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Bermúdez, George Stephen, Ph.D.

City University of New York, 1988

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BELIEFS, BOUNDARIES, AND BURNOUT:

THE THREAT OF BURNOUT IN THE HISPANIC CLINIC MODEL

FOR DELIVERY OF MENTAL HEALTH SERVICES

by

GEORGE S. BERMUDEZ

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1988

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Abstract

BELIEFS, BOUNDARIES, AND BURNOUT:
THE THREAT OF BURNOUT IN THE HISPANIC CLINIC MODEL
FOR DELIVERY OF MENTAL HEALTH SERVICES

by

George S. Bermudez

Advisor: Lawrence J. Gould, Ph.D.

The research focused on the relationship between organizational setting and the syndrome of burnout among mental health workers. This study specifically hypothesized a complex relationship among the variables of ethnicity (Hispanics) of practitioners, organizational structure and incidence of burnout. The model of the "Hispanic Clinic" (bilingual-bicultural clinicians) was viewed as a special case where group psycho- cultural processes are set in motion that idiosyncratically impact on organizational design and promote the incidence of burnout. The research design called for the administration of two survey instruments to all clinicians at two types of outpatient mental health settings serving predominantly hispanic catchment areas. The two types of settings were polar opposites: the first, an "Hispanic Clinic" model, and the second, a primarily non-Hispanic professional staff. One instrument assessed

organizational design and surveyed perceptions of organizational roles, decision-making and work-group climate (Michigan Organizational Assessment Questionnaire). The second instrument assessed the frequency and intensity of symptoms of burnout syndrome (Maslach Burnout Inventory). An unconscious "missionary phenomenon" was hypothesized that may generate dysfunctional organizational norms and structures. The prediction of higher incidence of burnout among Hispanic clinicians was not confirmed. Hispanic clinicians, the results indicate, have significantly lower experienced burnout than non-Hispanics. Multiple prediction of burnout reveals four factors predominantly explaining the variance in burnout: ethnicity, a factor designated as internal work motivation, age, and autonomy/influence, in that order. Three possible sources of explanation for the observed interethnic differences in experienced burnout are discussed: (1) patient-therapist linkages, (2) culturally based coping syles, and (3) work group factors.

Dedicated to
my family, my mother, Luz Concepcion,
and my daughters, Natasha and Macquiva,
who have given me life and hope.

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Introduction and Statement of the Problem

Recently, there has been an emergence of interest in the incidence of burnout in human service workers, including mental health workers (Maslach, 1976; Cherniss, 1980). Client (Maslach, 1976), individual (Freudenberger, 1974; Gann, 1979), organizational (Carroll, 1979; Cherniss, 1980; Eisenstat & Feiner, 1983; Ianni & Reuss-Ianni, 1983), as well as larger societal (Farber, 1983) factors have been cited as sources of burnout. There is an emerging consensus that burnout is a multipli-determined syndrome with at least two major aspects: emotional exhaustion related to stress and a loss of concern and sense of accomplishment related to a loss of commitment or motivation (Eisentat & Feiner, 1983). Both aspects are generally felt to be job related, although exclusively individually derived types of burnout can, of course, be identified (Hall et al, 1979). The most promising approach to understanding and investigating job-related burnout is conceptualizing it as an ecological dysfunction, a result of pathological interaction between person and organizational environment (Carroll, 1979; Ianni & Reuss-Ianni, 1983).

A recent paper by clinicians working in a major medical/ mental health center in the Bronx delineates some of the excruciating dilemmas facing clinicians and the contradictions in organizational structures that both stress clinicians and obstruct service delivery (Feiner and Brown, 1984). Staff

burnout is an ever present threat. Burnout according to the authors is "nowhere . . . more prevalent than in community-based services. Clinicians have no protection from ever-increasing caseloads. Waiting lists are ethically questionable; selection of patients is abhorrent in a population that has no alternative resources. Role confusion and functions different from those prepared for in . . . training add to a feeling of being overwhelmed. . . . the need for productivity levels that don't always mesh with the realities of the services demanded by patient problems. . . . interagency liaison may become problematic as agencies, themselves overwhelmed, serve as gatekeepers" (p. 134). The authors suggest a direction in addressing the problems: "extensive orientation to the workplace, role clarification. . . . changes of functions of clinicians. . . . and teams with positive collaboration. Many of these solutions emerge from considering the workplace from a systems perspective" and focusing on developing the mental health organization and its staff in terms analogous to patient care.

Miller and Gwynne (1972) in their study of residential institutions for the disabled argue that "Human institutions must satisfy certain needs of the people who staff them if they are to continue to survive . . . . satisfaction of these internal needs will tend to assume priority over the task that the institution exists to perform" (p. 212). Clearly, these authors have made a case for the fact that the unsatisfied

needs of staff caught in organizational contradictions can derail the entire function of the delivery system. The result can be emotionally depleted and demoralized staff within organizations that are empty shells of their promise to clients.

This study proposes to examine the above issues with respect to "Hispanic Clinics." The "Hispanic Clinic" has developed as part of the community mental health movement in response to a need in patient populations: a bilingual-bicultural staff treating an underserved Hispanic community. There are a number of reports of such experiments in mental health services delivery to Hispanic patients (Abad, Ramos, and Boyce, 1974; Padilla, Ruiz, and Alvarez, 1975; Delgado, 1981). The reports present some of the organizational and clinical dilemmas facing these clinics, their specific formulas for addressing the problems presented by community residents, and recommendations for future programs. None of this literature, however, addresses the stressful personal impact on Hispanic clinicians of treating a high-risk population with often overwhelming social and economic problems.

In addition, despite, the popularity of the burnout concept, there has been no investigation of burnout directed at the population of minority-group clinicians. This study proposes to address the risk and frequency of burnout among Hispanic clinicians in mental health settings. Three crucial

questions inform the structure of the proposed study: (1) Is the frequency of burnout higher among Hispanic clinicians than among non-Hispanic clinicians in comparable settings?; (2) Is stress and burnout related to the number of Hispanic staff in a clinical setting?; (3) Do "Hispanic Clinics" staffed predominantly or exclusively with bilingual-bicultural Hispanic clinicians generate unique normative and organizational structures that may increase risk of burnout?

My interest in this problem is related to my own personal and professional development as a minority-group member and psychotherapist treating minority-group patients. These patients, in effect, represent the people I grew up with and with whom I shared the ecstasy and the agony of being black, Puerto Rican, and poor in the Metropolis. The dangers of overidentification, dis-identification, and other dysfunctional countertransference reactions are ever present and I have become increasingly sensitized to them in my development as a psychotherapist. Overinvolvement, disillusionment, and despair leading to burnout can often be the result of unexamined countertransference.

In the last two years I have had the opportunity to work in two radically different clinical contexts. Although my internship setting offered clinical services to a culturally diverse community with a large proportion being Hispanic, it was staffed primarily by non-Hispanic, white, middle-class professionals. I was one of two Hispanics in the Department

of Psychiatry. My first job after the internship was in an "Hispanic Clinic" staffed by bilingual-bicultural Hispanic professionals serving the same population as the internship setting. I felt like Alice going through the mirror into another reality after this radical shift in working environments!

As a psychologist interested in group and organizational dynamics I began to wonder about the differences in organizational environments I had so vividly experienced. My new work environment manifested emotional expression that made the internship setting look like a morgue; bureaucratic structures were virtually non-existent at the new setting. I began to compare the two settings: I realized that in general, with a few exceptions, the internship seemed to have a flat, apathetic air while the "Hispanic Clinic" began to have an atmosphere of emotional demand bordering on exhaustion. I myself felt overwhelmed and others seemed to be complaining of similar feelings. I became concerned about staff functioning and voiced my observations, but an organizational dynamic appeared to have caught all of us in its grip: little heed was paid to my attempts at intervention.

My experience raised many questions. Do Hispanic organizations generate idiosyncratic organizational defense structures (Menzies, 1960; Jacques, 1978)? What are the anxieties and conflicts that inform organizational design and functioning? Can burnout be more frequent in these settings?

What is the relationship between the ethnic mix of staff, organizational structure, and burnout? Hence, it is in search of answers to these related questions that I propose the following work.

Instruments assessing burnout and organization design will be administered to clinicians working in various mental health clinics. Two types of settings will be surveyed: those either staffed exclusively or predominantly by bilingual Hispanic staff and those employing low numbers (1 or 2) bilingual Hispanic staff. My hope is that this study can shed light on the following general hypotheses: (1) In general, the number of Hispanic clinicians in a service setting has a meliorative impact on incidence of burnout; (2) however, "Hispanic Clinics" produce normative and organizational structures that tend to increase risk of burnout; (3) Hispanic clinicians, in general, in contexts serving Hispanic patients tend to have higher incidence of burnout than non-Hispanic clinicians.

In the next section, a literature review section will cover three areas: literature of the Tavistock School of open systems and organizational theory, literature on burnout with a focus on organizational factors as sources of burnout, and the literature on issues in Hispanic mental health and delivery of services. This will be followed by a method section that will specify the instruments to be used, the settings to be included in the survey, and the specific hypotheses.

Literature Review

Tavistock Open Systems Theory

Open systems theory has come to dominate the thinking of modern organization theorists (Baker, 1973; Miller & Rice, 1967; Katz & Kahn, 1978). Open systems thinking comprises three ideas that have become essential in analysis and intervention in organizations: (1) the idea of a system of relationships so that change in one element determines change in other elements; (2) openness to environmental influence: both the social field of forces and technological context should always be kept in mind; and (3) the hierarchal patterning of systems: activities at "higher" levels dominate actions at "lower" levels. The last bears special significance for social science investigations; it suggests that the optimal research strategy should be to focus on the most complex level. It is an anti-reductionist model (Katz & Kahn, 1978).

The Tavistock Open Systems approach to organizations represents a complex and unique attempt to develop a "theory of organization" that pulls together "task, human activities, and organization" into "one general framework" (Miller & Rice, 1967). In line with the work of other theorists (Argyris, 1962, 1964; Katz & Kahn, 1978), Miller & Rice have as their explicit aim the reconciliation of human (employee) needs with organizational needs (task completion). Their position is that human needs for satisfaction and defense are antithetical

to organizational needs; human needs are regarded as constraints to optimal task completion, but if they go unmet, task performance will suffer. The task for the would be change agent is to intervene in a way that strikes an optimal balance between organizational task demands and human needs.

Miller & Rice posit two general assumptions (with one corollary assumption) that guide their thinking: One, in general, an enterprise will require a differentiated form of organization. They argue that three instruments of organization are universally needed, the first, to control and regulate task performance; a second, to bind the members to the aims of the enterprise; and a third, to negotiate relations between task and sentient groups. Sentient groups are defined as those groups to which individuals look for emotional support and to which they are committed. A corollary to the first guiding assumption is that to enhance effectiveness sentient system activities should be relevant to task performance. In other words, the bases for association and the human activities from which members get emotional sustenance should be relevant to the skills and experience demanded by the task.

The second assumption is the significance of boundary definition and regulation between enterprises as well as within the organization. Boundaries are conceptualized as regions where transactions between systems or subsystems take place. An appropriate system boundary should occur at a point

of discontinuity which constitutes a combination of three dimensions: technology, territory or time (Miller, 1973). The significance of boundaries and their regulation cannot be overestimated: one writer in the Tavistock tradition compares boundary control and regulation to reality testing in the individual (being able to distinguish between inside and outside) with the loss of boundary control analogous to regression (Lofgren, 1975).

Miller & Rice view organizations as enterprises composed of three major processes: import, conversion, and export. Materials ("throughput") are imported, worked on and transformed ("conversion process"), and then exported to be exchanged for further intake material. Thus the organization is viewed as "biological organism", and open system, that survives by exchanging materials with its environment. There are three types of work or task to be performed: operating activities, maintenance activities, and regulatory activities.

Operating activities are work activities that make a direct contribution to one of the three processes of import, conversion or export. These activities/processes are those that define the nature of the enterprise and distinguish it from others. Maintenance activities are those activities that provide the resources that produce operating activities. This includes both human and non-human resources such as machinery. Thus, recruitment, induction, training and motivation of employees as well as purchase, maintenance, and

overhaul of machinery are included as maintenance activities. Regulatory activities connect and regulate relations between operating activities, between maintenance activities and operating activities, and between the internal activities of the enterprise (or unit) and the environment. Maintenance and regulatory activities can themselves be analyzed in terms of import-conversion-export processes.

Miller & Rice propose that an important heuristic concept in analyzing enterprises is the primary task. It is defined as the task the organization must perform at any given time in order to survive. This task may shift given internal and environmental circumstances. Primary task and dominant import-conversion-export system co-determine each other: the overtly defined primary task will, of course, determine the dominant import-conversion-export system, however, the complex social field may produce a covert shift in dominant import-conversion-export system which determines the primary task.

Argyris (1962, 1964) has argued forcefully and persuasively that interpersonal processes and intra-personal needs have been neglected in organization theory. He has tried to demonstrate (1) that the underlying values of organizational design, with an emphasis on rationality and efficiency, are in direct conflict with holistic human needs and (2) that the frustration of human needs in organizational settings with resulting interpersonal incompetence sooner or later obstruct the effective performance of the organization.

Miller & Rice in agreement with Argyris contend that a theory of organization in order to be complete requires a theory of human behavior. They propose to base their theory of human behavior on the psychoanalytic object relations theory developed by Melanie Klein (1952, 1959). In addition to a theory of personality they derive much of their thinking from a theory of group functioning, small and large, proposed by W. R. Bion (1961). Rice (1969) has integrated these two streams of thought with his own ideas concerning inter-group transactions and boundary regulation to produce an overarching theory of individual and group functioning. Three basic structural principles distinguish this model: individual, small group, and large group processes can each be described analogously in terms of (1) an internal world, an external environment, and a boundary function which regulates transactions between internal and external; (2) processes simultaneously occurring at two levels: the conscious and unconscious strivings of individuals and the work tasks and basic assumptions of groups; and (3) an entity, the "ego" in the individual and the "leader" in groups, which mediates between internal and external world, distinguishing between inner and outer realities and managing boundary transactions.

Klein's (1952, 1959) object relations theory adopted many of the theoretical notions of classical Freudian psychoanalysis, but refashioned them in order to understand the earliest processes in personality development. She

accelerated Freud's timetable for critical organizing events in psychological development: the oedipal complex and the development of the superego, for example. Klein's concepts have made an extremely valuable contribution to the elucidation of group psychology through concepts such as projection, introjection, projective identification, splitting as well as through her emphasis on such primitive emotional constellations as greed and envy. The continuing use of these processes in adult life have enormous implications for group life.

Klein viewed early interpersonal functioning in terms of relations between the inner world of the infant and its external world, i.e., the mother, or the breast, the first part-object. The infant, not being able to distinguish inside from outside, experienced any feeling as an attribute of the object. Feelings of the inner world are "projected" into the outer world, the mother. Thus, exciting and satisfying experiences are attributed to a "good object" which is loved and nurtured; frustrating or hurtful experiences are organized into a "bad object" which is the target of hatred and rage. Development consists of the continuous interplay between inside experiences and external events and the developing capacity to distinguish between the two: inner psychological reality and external reality. Thus, the "ego" evolves. The original splitting of the object gives way in health development to normal ambivalence with the realization that

the same object both satisfies and frustrates. However, this ambivalence remains an unstable organization throughout life, so that in the stressful context of interpersonal and group life, the two experiences may again be split apart in a defensive attempt to maintain dependent ties to a needed object or group.

Klein maintained that benign forms of potentially pathological processes such as introjection and projection formed the basis for empathy and social responsiveness. In addition, she stressed that envy when modulated and tempered by identification could energize group cooperation and cohesiveness. Greed when not excessive could fuel socially productive ambition. The influence of these processes and emotional configurations on the psychodynamics of leader-group and intra-group relations cannot be overstated.

Klein (1959) emphasized the continuing use in modified form of such processes such as projection, introjection, and projective identification in adult life. She felt that the understanding of individual personality was essential for insight into social processes: "A group--whether small or large--consists of individuals in a relationship to one another; and therefore the understanding of personality is the foundation for the understanding of social life" (p. 247). In addition, she felt the influence of the earliest experiences were pervasive and enduring: "nothing that ever existed in the

unconscious completely loses its influence on the personality" (p. 262).

Bion (1961), although influenced by the Kleinian school, developed a theory of group functioning that went beyond the one-body and two-body psychologies of the Freudian/Kleinian axis. He posited an emergent group process that had a life of its own above the individual psychologies of its members, although individuals contributed to it. Bion developed several concepts in order to understand small group work behavior: group mentality, protomental phenomena, basic assumptions, and sophisticated (work) group, and valency (Bion, 19671; Rice, 1951; Rioch, 1970, 1971).

Bion hypothesized that a group mentality existed which represented the collective will of the group. Individual members contributed unconsciously to this group mentality. Moreover, Bion felt that the group behaves as if it had met to fulfill functions which have little to do with the manifest task of the group. These as if functions are termed basic assumptions. Bion outlined three basic functions. Thus, the group acts if it had met to (a) depend on one individual to provide all security and nourishment (dependency assumption) or (b) reproduce itself (pairing assumption) or (c) preserve itself through attacking or running away from someone or something (fight/flight assumption). Bion held that all basic assumptions existed in potential or prototypical form in a protomental dimension of group life. (This protomental level

bears much resemblance to Freud's id/unconscious sector of the personality which has a somatic/phylogenetic matrix and to and from which many elements of psychic life are either relegated or called forth.) Although contribution and participation cannot be avoided by members of group, individuals are said to have a valency for a particular basic assumption if their personality structure disposes them to one or the other basic assumption.

Bion has been criticized for supposedly constructing a theory that sets up a false dischotomy between the group's emotional life and adaptive processes, with the implication being that emotional processes are viewed as exclusively irrational, hence pathological (Edelson, 1970). This appears to be a misreading of Bion. Basic assumptions may become pathological in Bion's view and disrupt the work (adaptive task) of the group. Adaptive tasks, when successful, however, are always supported by a basic assumption: the implication, of course, is that the emotional life of the group provides the fuel for task performance. There is never direct conflict between basic assumptions (Rice, 1951). Emotions of the basic assumptions are, however, mutually exclusive: the existence of one basic assumption excludes and controls the emotional state of the other assumptions. Tension created by conflicts from three sources produces changes in dominant basic assumptions which flow one into the other: (1) the prevailing basic assumption is in conflict with individual member needs; (2)

the sophisticated group versus the basic assumption groups; and (3) the sophisticated group supported by one basic assumption is in conflict with other basic assumptions in protomental system (Rice, 1951). The one sure way to maintain a sophisticated work-level is to utilize emotions of one basic assumption to support task and control emotions of the other two basic assumptions.

Action Research, Social Defense, and the Socio-technical System

The Tavistock school has an action research perspective. Theorists and researchers in this tradition see their analyses and theories as evolving from and impacting upon practical organizational interventions (Clark, 1976). These interventions are simultaneously conceptualized as experiment and research. Jacques (1978) has argued that given the anxieties of group life, pointed to by the work of Bion, Klein, and others, defenses against the powerful psychotic-level anxieties become permanent structures in organizations. Such social defense systems assert enormous resistance to change. The social structure of an organization both fosters particular social defenses and is used via projection by members to support both their individual and group defenses. Thus, the Church promotes an emotional climate of dependency; the Army, fight-flight basic assumptions; and the family, a pairing assumption.

In a complex social system such as exists in most modern organizations, the social defense system may have a differentiated structure. Basic assumptions may be sanctioned and supported by different leaders and sub-systems of the same organization. Splitting processes are used extensively: one leader may be elevated to dependency assumption leader, another becomes the fight/flight leader. Scapegoating processes, based on the paranoic denial of responsibility and the primitive idea that someone must be responsible for the individual's or the group's anxiety, are often quite rampant. Thus, basic assumptions are simultaneously fulfilled by splitting across leadership and organizational sub-systems.

A fruitful approach in analysis and intervention is to view the organization as a socio-technical system (Miller & Rice, 1967; Emery & Trist, 1969; Katz & Kahn, 1978; Dolgoff, 1973). The organization is analyzed as an open system which in order to achieve its purpose must balance social needs with the demands of task performance. Several studies and interventions have used this approach in the Tavistock tradition (Menzies, 1960; Miller & Gwynne, 1972; Rice, 1951, 1953, 1955). The uniqueness of this approach lies in its equal attention to the intra- psychic, interpersonal, and formal organizational structures and the interaction of the three dimensions (Dolgoff, 1973). Katz & Kahn (1978) analyze a socio-technical system as having six foci for analysis or intervention (Figure I). If the organization can be

conceptualized as having three levels: job (role), work group, organizational design, and two aspects: social and technical, then six foci are available for analysis or intervention. Intervention may be directed at any of these in order to improve fit between individual--social needs and abilities and technology.

	Organizational Aspect	
Organizational Level	Social	Technical
Job (Role)	1	4
Work Group	2	5
Organization	3	6

Figure 1. Six foci of socio-technical system. (From Katz & Kahn, 1978.)

Leadership

An analysis of leadership tends to bifurcate naturally into two aspects: (1) the formal, task related aspects of leadership and (2) the informal, emotion-suffused aspect. There have been a number of conceptualizations of these two kinds of leadership in organizational settings. Max Weber distinguished between charismatic and bureaucratic leadership and authority relations, others distinguish between instrumental and expressive leadership activities.

The Tavistock tradition introduces its own definition of leadership which is contrasted to management and authority. Authority is defined as the right to do assigned ("authorized") work with the related rights to use designated resources and make certain decisions on behalf of others. Authority resides with role. Two primary sources undergird authority: (1) managerial authority, that part delegated by institution flows from higher level role and role occupant to lower level and (2) leadership authority, attributed by followers in recognition of his capacity to carry out a task (Rogers, 1973; Kernberg, 1980). Rogers makes a further distinction between power and authority. Power is the capacity (physical, intellectual, or emotional) for carrying out a task; it is an attribute of the person, his skills, knowledge, experience, health, etc. Power is necessary for exercising authority, power exercised without authority is seen as illegitimate power. Authority and power must be

balanced organizationally for effective functioning both at organizational and personal levels. In addition, both Kernberg and Rogers stress the individual's responsibility at the level of maintaining an awareness and a commitment to address organizational problems and value conflicts.

Rice (1963) points to the overlapping between managerial and leadership functions at the manifest level, but argues that unconscious leadership functions cannot be circumscribed by the management concept: "At the level of manifest behavior a leader has to be able to carry his followers with him, to inspire them, to make decisions, and to communicate them effectively to others; a manager has to get the best results out of the resources he has available--money, time, materials, and people. . . . Some people are clearly better at leading enterprises . . . than they are at managing them; others may be better administrators or 'manager' in the narrower meaning of the title, than they are inspirational leaders. . . . While leading is not necessarily synonymous with office holding, there can be no clear boundaries between them at the manifest level . . . . leadership can also be exercised unconsciously, and at this level 'management' . . . cannot be applied" (p. 15, footnote). Hence, leadership is not synonymous with person in role of leader. Activities define leadership, not the verbal designation of someone as leader. At different times and in different contexts, various individuals may act on behalf of the group. The effective

leader-manager may have to deal with the "behavioral reality" that leadership activities are a function of the basic assumption group (Miller & Rice, 1967).

The perspective that best comprehends the nature of this unconscious leadership may be the psychoanalytic perspective offered by Freud (1921), Bion (1961), and Kernberg (1980). Freud postulated that the sense of closeness and intimacy among individuals in a largely unstructured group originates in their setting up the leader as ego ideal and in mutual identifications with each other. Responsibility, self-criticism, and moral constraints are concomitantly loosened in this group dynamic. In addition to the sense of unity, protection from the loss of a sense of identity is also gained. The leader in Freud's view represents unconsciously the primal father and is idealized as the oedipal father. The mythical hero represents a condensation of the parricidal son and oedipal father; the leader of the unstructured group, in turn, is unconsciously identified with both the father and the mythical, parricidal hero-son.

Bion's (1961) contribution implies that leadership behavior may often be a function of pervasive group dynamics. As was noted earlier, Bion posits three regressive basic assumption groups that operate in pure form only when task (workgroup) breaks down: dependency group, fight-flight group, and pairing group. In the dependency basic assumption, leadership must be omnipotent and omniscient with a

corresponding inadequacy, immaturity, and incompetence in followers. If the leader refuses or fails to live up to this expectation, the group at first redoubles its effort at getting dependency fulfilled by leader, but eventually completely devalues him or her and searches for a substitute leader. In the fight-flight basic assumption the leadership must direct a fight against identified enemies and protect the group from infighting. The leader is expected to exert aggressive control over members. In the third basic assumption, pairing, leadership is projected onto two members, not necessarily heterosexual, who represent the group's hope that the couple will reproduce itself and thereby ensure the identity and survival of the group. My own observations lead me to the hypothesis that many if not all group members unconsciously wish to assume the role of partner to the leader. It follows that there must be a vicarious enactment and therefore dual identification with the couple by the pairing b. a. group.

Kernberg (1980), synthesizing psychoanalytic personality theory and Bion's concepts, with application to mental health organizational settings makes some significant distinctions. He points out that there are two sources of regressive behavior on the part of administrators/leaders: (1) regressive pressure coming from the character pathology in the administrators and (2) regressive pressure from the organization. In order to rule out the former, and ensure

leadership effectiveness there must be an adequate relation between the organization's overall task and administrative structure. If resources are insufficient for the task or if there are contradictory goals or unclarified priorities, task group structure may break down leading to ascendance of regressive basic assumption group functioning. Hence, the task leader may be provoked into regression by the primitive basic assumption functioning of the group.

Kernberg points out that in mental health settings the very nature of the throughput may induce pathological group processes in the staff and impact on organizational functioning. Thus, often leadership may appear arbitrary or irrational as a result of a causal chain leading from throughput (patients) to operating activity to management. Kernberg believes that only a systems approach, as opposed to linear models which attribute source of disturbance to one (sub- or supra-) system or another, offers the possibility of clarifying the relationship between the leader's personality, group processes, organizational structure, and organizational task. Kernberg (1980) has also developed a typology of character types in administrator/ leadership roles which interact with group dynamics and organizational structure to produce particular organizational cultures. He delineates four types: schizoid, obsessive, paranoid, and narcissistic. They often produce mirror images of their internalized object relations throughout the organization.

Leadership function, at the manifest level, has been compared to the ego function in individual personality. It has an integrative and regulatory function. It has been defined as "centrally concerned with the management of boundaries" (Gilmore, 1982): distinguishing inside from outside, controlling boundaries between groups, subsystems, and superordinate systems (Miller & Rice, 1967). Leadership also involves defining roles and their functions, delegating authority, defining and managing the task, and prioritizing task demands. Three aspects of leadership skills have been delineated: (1) administrative competence, coordinating activities of one organizational group with another; (2) technical competence, skills necessary for performance of technical operations and requirements; and (3) human relations competence, integrating organizational aims with individual member needs (Levinson, 1962). Levinson makes further distinctions between competence in task and a quest for personal potency. He argues that the competent leader must also provide a supportive relationship to subordinates, but must balance all three: competence, quest for potency, and support. Gilmore (1982), in a similar vein, feels that leadership and boundary management is exerted at two levels: organizational, concern with the mission and distinctive competence of the enterprise; and individual/interpersonal, management of the complex social transactions between leader and followers. The latter often means the management of anxiety among followers via either accepting projections (adaptive) or rejecting inappropriate projections (omnipotence, for example). Gilmore

argues that the essential skill needed is the ability to manage the boundary between self and role as well as that between self and others.

Healthy followership has been defined as an activity in which the follower while confirming the authority of the leader in task definition and performance retains responsibility for his participation in the organized action. Inappropriate or pathological followership involves the absolute surrender of will to leader, hence, giving up the burden of responsibility. Pathological followership often takes the form of paranoia: if something untoward happens, someone must have conspired or planned it, the group negates collective or contextual responsibility for actions or events (Rioch, 1975).

Two recent contributions analyzing leadership and followership functions in organized settings provide enlightening perspectives. Gilmore (1982) argues that forces at work in the larger social field are creating new dilemmas and crises for organizational leadership, boundary management and control, and leader-follower relations. There is an increased rate of change in our era with many organizations experiencing crises of purpose. In addition, because of scarce resources and high specialization, interdependence has increased thus straining old formal institutional boundaries. Lastly, there is a decline in traditional authority and a rise in the negotiation of power and authority relationships. Gilmore stresses that the challenge for our future is "to create organizational processes that do not level the leader-follower distinction but rather

create opportunities for more parties to experience both positions and acknowledge within themselves the co-presence of leadership and followership" (p. 355).

Smircich & Morgan (1982) propose that the study of the leadership phenomenon may be enriched by viewing it as a dialectical process, a tension between leader and led, in which followers agree, implicitly or explicitly, to surrender the right and obligate someone, the leader, to define the nature of experience as well as the praxis that should flow from the defined reality. "Informal" organizational processes in this view are seen as an attempt on the part of followers to develop their own pattern of meaning in tension with the formal organizational reality. Leadership in their view is not simply the management of resources across boundaries but "It is a process of power-based reality construction" (p. 270). Four aspects of leadership dynamics are outlined: (1) it is a social process defined through interaction; (2) it involves a process of defining reality in ways sensible to followers; (3) it involves a dependency relationship wherein individuals surrender the power to interpret and define reality to others; and (4) organizational role structures provide a blueprint of how the experience of organizational members is to be structured. Smircich & Morgan criticize the conventional, "Western" view that organized action requires hierarchical structure; they hold out the hope that alternative organizations with autonomous work units, individuals or groups, with a redundancy of function, may be the wave of the future.

A NOTE ON MINORITY GROUP LEADERSHIP

A definitive study of the forms of minority leadership and their formative influences remains to be attempted. There is some scattered work that offers some leads for future work. It has been pointed out that black leadership, for example, has been shaped by the social needs and deprivations of black people: "there seems to be a unique role demanded of leadership in groups that are oppressed, denied, or alienated from societal institutions that determine the quality of life" (Davis, 1982, p. 313). This obviously applies to other minority communities with histories of oppression, including Puerto Ricans and other Hispanics.

Davis (1982) agrees with Burns (1978) that minority leadership falls under the transformational type of leader in the latter's typology of transformational versus transactional forms of leadership. The leaders of oppressed have faced the challenge of generating social change with a redistribution of decisions and resources. Leaders of dominant groups face the less formidable task of maintaining the status quo by managing resources and access to these. The formal social context may give rise to what Miller and Rice (1967) term heroic "personal leadership" which may be appropriate under conditions of great danger and threat to the organization. Under more normal circumstances this type of leadership may be inappropriate and dysfunctional. The implications of this social field for

minority leadership, followership, and organizational strategies remain to be drawn out.

Davis (1982), while acknowledging that there has been little work done on the nature of the "dynamic internal relationship between black leaders and followers", makes no attempt to link the social context with the dynamic internal relationship. He does, however, in a general way point to ten variables which, in his view, influence the nature of the relationship between black leaders and followers; among these variables he includes identification of mutual problems and a resulting sense of injustice, group identity and need for a sense of community, mutual support, mutual trust, and shared world view.

The literature on Hispanics is even more sparse. A recently published collection of papers on ethnic leadership in America does not include a single entry in its index on Hispanic leadership (Higham, 1978). Samora (1953) in a dissertation study looking at a Chicano community's relationship to its leaders revealed a tendency to reject its Hispanic leadership as too "Anglo", not sharing the community's world view, and as having "sold-out." This describes the paradoxical situation in which followers are alienated by the very qualities of leadership that may help an oppressed group in its relations with the dominant group, namely the leadership's familiarity with and understanding of the latter. Samora concludes that lack of effective leadership is a function of the lack of

cohesion of the minority group. From my perspective the lack of cohesion has to be examined further. Does it reflect a fundamental ambivalence of the community and its individual members toward the majority, dominant group and culture? Does it reflect a separation-individual process of identity formation on a community level with reapprochement-like ambitendency?

From a psychoanalytic view the work of Tylim (1982) provides some hints for enriching our understanding of leadership and followership dynamics among Hispanics given the social field of forces. Tylim's work deals specifically with group process among Hispanic patients. However, it points toward more universal group processes that may be amplified given the social context of Hispanics. Tylim describes a pattern of idealization, which he feels is a culturally determined response to authority, and merger among participants, i.e., an initial denial or suppression of differences among various Hispanic sub-groups. He also outlines a pattern of self-object relating with the leader that can be understood as transitional object phenomena and transference (Winnicott, 1953, 1980; Kohut, 1977 Goldberg 1980). In short, it is a description of a dependency basic assumption group with attribution of omnipotence and omniscience to the leader. I also believe that the merger or fusion culture is part of the dependency: the denial of differences guarantees inclusion and allays fears of abandonment and isolation. The group leaders' group induced countertransference has enormous implications for a model of

Hispanic leadership dynamics: this group leader, a South American, found it extremely difficult to deny the idealizing projections and felt a high degree of responsibility for the group's well-being; in addition, he also found it extremely difficult differentiating self from others, colluding with the "we are all Spanish-speaking and we are all alike" defense against the anxiety of separation and the unknown other. One must ask, are similar processes at work in other settings: work settings, political settings, supervisor-supervisee relations, etc.

Burnout and Organizational Design Introduction

A systems perspective of transactions among subsystems and suprasystems direct us to examine and analyze the phenomenon of burnout as a multi-determined syndrome with roots at the intrapsychic, interpersonal as well as organizational levels of analysis (Dolgoff, 1973). The earliest discussion of the concept of burnout in the literature does not stress the organizational context (Freudenberger, 1974). Although the potential burnout candidate is depicted as under a "three-pronged attack" from administration, clients and his over-commitment the presentation emphasizes the internal demands of the victim. In the same year as Freudenberger's introduction of the concept, there was a report published describing "depressive reactions" in trainees of such organizations as the Peace Corps and VISTA (Mullen and Spiegel, 1974). Although the overarching social process and the demands of the work were noted, the emphasis was on the intrapsychic needs of the volunteers. Middle-class guilt, search for identity, and a "search in the outer world for affirmation of idealistic values" were cited as among the most salient personal motivations leading to disappointment and significant depressions. This may have been burnout.

More recent work has moved from the early characterizations of burnout which relied on anecdotal evidence and focused on

individual dynamics and job stress (Cherniss, 1978, 1980a,b; Edlwich and Brodsky, 1980; Maslach, 1978a,b). Some work has focused on individual factors (Gann, 1979), away from anecdotal/theoretical to a more systematic analysis (Dames, 1982, Pines & Maslach, 1978) others have focused on the particular settings such as community mental health settings (Farber, 1983; Pines and Maslach, 1978).

What is Burnout?

Burnout has been defined in various ways as has been pointed out by Cherniss (1980). The early focus on who experienced the syndrome and on the emotional exhaustion (burned out feeling) which led to poor functioning has given way to a more differentiated view. Edelwich and Brodsky (1980) define burnout as a "progressive loss of idealism, energy and purpose . . . in the helping professions as a result of the conditions of their work" (p. 14) which cannot be prevented. Pines and Maslach (1978) define burnout as a "syndrome of physical and emotional exhaustion, involving the development of a negative self-concept, negative job attitude, and loss of concern and feeling for clients" (p. 233). Cherniss (1980) also places emphasis on the cognitive-attitudinal changes as well as the stress-related emotional exhaustion, viewing burnout as a unique response to job-related stress involving "the tendency to treat clients in a detached, mechanical fashion" (p. 16) representing "a response to an intolerable work situation" (p. 18).

Burnout has been differentiated from depression as a psychological phenomenon with physiological, cognitive and emotional sequelae (Farber, 1983). Depression is a complex psychological state that exists cross-situationally, while burnout is clearly situation-related (work) with interventions usually aimed at the environmental context. One author notes, in addition, that what distinguishes depression, a lowered sense of self-esteem with guilt, is absent: typical burnout victims maintain high self-esteem despite the distress with conscious anger the main affect (Fisher, 1983). Burnout has also been distinguished from temporary fatigue or strain (Cherniss, 1980b), turnover, and change in work attitudes due to socialization as well as from stress, although unmediated stress may lead to burnout (Farber, 1983). Physiological (urinary frequency, insomnia or lethargy, headaches, rashes, diarrhea, tachycardia, to name a few), psychological feelings of disorientation and disorganization, loss of concentration, feelings of frustration, depression, indecisiveness, as well as behavioral symptoms (such as easy irritability, suspiciousness bordering on paranoia, feelings of omnipotence with excessive risk-taking) have been identified as related to the burnout syndrome (Freudenberger, 1974; Gardner and Hall, 1981).

Thus the model that has emerged views burnout as a syndrome involving three major aspects: a lowered sense of efficacy or accomplishment together with a sense of alienation

and emotional exhaustion. It is viewed as a unique response to the job-related stress of human service work. This model is incorporated in the most widely used burnout assessment instrument, the Maslach Burnout Inventory (MBI) which has three subscales (emotional exhaustion, depersonalization, sense of reduced personal accomplishment) (Maslach and Jackson, 1981).

Sources of Burnout:

Several authors have pointed to the prevalence of burnout in human service settings (Maslach, 1976; Cherniss, 1980; Edelwich & Brodsky, 1980), with community mental health workers a population at high risk (Pines & Maslach, 1978). The emerging consensus is that burnout appears to be a profession-related "dis-ease" entity analogous to black lung disease in coal miners or stress-related illness in air traffic controllers (Farber, 1983).

In general two sources can be identified for burnout: external and internal (Wilder, 1981). The external source may be the job context with such factors as inadequate leadership, over-bureau- cratization, poor supervisory relationships, heavy case loads, difficult and unresponsive patients, and rigid and repetitive job assignments. Internal source refers to such factors as disillusionment, feeling that a sense of professional competence is lacking, personal needs for meaningful activities, stimulation, approval. External and internal factors may overlap with one source actually producing the other: for example, a heavy work load may lead to inadequate job performance which in turn may undermine a clinician's sense of competence.

Precise statement of the necessary and sufficient causes of burnout is elusive: stress is placed on different factors by various authors. Maslach (1976; 1978; 1982) emphasizes the "hidden dimension" in mental health and human service

settings: the normal wear and tear on professionals of dealing day in and day out with the emotional needs of clients. Edelwich and Brodsky (1980) that burnout is inevitable because of the idealism workers bring: the "seeds of burnout are contained in the assumption that the real world will be in harmony with one's idealistic dreams" (p. 16). One psychoanalytic model denies the organizational context as sufficient cause, emphasizing instead the narcissistic pathology of burnout victims (Fisher, 1983).

Others clearly place much more responsibility on the organization and view the pathogenic locus in the person-organizational interface. Carroll (1979) proposes a model of "ecological dysfunction." Perhaps the best statement of this position and the most psychologically sophisticated is the work of Ianni and Reuss-Ianni (1983). These authors argue that the "burnout syndrome is much more a phenomenon of stress in the person-organization relationship than it is a result of problems in the professional-client relationship" (p. 84). After analyzing the results from a number of studies they performed on school systems and police departments, they conclude that the stress generated by client contact results in "burnout only if the ideology or sense of community provided by the organization is insufficient to withstand the threat, or the reality of insult or injury from the environment" (p. 84).

Ianni and Reuss-Ianni go one step further: they argue that the organization, in both its ideological and structural

aspects, (1) both create their own stressors and mediate between individual and extra-organizational sources of stress and (2) organizational environments are internalized by individuals, affecting their behavior, attitudes, and beliefs. Organizations shape self-concepts, ambitions and aspirations, and self-esteem. However, (3) individuals also shape or modify their organizational environment by externalization of their inner world of conceptions. This notion of the interpenetration between organizational reality and individual subjective reality bears great similarity to Winnicott's (1953) concept of an intermediate area of experience: transitional objects and phenomena. It has also been suggested that organizational structures may be an externalization or reflection of our inner "self-systems" by at least one other organizational theorist (Diamond, 1984).

In making a contribution to the person-organization emphasis, Eisenstat and Felner (1983) make an important distinction. They argue convincingly that burnout as defined by the Maslach Burnout Inventory (MBI) is a multi-dimensional phenomenon: a stress model cannot account for all aspects of the syndrome. Research reveals that lack of intrinsic or extrinsic job motivators decrease job satisfaction and involvement but is not related to increase in level of emotional or physical exhaustion. Job stressors, on the other hand, do not affect the motivation or job involvement of staff significantly, but do have impact on emotional exhaustion.

Eisenstat and Felner also point out that interventions must take into account the unique characteristics of the work setting. They follow Alderfer (1980) in making an extremely useful distinction between overbounded systems, with precise role expectations, where people feel confined, not highly motivated, trapped in alienated roles, which are "burned-out systems," and underbounded systems, with unclear or conflicting role expectations, where people feel fragmented, lacking explicit expectations, which "burn out people." In one setting, motivation may have to be increased; while in the other type of setting, stress must be decreased.

Jayaratne & Chess (1983) also reject the stress model. Their work, they assert, indicates that the concept of "job satisfaction" is orthogonal to burnout syndrome. "Workers may report feelings of burnout and still remain on the job, be relatively happy with their work, and perhaps even perform well" (p. 140). They found that (a) non-stress job facets (challenge, promotional opportunities, and financial rewards) what others refer to as job motivators (intrinsic and extrinsic), were most important predictors of job satisfaction, turnover intent, (b) stress variables of role ambiguity, role conflict, and workload contribute very little toward explanation of job satisfaction, turnover intent or burnout, and (c) non-stress job facets such as challenge and promotional opportunities are significant contributors to burnout. "Challenge emerges as the only significant predictor

of depersonalization and promotional opportunities as the only significant predictor of emotional exhaustion" (p. 137). These findings are at odds with all previous findings as well as all theory and predictions concerning relationship between role conflict, other stressful job factors and burnout.

Cherniss and Krantz (1983) take a further leap away from the stress model, asserting that most previous theory and research on burnout has overlooked or failed to recognize that the "most important precursor of burnout is the loss of commitment" (p. 198). They argue that if we focus on how commitment is generated and sustained in social systems we may gain much understanding of burnout. They point out that human services tend to attract people who are highly committed and that burnout may be prevented not by reducing commitment, as some have suggested, but by understanding how identification with an ideology sustains many workers in human service work. They offer two models of ideological communities they have studied: (1) a residential setting for the mentally retarded operated by a core staff of Catholic nuns and (2) a Montessori School for mentally retarded and emotionally disturbed children.

Cherniss and Krantz suggest that the benefits of ideological communities may outweigh the pitfalls. Burnout is reduced by (1) the reduction of ambiguity and internal conflict inherent in "people-work"; (2) intrinsic rewards being stressed and special status placed on more routine,

unpleasant or aversive aspects of the work; (3) a shared commitment to ideology that can increase trust in the social system, reduce conflict, and increase autonomy since close supervision and control may be deemed unnecessary because of internalized normative system; and (4) the reduction of conflicts among staff since shared ideology removes a major barrier to collegiality and social support among staff. Some of the pitfalls of ideological communities cited are (1) intolerance of other viewpoints, fostering a rigid, authoritarian and uncreative organization; (2) goals may be displaced from service to ideology so that purity of ideology may become antithetical to quality care; and (3) inflexible, uncompromising defense of ideology may add to frustration and possibly lead to burnout. Cherniss and Krantz especially warn that ideology or guiding philosophy must be translated into specific guidelines for day to day work in order to have its beneficial effects. Thus, ambiguity is reduced, positive feedback increased, and the sense of accomplishment enhanced.

More ambitious models of analysis, prevention, and intervention which integrate personality, organization and social process have been developed (Cherniss, 1980a; Farber, 1983). Farber has proposed a model based on the critical sociology of the Frankfurt School (Sakharov & Farber, 1983). He hypothesizes that burnout is a manifestation of societal contradictions in the individual: individual psycho-pathology ("burnout = alienation") as a symptom of social process.

Cherniss (1980a, b), perhaps, provides the most comprehensive and systematic conceptual framework for understanding, preventing and treating burnout. Cherniss places equal emphasis on individual, organizational and larger socio-political sources of burnout. Cherniss defines burnout as a "transactional process" and provides a schematic model of how burnout may flow from organizational design. (CF. Figure 2).

Cherniss maintains there are three primary sources of burnout in the work setting: organizational design, leadership and supervision, and social interaction among staff. These three factors are interrelated: supervisors and administrators have some control over organization design, but institutional norms and other aspects of organizational design control what kinds of people become supervisors, administrators, or staff.

Cherniss conceptualizes organizational design as the formal, rational properties of organizations that can be controlled by those who manage or design programs. In his schema there are several important concepts: normative structure, role structure, and power structure. Both role structure and power structure are influenced and shaped by the normative structure. Normative structure refers to the explicit and covert goals, norms, and belief systems of organizations that provide the fundamental assumptions on which formal structures are constructed. Normative structure can affect levels of stimulation and variety, creativity and

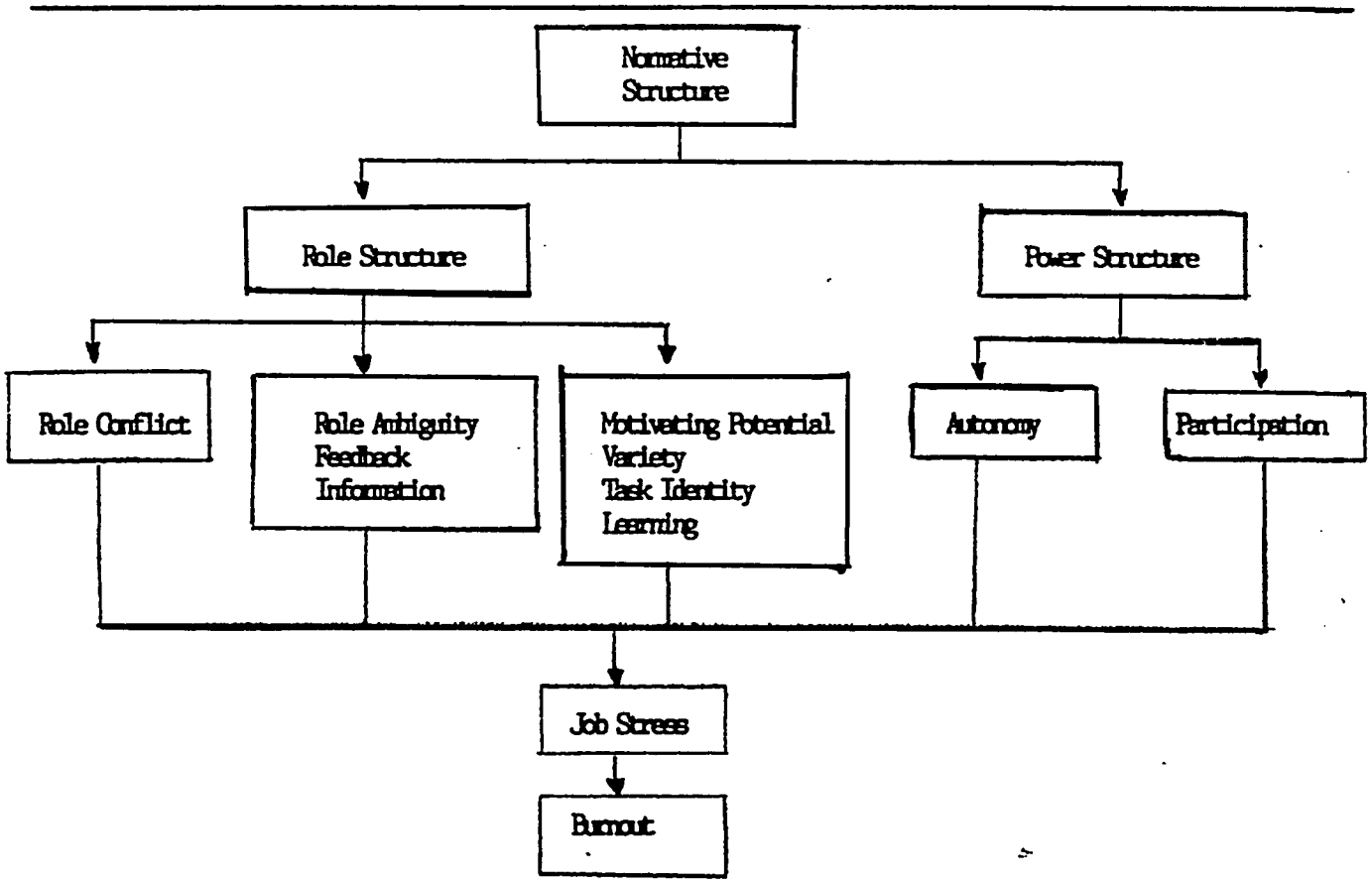

Figure 2 Impact of Organizational Design on Burnout
(From Cherniss, 1980a; p. 110)

innovation, and levels of staff cohesion and hope. Normative structure in turn is shaped by the degree of staff participation in creating a common framework and philosophy as well as by the impact of the demands of the external environment on the attitudes of organizational leaders.

Role structure refers to the way tasks and responsibilities are allocated among specified roles. There are several ways that role structure may be dysfunctional. One, there may be role conflict generated by role overload, where demands exceed time and effort available, or by incompatible role demands, or by personal-role conflict, where a role requires activity that is inconsistent with a role occupant's motives or moral values or abilities. A special case of role conflict is the tension between professional and bureaucratic norms. Two, there may be role ambiguity, where the role occupant lacks information necessary for adequate performance. There are five specific sources of role ambiguity: unclarity concerning (1) the scope and responsibilities of job, (2) co-workers' expectations, (3) opportunities for advancement, (4) supervisor's evaluation and feedback, and (5) what is happening in the organization. Cherniss argues that role conflict and ambiguity may lead to a lowered sense of psychological success which in turn may produce a sense of helplessness with emotional withdrawal.

Power structure refers to how decisions are arrived at. There are three ways that decision-making may be organized:

(1) autonomous, role occupant alone decides; (2) collective decision making, staff person with a group of other staff persons make decisions together; or (3) hierarchical, decisions handed down by supervisor or group in supervisory capacity. Research and theory suggests that hierarchical decision-making may increase job stress and burnout in human service setting (Cherniss, 1980a).

Cherniss also cites supervisory relationships, staff interaction and support, and the influence of the external environment on the work setting as factors in burnout process. Individual personality characteristics related to burnout are also highlighted. Cherniss suggests that supervision that is characterized by a high degree of support without reducing autonomy prevents burnout. The supervisor/leader must place equal emphasis on task structure, emotional support, and staff development.

Social interaction among staff has both positive and negative aspects. Staff relationships allow for catharsis, provide a source of technical information and practical advice, are a source of stimulation, and provide support against external threats (hostile or intrusive agencies, for example). However, differences in values and theoretical orientations as well as competition for resources, status and power may set staff against each other. In addition, informal norms of social interaction may inhibit creative use of staff interaction: norms against discussing the work for example.

The nature of the community served by the program, local politics and attitudes shaped by social and economic history of the community affect the functioning of staff. Inter-organizational relations and politics filter across organizational boundary and infect the entire culture and functioning of staff.

Finally, although he cites individual traits such as low self-esteem, "Type A" traits, locus of control, social activism, Cherniss fails to provide a model that indicates how individual factors may interact with organizational factors to produce burnout. He neither endorses the "ecological dysfunction" model of Carroll (1979) that posits an interaction between a stressful and demoralizing organizational and work climate and a "susceptible" individual; nor the internalization-externalization (introjectionprojection in Kleinian terms) model of Ianni and Reuss-Ianni (1983). The model Cherniss appears to favor is a model of linear causation with burnout as the unique end result of a three stage process of coping with stress. Stress is defined as an imbalance between resources and demands (stage 1) which can lead to lowered efficacy and decreased psychological success (stage 2) and eventually to the attitudinal changes unique to burnout (detachment from clients) (stage 3) (Cherniss, 1980a).

Cherniss, also, provides no discussion or awareness of unconscious covert influence and collusion of staff with

formal organizational design. This is precisely where the Tavistock approach with its emphasis on covert group processes and their impact on organizational planning and design fills the gap in a complementary fashion. Apparently, Cherniss seems to have an intuitive, though not explicitly stated sense for these dynamics when, in a tone which resonates to Miller & Rice's (1967) paradigmatic focus on the evolution of organizational designs, he advocates that "in the long run the most fruitful question to ask about organizational design . . . is 'How does a program get to be the way it is?' Once a program has become established, Most of what we have referred to as organizational design becomes routine and difficult to change. . . . It is . . . crucial to study the developmental history of both good and poor programs, focusing on the evolution of the organizational design" (Cherniss, 1980c, p. 151).

Individual and Institutional Defenses Against Burnout

Eric Trist (1976) asserts that the first task of a planner is to imagine and map out as far as possible the field of possible consequences. He points out that this is a very difficult task, since no one is privy to total prediction and foresight. He argues that several principles should guide us, however, in planning and designing organizations. One, organizational designs should enhance the quality of life for all actors in the social system; this must be a prevailing value. Two, a distinction should be kept in mind between immediate results and long term consequences, with every effort made to control for unintended and undesirable effects. Three, the posture of action research with a systems perspective provides the best approach to analyzing needs and planning solutions. A cybernetic and contextualist approach to causality is implied in his formulations.

With the phenomenon of burnout it appears that the community mental health movement, along with other human service institutions, is coming to terms with one of the unintended and undesirable consequences of their institutional mission. The position that this writer takes is that there is a syndrome of organizational burnout that must be assessed as a system or ecological dysfunction (White, 1978; Carroll, 1979). Actually, it is a variant of the ecological position taken by previous workers in that it postulates a "third area of experience" (Winnicott, 1953; Ianni & Reuss-Ianni, 1983) in

which organizational structure and ideology holds its individual members and is internalized (can provide cohesion, stability, and self-esteem). Individuals also externalize their inner object worlds onto organizational structure thus either influencing, distorting, or colluding with external structures (Klein, 1952; Miller & Rice, 1967). The result is often institutional phenomena that represent a merger between the objective structures of the organization and the inner worlds of individual needs and defenses (Bion, 1961; Jacques, 1978).

The implications for prevention and/or intervention are significant. A systems perspective eliminates scapegoating or "blaming the victim," i.e., focusing on the presumed inadequacies of individuals susceptible to burnout. The pathogenic dysfunction is located in the third area. Intervention and prevention programs must focus on the two levels as well as the interactional space. Carroll (1979) proposes a formula for the ecological view of burnout: SB = f(IxE), where SB (staff burnout) is a function (f) of the dynamic interaction of a variety of factors deriving from both intrapsychic (I) and extrapsychic (e) or ecosystem.

The position taken here is that burnout is a symptom of institutional structures/defenses against mutual anxieties (Miller & Gwynne, 1972; Jacques, 1978). An appropriate response to organizational burnout would be to address the institutional defense structures and the basic anxieties.

Providing social support groups, for example, provides only a band-aid solution; this solution does nothing to reorganize the work setting and address the pervasive group anxieties, basic assumptions, and defenses. Providing social support is a first order change which does not challenge the fundamental assumptions of the system; second order change processes are needed (Watzlawick et al., 1974). Hall et al. (1979) make some recommendations that represent second order change: (1) redefinition of the nature of the problem, institutional rather than unique to individuals involved; (2) reorganization of work priorities and staff interactions; (3) reallocation of authority so that those with responsibilities have the appropriate authority to carry them out; (4) development of a system which distributes equally among all staff frustrating tasks which must be performed.

Thus, a formula for institutional defenses against burnout can be derived from Carroll's (1979) ecological formula. First order defenses, more of the same attempted as a solution: SB def = $f(IxE)^1$; if second order defenses, meta-solutions that challenge the assumptions of the system: SB def = $f(IxE)$.[2] This formulation has implications for specificity of interventions. The specific defenses, sources, and level (first order and second order) must be analyzed and interventions should be situation specific. In this regard the work of Alderfer (1980) and Eisenstat & Felner (1983) on underbounded and overbounded systems is significant.

No one has conceptualized institutional defenses against burnout or institutional anxieties and defenses leading to burnout. The work of Pines & Maslach (1978), Cherniss & Krantz (1983), and Carroll (1979) provide some elements from which the following tentative framework of institutional and individual defenses has been constructed. Alderfer's (1980) concepts of underbounded and overbounded systems are also quite helpful.

Pines & Maslach (1978) in a report of a correlational study on a large number of mental health settings describe a remarkable consistency in the defenses used by individual workers. They discovered five techniques used by over 200 workers: 91) detached concern, individual worker attempts to maintain a strong sense of caring but with an emphasis on the physical and psychological boundaries between patient and self; (2) intellectualization, often used in conjunction with detached concern, this defense involves an attempt to control and manage the stressful experiences of patient care by moving from personal to more objective, jargonistic language; (3) compartmentalization, individual clinician attempts to make a sharp distinction between job and personal life thus confining emotional stress to a small part of their lives; (4) withdrawal, clinician spends less time with clients, communication with clients is more impersonal, with greater interaction with staff than with clients; (5) over-reliance on staff, individuals turn to other

professionals for advice, tension, reduction, comfort, diffusion of responsibility, intellectual and theoretical distancing from the situation.

These five individual defenses taken together with some of their other findings provide the groundwork for concepts of group and institutional defenses against burnout. For example, the over-reliance on staff can evolve into regressive group phenomena characterized by high dependency on and idealization of those of higher rank; a situation where responsibility is disowned. If supervisory and administrative staff then also become overburdened with the dependency of staff, burnout may be transmitted upward in the organization. This is an example of a primitive first order defense-solution that does nothing to address the basic assumptions and anxieties. Examples of a second order defense-solution would be, depending on the specific system dynamics, reorganization of work and staff interactions or organizationally providing carefully graduated levels of responsibility for new staff.

Pines & Maslach also discovered the following relationships: (a) the larger the ratio of patients to staff, the more job dissatisfaction and emphasis on salary; (b) the higher the percentage of severely disturbed patients, the less job satisfaction; (c) high frequency of staff meetings correlates with highly negative and dehumanizing attitudes toward patients; (d) lower ranking staff spent more time with patients than higher ranking staff (psychiatrists and

psychologists) who spent more time in administrative work; (e) staff who felt they had input into organization's policies and free to express themselves had more positive self-concept. These findings suggest that an institution in order to protect its members may begin to exert more control over the intake boundary, selecting out more disturbed or "disturbing" patients; increase staff meetings and other bureaucratic distancing techniques; become more precise and rigidly adhere to distinctions among roles and role functions; rigidify authority relations and emphasize hierarchical distinctions. These are all group-as-a-whole first order defense-solutions which can be quite maladaptive. However, their findings also suggest that second order solutions such as modifying the power structure or modifying the function of staff meetings (from defensive attitudes to genuine sharing concerning problems of task) can be fruitful.

Cherniss & Krantz (1983) point out that an emphasis on ideological purity may replace the primary task of providing relevant and effective help. This may or may not occur in defending against burnout: but clearly, rigid ideological adherence may be a defense against the guilt, anger, and despair generated by the ambiguity and the conflicts inherent in clinical work. Ironically, rigid ideologism is a first order defense that may exacerbate staff burnout. The need to maintain the ideology either against a hostile external environment or perceived internal enemies may add to the

emotional toll, increasing the potential for burnout. A sustained fight-flight basic assumption culture can be easily imagined under these conditions: where rigid ideological adherence and poor organizational-administrative structures interact to generate regression. White (1978) advocates outside consultation to guard against the stifling effects of ideological incest. This would be an example of initiating a second order solution.

The above discussion takes off from the client demand end of the burnout syndrome. However, what about institutional sources of burnout: those created by the organization itself. The impact of autonomy-reducing power structures and stress-generating role structures has already been suggested. Carroll (1979) points out that public service institutions (in contrast to private or voluntary ones) tend to be simultaneously the most undersupported and yet straddled with the mission of healing the most disabled and alienated. This leads easily to "treatment failure" and, of course, to a loss of a sense of psychological success on the part of clinicians. In addition, the low emphasis on opportunities for advancement and arbitrary or biased promotions are system-promoted factors in burnout. How do we conceptualize institutional defenses against this source of burnout?

Hall et al. (1979) observe that in a hospital setting the units on which burnout has occurred frequently have several structural similarities: (1) excessive performance demands on

its personnel; (2) heightened sense of personal responsibility and involvement with patients reported by staff; (3) ambiguous lines of authority in practice: actual authority to make decisions and implement them differs from that formally defined; (4) staff members given responsibility for tasks and decision-making without appropriate authority; (5) the nature of the unit or the throughput (types of patients) precludes "successful outcome." The authors point to some of the "symptoms of organizational burnout" such as high turnover of staff, increased absenteeism, frequent scapegoating, antagonistic group dynamics, a dependency culture manifested by anger at superiors and expressions of helplessness, progressive lack of initiative, and lack of cooperation.

The concepts of the underbounded and overbounded system may offer a helpful framework for understanding organizational burnout and defenses against it (Alderfer, 1980; Eisenstat & Felner, 1983). Alderfer has pointed out that there are systematic differences along dimensions such as authority relations and role definitions. The overbounded system provides precise, detailed and restrictive role expectations. Hierarchies are emphasized with controlling authority relations. People feel confined and restricted with a corresponding lack of creativity and stimulation experienced. In the underbounded system role expectations are unclear and often conflicting. Hierarchies are looser with a lack of clear or explicit authority relations. People feel confined

and restricted with a corresponding lack of creativity and simulation experienced. In the underbounded system role expectations are unclear and often conflicting. Hierarchies are looser with a lack of clear or explicit authority relations. People feel fragmented and isolated, with conflicting demands placed upon them from multiple sources.

Examples of the underbounded system are crisis intervention units, hospital emergency rooms, or hotlines. These settings can be extremely motivating but also extremely stressful because of the work and role overload. The combination of over-commitment and high stress may lead to emotional exhaustion, one aspect of the burnout syndrome. An example of an overbounded system is a state hospital, where the work has become routinized with rules extremely clear. There is no stress, at least of the type seen in an emergency room setting, but there may be very little motivation, either in terms of job design (variety or stimulation) or an inspiring guiding philosophy.

The following discussion is an attempt to extend this concept to our analysis of institutional defenses against burnout. The under-overboundedness continuum allows to see more clearly the differential contributions of a system to the two major aspects of the burnout syndrome: emotional exhaustion versus poor motivation and alienation from work and clients. The overbounded system and the underbounded system may be seen as in dialectical tension. For example, an

attempt to remedy organizational stresses such as role stress and ambiguity may lead to the excesses of the overbounded pole. There may be no emotional exhaustion but there is the stress of boredom and the alienation from non-motivating work. The overbounded system can be conceptualized as a defense-solution to the dysfunctions of the underbounded system with its sources of burnout such as role overload and ambiguity, poorly managed boundaries, and unbalanced hierarchical relations. However, the rigid advancement and poor promotion regulations of the overbounded system may stifle motivation and creativity while providing security.

The underbounded system, on the other hand, may be a defense-solution against the rigidities of the overbounded one. It fails to provide, however, the buffering or mediating needed to cope with the high demand on emotional resources. It does provide the challenge, excitement, variety, and opportunities that motivate workers. Although this type seems to be associated with less structure, it cannot be assumed that more regressive processes and defenses operate here. Both types probably generate idiosyncratic regressive group phenomena. It would be an important contribution to determine empirically the prevailing basic assumption cultures under each type of system.

The under-overboundedness conceptualization cuts across organizational, individual, and environmental distinctions. The two poles may be viewed as two prototypes of system

defenses that circumscribe basic assumption groups and administrative-task structures. A particular organization, for example, by the nature of its primary task, crisis intervention, is designated along underbounded lines. In addition, it attracts members with a particular valence for this type of task, and, of course, an idiosyncratic basic assumption culture is generated which is coherent with task structure and psycho-dynamics of workers. Where is the source of burnout here? Is it in the overcommitted clinicians who choose this type of highly stressful and emotionally demanding work? Or is it in the underbounded often chaotic structure which appears to be adaptive to the nature of the task?

Without reflecting and understanding the inherent nature and contradictions of the enterprise, staff may develop individual and group defenses against burnout. The defense-solutions they seek structurally may be in the overbounded range. This may not be a bad idea if the limits of this solution are kept in mind: the nature of the primary task limits the boundedness that the system can tolerate without losing its raison d'etre both for organization and individual staff.

The key to effective strategies of consultation and intervention may lie in approaching the organization-individual- environment simultaneously as a unity and as a composite. Some aspects or subsystems may need more boundedness than others. Individual, organization, and

environment can be usefully viewed as distinct entities but the "third area" of boundary mix-up and interpenetration must be the organizing principle for interventions. Appropriate second order solutions lie in finding an optimal balance between over- and underboundedness given the ecology and nature of the task and individual, organization, and environment boundary transactions.

This writer proposes that many of the symptoms of organizational burnout that some investigators have pointed to are actually attempted solutions or defenses (Carroll, 1979; Hall et al., 1979). It is as if the organization and its members are trying to address the problem, however, without a distance from fundamental assumptions inherent in the system, only first order solutions can emerge. An oscillation between underboundedness and overboundedness may occur with obvious impact on the task and on the individual members of the staff. The following is a list of common "symptoms" or solution-defenses: (1) the quality of the services offered to clients suffers but statistics continue to "look good" or even "improve;" (2) bureaucratic turf is increasingly defined and jealously guarded with subsystems and role players increasingly relating in distrusting and competitive manner; (3) authority conflicts occur more frequently and with greater bitterness; (4) important organizational decisions are more frequently decided by an isolated, elitist group with less input from lower-level staff; (5) the development of mutual

disrespect and distrust between line staff and management, often leading to both sides insisting that respective rights and responsibilities be formally codified; (6) staff lateness and failure to show up for important meetings and appointments; 7) humanistic, friendly or informal staff encounters are replaced by stereotyped, fixed-role, formal but "quite proper" staff interactions; (8) management is spending more and more time away from the organization and/or reducing time spent in direct contact with the staff; (9) deterioration of relationships between organization and other delivery systems; and (10) the toleration of high absenteeism (sick leave) and high turnover.

Puerto Ricans, Hispanics and Mental Health

Some psychiatric epidemiological research on residents of New York indicates that the incidence of psychiatric symptoms is higher for Puerto Ricans than other ethnic groups (Srole, et al., 19621; Dohrenwend et al., 1967; Guttmacher, 1971). The need for mental health services for Hispanics in general is supported by research that has found strong evidence for a relationship between low socio-economic status and migration, on the one hand, and mental illness (Hollingshead & Redlich, 1958; Struening et al., 1969; Rabkin & Struening, 1975).

Puerto Ricans do not utilize available psychiatric services as might be expected given the manifest evidence of mental health problems and the obvious impact of poverty and the acculturation process. There are least two reasons for

this underutilization: on the one hand, Puerto Ricans along with other Hispanics see mental illness as a stigma, so that psychological complaints are discouraged. Patients usually complain instead of multiple somatic problems and conceptualize emotional problems as having a medical-organic origin and treatment. Formal institutions are avoided: family, community, and folk healing practices taking their place.

The other side of the coin, is that traditional institutions fail to meet the needs of Puerto Ricans and other Hispanics. There are structural barriers that inhibit utilization by Puerto Ricans and other Hispanics. A number of factors that have been noted are: geographical inaccessibility of services, racism and discrimination, confusion and distortion caused by language barrier, and traditional and middle-class orientation to treatment (Bluestone & Purdy, 1977; Arce & Torres-Matrullo, 1978; Gonzalez, 1974; Romero, 1981; Padilla, Ruiz & Alvarez, 1975). Misdiagnosis resulting in overrepresentation in inpatient settings has been linked to language (Marcos et al., 1973). Another important factor that has been cited is the impoverishment of the treatment process because of the psycho-cultural distance between Hispanic patient and therapist (Inclan, 1985). Sensitivity to such cultural values among clients such as "confianza," "personalismo," "respeto," "verguenza," "orgullo," "machismo," and the concept of "present time" have all been emphasized as

organizing the Puerto Rican patient's orientation to treatment (Inclan, 1985).

Two avenues that have been explored to address the deficiences in mental health care delivery to Puerto Ricans and other Hispanics are (1) increasing allocation for the training of Hispanic mental health professionals and (2) the establishment of a bilingual-bicultural community mental health clinic for Hispanics. Models for the latter have been proposed by several authors (Abad et al., 1974; Delgado, 1981; Padilla et al., 1979; Mizio & Delaney, 1981).

Padilla, Ruiz & Alvarez (1975) offer a summary of the literature on the institutional barriers to adequate service delivery to the Spanish Speaking/Surnamed population. They also propose a three-pronged typology of service models for Hispanic patients: the Professional Adaptation Model, Family Adaptation Model, and the Barrio Service Center Model. The Professional Adaptation Model refers to a situation where professional and para-professional staff of the community mental health center, hospital or other mental health service receive non-standard training to sensitize or otherwise "adapt" themselves to specific service needs of Hispanics. The Family Adaptation Model refers to incorporating the world view and cultural values of Hispanics into otherwise traditional treatment modalities such as family therapy, individual therapy and group. Stress is placed on cultural values such as <u>respeto</u> (the high respect for traditional norms

and values), personalismo (interpersonal relations based on trust mingled with a distaste for institutions or organizations operating on a formal and impersonal basis), and compadrazco (the ritualized and quasi-religious protocol of extended family relations).

The Barrio Service Center Model seeks to respond to the major source of stress experienced by Hispanics: economic. The model essentially is that of a community center staffed with workers that can effectively intervene in the social field of community residents. The authors give several examples of this model that range from an exclusive orientation toward providing job counselling and referrals as well as advocacy in other basic economic services to delivery of mental health services with an explicitly broad definition of mental health. The authors report that all the examples given appear to be successful in engaging the target population in higher numbers than traditional service models. Padilla et al. recommend all three models as viable options in the need for active, socially sensitive approaches to treatment. In their recommendations they emphasize the need for "crisis intervention," defined broadly to include problems in social ecology of clients, and for multi-purpose use of the community center. Finally, they stress that the sine qua non of success for a mental health center is community involvement in the administration of the center.

Abad, Ramos & Boyce (1974) suggest a model based on their experiences at the "Spanish Clinic" of the Connecticut Mental Health Center. This model is cited by Padilla et al. as an example of the Barrio Service Center model. Abad et al. propose a model that they feel both accommodates to the cultural needs of Puerto Rican clients and the absence of a psychological model in Puerto Ricans' conception of mental health. They designed a clinic with four major principles: (1) it provided direct clinical services by a bilingual-bicultural staff in a walk-in formal with an "as needed" crisis intervention modality; (2) the guiding philosophy was to hold a broad conception of mental health. Problems dealing with welfare, housing, hospital clinics, courts were not simply turned away as non psychiatric: these were conceptualized as "customers" with a legitimate request that justified intervention at some level (Lazare, 1972). (3) Close community ties with Puerto Rican religious and political groups were emphasized: the clinic must have trust and support of the community. (4) The clinic should have as primary task the delivery of services but also provide consultation for Hispanic agencies and organizations as well as in-service training for para-professionals. After implementing their program the authors found that although large, unprecedented numbers of Puerto Rican patients came to clinic, there remained an erratic pattern in the use of services. This emergency room-like utilization was accepted by the staff: patients were not labelled "bad patients" and rejected.

Delgado (1981) also emphasizes the need for culturally-sensitive delivery of mental health services and outlines a series of principles developed in his experience at Worcester, Massachusetts Hispanic Program. He encourages (1) coordination of existing program resources: interagency collaboration stressed; (2) a broad conception of mental health needs; (3) that primary prevention must be a major thrust in the program; and (4) counselling in "generic" settings whenever possible to avoid the stigma associated with mental health. Two internal factors are stressed: one, the recruitment of staff that is bilingual and bicultural must be based on the understanding of the psycho-cultural and linguistic needs of patients. He warns, however, that "Agencies must be careful not to overburden staff treating special communities" (p. 125). The second internal factor emphasized is a need for administrative support from the host agency for special programs that "may present needs and goals that are not usually encountered in a traditional service setting. The uniqueness of these programs demands sensitive and cooperative administrative structures" (p. 126).

Mizio & Delaney (1981) also stress the need for sensitization on the part of programs to racist, sexist and anti-poor prejudices. They recommend a conceptual framework that views mental health and mental illness as products of a broad array of transacting processes which include poverty, racism, sexism with both cultural and psychodynamic roots and

levels of analysis. Their thinking is grounded in a systems and ecological perspective. They feel that organizations must accept responsibility for working external systems that are either dysfunctional or deficient in promoting human potential. They urge that organizations provide advocacy, counseling, and life education components. The practitioner in these response organizations must become social change agents.

All of these authors focus on the needs of clients, appropriately so, given the dire psychological, economic, and medical straits of most of these clients. However, the absence of a focus on staff needs in a holistic sense is alarming. Abad et al. do note some intra-staff divisiveness: Hispanic para-professionals versus Hispanic professional because of the latter's association with a distrusted Anglo institution (Yale University). Delgado also warns against the dangers of overloading Hispanic staff. There is an unfulfillable need to balance the internal needs of staff with organizational needs as well as with the needs and expectations of clients. Otherwise the conditions are ripe for the high incidence of burnout with obvious implications for the delivery of mental health services. The Barrio Service Center Model, with its wide ranging strategy of crisis intervention, interventions in institutional and social fields of patients, and traditional clinical services, may both promote role conflict, overload, and ambiguity among

clinicians. Role strain has been implicated as a factor in burnout among human service workers (Cherniss, 1980a). The following section will review some literature on the possible relationship between Hispanic psychotherapist and burnout.

Camayd-Freixas (1979) questions the generalizability of models: "intervention models have grown more comprehensive and sophisticated . . .; they respond to the characteristics of the target population, and its need for alternative intervention strategies. We need, however, to also address the generalizability of these models by analyzing the rationale, the operations, and the principles underlying new and innovative programs" (p. 2). This proposed study questions the thoughtfulness and responsiveness of those designing and implementing these innovative delivery systems. Staff needs are not balanced with client needs. A thoughtful analysis of organizational design is called for: overall task system requirements must be balanced with a responsiveness to staff and clients.

Burnout, Psychotherapists, and Hispanics

Very little research has been done on burnout among psychotherapists. The literature on burnout has primarily focused on (1) the general nature of burnout in human service settings and (2) clinical accounts of the difficulties of therapeutic work with a frequent emphasis on the specific problems of beginning therapists. The work of Farber & Heifetz (1982) provides the only investigation of the nature of burnout in a heterogeneous group of psychotherapists.

Burnout was viewed by the therapists surveyed as related primarily to the "nonreciprocated attentiveness, giving and responsibility of therapeutic relationship. The "lack of therapeutic success" was cited by 73% as the single most stressful aspect of therapeutic work. Eighty percent admitted to either feeling occasionally disillusioned with the therapeutic enterprise or defending against such feelings by taking stock of limitations of psychotherapy. No variable except work setting correlated with tendency toward disillusionment. Institutionally based psychotherapists more frequently acknowledged either overt feelings of disillusionment or need to defend against such feelings. There are clear implications for the delivery of mental services to those who can least afford private treatment and rely on public institutions.

With regard to research on burnout and minorities, researchers readily admit that their findings and

generalizations are limited to white, middle class subjects (Maslach, 1982). None of the variables taken into account by Farber & Heifetz (1982) included ethnicity or race. One isolated finding suggests that minority clinicians, specifically blacks, have significantly lower rates of burnout (Maslach, 1982). This finding is attributed to the presumed higher competence of blacks in managing stress suggested by their survival in an historically oppressive social environment.

Needless to say, research on burnout among Hispanic clinicians is non-existent. One contribution suggests that Hispanic therapists may be particularly vulnerable to burnout (Delgado, 1979). Delgado stresses that the Hispanic therapist-clinician often faces isolation and excessive demands from clients and organizations when working in primarily non-Hispanic settings. He points to the resulting impairment of service delivery because of turnover, frustration, and burnout. Among his recommendations are (1) that differences between Hispanic groups and culture must be attended to; (2) administrators must facilitate development of support groups among Hispanic staff by providing resources and time; (3) supervisors must control for excessive demands on Hispanic staff; and (4) the apparently cost-effective policy of hiring non-professionals can be replaced by a policy of sharing the cost of a professional with another agency.

Given the implementation of the bilingual-bicultural model of delivery, it can be expected that the isolation of the Hispanic clinician in a non-Hispanic setting will be eliminated. An Hispanic Clinic can be expected to provide both the ideological and motivational factors as well as the stress-buffering support of like-minded staff and supervisors. However, ironically the Hispanic Clinic model may generate normative and organizational structures that promote burnout. Specifically, emotional exhaustion may be increased while motivation may remain high because of the commitment to the guiding philosophy as well as ethno-cultural loyalty. Cultural factors have been implicated in organizational development in non-therapeutic work settings (Tainio & Santaleinen, 1984).

The central hypothesis that underlies the proposed study is that an unconscious missionary, "we can be all things to our Hispanic patients" posture is assumed by Hispanic Clinics. If attention is not paid by administrators and supervisors to this phenomenon, primary task structure, role structure, and intake boundary regulation may all become dysfunctional. Regressive group phenomena as well as stress, disillusionment, and despair may all consequently lead to burnout syndrome.

Method

The clinical staff at six mental health organizations offering outpatient services will participate in the study. Fourteen clinics were invited by letter and telephone contacts to participate in the research: eight were hospital-type psychiatric settings (four publicly administered hospitals and four voluntary hospitals); six were community mental health center (CMHC) types. One-half of the clinics originally invited agreed to participate. Five of these seven settings were of the CMHC type. Thus, hospital settings were highly resistant to participation in the research.

Of the six settings chosen for the sample four will be of the CMHC type. Psychiatrists, masters and doctoral level psychologists, social workers, psychiatric nurses and psychiatric caseworkers will be included in the sample. The six settings represent four conditions:

1. An "Hispanic Clinic setting ($\underline{HC}^1$ and $\underline{HC}^2$): Two Hispanic Clinics with a philosphy of bilingual-bicultural staff and culturally relevant delivery of services.

   $\underline{HC}^1$ is an outpatient Hispanic service in a voluntary hospital psychiatry department.

   $\underline{HC}^2$ is a free-standing mental health organization specializing in services to Hispanic patients. (Two out of three possible sites will be sampled: the third will not because it is a new site in operation less than one year.)

2. A clinic setting with a considerable number of Hispanic clinicians but not representing a majority ($\underline{H}^1$), i.e., approximately one-third.

$\underline{H^1}$ is the outpatient unit of Community Mental Health Center (CMHC) serving a Black and Hispanic community.

3. A clinic with a majority of Hispanic clinicians two-thirds of staff is Hispanic ($\underline{H^2}$.

   $\underline{H^2}$ is the adult outpatient unit of a Community Mental Health Center serving a Black and Hispanic Community.

4. A clinic with one or two Hispanics on staff representing a conventional "Non-Hispanic" (NH) mental health setting ($\underline{NH^1}$ and $\underline{NH^2}$).

   $\underline{NH^1}$ is CMHC type adult outpatient clinic serving a mixed community (roughly one-third Hispanic, one-third Black and one-third non-Hispanic white).

   $\underline{NH^2}$ is a hospital adult outpatient department.

The number of respondents per setting are as follows:

Condition 1.	HC^1:	5
	HC^2:	12
Condition 2.	H^1:	12
Condition 3.	H^2:	13
Condition 4.	NH^1:	5
	NH^2:	9

The total number of respondents is fifty-one.

Demographic Characteristics

Personal

The mean age of the total sample (N=51) of mental health clinicians is 38.6 years, ranging from 25 to 60. The sample comprised 33 females and 18 males. Ethnically, the participants were categorized into four types: Hispanics who considered themselves American in value orientation, Hispanics who considered themselves Bicultural, Hispanics who considered

themselves Hispanic-only in their values, and Non-Hispanics. Respondents categorized themselves on this dimension. There were 26 Hispanics and 25 Non-Hispanics in the sample. Forty-five percent of the clinicians were single, forty-three percent married, and eleven percent were either separated or divorced. Personal data distributions are presented in Tables 1-3.

Work

All respondents were mental health workers with a mean career length of 8.2 years. Although all mental health disciplines were represented, social workers made up slightly more than 54% of the sample. All respondents except one were employed full-time. One-third (17) of the clinicians were functioning at a supervisory level; seven Hispanic clinicians were supervisors. Median income was more than $32,000. In terms of work setting, the largest number of respondents were from community mental health centers (58.8%), and the smallest number from freestanding clinics (13.7%). Detailed work related data are presented in Table 4-9.

The Measures

1. The Michigan Organizational Assessment Questionnaire (MOAQ) with some modification will be used to assess organizational context (Camman et al., 1983). The authors of this factor-analyzed instrument intend it to be used flexibly and appropriately adapted to local organizational contexts. The instrument is designed in terms of seven modules, which

can be shortened, dropped, or language modified as deemed appropriate. The modules (demographics, general attitudes, job facets, task and role characteristics, work group functioning, supervisory behavior, and attitudes concerning pay) are designed to tap four areas delineated by job design and motivation theory and research (Hackman & Oldham, 1976):

(1) descriptions of important aspects of the work environment, (2) psychological states that are viewed as influenced by the work environment, (3) individual-leval outcomes usually valued by organizational members, and (4) individual differences (demography, preferences, personality). The questionnaire takes about one hour to complete. Respondents are asked to rate their answers on a Likert-type scale (7 points).

The modified questionnaire to be used in this study will include six of the original modules (pay module will be excluded) with modifications in language and content where appropriate to reflect clinical environments and the focus of this study. In addition, three modules will be added with items specifically designed for this study: (a) description of power structure (Module 6-Decision-Making), (b) description of intake boundary management (Module 8-Intake Process), and (c) description of attitudes toward the guiding philosophy (Module 7-Philosophy of Program). Most of the items in the Power (Module 6) and Normative (module 7) structure modules were

suggested by Cherniss (1980c). (See Appendices I and II for original MOAQ and modified version, respectively.)

The revised MOAQ instrument includes the following changes from the original questionnaire:

(A) Demographic data sheet from the Maslach Burnout Inventory (MBI) will be substituted with some additions and changes. The ethnicity item was changed to reflect the spectrum of Hispanic groups in New York City; items 6 and 11 from MOAQ Module 0 were added to the MBI demographic data sheet; item 11 was modified: sub-items (1) and (2) were dropped and salary ranges up to "$45,000 or more" were added, making a total of 10 salary ranges; two new items were added to demographic data sheet: an item identifying language spoken by the respondent and an item identifying type of ethno-cultural community in which the respondent spent his developmental years. The introduction to the MOAQ Module 0 Demographics is retained although most of the items represent the MBI Demographic Data Sheet (see Appendix III).

(B) Sub-items 1(a),(b),(d),(e),(f),(g),(h),(i),(k); 2(a),(b) (d),(e),(f),(g),(h),(i),(k); and all of item 3 were dropped from Module 2. The only scale retained taps the respondent's rating of importance of and satisfaction with his or her level of influence in the organization.

(C) Sub-items 1(b),(d),(e),(j), and items 2,3,4,5, and 7 through 15 were dropped from Module 3. Scales addressing role conflict, role clarity, role overload, freedom or autonomy, and perception of the adequacy of training were retained.

(D) Sub-items 1(c),(f),(j),(l),(m),(o),(p),(q),(t),(u),(w), (bb),(cc),(dd) were dropped from Module 5. Scales rating supervisor's production orientation, control of work, consideration for subordinates, participation and decision centralization were retained in their original form.

2. The Maslach Burnout Inventory (MBI) will be used as measure of burnout process. The survey instrument has been found to have high reliability and validity (Maslach & Jackson, 1981). The MBI comprises three subscales determined by factor analysis to represent three aspects of burnout

syndrome: emotional exhaustion, deperson- alization, and personal accomplishment. Each subscale has two dimensions: frequency and intensity. The emotional exhaustion sub- scale contains 9 items which describe feelings of being emotionally over-extended and exhausted as a result of one's work; the depersonalization subscale, 5 items which describe impersonal attitudes toward patients; the personal accomplishment subscale, 8 items which describe feelings of competence and effectiveness in one's work.

Burnout as conceptualized by the authors is a continuous variable. High degree of burnout is reflected by high scores on emotional exhaustion and depersonalization subscales and by low scores on the personal accomplishment subscale. Scores are high if they fall in upper third of normative distribution, moderate if in the middle third, and low if in the lower third (Table 1, p. 2 of MBI Manual).

In order to minimize response bias the authors recommend that privacy be secured (respondents should complete MBI without knowing how other respondents are answering), confidentiality be protected (respondents should feel comfortable about expressing their true feelings), and that sensitization to general issue of burnout be avoided (people have personal beliefs and expectations concerning burnout which may affect their responses). For the last reason the instrument should be presented as a survey of job-related attitudes and not linked to burnout in any way. The test form

itself has been labelled Human Services Survey rather than Maslach Burnout Inventory (CF. Appendix III).

This study will include a fourth subscale that has been dropped from the official MBI by its authors. This fourth factor which taps a dimension of involvement with clients demonstrates moderate correlations with the emotional exhaustion subscale (0.40 for frequency and 0.44 for intensity) but low correlations with personal accomplishment and depersonalization (CF. Appendix IIIa).

Procedure

Two questionnaires will be administered to the clinicians in a group setting; staff meeting or case conference time will be set aside for completion of the questionnaires. All respondents will be advised that the study focuses on job-related attitudes which would help improve work contexts as well as delivery of services to Hispanic patients. Although questionnaires are to be completed and collected in a group setting, respondents will be asked to participate on a voluntary, anonymous, and confidential basis. Respondents are advised to complete the questionnaires without consulting each other. The questionnaires can be completed in between 30 to 60 minutes.

Analysis of the Data

Analyses of the data included correlational analyses, analysis of variance, factor analysis, and multiple regression

analysis. Included among predictor variables were demographic variables, 25 scales from the Michigan Organizational Assessment Questionnaire (MOAQ), and improvised scales on Level of Decision-making, Conflict with Organizational Philosophy, and Regulation of Intake Boundary. In addition, an ethnic acculturation scale was tested for reliability and planned to be used also as a predictor variable. The predicted variables were the scales of the Maslach Burnout Inventory (MBI).

Constraints and Problems of Design

The proposed research design has several constraints and problems to contend with. Because of the complexity of organizational structures, cultures and environments, there are a few variables that cannot be controlled as one would like to ideally. Four factors present confounding difficulties for the proposed study: (1) control for type of mental health setting; (2) control for diagnostic categories and severity of psychopathology of patients; (3) control for social class of patient which has been implicated in incidence and severity of psychopathology (Hollingshead & Redlich, 1958), and (4) control for what one may call a "recency effect" in the development of the Hispanic clinic model.

Controlling for type of mental health setting is important because it can be reasonably assumed that the way services are organized (Hospital psychiatric unit vs. Community Mental Health Center vs. a free-standing outpatient mental health clinic) may produce differential rates of burnout. In addition, it has been pointed out by one burnout researcher that (a) different units in a setting may produce differential rates of burnout (Pines & Maslach, 1958) and (b) there is a variability in the sources of burnout within the same organization in different units. The present study tries to eliminate as much of the confounding variables by not sampling

any inpatient, day treatment, or children's services. All samples are drawn from outpatient clinics whether in a hospital or a community mental health center.

Controlling for diagnostic categories, and severity of psychopathology is accomplished to some degree by sampling only outpatient units which tend to treat less severe forms of psychopathology. Other diagnostic categories because of the lack of precision in diagnosis and discrimination of severity of pathology may continue to be a confounding factor in the study.

In attempting to control for social class, it was ascertained that all clinics sampled had high rates of patients covered by Medicaid (over 50% in all cases).

Because of the recency in development of Bilingual Hispanic clinics much of their structure, functioning and incidence of burnout may be associated with the developmental constraints of any organizations. To control for this an established Hispanic clinic was included in the sample. This clinic has been in operation for over a decade. No clinic sampled has been in operation for less than (3 years).

Hypotheses.

(1) Burnout bears relationship to ideological identification with organizational philosophy, power structures, role structures, and intake boundary management.

(a) The less identification or agreement with guiding ideology of organization, the lower

personal accomplishment scores and higher depersonalization scores on MBI.

(b) The less participation in decision-making and less autonomous functioning allowed, the lower personal accomplishment scores on MBI and higher emotional exhaustion and depersonalization scores.

(c) The less clearly defined roles and role overload, the higher emotional exhaustion scores on MBI.

(d) Inconsistent or non-existent coding of patients for intake is related to higher levels of emotional exhaustion on MBI.

(2) Burnout among Hispanic clinicians is related to number of Hispanic Clinicians at a setting.

(a) Incidence of high scores on emotional exhaustion component of burnout will tend to decrease as number of Hispanic clinicians increases.

(b) Hispanic clinics, on the other hand, generate organizational structures that tend to promote burnout. Higher emotional exhaustion and involvement scores and lower personal accomplishment scores are predicted.

Results

Analyses of Variables

Of the three improvised organizational scales, only the Decision-making scale generated a high enough reliability coefficient to merit inclusion as a predictor variable. This scale which assesses actual autonomy and influence in one's workgroup revealed very strong internal consistency as indicated by a Cronbach's coefficient alpha of .84. The ethnic acculturation scale, on the other hand, demonstrated weak internal consistency and was dropped from further analyses; ethnic self-identification was used as the ethnic predictor variable.

Consistent with Maslach's (1978) findings, the Personal Accomplishment subscale bears little relationship to the other subscales of the MBI in this study. In contrast to Maslach's results, the remaining three subscales (Emotional Exhaustion, Depersonalization, and Involvement) yielded high intercorrelations. Moreover, while Maslach found frequency and intensity correlations ranging from .35 to .73, Pearson correlational analyses indicated consistently high correlations (ranging from .78 to .92) for frequency and intensity scores in the present study. Reliability analysis of the three subscales yields a Cronbach's coefficient alpha of .83.

A global Burnout score was determined by weighting frequency and intensity scores equally and adding subscale

scores: Emotional Exhaustion and Depersonalization + Involvement equals Burnout (EE+D+I=B). Personal Accomplishment was treated as a separate and independent variable.

Hypotheses

Organizational Factors and Burnout

The first set of hypotheses predicted that ideological identification with organizational philosophy, work autonomy and influence, role conflict/overload and intake boundary management would all be related to experienced burnout. A second hypothesis was that ethnic group composition was related to burnout in a curvilinear fashion: the more Hispanics at a setting, the lower experienced burnout among Hispanics; however, Hispanic Clinics would produce higher mean burnout.

Because of the inadequacy of the Conflict with Philosophy scale, the hypothesis predicting that higher philosophical conflict would generate higher burnout could not be tested. Neither role conflict nor role overload were significantly related to burnout. The Intake Boundary scale suffered the same fate as the Conflict/Philosophy scale: little internal consistency and therefore no utility as a scale; thus, it was not possible to assess whether inconsistent or absent screening of patients was related to burnout.

Ethnic Identity and Burnout

The second set of hypotheses which predicted a relationship between the number of Hispanics in a setting and

experienced burnout among Hispanics were also not confirmed. Mean Burnout scores for Hispanic clinicians among the three Hispanic conditions are not significantly different. Hispanic clinics did not produce the predicted higher burnout but instead generated results in the opposite direction: the two Hispanic Clinics in the sample produced the lowest mean Burnout scores. However, this difference failed to be significant upon performance of an analysis of variance.

Yet ethnicity did prove to have an impact on experienced burnout. Hispanics have significantly lower mean Burnout than non-Hispanics (see Table 10). T-tests reveal two other significant differences between Hispanics and non-Hispanics: Hispanics are higher in job satisfaction ($t=2.24, df=49, p<.05$) and lower in attributing importance to levels of influence on the job ($t=2.36, df=49, p<.05$).

Sub-analyses within the Hispanic sample yielded the following results. Three factors within the Hispanic sample push Burnout scores upward: Bicultural Ethnic Self-identification, having been raised in an ethnically homogeneous community in the continental U.S., and Puerto Rican ethnicity. Each of these three sub-groups generated a trend towards higher Burnout scores ($p<.10$) but no statistical significance. There was no statistically significant difference between Hispanics at Hispanic clinics and other Hispanics although Burnout tends to be higher for Hispanics at non-Hispanic settings.

Clinical Settings and Burnout

A significant difference among clinics was on the MOAQ scale, Decision Centralization. One-way ANOVA and Scheffe's test reveals significantly higher Decision-Centralization at the non-Hispanic community mental health center than at the Hispanic Clinic hospital.

There were were no other significant differences among the various clinics. There were, however, some important trends: the two Hispanic clinics tended to have a unique profile in terms of higher scores on Open Group Process, Group Goal Clarity, Staff Participation, Group Cohesiveness, Job Satisfaction, and Job Involvement; lower scores on Internal Fragmentation (inspection of the two central means, HC^2, on Table 12 will reveal this pattern). Other Work Characteristics and Burnout

There were no significant differences found by discipline. Staff level did yield some significant differences. As one would anticipate, there are significant differences on scales tapping influence, freedom, and decision-making (see Table 13). An unexpected finding is that supervisors have higher role conflict than line staff. There is no statistical difference in Burnout scores or Personal Accomplishment scores between line staff and supervisors.

Multiple Prediction of Burnout

Multiple regression analysis was utilized in the present study in order to predict Burnout from the predictor variables

(Ethnicity personal demographic variables, Decision-making scale, and predictor scales of the MOAQ). Two preliminary steps were taken in data analysis:

(1) Two outlying Burnout scores that were greater than two standard deviations from the Burnout mean were moved to values just higher than next lower neighbors. This technique called winsorizing is recommended in these circumstances by Tukey (1977).

(2) Because of correlations among predictor variables factor analysis was performed on the Decision-making scale and the scales of the Michigan Organizational Assessment Questionnaire that would theoretically predict to Burnout. (Job Satisfaction, Job Involvement, Desire for Internal Turnover, Intention to Turnover, Self-report of Effort were not included in the factor analysis because it was assumed these variables are either tautologously or dependently related to Burnout.) Principal Factoring without iteration plus orthogonal rotation (Varimax) yield a 6-factor solution which accounted for 68% of the variance (see Table 14).

A multiple regression analysis with step-wise progression was performed in an attempt to predict Burnout utilizing seven demographic variables (ethnicity, marital status, sex, age, years on job, career length, and pay) and the six factor yield by the factor analysis. Four variables emerged to explain nearly forty percent of the variance in Burnout: Ethnicity,

Factor IV (Internal work motivation), Age, and Factor II (Decision-Making/Autonomy) in that order of power (see Table 15).

DISCUSSION

In designing this study, the researcher set out to test several hypotheses suggested both by the developing literature on burnout and experiences informally reported by Hispanic mental health professionals. Another stimulus was the Tavistock tradition of group and organization process. It continues to be the hope of this researcher that this last theoretical tradition can be brought to bear its considerable conceptual power on the burnout phenomenon. As will become clearer later in this discussion, burnout remains poorly understood, with theory remaining embryonic and research leaving many questions unanswered.

There is a caveat that must circumscribe any inferences drawn from the results of this study: we must keep in mind that the results of multiple regression analysis reveal that our predictor variables account for only 40% of the variance in Burnout, leaving 60% unexplained. This finding points to the major flaw of the design, its lack of focus on personality factors. Personality factors in transaction with organization structures may explain more of burnout than either alone. It is not a reasonable assumption that personality is a statistical constant. (In general, there are important political implications to focusing on one domain or the other: organizational leaders may seek to escape their responsibility by a too exclusive focus on personality factors in burnout.)

Only one hypothesis was partially confirmed: decision-making (influence and actual autonomy on the job) was found to be negatively related to Burnout. This finding seems to give mild support to the theory outlined by Cherniss (1980[a,b]) that organizational power structure has relation to burnout, specifically that hierarchical decision-making would promote more job stress and therefore higher burnout. However, although the result suggests that the more influence and autonomy the individual has on the job the less likely he is to burnout (as measured by Emotional exhaustion, Depersonalization and Involvement sub-scales of the MBI), there is no evidence indicating that on an organizational basis hierarchical structure or decision-centralization increases burnout.

The significant difference between supervisors and line staff on decision-making indicates that the scale is valid, scores reflecting formal functioning in the organization. However, the relationship between formal structure and burnout is not linear: despite the relationship between high decision-making and low burnout, line clinical staff do not have significantly higher burnout than supervisors. This suggests that either informal group process and/or individual differences account for some of the variance in decision-making and therefore significantly determine burnout.

The overall lack of power of work and organizational characteristics in statistically predicting burnout is

emphasized by the relatively low percentage of the Burnout variance accounted for by Decision-making, the only work setting variable significantly involved in the multiple regression formula. A larger portion of the variance is accounted for by Factor IV (with high loadings on Internal Work Motivation and influence Importance). This suggests that subjective, presumably personality factors play a larger role in determining Burnout than organizational structure.

These two scales of the MOAQ have been identified as "psychological state measures" and "intervening variables" mediating between interventions and outcomes in organizational theory research (Cammann et al, 1983). Factor IV seems to reflect a personal investment and personal need to do good clinical work which suggests further a commitment to the work. But this remains speculative. What is certain is that Factor IV is sensitive to a psychological state in the individual in which a great premium is placed on successful performance of clinical work. Paradoxically, it seems the higher emphasis and need by the individual on successful clinical work the lower the predicted Burnout. If Factor IV does tap a commitment to clinical work then the relationship makes no more sense (in the light of previous theorizing): ambivalence or low commitment to clinical work leads to higher burnout! However, Cherniss & Krantz (1983) do hypothesize that commitment to human service work sustained by an uplifting ideology may buffer against burnout.

The two findings taken together (significant portion of Burnout variance accounted for by Factors II and IV) suggest that the clinician with low or ambivalent personal investment-commitment to clinical work performing in a work group with high heteronomy (collective or hierarchical) is at high risk for burnout. There is no evidence in this study, however, for an interaction between personal and organizational factors; allowing us to say that low commitment and low actual autonomy interact to produce higher burnout than either would alone. Yet it is tempting to speculate concerning the possibility of an overbounded work-life space: ambivalently committed worker within a rigid system promoting little autonomy. This concept emphasizes the mutual transaction between organizational field and personality structure: the ambivalent commitment may be generated or reinforced by a toxic organization but also the worker may be ambivalently bonded to a particular work setting because of inner structures (ambivalent relation to authority introject, e.g.).

We must temper this speculative interlude with two remaining ambiguities: One, personal investment in the work may be dependent on some organizational factors. This is hinted at by the unexplained high loading of Group Homogeneity on Factor IV.

If this were the case, it would eliminate the presumed personality factor as an independent variable. Two, the direction of the causal relationship between Factor IV and

Burnout remains uncertain. It may be that Burnout predicts to Factor IV, after all, one of the dimensions of Burnout is defined by a loss of commitment and cynicism.

The major finding of this study is the differential impact of ethnicity on Burnout. Although a difference was hypothesized, the results were not in the expected direction. It remains a difficult finding to explain given that neither demographic nor organizational variables reveal systematic and significant differences between the Hispanic and Non-Hispanic samples. There are three possible sources of explanation for the observed differences in experienced burnout: (1) patient-therapist linkages, (2) culturally based coping styles, and (3) work group factors.

Hispanic therapists obviously share certain attributes with patients in the clinical settings sampled which may account for less stress and cynicism. Shared language, social class background, and basic assumptions may enhance therapeutic alliance, empathy and other factors which influence the course of the therapeutic relationship. There has been some interest on differences between therapist and patient revolving around culture, language, ethnicity. However, the focus has been on therapy outcome, length of treatment, self-dis- closure by patient, the focus has been on the patient. More attention, apparently, has to be paid to the potential impact on the clinician of ethno-cultural differences.

Culturally influenced differences in coping styles, personality factors, perception of or tolerance for experienced burnout may account for the lower Burnout scores. Cultural value orientations may prescribe ways of handling stress and ambiguity which may buffer in one case or increase risk in the other. That level of acculturation is influential is hinted at by the trend towards higher Burnout by Bicultural clinicians and those clinicians primarily raised in ethnically homogeneous communities in mainland United States. However, these differences are not statistically significant and a valid acculturation scale was not available.

Finally, group process factors may explain the difference between Hispanics and Non-Hispanics. The majority of Hispanics in the sample (80+%) work in settings where two-thirds or more of their colleagues are Hispanics. It is also more likely to be supervised by an Hispanic in these settings. There is no comparably sized group of Hispanics working in Non-Hispanic settings to contrast against the first group. This leaves open the possibility that the ethnic difference may be an artifactual product of the heavy emphasis on predominantly Hispanic work settings as a source of Hispanic clinicians. Clinicians sharing basic cultural assumptions may experience increased social support which has been cited as a possible buffer against burnout. Theory suggests two other possibilities: (1) Hispanic clinicians in Hispanic settings may share a sense of mission that may in

fact heighten commitment and reduce burnout as suggested by Cherniss and Krantz (1983). A scale is needed to assess ideological cohesiveness in clinical work groups. (2) The Bilingual- Bicultural model of delivery of mental health services is an example of a work group where the task group is supported by sentient group process: this synthesis may promote effective group functioning which in turn may lower burnout. Mild but encouraging evidence for this notion lies in the consistent trend of differences between Hispanic clinics and other settings. However, any hypothesized relationship between sentient group, task group functioning and low burnout remains an unsupported theory.

Implications for Burnout Theory and Research

There remains much controversy concerning the relationship between work characteristics and the burnout syndrome. More recent research is attempting to parse out the differential effect of various work factors on the three major sub-scales of burnout (Jackson et al, 1986). Theoretically derived hypotheses remain unconfirmed and findings across and within populations remain inconsistent and ambiguous. The present state of affairs suggests a need for (a) better theorizing and (b) more rigorous research design.

There are several directions suggested by the results of the present study in order that theory and research might be improved. In this study's population, three sub-scales (Emotional Exhaustion, Depersonalization, and Involvement)

were so highly intercorrelated that a decision was made to use a unitary Burnout score. The Personal Accomplishment sub-scale did not correlate at all with other sub-scales nor did it discriminate among any demographically or organizationally defined groups. The very high intercorrelation which differs from Maslach's findings raises some questions concerning the characteristics of the various populations sampled in the literature and burnout research in general. At least, two other studies conducted within a single professional group (Dames, 1983; Jackson et al, 1986), nurses and teachers respectively, have also generated significant correlations among sub-scales. This suggests that much research must be done to explore burnout between professions as well as within professions. Currently there are no norms for mental health professionals or any other professional group that can be relied on. Inter-occupational comparisons and intra-professional norms are fraught with possible skewness, for reasons cited by Maslach, herself: inter- professional differences may in fact be produced by hidden factors such as sex. For example, policemen and physicians are predominantly male, while females are more numerous among nurses and social workers.

A related issue is the choice of assessment instruments across studies and professions surveyed. Wherever possible scales should be geared to the organizational and occupational reality of the group being studied. Constructs such as role

conflict, role clarify, and role overload may have occupation-specific meaning although there may be some overlap across occupations. Role overload, for example, certainly has both qualitative and quantitative dimension: the type of patient or client may account for role overload as much as the number of patients or clients.

In addition, self-reported perception of role overload runs the risk of being determined by the phenomenon it is supposed to cause. Individuals experiencing high burnout may experience their task role as overloaded although the burnout is being determined by other processes. Hence, independently observed assessments of this and other constructs provide insurance against this directional ambiguity.

No one has focused on the possibility that there may be differences in modal personality among professions: this may account for differences among professional and occupational populations. This would be predicted by Bion's theory of valency in group formation and cohesiveness around basic assumptions. Here again personality in transaction with role and organizational process may be explanatory; the same personality domain may have a different impact across occupation, profession, or organizational setting. A particular coping or personality style may be useful for teachers but not policemen, for example. The entire dimension of personality and its transaction with organizational factors

in determining burnout remains promising, intriguing and puzzling. Longitudinal research with measures taken before and after organizational interventions may be an approach than can clarify the relationship between personality, work-organization, and burnout.

Implications for Intervention and Consultation

Interventions can be categorized into two general types: (1) those that address the individual or person, providing stress management skills, for example, (2) those that focus on organizational structure, with an emphasis on role and role relationships. The results of this study suggest that both types of intervention are needed, i.e., focus on role as ell as the person. Unfortunately, consultations with interventions explicitly aimed at persons may be too threatening for all concerned: staff as well as administrators. For that reason structural interventions targeting the relatively impersonal role relationships may be the most appropriate. In this regard training for supervisors and program administrators should emphasize supervisory/management skills that promote role autonomy and person in role autonomy for all staff.

With regard to addressing the person-role interface the role analysis component of Tavistock experiential conferences comes the closest. But how can this be translated into a non-threatening intervention in the work place? One worker (Thacker, 1984) has suggested and reported success utilizing

psychodramatic techniques with a staff group. The intervention must be presented as a means of improving job-handling skills with an emphasis on role management. Several psychodramatic procedures are especially fitting: role playing moments of difficulty (countertransference issues may be addressed this way), role reversal (staff can play supervisor or vice versa; clinician can role play patient), and role training. A number of functions are served by using these techniques in a voluntary group format: insight and awareness concerning, blockages in work relationships are enhanced, empathic perception of other role configurations in the system is encouraged, and the group's own resources (used in role training) are tapped and shown to be sufficient and available to staff members, thereby promoting, it is likely, support, cohesiveness and task effectiveness.

TABLE 1

Frequency Distribution: Respondents' age (N=51)

Age	Freq	Pct
25-28	4	8
29-32	10	21
33-36	12	24
37-40	6	12
41-44	7	14
45-48	3	6
49-52	1	2
53-56	4	8
57-60	2	4

Mean: 38.6 S.D.: 8.75 Median: 36.1

TABLE 2

Gender Distribution (N=51)

Gender	Freq	Pct
Male	18	35
Female	33	65

TABLE 3
Ethnic Self-Identification Distribution (N-51)

Ethnic Self-Identification	Freq	Pct
American-Hispanic	0	0
Bicultural-Hispanic	12	24
Hispanic-Hispanic	14	27
Non-Hispanic	25	49

TABLE 4

Career Length (N=51)

Years	Freq	Pct
0-2	10	20
3-5	13	25
6-8	7	14
9-11	9	17
12-14	2	4
15-17	4	8
18-20	5	10
21-23	0	0
24-26	1	2

TABLE 5

Years at Current Institution (N=51)

Years	Freq	Pct
1-2	19	37
3-4	11	21
5-6	7	14
7-8	6	12
9-10	2	4
11-12	2	4
13-14	2	4
15-16	0	
17-18	0	
19-20	2	4

TABLE 6

Distribution by Type of Institution (N=51)

Type	Freq	Pct
Hospital	14	27
Community Mental Health	30	59
Freestanding	7	14

TABLE 7

Distribution by Staff Level (N=51)

Level	Freq	Pct
Line Staff	34	67.
Supervisor	17	33.

TABLE 8

Salary Distribution (N=51)

Salary	Freq	Pct
20-25,000	13	25
26-30,000	12	23
31-35,000	12	23
36-40,000	0	0
41-45,000	6	12
46-50,000	8	16

TABLE 9

Distribution by Discipline and Ethnicity

Discipline	Ethnicity: Hispanic (N-25)		Non-Hispanic (N-26)	
	Freq	Pct	Freq	Pct
Casework	2	8	2	7
Social Work	14	56	14	53
Psychology-Masters	2	8	3	12
Psychology-Doctoral	0	0	3	12
Psychiatry	4	16	3	12
Nursing	1	4	1	4
Physician	2	8	0	0

TABLE 10

Mean Burnout Scores by Ethnic Self-Identification

Ethnic ID	$\bar{X}$
Bicultural Hisp	70.83[a]
Hispanic Hisp	47.93
Non-Hispanic	83.20[b]

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a Not significantly different from other Hispanics

b Mean score is significantly higher than the mean for all Hispanics ($x=58.5$; $p<02$).

TABLE 11

Burnout Means by Clinic Group*

Clinic Group	$\bar{X}$	N
H^1	91.33	12
H^2	64.92	13
HC^1	52.60	5
HC^1	49.29	7
NH^1	79.60	5
NH^1	72.78	9

* H^1 = 1/3 Hispanic CMHC HC^1 = Hispanic Hospital
H^2 = 2/3 Hispanic CMHC HC^2 = Hispanic Clinic Freestanding
NH^1 = Non-Hispanic CMHC
NH^2 = Non-Hispanic Hospital

TABLE 12

Selected MOAQ Scale Means by Clinic Group*

Scale-MOAQ	H^1	H^2	HC^1	HC^2	NH^1	NH^2
Job Satisfaction	15.58	15.38	18.80	18.14	17.20	15.33
Job Involvement	11.50	10.23	12.00	14.43	10.60	10.67
Intention tc Turnover	12.25	9.69	5.80	6.57	8.80	8.67
Role Overload	13.33	15.00	13.00	14.00	10.80	9.89
Group Homogeneity	11.17	10.69	11.60	10.29	12.40	11.56
Group Goal Clarity	8.58	9.46	10.60	10.14	7.80	8.56
Group Cohesiveness	10.17	10.77	11.80	11.14	9.00	8.33
Open Group Process	15.67	14.54	22.60	19.86	13.20	13.78
Internal Fragmentation	15.42	16.00	8.20	12.71	16.40	15.56
Production Orientation	15.58	17.08	15.20	16.29	14.00	13.56
Decision Centralization**	7.58	9.38	4.40	7.86	12.00	8.89
Participation	9.50	8.31	11.80	9.86	7.40	8.78

* H^1 = 1/3 Hispanic CMHC HC^1 = Hispanic Hospital
H^2 = 2/3 Hispanic CMHC HC^2 = Hispanic Clinic Freestanding
NH^1 = Non-Hispanic CMHC
NH^2 = Non-Hispanic Hospital

** Difference between lowest and highest mean is significant at the .05 level (Scheffe Procedure).

TABLE 13

Burnout & Selected MOAQ Scale Means by Staff Level

Scale	Staff Level	
	Line (N=34)	Supervisor (N=17)
Burnout[n.s.]	71.38	69.06
Decision-Making[a]	19.94	29.53
Influence Importance[b]	14.03	15.82
Influence Satisfaction[c]	8.24	10.71
Freedom[c]	12.65	15.88
Role Conflict[c]	3.09	4.65

a. $p<.001$; b. $p<.05$; c. $p<.01$ two-tailed

TABLE 14

INTERCORRELATIONS AMONG SCALES FOR MICHIGAN ORGANIZATIONAL ASSESSMENT QUESTIONNAIRE AND DECISION-MAKING/AUTONOMY SCALE

SCALE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)
(1) Decision	1.00																					
(2) Internal Work Motivation	.14	1.00																				
(3) Job Involvement	.13	.05	1.00																			
(4) Organizational Involvement	.12	.30	.16	1.00																		
(5) Locking In	.17	-.16	.35	.13	1.00																	
(6) Influence Importance	.11	.35	.07	-.08	-.12	1.00																
(7) Influence Satisfaction	.63	.20	.17	.18	.21	-.00	1.00															
(8) Training Adequacy	.31	-.04	-.09	-.19	.21	-.05	.11	1.00														
(9) Freedom	.63	.17	.08	-.06	.11	.30	.63	.28	1.00													
(10) Role Conflict	.07	.18	.03	.15	-.01	.11	-.16	.25	-.01	1.00												
(11) Role Clarity	.36	.17	-.07	.15	-.03	.04	.30	.33	.31	-.11	1.00											
(12) Role Overload	-.25	1.06	.07	-.03	-.10	-.04	-.35	-.03	-.26	.34	-.12	1.00										
(13) Group Homogeneity	.13	.35	.08	.09	.03	.24	.21	-.00	.28	.02	.01	.06	1.00									
(14) Group Goal Clarity	.35	.07	.01	.17	.12	-.16	.35	.19	.26	-.01	.35	-.00	-.13	1.00								
(15) Group Cohesiveness	.20	.16	.05	.19	.12	.20	.23	.04	.11	.02	.26	.48	.05	.45	1.00							
(16) Open Group Process	.21	.05	.20	.18	.21	-.05	.38	-.05	.27	-.18	.25	.18	-.14	.62	.59	1.00						
(17) Internal Fragmentation	-.05	.03	.00	.03	-.14	.01	1.26	-.01	-.12	.15	-.06	-.20	.14	-.44	.57	-.74	1.00					
(18) Product Orientation	.10	-.12	.09	.25	.02	-.02	.07	.16	1.12	.12	.20	.17	-.11	.27	.38	.21	-.06	1.00				
(19) Control of Work	.36	.02	.02	.16	-.02	-.06	.45	.09	.20	-.35	.49	-.08	.06	.41	.48	.42	-.34	.48	1.00			
(20) Consideration by Supervision	.25	.10	.16	.14	.05	.06	.38	1.01	.18	-.38	.57	.01	-.14	.37	.54	.42	.32	.37	.75	1.00		
(21) Decision Centralization	-.11	-.10	-.17	-.10	-.08	.17	-.35	.13	-.05	.31	-.28	.03	.05	-.37	-.35	-.52	.43	-.15	-.58	-.65	1.00	
(22) Participation	.30	.11	.22	.11	.24	-.03	.52	-.09	.24	-.30	.25	-.11	.01	.30	.39	.50	-.38	.32	.70	.72	-.74	1.00

N=51, $r = .35$, $p < .01$

TABLE 15
Factor Loadings of Decision-Making Scale and Scales of MOAQ

Scale	Factor I	II	III	IV	V	VI
Decision-Making		.78				
Internal Work Motivation				.77		
Job Involvement						.73
Organizational Involvement						.55
Locking In						.71
Influence Importance				.68		
Influence Satisfaction		.63				
Training Adequacy		.68				
Freedom		.76				
Role Conflict	-.71					
Role Clarity		.51				
Role Overload			.58			
Group Homogeneity				.64		
Group Goal Clarity		.42	.53			
Group Cohesiveness			.77			
Open Group Process			.77			
Internal Fragmentation			-.83			
Production Orientation					.76	
Control of Work	.73					
Consideration by Supervisor	.76					
Decision Centralization	-.75					
Participation	.77					

TABLE 16

Multiple Prediction of Burnout

Variable	Beta	Percentage of Variance	Percentage of Explained Variance
ETHNICITY	0.496[c]	13.7	34.5
FACTOR IV (Internal Work Motivation)	-0.372[b]	10.3	25.9
AGE	-0.319[a]	8.8	22.2
FACTOR II (Decision-Making Autonomy)	-0.249[a]	6.8	17.3
TOTAL	R=0.630	39.6	100.0

[a]p<05; [b] p<.01; [c]p<001, two-tailed

APPENDIX I

Michigan Organizational Assessment Questionnaire (MOAQ) as published in Chapter Four of Seashore, S. (1983). Assessing Organizational Change. New York: Wiley & Sons

APPENDIX II

Revised Michigan Organizational Assessment Questionnaire (MOAQ).

APPENDIX III

Maslach Burnout Inventory

APPENDIX IIIa

Fourth Factor (Involvement) of M.B.I.

How Often	How Strong	
0-6	0-7	Statements:
23. _____	_____	I feel similar to my recipients in many ways.
24. _____	_____	I feel personally involved with my recipients' problems.
25. _____	_____	I feel uncomfortable about the way I have treated some recipients.

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