrists toward Social Workers and Certain Attitudes |
|---|---|---|
| The greater the satisfaction of a psychiatrist toward social workers | \( r \) | Value of \( p \) |
| The more he feels he would “get along” with social workers if they were members of the same committee | .42 | .01 |
| The more he would like professional contacts with social workers | .45 | .01 |
| The more he wishes to spend leisure time with social workers | .24 | .01 |
| The more he is ready to talk to social workers regardless of the topic | .27 | .01 |
| The more he would prefer to communicate with social workers rather than his own profession | .33 | .01 |
| The more he feels liked by social workers | .33 | .01 |

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The greater the satisfaction expressed by psychiatrists concerning role relations with social workers, the more they tend to perceive social workers as currying favor ($r = .20, p .02$) and striving to win approval ($r = .35, p .01$). Both of these correlations indicate that the psychiatrist is most likely to be satisfied with the role relations when they operate so that the social worker acknowledges the psychiatrist's superiority.

Finally, it is interesting that psychiatrists are more ready to talk about their inadequacies when they are satisfied concerning their relations with social workers. The greater their satisfaction with the other profession, the more likely they are to mention to social workers their own personal mistakes ($r = .34, p .01$) and the faults of their own profession ($r = .25, p .01$). Past experience with the adjunct profession has apparently convinced them that relations are favorable to them and are likely to remain so.

**Satisfaction from Providing Advice for Others**

From the discussion in Chapter 1 we may assume that psychiatrists expect psychiatric social workers to turn to them for direction and supervision. Much of the evidence presented thus far indicates that the social workers also accept this relationship as proper between the two professions.

It may be anticipated that psychiatrists would be satisfied with the degree to which social workers come to them for counsel. *Eighty-one per cent of the psychiatrists are strongly satisfied with the extent to which social workers seek their advice. Only 12 per cent*
have a low degree of satisfaction on this matter and the remaining 7 per cent reveal fairly neutral feelings.

Satisfaction of this special type is closely related to cordial feelings. This fact is demonstrated in Table 10. It is apparent that psychiatrists who are satisfied concerning the frequency with which social workers turn to them for counsel are likely to feel positive toward individual social workers and to desire both professional and leisure-time contacts with them.

**Prestige in own Profession**

Some of the men interviewed were high-ranking members of their profession; others had few of the titles, offices, and other distinctions which were used as criteria for determining prestige within one's own profession. The correlation between a psychiatrist's prestige and his perceived power to influence is zero. Clearly, a psychiatrist's feeling that he has power over social workers is not related to his stature within his own profession. How does prestige influence attitudes toward social workers?

Those psychiatrists who have distinguished themselves within their own profession may be thought of as being strongly involved in their own peer group. They have taken offices, have accepted committee assignments, and have been granted important positions in psychiatric institutions. Their demonstrated interest in being good members of their own profession would lead one to expect that they might consider social workers to be more clearly an “out-group” than the lower-status members of their own psychiatric profession. The data in Table 11 support this expectation.

The attitudes described there indicate feelings of distance toward social workers.

<table>
<thead>
<tr>
<th>TABLE 11</th>
<th>Correlations between Prestige of Psychiatrists and Certain Attitudes toward Social Workers</th>
</tr>
</thead>
</table>
| The greater the prestige of the psychiatrist — |}
social workers. The high-status psychiatrists are less likely to want contacts with social workers and less likely to believe that they would “get along” with them; on the other hand, they are quite willing to discuss controversial matters with them.

Summary of Psychiatrists’ Attitudes toward Social Workers

Psychiatrists know they are members of a superior profession. They are highly confident that they have, on the average, great power to influence social workers, certainly much more than social workers can reciprocate. Furthermore, they believe that they have more knowledge and skills than social workers, and they clearly understand the resources available in the social worker role.

In general, psychiatrists believe relations between the two professions are highly satisfactory. This satisfaction is greatest if the psychiatrist attributes high power to himself and believes that social workers frequently assume a dependent position by coming to the psychiatrist for advice, counsel, or help. Psychiatrists are also more likely to be satisfied if they feel that social workers are capable and skilled. If a psychiatrist is low in power, if he feels that social workers do not seek his aid, or if he believes that social workers are incompetent, he is much less likely to feel that the relationship with the ancillary profession is a satisfying one.

When the psychiatrist is confident of his power to influence social workers, he directs toward them a number of supportive and accepting attitudes; these attitudes are reciprocated. When a psychiatrist has high power, he is willing to state that social workers should have more influence (and he less), he feels less distance between himself and social workers, and he wishes to increase the frequency of contacts and interaction with them. In addition, the belief that his own power is strong apparently leads to perceptions that social workers respect and like psychiatrists and that they strive to win their approval.

The psychiatrist with high prestige within his own profession, as distinct from one with high power over social workers, acts differently. Prestige stems from the recognitions and responsibilities he has won for carrying out the functions of his role in a superior fashion. Perhaps this location makes him more responsive to his own group than to other professions, or perhaps he is too busy with professional duties to have much interaction with social workers. Whatever the cause, it is apparent that the higher status psychiatrist perceives that there is a gap between the two groups and he has little inclination to decrease this distance;
he is ready to allow, however, that social workers should have more power to influence psychiatrists than they currently hold.

**CHAPTER SUMMARY**

The members of the psychiatric and social work professions have established good working relations. They understand the resources of each other's roles and show in many ways that they expect close and comfortable professional interactions.

Strain between members of these professions appears to occur for somewhat different reasons in each field. A psychiatrist feels that relations are less comfortable if he is low in power, feels that social workers do not seek his aid, or believes that social workers are incompetent assistants. In contrast, the social worker is uneasy in relations with psychiatrists when she attributes high power to herself and has little direct contact with psychiatrists. A high-status person in either profession tends to prefer his own group and to avoid the members of the other profession. Apparently a member of either group is most at ease with those in the other profession when he is occupying the position which he traditionally fulfils in the relations between these roles.
CHAPTER 5

RELATIONS BETWEEN PSYCHIATRISTS AND CLINICAL PSYCHOLOGISTS

Clinical psychologists as a professional group are quite different from psychiatric social workers in their task functions, responsibility relations, and aspirations. These differences are important enough to create unique attitudes and behaviors between psychologists and psychiatrists.

The profession of clinical psychology is relatively new. Only recently has the technical specialty of psychometrics ramified into a wider set of skills and knowledge having an organizational framework and written professional standards. During this time clinical psychologists have raised their level of aspiration. They have hoped to widen the range of their services to society and to become better recognized as a profession.

Clinical psychologists not many years ago were primarily engaged in the administration of measuring instruments; today they are doing much more. They often suggest diagnoses, administer therapy, and conduct a variety of research projects related to therapy, diagnostic methods, or personality development. As a result, the interdependence between the professions of psychiatry and clinical psychology has increased. What the eventual distinction between the functions of these two groups may turn out to be, however, is undecided, and doubtless will not be worked through for some time.

A COMPARISON OF THE AVERAGE ATTITUDES OF PSYCHIATRISTS AND CLINICAL PSYCHOLOGISTS TOWARD EACH OTHER

Clinical psychologists are similar to psychiatric social workers in that much of their work with psychiatrists puts them in the ancillary, therefore subordinate, position. Both adjunct groups respond by expressing a need to be admired and esteemed by psychiatrists. It may be seen in Table 12 that the psychologists, more than the psychiatrists, desire professional and leisure-time contact with the other group, and desire more strongly to be liked and respected by them. The psychologists
Comparing the Mean desire for Supportive Relations with Members of the Other Profession as Stated by Psychiatrists and Psychologists

<table>
<thead>
<tr>
<th>Nature of Desire</th>
<th>Mean rating made by:</th>
<th>Psychiatrists re Psychologists</th>
<th>Psychologists re Psychiatrists</th>
<th>p. value of diff between means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire to be respected</td>
<td>3.79</td>
<td>4.44</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Desire for professional contacts</td>
<td>4.66</td>
<td>5.05</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>Desire to be liked</td>
<td>2.72</td>
<td>3.60</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Desire for leisure time contacts</td>
<td>3.28</td>
<td>3.76</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Perception of how much other group &quot;likes&quot; me</td>
<td>3.25</td>
<td>3.51</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>In a committee, would &quot;get along&quot; with —*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) &quot;Best&quot;</td>
<td>85</td>
<td>120</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>(b) &quot;Neutral&quot;</td>
<td>36</td>
<td>29</td>
<td>by chi-square</td>
<td></td>
</tr>
<tr>
<td>(c) &quot;Least&quot;</td>
<td>32</td>
<td>14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Absolute numbers rather than means.

also feel that they would "get along" with psychiatrists on a hypothetical community committee more than the psychiatrists do in respect to them.

An interest in building comfortable relations with the other profession is also apparent in the topics both groups are most disposed to discuss. Table 13 indicates the comparative willingness of psychologists and psychiatrists to converse on various subjects. Psychologists are willing to discuss both the positive and negative aspects of their own profession as well as their personal career successes. There is little readiness to criticize a psychiatrist directly.

The psychiatrists are quite different in respect to preferred topics of conversation. They are unlikely to talk to psychologists about their own profession, or own performance, but they are willing to talk about mistakes made by psychologists. The psychiatrists appear to avoid

Comparing the Mean Desire for Communication with Members of the Other Profession as Stated by Psychiatrists and Psychologists

<table>
<thead>
<tr>
<th>Topic</th>
<th>Mean desire to talk shown by:</th>
<th>Psychiatrists to Psychologists</th>
<th>Psychologists to Psychiatrists</th>
<th>p. value of diff between means</th>
</tr>
</thead>
<tbody>
<tr>
<td>My profession's positive characteristics</td>
<td>2.08</td>
<td>2.74</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>My profession's inadequacies</td>
<td>2.65</td>
<td>3.08</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>My personal successes</td>
<td>2.12</td>
<td>2.61</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>My profession's skill</td>
<td>2.65</td>
<td>3.05</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>The other group's failures</td>
<td>2.39</td>
<td>1.92</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>
subjects which bring up their profession as a topic of conversation and which might create questions about its nature or about their own adequacy.

*Psychologists attribute high value to the psychiatric profession.* When they were asked to choose between their own career and psychiatry, assuming that they were able to begin their training anew, 42 per cent of the psychologists said that they would prefer to be psychiatrists; whereas all of the psychiatrists preferred their own field. When asked which profession would make the greatest contribution to a committee concerned with community mental health problems, psychologists ranked psychiatrists significantly higher (a mean of 3.10, lower number = higher rank) than they themselves were placed by the psychiatrists (a mean of 5.84). The significance of this difference has a $p$ value of .001.

Psychologists tend to assign less monetary value to their profession than to psychiatry. Less than 2 per cent of psychologists believe that they should earn more than psychiatrists do, whereas 85 per cent of the psychiatrists feel that their earnings should exceed a psychologist's. Almost half the psychologists state that their income should be less than that of psychiatrists, but only one psychiatrist believes that his salary should be less than that of psychologists. It seems clear that both groups agree that psychiatrists should be paid more money for their services than psychologists.

*Both the psychologists and psychiatrists are in general agreement as to many of the areas in which psychiatrists are competent.* In answer to an open question concerning the unique knowledge of each group, the responses about the psychiatrists' functions occurred in the following order of frequency: knowledge of psychopathology, clinical approach and attitudes, general clinical skills. In these areas of knowledge and ability there were no statistically significant differences in the frequency of replies by the members of the two groups when describing the resources of psychiatrists. (Table 44.)

In regard to several other types of knowledge, however, psychologists expected to benefit from psychiatrists more than the psychiatrists perceived themselves able to provide it. Psychologists attribute to psychiatrists a knowledge of neurology and a knowledge of therapeutic theory and methods more than the psychiatrists assigned this special knowledge to themselves. Since the freedom to engage in therapy is a crucial issue among these professions, it is striking that fewer psychiatrists perceive themselves as competent in that function than psychologists view them to be. Perhaps this denial implies an uneasiness.
or unwillingness on the part of psychiatrists to have psychologists benefit from such knowledge. Psychiatrists see themselves differently than do psychologists in one other respect. They anticipate that they can provide clinical psychologists with more information about psychodynamics than the psychologists state they would expect. Apparently psychiatrists feel that it is appropriate to share knowledge in this area more than psychologists seek it.

Disagreement is greater, however, in respect to the psychologists. The psychologists state that they can offer to psychiatrists knowledge and ability in psychological theory, diagnostic skills, and research methods. Psychologists mention all of these functions as attributes of their role significantly more than psychiatrists do. About 85 per cent of the psychiatrists expect psychologists to offer primarily one function, psychometrics, whereas less than half of the psychologists see this as an important skill they have to offer.

The two groups, then, have important differences in their perceptions of the functions included within the role of “clinical psychologist.” Most psychiatrists believe that a psychologist is one who primarily administers various measuring devices. There is little perception of the broader range of services which psychologists attribute to themselves. As a result of these differences in expectations it is probable that psychologists feel that their resources are poorly used.

In point of fact, only 18 per cent of the psychologists believe that psychiatrists make use of the knowledge and skills possessed by the ancillary profession. The reasons given by psychologists as to why psychiatrists seldom attempt to benefit from their professional help refer to situational matters (57 per cent) more than interpersonal difficulties (43 per cent). The psychiatrists’ reasons for failing to draw on psychologists’ resources fall about evenly in each category.

A majority of psychiatrists, in contrast, state that psychologists benefit from the competence of psychiatrists. Their explanations as to why some psychologists do not so benefit break evenly between the interpersonal and situational categories.

Psychologists, however, indicate that interpersonal problems are the major barriers when psychologists fail to take advantage of psychiatrists’ help. Sixty-two per cent of their responses fall into that category while only 38 per cent are situational reasons. The sensitivity of the psychologists to the quality of interpersonal relations with psychiatrists is apparent.

We have seen that the psychologists view themselves as persons who
can do more than administer psychometric tests, but that psychiatrists do not tend to see these wider functions as part of the psychologist's role. Are the psychiatrists not aware of the psychologist's broader skills? Or, do they know about them but consider them unimportant? These data cannot answer this question with finality but there is evidence that psychiatrists are alert to the ambitions of psychologists and that they are uneasy and uncertain about the proper relation between themselves and the other group.

In Table 14 the mean scores are shown on a number of questions concerning attitudes toward encroachment and role conflict. The psychiatrists perceive psychologists as encroaching on psychiatric functions, as seeking to enter private practice, as "threatening," as seeking to win approval, and as envying the psychiatrist's income more than the psychologists report these attitudes and behaviors about themselves. The psychiatrists on the average maximize the encroachment desires of the psychologists, whereas the psychologists minimize them. Psychologists more often stereotype psychiatrists as "striving" or as fearing psychologists to be a financial threat.

### Table 14
Average Responses of Psychologists and Psychiatrists Concerning Each Other's Motives

<table>
<thead>
<tr>
<th>Question Topic</th>
<th>Psychiatrists' Mn. Responses re Psychologists</th>
<th>Psychologists' Mn. Responses re Psychiatrists</th>
<th>p value of diff. between means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists attempting to encroach on psychiatric functions</td>
<td>3.93</td>
<td>3.04</td>
<td>.01</td>
</tr>
<tr>
<td>Psychologists entering into private practice</td>
<td>5.05</td>
<td>4.06</td>
<td>.01</td>
</tr>
<tr>
<td>Psychologists as a threat to psychiatrist's income</td>
<td>3.45</td>
<td>4.43</td>
<td>.001</td>
</tr>
<tr>
<td>Psychologists envy of psychiatrists' greater income</td>
<td>5.46</td>
<td>5.06</td>
<td>.01</td>
</tr>
<tr>
<td>Psychologists striving to win psychiatrists' approval</td>
<td>4.36</td>
<td>3.19</td>
<td>.001</td>
</tr>
<tr>
<td>Stereotype other group as:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;threatening&quot;</td>
<td>5.14</td>
<td>3.16</td>
<td>.01</td>
</tr>
<tr>
<td>&quot;striving&quot;</td>
<td>2.17</td>
<td>2.46</td>
<td>.05</td>
</tr>
</tbody>
</table>

Finally the psychologists stereotype psychiatrists as "insightful," "mature," and "defensive," while psychiatrists characterize psychologists as "well-trained," "scientific," and "likeable" but also tending to be "dogmatic," and "condescending" (See Table 42).
SUMMARY

On the whole, these average responses are again close to what one might expect from two groups on different levels in a social structure. The psychologists are eager to be admired and esteemed by psychiatrists. The psychiatrists are not so eager to be liked and respected by psychologists and the clinical psychology profession has very little attraction for them as a career.

Both groups have minor differences of opinion as to the functions in which psychiatrists are most competent, but there is clear disagreement between the two as to the activities appropriate to be included within the psychologist's role. The psychologists view themselves as able and willing to provide services beyond psychometrics but the psychiatrists attribute to them primarily test-giving functions. These responses suggest that the two professions are not in accord concerning their interdependence and that members of the two roles are in a stage of defining their collaborative activities and their expectations for mutual working relations. There is not yet, as in the average relationship between psychiatrists and psychiatric social workers, agreement on the proper co-ordination of their functions by both groups.

The effect of this state of flux and potential change is dramatized by the findings that the psychiatrists see the psychologists as encroaching, envious, and striving much more than the psychologists perceive these qualities in themselves. Although the psychologists strongly wish to be admired and appreciated by psychiatrists, there are attitudes present which are indicative of potential problems in the relations between the two groups.

PERCEIVED POSITION ON INDEPENDENT VARIABLES OF PSYCHOLOGISTS IN RELATION TO PSYCHIATRISTS

Perceived Relative Power to Influence

Although the psychologists are eager to increase their professional stature, the majority perceive themselves to have little power to influence psychiatrists. The degrees of power that psychologists assign to themselves in their relations with psychiatrists are highly intercorrelated in the three functions of diagnosis, therapy, and determination of own case assignments. The power measure used for this group is a summation of the separate replies in each of these three areas. In terms of this index, 51 per cent of the psychologists indicate that they believe
psychiatrists to have power which is greater than their own, 20 per cent feel that they have much power to influence psychiatrists, and 29 per cent perceive themselves as being equal to psychiatrists in the amount of power they possess.

One of the features which distinguishes the powerful psychologist from other psychologists is his high status within his own profession. The correlation between prestige and power is .35, which has a p value of .01. Either a psychologist earns prestige by having a position in which he has influence upon psychiatrists, or psychologists with much prestige have responsible and independent jobs which make them less "available" to psychiatrists' influence. It cannot be said with exactness which interpretation is closer to the truth, but the second explanation seems more reasonable since the more power a psychologist has, the less frequent are his contacts with psychiatrists (r = -.47, p .001).

A psychologist who attributes high power to himself also wishes to keep the frequency of contacts as low as possible (r = -.45, p .001).

The possession of power, we believe, is a rewarding state for a psychologist since it increases his control over his own fate and therefore increases his freedom to meet his professional needs. The powerful psychologist has a strong wish to identify himself as a psychologist, presumably because it is in this role that he has attained to this desirable degree of power and because he may profit from the support given him by colleagues. The psychologist with the greater power in relations with psychiatrists is most attracted to the profession of psychology, whereas the less powerful psychologist is more attracted to psychiatry (chi square, p .001).

If a psychologist who attributes high power to himself is more attracted to his own profession, it may be anticipated that he, in contrast to the average psychologist, would have little need to make a favorable impression on psychiatrists since he would obtain respect from his own colleagues. The psychologist who is powerful tends to report that he does not curry favor with psychiatrists (r = -.22, p .02), and that he makes few attempts to gain psychiatrists' recognition (r = -.29, p .01). When asked about the degree to which he feels he is in competition with psychiatric social workers for the approval of psychiatrists, he rejects this imputation. [The correlation between amount of power and competition with social workers is -.27 (p .01).] The greater his power, the less he feels that he would "get along" with psychiatrists were they both members of the same committee, (r = -.27, p .01). And finally, the more powerful psychologist seems to feel able to speak
frankly to psychiatrists concerning any behavior which he considers unpleasant (r = .21, p .01), and to mention the mistakes of a psychiatrist to him directly (r = .21, p .01).

The powerful psychologist, therefore, is less likely to be concerned with what psychiatrists think about him and his self-perception of greater power generates behavior in which he avoids their influence.

Acceptance of Power Position

Half of the psychologists expressed a desire to obtain greater power for themselves: 49 per cent felt that they should have greater power in relation to psychiatrists than they now have, 24 per cent said that their power should remain as it is, and 27 per cent stated that psychiatrists should have the greater power.

The psychologist who has less power is most likely to desire greater power. The correlation between the current amount of power held by the psychologist and his desire to obtain more is -.53 (p .001).

An interesting thing happens when we consider the knowledge and skill a psychologist attributes to himself. The psychologist who is low in power wishes for more regardless of the degree of knowledge and skill which he attributes to himself (See Table 15). A psychologist who feels confident of his own knowledge and skill, however, while he is also high in power, has a stronger yearning for an increase of influence than one who has little knowledge and skill accompanying his high power.

<table>
<thead>
<tr>
<th>TABLE 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mean Desire for Greater Power in Relation to Psychiatrists Expressed by Psychologists with Varying Degrees of Power and Knowledge</td>
</tr>
<tr>
<td>Amount of knowledge and skills</td>
</tr>
<tr>
<td>Amount of power to influence</td>
</tr>
<tr>
<td>* Numbers in cells describe mean desire for power to influence, 1-low, 7-high. Significant differences, .01 level (reading from left): Low-High &amp; Low-Low greater than High-High &amp; High-Low, High-High greater than High-Low.</td>
</tr>
</tbody>
</table>

These results indicate, we believe, that an attribution of high power to oneself provides the person with an awareness that he has already fulfilled an important group goal; namely, to be influential in relations with psychiatrists. Psychologists with high power, then, do not ordinarily aspire to more power. If, however, a psychologist with high power also believes he is high in knowledge and skill, the strong faith in his own
competence stimulates him to aspire to even greater power than his professional group desires. The psychologist who is low in power, in contrast, is still under the influence of the group goal and wishes to increase his power regardless of his individual knowledge and skill.

The interrole attitudes associated with a desire for power indicate a complex pattern of behavior toward the other group: rejection and attraction, hostility and friendliness, conflict and dependency, depending upon the strength of his wish for more influence and the strength of his present power. This ambivalence occurs, it appears, because the psychologist views the psychiatrist as a potential barrier to upward mobility, a barrier which must be treated in such a way that the psychiatrist's greater power is used in a helping rather than a frustrating fashion.

There are several kinds of indications that psychiatrists are seen as possible frustraters of a psychologist's wish for more influence. The stronger a psychologist's desire for increased power, the more he tends to blame psychiatrists for attempting to keep the psychologist's income down ($r = .21, p .01$). The psychologist who wishes for greater power is most likely to see psychiatrists as "threatening" ($r = .20, p .01$). And, the greater the psychologist's yearning for increased power, the more he frankly says that he is encroaching upon the psychiatrist's prerogatives ($r = .21, p .01$).

But a desire for power does not generate only negative attitudes since the more a psychologist wants power the more he is attracted to the profession of psychiatry rather than his own. (This analysis was done by chi square with a $p$ value of .001.) The more he desires power, the more he admits that psychologists find it necessary to curry favor with psychiatrists from time to time ($r = .19, p .02$), and the more he envies the psychiatrist's income ($r = .22, p .01$).

Thus, the desire for power seems to awaken feelings of uneasiness as well as hostility concerning relations with psychiatrists, yet these attitudes are accompanied by an awareness of the need for behavior which will stimulate the psychiatrist to use his power in a rewarding manner.

**Frequency of Professional Contacts**

Sixty per cent of the psychologists state that they work with psychiatrists practically every day, 23 per cent state that their contacts with the other group occur monthly or less often, and the other 17 per cent of responses fall between these two extremes.
The psychologists who work with psychiatrists most often are the least powerful. (The correlation between frequency of professional contacts and the perceived amount of own power is -.47.) It will be recalled that the less powerful psychologists are also those with the strongest desire for power. Thus, the psychologists who work with psychiatrists most often are in positions of little influence, have a strong desire to increase their power, and are frequently reminded of their lack of power by their position in the many interactions with psychiatrists.

To fulfill their professional aspirations psychologists may: (a) avoid psychiatrists, (b) attempt to reduce the power of psychiatrists, or (c) seek to win the approval of psychiatrists so that they may be allowed professional autonomy and granted respect. The psychologists who have frequent contacts with psychiatrists, however, are by that fact those who have not been able to avoid them, nor have they managed to reduce the power of the psychiatrists in relation to themselves. The psychologists' attitudes toward psychiatrists reveal that they are aware of their dependency upon psychiatrists and try to make a favorable impression on them.

The more contact a psychologist has with psychiatrists the more he believes that he would "get along" with them were they members of the same committee. (The correlation between frequency of professional contact and "getting along" is .37 which has a confidence level of .001.) Furthermore, the psychologist who most often works with psychiatrists wishes to have even more contacts than he presently has, both professional and leisure-time. (The correlations between frequency of contact and the desire for more professional interaction is .90, and the desire for leisure time together is .41.) The more a psychologist works with psychiatrists, the greater is the tendency for him to feel that he is liked and respected by them. (The frequency of contact correlates with perception of being liked and respected .21 and .26, both of which have p values of .01.) Clearly, the psychologist who often meets with psychiatrists believes that things go well and he would like that cordial relationship to continue.

Do these data mean that the psychologist who often meets with psychiatrists gives up a desire for improved professional stature? This may be true in part, but the weight of the evidence makes it appear more likely that psychologists work toward their professional goals by seeking to win approval for themselves. The more professional contact a psychologist has with psychiatrists, the greater is the probability that
his he feels it necessary to "soft soap" psychiatrists from time to time \((r = .26, p .01)\), and the more he states that he strives for the approval and recognition of psychiatrists \((r = .39, p .01)\). His aspirations, as well as his ambivalent attitudes, are most vividly revealed in the fact that the more professional contact he has, the more likely he is to encroach on the prerogatives of psychiatrists \((r = .21, p .02)\) and the more likely he is to try to decrease their influence \((r = .20, p .02)\).

In summary, the psychologists who are low in power and who have strong desire for greater power have frequent professional contacts with psychiatrists. These psychologists wish for even more frequent contacts with the other group. They accept the benefits of the relationship and maximize them as much as possible by attempting to win the good will of psychiatrists.

**Professional Knowledge and Skills**

_While psychologists as a group have great admiration for the abilities of psychiatrists, almost half of them feel equal to psychiatrists in this respect._ When asked how their own knowledge and skill compares to that of psychiatrists, 30 per cent stated that psychologists have more, 25 per cent stated that psychiatrists have more, and 45 per cent stated that both groups are equal.

Compared to the social workers, 50 per cent of whom feel that psychiatrists are superior in knowledge and skills, it is clear that the psychologists have relatively stronger feelings of professional competence. Fully 75 per cent believe that in professional ability they are equal to, or better than, psychiatrists. Presumably a majority feel that they are capable of fulfilling the expanded role which they aspire to create.

_Psychologists who have a more positive evaluation of their own competence have greater pride in their own profession._ When self-attributed knowledge and skill was related with preference for various professional fields it was found that the more ability a psychologist believes himself to have, the more likely is he to choose psychology rather than psychiatry as a favored career \((\chi^2 = .05)\). Thus, when he feels competent he is more content with being a psychologist. In support of the same thesis is the fact that the more ability a psychologist assigns to himself the greater is his readiness to enter private practice \((r = .21, p .01)\), and the greater is his willingness to direct communications toward members of his own profession rather than to psychiatrists despite the fact that upward-directed communica-
tion is a common tendency as a substitute for upward mobility (22). The correlation between amount of own competence and preferred communication to own group is .20 \( (p .02) \). Finally, the psychologist who attributes high knowledge and skill to himself is more likely to say that he would not "get along" with psychiatrists were they members of the same committee \( (r = -.24, p .01) \).

A psychologist's confidence in his own ability seems to operate in the same manner as his perceived power to influence. Both factors lead him to a stronger identification with his own professional group and to a lesser dependence upon psychiatrists. Power, however, is much more likely to be associated with such attitudes than is degree of knowledge and skill.

**Satisfaction with Interrole Relations**

*Most of the psychologists state that they are quite well satisfied concerning the relations they have with psychiatrists in their professional activities.* 80 per cent express high satisfaction, 7 per cent say that they are dissatisfied, and the other 13 per cent fall between these two extremes.

The more satisfaction the psychologist reports concerning relations, the more positive are his stereotypes about psychiatrists. He tends to see psychiatrists as more "likeable" \( (r = .23, p .01) \), less "threatening" \( (r = -.25, p .01) \), and less "striving" \( (r = -.25, p .01) \).

*A psychologist appears to be more secure in his relations with psychiatrists when he feels satisfied concerning relations with them.* As may be seen in Table 16, the psychologist who is satisfied concerning his role relations with psychiatrists reports a series of feelings which are indicative of trust in the other profession's members, and a relative lack of conflict with them. The psychologist envies psychiatrists less, feels that he would "get along" with them on a committee, and is ready to discuss various topics, even those which make his own weaknesses visible. In effect, the psychologist is less threatened when he is satisfied concerning his relations with psychiatrists and he has less need to be careful in his communication with them.

Accordingly, the psychologist when highly satisfied is more willing to discuss with psychiatrists any behavior which displeases him and any professional disagreements. The correlations between satisfaction with relations and willingness to talk about these two topics are .28 and .20 respectively, both having \( p \) values of .01. Furthermore, the more feelings of satisfaction a psychologist has, the greater is his
Correlations Between Satisfaction of Psychologists Concerning Relations with Psychiatrists and Certain Attitudes toward Them

<table>
<thead>
<tr>
<th>The greater the satisfaction of the psychologist</th>
<th>r</th>
<th>Value of p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The less he perceives psychiatrists as trying to keep his income low</td>
<td>-0.48</td>
<td>0.001</td>
</tr>
<tr>
<td>The more he feels that he would &quot;get along&quot; with psychiatric members of the same committee</td>
<td>0.46</td>
<td>0.001</td>
</tr>
<tr>
<td>The more is he willing to discuss psychiatrists' successes</td>
<td>0.31</td>
<td>0.01</td>
</tr>
<tr>
<td>The more is he willing to converse about his own successes</td>
<td>0.49</td>
<td>0.001</td>
</tr>
<tr>
<td>The more is he willing to talk to psychiatrists about his own professional mistakes</td>
<td>0.52</td>
<td>0.001</td>
</tr>
<tr>
<td>The more is he ready to describe the inadequacies of clinical psychologists as a group</td>
<td>0.33</td>
<td>0.01</td>
</tr>
<tr>
<td>The more is he ready for light conversation with psychiatrists</td>
<td>0.20</td>
<td>0.05</td>
</tr>
</tbody>
</table>

readiness to speak to psychiatrists no matter what the topic is \((r = 0.40, p = 0.001)\), and he even prefers to communicate with psychiatrists than to members of his own profession \((r = 0.30, p = 0.01)\).

The psychologist who describes relations with psychiatrists as satisfactory feels admired and respected by them. The more satisfaction he expresses the more he believes that psychiatrists like him \((r = 0.51, p = 0.001)\) and respect his competence \((r = 0.73, p = 0.001)\). The high numerical value of this correlation underlines the extreme importance of professional esteem from psychiatrists as a crucial factor in the psychologist's satisfaction in relations with the other group. In fact, the satisfied psychologist believes that psychiatrists have greater respect for psychologists than they do for social workers (chi square analysis, \(p = 0.001\)).

Satisfaction with interrole relations is naturally pleasant and desirable to the psychologist. That this is a condition he would like to maintain is shown by the fact that a psychologist who is highly satisfied is willing to have many professional contacts with psychiatrists \((r = 0.35, p = 0.01)\).

On the contrary, a consistent theme of discomfort, and a desire to remain distant from psychiatrists appears in the reaction of the psychologist who is less satisfied concerning relations with psychiatrists and who also attributes high power to himself. Power enhances the feasibility of obtaining autonomy, while dissatisfaction results in hostility and placement of blame upon psychiatrists for interprofessional difficulties. The interrole attitudes of psychologists with high power and low satisfaction concerning relations with psychiatrists were
compared with the feelings of all other psychologists. The findings from this analysis are described in the following list.

*Those psychologists who have high power and low satisfaction in their relations with psychiatrists*—

Desire least professional contact with psychiatrists.
Desire least leisure-time contact with psychiatrists.
Feel that they would not “get along” with psychiatrists on a hypothetical community committee.
Have little wish to be liked by psychiatrists.
Perceive that psychiatrists like them very little.
Perceive that psychiatrists respect them very little.
Have least desire to talk about personal problems with psychiatrists.

These comparisons were made by the use of $t$ tests. Each is significant at the .01 level or better.

The psychologist who attributes little power to himself seeks to maximize the rewards which may be available to him by ensuring himself of psychiatrists’ good will. Similarly, the psychologist with little satisfaction in his relations with psychiatrists aspires to earn acceptance and respect from them. Thus, in contrast to those who have high power and low satisfaction, the psychologist who has low power and low satisfaction in relations strongly desires admiration and esteem, is cautious in communication, but also rejects and blames psychiatrists. These results may be seen in the tabulation below.

*Those psychologists who have low power and low satisfaction in their relations with psychiatrists*—

Have the strongest wish to be respected by psychiatrists.
Feel they must curry favor with psychiatrists.
Believe that psychologists strive for the approval of psychiatrists.
Avoid discussion of psychiatrists’ mistakes with them.
Avoid discussion of psychiatrists’ unpleasant behavior.
Avoid discussion of their own personal mistakes.
Avoid discussion of the inadequacies of the clinical psychology profession.
Stereotype psychiatrists as trying to improve their status.
Stereotype psychiatrists as threatening persons.
Believe psychiatrists feel that psychologists are a financial threat.
Feel that psychologists envy the psychiatrist’s income.
State that the psychiatrists are deliberately attempting to keep the psychologists’ income low.
All of these comparisons were evaluated by the use of $t$ tests which contrasted this special group of psychologists with the rest. Each is significant at the .01 level or better.

In summary, satisfaction concerning relations with psychiatrists is accompanied by positive stereotypes, favorable attitudes, perceptions of being accepted and valued—plus a readiness to continue close interaction. The feelings which accompany dissatisfaction vary with the power of the psychologist. The dissatisfaction of the psychologist who perceives that he has high power is correlated with feelings of distance from psychiatrists, discomfort, rejection, and lack of concern about the impression he makes. Lack of satisfaction in the case of the psychologist who has little power is associated with a desire for admiration, caution in communication, and blame of psychiatrists.

**Satisfaction from Providing Advice for Others**

Few psychologists—only 18 per cent—perceive that psychiatrists make use of what the ancillary profession has to offer. In the light of this fact it is interesting that 44 per cent of the psychologists are highly satisfied with the degree to which psychiatrists come to them for advice, 38 per cent are dissatisfied, and the other 18 per cent do not feel strongly about the matter one way or the other. For those who are moderately or strongly satisfied this may be an instance of gratification over an infrequent event which stands out as rewarding when it occurs.

The psychologist who is satisfied because psychiatrists seek his advice feels more positive toward them, and is ready to collaborate with them.

Some of these positive attitudes might more properly be called cautious acceptance of psychiatrists, since the satisfied psychologist is less likely to accuse psychiatrists of attempting to restrict his income ($r = -.24, p .01$), believes that psychiatrists do not see psychologists as a financial threat ($r = -.24, p .01$), believes that psychiatrists do not see psychologists as a financial threat ($r = -.21, p .05$), and seldom stereotypes the psychiatrist as "threatening" ($r = -.26, p .01$).

When a psychologist is satisfied because his advice is sought he perceives that he would "get along" with psychiatrists ($r = .29, p .01$), and states that he respects the competence of psychiatrists (critical ratio, $p$ value .001).

Satisfaction from frequently providing advice strengthens the psychologist's hopes of fulfilling his professional ambitions. The more satisfied he is, the more he perceives that psychiatrists have respect for him ($r = .26, p .01$), and the more he feels that he should earn at least as
much as psychiatrists do (critical ratio test, \( p \leq .01 \)). In order to continue this pleasant relationship he is eager to have more frequent contacts with psychiatrists (\( r = .28, p \leq .01 \)).

It is quite apparent that a psychologist who is pleased because psychiatrists want the help he can offer (even though this seldom happens) is more positive toward psychiatrists and feels more satisfied with being a psychologist.

**Prestige in Own Profession**

It was earlier noted that the psychologists with the greatest prestige have the greatest power in relation to psychiatrists. How, then, will prestige influence their interrole attitudes?

A psychologist with prestige is one whose competence has been recognized and overtly appreciated by his colleagues. As a leader in this still-developing field he may also be one of the ardent supporters of its professional standards. Whatever his professional-organization activities are, it seems reasonable to assume that those psychologists with the greatest prestige feel most strongly attracted to their profession. The data indicate that this is true. The more prestige a psychologist has, the greater is his attraction to psychology rather than psychiatry as a career (chi square, \( p \leq .001 \)). Furthermore, the greater a psychologist's prestige, the less likely he is to envy the income of a psychiatrist (\( r = -.24, p \leq .01 \)).

Prestige, then, seems to provide a feeling of independence from psychiatrists and to lessen envy of their financial advantage. This status can be maintained best if the psychologist is able to avoid contacts with psychiatrists. Thus, when the psychologist has high prestige he tends to want less frequent contacts with psychiatrists (\( r = -.20, p \leq .01 \)), and feels he would not “get along” with them (\( r = -.18, p \leq .05 \)).

It is striking that a position of prestige in his own group causes the psychologist to behave in somewhat the same way he would behave as a result of an attribution of strong power, or high knowledge and skills. A position of prestige, high power, and knowledge on the part of a psychologist are all associated with a desire to increase the social distance between himself and psychiatrists and to prefer a closer identification with his own profession.

**Summary of Psychologists' Attitudes toward Psychiatrists**

Two themes characterize the attitudes of psychologists toward psychiatrists. One may be described as a desire for good will from a
group whose respect is needed. The other concerns the psychologist’s perception of himself as both willing and able to provide more professional services than he currently does. These two themes appear in various ways when the psychologist’s responses are examined in relation to their position on the independent variables.

Most psychologists believe that psychiatrists have power which is greater than their own. A psychologist who assigns little power to himself is more likely to desire recognition and approval from psychiatrists and to desire professional contacts with them. One who is relatively high in power is not inclined to need acceptance and rewards from psychiatrists, feels more independent from them, and identifies himself closely with his own profession. The more powerful psychologist, it has been assumed, has a measure of autonomy and wishes to avoid further contacts with psychiatrists in order to preserve this autonomy.

The psychologist who desires more power than he presently has blames psychiatrists for his currently low status and envies the position of the psychiatrists. The psychologist who has no desire for greater influence is less likely to accuse psychiatrists of trying to keep psychologists “in their place” and is less prone to envy psychiatrists.

A psychologist will more often state that he is satisfied concerning the nature of his relations with psychiatrists if he perceives that psychiatrists appreciate his help to the point of coming to him for advice—once again the desire for recognition and approval is apparent. And finally, the psychologist who has high self-confidence in his own knowledge and skills more closely identifies himself with his own profession and prefers his own career choice to psychiatry.

Differences Between Men and Women Psychologists in their Reactions to Psychiatrists

Of the psychologists interviewed, 38 per cent were females. Are there differences in the way that the men and women psychologists react to psychiatrists? A number of issues come to mind when this general question is raised. The reader will have noted that social workers behave somewhat differently from psychologists in regard to psychiatrists. Is it possible that it is not their professional aspirations or their various relationship locations which cause this difference but rather the sexual composition of the two groups? A second question concerns any contrasts between male and female psychologists. Do their responses differ, and if so what do these differences mean? Finally, we may inquire about the ways in which men psychologists differ from
women in their reactions to psychiatrists when they have high or low power vis-a-vis psychiatrists.

1. Do female psychologists behave more like social workers or more like male psychologists? The women clinical psychologists do not behave in a fashion strictly similar to either the social workers or their male colleagues. The responses of the women psychologists on twenty-eight measures of attitude and behavior toward psychiatrists were compared to the replies of the other two groups on the same items. On approximately half of these twenty-eight, the responses of the women psychologists were quite like those made by the men; on the other half they were similar to those of the social workers. When the meanings implied by the individual items were examined there were no patterns among the responses which would allow any useful conclusions about the ways in which female psychologists were similar either to social workers or to the men in the clinical psychology profession.

2. In what ways do female psychologists differ from male psychologists in their reactions to psychiatrists? There are a few places in which the average replies of the females are significantly different from those of their male colleagues. These few are interesting and consistent. The data appear to indicate that the men are more sensitive to a need for independence and more ready to work for it than are the women.

The males admit that psychologists are “encroaching” on the prerogatives of psychiatrists much more readily than the women do. The average response is the men is 3.46 while that of women is 2.25. The difference between these two is statistically significant at the .001 level. Furthermore, the men are more free in stating that they desire to decrease the influence of psychiatrists and that they are actively attempting to do so. The males yield an average of 2.83 on this question while the women rate 1.69. The difference is again significant at the .001 level of confidence.

The men view the psychiatrists as somewhat less “threatening” than do the women. The two average responses are 3.42 and 4.09 respectively, and these are significantly different at the .05 level of confidence. In addition male psychologists state that they find it necessary to curry favor with psychiatrists more than the women report this; the averages are 2.39 and 1.91 in the above order (p .001).

It would appear that the males are more active and ready than are the females to risk conflict in striving for independence. This relative lack of inhibition among the men is demonstrated in Table 17, which describes the desire of the two sexes to communicate on various topics.
**TABLE 17**

Significant Differences Between Male and Female Psychologists in Their Disposition to Communicate to Psychiatrists

<table>
<thead>
<tr>
<th>Topic</th>
<th>Female Psychologists Mean</th>
<th>Male Psychologists Mean</th>
<th>p value of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists' mistakes</td>
<td>2.30</td>
<td>2.59</td>
<td>.01</td>
</tr>
<tr>
<td>Complaints about psychiatrists' behavior</td>
<td>1.65</td>
<td>2.02</td>
<td>.05</td>
</tr>
<tr>
<td>Professional disagreements</td>
<td>2.53</td>
<td>2.92</td>
<td>.02</td>
</tr>
<tr>
<td>Own personal successes</td>
<td>1.55</td>
<td>2.06</td>
<td>.01</td>
</tr>
<tr>
<td>Mean volume of communication</td>
<td>1.11</td>
<td>1.80</td>
<td>.01</td>
</tr>
</tbody>
</table>

The males are significantly more disposed to point out mistakes made by psychiatrists, to complain about their behavior, to argue over differences of opinion, and to discuss their own successes. The females are less willing to discuss such matters. In fact, the mean volume of communication they would direct toward psychiatrists is considerably lower than that of the men.

We may conclude that the attitudes in which men and women psychologists differ in their reactions to psychiatrists are primarily those concerned with the eagerness for autonomy and the readiness to entertain feelings which, if carried into action, would often mean direct challenge.

3. **In what ways do female psychologists differ from males in the effects of power on their reactions to psychiatrists?** The men, in contrast to the women, seem to be more involved in the professional aspirations of their group. Their hopes for improved professional status are stronger no matter what their power relationship with psychiatrists.

In Table 18 it is apparent that where significant differences exist between the correlations of power and interrole attitudes for men and women, the correlations for females are consistently larger. These statistical relationships indicate that, in general, the less power a woman has in relation to psychiatrists, the less she is likely to be hostile in her communications to them and the less she encroaches upon psychiatrists. The male psychologist is more inclined to tell psychiatrists about their mistakes, complain about their behavior, encroach upon them, and argue over differences of opinion regardless of the degree of power he has.

In summary, the women psychologists do not behave in a fashion similar to either social workers or male psychologists. If this finding may be assumed to be an indication of the proneness to follow sex-determined tendencies, rather than to conform to role expectations,
TABLE 18
Correlations between Power and Certain Attitudes in Relation to Psychiatrists for Male and Female Psychologists

<table>
<thead>
<tr>
<th>Attitude correlated with power position</th>
<th>For Female Psychologists $r$</th>
<th>For Male Psychologists $r$</th>
<th>$p$ value of diff. between $r$'s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encroaching on psychiatrists' prerogatives</td>
<td>-0.42</td>
<td>-0.02</td>
<td>.01</td>
</tr>
<tr>
<td>Blaming psychiatrists for keeping psychologists' income low</td>
<td>-0.24</td>
<td>-0.15</td>
<td>.10</td>
</tr>
<tr>
<td>Willingness to discuss a psychiatrist's mistakes with him</td>
<td>-0.41</td>
<td>-0.22</td>
<td>.01</td>
</tr>
<tr>
<td>Willingness to complain to a psychiatrist about his behavior</td>
<td>-0.29</td>
<td>-0.20</td>
<td>.10</td>
</tr>
<tr>
<td>Willingness to discuss professional disagreements</td>
<td>-0.42</td>
<td>0.11</td>
<td>.02</td>
</tr>
<tr>
<td>Mean volume of communication</td>
<td>-0.37</td>
<td>-0.10</td>
<td>.02</td>
</tr>
<tr>
<td>Desire for professional contact</td>
<td>-0.33</td>
<td>-0.50</td>
<td>.05</td>
</tr>
</tbody>
</table>

It is clear that sex-determined tendencies and role prescriptions are equally important in influencing the woman's interrole behavior with psychiatrists. However, sex does make a difference in the way that men and women carry out the role of psychologist. The men appear to be more inclined to harbor feelings which indicate a need for independence and a willingness to enter into rivalrous relations—and this is true regardless of their power position. The women, on the average, are little inclined to challenge psychiatrists. However, when their power is high they are somewhat more ready to do so, and when it is low they are more likely to be passive in attitude. A larger proportion of male psychologists, then, have aspirations for improving the status of their profession, while the women appear to have such aspirations only if they feel that they have a strong power position in relation to psychiatrists.

PERCEIVED POSITION ON THE INDEPENDENT VARIABLES OF PSYCHIATRISTS TOWARD PSYCHOLOGISTS

We have seen the relations between psychologists and psychiatrists through the eyes of the psychologists. How do relations look to psychiatrists?

Perceived Relative Power to Influence

The self-attributed power of a psychiatrist is the result of his responses in the functions of therapy, diagnosis, and determination of case
assignments. These are the same three areas in which the psychologist's power in relation to psychiatrists was determined.

*A great majority of the psychiatrists feel that they have more power than psychologists.* Eighty-five per cent of the psychiatrists believe that their influence is greater, one per cent say that psychologists have more, and the other 14 per cent give responses which fall between these two.

The more power a psychiatrist assigns to himself, the more frequent are his professional contacts with psychologists. The correlation between power and frequency of contact is .27 (*p* .01).

*The psychiatrist who perceives himself to have high power appears to be comfortable with psychologists.* The more power the psychiatrist has the more he believes that psychologists like and respect him. The correlations between power and the two variables are .21 and .18 respectively. The correlation for "liking" has a *p* value of .01 and for "respecting" of .05.

The psychiatrist with much influence wishes to maintain these amicable and friendly relations, since the greater his power, the stronger his desire to be liked by psychologists (*r* = .25, *p* .01), and the greater his desire for professional contacts with psychologists (*r* = .35, *p* .01).

### The Acceptance of Power Position

*There is no clear majority opinion among psychiatrists concerning the amount of power they should have in relations with psychologists.* Forty per cent of them state that psychologists should have more influence than they presently have, 33 per cent feel that they (themselves) should have more than they now have, and the other 27 per cent say that the power relationship should remain about the same as it now is. It is worth special note that four out of every ten psychiatrists believe that psychologists should have more influence than they presently expect. Under what conditions are they most willing to increase the power of psychologists?

*The more powerful a psychiatrist perceives himself to be, the greater is his willingness to decrease his own power and to increase that of the psychologists.* The correlation between own power and the measure of the power relationship which "should" exist is .82. In addition, the psychiatrist is more ready to accept an increase in the influence of psychologists when he is satisfied with the frequency with which which psychologists turn to him for help. The correlation between willingness to increase the psychologist's power and the measure of gratification from advising the other is .40 which is significant at the .001 level.
Finally, the respect that a psychiatrist has for the knowledge and skills of psychologists has no relation to the amount of power he is ready to allow them; that is, the correlation is zero between these two variables. It may be concluded that a psychiatrist's willingness to accept an increase in the power of psychologists is determined more by his own power than by the perceived competence of the other group.

The psychiatrist who is most willing to accept an increase in the power of psychologists feels valued by them and is ready to have close and friendly relations with them. Table 19 describes seven attitudes held by psychiatrists and their correlation with the amount of power the psychiatrist feels psychologists should have. The more willing the psychiatrist is to grant greater influence to the adjunct group the more he perceives that he is liked by them, wants to be liked by them, and desires more contacts with psychologists. Furthermore, he is ready to praise psychologists, to discuss with them the professional problems of being a psychiatrist, and is aware that psychologists work to win his approval.

**TABLE 19**

Correlations between Degree of Power Psychiatrists Feel They Should Have in Their Relations with Psychologists and Attitudes Toward them

<table>
<thead>
<tr>
<th>The greater the feeling that psychologists should have more power than at present —</th>
<th>r</th>
<th>Value of p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more psychiatrists desire professional contacts with psychologists</td>
<td>.59</td>
<td>.001</td>
</tr>
<tr>
<td>The more psychiatrists desire leisure-time contacts with psychologists</td>
<td>.26</td>
<td>.01</td>
</tr>
<tr>
<td>The more psychiatrists perceive that they are liked by psychologists</td>
<td>.36</td>
<td>.001</td>
</tr>
<tr>
<td>The more psychiatrists wish to be liked by psychologists</td>
<td>.32</td>
<td>.01</td>
</tr>
<tr>
<td>The more is a psychiatrist willing to talk to psychologists about their successes</td>
<td>.26</td>
<td>.01</td>
</tr>
<tr>
<td>The more a psychiatrist perceives psychologists as seeking approval</td>
<td>.21</td>
<td>.01</td>
</tr>
<tr>
<td>The more is a psychiatrist ready to discuss the problems of being a psychiatrist</td>
<td>.21</td>
<td>.01</td>
</tr>
</tbody>
</table>

It should be emphasized that comfortable and accepting interrole attitudes accompany a psychiatrist's readiness to grant psychologists greater influence. Whereas, a lack of willingness to allow psychologists more power is related to uncomfortable and nonaccepting feelings about them.
Frequency of Professional Contacts

When asked how often they meet with psychologists in a professional relationship, 50 per cent of the psychiatrists report that they have daily contacts, 26 per cent say that they see psychologists not more than once a month, and the other 24 per cent give replies which fall between these two.

Since it is the more powerful psychiatrist who most often has professional interactions with psychologists, we might readily expect that the psychiatrist would welcome further contacts with them because contacts are likely to be satisfying and comfortable. The correlation between frequency of contact and the wish for more professional interaction is .76, and with the desire for more frequent leisure-time contacts .43. Thus, the more contact a psychiatrist has with psychologists, the more he wants.

Frequent contacts with psychologists are generally accompanied by positive attitudes toward them. The findings contained in Table 20 demonstrate these warm feelings in a variety of ways. Many contacts are correlated with the beliefs that the psychiatrist is liked and respected, and with desires to be admired and esteemed by psychologists. In addition, high interaction is related with a willingness to discuss both personal and professional inadequacies, to talk to psychologists in preference to psychiatrists, and to perceive psychologists as eager to win his approval.

| Correlations between Frequency of Professional Contact Psychiatrists Have with Psychologists and Attitudes toward Them |
|---------------------------------------------------------------|---------------------------------------------------------------|
| The more contacts a psychiatrist has with psychologists       | $r$ | Value of $p$ |
| The more he believes that psychologists like him               | .29 | .01   |
| The more he desires to be liked by psychologists               | .25 | .01   |
| The more he believes that psychologists respect him            | .28 | .01   |
| The more he wishes to be respected by psychologists            | .22 | .01   |
| The more is he ready to discuss the inadequacies of his own profession with psychologists | .21 | .01   |
| The more is he willing to talk about his own personal mistakes with psychologists | .23 | .01   |
| The more is he willing to talk to psychologists in preference to members of his own profession | .30 | .01   |
| The more he views psychologists as attempting to win his approval | .37 | .01   |

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Not all of the attitudes of a psychiatrist who often works with psychologists however are positive toward them. The psychiatrist who sees psychologists most often is likely to say that psychologists envy his income \( r = .24 \), that they seek to "curry favor" with him \( r = .19 \), and that they are "threatening" persons \( r = .19 \).

It appears that frequent contacts between psychiatrists and psychologists tend to result in amicable relationships which the psychiatrists would like to encourage.

**Professional Knowledge and Skills**

*More than half of the psychiatrists believe that psychologists are their equals or betters in knowledge and skill:* 44 per cent state that the other group is about equal to them, 12 per cent feel that psychologists have more wisdom and competence, while the other 44 per cent say that they themselves have greater knowledge and skill.

The psychologist who is wise and able is more useful to a psychiatrist than one who is less competent. Thus, the psychiatrist who places most value upon psychologists' knowledge and skills is eager to have frequent contacts with them and feels positive toward them.

*Those psychiatrists who believe that psychologists are high in ability tend to have favorable feelings about them.* The more a psychiatrist believes that psychologists are able people, the more he tends to have respect for them (chi square, \( p = .001 \)), and the greater is the likelihood that he will respect psychologists even more than social workers when asked to make a direct comparison between the two groups (chi square, \( p = .001 \)). He also sees psychologists as "likeable" \( r = .28 \), and feels he could "get along" with them on a committee \( r = .23 \). In addition, the more knowledge and skill he attributes to psychologists, the less does he view them as entering into private practice \( r = -.32 \) and encroaching upon psychiatric functions \( r = -.19, p = .05 \).

Within this frame of reference it is altogether reasonable that a psychiatrist who assigns high ability to psychologists would want to associate with such competent persons. The correlations between this perception and the desire to have frequent professional contacts with psychologists is .27, and more leisure-time interaction .20; both significant at the .01 level of confidence. Lastly, the psychiatrist tends to attribute greater ability to psychologists when he satisfied with the degree to which they come to him for advice \( r = .30, p = .01 \).

It seems clear that the psychiatrist appreciates interactions with one whom he perceives as an able helper.
Satisfaction with Interrole Relations

A majority of the psychiatrists are not highly satisfied concerning their relations with psychologists. When asked to rate how they feel about relations with the other group, 59 per cent say that they have little satisfaction, 10 per cent state that they are very highly satisfied, and 31 per cent give medium responses.

The psychiatrist who has the fewest contacts with psychologists is least satisfied concerning relations with them. The correlation between satisfaction and frequency of contacts is .27 (p .01). In the same direction is the finding that a psychiatrist is less satisfied concerning relations with the other group when he has little gratification with the degree to which they come to him for advice (r = .45, p .001).

The less a psychiatrist is satisfied concerning relations with psychologists, the greater is his belief that they do not admire him. The dissatisfied psychiatrist feels that psychologists do not like him (r = .23, p .01), and do not respect him (r = .22, p .01).

In turn, the psychiatrist who reports low satisfaction in relations with psychologists is less eager to have contacts with them (r = .20, p .01), and stereotypes them as “not likeable” (r = .29, p .01).

In contrast to these data, the psychiatrist who describes high satisfaction in his relation with psychologists has many professional contacts with them, desires more frequent interaction with them, feels that the members of the other group value him, and characterizes psychologists as “likeable.”

Satisfaction from Providing Advice for Others

A majority of the psychiatrists are well satisfied with the degree to which psychologists come to them for professional help: 56 per cent say that they are highly satisfied, 21 per cent report very little satisfaction, and the other 23 per cent describe a moderate degree of gratification in this respect.

A psychiatrist's satisfaction with the degree to which psychologists seek help is related to his belief that they are attempting to win his approval and esteem. The more a psychiatrist is pleased with the degree to which psychologists turn to him for counsel, the more he says that psychologists strive for his approval (r = .24, p .01), and the more he states that he must discourage psychologists from seeking favors from him (r = .20, p .02).

The reaction of the psychiatrist to an awareness that psychologists
seek help from him is characterized by cordial feelings toward them. A number of positive attitudes are shown in Table 21. It is apparent that the psychiatrist who is most satisfied concerning the extent to which psychologists turn to him for advice is ready to spend working time and leisure time with them and perceives that relations would be comfortable.

**TABLE 21**

Correlations between the Amount of Satisfaction Psychiatrists Feel Concerning the Frequency with which Psychologists Seek Their Counsel and Certain Beliefs about Psychologists

<table>
<thead>
<tr>
<th>The greater the satisfaction of psychiatrists toward psychologists</th>
<th>$r$</th>
<th>Value of $p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more they desire to spend leisure time with psychologists</td>
<td>.31</td>
<td>.01</td>
</tr>
<tr>
<td>The more they desire frequent professional contacts with psychologists</td>
<td>.22</td>
<td>.02</td>
</tr>
<tr>
<td>The more they feel that they could &quot;get along&quot; with psychologists</td>
<td>.24</td>
<td>.01</td>
</tr>
<tr>
<td>The more willing they are to discuss the problems of being a psychiatrist (with psychologists)</td>
<td>.23</td>
<td>.01</td>
</tr>
<tr>
<td>The more they wish to be respected by psychologists</td>
<td>.31</td>
<td>.01</td>
</tr>
<tr>
<td>The less they believe that psychologists are intending to enter private practice</td>
<td>−.32</td>
<td>.01</td>
</tr>
<tr>
<td>The less do they believe that psychologists envy psychiatrists' income</td>
<td>−.26</td>
<td>.01</td>
</tr>
</tbody>
</table>

**Prestige in Own Profession**

There is some slim evidence that the more prestige a psychiatrist has within his own field the greater the amount of power he attributes to himself in his relations with psychologists, and the more he is willing that psychologists be given greater influence than they presently have. The correlations between prestige and these variables are .18 in both cases ($p .05$). The degree of prestige is not significantly related to any other variables.

**Summary of Psychiatrists' Attitudes toward Psychologists**

Psychiatrists, we believe, assume that they have the right to supervise and instruct psychologists, and psychologists, for the most part, accept this situation. The nature of the relationships between the two roles is one in which psychiatrists are generally comfortable.

There is disagreement in the functions which the two groups attribute to the role of clinical psychologists. The skills of the psychologist are quite narrowly conceived by psychiatrists, and more broadly conceived
by psychologists. Despite their limited view of the psychologist's role, many psychiatrists were found to respect the knowledge and skills possessed by psychologists and a large proportion are willing to grant them greater influence than they now possess.

A majority of the psychiatrists believe that relations between themselves and the members of the other profession are unsatisfactory. This dissatisfaction is greatest when contacts are infrequent between the two groups and when psychologists seldom seek advice or counsel.

Four major themes stand out in the role relations as seen by the psychiatrist: (a) he knows that he has more power than psychologists, (b) he respects the ability of psychologists, (c) he believes psychologists should have greater influence, and (d) he is not strongly satisfied concerning the relations between the two groups.

These beliefs are associated with other attitudes toward psychologists. When a psychiatrist is aware that his power is high he is more likely to direct friendly attitudes toward psychologists, to be ready to associate with them, and to be confident of their esteem. Also, when a psychiatrist attributes high power to himself he is ready to grant psychologists more influence in their relations.

The psychiatrist who believes that psychologists possess much knowledge and skill is strongly positive toward the ancillary group. Since he perceives that a skilled psychologist will help him to do a good job, he has high respect for competent psychologists and encourages friendly and close relations with them.

A psychiatrist who has frequent contacts with psychologists, and especially if the psychologists come to him seeking advice, has strongly favorable feelings toward them. However, the amount of prestige the psychiatrist has within his own profession shows little association with unique attitudes toward psychologists.

The major factor determining the psychiatrist's attitudes toward psychologists, it is believed, is the security he feels in his relations with them. This security has many sources, no doubt, but it may be considered to be primarily a concomitant of the psychiatrist's power over psychologists. The psychiatrist who has greater power, who can exercise this power in frequent professional contacts, and who is recognized as an advisor by psychologists, is apparently more secure, as indicated by the nature of his feelings about psychologists. He becomes more objective, understanding, cordial, and accepting of psychologists and is willing to grant them greater power and to encourage close relations with them. It is different with the psychiatrist whose
location and relations with psychologists are not what he expected them to be. Because he is low in power, has few professional contacts with psychologists, or seldom meets the other group in an advice-seeking relationship, he is likely to be insecure and to develop a number of negative attitudes toward psychologists.

**Summary Comparing the Reactions of Psychologists and Psychiatrists toward Each Other**

In an examination of the group averages on the various interrole attitudes it was clear that these two professions are significantly different in a number of respects. The psychologists place high value on the profession of psychiatry and desire the good will of psychiatrists. The psychiatrists are less concerned with gaining favorable opinions from psychologists and value their own profession more strongly.

Psychologists and psychiatrists have minor disagreements as to the functions contained within the psychiatrist role. In respect to the psychologist's role, however, the psychologists attribute a greater variety of functions to it than do the psychiatrists. This finding was taken as an indication of the psychologists' desire to broaden the range of their services to society. Apparently the psychiatrists are aware of these motivations among the other group, since they reveal a greater degree of sensitivity concerning the psychologists' desire to improve their status as a profession than do the psychologists themselves.

In the broadest terms, a major difference between these two professional groups is that the psychologists desire to win more recognition for themselves and perceive that it is important that psychiatrists think well of their profession. The psychiatrists, in contrast, recognize the aspirations of the other profession and are uneasy about how they should receive and co-operate with the offers of greater service from its members.

We have, then, one profession with a strong motivation, the psychologists. Security and positive interrole attitudes for them depend upon the degree to which the other profession is an aid or a hindrance in achieving these objectives. The psychiatrists have a different orientation. They are the superior group, with strong social sanctioning for this position. Members of the psychiatric profession hope to maintain this status. Security and positive interrole attitudes for them depend upon the degree to which psychologists are seen as supporting or threatening their position.
A special analysis comparing the reactions of male and female psychologists was reported. No conclusive statement could be made as to whether the women react to psychiatrists more like social workers (mostly females), or more like male psychologists. It was clear, however, that the average woman psychologist, unless she attributes high power to herself, is less inclined to harbor hostile attitudes toward psychiatrists. A male psychologist is more likely than a female to feel aggressive toward psychiatrists and, no matter what the degree of his power, is inclined toward action.

We may conclude that psychiatrists and psychologists have quite different attitudes about one another. These differences, we believe, result from the contrasting motivations and positions of the two professions. To the psychologist the psychiatrists are gatekeepers. To the psychiatrist the psychologists are challengers.
CHAPTER 6

RELATIONS BETWEEN PSYCHIATRIC SOCIAL WORKERS AND CLINICAL PSYCHOLOGISTS

We have examined the attitudes which exist between psychiatrists and social workers, and those which exist between psychiatrists and psychologists. There is an obvious point of similarity in these two pairings: social workers and clinical psychologists are usually ancillaries when working with psychiatrists. There are few established patterns of collaboration which make the members of these adjunct professions likely to have supervising responsibility over one another. Thus, they may be considered to be peer groups.

What will determine their interrole attitudes? Because of their similar position in respect to psychiatrists, several questions come to mind. If, for example, a psychologist believes that social workers are more assured (than himself) of the psychiatrist's support, what effect does this belief have on interrole behavior? Will he become a rival of the social workers for closer collaboration with psychiatrists, or will he ignore their position as irrelevant to his own professional needs? Or, if a social worker perceives that psychologists are trying to win greater power by working closely with psychiatrists, how will this affect relations between social workers and psychologists? Will it hinder or help co-operative efforts between them?

Another relevant issue stems from the professional aspirations of these two groups. Clinical psychologists have a strong desire to demonstrate that they can provide a wide variety of services in the field of mental hygiene. They may want acceptance of these aspirations by social workers, and they may develop more favorable and accepting attitudes toward the social workers if they see that the other group understands and supports these ambitions. The social worker's apparent readiness, however, to accept her present role definition and status position in relation to psychiatrists may cause her to have few such affective reactions toward psychologists. Instead, she may feel that psychiatrists are more important in gratifying her professional desires and that psychologists, therefore, are relatively less important.

Finally, in contrast to the quasi-hierarchical role relationships
described in the previous chapters, it may be expected here that neither group will represent barriers to the other's fulfilment of professional aspirations, nor will they help one another to any great extent in furthering professional goals. How will this situation affect the nature of the interrole relations?

**A COMPARISON OF THE AVERAGE ATTITUDES OF PSYCHIATRIC SOCIAL WORKERS AND CLINICAL PSYCHOLOGISTS TOWARD EACH OTHER**

*Psychologists are more eager to be respected and liked by social workers than the other way about.* The mean of their desire to be respected is 4.29 compared to 4.01 for social workers (p .02). Psychologists describes a wish to be liked whose mean is 3.53, and social workers of 3.22 (p .05). Psychologists are also more confident that they would “get along” with social workers were they members of the same committee. Among them, 62 per cent, when asked to choose from a number of relevant professional groups, say that they would work best with social workers. Only 33 per cent of the social workers, however, state that they would be most comfortable with psychologists.

*Psychologists place greater monetary value upon their profession than on social work.* When asked about the relative salary members of each occupation should receive, 76 per cent of the psychologists feel that they should earn more than social workers, while 23 per cent say that the incomes of the two groups should be equal. Among the social workers, in contrast, only 16 per cent believe that the members of their role should have incomes larger than psychologists, while 82 per cent feel that the two groups should have equal earnings.

Similarly when asked whom they think psychiatrists respect most, each group ranked itself first. But more psychologists feel this way than social workers. Among the psychologists 57 per cent state that psychiatrists respect the psychologists more and only 19 per cent say they value social workers more. Among social workers 41 per cent believe that psychiatrists most respect social workers and 23 per cent that they respect psychologists.

The two groups assign quite different stereotypes to each other. Psychologists view social workers as “well-oriented concerning social problems.” They also characterize the profession as “mercenary,” “condescending,” “threatening,” and “striving,” to a greater extent than social workers assign these attributes to them. Social workers, in fact,
describe psychologists as "scientific," "insightful," "likeable," and "mature." They call them "defensive" as well. The average ratings for these stereotypes may be seen in Table 42 in the Appendix.

Each group was asked what kind of knowledge and skills they can offer the other. Both groups were in agreement (i.e. no statistically significant differences in frequency of mention) concerning the functions attributed to social workers. Both say that social workers are skilled in clinical approach and attitudes, clinical skills, therapeutic knowledge and skills, interviewing methods, and writing of case histories, in that order of frequency. Where differences of opinion exists they are minor. For instance, psychologists assign to social workers more competence in the practical use of community resources than social workers attribute to themselves. Social workers are more inclined to characterize their profession as having the ability to explain the influence of socio-cultural factors on mental health than psychologists are ready to attribute this ability to them. In general, however, both professions seem to have a fairly common understanding of what a social worker does.

The psychologists's role is not so clearly defined. Clinical psychologists see themselves as able to give social workers help in certain areas which social workers do not recognize as part of the psychologist's role. These functions are: research methods, diagnostic methods, and therapeutic knowledge and skills. Social workers perceive the psychologist's role to be more narrow and restricted. (Table 44.)

Psychologists see themselves as competent in diagnostic methods and therapeutic skill more than social workers perceive them to be. Diagnosis and therapy, it will be recalled, are the functions most central to the psychiatrist's role and those which best represent his special responsibilities. They are the duties which are most valued since they are the properties of the more powerful role. Social workers, on the contrary, do not perceive that psychologists can teach them about therapy and diagnosis, perhaps because these are skills which they intend to acquire through their relations with psychiatrists, perhaps because they feel that they have more power than psychologists in these areas.

Social workers state that psychologists can provide knowledge primarily about psychometrics. About 80 per cent of the social workers mention this function but only 46 per cent of the psychologists claim it as a major skill. The difference in frequency of mentioning psychometrics as a unique duty of psychologists is statistically significant at the .001 level. The function of psychometrics is seen both by social workers and psychiatrists as almost the only contribution of the clinical
psychologists. The psychologists' desire to increase their usefulness, then, meets barriers of unreadiness to accept these services among the members of both professions.

Each respondent was asked if the members of his profession use the opportunity to benefit from the knowledge and skill of those in the other role. About 20 per cent in each group stated that they utilize the others' help, and both groups agreed that a similar proportion of their own members provide such help.

About two-thirds of the reasons given for failing to benefit from the skills of the other group, and for the unwillingness of the other profession to use the interviewee's skill, are situational. These include such factors as lack of time or opportunity. They are typified by an absence of affect or attribution of motives to the other group as well as to the respondent's own group.

About 30 per cent of the reasons refer to interpersonal relations such as status conflict, insecurity, defensiveness, or other attitudinal barriers to ready communication or co-operation. Such comments are more emotion-laden. Clearly there is less tendency to explain professional distance in these terms than in terms of the more objective situational reasons.

The preference for situational reasons is, we believe, the result of the flexible expectations of each group concerning the ways in which they work together. Any failure to take advantage of each other's resources is not seen as a frustration of a desire by the members of the by-passed group since they do not expect their resources to be drawn on in this way.

Finally, social workers and psychologists are sensitive to one another's relations with psychiatrists. Social workers are viewed as close to psychiatrists and as seeking to maximize the benefits from such collaboration, whereas psychologists are seen as little interested in winning the approval of psychiatrists. The data show that social workers describe psychologists as encroaching upon the functions of psychiatrists (3.96) more than psychologists see social workers as so doing (3.16). Social workers are viewed as eager to win approval from psychiatrists (5.25) and as "currying favor" with psychiatrists (4.31), whereas psychologists are given ratings of 4.51 and 3.45 in these two respects. The differences between these three pairs of averages have a p value of .01.
SUMMARY

In general both professions are aware of the desire among psychologists to increase the number and variety of functions included within their role. Although the social workers perceive this desire as a means of improving the status of the other profession, they do not believe that psychologists have much to offer beyond a knowledge of psychometrics and they see their own profession as at least equal in value to clinical psychology.

The psychologists on the contrary, believe that social workers are willing to accept the status of an ancillary profession to psychiatry and that they seek to maximize the benefits which may occur in this relationship. The psychologists place more value on their own profession than on social work and are more eager for acceptance by social workers than the other way about.

PERCEIVED POSITION ON THE INDEPENDENT VARIABLES OF PSYCHIATRIC SOCIAL WORKERS TOWARD CLINICAL PSYCHOLOGISTS

Perceived Relative Power to Influence

Table 22 shows the proportion of social workers who attribute varying degrees of power to themselves in relation to psychologists in two different functional areas, community contacts, and clinical activities (diagnosis and therapy).

<table>
<thead>
<tr>
<th>Type of Social Work Function</th>
<th>Psychologists have most</th>
<th>Both Groups Equal</th>
<th>PSW's have most</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community contacts</td>
<td>8%</td>
<td>80%</td>
<td>12%</td>
</tr>
<tr>
<td>Diagnosis and therapy</td>
<td>4%</td>
<td>54%</td>
<td>42%</td>
</tr>
</tbody>
</table>

The middle column reveals that the greatest proportion of social workers believe their power is equal to that possessed by psychologists in both types of function. It is important to note that 42 per cent of the social workers believe themselves to have more power than psychologists in diagnosis and therapy. Indeed, only 4 per cent state that psychologists have the greater influence in these activities.

The amount of power a social worker has is not highly correlated
with any interrole attitudes or behaviors. The degree of her power is not associated with interrole attitudes, it is assumed, because these two professional groups have no organized hierarchical positions in respect to one another. It will be recalled that the possession of power has a major effect upon the attitude of the social worker toward psychiatrists. In that relationship she is traditionally in a subordinate position. With psychologists, however, there is no established set of responsibility relations and few integrated co-operative efforts. Thus, power has little consequence in the interrole attitudes.

Acceptance of Power Position

The great majority of social workers are satisfied with equality of power for themselves and psychologists. In the area of community contacts, 80 per cent wish the power relationship to be equal; while in the functions of diagnosis and therapy 68 per cent want equality. Eleven per cent believe that social workers should have greater power in community contact activities and 14 per cent wish for more power in diagnosis and therapy.

Social workers with a desire for more power have high prestige, low power, and few contacts with psychologists. First, the correlation between professional prestige and a desire for greater power is .42 (p .001) in diagnosis and therapy, and .31 (p .01) in community contacts. Apparently high status in their own profession leads them to expect to have influence on other groups.

Second, those who want more power are likely to be social workers who have few interactions with psychologists. The less professional interaction they have with psychologists, the greater is their desire for power (r = - .36, p .01) in diagnosis and therapy. The correlation between desire for power and community contacts is approximately zero. These results mean, we believe, that performing clinical duties is a point of pride. The functions of diagnosis and therapy are highly valued activities—probably because they are the distinguishing marks of the most powerful role among the professions, that of the psychiatrist. When social workers are active in these functions they are apparently aware of their superiority and of the recognition given them by psychiatrists. When, therefore, a social worker participates in diagnostic or therapeutic activities and has few professional contacts with psychologists, her desire for greater power is apparently awakened and perhaps justified by the functions she performs. If she engages in these activities while interacting considerably with psychologists, however, her desire
for power is diminished by the close relations which naturally develop. There is no correlation between desire for power and frequency of professional contacts in community functions, presumably because working in the community is not an area in which feelings about proper power relations with psychologists are likely to be aroused.

Third, those seeking more power are social workers with little power at present. The correlation between power presently possessed and the wish for more is .72 in diagnosis and therapy, and .20 in community contacts. The social workers who have little power wish to have somewhat more, and those with much desire an equality status with clinical psychologists. Again, it may be seen that power is a salient issue in the functions of diagnosis and therapy.

A social worker with a strong desire for power over psychologists wants to be respected by them \( (r = .26, p .01) \). This desire for respect by one who wishes for more power is an indication that the social worker wants to make increased power legitimate and effective by having the psychologists accept her as competent.

*The desire for power seems to be accompanied by signs of strain in role relations.* The social worker with a strong desire for influence is less interested in having psychologists like her \( (r = -.22, p .01) \). In addition, a social worker with greater interest in increasing her power tends to be unwilling to talk to psychologists regardless of what the topic may be. On nine out of eleven possible topics she is less willing to communicate if she has a wish for more power. All of these correlations are at the .01 level of confidence or better. Finally, the greater her desire for an increase in power over psychologists, the less she believes that she could “get along” with psychologists on a committee \( (r = -.27, p .01) \).

In summary, the social workers, on the average, are willing to keep the power relationship about as it is. However, those who wish for greater authority also want greater respect from psychologists and are less interested in maintaining positive and close contacts with them. The social workers who have the strongest desire for power are those who have much prestige in their own profession, who engage in diagnosis or therapy, who seldom work with psychologists, and who have little power in that relationship at present.

**Frequency of Professional Contacts**

*The majority of social workers state that they have frequent professional contacts with psychologists.* Fifty-six per cent said that contacts
occur almost every day, 18 per cent said about once a week, and the other 26 per cent approximately once a month.

It was earlier noted that social workers who have few contacts with psychologists and high prestige in their own profession tend to have a strong wish for power over them. It would be reasonable, then, to expect that social workers with high prestige would have fewer contacts with psychologists. The data support this anticipation. The correlation between prestige of the social worker and frequency of contacts with psychologists is -.22 (p .01).

The more frequently interactions occur on the job, the more a social worker feels accepted and respected, and the greater is the likelihood that she feels positive toward psychologists. The correlation between contact and perception of respect received is .52, and that for perception of being liked is .48. The more contact a social worker has with psychologists, the more she wishes for further contacts, both professional and leisure-time (r = .44). Finally, the social worker who most often works with psychologists tends to stereotype them as “likeable” (r = .25), but she also views them as trying to “curry favor” with psychiatrists (r = .43). All of these have p values of .01 or better.

Professional Knowledge and Skills

Social workers tend to believe that they are equal or superior to psychologists in professional knowledge and skill. Thirty-nine per cent say that they feel their own competence is greater, 43 per cent state the two professions are equal, and 18 per cent feel that psychologists have more knowledge and skill. Note then, that 82 per cent of the social workers believe they are equal to or better than psychologists in this respect.

The social worker who attributes high knowledge and skill to herself vis-a-vis psychologists appears to wish to be respected, and to perceive psychologists as upward mobile. The correlation between the degree of knowledge and skill she attributes to herself and the desire to be respected is .27 (p .01). She does not, however, feel that she is actually respected by psychologists (correlation is zero).

The more value a social worker places upon her own competence, the greater is the likelihood that she will view psychologists as striving for recognition from psychiatrists (r = .26, p .01), trying to curry favor with psychiatrists (r = .18, p .05), and attempting to encroach on the functions of psychiatrists (r = .18, p .05).

Confidence in her own competence, then, is accompanied by a wish
to be appreciated, and by feelings of uneasiness about the motives of psychologists in respect to psychiatrists.

Satisfaction with Interrole Relations

The large majority of social workers are well satisfied concerning their relations with psychologists. In both the clinical and community functions, approximately 70 per cent say that they are highly satisfied, 20 per cent express a medium degree of satisfaction, and only 10 per cent state low satisfaction.

The prestige of the social worker influences her degree of satisfaction concerning relations. The members of the social work profession having least prestige are more satisfied about relations with psychologists in the functional area of diagnosis and therapy than in community contacts. The correlation between prestige and over-all satisfaction with relations is \(-.35\) \((p \ .01)\), while the correlation between prestige and satisfaction while performing community contacts is zero. We see again that participation in diagnosis and therapy is considered important and valuable work. When doing diagnosis and therapy the social worker with little prestige is likely to feel satisfied in regard to psychologists because she is engaging in an important function. When active in community contact work, however, the typical social worker does not believe that she is participating in a function which other groups value highly and her prestige has no relation to the degree of satisfaction she feels.

A social worker who perceives that psychologists come to her for help to a gratifying degree is likely to be highly satisfied with psychologists. The correlation between satisfaction with interrole relations and the satisfaction deriving from the fact that one's counsel is sought is \(.52\) in diagnosis and therapy, and \(.41\) in community contacts. We may assume that the social worker's satisfaction is in large part due to the recognition given her knowledge and skill.

A social worker who expresses satisfaction concerning relations with psychologists feels accepted by them. The six correlations listed in Table 23 indicate the type of feelings which accompany such satisfaction. She feels that she would "get along" with psychologists, likes them, believes that this admiration is reciprocated, and wishes to spend leisure time with them.

The social worker who has strongly positive feelings concerning relations with psychologists is more likely to talk to them \((r = .39, p \ .01)\). Indeed, she is willing to talk to psychologists on any topic when
TABLE 23
Correlations between Satisfaction of Social Workers in Relations with Psychologists and Attitudes toward Them

<table>
<thead>
<tr>
<th>The greater the satisfaction of the social worker</th>
<th>r</th>
<th>Value of p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more she feels that she would &quot;get along&quot; with psychologists were they members of the same committee</td>
<td>.37</td>
<td>.01</td>
</tr>
<tr>
<td>The more she stereotypes psychologists as &quot;likeable&quot;</td>
<td>.33</td>
<td>.01</td>
</tr>
<tr>
<td>The less she states that psychologists are trying to encroach on the prerogatives of psychiatrists</td>
<td>-.19</td>
<td>.05</td>
</tr>
<tr>
<td>The more she perceives herself to be liked by psychologists</td>
<td>.21</td>
<td>.02</td>
</tr>
<tr>
<td>The more is she eager to spend leisure time with psychologists</td>
<td>.28</td>
<td>.01</td>
</tr>
<tr>
<td>The more she desires professional contact with them</td>
<td>.48</td>
<td>.001</td>
</tr>
</tbody>
</table>

she is highly pleased with relations. All eleven of the possible communication topics are significantly correlated with satisfaction. The results are a likely indication of the greater security she feels with psychologists when satisfied concerning relations with them since she is ready to make challenging comments to psychologists as well as supportive and friendly ones. Finally, the more gratified a social worker feels about relations, the greater is her readiness to talk to psychologists even in preference to her own colleagues ($r = .23$, $p = .01$). Feelings of satisfaction concerning relations, then, are clearly correlated with strong tendencies to communicate with psychologists.

In summary, the majority of social workers are pleased about the nature of the relations they have with psychologists. A member of the social work profession is most likely to be satisfied with psychologists when she is low in prestige and when they come to her for advice. The belief that relations are satisfactory is accompanied by positive attitudes toward psychologists and by frequent contact and easy communication with them. In general, we may conclude that satisfaction is fairly strong among social workers in regard to psychologists, and that it is likely to remain that way.

Satisfaction from Providing Advice for Others

In terms of frequency only 20 per cent of the social workers feel that psychologists take advantage of the opportunity to learn from social workers. How do they react to this situation? A majority of the social workers are highly satisfied concerning the degree to which they provide professional help for psychologists: 46 per cent say that they are highly
satisfied, 31 per cent express very little satisfaction, and the responses of the remaining 23 per cent fall between these two.

In general, satisfaction due to providing counsel for others is not highly important in affecting the attitudes of social workers toward psychologists. Those who are high in satisfaction are different in only a few respects from those who are low on this same measure.

The more satisfaction the social worker expresses because psychologists seek her counsel to a gratifying degree, the greater is the likelihood that she will see them as liking her ($r = .28$, $p = .01$). In addition, the more satisfaction she feels the greater is her perception that she would "get along" with psychologists, the correlation being the same as that just mentioned. Finally, the more she is satisfied the less she accuses psychologists of attempting to encroach on the prerogatives of psychiatrists. ($r = .29$, $p = .01$).

We may conclude that providing advice for psychologists is not seen as highly rewarding when it occurs often, nor punishing if it seldom happens. Expectations of social workers in this respect are not crucial to their interrole attitudes concerning psychologists. But, it will be recalled, they were highly important in relations with psychiatrists.

**Prestige in Own Profession**

Social workers having much prestige hold attitudes toward psychologists which are indicative of a desire to maintain a certain distance. These are not hostile feelings, but rather impulses to avoid psychologists.

The correlation between amount of prestige and willingness to have leisure-time contacts with psychologists is $- .30$ ($p = .01$), which indicates that social workers with prestige are less likely to desire leisure-time contact with psychologists. The social worker who has great prestige also feels that she would not "get along" with psychologists on a committee ($r = -.53$, $p = .001$). And, the greater her prestige the less a social worker is interested in discussing light matters ($r = -.28$, $p = .01$), her own success experiences ($r = -.25$, $p = .01$), nonprofessional differences of opinion ($r = -.24$, $p = .01$), and complaints about a psychologist's behavior ($r = -.20$, $p = .02$).

**Summary of Social Worker's Attitude toward Psychologists**

Mild cordiality is the social worker's general feeling toward psychologists. In a few instances one finds more strongly-toned attitudes but the over-all tenor is closer to neutrality than that described in the two previous chapters.
The social worker tends to see psychologists as having strong aspirations, and she becomes more sensitive about these motives and about efforts to win approval from psychiatrists if she is high in power or in knowledge and skills. But this awareness of the psychologists' desire for greater usefulness apparently is accompanied by feelings of rivalry, anxiety, or aggression against them since such efforts are seldom viewed as creating any relative deprivation for the profession of psychiatric social work. Perhaps the social worker is not usually made uneasy by her perception of the psychologist's motives because she has few needs to increase her own power. In fact, the majority of the social workers feel that they are equal or superior in power to psychologists and would like matters to remain just that way. The majority also believe that they are equal to psychologists in knowledge and skill.

All in all, the degree of power attributed to themselves is relatively unimportant in determining attitudes toward psychologists. Social workers with high power have almost no attitudes which are different from the feelings of those with low power. Social workers apparently do not view psychologists as either a likely source of rewards or as the origin of threats. The desire for power, however, is a different matter. The social workers who have a strong wish for greater influence in respect to psychologists tend to have little interest in positive relations with them.

The feelings of the average social worker, then, are neither highly favorable nor openly negative. She is most likely to have positive attitudes toward psychologists if she has little desire for more power, is low in professional prestige, has frequent contacts with psychologists, and has had satisfactory relations with them in the past. Unfavorable feelings occur under the opposite conditions. Also negative attitudes toward psychologists are more likely to develop when a social worker is performing the highly valued diagnostic and therapeutic functions than when she is performing community contacts.

PERCEIVED POSITION ON THE INDEPENDENT VARIABLES OF CLINICAL PSYCHOLOGISTS TOWARD PSYCHIATRIC SOCIAL WORKERS

Perceived Relative Power to Influence

Will psychologists perceive that their power is greater than that of social workers? Since they have a wish to increase their professional value, one might expect to find that psychologists would perceive that
they have great power in relation to social workers as a form of wish fulfillment. On the other hand there is no widely accepted hierarchical relationship between the two groups, and it might instead be anticipated that psychologists would perceive themselves to be equal in power to social workers.

Most of the psychologists see their power as being relatively equal to that of social workers. When asked to rate their amount of power, 9 per cent state that they have greater power than social workers, 10 per cent say that the influence of social workers is greater, and 81 per cent feel that their own power is equal to that of social workers.

These percentages describe results obtained when the psychologist answers in terms of participating in diagnostic activities. When responses are in terms of performing therapy or making community contacts there is little difference (with the one exception to be discussed below). In all three professional areas most psychologists perceive that the power of the two professions is roughly equal. In the following data the measure of perceived power will usually refer to power in diagnostic activities. The other two functions will be mentioned only where results are strikingly different.

The psychologist with great prestige tends to attribute high power to himself in all three functions. The correlation between professional prestige and perceived power is .25 (p .01).

The power of the psychologist over the social worker in community contacts is likely to be greatest when past relations have been frequent (r = .23), satisfying (r = .28), and when the social worker has often placed herself in an advice-seeking relationship (r = .34).

There are almost no attitudes which are significantly correlated with the degree of power the psychologist attributes to himself in diagnosis and therapy. The psychologist with high power feels very little different toward social workers than the one with little power. This may be because a psychologist does not participate in functions which require social workers to be in either a subordinate or a superior relationship to them. Power is not a relevant dimension in their relationships in these two functions.

It is noteworthy, however, that 20 per cent of the psychologists perceive themselves to have high power vis-à-vis social workers in the area of community contacts. Psychologists seldom work or assign social workers to work in this field. One-third of them, however, would like more power in community work. Perhaps this is a type of power which would help the psychologist to become more useful. He would like to
be able to assign social workers to make family contacts in order to aid him in his professional efforts. Furthermore, since making family contacts is a function he does not engage in, the social workers would have little reciprocal opportunity to influence him and a resultant power in his favor is possible. Whatever the reason might be for a psychologist's perception of power in this functional area, he tends to be more positive in his attitudes toward social workers when he believes he has high power of this type. The more his power the more he wishes professional contacts with them \((r = .25)\), the more he wishes to be respected \((r = .21)\), the more he perceives he is respected \((r = .26)\), and the less he sees them as striving for recognition from psychiatrists \((r = .23)\).

To summarize, the large majority of psychologists believe that their own power is about equal to that possessed by social workers. Those with high power in diagnosis and therapy are no different from those with low power in their feelings about social workers. However, those who attribute high power to themselves in community contacts tend to be positive toward them.

**Acceptance of Power Position**

The majority of the psychologists believe that their own power should be about equal to that of social workers: 17 per cent say that they ought to possess more power than they presently have, 18 per cent feel that social workers should have more than they now do, and 65 per cent state that the power relation should remain as it now is. These percentages refer to the power desired in diagnostic activities. Those in therapy and community contacts are roughly similar with one exception. One-third of the psychologists believe that they should have more authority than they now do in controlling the community contact activities of social workers. It is probable that the desire for relatively greater power in a functional area which is a traditional prerogative of social workers, is the result of an awareness that an increase of influence in this area will give him the most effective power over social workers.

It is the higher-status psychologists, having frequent contacts with social workers, who wants greater power over them. The correlation between professional prestige and power desired is \(.24 (p .01)\). That between present amount of power and degree desired is \(.30 (p .01)\), and between frequency of professional contacts and wish for power is \(.61 (p .001)\).

An interest in obtaining greater power over social workers is con-
ducive to a readiness to talk to them about matters which reflect on the competence of social workers. The more a psychologist desires greater power the more willing is he to communicate to social workers about their mistakes \((r = .29)\), their group's inadequacies \((r = .31)\), the displeasing aspect of their behavior \((r = .30)\), professional differences of opinion \((r = .28)\), as well as the successes that social workers may have had \((r = .24)\). All of these correlations have a confidence level of .01 or better.

The psychologist who desires greater power over social workers wants few contacts with them and feels that such interactions are uncomfortable. The greater his desire for power, the less he wants professional interaction with social workers, the less he seeks leisure time with them, the less he feels that he would "get along" with them were they members of the same committee, and the less ready he is to talk to social workers regardless of the topic. The correlations are, respectively, \(-.52\), \(-.44\), \(-.40\), and \(-.20\).

The more a psychologist wishes for power the greater is the likelihood that he will perceive social workers as seeking to win the approval of psychiatrists \((r = .26, p \leq .01)\) and attempting to curry favor with psychiatrists \((r = .26, p \leq .01)\). Apparently a psychologist's desire for power causes him to be sensitive to the social worker's proclivity to look to psychiatrists for support and approval.

**Frequency of Professional Contacts**

When psychologists were asked to estimate how often they met with social workers professionally, 40 per cent said nearly every day, 40 per cent estimated less than once a month, and the remaining 20 per cent described intermediate frequencies of contact. This is a low rate of interaction compared to the contacts reported in describing the other two role relations. Many of the responses given by psychologists, therefore, may be about a professional group which they know more by reputation than by first-hand experience.

The psychologist who has much interaction with social workers is most likely to see them as attempting to win approval of psychiatrists and to be upward mobile in their behavior. In Table 24 a number of correlations are reported between frequency of contact and certain attitudes toward social workers. The data indicate that the psychologist becomes uneasy about the motives of social workers when he works with them at close range. The psychologist tends to stereotype social workers a "striving" when he sees them often. Furthermore, the best means
that social workers have available to them for satisfying their professional needs, as seen by the psychologist, is to win approval of psychiatrists. Thus, the psychologist who often has professional interactions with social workers is more likely to view them as encroaching upon psychiatrists, trying to “curry favor” from psychiatrists, and working hard to win their recognition.

TABLE 24
Correlations between Perceived Frequency of Professional Contacts among Psychologists and Social Workers and Attitudes Concerning the Social Workers

<table>
<thead>
<tr>
<th>The more professional contacts the psychologist has with PSW's</th>
<th>r</th>
<th>Value of p</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more PSW's are stereotyped as “striving”</td>
<td>.26</td>
<td>.01</td>
</tr>
<tr>
<td>The more PSW's are seen as encroaching on the prerogatives of psychiatrists</td>
<td>.27</td>
<td>.01</td>
</tr>
<tr>
<td>The more do PSW's “curry favor” with psychiatrists</td>
<td>.19</td>
<td>.02</td>
</tr>
<tr>
<td>The more do PSW's strive for recognition of psychiatrists</td>
<td>.51</td>
<td>.001</td>
</tr>
<tr>
<td>The more are PSW's in competition with psychologists for approval of psychiatrists</td>
<td>.20</td>
<td>.01</td>
</tr>
<tr>
<td>The more are PSW's stereotyped as “threatening”</td>
<td>.34</td>
<td>.01</td>
</tr>
<tr>
<td>The less are PSW's stereotyped as “likeable”</td>
<td>.30</td>
<td>.01</td>
</tr>
</tbody>
</table>

That these perceptions do not leave the psychologist altogether comfortable is shown in the next three correlations in Table 24. Here we see that a psychologist believes that social workers are competing with his own profession in seeking to win approval of psychiatrists, and that the psychologist who frequently meets with social workers sees them as “threatening” and “unlikeable” people.

Why should frequent professional contacts with social workers make a psychologist more prone to harbor anxieties about the social worker’s objectives? We assume that psychologists are strongly motivated to win acceptance for themselves as a profession. Social workers may listen to psychologists, but from psychiatrists they can obtain for themselves freedoms and rights which the psychologists cannot always provide. Thus, psychologists are rivals of psychiatrists in the sense that social workers might obtain better need satisfaction in their relations with psychiatrists than with psychologist. The psychologist is the new arrival. When he has close working relations with social workers he is made aware of the more established state of affairs between social workers and psychiatrists.

Despite his uneasiness about the social worker’s intentions, the psychologist who most often meets with social workers feels that they
respect his competence and like him. The correlation between frequency of contact and perception of being respected is .66 (p .001), and that with perception of being liked is .55 (p .001). His wish to be respected increases with the number of contacts he has with social workers (r = .25, p .01).

Where does this leave the psychologist in his wishes for further professional interaction with social workers? Apparently the more often he meets with social workers, the more he would like to do so (r = .81), and the more too, he desires leisure-time contacts with them (r = .45).

To summarize, about four out of ten psychologists have infrequent professional contacts with social workers and an equal number see them often. When contacts occur frequently a psychologist is more likely to attribute upward mobility efforts to the other group and is also uneasy about the possibility that the opportunity for the fulfilment of his professional aspirations will be reduced. Nevertheless, the more he works with social workers, the more he feels respected and admired by them and the more is he willing to continue close relations with them—despite the fact that his stereotypes about them are somewhat negative.

**Professional Knowledge and Skills**

When asked about the degree of knowledge and skill they possess in comparison to social workers, 40 per cent of psychologists stated that they feel their knowledge is greater, 43 per cent equal, and 17 per cent less. Observe then, that 83 per cent of the psychologists believe they are equal or superior to social workers in professional competence. These percentages are almost exactly the same as the response given by social workers.

One might expect that a person who has high respect for his own competence would believe that others feel the same way about him. This does not appear to be the case in regard to psychologists concerning social workers. *The more psychologists take pride in their own professional knowledge and skill, the more they believe that social workers value them very little.* The greater the knowledge and skill a psychologist attributes to himself, the less he perceives that social workers respect him (r = -.25, p .01), the more he believes that they do not like him (r = -.22, p .01), and the less satisfied he is concerning the degree to which they come to him for advice (r = -.20, p .02).

Perhaps he wants more respect than he receives and he is disappointed. Similarly, he wishes to be liked and to serve as a source of
counsel for social workers when his perception of own knowledge and skill is high. But here again his experience is disappointing. He perceives that social workers do not grant him the amount of esteem and admiration which he feels he deserves.

The psychologist who see himself as an able person, therefore, is likely to enter into discussions which are relevant to improving his professional self-esteem. The more knowledge and skill he attributes to himself, the more willing he is to talk to a social worker about a mistake she may have made ($r = .25, p .01$). In addition, when he rates his own competence as high, he is more ready to discuss his own successes with social workers ($r = .27, p .01$) and is more willing to talk to them about the inadequacies of the social work profession ($r = .19, p .05$). It is apparent that the psychologist with a strong belief in his professional superiority tends to be willing to discuss those issues which may win greater esteem for himself.

**Satisfaction with Interrole Relations**

*The majority of psychologists are highly satisfied concerning interrole relations with social workers.* The proportions in the three levels of satisfaction are 63 per cent high, 25 per cent medium, and 12 per cent low. These figures are roughly similar for three functions: diagnosis, therapy, and community contact.

The psychologist tends to be more satisfied concerning relations with social workers if he has frequent professional contacts with them ($r = .41, p .01$), and if he is gratified with the degree to which they come to him for advice ($r = .36, p .01$).

*The psychologist's satisfaction concerning relations with social workers are strongly influenced by the relationship he perceives then to have with psychiatrists.* Here we note that he is most satisfied when he views them as unconcerned about relations with psychiatrists and appreciative of psychologists instead. In Table 25 it may be seen that the psychologist who is satisfied in his relations with social workers has less tendency to see them as interested in winning the good will of psychiatrists, currying favor with psychiatrists, trying to win the psychiatrist's recognition, competing with psychologists, or as "striving." He also tends to believe that he is highly esteemed and admired by them.

*A psychologist who expresses satisfaction concerning relations with social workers is comfortable with them.* The more satisfaction a psychologist feels the more he wishes frequent professional interactions ($r = .81$) as well as leisure-time contacts ($r = .34$). A psychologist
TABLE 25

Correlations between Satisfaction of Psychologists in Relation to Social Workers and Attitudes about their Motives

<table>
<thead>
<tr>
<th>The greater the satisfaction of the psychologist</th>
<th>( r )</th>
<th>Value of ( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>The less are PSWs perceived as “currying the favor” of psychiatrists</td>
<td>( -0.53 )</td>
<td>( 0.01 )</td>
</tr>
<tr>
<td>The less are PSWs perceived as striving for recognition from psychiatrists</td>
<td>( -0.41 )</td>
<td>( 0.01 )</td>
</tr>
<tr>
<td>The less are PSWs perceived as competing with psychologists for the approval of psychiatrists</td>
<td>( -0.28 )</td>
<td>( 0.01 )</td>
</tr>
<tr>
<td>The less are PSWs stereotyped as “striving”</td>
<td>( -0.27 )</td>
<td>( 0.01 )</td>
</tr>
<tr>
<td>The more are PSWs perceived as having respect for psychologists</td>
<td>( 0.19 )</td>
<td>( 0.05 )</td>
</tr>
<tr>
<td>The more are PSWs perceived as liking psychologists</td>
<td>( 0.33 )</td>
<td>( 0.01 )</td>
</tr>
</tbody>
</table>

who reports high satisfaction is more ready to communicate to social workers regardless of the topic \( (r = 0.34) \), and believes that he could “get along” with them on a committee \( (r = 0.24) \).

In summary, the large majority of psychologists are highly pleased concerning relations with social workers, more so when they have frequent contacts with them, and when social workers seek advice from them. Psychologists who report high satisfaction perceive that social workers are less intent on winning approval of psychiatrists and are willing to be supportive of psychologists. Finally, the more they are satisfied about relations with social workers, the greater is their readiness to work and communicate with them.

Satisfaction from Providing Advice for Others

Psychologists and social workers are alike in the proportion of their number who take advantage of what the other group has to offer. In each profession about 20 per cent reply that they do so. When asked how gratified they are concerning the frequency with which social workers come to them for advice 45 per cent say they are highly pleased, 25 per cent express a medium degree of satisfaction, and 30 per cent state that they are dissatisfied.

The more that the psychologist is pleased with the degree to which the social workers come to him for advice, the greater are his feelings that he is both respected and liked by them \( (r = 0.21, p 0.01) \). Thus, one who believes that social workers sometimes learn from him also feels that they value him.
He returns the good feelings. The psychologist who is most satisfied that they seek his advice is likely to wish for frequent professional contacts \( (r = .32, p .01) \). Furthermore, the more satisfied a psychologist is, the greater is the likelihood that he will believe that he can “get along” with members of the social work profession \( (r = .37, p .01) \). Finally, the more a psychologist is satisfied with the degree to which social workers come to him for help, the more ready he is to communicate to social workers \( (r = .20, p .01) \).

What sort of topics does he choose to discuss with them? Apparently he prefers those which may increase the ease rather than the discomfort of social workers. The greater the gratification of the psychologist, the more willing he is to discuss the inadequacies if his own profession \( (r = .32) \), the mistakes he has made as a professional person \( (r = .22) \), and the successes that social workers have had \( (r = .21) \). However, he avoids discussion of professional disagreements \( (r = .19) \). All of these correlations are significant at the .05 level or better. These data, incidentally, are in distinct contrast to the attitudes shown by a member of either of the ancillary professions when satisfied with the degree to which psychiatrists seek help. In those instances the adjunct worker becomes less inhibited in his communication and freely points out the faults of the psychiatrists.

In summary, about half of the psychologists are gratified by the frequency with which social workers turn to them for counsel. This satisfaction is accompanied by positive feelings toward social workers, readiness to spend more time with them, and willingness to discuss matters which make the social worker comfortable and the psychologist appear somewhat less than perfect.

**Prestige in own Profession**

Throughout the data it has been found that the high-status member of any profession tends to be little interested in close interaction with the members of another. The explanation of this has been that persons with much prestige are more closely drawn to their own group and are more likely to see the other profession as less relevant to their needs. The psychologists conform to this trend in their responses concerning social workers.

*The more prestige a psychologist has, the less he desires professional contacts with social workers,* the less he wishes to be liked by them, and the less he is interested in light conversation with social workers. The correlations are, respectively, \(-.24, -.20, \) and \(-.19\).
Summary of Psychologists' Attitudes toward Social Workers

There are four different aspects of the psychologists' feelings toward social workers which are worthy of special discussion. They may be reviewed first in terms of the beliefs which are held by the average psychologist toward social workers: (a) psychologists are eager to be esteemed and admired, (b) they believe that they have good relations with social workers, (c) they are not strongly motivated to win power over social workers, and (d) they see social workers as willing to be an adjunct profession for psychiatry and as trying to profit from this relationship.

(a) The psychologist, on the average, has a stronger wish to be liked and respected by social workers than that group has toward him. This hope for positive valuation stems from the fact that psychologists have a strong motivation to include functions in their role beyond the administering of psychometric tests. To be admired and esteemed, therefore, is a means whereby the probability is increased that he will be enabled to engage in a wider variety of activities. Furthermore, the psychologist is a relative newcomer who is attempting to win acceptance for himself in agencies employing mental health workers. To be valued is reassuring since it indicates that his help is considered useful by persons who may encourage the use of the services he has to offer.

The psychologist is most likely to perceive that he is highly valued by social workers when he has frequent contacts with them, when he is gratified by the degree to which they come to him for advice, and when he believes that his own knowledge and skill is not unduly high compared to that possessed by social workers. Apparently the psychologist with a strongly favorable impression of his own professional competence believes that social workers appreciate him less than they should, while one with a low evaluation of himself believes that he is admired by social workers.

(b) Strong feelings of satisfaction are accompanied by many positive and warm attitudes toward social workers. The psychologist feels most favorable toward them when he is low in prestige within his own profession, when he has little desire for greater influence, and when he is content with the degree to which they ask him for help or advice. Unfavorable feelings toward social workers are most likely to develop when a psychologist is made sensitive concerning his status because of his high prestige, his desires for more power, or his feelings that his help is not used by social workers.
(c) The psychologist does not tend to see himself as having greater power than the social workers, and he does not strongly wish for more influence over them. This, it will be recalled, duplicates the opinions of the social workers. Since neither of these two professions is traditionally able to supervise, teach, or instruct the other it seems reasonable that power over each other would not be an important issue. The psychologist who perceives himself as having strong power over social workers is little different from the one who attributes small influence to himself. Clearly, power position is not a strong determinant of the interrole attitudes among members of these two professional groups.

(d) They are quite alert to the nature of the relations between social workers and psychiatrists and the possible implications this may have for fulfilling their own professional aspirations. The average psychologist believes that social workers are not strongly motivated to improve their professional status. But when a psychologist has frequent professional contacts with social workers he is likely to believe that they are striving, and intent upon improving their position as a profession by seeking to win the approval and support of psychiatrists.

The nature of the social worker's interactions with psychiatrists, then, is an important issue for the psychologist. When he believes that they make few efforts to win approval from psychiatrists, he is most likely to express strong satisfaction concerning his relations with them and even believes that they highly value him. In contrast, if he perceives that social workers are both striving and eager to gain the support of psychiatrists, he feels much less satisfied toward social workers and believes they value him less. In a sense, psychiatrists are rivals of the psychologist in acquiring stature in the eyes of social workers.

**Chapter Summary**

The attitudes and behaviors existing between social workers and psychologists have been examined in this chapter. A unique feature here is that both professions are ancillary groups to psychiatry and neither has a traditional pattern of activities to be performed in close collaboration with the other.

In the description of the average interrole attitudes it was noted that the social workers tend to see psychologists as eager to advance as a profession, whereas they (social workers) are viewed as being content in their position as an adjunct to psychiatry.

While the social worker recognizes the aspirations of psychologists, she perceives them as skilled in psychometrics and not in the wide
range of functions which psychologists attribute to themselves. The psychologist, in contrast, believes that he can do many things beyond administering tests. Thus, the social worker does not recognize that psychologists have the skills which they would like to perform in order to advance their profession.

In general, the roles of these two professions are not well integrated. About 20 per cent of the interviewees in each profession feel that they make use of what the other profession has to offer them. The other 80 per cent fail to do so for situational rather than interpersonal reasons. Therefore, the two professions appear to view each other across a gulf created by the lack of any strong need for professional collaboration between them. This leads to some mildly negative perceptions but not to strong fears or misapprehensions about the other.

The psychologists are more eager to be liked and respected by social workers than are social workers by psychologists. This situation may be due to the psychologists' eagerness to be accepted as regular and useful members of the clinical team as well as their motivation to establish the field of clinical psychology as a recognized profession. Thus, they tend to place stronger value on their own profession than they do on social work, whereas the social workers do not view themselves as better or worse than psychologists but as equals.

It is apparent that the possession of power and the desire for greater power are not strongly related to interrole attitudes among the members of these two groups. On almost every relationship dimension these two groups were alike in the beliefs expressed by the majority of members, and in most instances the attitudes associated with a given position were alike.

The psychologists and the social workers do not represent a threat or barrier to one another; they are more concerned with the nature of the relations that the other profession has with psychiatrists. Under certain conditions these concerns are readily expressed. For the social worker, uneasiness about the psychologist's intentions vis-a-vis psychiatrists is most aroused when she attributes high power to herself and when she perceives herself to be most proficient in knowledge and skills. The psychologist becomes most aware of the problem when he aspires to have greater power in relation to social workers than he now possesses and when he has frequent professional contacts with them. The psychologist, in fact, is most satisfied in his relations with social workers when he believes that they are disinterested in winning the good will of psychiatrists and instead are ready to support and respect psychologists.
CHAPTER 7

ATTITUDES OF EACH PROFESSIONAL GROUP TOWARD THE OTHER TWO GROUPS

We have seen that membership in a given profession influences a person's attitudes toward those in other relevant professions. Thus far this assertion has been examined by comparing the average interrole feelings among members of three mental health professions and noting how these attitudes are correlated with an individual's position on various role relationship dimensions.

Attention now turns to a treatment of the way in which persons in each role differ in their attitudes toward persons in the other two roles. This information broadens our understanding of role relations because it specifically compares A's feelings about B and C, B's feelings about A and C, and C's feelings about A and B. These contrasts also reveal whether feelings toward the other groups are alike or different in the light of the position of each respondent group in the social structure of these professions.

It is convenient to describe these contrasts by reporting those data in which there is a statistically significant difference in the average feelings of a particular group about each of the other two.

Comparing the Social Worker's Attitudes toward Psychologists and Psychiatrists

The working relations that psychiatric social workers have with psychiatrists and with psychologists are different in a number of respects. Social work has had close connections with psychiatry for many years. The role is ordinarily thought of as an adjunct to psychiatry and many of the duties of a social worker are intended to lighten the load for psychiatrists. This means that the functions of the two professions are usually well integrated and much of the work done by social workers is either requested or sanctioned by psychiatrists. A social worker's usual relationship with psychologists is quite different. Psychologists have no authoritative or sanctioning position vis-a-vis social workers.

Because psychiatrists are more relevant and authoritative in the social worker's life, we will see that she has greater respect and admiration
for the members of that profession, accepts a more subordinate position while wanting greater freedom and respect from them, and perceives that relations are more satisfactory in regard to them. The responses of the average social worker, in short, indicate more deference and awareness of the other's power in her reactions to psychiatrists than to psychologists.

*It is apparent that the majority of social workers attribute high power to psychiatrists, whereas they see psychologists as having power equal to their own.* This is shown in Table 26.

<table>
<thead>
<tr>
<th>TABLE 26</th>
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</table>

Per Cent of Social Workers Claiming Various Degrees of Power in Relation to Psychiatrists and Psychologists

<table>
<thead>
<tr>
<th>Social work function</th>
<th>Degree of attributed power</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other group has most</td>
</tr>
<tr>
<td>Diagnosis and therapy</td>
<td></td>
</tr>
<tr>
<td>In relation to psychiatrists</td>
<td>55%</td>
</tr>
<tr>
<td>In relation to psychologists</td>
<td>4%</td>
</tr>
</tbody>
</table>

Chi square (based on frequencies) is 445, $p$ equals .001

Social histories and community contacts

| In relation to psychiatrists           | 61%                        | 32%                    | 7%                         |
| In relation to psychologists (community contracts only) | 8%                         | 80%                    | 12%                        |

Chi square (based on frequencies) is 772, $p$ equals .001

Despite this gap in power between themselves and psychiatrists, or perhaps because of it, social workers are more eager to increase the influence they might have on psychiatrists. When asked what the power relationships should be in respect to psychiatrists, 44 per cent of the social workers say that they desire greater power than they now have, 22 per cent feel that psychiatrists should have more, while the remaining 34 per cent feel that the two groups should be about equal in power. In regard to the proper influence on relations with psychologists, 14 per cent say that they want more than they have at present, 18 per cent are ready to have less, and 68 per cent believe that the two professions should be equal.

*The average responses of the social worker reveal in a number of ways that they place more value on psychiatrists than on psychologists.* Social workers give psychiatrists a mean rank of 3.78 and psychologists a rank of 6.64 when describing the contribution potential each profes-
sion has for a committee dealing with mental hygiene problems in the community. The difference is significant at the .001 level of confidence. They also stereotype psychiatrists as more "competent" (4.83), better "trained" (4.88) and more "scientific" (5.32) than psychologists. The averages given to psychologists in these three characteristics are 4.58, 4.64, and 4.81 respectively.

In addition social workers would prefer to be psychiatrists if they had their career to choose again. Psychiatry is chosen over psychology as a first choice in the ratio of 59 to 3, and as a second choice in the ratio of 68 to 15. The large majority of social workers feel that they should earn less than psychiatrists do, whereas they believe that a psychologist's salary should be the same as their own. When comparing their proper income to that of psychiatrists, no social workers feel that they should earn more, 12 per cent believe that their pay should equal a psychiatrist's, and 88 per cent say they should get much less than psychiatrists do. When comparing their income to that of a psychologist, 14 per cent state that they should be paid more than psychologists, 80 per cent feel that both groups should have equal incomes, and only 6 per cent believe that they ought to be paid less than psychologists.

Finally, the social workers place higher comparative value on the knowledge and skills of psychiatrists. When asked to compare their own wisdom and information to that possessed by psychiatrists, 51 per cent say that psychiatrists know more, 9 per cent that social workers know more, and the remaining 40 per cent that both groups are equal. On the other hand, when social workers compare themselves to psychologists, 18 per cent think that the other group knows more, 39 per cent believe that they themselves are wiser, and the remaining 43 per cent give equality responses.

The social workers have more frequent contact with psychiatrists than with psychologists. Sixty-seven per cent estimate that they meet with a psychiatrist almost every day, while 55 per cent say that they see a psychologist that often. Sixteen per cent of the social workers have contacts with a psychiatrist no more than once a month, while 27 per cent of them state that their interaction with psychologists is as infrequent. The difference is significant at the .05 level.

Relations with psychiatrists are seen as more satisfactory than with psychologists. Eighty-three per cent of the social workers say that relations with psychiatrists are highly satisfying and only 7 per cent state that they are not satisfactory. When reacting to psychologists 67 per cent feel that relations are satisfying and 13 per cent believe
they are poor. The difference is statistically significant at a confidence level of .02.

Furthermore social workers feel that they would “get along” with psychiatrists better than with psychologists were they all members of the same committee. Of those interviewed, 135 say that they would get along very well with psychiatrists and only 3 feel it would be difficult to work with them. When reacting to psychologists, however, 45 say that they would be uncomfortable with them. It is clear that social workers foresee more pleasant relations with psychiatrists than with psychologists if they were to work together in a community group.

Social workers stereotype psychiatrists as less “dogmatic” (2.74), less “defensive” (3.68), and less “striving” (2.42) than psychologists, who are given average ratings of 3.31, 4.29, and 2.68 on these three characteristics. But they also see psychiatrists as more “threatening” (4.82), more “mercenary” (3.57), less “mature” (4.35), and less “likeable” (4.86) than psychologists. The mean score for psychologists on these attributes are 4.48, 2.86, 4.68, and 5.06 respectively. All differences between these average scores have a \( p \) value of .05 or better.

The members of the social work profession are more eager to be positively valued by psychiatrists than by psychologists. When asked how much they desire to be respected by psychiatrists they give an average response of 4.28, and in regard to psychologists the mean is 4.0 (\( p \) of diff. .05).

Finally, the social worker desires more frequent contacts with psychiatrists than with psychologists. The mean wish for more professional interaction with psychiatrists is 5.32 and with psychologists 4.29. The desire for more leisure time together is 3.72 in respect to psychiatrists, and 3.28 in relation to psychologists. The differences in each type of interaction are statistically significant at the .01 level.

To summarize, the social workers are more deferential yet more positive in their attitudes toward psychiatrists. Both the clarity of their functions as ancillary workers and the subordination of their status make them so. We have seen that the major differences in attitude toward psychiatrists, as compared to psychologists, indicate that social workers attribute more power to psychiatrists, hope to reduce this power gap, place more value on them as a professional group, and enjoy closer and more satisfying relations with psychiatrists than with psychologists.
Comparing the Psychologist’s Reactions to Social Workers and Psychiatrists

The position of clinical psychology in regard to psychiatry historically has been one in which services have been provided to facilitate clinical diagnosis. Yet, as we have seen, psychologists aspire to increase the functions and enlarge the scope of their role. Since psychiatrists can influence the nature of this role expansion, they may be seen by psychologists as gatekeepers, who can act either as frustraters or as helpers in respect to the psychologists’ ambitions.

In contrast, as has been said, the traditional interrole relationship between psychologists and social workers has been one in which there is no close integration of functions and no regular hierarchical placement in regard to each other.

Where psychologists differ in their reactions to the two groups, they appear more willing to state that they have a subordinate status to psychiatrists, want more influence in respect to psychiatrists, have greater satisfaction in relations with them and place greater value upon them. At the same time psychologists are more uneasy concerning the motives and reasons for psychiatrists’ actions where they are relevant to psychologists’ aspirations. In short, psychologists act more like a subordinate group to psychiatrists than to social workers, and they fear or perceive frustration to their desires more often by psychiatrists.

Psychologists attribute more power to psychiatrists than they do to social workers. When asked how much power they presently have in relation to the two groups, 51 per cent say that psychiatrists have most and only 20 per cent attribute high power to themselves. In respect to social workers, 10 per cent of the psychologists feel that social workers have more influence and 9 per cent believe that their own profession has more. The majority of the psychologists (81 per cent) state their own power is equal to that of social workers.

The psychologist is eager to reduce the power gap between his own profession and psychiatry while he accepts equality with social workers. When asked what the relative power of the two professions should be, 49 per cent of the psychologists say that they should have more than they have now in their relations with psychiatrists, 27 per cent state that psychiatrists should retain the greater power, and the other 24 per cent feel that the two professions should be equal. In regard to social workers, 17 per cent of the psychologists believe that they themselves should have greater power than they have at present, 18 per cent say
that social workers ought to have more, and the other 65 per cent feel that the two professions should be about equal.

In a manner very similar to the social workers, psychologists place more value on psychiatry than they do on the other adjunct profession. They rank psychiatrists as more likely to be helpful on a community committee than the social workers would be. The mean rankings are 3.10 and 4.60 respectively and the difference between these two is statistically significant. Furthermore, they are much more attracted to psychiatry as a career; if they could choose again, 69 give psychiatry as a first choice while only one psychologist prefers social work.

In addition, psychologists feel that they should earn more than social workers but only as much money as psychiatrists or less, 4 per cent say that they should have higher incomes than psychiatrists, 52 per cent believe that their earnings should be equal to psychiatrists', and 44 per cent state that it is acceptable for psychiatrists to have larger incomes than psychologists. In respect to social workers, however, 76 per cent of the psychologists say that their financial return should properly be greater than the other group's, 21 per cent state that both groups should be equal, and only 3 per cent feel that social workers should earn more than psychologists.

Furthermore, the psychologists perceive themselves to be better than social workers in knowledge and skills but closer to a peer level with psychiatrists: 30 per cent say that they know more than psychiatrists, 25 per cent state that psychiatrists know more, and 45 per cent believe that both groups are equal. In respect to social workers, 45 per cent of the psychologists claim greater knowledge, 18 per cent say that social workers have more, and 37 per cent state that both groups are equal. The difference in these distributions is statistically significant at the .001 level of confidence.

Finally, psychiatrists are stereotyped as more "insightful" (4.33), more "mature" (4.47) and more "scientific" (2.75) than are social workers. However, they are also described as more "well-trained" than social workers (4.08). The ratings given to social workers on these same characteristics are 4.14, 4.21, 1.79, and 4.59 respectively. All differences between these averages have a p value of .05 or better.

Psychiatrists also are described as less "dogmatic," "mercenary," "condescending," "threatening," and "striving" than the social workers are seen to be. However, the social workers are described as more "likeable." (Table 42). All of these differences are statistically significant.

The majority of psychologists, then, feel that the potential contribu-
tion of psychiatry is greater than that of social work and are more attracted to that profession. They also feel that psychologists' incomes should be greater than that of social workers, and that they know more than social workers do. Further, psychologists feel that they should earn about as much as psychiatrists do, that they know about as much as psychiatrists, and that psychiatrists have more valued professional attributes than do social workers.

**Psychiatrists are much more important persons for a psychologist than are social workers.** Despite the approving attitudes just described, psychologists are aware of sources of strain in their relations with psychiatrists. We assume that such feelings are caused by the awareness that psychiatrists are potentially more disturbing for psychologists since they, in contrast to social workers, have the ability to promote or frustrate their aspirations.

In explaining why they do not make use of the help available from psychiatrists, 62 per cent of the psychologists refer to difficulties in interpersonal relations. When stating why they do not take advantage of social workers' skills only 28 per cent mention interpersonal relations (p of diff. .001). When psychologists were asked why members of the other two professions fail to use the psychologists' resources, situational reasons were given most often vis-a-vis both groups and in roughly equal proportions.

**Psychologists have more frequent contacts with psychiatrists and place higher value on interactions with them than with social workers.** Of the number interviewed 60 per cent say that they have professional contacts with psychiatrists every day, while 23 per cent state that these occur no more than once a month. Forty per cent estimate that they see social workers daily and another 40 per cent say that such contacts seldom occur. The mean desire for further professional meetings with psychiatrists is 5.05 and with social workers it is 4.29. In addition, the average wish to spend more leisure time with psychiatrists is 3.76, and it is 3.07 in respect to social workers. The difference between both these pairs is significant at the .01 level of confidence.

Psychologists describe relations with psychiatrists as being more satisfying than those with social workers. In respect to psychiatrists 80 per cent express high satisfaction with relations and 7 per cent say that relations are unsatisfactory. When reacting to social workers, 63 per cent say that relations are satisfactory and 12 per cent that they are poor.

*Finally, psychologists have a stronger wish to be respected by*
psychiatrists than by social workers. They express an average desire to be esteemed by psychiatrists of 4.44 and by social workers of 4.29. The difference between these means is statistically significant.

To summarize, the psychologists consider themselves as subordinates to psychiatrists but they also hope to improve their position in that relationship. They admire psychiatrists, attribute more positive stereotypes to them than to social workers, and express greater satisfaction in relations with them despite feelings that they, the psychologists, do not use psychiatrists’ resources fully because of difficulties in interpersonal relations. All of these feelings are expressed more strongly concerning psychiatrists than social workers. Indeed, it may be said that both the social workers and psychologists look past each other to the psychiatrist as the more important member of the mental health team.

Comparing the Psychiatrist’s Reactions to Social Workers and Psychologists

In what ways might the behavior and opinions of psychiatrists differ in respect to social workers and to psychologists? It is apparent that both of the subordinate groups are similar in many ways concerning their perceptions of, and feelings toward psychiatrists. Do the psychiatrists react to both groups similarly, or do they differentiate between the two?

The services provided by social workers are clearly understood by psychiatrists and widely accepted by them. In regard to psychologists there has been less comprehension and use of the group’s fuller capacity. Yet, many of the significant differences which occur in psychiatrists’ evaluation of the two professions indicate that psychiatrists see psychologists as superior to social workers.

Psychiatrists generally place more value on psychologists than on social workers. The majority of psychiatrists perceive that they themselves have greater professional competence than members of the other professions; but they see psychiatry as more superior to social work than to clinical psychology. When asked to place themselves in relation to the two groups 44 per cent stated that they have more knowledge and skill than psychologists and 12 per cent that psychologists are superior. When comparing themselves to social workers, 69 per cent said that psychiatrists are better and only 3 per cent that social workers have the advantage. The evaluation of the two groups is significantly different at the .01 level of confidence.
Furthermore the psychiatrist would rather be a psychologist than a social worker. When asked which career he would choose if he had the opportunity to begin again almost 100 per cent would want to be psychiatrists. However, 88 per cent would prefer psychology as a second choice after psychiatry, while only 12 per cent would choose social work.

Finally, fewer negative stereotypes are assigned to psychologists than to social workers. Psychologists are described as less "dogmatic," "mercenary," "threatening," "defensive," and "striving," than are social workers.

Despite the greater admiration for psychologists in these respects the stereotypes psychiatrists assign to psychologists reveal an ambivalence of feeling about them. They characterize psychologists as less "competent" (4.43), "insightful" (3.90), and "well-trained" (4.48) than are the social workers who are given ratings of 4.74, 4.14, and 4.89 respectively on these same attributes.

Psychiatrists see psychologists as more likely to encroach upon the prerogatives of psychiatrists. They give an average encroachment score of 3.93 to the psychologists and 3.01 to the social workers. The p value of the difference is .01.

Psychiatrists have closer and more cordial relations with social workers than with psychologists. Psychiatrists estimate that they have more frequent professional contacts with social workers: 62 per cent say that they meet with social workers daily, and 19 per cent say less than once a month. In respect to psychologists, 50 per cent of the psychiatrists have daily interaction with them and 26 per cent estimate once a month.

Professional contacts with social workers are more satisfying to psychiatrists than those with psychologists. Among the psychiatrists 89 per cent describe relations with social workers as highly satisfying and only 3 per cent say they are poor. In respect to psychologists, 10 per cent state that relations are highly satisfactory and 59 per cent say they are poor. The difference in the psychiatrist's satisfaction with relations regarding the two professions is statistically significant at better than the .001 level of confidence.

In several other ways the psychiatrists indicate that they feel more comfortable with social workers. They believe that they would "get along" with social workers better on a hypothetical committee including members of all three professions. And they believe themselves to be better liked by social workers than by psychologists. They give an
average estimate of liking by others of 3.53 for social workers and 3.25 for psychologists. The difference is statistically significant at a confidence level of .01.

In summary, psychiatrists place somewhat more value on the professional competence of psychologists. At the same time they perceive psychologists to be a more challenging group and feel less comfortable with them than they do with social workers.

**Chapter Summary**

This chapter has contained a description of the attitudes of each professional group toward the other two. The contrast in reactions has been shown by reporting only those data in which there was a statistically significant difference in the average responses of one group in relation to each of the other two groups. The results show that both social workers and psychologists tend to look past each other to psychiatrists as the more authoritative persons. Social workers attribute greater power to psychiatrists than to psychologists. They also hope to narrow the power differential between themselves and psychiatrists. They value psychiatrists more, and are closer and more comfortable than with psychologists.

The psychologists react in a somewhat similar fashion. They perceive that psychiatrists have more influence and desire strongly to close this gap. They admire psychiatrists more than social workers and feel satisfied concerning relations with them. The psychologists are likely to feel that they know about as much as psychiatrists and that they should earn as much. They state that interpersonal strain prevents effective professional interaction on their part. They attribute positive stereotypes to psychiatrists more than to social workers.

Psychiatrists tend to value and respect psychologists more than social workers, and to see them as a group which is more challenging to their own profession. Their relations with social workers are better and they are more comfortable with them than with psychologists.

In interpreting these data we assume that psychologists have a stronger desire for increased stature than do social workers. This desire is recognized by psychiatrists as a challenge. Psychologists sense the feelings of psychiatrists and, as a result, are uneasy as to whether their needs will be understood and supported. The power and social sanctioning of the psychiatric profession is strong. Psychologists are more concerned about possible frustrations which might stem from psychiatrists than they are about social workers. The social workers,
in contrast, are anxious to maintain their good relations with psychiatrists.

Why then are psychologists more highly satisfied concerning relations with psychiatrists than with social workers? This situation, we believe, is an indication that relations with psychiatrists are on the whole more satisfactory than unsatisfactory, and it is important for psychologists that they be kept so, or seen so. Psychiatrists are, in fact, recognizing and respecting the value of the contributions that psychologists offer and say as much. But the greater power represented by psychiatrists causes psychologists to perceive that this support and acceptance can be removed. Therefore it is necessary for them to build and maintain good relations so that this greater power will be used in a rewarding rather than a depriving fashion.
CHAPTER 8

REACTIONS OF EACH PROFESSIONAL GROUP
TOWARD OWN COLLEAGUES

The lives of professional persons are shaped by their chosen careers. Their roles determine the work they will do, the people they will associate with, the nature of their interpersonal relationships, and even their values and goals. Their roles determine at least in part what persons in other roles think of them.

A professional person then is not isolated. He works with colleagues on similar duties and he perceives himself and the others as members of the same group. The expectations of other group members exert powerful influences on him.

It is important for an understanding of interrole relations to examine the attitudes of professional persons toward their colleagues. Membership in a given profession may be seen as either satisfying or frustrating, and feelings toward colleagues, as well as toward those in other roles, may vary accordingly from favorable to unfavorable.

We may examine attitudes toward colleagues most fruitfully by considering the few data obtained in which the average feelings about colleagues are significantly different from the feelings about colleagues expressed by members of another group. We shall see that social workers tend to be most comfortable in their attitudes toward members of their own profession.

A COMPARISON OF THE REACTIONS OF PSYCHIATRISTS
AND SOCIAL WORKERS TO THEIR RESPECTIVE
PROFESSIONAL COLLEAGUES

There is some indication that psychiatrists stereotype their own professional group less favorably than do social workers. We might have assumed that they would derive greater satisfaction than social workers from membership in their profession because of the advantages it provides. Furthermore, psychiatrists expressed greater assurance concerning their power and competence than did social workers. Therefore we might expect them to have more warm feelings and favorable
stereotypes about their colleagues. The following results indicate that this may not be so.

The stereotypes that respondents attributed to the members of their profession indicate that social workers tend to assign more favorable characteristics to their colleagues than do psychiatrists. (See Table 27) It is noteworthy that the social workers describe their own group as more "insightful," "competent," "well-trained," "likeable," "social-problem oriented," and less "threatening" than do the psychiatrists. On the other hand, they also view themselves as more "mercenary," "condescending," and "striving" than do the psychiatrists.

TABLE 27
Some Stereotypes about Own Professional Group on Which Psychiatrists and Psychiatric Social Workers are Significantly Different

<table>
<thead>
<tr>
<th>Stereotype</th>
<th>Mean Response by Psychiatrists</th>
<th>Mean Response by PSW's</th>
<th>p value of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent</td>
<td>4.53</td>
<td>5.05</td>
<td>.02</td>
</tr>
<tr>
<td>Insightful</td>
<td>4.53</td>
<td>4.81</td>
<td>.05</td>
</tr>
<tr>
<td>Well trained</td>
<td>4.52</td>
<td>4.93</td>
<td>.03</td>
</tr>
<tr>
<td>Soc. Prob. Oriented</td>
<td>3.90</td>
<td>5.04</td>
<td>.01</td>
</tr>
<tr>
<td>Mercenary</td>
<td>3.28</td>
<td>4.59</td>
<td>.01</td>
</tr>
<tr>
<td>Likeable</td>
<td>4.85</td>
<td>5.13</td>
<td>.05</td>
</tr>
<tr>
<td>Condescending</td>
<td>4.41</td>
<td>4.99</td>
<td>.02</td>
</tr>
<tr>
<td>Threatening</td>
<td>5.30</td>
<td>4.79</td>
<td>.05</td>
</tr>
<tr>
<td>Striving</td>
<td>2.13</td>
<td>2.58</td>
<td>.02</td>
</tr>
</tbody>
</table>

Perhaps social workers are more inclined to so stereotype their group because it is more important to them. They have more interest in being liked by their group than psychiatrists have. Psychiatrists express a mean desire to be liked by their colleagues of 3.31, and the social workers of 3.64. These two ratings are significantly different at the .05 level.

In sum, psychiatrists are less likely to have favorable feelings toward their colleagues than social workers. Social workers, we believe, more strongly appreciate support from their professional colleagues than do psychiatrists. Psychiatrists, it seems, are less in need of appreciation by their peers.

A COMPARISON OF THE REACTIONS OF PSYCHIATRISTS AND CLINICAL PSYCHOLOGISTS TO THEIR RESPECTIVE PROFESSIONAL COLLEAGUES

The psychiatrists should be the most tightly knit of these two groups since they have been well established for many years and their
profession has been accepted and supported by society. On the other hand, it can be argued that the psychologists should be most drawn together since they are smaller in number and share a common goal. The data show that psychologists are more sensitive than psychiatrists both to the need for support from their own group, and to the perception that they are getting it.

Table 28 contains a number of attitudes toward own profession in which psychologists and psychiatrists are significantly different. The first four categories indicate that psychologists have more desire to be liked and respected by their own group, and also that they have a stronger perception that they are getting it, than do psychiatrists. In addition, they are more willing to discuss their own mistakes and the weaknesses of their profession with colleagues than psychiatrists are. Finally, psychologists are less willing to talk to colleagues about professional differences of opinion than are psychiatrists.

**TABLE 28**

Some Attitudes Toward Own Professional Group on Which Psychiatrists and Psychologists are Significantly Different

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Mean Response by Psychologists</th>
<th>Mean Response by Psychiatrists</th>
<th>p value of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire to be liked</td>
<td>3.91</td>
<td>3.31</td>
<td>.01</td>
</tr>
<tr>
<td>Desire to be respected</td>
<td>4.45</td>
<td>4.02</td>
<td>.01</td>
</tr>
<tr>
<td>Perception of being liked by own group</td>
<td>3.75</td>
<td>3.49</td>
<td>.02</td>
</tr>
<tr>
<td>Perception of being respected by own group</td>
<td>4.02</td>
<td>3.81</td>
<td>.05</td>
</tr>
<tr>
<td>Readiness to make light conversation</td>
<td>2.77</td>
<td>2.37</td>
<td>.05</td>
</tr>
<tr>
<td>Readiness to discuss own successes</td>
<td>2.90</td>
<td>2.70</td>
<td>.05</td>
</tr>
<tr>
<td>Readiness to discuss professional inadequacies</td>
<td>3.31</td>
<td>3.17</td>
<td>.05</td>
</tr>
<tr>
<td>Readiness to discuss disagreements of opinion</td>
<td>2.31</td>
<td>2.61</td>
<td>.05</td>
</tr>
</tbody>
</table>

Yet psychologists are critical of their profession in the stereotypes they attribute to themselves; more so, in fact, than psychiatrists. Table 29 shows that they characterize their group as “dogmatic,” “mercenary,” “condescending,” and “striving” more than do the psychiatrists. Moreover they view their professional body as less “insightful” and “well-trained” than do the psychiatrists. The positive characteristics they assign to themselves are “scientific” and “social-problem oriented.”

In short, psychiatrists do not seem to need the approbation of their
TABLE 29  

<table>
<thead>
<tr>
<th>Stereotype</th>
<th>Mean Responses by Psychiatrists</th>
<th>Mean Responses by Psychologists</th>
<th>p value of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dogmatic</td>
<td>2.75</td>
<td>3.52</td>
<td>.01</td>
</tr>
<tr>
<td>Insightful</td>
<td>4.53</td>
<td>4.21</td>
<td>.05</td>
</tr>
<tr>
<td>Well trained</td>
<td>4.52</td>
<td>4.29</td>
<td>.05</td>
</tr>
<tr>
<td>Scientific</td>
<td>3.98</td>
<td>4.66</td>
<td>.02</td>
</tr>
<tr>
<td>Soc. Prob. Oriented</td>
<td>3.90</td>
<td>4.42</td>
<td>.02</td>
</tr>
<tr>
<td>Mercenary</td>
<td>3.28</td>
<td>3.93</td>
<td>.02</td>
</tr>
<tr>
<td>Condescending</td>
<td>4.41</td>
<td>4.99</td>
<td>.05</td>
</tr>
<tr>
<td>Striving</td>
<td>2.13</td>
<td>2.58</td>
<td>.02</td>
</tr>
</tbody>
</table>

peers and do not believe they are getting it. Yet they express more favorable feelings toward their colleagues than do psychologists. Psychologists, it appears, are more closely drawn together and act, as members of cohesive groups often do, to preserve good relations with their colleagues.

A COMPARISON OF THE REACTIONS OF SOCIAL WORKERS AND CLINICAL PSYCHOLOGISTS TO THEIR RESPECTIVE PROFESSIONAL COLLEAGUES

The close dependency of psychologists upon their own professional colleagues is apparent when the feelings of social workers and psychologists are compared. Dependency is used here in the sense that psychologists appear to be more sensitive to the degree of approval given by members of their profession.

Psychologists have a stronger average wish to be liked by their professional colleagues (3.91) than social workers have (3.64). In addition they are more eager to be respected by their own group (4.45) than social workers are (4.18). The difference between these pairs has a p value of .01.

But psychologists are not quite certain that they are accepted by their fellow members. The data reveal that psychologists perceive themselves to be liked by their associates to an average degree of 3.54 while social workers assign a score of 3.75 to this measure (p .01).

Because, perhaps, of this uncertainty about acceptance, psychologists are cautious concerning communication with colleagues. The psychologist is relatively unwilling to talk to an individual associate
about any mistake he may have made. The mean desire of psychologists to discuss such a failure with another psychologist is 2.14, whereas the willingness of social workers to talk to a colleague on such a matter is 2.37.

On the whole the psychologists assign less favorable characteristics to their colleagues than do the social workers. They rate their group as less "competent," "insightful," "well-trained," "mature," and "likeable" and also as more "threatening" than the social workers do. These data may be seen in Table 30. However, they stereotype their group as less "mercenary" and "defensive" and as more "scientific" than do social workers.

<table>
<thead>
<tr>
<th>Stereotype</th>
<th>Mean Response by Psychologists</th>
<th>Mean Response by PSW's</th>
<th>p value of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent</td>
<td>4.67</td>
<td>5.05</td>
<td>.02</td>
</tr>
<tr>
<td>Insightful</td>
<td>4.21</td>
<td>4.81</td>
<td>.02</td>
</tr>
<tr>
<td>Well-trained</td>
<td>4.29</td>
<td>4.93</td>
<td>.02</td>
</tr>
<tr>
<td>Mature</td>
<td>4.33</td>
<td>4.61</td>
<td>.05</td>
</tr>
<tr>
<td>Soc. Prob. Oriented</td>
<td>4.42</td>
<td>5.04</td>
<td>.02</td>
</tr>
<tr>
<td>Mercenary</td>
<td>3.93</td>
<td>4.59</td>
<td>.05</td>
</tr>
<tr>
<td>Likeable</td>
<td>4.90</td>
<td>5.13</td>
<td>.05</td>
</tr>
<tr>
<td>Defensive</td>
<td>3.71</td>
<td>4.01</td>
<td>.05</td>
</tr>
<tr>
<td>Scientific</td>
<td>4.66</td>
<td>3.76</td>
<td>.05</td>
</tr>
<tr>
<td>Threatening</td>
<td>5.16</td>
<td>4.79</td>
<td>.02</td>
</tr>
</tbody>
</table>

Why should psychologists react so strongly? It may be that the greater need for approval from their professional group and the relatively low perception of acceptance by them makes the psychologists more critical about their colleagues than are social workers. There is the additional fact that being a clinical psychologist makes uncomfortable relations with psychiatrists more likely for them than for social workers. This tenuous relationship is another source of uneasiness in their professional role.

The results indicate that psychologists see their group as having more difficult relations with psychiatrists than do social workers. When asked how much their group envies psychiatrists, psychologists gave an average rating of 5.06, whereas social workers scored their group at 4.47 in this respect. Furthermore, psychologists say that their
colleagues perceive psychiatrists as deliberately seeking to keep down the income of psychologists (3.40) more than social workers attribute this attitude to their colleagues (2.41). Finally, psychologists perceive that the members of their group are actively attempting to decrease the power of psychiatrists (2.47) more than do social workers (1.87). The differences between these three pairs of averages are all significant at the .01 level of confidence.

In summary, psychologists in comparison with social workers appear to feel less accepted by their colleagues, to desire approval from them more strongly, to attribute more negative characteristics to them, and to be more uneasy with psychiatrists.
CHAPTER 9

INTERPRETATIONS AND CONCLUSIONS

We have examined the nature of interrole attitudes and behaviors among psychiatrists, clinical psychologists, and psychiatric social workers. We have shown how these attitudes were different under diverse conditions. In this chapter we offer an explanation of these results. In order to do so, we return to the theoretical approach described in Chapter 2 and use it as a guide.

A simplified review of the central conceptions concerning role relations is presented first. This review is followed by a summary of the findings of this study and an interpretation of them. Tentative conclusions are next described regarding role relations under various specified conditions. Finally methods for maintaining good relations among professional groups are suggested. New directions for research in interrole behavior are briefly discussed.

CENTRAL CONCEPTIONS

Relationships between roles

Each professional role has a limited set of behaviors prescribed for it. Because of the interlocking of prescriptions, this set of behaviors also determines the most relevant relationship dimensions between persons in one role and persons in another. The relationship dimensions used as independent variables in this study are: perceived relative power to influence, acceptance of power position, frequency of professional contacts, relative knowledge and skills, and satisfaction with providing advice for others.

Though there usually are standard locations on these interrole relationship dimensions for members of a given profession, some persons may differ from the majority of their colleagues in the locations they attribute to themselves.

Professional Aspirations

Each profession has its own goals. Among professional groups, goals are alike in that they commonly motivate the members to actualize
their fullest professional capacities. For different professional groups, goals are unlike in respect to content. Furthermore, they are determined in part by interprofessional relations with relevant other groups.

The average social worker appears to have an ambition to increase the variety of her professional services, and to achieve more responsibility while performing professional activities under the supervision of psychiatrists. The clinical psychologist desires, apparently, to increase the usefulness of his profession by engaging in diagnosis and therapy as well as in psychometrics and research, and by working independently of psychiatrists. The psychiatrist aspires to make more effective use of the assistance provided by ancillary workers so that he can increase the value of his own services.

It was assumed that the needs of an individual member of these professions, insofar as his career aspirations are concerned, are highly similar to those of his professional colleagues.

Interrole Security

A member of a profession may be secure or insecure in his relations with members of other professions. Interrole security was defined as that state in which a person feels that the needs he aspires to gratify can or will be satisfied in a given relationship with others.

A specific location which a person attributes to himself in a relationship with members of another role may be seen by him as promising a high probability that his professional aspirations will be satisfied; while a different location may be viewed as offering him, instead, little possibility of satisfying professional desires. Thus, certain locations will provide security and others will create insecurity, depending upon the degree to which he perceives it possible (at some level of awareness) to satisfy his professional ambitions.

The location of a person in role A in a relationship with persons in role B which offers to him small probability of need satisfaction implies that persons in role B (or relations with them) are a hindrance to need satisfaction for A; while a location which promises high likelihood of need satisfaction implies that persons in role B (or relations with them) are facilitative to the need gratification of A.

Interrole Attitudes and Behavior

A person occupying a given role has certain attitudes and behaviors toward persons in other roles. These feelings, it is assumed, are either
active attempts to maximize security in these relationships or they are passive symptoms of the degree of security the person feels.

In his efforts to maximize security in a relationship with persons in role B, person A will either "work" to increase facilitative behavior of B's, to decrease their hindering behavior; or he will try to change the relationship between himself and persons in role B. The kinds of interrole feelings which A displays and the kinds of actions which he takes are dependent upon the courses available to him, and their comparative likelihood of eventually securing need fulfilment. When an individual, however, does not consider it necessary to act in behalf of his need satisfaction, or cannot do so, he will only reveal passive symptoms which demonstrate that he sees the others as facilitating or hindering, as the case may be.

In the discussion of conclusions we shall see that the degree of dependence which the occupant of a role has upon those in other roles is also important to an understanding of interrole attitudes.

SUMMARY AND INTERPRETATIONS OF FINDINGS

Average Attitudes of One Professional Group toward Another

In comparing average attitudes we must keep in mind that the mental health professions comprise a hierarchical society of persons who commonly value close teamwork. Psychiatry is at the top of the triangle while clinical psychology and psychiatric social work occupy the bottom corners. The psychiatrists have the superior position because usually the prescribed working relations are such that they are expected to supervise members of the ancillary professions; the ancillary workers, in turn, are likely to see themselves as subordinated in some manner when working with psychiatrists.

Feelings of psychiatrists toward ancillary group members. Results reveal that the psychiatrist believes he is admired and liked by those in the assisting groups. He is friendly toward them and willing to work with them, but he is not so interested in winning their favor or good will, nor is he so anxious to have their liking for him increased. He places much higher value on his own profession than he does on theirs.

These attitudes are indications that the average psychiatrist perceives the adjunct persons as facilitative to his own need satisfaction. He reveals no effort either to get them to increase facilitating behavior or to decrease hindering behavior. His feelings demonstrate that he is secure in his relations with the ancillary persons.
Within these averages, however, it is noteworthy that the responses of the psychiatrist toward psychologists are somewhat different from his responses toward social workers. He reveals that he is less comfortable with psychologists and prefers fewer contacts with them. He views psychologists as more challenging than social workers and he tends to value and respect them more. The attitudes of the psychiatrists, then, may be viewed as inclinations to decrease the impact of any potential need frustration in his relations with psychologists. He values and admires their professional contributions yet he seeks to avoid their sphere of influence.

*Feelings of adjunct persons toward psychiatrists.* The typical adjunct person is eager to be liked and respected by psychiatrists, tries to do those things which will gain a favorable impression for himself, and places great value on the profession of psychiatry.

These attitudes, we believe, indicate a desire to increase the need-facilitating behavior of psychiatrists. They represent efforts on the part of the ancillary persons to get psychiatrists to be rewarding and helpful. Such feelings develop because typical members of the adjunct professions must depend in large part upon the good offices of psychiatrists in their attempts to obtain need satisfaction.

*Feelings of ancillary groups toward each other.* The psychologist is eager to be liked and respected by social workers and behaves in a fashion which will promote cordial relationships. He places more value on his own profession than on social work and views the social workers as content in their role as assistants to psychiatrists. His attitudes indicate a desire to win appreciation and support from social workers.

The social worker views psychologists as intent upon winning recognition for their profession. She accepts these aspirations without any uneasiness since, apparently, they represent no threat to her own professional ambitions. At the same time she believes that she is equal to psychologists in ability and influence, and feels that she should remain in that position. The social worker, it appears, feels that psychologists are not highly relevant to her need satisfaction. Because of the low interdependence of her role with that of the psychologist, she perceives psychologists as neither facilitating nor hindering her own need satisfaction.

**Location on Independent Variables and Interrole Attitudes**

We turn to a summary of the interrole attitudes and behaviors reported by persons at different locations in each of the role relation-
ships. In addition, two types of interpretation are offered: (a) why a given location provides high or low probability of need satisfaction, and (b) why a particular type of interrole attitude occurs in association with a given location.

1. Perceived relative power to influence. In general, we assume that a person who attributes high power to himself in a relationship with those in another role will perceive greater probability of meeting his own professional needs than one who has little power. He can control his own fate and also influence the fate of others. Both of these facts increase the likelihood that events will occur as he might wish.

Results reveal that a psychiatrist with much power perceives that members of the ancillary groups respect and admire him, and seek to win his favor. He is ready to associate with them. These interrole attitudes occur, we believe, because he has sufficient power to do as he wishes, and to maintain that power. As a consequence he views relations with ancillary persons as more need facilitative than hindering. He is willing to work with them because when he does so the contacts gratify rather than threaten his aspirations.

A clinical psychologist or psychiatric social worker who has more than his group's average amount of power (in relation with psychiatrists) wants few contacts with psychiatrists, has little desire to talk to them, is unconcerned with winning their good will, and thinks more highly of his own profession than he does of psychiatry. Apparently the adjunct person perceives himself as able to make autonomous efforts for meeting his own needs without the aid of psychiatrists. He indicates a tendency to avoid psychiatrists because interactions put him in a subordinate role, and thus reduce his possibilities of need satisfaction.

Turning to the persons who attribute low power to themselves, it is evident that a psychiatrist with less power than his group's average believes that members of the ancillary groups do not like him, and that he wishes to avoid associating with them. His attitudes reveal that he is uncomfortable in a low-power position, and that he seeks to reduce the effectiveness of any hindering impact of ancillary persons by avoiding them.

Members of the adjunct professions who are low in power, however, say that they are eager for more frequent contacts with psychiatrists, like to talk with them, seek to win their approval, and value psychiatry more than their own profession. Their professional aspirations,
presumably, can best be fulfilled by winning the goodwill and help of their superiors.

High or low power locations have no apparent effect upon the nature of the interrole attitudes and behaviors between clinical psychologists and psychiatric social workers. The members of these two professions apparently do not see one another as either helping or hindering their career aspirations.

2. Acceptance of power position. It might be expected that most of the members of all three professions would want more power, since power enhances the possibility of fulfilling professional aspirations. Results show, however, that only those who are low in power in each of the three roles feel that they would like to have more. There are several special cases: A social worker with small power, who is also highly satisfied concerning relations with psychiatrists, is not likely to want greater power. In contrast, a psychologist who has little power wants more whether or not he is satisfied in his relations with psychiatrists. The psychologist's professional aspirations make an increase in power more important for him than for the social worker. In fact, the psychologist with high power wants even more if he perceives himself as highly competent.

The psychiatrist who wants more power over psychologists perceives that he is not respected or admired by clinical psychologists, whereas the psychiatrist with little desire to increase his influence over psychologists believes that he is held in high esteem by them. In his relations with social workers, however, a psychiatrist who desires more power is no different from one who is content with his influence. The need for power on the part of the psychiatrist is an indication that he is uncertain about the potentialities of need satisfaction, but only with respect to psychologists. Apparently the stabilized interdependence between his own group as superiors and the social workers as assistants means that a wish for more power over social workers is not an indicator of potential need frustration in that relationship.

The clinical psychologists and the psychiatric social workers who want more power in relations with psychiatrists have strong desires for respect and treatment as equals. Although they are low in power, it is striking that these people show none of the deference and solicitousness toward psychiatrists observed as typical of their groups. Instead, they appear to be intent on decreasing the relative effectiveness of the psychiatrists' influence. Their attitudes reveal the importance they attach to greater power as a means of fulfilling their professional aims.
In the relations between persons in the two ancillary professions, when a member of either is content with his power location, the interrole attitudes are friendly. When he feels that he should have more power over those in the other ancillary profession, he is quite disinterested in maintaining cordial relations with them. Instead, symptoms of competitive relationships appear as well as attempts to resist the influences of the other. In addition, the discontented person becomes uneasy about the nature of the other group's relations with psychiatrists. Though an occupant of either role ordinarily does not see himself as able to help or hinder the other, when he desires greater power he becomes aware of a nonfacilitative interdependence with them which is uncomfortable to him.

3. Frequency of professional contacts. Professional contacts have a different significance for psychiatrists and for the assisting professions. Psychiatrists in general are ready to work with adjunct persons because, for one good reason, they are helpful to him. The ancillary worker, on the other hand, feels that interactions with psychiatrists place him in a subordinate relationship. Frequent contacts with adjunct workers are a source of need satisfaction for psychiatrists, but often they are just the opposite for the members of the ancillary professions.

The findings reveal that the psychiatrist who has many contacts with members of the assisting professions feels that he is respected and admired by them (though he is more sure that social workers feel this way than that psychologists do), and believes that they are trying to win his good will.

The social worker feels accepted and respected by psychiatrists when she shares many professional activities with them. It is the social worker with little power who meets most often with psychiatrists, and it is the psychiatrist with much power who has the most frequent contacts with social workers. Furthermore, the occupant of these two roles are highly interdependent in their task functions. Perhaps, then, the social worker perceives that her abilities are being well used when she collaborates with psychiatrists. She is gratified by the recognition received and by the realization that her services are wanted by them.

The psychologist who has interactions with psychiatrists most often, however, does not feel accepted or admired by them, and freely admits that he seeks to win approval from psychiatrists. His role is not interdependent with that of the psychiatrists. Psychiatrists view the role of clinical psychologists as narrower in function than do psychologists. Close working relations with psychiatrists prevent the psychologist
from doing the things he would like to do autonomously. His professional aspirations make it difficult for him to accept this state of dependency and he attempts to increase the facilitative behavior of psychiatrists in order to increase the chances that they will gratify his need.

Finally, frequent contacts between members of the ancillary professions appear to foster friendly relations. A social worker feels that psychologists respect and admire her if she often meets with them. These feelings are reciprocated by the psychologist who frequently associates with social workers. The more contacts he has with social workers, the more he desires their respect.

4. **Professional knowledge and skills.** In general, a person who assigns a high degree of professional competence to himself should be more secure in his interactions with others than a person who is less confident. We must keep in mind, however, that the group goals are different among these professions and that the nature of the respective aspirations of each group will be important in determining the quality of individual relationships.

For the psychiatrists the fact that an ancillary worker is highly capable is not a source of need deprivation. His aspirations are such that he welcomes such beneficial assistance. The data indicate that a psychiatrist wishes to have frequent contacts and many communications with members of the adjunct professions when he sees them as able people who are equal, or even superior to himself; and he wishes to avoid association with them if he views them as incompetent. Even when the psychiatrist sees the two assisting groups as capable, he differentiates between them. He is more likely to have high respect and strong positive stereotypes for psychologists than for social workers.

The social worker aspires to obtain increased responsibility so that she can be more useful to psychiatrists. When she has high professional knowledge and skill relative to psychiatrists, she demands from them greater admiration and respect; she wishes to be treated more as an equal. When she perceives herself to be low in ability she is willing to assume a more dependent relationship.

The psychologist aspires to obtain autonomy in some professional areas as well as to make himself more helpful to psychiatrists. Superior professional ability apparently represents for the psychologist a means to obtain improved status. Thus, if he has much professional knowledge and skill he "breaks away" from a dependent relationship with psychiatrists and feels motivated to weaken the effectiveness of psy-
psychiatrists' influence. The psychologist who has much respect for his own competence has a strong desire for more power in relation to psychiatrists. He prefers to associate with members of his own profession, and to avoid psychiatrists as much as possible.

In the relations between the two ancillary groups, a social worker who sees herself as highly competent in comparison to psychologists describes them as upward mobile, but she views the psychologists' ambitions objectively without any apparent affect. Since the social worker more regularly turns to the psychiatrist as a major source of support, her awareness of striving by psychologists is of no great concern because she is assured of her stable connections with psychiatrists.

A psychologist who believes that he is very capable in comparison with social workers tends to feel that he is not sufficiently respected and admired by them; and he attempts to win their admiration and respect.

In summary, for the adjunct person a favorable opinion of his own ability seems to stimulate him to move actively toward the gratification of his professional needs. The social worker is willing to meet her needs within her usual role relationship as psychiatric assistant, while the psychologist is more likely to seek autonomy. Low evaluation of himself, however, seems to encourage the perception in the ancillary person that improvements in professional status will come through soliciting the good will and facilitative behavior of psychiatrists.

5. Satisfaction from providing advice for others. When a person provides advice for others he is usually in a position which implies that he is the superior and that the counselees are dependent upon him. An adviser, it is expected, is more likely to feel that he will gratify his professional aspirations, than a person who asks for advice.

The prescribed relations among these roles would have psychiatrists seldom turn to members of the ancillary professions for consultation. Similarly the adjunct groups would anticipate only infrequent solicitation of their advice by a superior. Our data indicate that this prescription still holds: A majority of the psychiatrists state that they give advice more than they ask for it. Only one-fifth of the social workers and psychologists state that psychiatrists seek their advice.

In view of this disparity, it is striking that the large majority in every relationship are highly satisfied with the amount of cross-consultation which occurs. For the ancillary groups this is apparently a case of satisfaction with being asked for counsel even infrequently.
Psychiatrists are pleased when they provide advice frequently since presumably they assume advice-giving to be the prerogative of their role.

The psychiatrist who is more than usually gratified because members of the assisting professions ask him for counsel, views them as facilitative to his need satisfaction. He is ready to associate with them and perceives that they admire him. Again he differentiates between the two groups in that he views the psychologists' request for advice as attempts to win approval, but he does not see the social workers' in the same way.

An ancillary worker who is satisfied by the degree to which psychiatrists come to him for advice apparently is confident that he has attained a position in which he is relatively outside the power of psychiatrists. The fact that psychiatrists ask him for help causes him to feel that his professional aspirations will be met. In this situation he begins to act just as a psychiatrist usually does. He is willing to point out the inadequacies of the other group, a prerogative which he does not usually assume. He is also less likely to accuse psychiatrists of attempting to block or restrict the efforts of the adjunct member. He feels that psychiatrists respect and admire him, and he is willing to have frequent and close association with them.

Finally a person in either of the two ancillary professions who is satisfied by the degree of consultation sought by his peers indicates that he intends to be helpful and shows no other types of affective reactions.

6. **Prestige in own profession.** A person who has high prestige within his own profession is drawn to closer association with his own group, and wishes to have few contacts with persons in other relevant professions. (There is one exception: The psychiatrist with high prestige feels no closer nor more distant from psychologists than the psychiatrist who has little prestige in his own profession.) Probability of need satisfaction, we believe, is again the crucial variable. A person with much prestige is more secure in his own profession, since his professional aspirations are already gratified there. He may sense that the chances are small that he will derive as much gratification from association with the members of a different profession. Thus, he prefers to remain with his colleagues and to avoid association with the others.

7. **Satisfaction with interrole relations.** The degree of satisfaction each respondent reported concerning his relations with those in other
roles may be thought of as his evaluation of the locations he has in the prescribed role relationships.

The data reveal that the psychiatrist who describes himself as highly satisfied concerning relations with members of the ancillary groups is ready to associate with them, sees them as admiring and respecting him, regards them as persons who wish to win his good will, makes favorable comments about them, and even feels free to talk to them about the inadequacies of his own profession.

The social worker, who is highly satisfied about her relations with psychiatrists, perceives that psychiatrists are rewarding and supporting persons. She wants frequent professional contacts with them, behaves solicitously toward them, and states a readiness to talk to psychiatrists about any unpleasant behavior on their part.

The psychologist, when satisfied in his relations with psychiatrists, reacts in a way which conforms to what we know about his professional aspirations. The satisfied psychologist is uninhibited in his communications with psychiatrists, feels he is liked and respected by them, wants frequent interaction with them, has positive stereotypes about them, is ready to discuss professional differences of opinion, and feels content that psychiatrists are not trying to block or control his professional activities.

Satisfaction for the two adjunct groups, then, appears to mean something different to each. Social workers are more satisfied when they assume that they are accepted as capable assistants. Psychologists are more satisfied when they are respected as assistants and also are given freedom to develop and use their skills independently. These feelings are clearly in close conformity with the group goals.

Finally, social workers and psychologists are highly satisfied concerning relations with one another. The social worker is most satisfied when she is low in prestige and psychologists come to her for advice. Psychologists are most satisfied when they have many contacts with social workers, contacts in which social workers often seek their advice. Both groups when satisfied with relations desire more contacts and more communication. In addition, when psychologists are highly satisfied concerning relations with social workers, they perceive that social workers are less intent on winning the approval of psychiatrists (and are more supportive of psychologists).
CONCLUSIONS

Data obtained from a real-life setting must be cautiously interpreted. Many variables are operating at once so that the student can never be sure what is cause and what is effect. He can move toward settling such an issue by starting at some point in the array of possible causes, stating clearly what he is taking for granted and what questions he seeks to answer, and by making tentative interpretations about causes and effects. He cannot examine all of the crucial variables and must, as we did, make a choice from among the wide variety available to him. This necessarily means that only part of the total picture can be studied.

Having a tentative approach beforehand provided us with hypotheses to be tested. Some of these hypotheses were developed before data collection began, and many were devised during the analysis stage as the shape of the results became clear. Since this study has been an exploration of role relations, it will be helpful to state our conclusions in the form of hypotheses worthy of further study and in terms which concern professional role relations in general—rather than the interactions of these three professions alone.

Many of these hypotheses have support in this investigation and should stand up (or have already been supported) under further study with better controlled procedures than were then possible. Others are not well corroborated, and still others are more in the nature of conjectures which could not be tested with the data on hand but are reasonable derivations from some of the better-established hypotheses. The degree of support for any hypothesis is relative, varying with both the quality and quantity of the data as well as the adequacy of the concepts involved and the validity of the theory from which it is derived. We will not pause to cite the nature of the evidence for each hypothesis beyond indicating in which chapter or chapters the relevant information can be found.

The hypotheses concern the nature of the interactions which might be expected between professional groups ordered in a hierarchy: in a downward direction, in an upward direction, and among role occupants who are at a peer level.

1. The interrole behavior of superiors toward subordinates in a hierarchical relationship

It may be assumed that persons who occupy a role which is at or near the top of a hierarchy would usually not want to move to a place
lower in the system. Their primary goal is to maintain their autonomy, and the attributes of the role which ensure a continuation of their high standing. Any individual occupant of the role will accept these goals as his own. Much of his behavior will be intended to guarantee that his role retains the attributes of high status.

Threats to the status of the role originating outside the hierarchical system will be met by efforts to reduce this danger. The adaptive efforts may be attempts to influence public opinion, to obtain support from persons in other roles, or to promote protective legislation.

The occupant of a superior role may perceive that his standing is endangered by the actions of his subordinates. In such a situation the higher-status members will reveal specific behavioral tendencies which we list here as hypotheses:

When the higher status of a role is threatened from below, the occupant of the superior role will react in some of the following ways:

(a) He will perceive subordinates as hindering more than facilitating.

1. He will fear that subordinates are attempting to encroach upon his role's prerogatives and functions. (Chap. 5)
2. He will perceive that subordinates do not value his knowledge and skills. (Chaps. 4, 5)
3. He will feel that subordinates do not like him. (Chaps. 4, 5)
4. He will feel that subordinates do not respect him. (Chaps. 4, 5)

(b) He will try to keep lower-level roles at a subordinate status.

1. He will define the functions of the subordinate role as those which are intended to assist the superior. (Chap. 5)
2. He will exercise influence in determining the assignment of subordinates so that their functions are primarily those which assist the superior.
3. He will avoid professional interactions with those subordinates who are performing autonomous functions which do not assist the superior. (Chaps. 4, 5)
4. He will talk freely to subordinates about professional mistakes they have made. (Chaps. 4, 5)
5. He will have negative feelings about the aspirations of subordinates. (Chap. 5)
6. He will minimize the competence of subordinates. (Chap. 5)
7. He will do more talking than listening in any verbal inter­
action between him and subordinates. (Chap. 4, 5)

When an occupant of a higher-level role perceives that there is little
danger of losing the properties which assure his role of its standing,
he may exhibit any or all of three reactions to subordinates. These
reactions, and a variety of ways in which each may appear are listed
here as hypotheses.

When the superior status of a role is certain in relations with
subordinates, the occupant of that role will react in some of the
following ways:

(a) He will perceive subordinates as supportive.
   1. He will speak positively of contacts with subordinates.
      (Chaps. 4, 5)
   2. He will have little fear that subordinates are attempting
to encroach upon his functions or other prerogatives.
      (Chaps. 4, 5)
   3. He will assume that subordinates admire him. (Chaps. 4, 5)
   4. He will assume that subordinates like him. (Chaps. 4, 5)
   5. He will assume that subordinates perceive him as superior
      in knowledge and skills. (Chaps. 4, 5)

(b) He will stimulate co-operative effort between roles.
   1. He will make sure that the functions of his own role are
      clearly understood by subordinates.
   2. He will obtain a clear but flexible perception of the
      functions which those in subordinate roles can provide.
      (Chap. 4)
   3. He will be ready for interdependent working relations with
      subordinates. (Chaps. 4, 5)

(c) He will encourage professional growth of subordinates.
   1. He will encourage and assist the occupants of subordinate
      roles to define autonomous functions for themselves, which
      are not under the supervision of the superior group.
   2. He will make sure that any necessary boundaries to each
      other's areas of freedom are clearly defined for both
      groups.
   3. He will accept the aspirations of subordinates and encour­
      age their efforts in fulfilling these desires. (Chaps. 4, 5)
II. The interrole behavior of subordinates toward superiors in a hierarchical relationship

Persons who occupy an inferior role may either aspire to improve their status or may be content with their situation. Those who have very few aspirations will have almost no strong attitudes which are relevant to role relations. Role aspirations for those who have them, imply that the subordinate wishes to engage in functions or to obtain rights and prerogatives which he and others in his role have come to value. The amount of effort and interest a subordinate will invest toward the end of protecting or improving his status has a direct relationship to the strength of his desire to achieve his goals and the actual or perceived probabilities of changing unfavorable conditions.

The quality of a subordinate’s acts in his interactions with superiors is determined by the nature of his relationship with them and his perception of the superiors’ intentions. Insofar as relationships are concerned, the subordinate may believe that he is dependent upon the support or permission of superiors for gratification of his needs, or he may perceive that he can satisfy his needs in an independent fashion. Concerning the superiors’ intentions, a lower-level person may perceive them as either helpful or hindering to the subordinate’s need satisfaction. The prescriptions of the subordinate’s role, the nature of his location in the prescribed relationships, and the degree to which he identifies with others occupying his own role determine his perceptions of dependency and facilitation in relations with superiors.

With these assumptions in mind, we may examine how the behavioral tendencies of subordinates toward superiors will be affected by various conditions.

We first consider the case of the subordinate who is in a dependent relationship to superiors because he perceives that the betterment of his status depends upon the acquiescence of those above him. In such an instance if the subordinate believes that the superior will be facilitating more than hindering he will reveal attitudes indicative of that belief and will show that he is trying to win even more support for himself.

An occupant of a lower-level role in a hierarchical relationship who perceives that the achievement of his aspirations depends upon the permission of superiors, and who sees them as facilitating more than hindering, will act toward them in some of the following ways:
(a) *He will perceive them as supportive.*

1. He will attribute favorable characteristics to superiors. (Chaps. 4, 5)
2. He will believe that he is liked by superiors. (Chaps. 4, 5)
3. He will believe that he is respected by superiors. (Chaps. 4, 5)
4. He will believe that superiors intend to aid him in his efforts at need satisfaction. (Chaps. 4, 5)
5. He will feel comfortable with superiors. (Chaps. 4, 5)
6. He will believe that the others feel comfortable with him. (Chaps. 4, 5)

(b) *He will try to win their support and help.*

1. He will communicate information to superiors which is complimentary to them. (Chaps. 4, 5)
2. He will avoid giving superiors information which is uncomplimentary to them. (Chaps. 4, 5)
3. He will tell his superiors about his own successes. (Chaps. 4, 5)
4. He will want, and will develop frequent contacts with superiors. (Chaps. 4, 5)
5. He will seek to be liked by superiors. (Chaps. 4, 5)
6. He will ask superiors for advice. (Chaps. 4, 5)

If the dependent subordinate believes that superiors are hindering in intent more than facilitating, his interrole attitudes will indicate that he is aware of this, yet he will try to win support from the superiors since he is dependent upon their approval for need satisfaction.

*An occupant of a lower-level role in a hierarchical relationship who perceives that the achievement of his aspirations depends upon the permission of superiors, and who sees them as hindering more than facilitating, will act toward them in some of the following ways:*

(a) *He will perceive them as nonsupportive.*

1. He will feel that superiors are unfriendly. (Chaps. 4, 5)
2. He will believe that superiors do not like him. (Chaps. 4, 5)
3. He will believe that he is not respected by the superiors. (Chaps. 4, 5)
4. He will accuse superiors of blocking his professional gains in prerogatives and rewards. (Chaps. 4, 5)
5. He will feel uncomfortable with his superiors. (Chaps. 4, 5)
6. He will sense that superiors are threatened by him. (Chaps. 4, 5)

(b) *He will try to win their support and help.* (As listed on p. 146)

Now we turn to the situation in which the subordinate perceives that he is not in a dependent relationship to superiors. If he believes that the superiors are potentially helpful, his attitudes will be indicative of these perceptions and he will wish to benefit from their support by behaving in a way which encourages their facilitative behavior.

If he believes the superiors are hindering more than facilitating, his interrole attitudes will reveal these beliefs and he will indicate that he wishes to reduce the effectiveness of their hindering influence.

An occupant of a lower-level role in a hierarchical relationship who perceives that the achievement of his aspirations is not dependent upon the permission of superiors, and who sees them as hindering more than facilitating, will act toward them in some of the following ways:

(a) *He will perceive them as nonsupportive.* (As listed on p. 146)

(b) *He will seek to reduce the effectiveness of the superior's influence.*

1. He will not want contacts with superiors and will avoid them as much as possible. (Chaps. 4, 5)
2. He will be little concerned with winning the good will of superiors, and will behave in ways which indicate that he cares very little about their opinion of him or their feelings about him. (Chaps. 4, 5)
3. He will point out the faults of superiors to them. (Chaps. 4, 5)
4. He will value and prefer members of his own group more than superiors. (Chaps. 4, 5)
5. He will not ask superiors for advice, help, or instruction. (Chaps. 4, 5)

In summary, the actions of a subordinate person in a hierarchy toward those in a superior role are a function of the degree to which that person perceives himself to be dependent upon the higher level for achievement of his goals, and the intentions which the subordinate attributes to the superiors. When he is highly dependent upon them
he behaves in such a way that their power will be used in a supportive and rewarding fashion, regardless of the inclinations attributed to superiors. When he is not dependent, he seeks to reduce the effectiveness of any hindering influences or to increase the impact of facilitating behavior, depending on whether he attributes more hindering or facilitating behavior to his superiors.

III. The interrole behavior of a subordinate person toward those who are in a role at the same level

Persons on the same level in a hierarchy may view one another as relatively unimportant in their efforts pertaining to need satisfaction. The nature of their position in respect to the higher roles is usually more important than their relationships with peers.

There are, however, situations in which the occupants of lower-level roles are dependent upon those in another peer role for achievement of role aspirations. Furthermore, role occupants may attribute either facilitating or hindering intentions to those in other roles. We may expect, then, that different interrole attitudes between role peers will occur when various combinations of dependency and facilitation are present.

Let us assume that a person occupying a low-status role believes that he is dependent upon those in a different role on the same level as his own, and that he ascribes helpful purposes to them. His behavioral tendencies are listed here as hypotheses.

An occupant of a subordinate role in a hierarchical relationship who perceives that the achievement of his aspirations depends upon the support of peers, and who sees them as facilitating more than hindering, will act toward them in some of the following ways:

(a) He will perceive them as supportive.

1. He will believe that he is liked by the others. (Chap. 6)
2. He will believe that his competence is respected by the others. (Chap. 6)
3. He will believe that he can work well with the others. (Chap. 6)
4. He will believe that the others are concerned with supportive behavior from him more than from superiors. (Chap. 6)
(b) *He will try to win their support and help.*

1. He will want admiration from the others and will try to earn it. (Chap. 6)  
2. He will want respect from the others and will try to win it. (Chap. 6)  
3. He will want frequent contacts with others. (Chap. 6)  
4. He will want frequent communication with the others. (Chap. 6)  
5. He will exert himself to make others comfortable in their interactions with him. (Chap. 6)  
6. He will avoid discussing his own inadequacies or failures with the others. (Chap. 6)

If the person attributes hindering more than facilitating intentions to the peers with whom he has a dependent relationship, he will perceive them as nonsupportive but he will seek to win their favor.

*An occupant of a subordinate role in a hierarchical relationship who perceives that the achievement of his aspirations depends upon the support of peers, and who sees them as hindering more than facilitating, will act toward them in some of the following ways:*

(a) *He will perceive them as nonsupportive.*

1. He will believe that the other group is attempting to increase their power over him. (Chap. 6)  
2. He will become concerned about relations between the peers and superiors. (Chap. 6)  
3. He will feel that he is not admired by the others. (Chap. 6)  
4. He will feel that he is not respected by the others. (Chap. 6)  
5. He will believe that he cannot work well with the others. (Chap. 6)

(b) *He will try to win their support and help.* (As listed above)

Consider, now, the case in which a subordinate person believes that his role is independent from other subordinate roles insofar as need gratification is concerned. If he attributes helpful inclinations to those in the other group, he will develop interrole attitudes which are indicative that he sees them as supportive, and he will seek to win support and help in ways just described. If he ascribes negative designs to them he will think and act in quite the opposite fashion.
An occupant of a subordinate role in a hierarchical relationship who perceives that the achievement of his aspirations does not depend upon the support of peers, and who sees them as hindering more than facilitating, will act toward them in some of the following ways:

(a) He will perceive them as nonsupportive. (As listed on p. 149)

(b) He will seek to reduce the effectiveness of the other's influence.

1. He will avoid contacts with the others which do not win respect for him. (Chap. 6)

2. He will become more concerned with winning the good will of superiors than with relations with those on his own level. (Chap. 6)

3. He will freely discuss with them the inadequacies and mistakes of the others. (Chap. 6)

4. He will claim competence in functions which are usually considered to be the unique skills of the others.

5. He will prefer association with occupants of his own role more than with others. (Chap. 6)

6. He will try to make the superiors place little value on the others.

In summary, the nature of interrole attitudes between persons in lower-level roles is a function of their degree of dependence and the motives attributed to one another.

IV. The behavior of a person in a hierarchical relationship toward occupants of his own role

It has been stated that the attractiveness of any group for a given person is directly proportional to the probability that he will meet his needs in that group (4, p. 76). We may assume therefore that the degree of attraction of a person's own occupational group depends upon the perceived possibility that his aspirations will be fulfilled within that group.

An occupant of a role who perceives that his aspirations are likely to be satisfied in an association with others in the same role, will act toward his colleagues in some of the following ways:

1. He will have high respect for their competence. (Chaps. 5, 8)
2. He will express admiration for them. (Chap. 8)
3. He will prefer that professional role to any other. (Chaps. 4, 5, 8)

4. He will want frequent contacts with professional colleagues. (Chap. 5)

5. He will freely communicate with them. (Chaps. 4, 5, 8)

6. He will closely adhere to the norms of his professional group. (Chaps. 4, 5)

The person who perceives that his colleagues provide little likelihood of gratifying his aspirations will avoid them and will feel negatively toward them. Any other group in his environment which offers more promise of need fulfilment will be preferred to his own.

An occupant of a role who perceives that his aspirations are not likely to be satisfied in association with others in the same role, will act toward his colleagues in some of the following ways:

1. He will have low respect for their competence. (Chaps. 5, 8)

2. He will express little liking for them. (Chap. 8)

3. He will avoid contacts with his professional colleagues. (Chap. 5)

4. He will seldom communicate with his colleagues. (Chaps. 4, 5, 8)

5. He will engage in cautious and guarded communications with colleagues.

6. He will often deviate from the norms of his professional group. (Chaps. 4, 5)

An occupant of a role who perceives that those in a different role are most likely to gratify his aspirations will act toward the others, in contrast to his colleagues, in some of the following ways:

1. He will have more respect for the competence of the other group than for his own. (Chaps. 4, 5)

2. He will express greater admiration for the other group than for his own. (Chaps. 4, 5)

3. He will prefer to be in the other role rather than in his own. (Chaps. 4, 5)

4. He will want contacts with those in the other role more than with his own colleagues. (Chaps. 4, 5)

5. He will communicate more with occupants of the other role than with those in his own role. (Chaps. 4, 5)
6. He will conform more closely to the norms of the other group than of his own.

A person who has much prestige in his own profession, let us assume, is more likely to perceive that his professional desires are being gratified in that group than one who has little prestige. It would be expected then, that the person with much prestige would place great value on his profession and would prefer association with members of his own occupation. The findings support that expectation.

**MAINTAINING COMFORTABLE ROLE RELATIONS**

At the outset of this report it was stated that teamwork among persons in different disciplines, professions, or occupations has been one of the important sources of strength in modern society. Teamwork implies a degree of ease in working relations. How does this ease come about?

In practice, certain conditions are often brought about among cross-disciplinary groups which minimize insecurity. In some cases satisfactions from the collaborative arrangements are made personally rich and rewarding so that necessary lack of gratification of individual professional aims is balanced. Sometimes warmth and acceptance among members of different professions creates a readiness to tolerate frustration of important needs. In still other instances high- and lower-status members become aware of their interrole attitudes and behaviors arising from their position in the social structure, and learn to control those which might generate strain within the team.

Various methods can be used to reduce the insecurity among persons in different professions. All groups concerned can develop and agree upon a common set of goals. Thus, the efforts of any separate group toward the goals will be considered to gratify the needs of the rest, which is, after all, the essence of the co-operative relationship. Sometimes functions and role responsibilities can be so arranged that the interactions of persons with those in different professions will satisfy mutual needs. At other times functions can be assigned so that they provide autonomy in certain areas for each individual. In certain cases procedures can be developed so that unsatisfactory relationships are identified and analyzed, and appropriate adjustments made.

We are in need of social inventions which will help professional groups to examine the consequences of their acts for one another and to plan ways of eliminating situational effects which cause insecurity.
and strain in interrole behavior. Mann (26) and Jacques (19) have demonstrated that the members of large formal organizations may improve morale at all levels, and integration among persons at various levels, by means of problem-solving discussions based on data concerning their own role relations. Zander and Gyr (41) studied the results obtained when persons with authority in a large organization attempted to explain their actions. In this case, the employees changed their attitudes in a way which may be interpreted to mean that they became more secure in their relations with their superiors, but only if they felt that top management was sincere in its actions and the supervisor doing the explaining knew what he was talking about. A forthcoming book by Luszki (25) reports the teamwork methods used in social science research by groups composed of persons from several disciplines. The report clearly indicates that the persons involved must help in solving problems of interrole difficulties. Coch and French (5) have demonstrated the same point in industry, as has Lippitt (24) in intergroup relations. These writings suggest that we may anticipate further development of successful methods for maintaining satisfactory relations among persons from various professions.

What can be done when interprofessional relations are laden with stress and negative affect? The results suggest that efforts at improving role relations which are based upon a simple mechanism, such as providing more frequent contacts, or increasing one another’s knowledge of what each profession values and does, will not be sufficient. Other more basic difficulties may prevent these laudable efforts from having a lasting effect. For example, we have seen that frequent contacts of a person low in power with one having greater power may create either striking uneasiness or ease in relations, depending upon other conditions. It seems clear that cross-disciplinary investigations must explore the causes of insecurity, the means whereby the relevant groups may be helped to provide mutual security, the sources of resistance to employment of these means, as well as ways to deal with these causes of resistance.

The study results indicate that it is of major importance that members of a group with greater power extend themselves in such a diagnostic effort, both because they are less likely to be uneasy, and because they may best set a mood of accepting change. Persons in a dependent position are by definition less able to initiate such action and to create an accepting climate for change.

It must be added, however, that improvement of attitudes by diagnosis
and discussion deals with only a part of the problem. The functions a person performs and the required relations he has with others strongly determine the nature of the interactions. If the members of a certain profession expect and accept specific relations with others, this acceptance does much toward eliminating strain in role relations. It is therefore more important to change role relations by reorganizing role prescriptions than to attempt to change attitudes by discussion or persuasion alone.

There are encouraging signs that effective procedures can be developed for maintaining comfortable role relations. Such procedures are easier to develop within any one organization. Once they are understood it should be possible to transfer them to intergroup situations. It seems obvious that the fullest advantages of the many professions demanded by today’s complex life can be derived only if we develop skills which allow the most effective co-ordination among professional persons. This task is worthy of the wisest and most vigorous social engineering.

NEW RESEARCH DIRECTIONS

An exploratory study provides data which may be examined from many points of view. Some of these points of view suggest problems which are worthy of further attention. In these closing pages we shall discuss issues which have emerged from this investigation and point to those which seem to us most worthy of study.

Social Structure and Relationships between Professional Groups

It is useful to think of professional groups as having different positions in social space. Among the mental hygiene professions, a unique social structure exists in which each group has a place. The position of any one person in relation to the members of another role was described in this study by his perception of this location on a number of prescribed relationship dimensions.

The locating of a person on variables describing interpersonal relations is a familiar practice. Others have used such terms as tele, bond, connection, or path to describe the fact that two or more persons have different positions in a given relationship with each other. The relationships used in the present investigation were selected because they were likely to influence the security of the respondent. It is instructive to speculate about some of the properties of these relationships.

It is possible that certain relationships are more important than
others in the sense that they have greater potency in determining the nature of interrole behavior. Furthermore, certain relationships may be more important between some roles than between others. There were many indications in the present research that power was often crucial in this respect. Is power important because we were dealing with persons in a hierarchical social structure or is it always so? What is it that determines the relative power of a role?

A given location on one dimension may determine the nature of a person's location on others. A number of instances of such position congruence were noted. For example, it was observed that persons with little power in an adjunct profession are most likely to have frequent contacts with members of the major profession. Or, to cite a more complicated instance, a psychologist with high power is likely to want more influence in relations with psychiatrists only if he also perceives himself to have high competence in professional knowledge and skills. Also, the psychiatrist who is high in power over psychologists is likely to be powerful in relation to social workers. The relations among professional groups require more examination in order to determine why congruence or incongruence in perceived locations occur.

These examples suggest that one location may substitute for another. That is, if a person perceives that he cannot hope to have much power deriving directly from the ability to determine the fate of others, he may seek to attain a location on another dimension which may serve as a substitute. The individual, for example, who desires more power, and who is not able to obtain it, may avoid contacts with others as a substitute. Or a psychologist who is low in power with psychiatrists may substitute by perceiving himself as high in knowledge and skill over social workers. In this instance, substitution involves relations with more than one group.

Perception of Self

We have contended that a location in a relationship with another professional group provides more or less security for the individual. There is another way these data may be viewed. It is well understood that a person develops perceptions of himself in his daily interactions with relevant people. Let us assume that the location he assigns to himself in any interrole relationship describes the amount of value he attributes to himself. Thus, for example, a person who believes that he is highly competent, or has much power, in his relations with others could be said to have high self-esteem.
The behavior of persons who are high in self-esteem is different from the behavior of those who value themselves little. The ways in which they differ in role relationships have been examined in several studies. Ross (34) simplified the role of supervisors in a company in such a way that their control over the fate of a subordinate was reduced and they were left only with the task of being on-the-job teachers. The task-assignment, quality control, and other supervisory functions were given to supervisors other than these coaches. As a result of this change the employee who had little faith in herself became more willing to communicate to her teacher-supervisors concerning the mistakes she had made on the job and showed in a number of other ways that she felt safer in her interactions with superiors. A change in the power of the supervisor was more crucial in these respects for the worker with low self-esteem than for the one with high self-evaluation. It appears that the potential threat of a person with authority is greater for one with low self-esteem than it is for one possessing a high degree.

This hypothesis was studied by Cohen (6) who demonstrated that a subordinate with less self-esteem is clearly more anxious and troubled when working closely with a superior who has control over his fate than is the person with high self-esteem. In addition, when the task was unclear or the supervisor inconsistent in his instructions, the effect on the person with low self-esteem was more upsetting. The person with a high evaluation of himself, however, tended to be less disturbed by such factors.

If it can be shown in the future that the location one perceives himself to have in his relations with others may be due to variations in his self-esteem, we will have a further source of evidence in explaining the nature of security in interrole relations.

There are indications that a person's self-esteem may be influenced by the expectations of professional peers. For example, Rasmussen and Zander (32) have found that feelings of failure develop in a professional person who is unable or unwilling to perform his role in the way he believes his colleagues expect him to. The more he is attracted to the group of peers and the more he is deviant on the issues most important to the group, as he sees them, the lower is his self-esteem. Furthermore, Jambor (20) has demonstrated that a middle-level social work supervisor who does not conform to the perceived expectations of her superiors behaves toward them in a way which may be interpreted as indicative of insecurity feelings.

It is highly probable that fruitful insights concerning the nature of
interrole behavior may be derived from investigation of the effect that a given social position has in determining self-evaluation. It may be that the degree of self-esteem is a crucial aspect of what we have been describing as the location of the person.

**Perception of Others**

Pepitone (30), Hurwitz *et al.* (17) and others have noted that a person in a low-status position is likely to engage in facilitative distortion concerning the intentions and actions of a superior. He perceives events as he would like to see them. Many instances in which such distortion probably occurred may be found in the results of the present research. One wonders, however, if motivated misconstruction happens only when the person is insecure. Might not secure role occupants be distorting when they state that they are confident of being well liked by the members of another role? The more power a psychiatrist has, for example, and presumably the more security, the more is he likely to make this assertion. It appears possible that facilitative distortion may occur when a person is secure, because both security as well as insecurity may cause a person to see things from one point of view.

**Functions and Roles**

In an effort to understand what the term "role" has meant to various writers, we discovered fourteen different definitions. Clearly there is no wide agreement as to the meaning of this concept. The definition used here is a useful one, but it generates several questions.

A primary issue concerns the specific functions to be included within a role. How are these functions assigned? Are role functions accepted by the members of a profession because they determine the relationships with different groups? Or do members obtain possession of certain functions because of their particular training or ability? It is likely that both of these events occur in a circular causal sequence. If we knew the conditions under which a given function becomes the property of a role we would be able to make progress in understanding the nature of role conflict.

It has been asserted that role conflict, defined as differences of opinion concerning the functions which should be contained within one's own and others' roles, is a cause of interrole unhappiness and strain (20, 30, 34). There is also the possibility that differences in expectations arise out of defensiveness, and the ensuing misconstructions when the members of roles are insecure in their relations with one another. It is
difficult at present to say whether insecurity is either the result or the
cause of discrepancies concerning appropriate role functions.

In passing, we may question whether the occupants of a role must
be absolutely clear about a strictly defined set of functions of another
profession in order to prevent conflict between them. Ross (34) has
reported that subordinates were able to communicate with their superiors
when the role of the superiors was simplified. But perhaps clarity of the
functions included within a role can also be harmful. It may create a
fixed equilibrium in interactions and expectations which would prevent
ready interpersonal adaptations when conditions might require a change
in functions. Here again, it would be useful if we knew how functions
come to be part of a role and what part these functions play in
determining the positions that one group has in relations with another.

Finally, an interesting problem is raised by the ambiguity of the
findings concerning the influence of sex and role on interrole behavior.
It is very probable that relations among persons of different sexes
confound the role expectations, but the way in which this happens is
little understood.
APPENDIX

The purpose of the Appendix is to describe the study methods and data in greater detail than seemed appropriate in earlier pages. It is divided into three sections concerning (a) the sample, (b) the interview, and (c) tables of data.

CHARACTERISTICS OF THE SAMPLE

The nature of the sample and the methods for selecting the respondents were described in Chapter 3. The following findings further describe the persons who were interviewed.

1. PRIVATE PRACTICE IS MORE TYPICAL OF THE PSYCHIATRISTS THAN OF THE OTHER TWO PROFESSIONAL GROUPS. Members of each of the three occupations, a minority in the two groups other than psychiatrists, devote at least some time to a private service in their own quarters.

<table>
<thead>
<tr>
<th>TABLE 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Respondents in Private Practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Clinical Psychologists</th>
<th>Psychiatric Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60.4%</td>
<td>27.4%</td>
<td>6.4%</td>
</tr>
<tr>
<td>No</td>
<td>39.6%</td>
<td>72.6%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

2. THE MAJORITY OF PSYCHIATRIC SOCIAL WORKERS ARE WOMEN. Differences in the sexual composition of the three professions were shown to have a bearing on the nature of the interactions and attitudes between the groups. Table 32 indicates that nine out of ten of the social workers interviewed were women, whereas the other two groups were predominantly males.

<table>
<thead>
<tr>
<th>TABLE 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Respondents of Each Sex</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Clinical Psychologists</th>
<th>Psychiatric Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>88%</td>
<td>72%</td>
<td>9%</td>
</tr>
<tr>
<td>Female</td>
<td>12%</td>
<td>28%</td>
<td>91%</td>
</tr>
</tbody>
</table>

3. THE PSYCHIATRISTS ARE A SLIGHTLY OLDER GROUP. The average age for the psychiatrists interviewed was in the 40's. For the other two professions it was in the 30's.
TABLE 33
Proportion of Respondents of Various Ages

<table>
<thead>
<tr>
<th>Age</th>
<th>Psychiatrists</th>
<th>Clinical Psychologists</th>
<th>Psychiatric Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>4%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>31-40</td>
<td>34%</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>41-50</td>
<td>37%</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>51-up</td>
<td>25%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

4. INCOMES FOR MEMBERS OF THE THREE PROFESSIONS VARY WIDELY. Psychiatrists earn most, psychologists follow, and social workers earn much less.

TABLE 34
Proportion of Respondents in Various Income Brackets

<table>
<thead>
<tr>
<th>Income</th>
<th>Psychiatrists</th>
<th>Clinical Psychologists</th>
<th>Psychiatric Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $3,000</td>
<td>0%</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>3,000-4,999</td>
<td>0%</td>
<td>8.3%</td>
<td>62.3%</td>
</tr>
<tr>
<td>5,000-6,999</td>
<td>4.5%</td>
<td>42.7%</td>
<td>29.9%</td>
</tr>
<tr>
<td>7,000-9,999</td>
<td>14.9%</td>
<td>28.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>10,000-14,999</td>
<td>27.1%</td>
<td>11.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>15,000 and over</td>
<td>53.5%</td>
<td>6.4%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

5. THE RESPONDENTS ARE EMPLOYED IN A VARIETY OF INSTITUTIONS. The agencies in which the various interviewees were primarily employed, and the proportion of respondents employed in each may be seen in Table 35.

TABLE 35
Proportion of Respondents Employed in Various Agencies and Institutions

<table>
<thead>
<tr>
<th>Institution</th>
<th>Psychiatrists</th>
<th>Clinical Psychologists</th>
<th>Psychiatric Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universities</td>
<td>12.4%</td>
<td>19.5%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>22.0%</td>
<td>2.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Psychiatric clinics</td>
<td>7.3%</td>
<td>2.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>General clinics</td>
<td>16.8%</td>
<td>20.0%</td>
<td>24.5%</td>
</tr>
<tr>
<td>V. A. hospitals</td>
<td>17.5%</td>
<td>26.2%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Welfare agencies</td>
<td>8.0%</td>
<td>12.8%</td>
<td>32.9%</td>
</tr>
<tr>
<td>State hospitals</td>
<td>16.0%</td>
<td>4.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Schools</td>
<td>0%</td>
<td>12.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
THE INTERVIEW

Of the total sample (707), selected by probability methods, 82% (580) agreed to be interviewed. The total no-interview rate is therefore 18%. Of the psychiatrists, 23% could not be seen, while 11% of the psychologists and 19% of the social workers were not available.

For psychiatric social workers, the main reason for noninterview was the fact that the candidate had retired, a reason which accounts for 39% of the refusals for this group. For the psychologists, 33% were not interviewed because they had moved—perhaps a reflection of their itinerant state. Finally, for the psychiatrists, the major factor in their nonavailability was their lack of interest in the problem, accounting for 46% of the refusals.

The interview schedule was composed for the most part of questions to which the respondents replied in terms of a list of pre-established scales. It was assumed that data deficiencies resulting from the use of an interval scale would be balanced by a greater flexibility in analysis and a greater certainty that respondents were answering in terms of the dimensions to be measured.

THE MEASURES AND THE DEVELOPMENT OF INDICES

INDEPENDENT VARIABLES (prescribed role relationships)

1. Perceived Relative Power to Influence. The respondent's location on the power dimension was determined by first obtaining the degree of "authority" he attributed to himself and to others. The differences between these two ratings provided a resultant score indicating the interviewee's location on the dimension of relative power to influence. The term authority was used in the interview, instead of power, since power was not commonly understood.

The power score for each respondent was determined for five separate task functions: diagnosis, therapy, case-history writing, community contacts, and selection of cases for individual consultation. It was assumed that these duties concern all three of the professional groups to a greater or lesser degree.

Each respondent answered the question concerning his authority relations on the "degree" scale which had a range of from 1 to 7. After obtaining the degree of attribution of authority to himself, and that attributed to persons in the other group, a discrepancy was computed between these two. This discrepancy was the location on the power dimension for the particular function. Thus persons of any one
occupational group could be ordered relative to another in terms of the size of the discrepancy.

In order to obtain a unitary dimension of power which would facilitate analysis and better characterize the group interrelationships, perceived locations in the different task functions were averaged where the intercorrelations were high. In addition to this statistical criterion for combination, there was the theoretical criterion of combining functions which were thought to go together as a result of initial insights into the professional activities and the typical collaboration patterns among the various groups.

Since some members of the three professions stated that they did not participate in some of the functions earlier described, the work areas which were combined to compute the final power location varied somewhat from one role relationship to another. The intercorrelations between the function power scores in each of the role relationships are stated below along with the combination which was used to determine the final location on the index of power. The first-named is the respondent.

a. Psychiatrists in relations with clinical psychologists

<table>
<thead>
<tr>
<th>Functions</th>
<th>Intercorrelations of power scores in functions:</th>
<th>Diagnoses</th>
<th>Therapy</th>
<th>Case assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>—</td>
<td>.78</td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>.78</td>
<td>—</td>
<td>.68</td>
<td></td>
</tr>
<tr>
<td>Case assignment</td>
<td>.72</td>
<td>.68</td>
<td>—</td>
<td></td>
</tr>
</tbody>
</table>

The power location of psychiatrists in their relations with clinical psychologists was determined on the basis of an average of the separate scores on diagnosis, therapy, and assignment of cases. Power scores in these three functions had a .73 correlation.

b. Clinical psychologists in relations with psychiatrists

<table>
<thead>
<tr>
<th>Functions</th>
<th>Intercorrelations of power scores in functions:</th>
<th>Diagnoses</th>
<th>Therapy</th>
<th>Case assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>—</td>
<td>.47</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>.47</td>
<td>—</td>
<td>.68</td>
<td></td>
</tr>
<tr>
<td>Case assignment</td>
<td>.53</td>
<td>.68</td>
<td>—</td>
<td></td>
</tr>
</tbody>
</table>

The power location of psychologists in their relations with psychiatrists was determined on the basis of an average of the separate scores in diagnosis, therapy, and assignment of cases. These had a .54 correlation.
c. Psychiatrists in relations with psychiatric social workers

The power location of psychiatrists in their relations with social workers was determined by averaging the separate scores in diagnosis, therapy, case-history writing, and community contacts. The power scores on these four functions had a correlation of .69.

d. Psychiatric social workers in relations with psychiatrists

The power location of social workers in their relations with psychiatrists was determined on the basis of two separate indices. One index was power in the functions of diagnosis and therapy which had a correlation of .68. The other index was degree of power in the combined functions of case-history writing and community contacts. The power scores on these functions had a correlation of .78. In the chapters reporting results, therefore, the power measure for each of these pairs was treated separately.

e. Clinical psychologists in relations with social workers

In the determination of the power location for psychologists in their relations with social workers it was not possible to combine the separate scores into one over-all measure since, as may be seen in the above tabulation, the power responses in the various areas had little correlation with one another. Thus, the power location of the psychologist in respect to social workers was determined in each of the three areas of
diagnosis, therapy, and community contacts, and are treated separately in the results.

f. Psychiatric social workers in relations with psychologists

The only functions which social workers perceive themselves performing in collaboration with psychologists are therapy and diagnosis. Thus, the final power location on this relationship was determined on the basis of a combination of therapy and diagnosis which had a correlation of .58.

2. Acceptance of power position. The procedure on this dimension followed that for perceived power to influence. Acceptance of power position includes both “do” and “should.” That is, in addition to encompassing the attributed power relationship, it includes the question of whether a given power relationship should be the way it is. The location of respondents on this dimension was determined by computing the difference between two discrepancies.

A discrepancy was determined between the perception of power the interviewee has, and his judgment as to whether he should have this much. A discrepancy was also calculated between the respondent’s perception of the power the other person has to determine his work, and his feelings as to whether the respondent should have power to determine the other person’s work. In this manner two scores were obtained, each of which could vary from +6 to —6. Then, taking the discrepancy between these two discrepancies (i.e. \((a-b)-(c-d)\)) provided a scale enabling the placement of persons along the dimension of “do-should.”

This dimension has some interesting characteristics. A person whose location, relative to other persons in his group, falls between 1 and 5 has less power than he feels he should have and is therefore complaining about the “power relationship” with people of the other group. A person whose score is between 7 and 11 is someone who feels that he has more power over people of the other group than he should have. His score therefore is an indication of his desire to reduce what power he has. A person who falls at 6 is one who is content with the existing balance of power.

The functions in which the acceptance of power position were measured were those used in measuring the dimension of power. The combinations of areas, where designated, were the same as for the dimension of power.
3. **Amount of Knowledge and Skills.** To establish an interviewee’s location on this dimension, the discrepancy between differential attribution of own and other’s knowledge was determined. Two questions were asked:

   a. To what extent do you think that (respondent’s occup.) have knowledge and skills from which (referent’s occup.) can benefit?

   b. To what extent do you think that (referent’s occup.) have knowledge and skills from which (respondent’s occup.) can benefit?

   Again, the measurement was obtained by taking the discrepancy between an individual’s responses to questions a and b, and then converting the resultant scale into a dimension on which positions could vary from 1 to 11. There was no differentiation as to functions.

4. **Amount of Professional Contact with the Other Group.** The respondents’ locations on this dimension were established by their responses to the question: “Over the past five years, approximately how much professional contact have you had with (occup.)?” This question was answered in terms of a simple scale ranging from “never” to “two or three times daily.” No discrepancy score was involved since the specification of contact implies a relationship with other persons.

5. **Satisfaction from Providing Counsel for Others.** The degree of “satisfaction with helping others” was established by asking the question: “How satisfied are you with the extent to which (referent’s occup.) come to (respondent’s occup.) for guidance and help?” This question was asked in the part of the interview devoted to the degree of knowledge and skills, and the frequency with which the occupants of another role sought the respondent’s advice. It was measured in terms of a simple 7-point scale. Associated with this was an open-ended question which determined the reasons why they do not take advantage of consultation opportunities.

6. **Satisfaction in Interrole Relations.** This measure was made in terms of the five functions earlier described. The subscores were combined or kept separate in the same way and according to the same criteria as in determining the power index, thus enabling the placement of each respondent on the dimension of satisfaction in interrole relations in all the relations in all the relevant work areas.

   The question was, “Generally speaking, how do you feel about your relations with (X’s) in regard to (the function)?” No discrepancy score was involved.
7. **PRESTIGE IN OWN PROFESSION.** This measure, it will be recalled, does not describe a type of relationship which may exist between roles. It was included as an independent variable, however, on the assumption that a person's status within his own profession might influence his behavior and attitudes toward members of other professions.

The prestige rating assigned to an individual was determined by the degree to which he had various characteristics which are valued in professional circles such as income, title of job, offices in professional societies, and so on. It was presumed that each of these attributes contains latent scales; that is, it is better to make much money than little, better to be a director than a staff member, and better to be a president of a professional society than a member. The prestige of a respondent, then, is a function of the number of valued professional attributes he possesses.

The criteria which were used in preparing the prestige index were taken from the face-sheet data of a 25% random sample in each of the three professions. When a list of possible prestige-characteristics had been prepared by this procedure, each was organized into an a-priori scalar form. Then the remaining 75% of the interviewees in each group were rated on these. Finally, the degree of correlation of the ratings on all of the scales was determined. Any potential prestige-attribute which did not significantly correlate with all the others was eliminated. The ratings of each respondent on the final refined scale were then determined and averaged. These final means were arranged into a formal distribution. This resulted in a scale of prestige which varied from 1 (high) to 5 (low).

The following criteria were used for each of the three professions:

<table>
<thead>
<tr>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
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<tr>
<td>1. Type of organization</td>
<td>1. Title of present position</td>
<td>1. Title of present position</td>
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<td>2. Title of present position</td>
<td>2. Professional Society and position</td>
<td>2. Age</td>
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<tr>
<td>4. Age</td>
<td>4. Income</td>
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</tbody>
</table>

**DEPENDENT VARIABLES (interrole attitudes)**

The measurement of these variables was often difficult since some of them concerned matters which the respondents disliked to discuss. Consequently, procedures were developed with such barriers in mind.
1. **Communication.** Data were obtained concerning the degree to which a respondent was disposed to communicate on a variety of topics to members of his profession and to members of the other two groups. It was felt, for example, that people would infrequently say negative things to groups which they felt to be superior; and the less power they had in relation to the others, the less they would tend to make unfavorable comments.

Such a hypothesis demanded that we establish the disposition to communicate that any respondent had with the members of the other two groups and with his own group. It also required that we do this in terms of a range of communication topics since the content of a comment was expected to vary depending upon the individual's position on relationship dimensions. The items were chosen on the assumption that people behave differently when they act in reference to their own group as compared to another; when they are viewing positive aspects of themselves as against viewing negative aspects of themselves; and when they are involving themselves in their group as against disassociating themselves from it. To maximize the variability of the items of communication, the respondents were asked to rate their disposition to talk with others in terms of a 5-point scale ranging from "very much disposed to talk to" to "very much disposed to avoid talking to."

They were questioned about communication with all three groups, on the following items:

a. *Your own* boners and failures  
b. *Your* successes  
c. *Their* boners and failures  
d. *Their* successes  
e. Your perception of *your* professional group's inadequacies  
f. Your perception about *their* professional group's inadequacies  
g. The positive aspects of *your* group's training and skills  
h. Your gripes about the way *they* act toward you  
i. The disagreement in opinion between yourself and them on the job, e.g., theory, diagnosis, etc.  
j. The disagreement in opinion between yourself and them off the job, e.g., music, politics, etc.  
k. Light conversation about unimportant things

To prepare these data for examination, a number of operations were necessary: (a) For each individual there were ratings on each item
which specified his readiness to communicate to members of the other
two groups and to his own group, thereby permitting analysis of each
separately.

(b) The mean of all his ratings over all topics provided a measure
of the total volume of communication an individual is disposed to
direct to a given group.

(c) For each individual the discrepancy between the mean volume
of communication to the other two groups and the mean volume of
communication to his own group, established the disposition of each
individual to over-communicate or under-communicate to other groups
in relation to his own. This score then became the "mean own-group
communication minus mean other-group communication" score.

(d) The mean, for any one group communicating an item to any
other group was calculated, which gave eleven means for each profes­
sion.

(e) A final measure was the mean of the means to obtain some idea
of the total volume of communication which may be directed to a given
group by another profession over all the individual items. This provided
three means for each group: one representing the communication over
all items to own group, the other two representing the volume of
communication over all items to the other two occupational groups.

With the refined data provided by these operations it was possible
to test hypotheses concerning communication: that communication
would vary as a function of the location of the individual on a particular
dimension, as a function of the persons to whom it was directed, as a
function of the person doing the communication and finally, as a
function of the item.

2. ATTITUDES OF ADMIRATION AND ESTEEM. A complex of factors
was used which taken together gave information on the affect and
evaluation that existed among these persons. The following items were
used to obtain a measure of affect and evaluation.

(a) Stereotype "likeable": This was a measure of the extent to which
persons in all three groups felt that members of their own and the two
other groups were likeable.

(b) Desire for professional contact and desire for leisure contact: In
the context of gathering data which established respondents' locations
on the professional contact dimension, the respondent was asked about
his desires for professional and leisure-time contact with members of
the other two groups. The exact queries were:
(i) How much professional contact would you like to have with (referent occup.) at present?
(ii) How much leisure-time contact would you like to have with (referent occup.) at present?

It was assumed that if an individual desired contact with members of the other groups (no matter what the reasons for this desire), it was some indication of his positive feelings toward them.

(c) Attraction: The following question was asked of all the respondents: "If you could begin your professional career all over again and you could become either a psychiatrist, clinical psychologist or a psychiatric social worker, and assuming that equal effort would be required to become a member of each of these professional groups, which would be your first choice? Your second choice? Your third choice?"

(d) Rank order of group contribution: Respondents were asked the quality of the contributions each of eleven occupational groups could make to the field of mental hygiene. The responses were used as an index of the comparative esteem in which each occupational group was held by a given respondent.

The question was: "In some cities, there has been planning for the development of a group of professional workers whose job is to help meet the community mental health problems arising today. The following groups have customarily been invited to participate in such planning committees: group workers, ministers, clinical psychologists, school guidance counselors, public health nurses, psychiatrists, case workers, psychiatric social workers, teachers, general practitioners, and court workers." [A list was handed to the respondents and they were asked to rank them as follows.] "I would like to have you rank these groups in the order in which you think they would contribute to such a committee; e.g., the group that you think would contribute most, you would rank 1, etc." Only the reactions of the three occupational groups toward one another were averaged.

(e) Get along with: This question was asked in the following way: "Now let us assume that you were on such a committee (as mentioned above), including your own group, with the members of which professional group would you be most likely to get along?

1. Name the first two.
2. Name the second two.

With the members of which professional groups would you be least likely to get along?
3. Name the first two.
4. Name the second two.

Again, from this over-all rating of all eleven groups were isolated the ratings of these three groups relative to one another, producing two scores; for the group as a whole and for each individual.

3. **Desire for Admiration and Esteem.** Data were collected on the respondent's desire for affect and valuation. In terms of the liking and respect scales presented above, the following questions were asked:
   a. How do you want \(\text{(referent's occup.)}\) to feel towards you? (answered by use of the liking scale)
   b. How do you want \(\text{(referent's occup.)}\) to feel towards you? (answered by use of the respect scale)

Both of these questions were asked of the respondent in reference to his own group as well as to the other two groups.

4. **Perception of Their Admiration and Esteem for You.** In the same manner data were gathered on the respondent's perception of the evaluation of himself by others, whether his own group or the other two. He was asked:
   a. Now, how do they \(\text{(referent's occup.)}\) feel towards you? (answered in terms of the liking scale)
   b. Now, how do they \(\text{(referent's occup.)}\) feel towards you? (answered in terms of the respect scale)

5. **The Use or Receipt of Solicitousness.** The exact form of the questions was not the same for all roles, nor were questions asked in reference to all the groups with which a respondent had relations. For example, it was considered unnecessary to ask the psychiatrist if he attempted to cater to the social worker since all of them in the pilot stage replied in the negative; and it did not seem appropriate to ask the social worker and the psychologist if they engaged in these behaviors in regard to each other. These decisions were made on the basis of prior explorations of the environment. The following questions were asked:
   (a) Of the psychiatrist; in reference to psychologists and social workers:
   1. To what extent have \(\text{(referent group)}\) attempted to curry favor with you?
   2. To what degree do \(\text{(referent group)}\) strive for your recognition?
(b) Of the psychologists and social workers in reference to the psychiatrists:
   1. To what extent do you find it necessary to soft-soap or flatter psychiatrists occasionally?
   2. To what extent do you find it necessary to strive for any psychiatrist's approval?
(c) Of the psychologists and social workers in reference to each other:
   1. To what extent do you think (referent's occup.) soft-soap or butter-up psychiatrists?
   2. To what extent do (referent's occup.) strive for the psychiatrist's approval?
   3. To what extent do you find yourself in competition with (referent's occup.) for the psychiatrist's approval?

6. THE USE OR RECEIPT OF ENCROACHMENT OR HOSTILITY. The questions asked about interrole conflict were not exactly the same for all three groups since the methods for engaging in negative behavior differ from group to group. All of the questions, except where designated, were asked in terms of an amount or of a degree scale.

The syndrome of conflict and threat can in turn be broken down into a number of areas which have different qualitative meanings though they are all part of the same range of behaviors.

(a) Encroachment on the psychiatrist. These questions were designed to get at phenomena of movement into functions or prerogatives of other professional groups. Questions:

   (i) Of the psychiatrists in reference to the other two groups: "To what extent are (referent's occup.) trying to encroach on areas of activity which ought to be your own?"

   (ii) Of the psychologists and social workers in regard to themselves: "To what extent are you trying to encroach on areas which the psychiatrist considers to be his own?"

   (iii) Of the psychologists and social workers in reference to each other: "To what extent are (referent's occup.) trying to encroach on areas of activity which the psychiatrist considers to be his own?"

(b) Psychologists entering private practice. This item was used to explore encroachment, and was also considered a point of conflict in the relationships between these roles. The question was not asked either of, or in relation to, social workers since they are not involved in questions of private practice to any degree. The following query
was made of the psychiatrists and psychologists in reference to the psychologists: “To what extent are psychologists attempting to enter private practice in order to increase their income?”

(c.) *Upward mobility.*

(1) Stereotype “striving”: This is a measure of the characteristics of a given group in regard to how striving the respondent thinks they are. It was gathered in the context of the stereotype data to be described later.

(2) Earn as much: These data are a measure of the self-evaluation of each of the three groups, but more importantly they are an indication of the acceptance or nonacceptance of income differences between them.

All respondents were asked in reference to members of the other two groups: “Do you think that (referent’s group) should earn more ——; less ——, or as much as —— (referent’s occup.)?

(3) Would you like to sit down with a psychiatrist, etc.: Another measure of professional aspirations was the desire for each of two less powerful groups to relate to the psychiatrist; vis:— “To what extent would you like to sit down with a psychiatrist and discuss with him the problems which are unique to being a psychiatrist when all you’d get out of it is the enjoyment of this type of discussion?” This was considered to be a measure of substitute-upward mobility on the part of psychologists and social workers.

(d) *Active efforts to decrease the psychiatrist’s influence:* The psychologists and social workers were asked in reference to the psychiatrists: “To what extent are you actively trying to decrease the amount of influence that the psychiatrist can have on your professional life?”

(e) *Envy and threat.*

(1) Envy of the psychiatrists income: To get a necessary measure of some of the sources of conflict in this social structure the question was asked:

(i) Of the psychiatrist in reference to the psychologist: “To what extent do psychologists envy the psychiatrist because of his income?”

(ii) Of the psychologists and social workers in reference to themselves: “To what extent do (respondent’s occup.) envy the psychiatrist because of his income?”

2. Financial threat: A possible source of conflict and threat-orientation was tapped by asking psychologists and psychiatrists: “To what extent do you think psychiatrists perceive clinical psychologists as a financial threat?”

(f) *Mutual threat and threat from the psychiatrist.*
(1) Stereotype "threatening": This measure was obtained from the data on interrole stereotypes and will be discussed below.

(2) Are psychiatrists keeping income down?: The perception of threat on the part of the ancillary respondents was expected to vary in accordance with their perception of own power. The psychologists and social workers were therefore asked in reference to the psychiatrists: To what extent are psychiatrists responsible for keeping (respondent's occup.) income from being higher?"

(g) Rejection by the psychiatrists

(1) Reluctance to talk with others: To get a measure of the psychiatrists' disapproval of the other two groups he was asked: "To what extent would you be reluctant to sit down with (referent's occup.) to discuss with him problems which are unique to being a psychiatrist?"

(2) Discourage from currying favor: For the same reasons as in the above questions, and also to check on the solicitous behaviors of the other two groups, this question was asked of the psychiatrist: "To what extent have you found it necessary to discourage (referent group) from attempting to curry favor with you?"

7. Stereotypes about other groups. The measurement of interrole stereotypes required a variety of characteristics. Thirteen were felt to be important for the particular groups under study, and for the environment in which they were situated. Each respondent was asked to judge his own group and the other two on a series of characteristics. The ones employed were.

a. Competence
b. Clinical insightfulness
c. Quality of training
d. Likeable
e. Maturity
f. Dogmatism
g. Scientific minded
h. Orientation to social problems
i. Mercenary
j. Condescension
k. Threatening
l. Defensive
m. Striving

The respondent indicated what percentage of the group he was judging on a given trait fell into each of the three categories: e.g., competent, mediocre, or incompetent. He was to distribute the percentages over the trait so that they totaled 100% for the given group for any one characteristic, e.g., competent 60%, mediocre 10%, incompetent 30%.

(a) Functional expectations data: After asking each respondent about the knowledge and skills he thought each of the other two groups
could obtain from him and those that he could get from them, the following question was asked: "Briefly, what kinds of things can (referent's occup.) benefit from?" These questions were asked in relation to each of the two other groups.

The coding categories:

1. Knowledge of physiology
2. Knowledge of psychopathology.
3. Knowledge of psychodynamics
4. Broad psychological perspectives
5. Research and methodological approach
6. Psychometrics
7. Clinical and professional approach and attitudes
8. General clinical skills
9. Therapeutic knowledge and skills
10. Diagnostic skills and techniques
11. Interviewing skills and techniques
12. Case histories
13. Knowledge of and contact with family situation
14. Knowledge and use of community resources
15. Environmental adjustment and manipulation
16. Understanding of broad, environmental (socio-cultural) factors
17. Recognition of interdependence of roles and value of interdisciplinary co-operation
18. Supervisory techniques

These data provide an indication of the perceptions each of the groups had about the other two in terms of their functions and also offers a comparative base of the way in which they perceive their own unique functions.

(b) Barriers to taking advantage: Associated with the scalar question which asked about the extent to which they took advantage of each other's knowledge and skill was an open-ended question which inquired into the reasons for inability to take full advantage of the available knowledge and skills. This allowed penetration into the reasons for lack of co-operation of the three groups. The exact question was: "Briefly, why do you think it is that (referent's occup.) don't take more advantage of this knowledge and skill?" and "Briefly, why do you think it is that (respondent's occup.) don't take more advantage of this knowledge and skill?"
The coding categories:

1. Lack of time and opportunity
2. Lack of contact
3. Interdisciplinary difference—problems of interprofessional communication (different theoretical orientation)
4. Problems of competition and rivalry
5. Individual personality considerations
6. Technical and training inadequacies of the other group
7. Problems of status and superiority with other group
8. Feelings of self-sufficiency of other group (negative attribute)
9. Defensiveness and insecurity of other group
10. Technical and training inadequacies of own group
11. Problems of status and superiority within own group
12. Feelings of self-sufficiency of own group
13. Defensiveness and insecurity of own group
14. Feelings of self-sufficiency of own group (positive attribute)
15. Take as much advantage as possible

(c) Satisfaction with relations: In conjunction with the question which served to establish the degree of satisfaction with interrole relations was an open-ended question which was used to inquire into the reasons that an individual may have for feeling positive or negative about their relations with members of other groups in a given work area. After the scalar satisfaction questions in each work area came the question: "Why do you feel that way?"

The coding categories:

1. Lack of time and opportunity
2. Lack of contact
3. Satisfaction with the behavior and performance of the subordinate
4. Satisfaction with the superior's behavior and supervision
5. Freedom and independence in area of competence
6. Satisfactory teamwork
7. Mutual respect
8. Satisfactory interdisciplinary supplementation
9. Satisfactory training and competence of own group
10. Satisfactory training and competence of other group
11. Dissatisfaction with the behavior and performance of subordinate
12. Dissatisfaction with the superior's behavior and supervision
13. Lack of freedom and independence in areas of competence (lack of structural independence)
14. Lack of or unsatisfactory teamwork
15. Lack of mutual respect
16. Inadequate or lack of interdisciplinary supplementation
17. Inadequate or lack of training and competence on part of own group
18. Inadequate or lack of training and competence on part of other group
REFERENCES


25. Luszki, Margaret, Methods and problems of interdisciplinary team research in mental hygiene. Ann Arbor: Research Center for Group Dynamics, 1955, mimeo.


Summary Tables of Results
<table>
<thead>
<tr>
<th>Relationship Dimension</th>
<th>Psychiat. re Psychologist</th>
<th>Psychol. re Psychiatrist</th>
<th>Psychiat. re PSW</th>
<th>PSW re Psychiatrist</th>
<th>Psychiat. re PSW</th>
<th>PSW re Psychologist</th>
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<td>2.67 (D, T, &amp; C)</td>
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Abbreviations: D-diagnosis, T-therapy, C-cases for individual help, CC-community contacts, SH-social history writing, R-research, PSW-psychiatric social worker.
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Abbreviations: P-psychiatrist, CP-clinical psychologist, PSW-psychiatric social worker, Respondent in numerator and referent in denominator at head of columns.
### Table 38

Average Attitudes of Admiration and Esteem for Others in Each Role Relationship

<table>
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<tr>
<th>Attitude</th>
<th>P/CP</th>
<th>CP/P</th>
<th>P/PSW</th>
<th>PSW/P</th>
<th>CP/PSW</th>
<th>PSW/CP</th>
<th>P/P</th>
<th>CP/CP</th>
<th>PSW/PSW</th>
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<td>3.76</td>
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<td>Stereotype &quot;likeable&quot;</td>
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<td>5.06</td>
<td>4.85</td>
<td>4.90</td>
<td>5.13</td>
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<td>&quot;Get along&quot; with—</td>
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<td>Desire to “sit-down” with</td>
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<td>4.54</td>
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Blank cells indicate that these data were not obtained for that relationship.

### Table 39

Average Desire for Favorable Evaluation and Perceived Amount Obtained from Others

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<th>CP/P</th>
<th>P/PSW</th>
<th>PSW/P</th>
<th>CP/PSW</th>
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<th>P/P</th>
<th>CP/CP</th>
<th>PSW/PSW</th>
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<td>Desire to be liked</td>
<td>2.72</td>
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<td>3.22</td>
<td>3.31</td>
<td>3.91</td>
<td>3.64</td>
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<tr>
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<td>4.44</td>
<td>3.99</td>
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<td>4.01</td>
<td>4.02</td>
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<td>Perception of being liked</td>
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<td>3.53</td>
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<td>3.49</td>
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<td>Perception of being respected</td>
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<td>3.83</td>
<td>3.94</td>
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<td>3.81</td>
<td>3.64</td>
<td>3.81</td>
<td>4.02</td>
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<td>CP/P</td>
<td>P/PSW</td>
<td>PSW/P</td>
<td>CP/PSW</td>
<td>PSW/CP</td>
<td>P/P</td>
<td>CP/CP</td>
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<td>Do you curry favor?</td>
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<tr>
<td>Do others seek your favor?</td>
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<tr>
<td>Do you strive for approval?</td>
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<td>Do others seek your approval?</td>
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<tr>
<td>How much need to discourage favor seeking?</td>
<td>1.82</td>
<td>—</td>
<td>1.77</td>
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<tr>
<td>Do X's seek favor of P?</td>
<td>—</td>
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<td>4.31</td>
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<td>Do X's seek P's approval?</td>
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<td>Do you compete with X's for P's approval?</td>
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<tr>
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<td>2.17</td>
<td>2.46</td>
<td>2.65</td>
<td>2.42</td>
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<td>2.68</td>
<td>2.13</td>
<td>2.44</td>
<td>2.58</td>
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<td>Do you encroach on—</td>
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<td>Do X’s encroach on P?</td>
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<td>3.96</td>
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<td>4.82</td>
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<td>4.48</td>
<td>5.30</td>
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<td>Try to decrease P’s influence?</td>
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<td>Do P’s keep your income low?</td>
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<td>Do X’s compete with you for P’s support?</td>
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<td>1.73</td>
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### TABLE 42
Mean Stereotype Scores Attributed to Each Profession

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<th>SW/SW</th>
<th>P/SW</th>
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<th>P/CP</th>
<th>CP/SW</th>
<th>SW/CP</th>
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<td>4.43</td>
<td>4.56</td>
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<td>4.81</td>
<td>4.14</td>
<td>4.33</td>
<td>4.70</td>
<td>3.90</td>
<td>4.14</td>
<td>4.82</td>
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<tr>
<td>Well trained</td>
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<td>4.93</td>
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<td>Mature</td>
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<td>4.61</td>
<td>4.25</td>
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<td>4.35</td>
<td>3.93</td>
<td>4.21</td>
<td>4.68</td>
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<td>Dogmatic</td>
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<td>3.52</td>
<td>3.74</td>
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<td>5.09</td>
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<td>2.86</td>
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<td>5.01</td>
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<td>5.14</td>
<td>5.35</td>
<td>4.48</td>
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<td>4.01</td>
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<tr>
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<td>2.17</td>
<td>3.41</td>
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### Table 43-c

Correlation Matrix of Independent and Dependent Variables

a) Psychiatrist in relation to psychologist

<table>
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<tr>
<th>Dependent Variables</th>
<th>1. COMMUNICATION TOPICS</th>
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<th>Light Conversation</th>
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<tbody>
<tr>
<td></td>
<td>Your Boners</td>
<td>Your Success</td>
<td>Their Boners</td>
<td>Their Success</td>
<td>Your Group's Inadeq.</td>
<td>Their Group's Inadeq.</td>
<td>Your Group's Training</td>
<td>Gripe About How They Act</td>
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<td>1. Power (D, T, &amp;C)</td>
<td>-.04</td>
<td>.00</td>
<td>-.06</td>
<td>.04</td>
<td>.00</td>
<td>-.03</td>
<td>.14</td>
<td>-.07</td>
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<td>2. Acceptance of power (D, T, &amp; C)</td>
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<td>.08</td>
<td>-.14</td>
<td>.26</td>
<td>.02</td>
<td>-.08</td>
<td>.16</td>
<td>-.06</td>
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<tr>
<td>3. Knowledge and skills</td>
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<td>-.01</td>
<td>.00</td>
<td>-.10</td>
<td>-.16</td>
<td>.09</td>
<td>.06</td>
<td>.01</td>
</tr>
<tr>
<td>4. Professional contact</td>
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<td>.15</td>
<td>.10</td>
<td>.19</td>
<td>.21</td>
<td>.05</td>
<td>.06</td>
<td>.11</td>
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<tr>
<td>5. Satisfaction with CP's coming for help</td>
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<td>-.08</td>
<td>-.03</td>
<td>.14</td>
<td>.05</td>
<td>-.01</td>
<td>-.06</td>
<td>-.10</td>
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<tr>
<td>6. Satisfaction in relations (D, T)</td>
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<td>-.04</td>
<td>.01</td>
<td>.05</td>
<td>.15</td>
<td>-.05</td>
<td>.08</td>
<td>-.10</td>
</tr>
<tr>
<td>7. Prestige</td>
<td>.07</td>
<td>-.01</td>
<td>.07</td>
<td>.11</td>
<td>.03</td>
<td>.04</td>
<td>.03</td>
<td>.01</td>
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</tbody>
</table>

Abbreviations: D-diagnosis, T-therapy, C-cases for individual help, CC-community contacts, SH-social histories, P-psychiatrist, CP-clinical psychologist, PSW-psychiatric social worker.
# Table 43-a (continued)

**a) Psychiatrist in relation to psychologist**

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<td></td>
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<td>M. vol. own. M. vol. other</td>
<td>Stereotype &quot;likeable&quot;</td>
<td>Desire for prof. contact</td>
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<td>1. Power, (D, T, &amp; C)</td>
<td>.17</td>
<td>.00</td>
<td>.05</td>
<td>.35</td>
</tr>
<tr>
<td>2. Acceptance of power (D, T, &amp; C)</td>
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<td>.14</td>
<td>.12</td>
<td>.59</td>
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<tr>
<td>3. Knowledge and skills</td>
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<td>.27</td>
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<td>4. Profess. contacts</td>
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<td>5. Satisfaction with CP's coming for help</td>
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<tr>
<td>6. Satisfaction in relations (D, T)</td>
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<td>.02</td>
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<td>.20</td>
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<td>7. Prestige</td>
<td>.04</td>
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<td>-.05</td>
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TABLE 43-a (continued)

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<th>Dependent Variables</th>
<th>5. Solicitousness</th>
<th>6. Encroachment and Hostility</th>
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<td>Do they carry favor</td>
<td>Do they strive for recognition</td>
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<td>1. Power (D, T, &amp; C)</td>
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<tr>
<td>2. Acceptance of power (D, T, &amp; C)</td>
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<tr>
<td>3. Knowledge and skills</td>
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<td>4. Professional contacts</td>
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<td>5. Satisfaction with CP’s coming for help</td>
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<tr>
<td>6. Satisfaction in relations (D, T)</td>
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<td>.05</td>
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<td>7. Prestige</td>
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### Table 43-b

**b) Psychologist in relation to psychiatrists**

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<th>Dependent Variables</th>
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<th>Your Success</th>
<th>Their Boners</th>
<th>Their Success</th>
<th>Your Group's Inadeq.</th>
<th>Their Group's Inadeq.</th>
<th>Your Group's Training</th>
<th>Gripes About how They Act</th>
<th>On the Job Disagreements</th>
<th>Off the Job Disagreements</th>
<th>Light Conversation</th>
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<td>.00</td>
<td>.21</td>
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<td>.13</td>
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### TABLE 43-b (continued)

#### b) Psychologist in relation to psychiatrists

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<td>Stereotype &quot;likeable&quot;</td>
<td>Desire for professional contact</td>
<td>Desire for leisure time contact</td>
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### TABLE 43-6 (continued)

**b) Psychologist in relation to psychiatrists**

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c) Psychiatrist in relation to psychiatric social workers

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<th>Their Group's Inadeq.</th>
<th>Your Group's Training</th>
<th>Gripes About How They Act</th>
<th>On the Job Disagreements</th>
<th>Off the Job Disagreements</th>
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TABLE 43-e (continued)

c) Psychiatrist in relation to psychiatric social workers

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TABLE 43-c (continued)

c) Psychiatrist in relation to psychiatric social worker

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### TABLE 43-d

**d) Psychiatric social worker in relation to psychiatrists**

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<th>Your Group's Professional contact</th>
<th>Your Group's Satisfaction with P coming for help</th>
<th>Your Group's Satisfaction in relations</th>
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**1. Communication Topics**

- **Your** gripes on the job
- **Their** gripes on the job
- Dependent variables
- On the job dissatisfactions
- Off the job dissatisfactions
- Light conversations
### TABLE 43-d (continued)

*d) Psychiatric social worker in relation to psychiatrists*

<table>
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**Notes:**
- Mean volume commun.: Mean volume of communication.
- M. vol. own, M. vol. other: Mean volume of own, mean volume of other.
- Stereotype "likeable": Stereotype likeable.
- Desire for professor contact: Desire for professor contact.
- Desire for leisure time contact: Desire for leisure time contact.
- Get along with: Get along with.
- Desire to be liked: Desire to be liked.
- Desire to be respect: Desire to be respect.
- Percep. of their liking: Perceptions of their liking.
- Percep. of their respect: Perceptions of their respect.
### TABLE 43-d (continued)

**d) Psychiatric social worker in relation to psychiatrists**

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<th>Dependent Variables</th>
<th>5. SOLICITOUSNESS</th>
<th>6. ENCROACHMENT AND HOSTILITY</th>
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<td>Do you encroach</td>
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### TABLE 43-e

*e) Psychologist in relation to psychiatric social workers*

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<th>Your Success</th>
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TABLE 43-e (continued)

e) Psychologist in relation to psychiatric social workers

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<th>3. DESIRE FOR ADMIRATION</th>
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<td>6. ENCROACHMENT, HOSTILITY</td>
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<td>Percep. of their liking</td>
<td>Percep. of their respect</td>
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### Table 43-f

#### Psychiatric social worker in relation to psychologists

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**TABLE 43-f (continued)**

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<th>3. DESIRE FOR ADMIRATION</th>
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### TABLE 43-š (continued)

**f) Psychiatric social worker in relation to psychologists**

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<th>6. ENCROACHMENT, HOSTILITY</th>
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TABLE 44
Professional Knowledge and Skills Each Group States They May Offer or Receive from Others
(Number of responses within each category)

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<th>Professional Skill Functional Area</th>
<th>P's offer to</th>
<th>P's benefit from</th>
<th>PSW's offer to</th>
<th>PSW's benefit from</th>
<th>CP's offer to</th>
<th>CP's benefit from</th>
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### TABLE 45

Interrelation of Independent Variables

* * Psychiatrist in relation to psychologists *

<table>
<thead>
<tr>
<th>1. Power (Therapy, diagnosis, and cases)</th>
<th>2. Acceptance of Power (Do-Should) (Diagnosis and therapy)</th>
<th>3. Knowledge and Skills</th>
<th>4. Professional Contact</th>
<th>5. Satisfaction (with psychologists coming for help)</th>
<th>6. Satisfaction in Relations (areas of diagnosis and therapy)</th>
<th>7. Prestige</th>
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<tr>
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<td>+.82</td>
<td>+.09 -0.09</td>
<td>+.27 +.39 -.14</td>
<td>+.17 +.40 +.30 +.36</td>
<td>+.06 +.21 -.02 +.27 +.45</td>
<td>+.18 +.18 +.07 -.06 +.05 +.02</td>
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* a) The correlation figures should be read in conjunction with the significance figures given earlier and reproduced here. This will be true of all the matrices.

For a correlation of .16-.20 the significance level is .05.
For a correlation of .21-.36 the significance level is .01.
For a correlation above .36 the significance level is .001.
### TABLE 45 (continued)

**Psychologist in relation to psychiatrists**

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### Table 45 (continued)

**c) Psychiatrist in relation to psychiatric social workers**

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<td>Professional Contact</td>
<td>Satisfaction (with psychiatrists coming for help)</td>
<td>Satisfaction in relations</td>
<td>Prestige</td>
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<td>Knowledge and Skills</td>
<td>Professional Contact</td>
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TABLE 45 (continued)

f) Psychiatric Social Worker in relation to psychologists

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