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MENTAL HEALTH COUNSELORS AT WORK

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Assessment of Non-Traditionally Trained Mental Health Workers and Implications for Manpower Utilization

by

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Preface

THE DEVELOPMENT of the NIMH Pilot Training Program for Mental Health Counselors was one which I and my colleagues viewed with much interest. Drs. Rioch and Elkes discussed their developing ideas with us on a number of occasions. We shared our caseload with them in order that they might clarify their questions regarding adolescent-aged college students who came to our center. Also, our center was one of the field training locations where the MHCs acquired directly supervised practice during their training period. These indirect experiences with the Pilot Training Program led us to be quite receptive to an NIMH request to conduct an evaluative study of the trainees as they moved into mental health positions upon the completion of their training.

For this Mental Health Project Grant, we were most fortunate in securing as professional staff members, Dr. Stuart Golann as the Chief Investigator, Dr. Robert Freeman (first as a Research Assistant, and later as a part-time Research Psychologist), and a number of able graduate assistants, including Dennis Breiter, Carolyn Wurm, and Sally Steiniger Ridgway.

In addition, we were helped on many occasions by our Advisory Committee (Drs. Eugene Brody, Verl Lewis, and Daniel Prescott), particularly in review of instru-

ment development, and in planning for our surveys which involved psychiatrists, social workers, psychologists and counselor-educators across the country.

Certain portions of our investigation required the experience and materials collected by Drs. Rioch and Elkes during the training period. Their cooperation was gladly given and was much appreciated. Of course, our studies made many demands upon the mental health agencies employing the MHCs. Much of our descriptive and evaluative material comes from the directors, supervisors and co-workers within these agencies. The cooperation we needed was substantial and they provided it. The agencies included the following:

Prince Georges County Mental Health Clinic
Fairfax-Falls Church Mental Health Center
Arlington, Va. Mental Hygiene Clinic
Hillcrest Children's Center
Hood College
Montgomery Blair High School
Crownsville State Hospital
National Institute of Mental Health
Bethesda Community Psychiatric Center

Last to be mentioned are the eight Mental Health Counselors:

Jane Donner
Anita Gamson
Leslie Hogeboom
Mabel Mango
Margaret Stolzenbach
Margaret Reid
Alison Sharpe
Lois Showalter

Few groups of employed adults have participated in so much assessment on their ongoing vocational activities. Their cooperation was most heartening, and indeed without it there would have been no study. To each of them go our special thanks and large measures of personal and professional respect.

Thomas Magoon

CHAPTER I

INTRODUCTION

THE RECENT intensive study of the Joint Commission on Mental Illness and Health provides a very broad gauged approach to mental health. Included in its study are searching analyses of programs, economics, public attitudes, prevalence of mental health problems and the status and needs for mental health manpower.

In *Mental Health Manpower Trends,* Albee (1959) presents a pessimistic view of the future regarding the supply of mental health professionals. He finds striking deficiencies in manpower available to eliminate present deficiencies in mental health care. He anticipates that the needed professionals will never be available to keep up with population trends without drastic changes in our recruitment and training programs. This issue is particularly impressive in light of the fact that the needs he finds are not composed of vague desires for more financial support for desired increases in manpower. Rather, the needs are apparent now in budgeted, but unfilled positions. For example, consider positions in state and county hospitals. About 1/4 to 1/5 of the positions for physicians, psychologists, social workers and nurses are vacant.

In a similar vein, in another publication (Robinson, *et al.* 1960), dealing with community resources in mental health, the authors report that the demand for manpower in the community setting among promotional and supportive resources is as pressing as it is for patient care and for research in large clinics and hospitals. If we are to emphasize community mental health programs of a preventive and supportive nature, we must give consideration to the personnel necessary for such developments. Manpower in the local community includes personnel not necessarily included in the traditional view (p. 387).

These authors also support Albee's findings from their systematic surveys of mental health resources available in communities throughout the country. For example, in a sample of resources available in 15 representative counties across the country, three of these counties had *no* psychiatrists, psychologists, social workers or psychiatric nurses available for the population.

Indeed, one might regard manpower as the primary facet of mental health problems. The Final Report of the Joint Commission on Mental Illness and Health (1961) stated that any progress in the mental health field depended on the solution of three problems: "(1) manpower, (2) facilities, and (3) costs." (p. 229) The problems involve the limited professional manpower available, the limited productivity of graduate and professional schools in preparation of future mental health specialists, and the costliness of treatment in time and money. Mental health agencies commonly report the presence of lengthy waiting lists and the waiting periods may extend from months to years. Further numbers of unknown magnitude exist among those who are un-

aware of services, slightly less motivated or deterred by the above conditions.

The Joint Commission on Mental Illness and Health has made extensive recommendations to alleviate these conditions. Their recommendations include provision for a community mental health clinic per every 50,000 people in the population. The manpower implications of this proposal are quite staggering. Albee has observed that to staff such clinics just with psychiatrists, social workers, and psychologists would require half of the combined membership of the American Psychiatric Association, the National Association of Social Workers, and the American Psychological Association.

There are three directions which change in the *status quo* may take. One direction concerns prevention. From a public health viewpoint, this direction is aimed at reducing the severity or the incidence of mental health problems in a population. A second direction is concerned with development of different treatment models, that is, different methods than the traditional counseling/psychotherapeutic methods for effecting change. The third direction and the one involved in this report concerns manpower utilization and development, that is, who performs various mental health functions.

Manpower issues are far from static issues. Role relationships and functions appear quite fluid and changing over time. For example, the 1956 survey entitled *Role Relations in the Mental Health Professions* (Zander *et al.*, 1956) revealed little sign of engagement in psychotherapy by non-psychiatrists at that time. In contrast, recent signs point to more emphasis upon individual competence as the determinant of who shall perform mental health functions. Similarly, the Joint

Commission's recommendations regarding manpower start off with the following: "In the absence of more specific and definitive scientific evidence of the causes of mental illness, psychiatry and the allied mental health professions should adopt and practice a broad liberal philosophy of what constitutes, and who can do, treatment. . ." (1961, ix).

These concerns regarding who should provide treatment have until recently involved only the various mental health professions themselves. Changes in roles in the core professions are noteworthy, but can have only limited effect since there are such limited numbers of mental health professionals with traditional academic preparations. If only because of the limited numbers of present mental health professionals, innovation in manpower sources and utilization warrant considerable attention.

The Pilot Project in Training Mental Health Counselors is one of a growing number of recent experiments concerning mental health manpower sources and utilization. The development of a program where college students interacted with patients in mental hospitals as described by Umbarger *et al.* (1962) is one of a number of student volunteer programs (Holzberg, 1963; Holzberg & Knapp, 1965). Goodman (1965) has trained selected college men to be activity therapists to pre-adolescent boys who were thought to be troubled by their parents and teachers. Filial therapy, as described by Guerney (1964), involves the training of parents to conduct play sessions with their emotionally disturbed young children. Hospital aides and attendants have been trained to work with patients within a behavior therapy framework by Allyon & Michael (1959) and within a client-centered framework by Carkhuff and

Truax (1965). Reiff and Reisman have proposed the use of non-professionals indigenous to the population (1964). Tape recorders have been used as manpower supplements by Slack (1960), by the Schwitzgebels (1961) and by Stollak & Guerney (1964).

Mental health services may be viewed as having three primary dimensions. First, a *transaction occurs,* whereby some person or persons provide a specifiable service to another person or persons. A second dimension concerns the *ecological specification* for any mental health transaction of the geographic-sociologic location where the service is provided and time or occasion when it is received by a client. A third dimension concerns the *institutional structures, goals* and *resources* within which programs of mental health transactions are planned and carried out. Innovation and experimentation with the service has been apparent throughout the history of the mental health field. It is apparent from the foregoing that experimentation along another of the components of the mental health transaction, the person who provides the helping service, has started to increase. Similarly, changes in the timing and location of mental health transactions coupled with changes in the recipient of the services are basic to the reorganization and innovations described as community mental health. The Pilot Project may then be viewed as one of a growing number of important experiments in a field which is rapidly undergoing change.

In short then, actual and potential demand for mental health services, and particularly those of a counseling/psychotherapeutic type, is apparent. Also apparent is the limited availability of professional mental health workers competent to provide such services. An intra-

mural NIMH Pilot Training Program was initiated by Drs. Rioch and Elkes, one purpose of which was to determine the feasibility of training carefully selected, mature women to perform psychotherapy under supervision. To the extent the program succeeded, several purposes would be served:

(a) one training program model would have been devised and its student products studied.

(b) the type of students sought and selected would be those *not* presently in the labor force. Hence, as a model the training program would be investigating a source of mental health manpower whose use on a larger scale would not merely shift the locus of manpower shortages from one area to another.

(c) related to the above purpose was that of determining whether such women would indeed find the pilot training and their subsequent employment to be personally and professionally satisfying — sufficiently so, to complete the training, enter employment, and maintain a mental health position for some years.

(d) implications for other forms of training programs, procedures, characteristics of suitable trainees, and vocational roles to be performed should emerge.

THE PILOT TRAINING PROGRAM

This program has been described in considerable detail elsewhere (Rioch, Elkes, and Flint, 1965). Its general characteristics are summarized here since they provide the meaningful background from which to view

the Mental Health Counselor (MHC), her preparation, employment, and her varied vocational roles.

Eight mature, bright, socially sensitive women were selected for this training after an intensive selection process. The process involved the following stages:

(a) completion of an application blank.

(b) preparation of an autobiography emphasizing the person's own development.

(c) 5 hours of observed group procedures (8 to 10 at a time), at NIMH including:
pairing off and interviewing each other;
reaching consensus as a group on a task (finding an appropriate name for themselves);
taking several paper and pencil tests;
listening to and discussing a tape recording of an initial psychiatric interview.

(d) individual interviews with two different members of the staff.

(e) individual testing.

(f) a second group session.

These women were married (median age between 40 and 44), all were college graduates in various fields, and three had advanced degrees. They all had raised children of their own. Their husbands held professional or executive positions.

The training began in September, 1960, and lasted for two academic years. It was originally planned to be half-time work and study; but increased to approximately 2/3 time, due almost entirely to the motivation of the trainees themselves.

The content of the training program was narrow but intensive, focusing upon instruction and practice in

and about psychotherapy. Over the span of the two years, the trainees participated in course-work seminars, in personality development, problems of adolescents, family dynamics, psychopathology, contributions

TABLE I-1
THE PILOT TRAINING PROGRAM IN OUTLINE

Training Experience	Average Hours 1st Year	Per Week* 2nd Year	Approximate Total Hours
1. Interviewing of normal subjects, and referred patients; group therapy with adolescents and parents; individual and group supervision, including listening to playbacks of interviews.	14	7	798
2. Observing experienced professionals conduct individual, group and family interviews.	2	1	114
3. Lectures and seminar discussions.	8	10	684
4. Outside reading and report writing.	4	10	532
5. Work-placement experience in a community mental health agency, nonpaid, part-time.	4	10	532

*Based on a 38-week year.

of modern psychiatry, and casework presentations. Starting with the second semester, they spent part of each week in another setting to supplement their work at NIMH. The field placements included probation, juvenile court, mental health clinic, university counseling center, women's college, social service, and high school settings. The trainees carried on directly supervised casework at NIMH and in these field settings. Individual and group supervision was a regular component of their training, as was the tape recording of their interviews. Over the course of training, the trainees also had opportunity to directly observe the therapeutic work of at least 14 different therapists.

Table I-1 depicts the amounts of training time devoted to various topics and functions.

As the pilot training program neared completion, concern arose regarding evaluation of the program — an evaluation which would be performed by others than the NIMH staff. Dr. Magoon was asked to submit a project grant for this purpose and did so. At that time, (several months before completion of the program), it was believed that the MHCs would be employable in mental health settings in the metropolitan Washington, D.C. area. The follow-up study was designed to encompass a three-year period, involving systematic description and evaluation of the MHCs as staff members of mental health agencies.

The project was a challenging one, both because of the important mental health manpower implications and because of the extreme limitations involved. On the latter point, there were only eight women to be studied; they each would likely work in a different setting — perhaps changing settings over several years — and their supervisors and co-workers would undoubtedly vary

from time to time. Furthermore, since this study was not initiated until the end of the training program, there were no pre-training measures at hand; and, of course, there were no control groups at hand. In spite of these challenging limitations, there was considerable information to be gleaned from careful observations and analyses.

The three-year study would entail considerable cooperation from both the MHCs themselves and from the mental health agencies employing them. To facilitate this cooperation, the study provided $2500 toward their annual salaries for each of their first two years of employment, with the agencies providing total remuneration, beginning with the third year of employment.

A wide range of approaches was taken toward description and evaluation of the MHCs and their work. The guiding questions for the development of the project were the following:

(a) *Work Settings:* In what kinds of mental health settings were the MHCs employed?

(b) *Job Mobility:* What was the incidence and nature of shifts in positions, if any?

(c) *Job Functions:*

 (1) How could the work of the MHC, and other mental health workers, be described systematically?

 (2) What job functions will each MHC perform?

 (3) What changes will occur in their job functions over time?

 (4) How much counseling/psychotherapy will they provide and with what intensity?

(d) *Job Aspirations:*

(1) What will be their aspirations, and how much will these change over time?

(2) How different are their aspirations from their job functions and how does this difference change over time?

(e) *Reflections on Training and Work Experience:*
What can these individuals contribute from their personal experience to a clearer understanding of the training and work experience involved in such a program?

(f) *Quality of Counseling/Psychotherapy:*

(1) How do supervisors evaluate this, during the initial three years?

(2) How do co-workers evaluate this, during the initial three years?

(3) How do independent judges evaluate this, and what changes occur over time?

(g) *Comparison of MHCs with Other Mental Health Workers:*
What instruments or measures allow comparison of the MHCs' information, judgment, or attitudes with that of known mental health worker groups?

(h) *Perceived Employability of Non-Traditionally Trained Mental Health Counselors:*

(1) What attitudes exist among the employers of mental health workers in different settings regarding employability of women so trained?

(2) What attitudes exist among the educators of mental health professionals regarding employability of women so trained?

The following chapters report the development of various procedures by which data regarding these questions could be gathered and analyzed, and the results of such analyses. The Appendix contains descriptions of the instruments developed, survey samples and related materials.

CHAPTER II

DESCRIPTIVE MATERIAL CONCERNING THE MENTAL HEALTH COUNSELORS DURING THREE YEARS OF EMPLOYMENT

THIS CHAPTER has a three-fold purpose. The first is to describe the settings in which MHCs were employed 1962-3, 1963-4, and 1964-5. (In later references, these appear as First Year, Second Year, and Third Year.) The second is to describe the characteristics of the MHCs' work in terms of their work records, caseloads, types of job functions performed, the stability of functions and the roles each MHC performed. The third purpose is to describe the vocational aspirations of the MHCs and how these relate to the job functions they perform.

SETTINGS

Introduction. The selection of mental health agencies as places of employment for the MHCs was an important aspect of the post training period. The initial salaried positions for the most part had been located by

the training staff and were continuations of the second-year training placements. The agencies varied in the clients they served and the services they offered. One characteristic they had in common was a willingness to experiment with the MHCs who were not trained in a traditional degree program. The MHCs were employed in nine different settings during the first three years after their training. A measure of comparability of agency directors to agency directors elsewhere in the country is found in their opinions concerning the attributes of "above average" and "below average" therapists. To the extent that comparison was possible, their opinions were quite similar (see Append. A). A word about these agencies will give some context to the description of their performance.

Agency Settings and Staff. There were three types of settings: schools (educational), institutions, hospitals (in-patient wards), and out-patient clinic (mental health clinics). In the school area, one MHC worked as a school counselor at Montgomery Blair Senior High School, a public high school with a student population of about 2,800. She worked full time, had seven full-time certified school counselors as her co-workers and was supervised by the director of the counseling service and a psychiatric social worker. A second MHC in a school setting was employed two days a week at Hood College, a private women's college in Frederick, Maryland. Hood is a four-year, liberal arts college with an enrollment of about 700. The college did not have a formal counseling service prior to the MHC's employment and she handled students' personal-social concerns. This MHC worked in conjunction with the Dean of Students and College Chaplain; consultant supervision by a psychiatrist was contracted for by the college.

This was the only setting where there were no other colleagues providing direct mental health services.

Two MHCs worked in hospital (in-patient) settings. One setting was an adolescent unit at Crownsville State Hospital in Maryland. The unit was opened in 1962 to provide intensive short-term treatment for up to 34 emotionally disturbed male and female adolescents. The MHC at Crownsville worked three days a week during the first two years of her employment doing individual therapy and parent counseling. In her third year of employment, she shifted to a mental health clinic. Her supervisors at Crownsville included psychiatrists and a social worker. This MHC's co-workers included psychiatrists, a social worker, nurses and hospital aides.

The second MHC was employed full time in an experimental milieu treatment ward in the Clinical Center at the National Institute of Mental Health in Bethesda, Maryland. She worked with patients in a variety of ways, primarily through brief interviews concerned with vocational and educational activities. Part of this was a weekly meeting away from the hospital to discuss problems around employment. She also did liaison work with the community. The Unit was organized to provide increased motivation and community contact for up to 18 seriously disturbed young adults. Some patients worked in the community and lived at the hospital. In this setting, the MHC was supervised by a psychiatrist and had as co-workers other psychiatrists, a social worker, nurses and aides.

At different times, six MHCs have worked in five different out-patient clinics. There is general similarity in the five clinics although each has distinct features which were relevant to the MHCs' work.

One clinic was an integral part of the Prince

Georges County Health Department in Cheverly, Maryland. The mental health clinic program was organized in 1955 and in its physical as well as organizational proximity to the health department has offered a broad base of staff contacts so that professional groups such as public health nurses become co-workers to those in the clinic. The funds for operating the clinic came primarily from County and State taxes with a portion from fees and donations. At different times, two MHCs have worked in this clinic providing individual therapy and telephone intake interviews and they were supervised by the psychiatrist-director. In addition to the psychiatrist and nurses, there were several social workers and two psychologists on the staff. One MHC worked full time during her stay here, while the second was employed three days a week.

Another clinic, Fairfax-Falls Church Mental Health Center located in Virginia in the greater Washington metropolitan area has been in existence over 20 years. The center operates under the Virginia Department of Mental Hygiene and Hospitals and receives 2/3 of its money from state and federal funds, and 1/3 from fees and local contributions. The feature of this center is its emphasis and orientation on group psychotherapy. Job functions in this agency are determined by staff members' interests and capabilities which has had the effect of blurring interdisciplinary differences and traditional lines of authority. The MHC employed here full time has been supervised by psychiatrists, a social worker and a psychologist. Other staff are part-time psychiatrists and a remedial therapist.

Hillcrest Children's Center in Washington, D.C. is a comprehensive mental health service for emotionally disturbed children and their families. As a part of this center, there is an out-patient service for adults from

the community. The center is a private psychiatric agency which derives funds from the United Givers Fund, fees, and contributions. Two factors of importance to the present discussion are that there is a strong identification within disciplines, and the center has functioned as a training agency for psychiatric residents. The MHC in this setting worked full time doing individual therapy and intake interviews and has been supervised by psychiatrists. Other staff includes social workers, psychologists and psychiatric residents.

Another clinic is the Arlington, Virginia, Mental Hygiene Clinic which is supported primarily by County and State tax funds. This agency has operated for over 15 years and is directed by a psychiatrist. In addition to typical agency functions of individual and group therapy, diagnosis and consultation, this agency has put emphasis on two innovations, art therapy sessions and vocational motivation programs. The MHC employed in this agency worked three days a week and was supervised by the psychiatrist-director. The staff includes social workers, a psychologist and an art therapist.

The final agency is the Community Psychiatric Clinic in Bethesda, Maryland. It is a small private clinic supported by United Givers Fund, fees, and contributions. In this agency, there are traditional disciplines represented, but the limited size makes a team approach necessary. There have been two MHCs employed at this agency, both working full time and supervised by psychiatrists. The staff includes psychiatrists, psychologists, and social workers.

Changes in Setting. The initial expectation was that the MHCs, if successful, would remain in the agencies

where initially employed. In fact, there were four shifts in employment. These shifts did offer some comparison between different positions, a broader view of a MHC's actual performance and a greater number of different evaluations of the MHC in a wider range of situations. Table II-1 contains information on the counselor placements and shifts during the three-year evaluation period.

TABLE II-1
TYPES OF AGENCIES IN WHICH MHCs WORKED AND DAYS EMPLOYED DURING THE THREE YEAR EVALUATION.

	Mental Health Counselors																							
	1 Year			2 Year			3 Year			4 Year			5 Year			6 Year			7 Year			8 Year		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3*
Days employed per week	3	5	5	5	5	5	5	5	5	5	5	5	3	3	3	2	2	2	5	5	5	5	5	5
Clinic	x	x	x		x	x	x	x	x						x				x	x	x	x	x	
In-patient										x	x	x	x	x										
School				x												x	x	x						

*Not agency based

Four MHCs have remained in the settings they were in at the end of the training program; the other four have resigned their first positions and have taken positions in other agencies.

Only one of the four moved to an agency similar to the one in which she had been working. She left a state supported mental hygiene clinic to work in a small psychiatric clinic. Two others moved to mental health clinics, one from the high school and the other from the in-patient adolescent unit. The fourth one has moved

from a county mental health clinic (she was replaced by the MHC from the adolescent unit) to an administrative position assisting in the training of another group of women in training to provide counseling in well-baby clinics and nursery schools.

This section has presented the context within which the MHCs worked by providing a description of the agency and a brief picture of the co-workers. In addition, mention is made of the fact that four of the MHCs have shifted agencies during this three-year period. What work did the MHCs perform in the mental health settings described above? The ensuing section describes characteristics of their work.

CHARACTERISTICS OF THE MHCS' WORK

Introduction. One attempt to describe the MHCs' work was to have a few MHCs keep a diary of their day's activities for a brief time. The activities reported included individual patient hours, group meeting hours, staff meetings, supervision and note writing. A person familiar with mental health agency work would have found it difficult to differentiate the MHC from the traditional worker on the basis of such information. How can the MHCs' work be described beyond "like the others in the agency?" As a group, the main functions that MHCs perform (as obtained from yearly questionnaires) can be categorized as direct and indirect client services and functions related to their own professional growth. They perform, to a lesser degree, functions of a supervisory, administrative or research nature.

Inventory of Job Functions. During each of their

three years of employment, the MHCs were asked to fill out the Inventory of Job Functions (IJF, see App. B & C). The IJF contains a comprehensive listing of functions performed by staff in a mental health agency. These functions are grouped under eight main headings which are briefly described in Table II-2.

TABLE II-2
DESCRIPTION OF IJF CATEGORIES

Section of IJF	Category	Description of Category
1.	Educating-Training	Providing supervision, training or consultation within the agency
2.	Administrative and Clerical	Personal, budget, determine fees, keep inventory
3.	Community and Professional	Community relationships (speaking engagements, committee work, agency representation)
4.	Professional Growth	Further training, workshops, conventions
5.	Research-Scientific	Plan research, analyze data, review literature
6.	Direct Client Service-Evaluative	Direct service to clients of an evaluative, diagnostic, or judgmental nature
7.	Direct Client Service-Helping	Direct service to clients designed to be of a helping nature
8.	Indirect Client Service	Services designed to be in the interest of the client, but not directly administered to him

Each MHC was asked to fill out the IJF at three points during her three years of employment:

First Year (after five months of employment)
Second Year (after 18 months of employment)
Third Year (after 30 months of employment)

The IJF was administered each time under three different sets of instructions. The one of interest here is: "Indicate job functions you have been performing during the past two months."

Before discussing findings from the IJF, it should be stated that a measure of accuracy of report for functions which the MHCs reported as performing was obtained. Supervisors of the MHC were asked independently which functions the MHC was performing. Comparing supervisors' judgments of what the MHC was performing with each MHC's report on what she was actually performing yielded a percent agreement of 84.

Job Functions Performed. The categories of job functions performed describe the work of the MHCs. Although the MHCs were working in different agencies, there is a similarity among them when the categories are considered. The data obtained for the three years indicates that the MHCs are primarily performing functions in these categories:

(a) Direct Client Service-Helping
(b) Indirect Client Service
(c) Professional Growth
(d) Direct Client Service-Evaluative

To a lesser degree, they are performing functions in the other categories:

(a) Administrative-Clerical
(b) Community and Professional
(c) Educating-Training
(d) Research-Scientific

TABLE II-3
PERCENTAGE OF FUNCTIONS PERFORMED IN EACH CATEGORY ON THE IJF BY YEARS

IJF Category	Functions in Category	Percentage of Functions Lowest							Highest	Year
1. Educating-Training	10	0	10	10	10	20	20	30	40	1st
		10	10	10	10	30	40	50	50	2nd
		10	10	10	20	20	20	50	80	3rd
		10	13	17	20	20	23	43	43	Composite
2. Administrative-Clerical	20	10	15	20	25	25	35	35	40	1st
		15	15	25	25	30	30	45	55	2nd
		15	20	25	30	35	40	45	60	3rd
		17	20	22	27	28	33	47	47	Composite
3. Community and Professional	7	0	0	14	29	29	29	57	57	1st
		0	14	29	29	43	43	57	57	2nd
		0	0	0	14	28	28	43	100	3rd
		0	10	14	29	38	43	48	52	Composite
4. Professional Growth	6	50	67	67	67	83	83	100	100	1st
		33	50	50	67	67	67	83	100	2nd
		17	33	50	67	67	83	83	100	3rd
		44	50	67	67	72	78	78	89	Composite
5. Research-Scientific	9	0	0	0	0	11	11	11	11	1st
		0	0	0	0	0	11	22	44	2nd
		0	0	0	0	0	33	56	89	3rd
		0	0	0	0	7	30	30	33	Composite
6. Direct Client Service-Evaluative	9	22	22	33	44	67	67	67	68	1st
		44	44	56	56	67	67	67	78	2nd
		0	44	67	67	67	78	78	78	3rd
		41	44	48	52	63	67	67	70	Composite
7. Direct Client Service-Helping	36	64	67	67	72	75	78	81	89	1st
		72	75	78	80	81	89	89	92	2nd
		0	67	67	75	75	86	89	92	3rd
		50	70	71	72	75	86	86	89	Composite
8. Indirect Client Service	11	36	64	82	82	82	82	91	91	1st
		64	73	73	73	91	91	91	100	2nd
		18	36	45	73	82	91	100	100	3rd
		48	70	73	73	79	85	88	88	Composite

Table II-3 presents the percent of functions performed in each of the categories for each year. A composite percentage for the three-year period is also included. The percentages are ordered from low to high.

The composite three-year percentages of functions show the clear demarcation of the categories indicated in Table II-3. Median percentages are displayed in Fig. II-1.

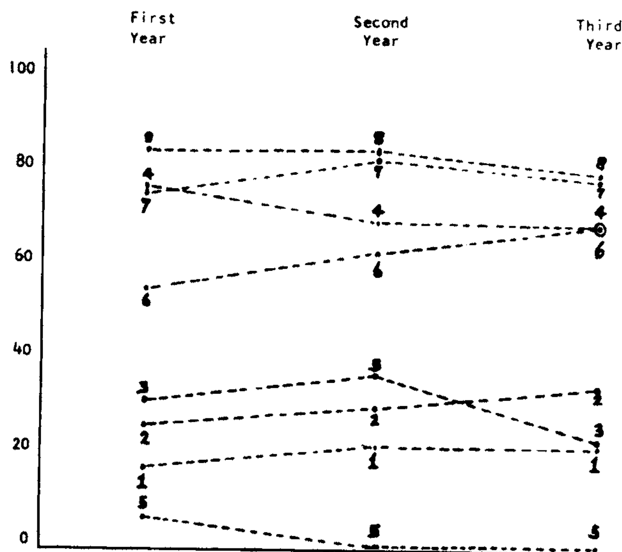


Fig. II-1. Median percentages of functions performed during three years of employment.

Categories of functions:

1. Education-Training
2. Administrative-Clerical
3. Community and Professional
4. Professional Growth
5. Research-Scientific
6. Direct Client Service-Evaluative
7. Direct Client Service-Helping
8. Indirect Client Service

Over the three-year period, there were differences in individual MHCs, but there is a consistency in the types of functions they performed. These were primarily Direct and Indirect Client Service and Professional Growth functions.

TABLE II-4
PERCENT TIME MHCs SPENT WEEKLY IN TERMS OF CATEGORIES OF FUNCTIONS*
(ONLY VALUES > 5% ENTERED)

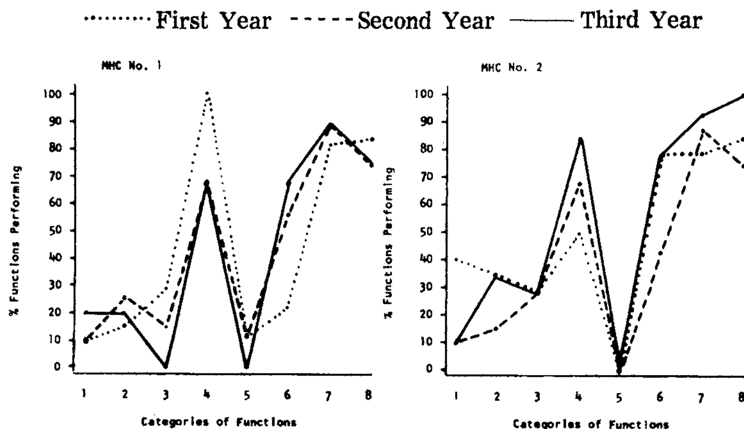
	MHCs							
	1	2	3	4	5	6	7	8
1. Educating-Training	-	-	-	-	-	-	-	25
2. Administrative-Clerical	-	-	10	-	15	-	-	30
3. Community and Professional	-	-	-	-	-	-	-	30
4. Professional Growth	12	-	-	6	10	-	-	-
5. Research-Scientific	-	-	-	25	-	-	-	15
6. Direct Client Service-Evaluative	-	-	-	20	15	-	35	-
7. Direct Client Service-Helping	70	60	50	33	30	70	50	-
8. Indirect Client Service	10	26	28	15	20	-	15	-

*Based on MHCs' work during their third year of employment

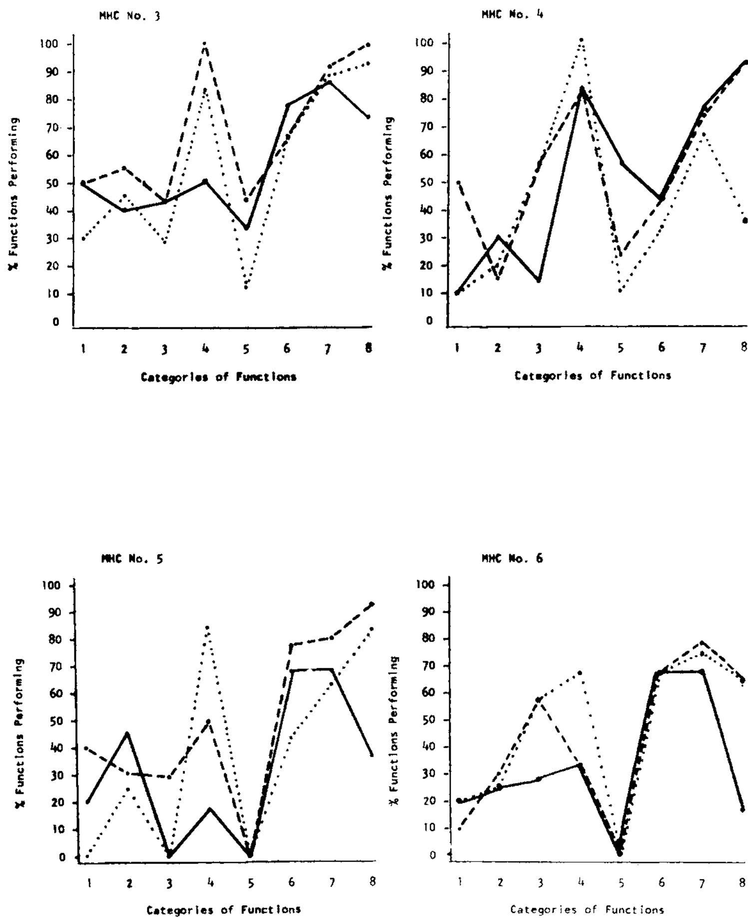
What percentage of time did the MHCs spend on different types of functions? An estimate of the percentage of time spent was obtained from the MHCs and is presented in Table II-4. Most time was spent on Direct Client Service-Helping functions. The percentage estimates generally agreed with the number of functions endorsed in the previous table (see Appendices D & E).

The exception to the above was MHC No. 8, the one who changed to doing administrative-training work the third year. It might be noted also that MHC Number Four's duties were altered during this year to provide some research time.

Stability of Job Functions. The consistency of types of functions performed has been mentioned above for the MHCs as a group. Is this as true for each individual MHC? A graphical presentation for each MHC reveals considerable stability in the percent of functions performed in each category over the three years. Figure II-2 depicts these patterns.



·····First Year - - - - - Second Year ——— Third Year



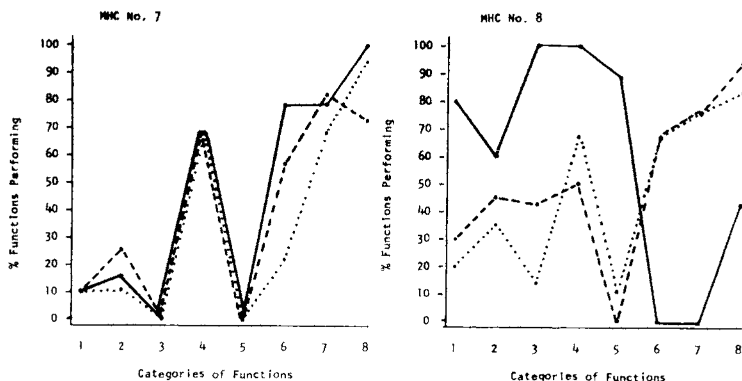


Fig. II-2. Patterns of functions for MHCs during three years of employment: ····· First Year, - - - Second Year, —— Third Year.

There are in these individual patterns more similarities than differences. The most disparate pattern was MHC No. 8 who was not in an agency the third year. MHC No. 5, who changed settings at the end of the second year, is also not uniform. Generally, however, there is stability in the percentage of functions performed.

Role Characterization. As a part of the evaluation, each year there was an attempt to cull from various sources a conceptualization of each MHC's actual role with the agency. These role characterizations were obtained from interviews with each of the MHCs, their supervisors and co-workers as well as from an examination of ratings on the IJF. The intended role for the MHCs had been depicted at the conclusion of the two-year training program by Dr. Rioch. She gave the following examples of duties a MHC might be expected to perform:

(a) Subsequent to acceptance of patient for treatment by the clinic, performs individual therapy under supervision.

(b) Performs group therapy under supervision.

(c) Counsels with parents or others under supervision.

(d) Performs family therapy under supervision.

(e) Maintains case records, prepares reports and correspondence related to cases receiving treatment.

(f) Participates in staff conferences and presents cases.

The roles of most of the counselors are varied but fit within the framework of Dr. Rioch's description. The functions are technically similar, but the ways these are performed depend in large measure on the types of agency, the needs of the agency, the ways in which the agency is organized, and the training and role perceptions of the co-workers. One MHC for instance is performing functions which make her indistinguishable from other staff members in her agency, while another may be performing the same functions, yet is considered by others in the agency as a junior staff person.

Time and Caseload. An examination of the nature and stability of functions as well as the roles MHCs performed in their respective agencies is one way of characterizing their work. A more concrete characterization involves the amount of time they worked and the kind of caseload they carried in their agencies.

Five MHCs have been employed full time throughout the three-year period. For each year, the days each

MHC worked and the job settings have been noted in Table II-5.

TABLE II-5
DAYS WORKED AND SETTINGS FOR EACH YEAR FOR EIGHT MHCs

Institution	1st	2nd	3rd*
Arlington (Clinic)	3		
Montgomery Blair (School)	5		
Community Psychiatric (Clinic)†		10	10
Fairfax-Falls Church (Clinic)	5	5	5
N I M H (In-patient)	5	5	5
Crownsville (In-patient)	3	3	
Prince Georges County (Clinic)	5	5	3
Hood College (School)	2	2	2
Hillcrest (Clinic)	5	5	5
Total Weekdays Worked	33	35	30

*One MHC not in an agency setting
†Two MHCs worked at this agency: 2nd & 3rd years

The evidence suggests that each MHC worked many hours. To study this more closely, information from the third year of employment was obtained from a monthly report form (see Append. F), and is given in Table II-6.

TABLE II-6
DAYS WORKED BY MHCs: (May 1, 1964 to April 30, 1965)

MHC	Days Employed Per Week	Total Days Worked 1964-1965	% Possible Days 1964-1965†
1	5	232	95
2	5	226	95
3	5	234	95
4	5	229	95
5	3	113	54
6	2	48	23
7	5	221	95
8	5	*	†

*Not in agency setting

†The possible number of workdays in this period varied slightly in different agencies. Account was taken of the vacation month and the percentage derived from the average days per month based on 253 possible working days during the period.

The percentage of days worked follows a similar pattern found during a part of the Second Year, (see Golann and Magoon, 1964).

During the third year of employment, each MHC's caseload was analyzed. Information about terminated clients was obtained from the monthly report form. A listing of the types of problems encountered by the MHCs appears in Appendix G. In addition, cases carried, but not terminated were determined by including each MHC's active cases as of April 30, 1965. The information gained about patient characteristics and number of cases, type of interview, and amount of contact is found in Tables II-7 and II-8.

While agency policies differ in terms of recording cases seen and carried in any given year, a conserva-

tive estimate suggests that the seven MHCs have had contact with 317 different patients during the year May 1, 1964 to April 30, 1965.

This included problems which were described primarily in situational terms such as "academic difficulty," "threatened school drop out," others described primarily in interpersonal terms such as "trouble with boyfriend," "marital conflict" and many described in neuropsychiatric terms including affective disorders, personality disorders, neurotic disorders and psychotic disorders. The modal patient was female, between the ages of 30-39 and had had 13 to 16 years of formal education.

When the caseload in terms of individual and group interviews is examined, there is a variety among the seven MHCs. Over one-half are currently doing group therapy in addition to individual therapy. One (MHC No. 3) is seeing almost all her patients in groups. The median number of sessions for cases carried indicates that over half are seeing patients on a long term basis.

This section has given an added dimension to the characteristics of the MHCs' work by presenting caseload information. Such information gives substance to the context within which they worked and the functions they have performed.

TABLE II-7
CHARACTERISTICS OF PATIENTS SEEN BY MHCs
MAY 1, 1964—APRIL 30, 1965

MHC	Total No Patients	Sex of Pt. M	Sex of Pt. F	Age 5-13	Age 14-19	Age 20-29	Age 30-39	Age 40-49	Age 50-59	Age 60 and Over	Age No Resp.	Education 1-8	Education 9-12	Education 13-16	Education Over 16	Education No Resp.
1	63	28	35	15	7	4	20	14	3	-	-	20	28	14	1	-
2	59	28	31	14	11	5	19	8	2	-	-	19	29	8	3	-
3	57	12	45	8	2	2	29	14	2	-	-	8	8	37	4	-
4	56	24	32	-	11	24	16	2	2	1	-	2	27	26	1	-
5	20	3	17	1	6	7	4	-	2	-	-	2	15	1	-	2
6	27	0	27	-	16	11	-	-	-	-	-	-	-	27	-	-
7	35†	11	24	-	2	5	7	3	-	-	18	2	4	10	-	19
8*																
TOTALS	317	106	211	38	55	58	95	41	11	1	18	53	111	123	9	21

*Not seeing patients during this period
†Figures estimated from partial information

Table II-8
Caseload of MHC's May 1, 1964 - April 30, 1965

M H C	Days Worked (Weekly)	Caseload	Cases Terminated	Individual	Median Sessions	Group	Median Sessions	Cases Carried	Individual	Median Sessions	Group	Median Sessions
1	5	63	20	11	17	9	10	43*	13	38	34	13
2	5	59	11	11	22	0		48*	16	23	33	15
3	5	57	1	1		0		56*	23	31	50	44
4	5	56	33*	33**	9	33	80	23*	23	3	23	60
5	3	20†	10	10	19	0		10	10	11	0	
6	2	27	23	23	6	0		4	4	6	0	
7	5	35††	16††	14	17	2	26	19††	19	30	0	
8*†												
Total		317	114	103		44		203	108		140	

*Some patients participated in both Individual and Group sessions.
†Change of setting during the year
**Brief Interviews
††Numbers estimated from partial information
*†Not seeing patients during this period

VOCATIONAL ASPIRATIONS

Introduction. — In addition to learning what the MHCs were doing each year, it was also important to learn of their expectations regarding future job functions. A comparison of their actual functions with those functions "aspired to" suggests the direction their work may take, their utilization by agencies and also might be viewed as a measure of "job satisfaction." If there is a close relationship between job functions performed and job functions "aspired to," it may be inferred that the individual is satisfied with what she is doing. While there are other significant aspects to job satisfaction, this comparison of functions performed and functions aspired to is worth examining.

Job Functions Aspired to. A first step is to look at the functions which MHCs report they would like to perform in the future. Such information is available from a segment of the yearly administration of the IJF. Over the three years of follow-up, the instructions given regarding aspirations focused on the year 1966. They read as follows:

First Year Instruction: "Indicate job functions you would like to be performing in three years."

Second Year Instruction: "Indicate job functions you would like to be performing in two years."

Third Year Instruction: "Indicate job functions you would like to be performing in one year."

The way instructions were phrased, there was really one question, "What would you like to be performing in 1966?" Thus the MHCs' aspirations represent different perceptions of that year as it gets closer. Table II-9 contains the ranked percentages of functions aspired to for each year and for the composite three year period.

These data indicate that the functions aspired to are generally the same as the functions performed (that is Direct and Indirect Service and Professional growth) with the addition of Community and Professional functions which the MHCs wish to perform and are not presently doing.

The foregoing information has been presented in terms of categories and the percentage of functions aspired to. Aspirations regarding each individual function also have been considered across the three years. A measure of stability of aspirations can be derived from an analysis of aspirations for each function, year by year. All MHCs responded "Yes" each year to 27 of the 108 IJF items. All MHCs checked "No" each year to seven items. On 31 per cent of the items, there was both consensus and stability in aspiration. The 34 items are noted in Appendix D and are comprised primarily of Direct and Indirect Client Service type of functions.

It is interesting to note that the MHCs individually had quite stable aspirations about their future functions. For example, each MHC responded the same way every year to a minimum of 69 per cent of the functions. Thus there is consensus across MHCs and consistency within each MHC as to the functions they aspire to perform. And, from the description of the Pilot Training Program's expectations, the MHCs mainly aspire to those functions for which they were trained.

TABLE II-9
PERCENTAGES OF FUNCTIONS "ASPIRED TO" BY MHCs IN EACH CATEGORY ON THE IJF

IJF Category	N Functions	Lowest							Highest	Year
1. Educating-Training	10	20	20	30	30	30	50	80	80	1st
		10	10	30	40	60	70	70	90	2nd
		20	40	40	50	50	60	90	90	3rd
		27	37	40	47	47	50	70	70	Composite
2. Administrative-Clerical	20	20	20	25	35	35	40	50	55	1st
		15	20	30	35	40	40	45	45	2nd
		20	25	30	30	30	35	45	50	3rd
		20	23	28	35	38	42	42	43	Composite
3. Community and Professional	7	14	29	57	86	86	100	100	100	1st
		14	43	43	71	71	86	100	100	2nd
		0	57	86	86	86	100	100	100	3rd
		24	38	52	81	81	90	100	100	Composite
4. Professional Growth	6	83	83	83	100	100	100	100	100	1st
		83	83	100	100	100	100	100	100	2nd
		83	83	100	100	100	100	100	100	3rd
		89	89	94	94	94	100	100	100	Composite
5. Research-Scientific	9	0	11	22	33	44	56	89	89	1st
		0	0	33	33	56	46	89	89	2nd
		0	0	22	89	89	89	100	100	3rd
		0	15	15	52	63	81	81	89	Composite
6. Direct Client Service-Evaluative	9	44	44	44	67	67	78	78	78	1st
		33	44	44	67	78	78	78	78	2nd
		44	56	67	67	67	67	78	78	3rd
		41	48	59	63	70	70	78	78	Composite
7. Direct Client Service-Helping	36	78	78	73	73	73	76	76	89	1st
		80	83	83	83	83	86	89	92	2nd
		78	78	80	86	89	89	92	94	3rd
		79	80	82	85	86	87	89	90	Composite
8. Indirect Client	11	55	73	100	100	100	100	100	100	1st
		73	91	91	91	100	100	100	100	2nd
		82	100	100	100	100	100	100	100	3rd
		76	91	94	97	97	97	100	100	Composite

Comparisons of Job Functions "Aspired To" with Job Functions "Currently Performing." Previous sections have presented information on the types of functions MHCs were actually performing and those types of functions MHCs wished to perform in the future. What was the correspondence between the category of functions they performed most and the category to which they most frequently aspired?

Comparison of the data presented in Table II-9 and II-3 suggests that the type of functions the MHCs aspire to perform corresponds closely with the type of functions they had been performing during the three years. In both analyses, direct and indirect client services stand out from the rest. One additional type of activity that several MHCs were apparently becoming more interested in was the type of function described as community-profession.

Analysis of the response correspondence for all items comparing functions each MHC reported performing with functions she aspired to facilitated a quantitative analysis of the overall correspondence between functions and aspirations. Table II-10 presents the results of this analysis.

In addition to a category consideration, a function-by-function correspondence was determined between job functions each MHC was performing and those which she aspired to for each year.

The general pattern was for a closer correspondence during the second year with the first and third years somewhat lower. These findings warrant a general observation. Considering the fact that these were new trainees, who had recently completed a relatively short, non-degree program, and who had just started to work in established service agencies staffed by traditionally

TABLE II-10
FUNCTION BY FUNCTION CORRESPONDENCE OF MHCs' JOB FUNCTIONS AND ASPIRATIONS FOR THREE YEARS OF EMPLOYMENT
(CORRESPONDENCE EXPRESSED BY PHI COEFFICIENTS*)

M H C	First Year	Second Year	Third Year
1	.64	.73	.61
2	.68	.86	.70
3	.62	.60	.56
4	.41	.47	.31
5	.45	.68	.46
6	.74	.56	.62
7	.40	.56	.49
8	.38	.43	.10†
Overall:	.52	.60	.50

*All phi coefficients are significant at .01 except MHC No. 8 for 1965.
†Not in agency setting.

trained mental health personnel, the correspondence between job functions they were performing in the first year and job functions to which they aspired is surprisingly high. The most change in the third year was MHC No. 8 who had changed out of an agency setting.

The data from which the phi coefficients were computed add a further piece of information. The correspondence between present and future was decreased more by those functions a MHC was not currently performing but aspired to, than by those functions they were currently performing but did not want to perform in the future. This is consistent with other information concerning the MHCs' desire for further professional growth.

SUMMARY

This chapter has presented descriptive material concerning the employment of MHCs during the period 1962-5. The settings and staff were described to give a context to the employment. The shifts in employment are described to complete this background. The characteristics of MHCs' work in these agencies were presented from two sides: First, through descriptions of job functions and roles performed; and second, through their actual case load information. The last section presented the vocational aspirations of the MHC's and related these to their current performance.

CHAPTER III

EVALUATIONS OF MENTAL HEALTH COUNSELORS DURING THEIR INITIAL THREE YEARS OF EMPLOYMENT

INTRODUCTION

EVALUATIONS of the MHCs during their training period have been reported by Rioch *et al.* (1965). A number of procedures were used during the two year training program including on-the-job ratings, judgments of tapes, instructor ratings and ratings by special examiners. In general, the results reported were quite postive. In concluding, Rioch stated ". . .that all of these methods of evaluation are attempts to do the impossible, namely, to give some kind of objective measure of the performance of these students as therapists," and that, "The significance of this program can be evaluated fully only later, when the results of the 3-year follow-up study. . .are reported" (p. 24).

The difficulties of evaluation during the training period were, of course, compounded when the MHCs began salaried positions at several mental health agencies. At the same time, any information concerning the MHCs' performance in the actual working situation promised to be important for the planning of subse-

quent programs. Therefore, we did what we thought would be possible: (a) collect judgments of the MHCs' performance from a number of perspectives; (b) adapt and develop procedures to help systematize these judgments; and (c) try out certain techniques which might permit the comparison of MHCs with known professional groups under conditions which could be duplicated.

The evaluations of the MHCs are presented in six sections which concern: (a) supervisor evaluations of on-the-job performance; (b) co-worker evaluations of on-the-job performance; (c) judgments of tape recorded interviews; (d) comparison with traditionally trained groups on measures of attitude, clinical judgment and information; (e) potential job function and role contribution to mental health agencies; and (f) employability potential as perceived by directors of mental health agencies and mental health training. The sequence of presentation is the same.

SUPERVISOR EVALUATIONS OF THE MHCS'-ON-THE-JOB PERFORMANCE

Rating Scale Evaluations by Supervisors. During each year of employment, judgments of the quality of the MHCs' work with their clients were provided by their psychotherapy supervisors. During the three year period there were 21 supervisors including 18 psychiatrists, one school counselor, one social worker, and one psychologist. Ratings of the MHCs' performance were provided by 20 of the 21 supervisors one or more times during the three years (see Appendices H, I, & J).

Table III-1 summarizes the supervisors' general

evaluations of the quality of the MHCs' performance as compared with new therapists or counselors. In no instance was the quality of a MHC's therapy rated as below the average of new therapist or counselors in

TABLE III-1
RATINGS OF QUALITY OF MHCS' THERAPY
COMPARED WITH NEW THERAPISTS IN GENERAL

Rating	Year of Employment 1st*	2nd†	3rd**	All Supervisors††
Far Above Average	3	3	1	5
Above Average	5	4	2	10
Average	0	1	3	5
Below Average	0	0	0	0
Far Below Average	0	0	0	0

*Includes one rating of each MHC by her initial therapy supervisor.

†Includes one rating of each MHC by her second year supervisor. One MHC had two supervisors whose ratings were the same and are presented as one.

**Only six MHCs are rated here. One supervisor did not complete the form and one MHC had a position where she did not see clients. Four of these six MHCs were rated by two supervisors. There were two instances of agreement where ratings were in adjoining categories. Where there was not perfect agreement, the rating of the supervisor who had worked with the MHC the longest time was used.

††In all, 20 different supervisors provided ratings over the three year period. The most recent rating provided by each is included here.

general. The ratings of all MHCs in the first year of employment, and seven of the eight in their second year placed them above the average or far above the average as compared with this same group. Only in the third year were as many as three of six MHCs

rated as low as "Average" compared with new therapists in general. It is difficult to explain this trend because of changes in the raters and number of MHCs being rated.

Over the three year period, 20 different supervisors provided judgments of the MHCs' performance in psychotherapy. Of the 20 supervisors, 10 rated the MHCs performance as "Above Average," five rated the MHCs performance as "Far Above Average" and five as "Average." Compared with new therapists or counselors starting their first professional position, the evaluations of the MHCs' therapy performance are very positive.

To introduce more specificity into the ratings, two more comparison groups were used. Table III-2 summarizes the judgments of these same supervisors as they compared the MHCs' performance with that of the MSW Social Worker starting her first regular position.

TABLE III-2

MHCs' THERAPY COMPARED TO NEW SOCIAL WORKERS*

Rating	Year of Employment 1st	2nd	3rd	All Supervisors
Far Above Average	2	4	2	4
Above Average	5	3	1	8
Average	1	1	3	5
Below Average	0	0	0	1
Far Below Average	0	0	0	0
Don't Know	0	0	1	2

*Provided by the same groups as described in Table III-1 in answer to the question "compare the quality of Mrs. .. .. performance with that of the Social Worker (MSW) starting her first post-masters position."

Again, the ratings are positive. Only one of 20 supervisors rated an MHC's performance as below the average of new Social Workers. Four rated the MHCs' performance as "Far Above Average," eight as "Above Average," and five as "Average." Two supervisors felt they had no basis for comparison. No differences among the three years' ratings are apparent.

The next evaluation required that each supervisor compare the MHCs with the group with which he was most experienced. After choosing the reference group with whose counseling or therapy the supervisor was most familiar, he again rated the MHCs' performance. These data are summarized in Table III-3.

TABLE III-3
SUPERVISOR RATINGS OF PERFORMANCE OF MHCs COMPARED WITH SELECTED REFERENCE GROUPS

Compared with:	Experienced Psychiatrists*	Psychiatric Residents†	Psychologists**	Social Workers††	School Counselors	
Far Above Average	0	0	0	1	0	1
Above Average	2	3	0	2	1	8
Average	1	3	1	1	0	6
Below Average	3	1	0	0	0	4
Far Below Average	1	0	0	0	0	1
TOTALS	7	7	1	4	1	20

*Psychiatrists having completed more than 2 years of residency, starting their first post-resident position
†Psychiatrists having completed less than 2 years of residency
**Clinical Psychologists (Ph.D.) starting their first post-doctoral position
††Social Caseworkers (MSW) starting their first post-masters position

Overall, three-quarters of the ratings depict the MHCs as "Average" or better. Experienced psychiatrists were the most difficult comparison group with four of seven ratings being below the average. Psychiatrists with less than two years of residency constituted a less difficult comparison group with six of the seven ratings being average or better.

Overall, 20 supervisors rated the therapy performance of the eight MHCs during their first three years of employment. These ratings were very positive as compared with new therapists in general and with new Social Workers. When the MHCs are compared to a reference group with whose work the supervisor is most familiar (typically the profession of the supervisor), the ratings are distributed over a wider range with a median and mean of "Average."

Supervisor Judgments on Therapists' Characteristics Sort. A second procedure involved a description of the MHC and a comparison of her attributes and techniques with her supervisor's description of the above average and the below average new psychotherapist.

The Therapists' Characteristics Sort*, (TCS; see Append. M) consists of 104 items which describe attributes or procedures of psychotherapists. Illustrative items are: "tries to elicit affect from the client" or "seems accepting of the client." After the first year and again after the second year of the MHCs' employment, the supervisors were administered the TCS under two different sets of instructions.

*A large number of the items were taken or adapted from an experimental Q-Sort being developed by Drs. Ronald Fox and Hans Strupp of the University of North Carolina.

The first administration required that each supervisor evaluate each item as either, (a) "Characteristic" or (b) "Uncharacteristic" of the MHCs' current work with clients. The second administration required the supervisor to sort each of the same 104 items two to four months later as characteristic of either the "Above Average" or "Below Average" new therapist or counselor.

These data provide four frequency scores for each MHC. The four scores were the number of items which, in the supervisor's judgment, were: (1) characteristic of the MHC and also the above average new therapist; (2) uncharacteristic of both the MHC and the above average new therapist; (3) characteristic of the MHC and also the below average new therapist; and (4) characteristic of the above average new therapist, but not characteristic of the MHC. The first two frequencies would connote a positive evaluation of the MHC; the latter two, a negative evaluation.

A Phi Coefficient was used to express the extent to which these four scores departed from a chance distribution of 26 items in each cell. Inspection of the table then shows if the departure connotes a positive or negative evaluation. Over the first two years, 16 such comparisons were made from the judgments of 14 different supervisors. In all 16 comparisons, the results were statistically significant and connoted a positive evaluation. The distributions and the Phi Coefficients are summarized in Table III-4.

The lowest of the 16 coefficients was .34. Here the evaluation was positive and significant but primarily because the characteristics of the below average new therapist, as seen by her supervisor were not shared by the MHC. The highest of the coefficients was .87

which connotes a very positive evaluation. Here the MHC was described as demonstrating almost all of the attributes which her supervisor considered to be characteristic of the above average new therapist, yet demonstrating few of those he rated as characteristic of the below average new therapist. The remaining coefficients ranged between these values as may be seen in the table. These data are, in general, consistent with the previous supervisor ratings in that a few are very positive, most are positive, and a few less positive, but not negative.

TABLE III-4
FREQUENCIES OF ITEM CORRESPONDENCE BETWEEN TWO ADMINISTRATIONS OF THE THERAPIST CHARACTERISTICS SORT

Mental Health Counselor*		Year	Characteristic of New Psychotherapists Who Are: Above Average	Below Average	Phi
1	Characteristic	1st	39	16	.40
	Uncharacteristic	1st	15	34	
	Characteristic	2nd	48	10	.69
	Uncharacteristic	2nd	6	40	
2	Characteristic	1st	62	7	.72
	Uncharacteristic	1st	6	29	
	Characteristic	2nd	50	19	.58
	Uncharacteristic	2nd	4	31	
3	Characteristic	1st	46	6	.81
	Uncharacteristic	1st	4	48	
4	Characteristic	1st	60	7	.75
	Uncharacteristic	1st	5	32	
	Characteristic	2nd	51	11	.53
	Uncharacteristic	2nd	13	29	

TABLE III-4 Contd.

Mental Health Counselor*		Year	Characteristic of New Psychotherapists Who Are: Above Average	Below Average	Phi
5	Characteristic	1st	37	16	.35
	Uncharacteristic	1st	18	33	
	Characteristic	2nd	52	8	.77
	Uncharacteristic	2nd	4	40	
6	Characteristic	1st	48	7	.81
	Uncharacteristic	1st	3	46	
	Characteristic	2nd	48	6	.87
	Uncharacteristic	2nd	1	49	
7	Characteristic	1st	47	10	.67
	Uncharacteristic	1st	7	40	
	Characteristic	2nd	41	8	.62
	Uncharacteristic	2nd	12	43	
	Characteristic	2nd	48	14	.64
	Uncharacteristic	2nd	5	37	
8	Characteristic	1st	48	9	.69
	Uncharacteristic	1st	7	40	
	Characteristic	2nd	28	18	.34
	Uncharacteristic	2nd	16	42	

*In Year 2, MHC No. 7 was rated by two supervisors and MHC No. 3 was not rated on the TCS.

Supervisor Comments on the Final Report. A final evaluation form was sent to all of the MHCs' current and former supervisors who had retained their agency affiliations toward the end of the third year of follow-up. This Final Report (see Append. J) differed from earlier supervisor questionnaires in two ways: (a) it was not administered as a semi-structured face-to-face interview, but instead was completed by the super-

visor himself; and (b) it asked more specifically for reservations about the MHC's work. Of the 17 Final Reports sent, 16 were completed, representing ratings of all MHCs by 15 different supervisors.

The ratings which have been presented revealed the generally positive impressions formed by the MHCs' supervisors. Such ratings, however, do not allow for elaboration and qualification. Did the supervisors have preferences concerning the types of patients the MHCs should see or qualification of their general ratings? Many did report such information in answer to specific questions.

Of the 16 supervisors, 10 responded "yes" to the question "were there certain types of patients that you preferred the MHC to work with?" and 9 responded "yes" when asked if there were types of patients they thought the MHC should *not* work with. Type of patients preferred for MHCs by their supervisors were:

(a) neurotics
(b) neurotic acting-out children
(c) emotional problems
(d) adolescents with situational problems
(e) women with depressive reactions
(f) the most sick patients
(g) adolescent girls
(h) emotionally disturbed pupils
(i) recreational and vocational problems.

Patients that supervisors preferred a MHC *not* work with were:

(a) psychotics
(b) patients with suicidal potential
(c) academic and financial problems
(d) very sick adults who try to defeat therapy

(e) very dependent patients
(f) lower socio-economic classes
(g) acting out patients
(h) character disorders who are subtly self-destructive
(i) chronic disciplinary problems
(j) patients with insurance policies specifying M.D.s.

Typically these preferences pertained to only one or two of the MHCs. Several supervisors expressed no preferences. The actively or subtly self-destructive patient and the most disturbed patients are most often mentioned as patients that the supervisors preferred the MHC not work with. On the other hand, the patients certain supervisors preferred the MHC to work with were often the most disturbed at that particular setting.

Another question which attempted to elicit reservations or further qualification of the supervisor's evaluations of the MHC's therapy was: "In her *work with patients,* what types of things would you have liked the MHC to do that she was often *unable* to do?" No such qualifications were indicated in 7 of the 16 supervisor ratings. The comments that were reported follow:

(a) separate the reality of a situation from the neurotic conflicts of the patient and tend to minimize the latter.
(b) be more patient and less depending on reward derived from patients responding favorably.
(c) getting therapy underway-intake type work.
(d) stick with dealing with the patient and his feelings.
(e) could have used more knowledge of psychic structure and development, especially psychosexual.

(f) should have been tougher and less giving.

(g) be a little more flexible.

(h) gain more distance to notice the transference implications of patient's activity and to inhibit more her own "helpful" and "mothering" activity.

(i) correlate closer with entire staff, more follow-up activities.

A similar question pertained to the MHCs' *other work in the agency,* aside from her work with patients. No reservations were indicated on 11 of the 16 ratings. The reservations that were reported follow:

(a) communication lag between MHC and the administration.

(b) intake type work; lacked skill and judgment in deciding what was needed and guiding them to it.

(c) concentrate on more basic principles of psychotherapy before launching so enthusiastically in several directions at once.

(d) disseminating test data bearing on the patients and playing a more prominent role in curriculum planning for her patients.

(e) in the last several months, we have observed an undue degree of competition with professional staff (social workers and psychiatrists) in the agency and think this may be a reflection of her difficulty in assessing her own role and identity in the profession. I also feel that she has not been as supportive to various people in training in the agency as she should have been.

These two questions did elicit a number of reser-

vations or qualifications from the supervisors pertaining especially to the therapy situation and the MHCs' work with patients. Other reservations involved communication problems, staff relationships, and scope of training. It should be kept in mind that on all of these same 16 Final Reports, the general rating of the MHCs' work with patients was average or better and that nine of the 16 were rated as above average or better.

Particularly effective features of the MHCs' work were likewise quite variable. Of the 16 ratings, 14 indicated some facet of *patient work* where the MHC was particularly effective. These were:

(a) individual therapy.

(b) interpretation of self; willingness to see clients at all hours.

(c) able to be interested, curious and involved, but without fostering dependence—allows patients much autonomy.

(d) has an excellent clinical sense, seemed to grasp the essentials of a clinical problem, had good empathic capability, could present interpretations and clarifications very well, and provides a good quality of support.

(e) has the ability to establish good relationships, especially with adolescents.

(f) helping them examine feelings.

(g) the more sick the patient, the more effective her work seemed to be.

(h) effective with youths and particularly adolescent males.

(i) very good with children.

(j) forming warm, trusting relations; giving more of herself than called for.

(k) caseload.
(l) involved and interested.
(m) very good with adolescent girls.
(n) quite ready to be always available to her patients, greatly increasing her ability to establish contact with acting-out teenage girls.
(o) establishing rapport with patients, parents and teachers; gathering information of cause and effect relationships; utilizing current data in the field.

Particularly effective features of MHCs' *other work in the agency* were indicated in 10 of the ratings. These were:

(a) development of non-professional staff.
(b) work with parents of children to aid understanding.
(c) clarity and professional attitude in dealing with administration.
(d) assumes responsibility; ambitious.
(e) bringing ideas, feelings and creative potential to clinic morale.
(f) aggressive, energetic and enthusiastic; has stimulating ideas.
(g) flexible, partly because of lack of clear professional definition.
(h) stabilizing influence among other female professionals.

Inspection of these comments on the Final Report revealed both reservations and praise concerning MHCs' work which serve to clarify the general ratings presented earlier. These comments suggested the conclusion that the overall impression of the MHCs' work was one of a high degree of effectiveness.

CO-WORKERS' EVALUATIONS OF THE MHCs' ON-THE-JOB PERFORMANCE

The largest number of impressions of the MHCs' on-the-job performance were provided by their co-workers at the several agencies. These were obtained at the end of each of the three years (see Appendices K & L).

Initial Interviews. Semi-structured individual interviews which lasted from 20-35 minutes were conducted by the evaluation staff during the first two years. The co-workers were asked to give a professional opinion of their MHC and her work in the agency and to describe the following: (a) the MHC's greatest strength; (b) the MHC's greatest weakness; (c) how her training might have been modified; (d) contribution of the MHC compared with traditionally trained new staff members; and (e) feelings about having the MHC as a colleague for the next five years.

In most of the settings, the group of co-workers was heterogeneous and included social workers, psychiatrists, psychologists and, in some settings, additional personnel. The exception occurred for one MHC who spent her first year in a high school counseling service where she functioned essentially as school psychotherapist. Her co-workers were seven certified school counselors. The reaction of these seven counselors to the MHC was very positive. Of the seven co-workers interviewed, six made specific mention of the effectiveness of the MHC's work with students. These were very positive comments such as, "She has contributed more to our counseling effectiveness than anyone else in our department"; and "she has done an excellent job."

Additional characteristics of this MHC's work that

were praised were: (1) her interactions with students' parents; (2) her knowledge and use of community resources to which students could be referred; and (3) her interactions with her co-workers. Three of the co-workers reported that they had used the MHC as a resource for consultation concerning their own work with students. All of the co-workers appreciated the availability of someone who had both the time and the training to work with more seriously disturbed students.

There were few criticisms or reservations expressed by the school counselors. One felt that the MHC should share more fully in the administrative-clerical duties and spend less time on psychotherapy. Inexperience with routines and communication channels was mentioned by two co-workers, and one thought the MHC's approach to students seemed to be too permissive.

The reactions of the co-workers at the seven other agencies toward the end of the first year were much the same. Some were exceptionally positive such as the following comment made by a staff psychiatrist: "She's a remarkably competent person . . . to put it directly, when I was looking for a co-therapist, she was my first choice of anybody on the staff. . ." And this comment was made by a chief social worker: "Her capacity for work and the load she has taken on, strike me as phenomenal; she's seeing more patients, individual and group, than anybody else here. If any of the social workers I had hired had done as well, I would be delighted."

Most co-worker reactions were not so unusual, but still clearly positive. For example, a staff social worker at another agency said that she liked to see people of the MHC's caliber identified with the agency, that the MHC was extremely competent in her work, and

that she had a large amount of knowledge which she was able to utilize in a kind of teaching way. A public health nurse at the same agency described the MHC's work as "terrific" and said that she had "personally gained a great deal of understanding from discussing dynamics with her . . . ." A psychiatric resident at another agency stated that the MHC was "capable of treating patients in psychotherapy." The head nurse at the same agency reported that the MHC helped her to help patients and gave her excellent suggestions. At an in-patient setting, the attendants and aides were rather guarded or hesitant in offering opinions. One reported that she felt free to talk to the MHC and say what she wanted to say and also that she thought that the MHC may have overestimated the truthfulness of many things the patients said.

No serious reservations were apparent after the first year's work at any agency concerning a MHC's work with clients or her interpersonal relationships. In one setting, it was mentioned that the MHC's training had not fully equipped her to respond appropriately to the crisis situations which arise on a milieu ward for seriously disturbed young adults. A psychiatrist also felt that the MHC tended to get taken in by psychopaths. At another agency, it was stated that the MHC dealt too much on a reality level. While her "fresh, common sense" approach was praised, it was thought she tended to explain away too much pathological behavior and still had a lot to learn.

The only reservations that were mentioned at more than one agency were as follows:

(a) The MHC at times appeared to be over-involved with either the dynamics of an individual or with the individual himself and did not show

the detachment characteristic of a more experienced professional.

(b) A MHC at times seemed impatient to see therapeutic results, to know that she was accomplishing something.

(c) The MHC tended to undervalue herself and the contribution she was capable of making.

(d) Initially the MHC did not know the ropes of the agency and did not coordinate her interviews at all times with the appropriate personnel.

These reservations with the exception of "overinvolvement," were not noted in our interviews conducted after the second year. These interviews provided the following information:

(a) Overall co-worker opinions continued to be highly positive.

(b) Co-workers at a number of agencies noted that the MHC had become more self-assured and confident permitting more effective interaction with clients and staff members.

(c) Over-involvement of one type or another was still mentioned at more than one agency. (For example: "She tended to be much more personally involved with her patients; I tend to be colder and a bit more aloof . . .").

(d) Impatience for results was mentioned only once and communication problems not at all.

Termination Interviews. Another series of interviews conducted at three agencies after the MHC had terminated employment concerned retrospective evalua-

tions and explanations of termination. These interviews revealed the following trends:

(a) Almost all of the co-workers seemed quite disappointed that the MHC had left their agencies. Many described a feeling of personal loss as well as a professional one.

(b) Their MHC's leaving was reported to have had effects on her patients, (who were reported as missing her, expressing affection for her, or having positive transference).

(c) The MHCs' leaving was reported to have made a notable difference in the working force. In some agencies cases were transferred and duties realigned as necessary, but the reduced total number of manpower hours was noted. In other agencies programs or services which the MHC had provided were discontinued.

(d) All of the co-workers interviewed and the directors of the agencies, answered affirmatively the question: "If there were another woman available for employment, who had been trained non-traditionally in a way similar to Mrs. X, what would your recommendation toward hiring her be?" One of these agencies has, in fact, hired a second MHC.

CO-WORKERS' FINAL QUESTIONNAIRE

Near the end of the third year of employment, a final questionnaire was sent to the 39 co-workers of seven MHCs*. In all, 33 different co-workers completed

*One MHC had taken an administrative-training position and was not performing mental health services.

39 forms describing their working relationship with and evaluation of the MHCs.† This is equal to an 85 per cent rate of return which includes all of the MHCs' full-time co-workers during this third year. Of the six co-workers who did not respond, four were part-time employees and two were new in their position.

Included among the 33 co-workers were 13 social workers, eight psychiatrists, five psychologists, three psychiatric nurses, one chaplain, one public health nurse, one administrative officer, and one remedial therapist.

All of the 13 social workers had their Masters' degrees. Their years since degree ranged from 0 to 29 with a median of six years. The seven psychiatrists were less experienced than the group of psychiatrists who supervised the MHCs; four had less than five years experience since the completion of their M.D. degree. Of the five clinical psychologists, one had eleven years of post doctoral experience, one had 29 years of post-Masters' experience, and three others had Masters' degrees and several years of experience.

The length of time the co-workers had worked in the same agency with a MHC ranged from 5 to 48 months with a median of 17 months. During this time, there were many occasions for collaboration between a MHC and one of her co-workers. Frequently reported types of collaboration included a milieu team, shared intake responsibilities, conferences and team therapists. The primary type of collaboration reported by each of the co-workers is summarized in Table III-5.

†Two MHCs were working at one agency. Their six co-workers each completed two forms. (see Appendix L).

TABLE III-5
COLLABORATION ON JOB FUNCTIONS REPORTED BY MHCS' CO-WORKERS

Primary Collaboration	Number of Co-Workers
Milieu Ward Team*	7
Conferences†	7
Intake and Referral	6
Individual Psychotherapy**	5
Group Therapy††	4
Mental Health Consultation*†	1
None or No Response	3
TOTAL	33

*Involves group planning meetings, daily rounds, staff meetings, group therapy, etc.

†Includes administrative, case, staffing and supervision conferences

**Team-therapy, each seeing different members of one family

††Co-therapists in one or more groups

*†Group consultation with Public Health Nurses

Typically the co-workers did not supervise the MHC or have the responsibility for determining how the MHC's services would be utilized. The frequency with which the 33 co-workers reported that they determined what job functions the MHC would perform or helped select the patients the MHC would see is summarized in Table III-6.

The table suggests that these co-workers rarely were administratively responsible for the MHCs' work. The

TABLE III-6

CO-WORKERS' ADMINISTRATIVE RESPONSIBILITY FOR MHCs

Frequency	Number of Co-Workers Who: Determined MHCs' Job Functions	Number of Co-Workers Who: Helped Select MHCs' Patients
Always	0	1
Usually	1	2
Occasionally	11	12
Never	20	18
No Response	1	0
TOTAL	33	33

co-workers expressed general satisfaction with the ways the MHCs' services were utilized. Asked if there were certain types of work they thought the MHC should do more of and certain types less of, 17 of the 33 co-workers responded negatively to both questions suggesting that they would leave her job functions essentially as is. Of the 16 co-workers who responded "yes" to either of the questions, 11 suggested more job functions such as more individual therapy or consultation with no consequent reduction in other functions. The remaining five of the co-workers would have wanted to see some change of emphasis in the utilization of the MHCs' time such as more work with adolescents and less with parents.

Many of these co-workers had considerable opportunity to observe the MHC perform a variety of functions in the working situation. Several questions were

asked of them concerning their evaluation of the quality of the MHC's work with patients and of her overall work in the agency.

Table III-7 summarizes the global evaluations of the co-workers when they were asked to compare the MHCs' therapeutic work with that of new counselors or therapists starting their first professional position.

TABLE III-7
GLOBAL RATINGS OF MHCs' THERAPY PERFORMANCE BY AGENCY CO-WORKERS*

Rating	N
Far Above Average	13
Above Average	11
Average	11
Below Average	2
Far Below Average	0
No Response	2
TOTAL	39

*There are 39 ratings in each of these and several subsequent tables since six of the 33 co-workers were rating 2 MHCs. For analyses where the evaluation was of specific MHCs, the 39 ratings are presented.

Of the 39 ratings, 24 evaluated the MHCs' work as "Far Above Average" or "Above Average" as compared with the new therapist or counselor. Only two of the 39 ratings described the MHCs' performance as below the average of this group.

How would these co-workers evaluate the MHC compared with a group they knew best? Table III-8 shows the co-workers' evaluations of the MHCs' performance

as compared with the group with whose therapy the judge was most familiar.

TABLE III-8
CO-WORKER RATINGS OF PERFORMANCE OF MHCs
COMPARED WITH SELECTED REFERENCE GROUPS

Compared With:	Experienced Psychiatrists*	Psychiatric Residents†	Social Workers**	Clinical Psychologists††	Clergy	TOTALS
Far Above Average	4	0	5	1	0	10
Above Average	4	1	3	0	1	9
Average	2	1	4	0	0	7
Below Average	6	1	2	0	0	9
Far Below Average	2	0	0	0	0	2
TOTALS	18	3	14	1	1	37*†

*Psychiatrists, having completed more than 2 years of residency, starting their first post-resident position.

†Psychiatrists, having completed less than 2 years of residency.

**Social Workers (MSW) starting their first post-masters position.

††Clinical Psychologists (Ph. D.) starting their first post-doctoral position.

*†Two (no response) co-workers did not respond.

Regardless of selected groups, over 70 per cent of the co-workers evaluate the MHC as "Average" or above. Compared to experienced psychiatrists, eight ratings placed the MHC as "Above Average," eight as "Below Average." Overall, both sets of ratings suggest a positive evaluation of the MHCs' work with patients on the part of their co-workers at the several agencies.

The co-workers also evaluated the MHCs on a greater range of dimensions pertaining to the MHCs' contribution to the agency. In these ratings which supplement judgments of therapy performance, the MHCs were compared with the traditionally trained new staff member.

Comparisons of MHCs' Contribution in the Agency. Table III-9 summarizes the 39 judgments comparing a MHC with the traditionally trained staff member in the agency on a variety of attributes.

TABLE III-9
CO-WORKER COMPARISONS OF MHCs WITH TRADITIONALLY TRAINED STAFF

Dimension	Co-Worker Ratings of MHCs			
	More Than Avg.	About Avg.	Less Than Avg.	No Resp.
Identification with the agency	19	16	3	1
Effort and work output	25	11	1	2
Contribution to case discussions	19	15	4	1
Source of new ideas	21	15	2	1
Openness to new ideas	29	7	2	1
Friendliness	24	11	3	1
Co-operativeness	28	8	2	1
Job satisfaction obtained	20	14	1	4
Role definition achieved	16	9	10	4
Overall contribution to the agency	25	11	2	1

The modal rating by co-workers is "More than Average" for every dimension rated — a highly favorable evaluation. The MHCs are typically described as open

to new ideas and as friendly. Both their work output and their overall contribution to the agency tends to be rated as above average by their co-workers. A clear role definition — knowing who she is and what she should do in the professional setting — is less characteristic of the MHCs according to these ratings. This was the only dimension where a sizable number of the ratings described a MHC as "Less Than Average."

Typically the co-workers felt quite positive toward the MHC with whom they had been working and would like to continue association with her as a colleague. Table III-10 summarizes the responses given over three years to the question: "How would you feel about having the MHC as a co-worker for the next five years?"

TABLE III-10
CO-WORKER FEELINGS TOWARD HAVING THE MHC AS A COLLEAGUE FOR FIVE MORE YEARS

Response	1st Year		2nd Year*		3rd Year†		Total	
	N	%	N	%	N	%	N	%
Very positive	35		16		28		79	
		100		95		90		95
Positive	14		2		7		23	
Uncertain	0		1	5	3	8	4	4
Negative	0		0		1		1	
						2		1
Very Negative	0		0		0		0	

*A number of co-workers were interviewed after a MHC had left the agency. This question was not included on these termination interviews.

†Question was included in Final Co-Worker Form, not as a face-to-face interview.

Over the three years of follow-up 95 per cent of the co-workers indicated that they would feel positively or very positively toward having their MHC as a colleague for a continuing period of time. To some extent, this apparently generalized to the possibility of having additional MHCs as co-workers as shown in the following analysis.

As a final question, the co-workers were asked, "If more MHCs were trained in the next three or four years, how many, if any, would you want the agency director to hire?" Their responses are summarized in Table III-11.

TABLE III-11
HOW MANY NEW MHCs WOULD YOU WANT THE DIRECTOR TO HIRE?

Number of MHCs	Clinic A	Clinic B	Clinic C	Clinic D	Hosp.	College	Total Co-Work
None	2	0	0	0	1	0	3
One	0	1	2	0	4	1	8
Two-Three	3	3	3	4	2	0	15
Four-Five	0	0	1	0	0	0	1
More Than Five	0	0	1	1	0	0	2
No Response	1	2	1	0	0	0	4
Total Co-Workers	6	6	8	5	7	1	33

The most frequent response from the co-workers was that they would want the director to hire two or three more MHCs. Only three of the thirty-three co-workers responded "None." A higher proportion of co-workers in the hospital setting would request less than two new MHCs, but overall, there were no sizeable

differences among the co-workers' responses at the several agencies.

Reservations on Final Form. The overall evaluation of the MHC as a therapist and a co-worker was clearly positive. There were, however, a number of reservations expressed by co-workers toward the end of the third year. As was true for the supervisors' Final Report, the Co-workers' Final Questionnaire specifically requested reservations or qualifications.

Over 80 per cent of the co-worker reports did not list features of a MHC's work which were judged to be highly ineffective. Asked if there were certain things in her *work with patients* in which a MHC was highly ineffective, six of the 39 reports answered affirmatively. Asked if there were highly ineffective things in the MHCs' *general agency work,* seven of the 39 answered affirmatively. The reservations that were expressed were as follows:

(a) Two co-workers reported that one MHC tended to support some patients' pathology in certain areas where the MHC herself had problems.

(b) two co-workers reported that another MHC had difficulty in accepting supervision.

Single co-workers each offered one of the following reservations:

(c) ineffective with highly anxious-aggressive patients

(d) ineffective in cooperating with a co-therapist

(e) ineffective in staffing cases

(f) not sufficiently involved in agency

(g) intake work not thorough

(h) ineffective co-worker cooperation

(i) tends to get sucked in by patients' manipulations and pathology

(j) did not keep clerical staff informed of appointments

With the exception of the last listed, these appear to be reservations which were not cited previously. The few reports of ineffective collaboration must be coupled with the many reports which singled out the MHCs' interpersonal relationships for praise. Reservations about intake and staffing work must be coupled with two facts: (1) in most instances, MHCs' performance in intake has been highly praised, despite the fact that, (2) they were not trained to do intake work.

Evaluations of MHCs by their co-workers have been highly positive throughout their first three years of employment. Reservations or qualifications were apparent in the first and second year interviews and in the Co-workers' Final Questionnaire, but these were given in the context of otherwise high regard for the MHCs' contribution. The evaluations and qualifications provided by the co-workers were, in general, congruent with those provided by the supervisors.

JUDGMENTS OF TAPE RECORDED INTERVIEWS

The majority of the judgments provided by supervisors and co-workers were indirect ratings of interview behavior. Ratings of tape recorded interviews provide more direct assessment.

At the end of the first year of training, each of seven trainees (one was out of town) was asked to select two interviews which she had recorded during

the month of May, each with a different patient, none of them initial sessions. The tapes were divided into two series. Each single series, composed of seven tapes, was independently rated on a five point scale by one of two sets of two different judges. Seven tapes and a comparison tape were provided to each judge. They were asked to first listen to the comparison tape (Interview X) which they were instructed to consider as a reference point. It had previously been rated by six judges as near the midpoint of the five point scale (see Rioch 1965, p. 21). After listening to the comparison interview, the judges were to proceed with the trainee's interview each of which was accompanied by a brief description of the patient.

Three and one-half years later, we followed a similar procedure. While the MHCs had routinely recorded their interviews during training, they recorded only infrequently on the job. However, each was asked to record and select two interviews during the month of December each with a different patient. All of the interviews were not submitted until early March. Only six of the seven MHCs who had submitted tapes during training were currently performing individual psychotherapy so only six MHCs were involved in this portion of our evaluation.

To retain as much comparability as possible, the same five point rating scale and the same comparison interviews selected by Rioch were used again. While our judges were different from those used by Rioch, it was possible to introduce some measure of control by having them rate six of the 1962 tapes which had been rated by those judges.

Rioch reported that the four judges used were psychiatrists who had 8, 9, 14 and 15 years of experience

in psychotherapy. They did not know who had recorded the tapes nor did they know anything about the background of the trainees.

In the present evaluation, the four judges used were clinical psychologists who had 11, 11, 15, and 15 years of post-doctoral experience in psychotherapy and in supervision and training of clinical psychologists and psychology interns.

One tape was randomly selected from the two submitted by each counselor in 1965. One tape was selected from the two submitted in 1962 on the basis of audibility. Each of the four clinical psychologists rated all twelve tapes. This was done during a period of two days. First, the four judges listened to the comparison tape together. Then they listened independently to six tapes in a randomly selected and counterbalanced order. The following day, the procedure was repeated with the remaining tapes. While these judges were not told who recorded the tapes, they did know about the MHC training and follow-up evaluation. They did not know that six of the tapes had been recorded in 1965 and six in 1962. The results are summarized in Table III-12. The table presents the three sets of judgments, two of which were done by the clinical psychologists in 1965. The third set was computed from data provided by Rioch.

Comparison of the ratings made of MHCs' interview tapes made in midtraining and again three years later, indicates no significant difference in the quality of their interview behavior as judged in the described manner by the four psychologists. In their third year of employment, five of the six MHCs are evaluated as between "Satisfactory" and "Good" and one between "Satisfactory" and "Passable."

TABLE III-12
RATINGS OF MHCS' QUALITY OF INTERVIEW BEHAVIOR

MHC	Mean Ratings of 1962 Tapes: Two Psychiatrists	Mean Ratings of 1962 Tapes: Four Psychologists	Mean Ratings of 1965 Tapes: Four Psychologists
1	3.00	3.50	3.50
2	1.50	3.00	3.25
3	3.00	3.25	3.25
5	2.50	3.00	2.50
6	2.00	3.75	3.25
7	4.00	3.75	3.50
Overall Mean Rating	2.67	3.38	3.21

The lack of change in judged quality from mid-training to a point three years later raises a number of questions including, (a) how much direct supervision and training is needed in such a training program to reach a level of interview quality judged to be satisfactory by experienced therapists, and (b) are global ratings of interviews sufficiently sensitive to reflect changes in psychotherapy performance?

COMPARISON WITH TRADITIONALLY TRAINED GROUPS ON MEASURES OF INFORMATION, ATTITUDE, AND CLINICAL JUDGMENT

The evaluations to which we next turn were obtained by the utilization of several standarized or experimental measures. These measures enable us to make some comparisons of the MHCs with the performance of known groups of mental health workers under conditions which could be replicated.

Information. In this regard, one of the evaluation procedures employed by Rioch and her colleagues (1965) will be summarized briefly. At the completion of the training program, it was arranged for the eight trainees to take a modified form of the National Board examination in Psychiatry administered by the testing service of the National Board of Medical Examiners. The form administered included 122 of the 174 items on one form of the test designed to assess the level of psychiatric knowledge expected of fourth year medical students. The omitted items concerned physiology, chemotherapy, and forensic psychiatry. The mean raw score of National Board candidates taking this exam was 90.4 on the 122 item form. The mean score of the MHCs was 97.1 None of the eight MHCs scored at or below the average score of Board candidates which suggested a favorable assessment of their academic knowledge of psychiatry. The average score for Board candidates who passed the examination was not reported.

Attitude. Another assessment procedure used was the Therapist Orientation Questionnaire (TOQ; see Append. N) which was developed by Sundland and Bark-

er (1962) as an "economical and comprehensive measure of psychotherapeutic orientation," to obtain, "actuarial information about the methods and attitudes of psychotherapists" (p. 201). It consists of 99 items such as "A treatment plan is *not* important for successful therapy" to which the examinee responds using a five point scale of agreement: "Strongly Agree," "Agree," "Undecided," "Disagree" or "Strongly Disagree."

An earlier form of the Questionnaire had significantly differentiated among psychologists of different psychotherapeutic orientation on 9 of 16 *a priori* content scales (Sundland and Barker, 1962). Data provided by these authors on the 1962 revision of the TOQ (which had been administered to a group composed of 100 clinical psychologists, 100 psychiatrists, and 100 psychiatric social workers) permitted some measure of comparison of the attitudes of 300 mental health professionals with those of eight MHCs. Rather than use the *a priori* scales, the comparison involved a rudimentary item analysis.

There were only 18 items where the response given most frequently by the psychologist, psychiatrist, or social worker groups differed among themselves. After combining "Strongly Agree" with "Agree" and "Strongly Disagree" with "Disagree," the number of items on which all three groups agreed was 81.

The response given most frequently by the group of eight MHCs was the same as the mental health professionals on 64 of these 81 items. This equals 79 per cent agreement which suggests a high level of similarity in psychotherapeutic orientation and attitudes between MHCs and traditionally trained mental health workers as measured by the TOQ.

The MHCs disagreed with the other groups on 13

of the 81 items; on four items the MHCs were equally divided between agreement and disagreement. The stability of these differences is uncertain. However, several of the 13 items on which differences were found concerned the issues of a planned versus a spontaneous approach to psychotherapy and the therapist's level of activity.

The following trends were suggested by inspection of the few items where differences were obtained:

(a) the MHCs believed *less* in a planned approach, an overall treatment plan, long range goals, almost always knowing what they are doing and why. They tended to believe that a treatment plan is not necessary for successful therapy.

(b) in contrast to the remaining groups, the MHCs *did not* think it unwise for a therapist to respond overtly to patients and express feelings without censoring them. At the same time, they did not feel as secure and comfortable in their relationships with patients as the other groups and indicated that strong criticism or appreciation from a patient would result in a change of feeling toward the patient.

(c) the MHCs disagreed with the others that good therapists are mostly silent during the treatment hour and indicated that they were fairly active and talkative compared to most therapists.

(d) in contrast to the others, the MHCs believed that one can be a good therapist without training in psychopathology.

These attitude statements were provided by the

MHCs at the beginning of the first year of follow-up and may have undergone considerable modification in the subsequent three years of experience. The stability of the differences is uncertain not only because of the question of the reliability of such attitudes over a three year period, but also because of the small number of MHCs in our population. The finding that, as measured by the TOQ, the attitudes of MHCs are highly similar to those of the traditional mental health professions is probably a more stable one.

The next assessment technique lent itself better to a comparison of MHCs with mental health professionals of different levels of experience and with a non-professional control.

Clinical Judgment. A technique used in the follow-up study was a filmed interview developed by Stoller and Geertsma (1958), to assess clinical judgment. An attempt was made to compare the MHCs' performance with that of the groups that had been previously studied by Geertsma and Stoller. These included: second and third year psychiatric residents (residents II); first year psychiatric residents (residents I); senior medical students; freshman medical students; and hospital volunteer workers similar in many respects to the MHCs, but lacking the specialized training in therapy.*

*The data for the comparison groups were supplied by Dr. Robert H. Geertsma, University of Kansas Medical Center. The film was provided by Dr. Robert Stoller of the U.C.L.A. Medical School. In our analyses of these data the *r*'s obtained differed slightly from those reported by Geertsma and Stoller (1960). The range of the differences in the average *r*'s was from .02 to .04. These are attributable to differences in the compositions of the samples made available to us.

A spontaneous filmed interview, 30 minutes in length, conducted by a psychiatrist with a female outpatient served as the vehicle for comparison between groups. Five psychiatrists in a large medical school viewed the film independently and evaluated the patient by assigning ratings to about 300 statements on a seven point scale. The ratings could range from "Not Characteristic" to "Very Characteristic." From this larger group of statements, 109 items were selected on the basis of interjudge agreement (see Appendix O). The criterion for agreement was the restriction of all five ratings to three or less consecutive categories. The mean of the five psychiatrists' ratings for each item was then computed. These means were then used as criterion ratings for evaluating other groups' responses to the filmed interview.* The measure of agreement with the criterion was taken as the correlation coefficient (r) for separate individuals across items. These rs are then viewed primarily as test scores and are converted to Zs by Fisher's transformation.

The items represent both observational and inferential statements about the patient's background, present status, prognosis, and dynamics. Some examples are: "Has had more than her share of painful experiences," "Feels in danger," "Patient could probably benefit from short term psychotherapy," "Identifies primarily with father."

The eight MHCs viewed this film shortly after the completion of their training period. The group of psychiatric residents II viewed the film in either their second or third year of residency. The psychiatric resi-

*See Stoller and Geertsma (1958) for a full description of the development of the film and criterion ratings.

dents I viewed the film in their first year of residency. The senior medical students viewed the film as part of a final examination for a senior clerkship in psychiatry. The remaining two groups viewed the film as part of the study reported by Geertsma and Stoller (1960).

Only the first 105 items of the complete 109 item test were used in this investigation since the final four items were not available for all the subjects. The correlation of each subject with the criterion was obtained, converted to *Z* scores, and the means and standard deviations of the Zs were obtained in order to compute an overall analysis of variance and t-tests between the mean of the MHCs and the other groups.

Table III-13 lists the sample size for each group, the mean *r* with the criterion experts, the mean *Z*, and the *SDz* in order of magnitude of the means.

TABLE III-13
COMPARISONS WITH CRITERION:
GROUP MEANS AND VARIANCES

	Mean *r*	Mean *Z*	*SDz*	N
Residents II	0.776	1.0356	0.174	7
Residents I	0.718	0.9029	0.159	8
MHCs	0.681	0.8316	0.124	8
Seniors	0.681	0.8304	0.173	47
Freshmen	0.510	0.5630	0.145	42
Volunteers	0.490	0.5368	0.181	30

The position or performance of the MHCs with respect to the other groups as expressed by the transformed scores was nearer that of the trained residents,

virtually equivalent with that of the senior medical students and somewhat distant from that of the two relatively untrained groups. The corresponding *r*s in Table III-13 reflect the same results. In this regard, the MHCs' *r* of 0.681 revealed the amount of agreement with the psychiatrists' criterion ratings. The stability of the correlations may be suspect because of the small number of subjects.

An analysis of variance was computed, between the mean *Z*s for the six groups as a preliminary to the comparisons between the mean of the MHCs and the other groups. Table III-14 contains the summary analysis of variance.

TABLE III-14
ANALYSIS OF VARIANCE OF MEAN Zs IN TABLE III-13

	SSD	DF	MSQ	F
Between	3.6414	5	0.7283	27.058*
Within	3.6606	136	0.0269	
TOTAL	7.3020	141		

*p >.001

There are significant differences among the performance of the several groups. These data represent an overall analysis of the individual mean analyses reported by Geertsma and Stoller (1960).

The results of the t-tests between the mean Z for the MHCs and the mean *Z*s for the other five groups are presented in Table III-15 which will further clarify the visual inspection of the order of the means.

TABLE III-15
t-TESTS BETWEEN THE MHC MEAN AND THE FIVE COMPARISON GROUPS

	D	t	Significance
Residents II	—0.2040	—2.404	0.05
Residents I	—0.0713	—0.870	NS
Senior Medical Students	0.0012	—	NS
Freshman Medical Students	0.2686	4.245	0.01
Volunteers	0.2948	4.517	0.01

The MHCs performed at a level below that of the more experienced resident group. They were more similar to residents I and essentially equal to the senior medical students.

On the other hand, when compared to the relatively untrained groups of freshman medical students and volunteer hospital workers, the differences are of much greater magnitude. In this regard, the comparison with the volunteers is of most interest.

This group consisted of 27 women and three men who were hospital volunteers, and who had at least a BA degree. They appear to be similar to the MHCs on variables of education and socioeconomic status. One obvious difference between these two groups was the specialized training of the MHCs. Although factors associated with selectivity can not be ruled out, it seems likely that the training experience did contribute to the level of performance of the MHCs. However, the design does not permit us to state this with any specifiable degree of confidence.

These results suggested that the MHCs who were not trained in a traditional professional program did acquire considerable capacity to effectively utilize concepts and observational skills normally associated with professional groups who have undertaken a relatively more defined and better understood course of training.

The studies of the MHCs' information, attitudes and clinical judgment using several experimental techniques suggest that in their academic knowledge of psychiatry and in their demonstration of clinical judgment of a filmed interview, the MHCs resembled psychiatrists in the first year of residency training. In their attitudes and psychotherapeutic orientation, the MHCs resemble mental health professionals in general.

The evaluations to be presented next pertain to the job functions which MHCs could perform, the supervision they would require, and the components of a comprehensive mental health service where they might be most usefully employed.

EVALUATIONS OF JOB FUNCTION AND SERVICE CAPABILITIES

Self-Evaluations. The first series of judgments concerns the job capabilities or role qualifications of the MHCs. The Inventory of Job Functions, (IJF), which is described in more detail in Append. B & C, lists 108 functions classified into eight content categories. Each year the MHCs completed the inventory in response to the question, "Which job functions do you think you are presently qualified to perform on the basis of your training and experience?" Table III-16 summarizes the percentage of functions in the IJF categories that

each MHC felt she was qualified to perform, in the first year after about five months of employment, and then again two years later in their third year of employment.

TABLE III-16
SELF-EVALUATIONS BY 8 MHCs IN THE FIRST AND THIRD YEAR

IJF Category	N Functions	Percentage of Functions Qualified to Perform: Lowest							Highest	Year
Educating-Training	10	40	40	50	60	70	90	100	100	1st
		20	70	80	100	100	100	100	100	3rd
Administrative-Clerical	20	55	60	60	65	70	80	90	100	1st
		35	65	65	70	80	85	90	100	3rd
Community and Professional	7	29	57	57	71	71	71	86	100	1st
		43	71	86	86	100	100	100	100	3rd
Professional Growth	6	100	100	100	100	100	100	100	100	1st
		100	100	100	100	100	100	100	100	3rd
Research-Scientific	9	33	33	56	67	67	78	100	100	1st
		33	56	67	89	89	100	100	100	3rd
Direct Client Service-Evaluative	9	56	67	67	67	67	78	89	100	1st
		67	67	67	78	78	78	100	100	3rd
Direct Client Service-Helping	36	75	80	83	86	89	92	94	100	1st
		80	80	89	92	97	100	100	100	3rd
Indirect Client Service	11	100	100	100	100	100	100	100	100	1st
		91	100	100	100	100	100	100	100	3rd
Total Inventory	108	71	74	77	78	79	80	87	100	1st
		64	85	85	87	88	89	94	100	3rd

In terms of function or role capabilities, the self-evaluations of the MHC are quite high. In the first year of follow-up, each of the MHCs evaluated herself as capable of performing more than 70 per cent of the

total job functions listed on the IJF including evaluative-diagnostic, helping and indirect services to clients. Relative to these, they less frequently judged themselves to be qualified to perform education-training, administrative-clerical, and research functions. Sizeable differences among the MHCs' self-evaluations were apparent, especially on job functions concerning education-training, administration-clerical, community-professional and research. The general message of these self-evaluations is clearly "can do."

TABLE III-17
COMBINED SELF-EVALUATIONS OF FUNCTIONS QUALIFIED TO PERFORM BY YEAR AND LEVEL OF SUPERVISION

	Supervision Level*			
Year	Low	High	Total	Ratio Low : High
First	412	285	697	1.4 : 1
Third	609	138	747	4.1 : 1

**Low Supervision* includes IJF Supervision level 1, defined as "no supervision" and level 2, defined as "minimal supervision," where little, if any, scheduled supervisory time is required and where supervision or suggestions are requested when and if needed.

**High Supervision* includes IJF level 3, "moderate supervision" where scheduled supervisory time is maintained, where questions and work are regularly discussed, suggestions are made and additional help is also available when needed; and level 4, "close supervision" where weekly scheduled supervisory time is maintained and where instruction and teaching are provided in addition to discussion and suggestions.

Two years later the message was much the same. Small increases can be noted in the percentage of functions the MHCs felt qualified to perform. However, they started with a positive self-evaluation and the two year increment was relatively modest.

What had changed was the amount of supervision they judged they would need to perform these functions. This change can be seen in Table III-17 where the self-evaluations of all MHCs across the eight categories are combined and then subdivided by year and level of supervision.

While the number of functions the MHCs felt qualified to perform did increase slightly from 697 to 747, the ratio of the number of functions they felt qualified to perform with low as opposed with high supervision increased from 1.4 : 1 in 1963 to 4.1 : 1 in 1965. Over the three years of follow up, the range of functions the MHC felt qualified to perform increased only slightly, but the amount of supervision they felt they required decreased considerably.

Supervisor Judgments. It is important to note that the judgments of function capabilities made by the MHCs' supervisors were similar to those given by the counselors themselves. Table III-18 summarizes the IJF responses of the eight supervisors to the question, "What functions do you think the MHC will be qualified to perform three years from now?" These data were collected in 1963 and hence would be most comparable to the 1965 self-evaluations. The message is the same: A very high estimate of the MHC in terms of the job functions she is qualified to perform.

TABLE III-18
SUPERVISOR JUDGMENTS OF FUNCTIONS MHCs WOULD BE QUALIFIED TO PERFORM IN 1966

IJF Category	N Functions	Percentage of Functions Judged Qualified To Perform: Lowest							Highest
Educating-Training	10	10	60	60	100	100	100	100	100
Administrative-Clerical	20	25	35	80	85	90	95	100	100
Community and Professional	7	43	43	86	100	100	100	100	100
Professional Growth	6	83	100	100	100	100	100	100	100
Research-Scientific	9	0	56	100	100	100	100	100	100
Direct Client Service-Evaluative	9	67	67	67	67	78	78	100	100
Direct Client Service-Helping	36	72	83	86	92	94	97	100	100
Indirect Client Service	11	82	91	100	100	100	100	100	100
Total Inventory	108	59	61	80	92	94	97	98	100

Summing the supervisors' judgments, the total number of functions which MHCs were rated as qualified to perform in 1966, was 735. Of these 735, it was estimated that the MHCs would require low supervision on 541 and high supervision on 194. This yields a low-high ratio of 2.8 : 1 which falls between the MHCs' 1963 ratio of 1.4 : 1 and their 1965 ratio of 4.1 : 1.

In all, twelve different supervisors provided these ratings during the first two years of follow up. Of interest are the kind of direct helping functions which supervisors regarded as requiring a high degree of

supervision. The following functions were so regarded by six or more of these supervisors:

(a) aid the client to re-experience currently unconscious memories.

(b) attempt to enhance client's self understanding and self acceptance.

(c) interview clients with intent to modify the clients' defenses.

(d) interview clients with extremely complex problems.

(e) work with clients for a limited number (3-24) of interviews.

The remaining 31 items concerned with direct helping services were less frequently chosen as services for which the MHCs would require high supervision. For example, of the twelve supervisors, four indicated that the MHC would continue to require high supervision to "interview clients with somewhat complex problems" and one indicated high supervision would be needed to "interview clients with relatively simple problems."

The supervisors think the MHCs will be qualified to perform a wide range and a large number of job functions. For many of these functions, they feel the MHCs will not require close supervision.

In summary, supervisor judgments and the MHCs' self-evaluations regarding future capabilities were congruent and generally positive.

Usefulness in Comprehensive Mental Health Services. Next, we turn to judgments of the usefulness of MHCs in the components of a comprehensive mental health service. The co-workers and the supervisors of

each MHC provided their impressions of the MHCs' role qualification at the end of the third year of follow-up. Table III-19 summarizes the judgments of 33 co-workers and 16 supervisors concerning the utility of a MHC in different types of mental health services.

These data suggest that the MHCs are judged as having the ability to perform mental health services in a variety of settings. The service setting which most frequently was selected (93 per cent) by the supervisors and co-workers as one where a MHC could be "usefully" or "very usefully" employed was the out-patient clinic. The day hospital, the 24 hour walk-in service and the rehabilitation service were all selected by 80 per cent or more of the respondents. All the settings were selected by sixty per cent or more of the respondents. The night hospital and the diagnostic and referral service were the least frequently selected. In short, while the supervisors and co-workers do discriminate among settings, the MHCs were seen as having a useful role in a wide variety of the components of a comprehensive mental health service. The studies which we turn to next enlarge upon questions of the perceived usefulness of non-traditionally trained personnel such as the MHCs.

TABLE III-19

JUDGED USEFULNESS OF MHCs IN COMPONENTS OF A COMPREHENSIVE MENTAL HEALTH SERVICE

	Number of Judgments										
	Supervisors			Co-Workers			Totals				
Service Component	Very Useful or Useful	Doubtful Use or No Use	No Response	Very Useful or Useful	Doubtful Use or No Use	No Response	Very Useful or Useful N	%	Doubtful Use or No Use N	%	N
al for long-term care	13	3	0	26	10	3	39	71	13	24	3
atric unit in general hospital	14	2	0	26	9	4	40	73	11	20	4
ospital	15	0	1	30	4	5	45	82	4	7	6
hospital	12	1	3	21	12	6	33	60	13	24	9
r "walk-in" service	13	3	0	31	4	4	44	80	7	13	4
ient clinic	14	2	0	37	1	1	51	93	3	5	1
ostic and referral service	12	4	0	23	14	2	35	64	18	33	2
ilitation service	14	2	0	31	4	4	45	82	6	11	4
l health consultation service	11	5	0	30	6	3	41	74	11	20	3
unity mental health education vice	13	2	1	29	6	4	42	76	8	14	5
L N	16			39			55				

EMPLOYABILITY OF MHCs AS EVALUATED BY AGENCY DIRECTORS AND DIRECTORS OF PROFESSIONAL TRAINING

Evaluations of a group such as the MHCs take on fuller meaning when incorporated with assessments of attitudes toward the employability of such trainees. The realities of the world of work introduce critical considerations as to the feasibility of employment of any non-traditionally trained persons.

Samples. Eight different groups were chosen. The intent was not to select a sample which would be representative of the total profession but instead to sample the attitudes of employers and educators within the four fields of Education, Psychiatry, Psychology, and Social Work. Therefore, we sampled from populations of State Directors of Counseling and Guidance and from Counselor Educators; from Directors of Psychiatric Out-patient Clinics and from Chairmen of Departments of Psychiatry; from Directors of University Counseling Centers and from Directors of Clinical Psychology Training Programs; and finally, from Directors of Family Service Agencies and from Deans of Schools of Social Work. In this manner it was possible to obtain two samples from within each profession, one of which had responsibilities for employment of new staff and another which undoubtedly influences the attitudes and values of future mental health professionals regarding non-traditionally trained mental health workers.

The sources and procedures for obtaining the samples are described in Appendix P. Table III-20 describes the size of the samples and the returns received.

TABLE III-20
SAMPLE SIZE AND RETURNS

Sample	Number Selected	Number Returned	Number of Useable Returns	Percent of Useable Returns
State Directors of Guidance	50	45	44	88
Counselor Educators	53	43	43	81
Psychiatric Outpatient Clinic Directors	52	40	39	75
Chairmen, Psychiatry Departments	52	40	36	69
University Counseling Center Directors	52	51	50	96
Directors' Clinical Psychology Training	58	47	47	81
Family Service Agency Directors	48	43	43	89
Deans, Schools of Social Work	61	48	47	77
TOTAL	426	357	349	82

The overall rate of return was 82 per cent. The rate of useable returns of the individual samples ranged from 96 per cent from directors of University Counseling Centers to 69 per cent from the chairmen of Psychiatry Departments. These rates of return are high and with the possible exception of the Psychiatry

Department Chairmen, there is no reason to suspect any bias due to rate of return.

Questionnaire. A three item questionnaire, with repeated follow ups, was sent to each respondent. A brief description of the training program which had been abstracted from a paper by Rioch (1963; see Append. Q) accompanied each questionnaire. While not identified as such, the selection and training procedures and the preliminary evaluations which were described were those which had been reported by Rioch.

The three questionnaire items concerned: (a) attitudes toward employment of a non-traditionally trained mental health worker; (b) judgments of settings where such personnel could be usefully employed; and (c) an estimation of an appropriate salary level for such persons.

In order to assess their attitude, the professional employer samples were asked, "As director of your agency, would you recommend the hiring of such a person to work with your clients?" They responded on a five point scale: "Very Likely," "Likely," "Undecided," "Doubtful," and "Very Doubtful." The chairmen of Departments of Psychiatry were asked the same question since they were often employers of mental health personnel. The mental health educator samples were asked a similar question as to the likelihood of their recommending employment of such trainees if consulted by the director of a specified agency. The agencies specified were: A School Counseling Service for Counselor Educators; a mental health clinic for Directors of Clinical psychology programs; and a Family Service Agency for Deans of Schools of Social Work. All respondents were asked to assume that

funds for such employment were available and that evaluations of the trainees described were positive. In this manner, it was hoped that responses would be determined primarily by attitudes toward the utilization of non-traditionally trained mental health personnel.

Results. Table III-21 presents the ratings of likelihood of employment given by the eight groups in answer to the questions described.

TABLE III-21
RATINGS OF LIKELIHOOD OF EMPLOYMENT

	Agency Directors									
Likelihood of Employment	Counseling Center		State Guidance		Family Service		Psychiatric Clinic		TOTAL	
	N	%	N	%	N	%	N	%	N	%
Very Likely	7		3		6		6		22	
		41		37		37		45		40
Likely	14		13		10		12		49	
Undecided	10	20	6	14	10	23	5	13	31	18
Doubtful	12		10		9		7		38	
		39		49		40		43		42
Very Doubtful	8		11		8		10		37	
TOTAL	51	100	43	100	43	100	40	101	177	100

	Directors of Training									
Likelihood of Employment	Clinical Psychology		Counselor Education		Social Work		Psychiatry		TOTAL	
	N	%	N	%	N	%	N	%	N	%
Very Likely	15		8		3		5		31	
		62		40		16		33		38
Likely	14		8		5		7		34	
Undecided	8	17	9	22	16	35	0	0	33	19
Doubtful	7		5		6		9		27	
		21		38		48		67		42
Very Doubtful	3		10		17		15		45	
TOTAL	47	100	40	100	47	99	36	100	170	99

Of the 177 agency directors, 40 per cent responded either "Very Likely" or "Likely" and 42 per cent responded "Doubtful" or "Very Doubtful." Of the 170 directors of training, 38 per cent responded either "Very Likely" or "Likely" and 42 per cent responded "Doubtful" or "Very Doubtful." In round numbers, 40 per cent of both agency directors and directors of training had positive attitudes toward the employment of non-traditionally trained mental health workers, another 40 per cent of both groups had negative attitudes, and the remaining 20 per cent were undecided. There appear to be rather polarized views regarding this question—most noticeable among the chairmen of Departments of Psychiatry.

There were differences among the sample groups, particularly among the directors of training. The directors of clinical psychology programs were the group with the highest percentage of "Very Likely" or "Likely" responses. The Deans of Social Work had the lowest percentage of "Very Likely" or "Likely" responses and the highest percentage of "Undecided" responses. The Chairmen of Psychiatry Departments had the lowest percentage of "Undecided" responses and the highest percentage of "Doubtful" and "Very Doubtful" responses. It may be that these differences are attributable to the different agencies specified in the questions asked. However, the impression derived from the remaining questionnaire items is that these differences do reflect differences in attitudes toward the training and utilization of new sources of mental health manpower.

The judgments of settings where such personnel might be usefully employed were obtained from reactions to a list of nine different settings. The respondents were asked to mark the one setting where, in their estimation, the trainees could be most useful,

TABLE III-22
JUDGMENTS OF SETTINGS WHERE NON-TRADITIONALLY TRAINED COUNSELORS COULD BE USEFULLY EMPLOYED "EXPRESSED AS PERCENTAGE OF RESPONDENTS SELECTING EACH SETTING"

	Respondent Groups								
	Agency Directors				Training Directors				
Settings	Counseling Center	State Guidance	Family Service	Psychiatric Clinic	Clinical Psychology	Counselor Education	Social Work	Psychiatry	Median Percentage
State NP Hospitals	45	19	56	45	57	35	34	55	45
Child Guidance Clinics	69	74	21	30	76	70	13	39	54
Residential Treatment	53	38	42	52	70	53	42	42	47
Day Care Centers	69	52	58	67	81	65	38	44	62
Private In-patient	29	26	30	12	40	25	34	8	28
Out-patient Clinics	82	69	49	47	68	85	19	44	59
Family Service	84	76	42	60	79	90	15	33	68
High School Counseling	43	28	53	55	57	28	30	61	48
University Counseling	47	24	44	45	40	30	23	36	38
Median Percentage	53	38	49	47	68	53	34	42	
No Settings Checked	4	2	12	2	4	0	25	5	4
Useable N	51	43	43	40	47	40	47	36	347

and then check any other settings among the nine where the trainees could also be usefully employed. A sizeable number of the respondents did not provide this differentiation, therefore, the data were analyzed in terms of the percentage of respondents in each sample that checked each of the nine settings. The settings and the results can be seen in Table III-22.

Differences are apparent both in the perceptions of the settings where non-traditionally trained personnel could be useful and among the sample groups in their estimation of the usefulness of such trainees. Overall, the settings which were rated most frequently as ones where trainees could be useful were: Family Service Agencies, Day Care Centers, and Out-patient Clinics. The least frequently checked were private in-patient facilities and University Counseling Centers.

Among the sample groups, the directors of Clinical Psychology training programs had the highest estimation of the usefulness of the trainees. They were more likely to see a larger number of agencies as ones where such trainees could be employed. The Deans of Social Work, on the other hand, saw the fewest number of agencies as having employment possibilities for the trainees and 25 per cent of the Deans did not rate even one of the nine agencies as a setting where the trainees could be usefully employed. The ambiguity resulting from the differences in the agencies specified for the data in Table III-21 is not present here. Note, for example, that Child Guidance Centers were indicated to be settings where the trainees could be usefully employed by 76 per cent of the directors of Clinical Psychology training, 39 per cent of Psychiatry Department Chairmen, and 13 per cent of Deans of Social Work. There do appear to be differences in attitudes among the trainers of the mental health professions toward the training and utilization of new manpower groups. There is also a ten-

dency within the sample to rate one's own setting as relatively less suitable for the employment of such trainees. The explanation for this is uncertain but probably involves a more intimate knowledge of a setting leading to perception of more problems contingent upon the employment of non-traditionally trained workers. The third question concerned an estimation of the appropriate salary level for such trainees. These data were obtained during 1963 and 1964. The respondents were asked "On the basis of the information provided, at approximately what 12 month salary level would you place the full time Mental Health Counselor?" Their responses were recorded on a six-point scale which ranged from "less than $4000" to "more than $8000" with our four intermediate intervals of $1000. Table III-23 summarizes these results.

Eighty per cent of the judgments were at a salary level of $5000 or more; sixty-one per cent of the salary judgments were between $5000 and $7000. The differences among the sample groups were small. More than half of the estimates from each sample group were within the $5000—$7000 range, the one exception being the Chairmen of Psychiatry departments.

These findings revealed that there was a substantial proportion of individuals among the directors of mental health service agencies who apparently would consider the employment of certain non-traditionally trained mental health workers. At the same time, cognizance should be taken of equal or greater proportions of respondents, particularly the directors of psychiatric and social work training, who viewed employment of non-traditionally trained persons as unlikely.

In terms of likely employment settings, out-patient clinics ranked high in these judgments (as they did in

TABLE III-23
JUDGMENTS OF TWELVE MONTH SALARY APPROPRIATE FOR MENTAL HEALTH COUNSELORS

	Respondent Groups									
	Agency Directors				Training Directors					
Salary Level	Counseling Center	State Guidance	Family Service	Psychiatric Clinic	Clinical Psychology	Counselor Education	Social Work	Psychiatry	TOTAL N	TOTAL %
More Than $8000	1	5	0	0	4	5	2	0	17	5
$7000-$8000	8	6	0	2	11	12	3	2	44	14
$6000-$7000	15	20	5	5	11	15	11	5	87	27
$5000-$6000	24	7	18	14	16	8	11	10	108	34
$4000-$5000	2	2	12	11	0	3	6	11	47	15
Less Than $4000	0	1	4	5	1	0	2	5	18	6
TOTAL	50	41	39	37	43	43	35	33	321	101

the judgments of supervisors and co-workers) along with Family Service Agencies and Day Care Centers.

SUMMARY

This section has presented the evaluations obtained during the first three years of the employment of the MHCs. Self-evaluations, supervisor evaluations, co-worker evaluations and the responses of samples of mental health agency directors and directors of training were presented. Included were evaluations of on-

the-job performance, especially work with patients; judgments of recorded interviews; comparisons with traditionally trained groups on experimental measures; projections of the job functions which MHCs could perform and the components of a comprehensive mental health service where they could be used; and finally attitudes toward the training and utilization of non-traditionally trained personnel. Reservations notwithstanding, the overall reaction to the MHCs is highly positive.

CHAPTER IV

REFLECTIONS OF THE MENTAL HEALTH COUNSELORS

OF ALL the individuals who contributed information throughout the three years, none were so close to the source as the MHCs themselves. At the end of the third year, each MHC completed a final questionnaire (see Append. R). They described their sources of satisfaction and of stress, their future plans, the reactions of families and friends, and some further self-evaluations.

SOURCES OF SATISFACTION

In answer to the questions "What would you say were the high points in your professional work as an MHC?, What do you point to with most pride?", the MHCs wrote as follows:

(a) About four or five patients — two long term; one medium; one short (10 interviews) and one very brief — (1-3). In the interactions with them I felt that my ability to learn and be flexible and my professional skill was significant.

The abilities I learned in doing telephone intake screenings and "walk-in" intakes when I could encourage a patient to come in at once and talk. These were often short-term interventions, but were made at the "right" time — this work led to my interest in preventive or crisis therapy — to be done on a short-term basis, but perhaps in intervals over a long period like a year or so.

(b) High points were several cases in which it was obvious that my patients were clearly helped by their therapy; then my growing feeling of competence and realization that people in this field whom I respect accept and value my work. A high point in the past year has been exciting success in group work. I suppose I am proudest simply of the fact that I know that I can do useful work in this field.

(c) Those instances where my judgment was confirmed by later events. Also in my ability to work in a project which is pioneering and where there is much uncertainty.

(d) My own work with people has improved. It is very valuable learning with others in an agency.

(e) Therapy interviews with young adults — college students in particular.

(f) My acceptance by other professional people, and my own self concept as a therapist. I am much better able to deal with difficult, hostile situations, and to confront people when I feel it is necessary.

(g) There are several girls here whose

changed attitudes have given them a much easier feeling about themselves, and because of this, they have gone out into the world with a more positive attitude.

(h) In-patient and out-patient treatment of a 15-year-old girl with psychomotorepilepsy. Also treatment of a boy, 15, and a girl, 13, each with brain damage and schizophrenic reactions.

Most often cited was work with a particular patient or patients, and the experience of utilizing new skills which led to a feeling of professional growth and competence.

SOURCES OF STRESS

There were, of course, many sources of stress during the training period and three year follow-up. The MHCs described the stress points in their training and employment as follows:

Selection Period.

(a) Writing my autobiography and going to the first group meeting. Once started I was fairly well committed and got carried along.

(b) As we entered the last rounds, and I participated in that last round-table discussion, my mouth was dry and I was very conscious of being judged by the surrounding psychiatrists and psychologists. I found this the most painful part.

(c) At this period, I had nothing yet to lose.

My attitude was "Nothing ventured, nothing gained." I had alternatives in mind to selection for the program. It was rigorous, but stimulating.

(d) —

(e) As the selection period drew toward a close, I felt increasingly nervous about being accepted and wanted desperately to be in the program. It was particularly stressful to have to be observed by the selection committee as I "performed" in group situations.

(f) None.

(g) In the selection period, I felt quite a bit of stress in being under such close scrutiny where my selection for the program I wanted very much to be a part of was concerned.

(h) Play acting with the Director.

As might be expected, being in an assessment situation was reported as a source of stress by several, but not all of the MHCs.

Training Period — First Year.

(a) My doubts about my own ability and also not quite knowing what I was supposed to be doing, or how. Also difficulty with one resistant, "normal control" client.

(b) Anxiety about revealing feelings, particularly in group.

(c) In the middle of the first year, I felt considerable stress as I faced some of the doubts I had about whether I could do the job I had set out to do.

(d) This was still the '"honeymoon" period. Toward the end of the first semester, I began to see and feel some of my own difficulties.

(e) Uncertainty about belief in therapy as useful for patients.

(f) It was hard to expose oneself as we had to do as we were continually observed, criticized and our taped interviews were pulled apart.

(g) Oral presentation of first case.

(h) My first "interview" and listenings to the resulting tape and the growing realization that I would have to change myself before I could practice at psychotherapy. The bafflement and frustration and the painful period just before starting my own therapy.

Retrospective accounts of the first year's training reveal doubts about their own ability to become therapists and some growing recognition of their own feelings. Group case presentations and supervision also constituted a source of stress.

Training Period — Second Year.

(a) The prospect of the approaching end of training and the big question whether we could really take over this new identity as therapists was continually in mind.

(b) None

(c) Final oral examination with three experts.

(d) Doubts — though somewhat lessened — about my ability as a therapist.

(e) Being open to more awareness about myself — sometimes suddenly — and of the long road ahead of learning and practice needed. I felt rebellious at times about the fact some of my "skills" were, in fact, defenses and that I could not take an easier course to self-actualization.

(f) I felt some stress in the second year having to do with whether I could get a job and whether I was likely to be successful at it.

(g) Rigorous training in group work.

(h) During this year, I also faced the difficulties I had begun to experience and at the end of the first semester I entered personal therapy.

During the second (and final) year of the training program, we find stress resulting from increased self awareness mixed with concerns about ability and employability.

First Year at Work.

(a) Difficulty in fitting into an extremely orthodox setting.

(b) I had quite a bit of stress about whether my employer was satisfied with my performance and whether I was meeting the expectations in my employment.

(c) Relations with co-therapists.

(d) Active participation in staff meetings.

(e) Long and difficult ride to work each day. Difficulty in deciding whether to continue this position.

(f) Actually, the supervision and the amount of acceptance and support was so good that I felt adequate and quite stimulated most of the time. Supervision was full of pressure but was also skillful; the change of my supervisors was difficult.

(g) This was stressful. Each day I was faced with the question "fight or flight," but I feel this was as much due to the type of project as my personal reaction.

(h) To be at the bottom of the totem pole as unconventionally trained people without a comfortable slot to fit into.

The first year of employment appears to have been more stressful than any previous time. Role-relationships, status hierarchies, unfamiliar job demands, self-doubts and some of the minor unpleasantries of working itself were all reported as sources of stress.

Second Year at Work.

(a) Making a decision to shift to another agency was difficult as I felt very comfortable and fond of the people there. I believe it was a good move professionally, though, particularly in improving my salary position and, as it turned out, getting some excellent training in group work.

(b) The unrest and lack of openness on the part of the agency staff was a constant irritant. There seemed to be a divisiveness among staff that I had to cope with and my supervision became more a matter of discussing

procedures and administrative details than of learning. I did feel accepted — but "stuck."

(c) Explaining and defending conflicting views in staff.

(d) The stress I have felt in these two years is concerned with improving and enlarging the Mental Health program here and generally making myself optimally useful.

(e) Very few. Some anxiety in handling groups. It was in general a non-competitive accepting atmosphere.

(f) Difficulty in finding a role in our agency which was in transition from a mainly service oriented one to a mainly training one.

(g) Departure of director.

(h) This too was a stressful year. Our program seemed to be in perpetual tumult. However, I committed myself to work with it in the most effective way possible.

The stresses reported in the second year are less personal or introspective than those previously reported. They appear to be more environmental in nature. The sources of stress cited included job change, and stresses on the employing agency itself such as staff changes, program changes, agency conflicts and growing pains. The MHCs' retrospective reports are those of staff members who share in these problems.

Third Year at Work.

(a) It has been easier to work with the immediate supervisor, a clinical associate. However, stress is built into this job. As the project needs a

"research assistant" more than another therapist and my position has changed to part-time research and part-time clinical work, I have been re-evaluating the job.

(b) I had a hard encounter with one supervisor.

(c) None.

(d) Maintaining enthusiasm, drive and initiative with both hands and feet tied.

(e) Working out stresses and strains with co-therapist. Anxiety of new director and leaving of old one. Anxiety also regarding new kinds of multi-family groups.

(f) Too much work.

(g) Feeling undervalued, underpaid.

(h) None.

These reports were not so retrospective as they were current, which perhaps accounts for the heightened feeling tone. The impression presented is one of more stress induced by different sources than in the previous reports. Stresses now appear to be focused on one or two persons rather than being general. At this point it has become possible for a MHC to work with, or to be supervised by a person trained in a traditional degree program who has had less experience than she. This may be a new source of stress, possibly related to feelings of being used in less than optimum ways, which appear for the first time. Agency problems and job demands still constitute a source of stress and the first reports of tiredness (perhaps forgotten in retrospection) appear.

THE FUTURE

Next Five Years. What do the MHCs anticipate doing in the future? Regarding the next five years, they comment as follows:

(a) The same thing. Hope to do more intakes in the clinic and consulting with schools.

(b) I suspect I will gradually branch out from straight therapy to things more community oriented—working with those who work with poor, who do job counseling, etc.

(c) Seeing part-time work in organization with some flexibility that permits greater independence and personal choice. Possibly finding volunteer job with D.C. schools in same line of counseling.

(d) Remain in the same field; possibly gain further education through course work at a university or the Washington School of Psychiatry.

(e) WORK! Family, individual, group treatment—hopefully more research—more training.

(f) Doing individual counseling—with supervision and also with more training, preferably working with short-term crisis situations or with problems of non-sick, still functioning people. I would like to use some of my know-how in working with a program that has some social goals.

(g) I would like to enlarge the program here, including some teaching, some group work and more availability of my services time-wise and location-wise.

(h) More of the same, with greater concentration on group work and increasing competence and flexibility.

Seven describe areas of interest that should keep them in the salaried working force. One, seeking greater independence and personal choice, will seek part-time employment and possibly work as a volunteer. Increased involvement in community mental health and social action roles are mentioned in their plans. Noteworthy also is that three of the MHCs make specific mention of seeking further training during the next five years.

Next Ten Years. Projecting five more years into the future, the following comments were made:

(a) Similar to above—community orientation. I also expect at some point to work directly in a college setting.

(b) Would like to be in on preventive mental health measures on a community basis as well as the above—time for writing.

(c) Retire!

(d) Same as above. The job may change, but therapeutic work with individuals and groups will remain my vocational interest.

(e) The same as above.

(f) Same at the moment.

(g) Same as above.

(h) If I can increase my knowledge and skill I would eventually enjoy a supervisory-teaching job without losing personal counseling contacts entirely. I have a feeling that trained

personnel will feel obliged to spread a bit then and use other sub-professionals to the best advantage in a manpower-short field.

One of the MHCs anticipates retirement during the next 10 years. Five see the 10 year span as essentially the same as for the next five year period. Changes of emphases involving community orientation, preventive roles, and more supervision and teaching are noted.

REACTIONS OF FAMILY AND FRIENDS

The MHCs were also asked "Describe their reactions to you as an MHC." Their reports are as follows:

(a) Family pleased and proud though feel I do not have enough energy left for them at times. Friends very much interested and talk of it a good deal. Fairly often I am asked, "Does psychiatry really help?"

(b) My husband is quite proud though sometimes threatened by the independence having a job gives me. My children seem to be quite proud of my having a job and finding something constructive to do. One sometimes resents my not being home at particular times of need, but this does not happen often enough to be a serious problem. My women friends are most interested and often quite envious of what I'm doing.

(c) It has increased their knowledge and interest in mental illness and psychiatric viewpoints. The main reaction has been curiosity about "What do you do?" During the training period many friends expressed envy.

(d) *Friends:* Aren't you wonderful!! Oh! Are you one of those! I wish I could do something like that! Isn't it depressing?! How can you stand it!?

Children: Don't give up mom—it's good for you and keeps you off our backs. You'd never be happy in a bridge club.

Husband: Can't you take a week off when I want to?

(e) *Family:* Family interested and approving. One child views any "therapy", at home or elsewhere with some suspicion; another is very interested and is at present planning to be a clinical psychologist (for which I may not be too thankful considering the length of education!!)

Friends: A lot of rather unrealistic envy and interest mixed with some real appreciation and personal interest in a similar program.

(f) Mother, relatives do not mention my profession; friends think it is great. Kids happy as long as I am—proud of me.

(g) All are supportive. Some friends feel it is better to have a more traditional training and degree. My husband feels I should refuse to work for such low pay.

(h) They are generally approving and admiring.

These reactions, from what may be regarded as the "significant others" in the MHCs' lives, offer varied and concrete impressions. The impact of such a training and work experience upon the individual with family responsibilities and with social roles of longer standing are indeed impressive.

SELF-EVALUATIONS

The MHCs also evaluated their potential usefulness in the various components of a comprehensive mental health service. Tables IV-1 and IV-2 summarize their responses.

TABLE IV-1
SELF-EVALUATIONS OF MHCs AS COMPARED WITH TRADITIONALLY TRAINED STAFF

Dimension	More than Average	About Average	Less than Average	No Response
Identification with the agency	3	3	1	1
Effort and Work Output	4	4	0	0
Contribution to case discussion	3	4	0	1
Contribution to morale	3	5	0	0
Source of new ideas	5	3	0	0
Openness to new ideas	5	3	0	0
Co-operativeness	2	5	0	1
Friendliness	2	6	0	0
Job satisfaction obtained	2	6	0	0
Role definition achieved	1	4	2	1
Overall contribution to the agency	2	5	0	1
TOTAL	32	48	3	5

Again the MHCs' self-evaluations are quite positive. Their self-evaluations on all the dimensions in Table IV-1 were "average" or "above average;" also they

TABLE IV-2
SELF-EVALUATIONS OF POTENTIAL USEFULNESS IN COMPONENTS OF A COMPREHENSIVE MENTAL HEALTH SERVICE

	Number of Judgments			
Service Component	Very Useful	Useful	Doubtful Use	No Use
Hospital for long-term care	2	3	3	0
Psychiatric unit in general hospital	2	6	0	0
Day hospital	3	4	1	0
Night hospital	1	4	1	2
24 hour "walk-in" service	5	2	1	0
Out-patient clinic	7	1	0	0
Diagnostic and referral service	0	8	0	0
Rehabilitation service	1	6	1	0
Mental health consultation service	2	5	1	0
Community mental health education service	1	5	3	0
TOTALS	24	44	11	2

rated themselves as potentially useful in each of the 10 service components listed in Table IV-2.

These ratings are similar to those provided by the supervisors and co-workers. The setting where the MHC is most frequently depicted as having a high degree of potential usefulness is the out-patient clinic. The major difference is that all eight MHCs felt that they could be usefully employed in a diagnostic and referral service, while one-third of their supervisors and co-workers thought otherwise.

SUMMARY

This reaction has presented a number of retrospective reports and self-evaluations given by the MHCs. Included were sources of satisfaction and stress during the past five years and further self-judgments of potential usefulness in mental health services. A discussion of the implications of all the materials follows.

CHAPTER V

IMPLICATIONS

AN OVERVIEW

AMONG THE ROLES recommended for new mental health workers in the Final Report of the Joint Commission on Mental Illness and Health was the ". . .treating of persons by objective, permissive, nondirective techniques of listening to their troubles and helping them resolve these troubles in an individually insightful and socially useful way" (1961, p. 249).

Dr. Rioch was asking more than this of the MHCs: ". . .could they work with patients or clients whose problems cannot be solved only by the sympathetic listening ear of a neighbor, or the commonsense advice of a friend? Could they learn to understand the unfamiliar inner world of the schizoid person, draw out the hidden anger of the depressed person, and help the anxiety-laden client or patient to discover the source of his anxiety?" (1965, p. 2).

The implications of our assessments over the past three years need to be measured against the goals and expectations of Rioch and her colleagues. These goals

may be summarized briefly as follows: to identify, and to select from a new source of mental health manpower, individuals who could be trained in a two-year, part-time program to become skillful, psychodynamically-oriented psychotherapists and who could then provide services to troubled people under the auspices and supervision of a mental health agency.

There is not much question from our data gathered over the past three years that these goals have generally been achieved. A wide variety of measures, from the vantage point of many different mental health workers and groups, and from assessments made at a variety of different times — all indicate the women trained in the Pilot Project to be competent counselor/therapists in their jobs. Any single estimate of the quality of their work may be suspect, but the consistent pattern of a large number of positive judgments by supervisors, co-workers, and independent observers would lead to one of two conclusions: (a) The quality of their work is really not too high, but due to a powerful and ubiquitous "halo effect" surrounding the program, the ratings are greatly enhanced; or (b) their performance is, at a minimum, quite competent. The latter appears much more likely since the few experimental evaluations were also positive, and since the supervisors and co-workers were able to report specific reservations. There may have been some "halo effect" but this could not explain adequately the evaluations which have been presented.

It may be that the greatest significance of this project will be historical, as a systematic demonstration that the effective performance of individual psychotherapy with troubled people does not necessarily require degree preparation in psychiatry, psychology, or psychiatric social work.

Certainly, the significance of this project cannot rest solely upon the contribution of eight women. If a larger measure of significance is to be achieved, much more experience must be gained through further programs, additional research and experimentation.

Considerable evidence that the project has stimulated or reinforced innovations in mental health training already is apparent. Numerous programs are underway currently: one involves training for work as a child development counselor with mothers of young children; another involves training of mental health workers for work with individuals who require long-term guidance and support. Both of these are using mature women as their source of manpower. Other groups being trained for mental health roles include college students, high school graduates, psychiatric aides and attendants.

What should the goals of such programs be? Should they attempt to train highly skilled, psychodynamically-oriented psychotherapists? Should they focus upon less intensively trained mental health workers who would provide support, therapeutic listening, interest, and companionship rather than psychodynamically-oriented, personal exploration? Should they train technicians who might administer tests, conduct standardized interviews or be clinical assistants to the treatment team? Undoubtedly there should be multiple training goals.

The great need for additional mental health manpower was described with clarity and force by Albee (1959). This need has been repeated and underscored so many times that it becomes almost trite to call attention to it. The issue which is less often considered is what functions individuals should be trained to per-

form in the light of increasing needs and changing patterns of services within the mental health field. A brief overview of developments underway in a variety of settings may provide some answers.

Mental Health Services in Schools. The legitimacy and scope of mental health services in the educational system present questions on which there exists a range of opinion and practices. A monograph of the Joint Commission on Mental Illness and Health (Allensmith & Goethals, 1962), concerns the role of the schools in mental health.

A strong argument can be made for the school system as a primary locus of mental health programs, both preventive and treatment. This follows from the fact that schools are populated by a complete subpopulation of the community and they are a social institution whose concern is growth and development of individuals. Furthermore, family units are identified with the schools since their children are involved. Few other social institutions can meet their criteria.

It would appear that here is a setting (the school system), and an area of functioning (psychotherapeutic counseling with troubled students and consultation with their teachers), which could well be served by special training programs similar to the one discussed in this report. Our assessments of two MHCs' work in school settings would suggest that such persons can be unusually effective in dealing with the personal problems of these adolescents and young adults in those settings. In public education, the presence of certification requirements poses a somewhat, but not entirely unique obstacle to their employment.

Out-patient Mental Health Services. In many parts of the country, the services offered by out-patient clinics are undergoing considerable change. The primary directions of change concern provision of immediate help for troubled people, extending services into the community, diverting a higher proportion of staff time to consultation with caretaker agent and agencies, and broadening the conceptions of helping services. As the highly trained mental health professionals spend increasing amounts of time in mental health consultation and other community activities their amount of clinic time available for direct, client out-patient services will decrease correspondingly. Moreover, the number of out-patient mental health clinics should increase considerably in the near future. Could some of the additional manpower needed be provided by specially trained mental health workers, some trained in psychodynamically oriented psychotherapy and some trained to provide support and guidance? Our experiences with five of the MHCs during these three years would suggest that the answer is "Yes."

In-patient Services. Two observations suggest that non-traditionally trained manpower might be especially needed in the state hospital systems: (a) "The state hospitals account for 80 percent of all hospitalized mental patients at any given time;" and (b) ". . .the longstanding shortage — in some instances, the nearly complete absence — of competently and specially trained professional personnel in mental hospitals — particularly in many state hospitals — has been aggravated rather than relieved by a tremendously increased demand for mental health services in other agencies . . ." (Joint Commission on Mental Illness and Health, 1961, pp. 142, 173.)

At the same time, changes in the administration and services of such hospitals have moved in the direction of both more interaction with patients and a higher quality of interaction in contrast to earlier custodial emphases. These changes suggest desirable responsiveness to improvement of patient care. However, they do little to alleviate the great shortage of manpower in these hospital settings. It is likely they will generate even greater manpower needs. There should be a large number of roles and functions in the state hospitals some of which could be fulfilled by non-traditionally trained mental health workers.

After-care Services. With increasing numbers of people discharged from mental hospitals, the need for after-care services also increases. Such services are carried on in a variety of settings and by a range of personnel. In many areas the public health nurse has made large contributions to after-care programs and there is every reason to believe that specific kinds of functions could be identified and that new training programs could be developed to meet these needs.

TRAINING PROGRAMS

Our initial intent had been to give considerable attention to characteristics of the pilot training program itself. This did not prove to be the case largely because of the press of our other assessments. In the process of these assessments we have gleaned relatively little in the way of possible modification of the training program from the agencies employing the MHCs. The collective impressions of the MHCs as reported do offer some personal insights in this regard. Clearly, the ori-

ginal pilot training program offers much as one model for future MHC-type training programs.

The very presence of the program and its working graduates has made a notable impact upon the mental health planning underway in the state of Maryland. As an example, one of the large metropolitan counties is placing considerable emphasis upon its mental health manpower needs. As part of such emphasis, the county planning group is recommending the establishment of a mental health training institute, operative through the State University and its adult education college. The institute, in close and continuing collaboration with mental health agencies and institutions, would develop specific training programs for which the agencies had any reasonably common personnel needs. This collaboration would be essential in that the source of ultimate employment of trainees, paid or volunteer, would be those agencies and institutions. In short, they would identify the kinds of mental health functions for which they desired trained personnel. Then, in collaboration with the institute representatives, issues such as curriculum, field training and selection of trainees would be identified and resolved. The institute would conduct the training program with considerable reliance upon the agencies as locales for supervised field work experience. Upon completion of training, the agencies would then bring the qualified persons so trained into their units for employment. The institute is conceived as being an exceedingly flexible educational instrument, responsive to community needs and probably offering, concurrently, a number of different training programs varying in length, content and purpose.

MANPOWER

As to manpower sources available for non-traditional mental health training programs, the present study illustrates one source—i.e. bright, mature, socially sensitive women who have raised children of their own and who are interested in assuming social service roles in the world of work. This is an intriguing source for several reasons. For one, a growing number of women are becoming interested in entering or returning to the world of work as an added means of self-fulfillment. For another, such women are not employed currently. The importance of this is that training and employment of these individuals do not leave vacancies in other positions. Of course, they represent only one of a number of manpower sources. Aside from their vocational availability, how necessary are the other attributes which characterized the MHCs? We have no way of knowing how necessary each of these attributes was to the MHCs' successful performance. It seems logical that the social service motivation would be a necessary characteristic since that is a prerequisite condition for the subsequent work performed. However, the degree of education, the maturity level, the experience in child rearing may or may not be critical ingredients.

The picture is further complicated when one considers the array of possible mental health job functions. The training program we have studied was designed to prepare these individuals to perform counseling/psychotherapy. Among mental health activities this subsumes a large and complex group of functions. However, mental health agencies include a wide variety of job functions among their current activities. Still more functions will likely emerge as mental health knowledge

and programs advance. A number of these developments have been cited earlier in this chapter.

To capitalize upon the contribution of non-traditionally trained persons, it appears that mental health professionals would do well to analyze their job functions closely and objectively. A guiding question in such analyses would be, "What functions are we performing which could be performed by others who might be trained specifically to perform them?" This does not mean training to *be* a psychiatrist, social worker, psychologist, etc., but rather training to perform a particular function or set of functions. In this context, the nature of the training program and the characteristics of persons acceptable or competent in such training will undoubtedly vary with the functions involved.

The guiding question is easy to pose but more difficult to act upon. Our studies of four different samples of mental health employers sheds some light on this difficulty. The survey samples were used to gather data as to the perceived employability of non-traditionally trained mental health workers in their own or similar agencies. Among the negative or uncertain responses were a number reflecting the view that: (a) their staff all had traditional, professional and academic training; and (b) the staff were able to perform a wide variety of functions such as teaching, supervision of interns, community education, research, etc. In one sense, the picture presented is one of the traditionally educated professional as a generalist. Many health agencies perform a wide array of services and the traditionally educated persons have undoubtedly acquired a wider array of competencies as a result. However, it hardly seems to follow that because of these needs and precedents that *each* prospective staff member should be a generalist who is

capable of performing the full gamut of agency functions. To hold to such a view—even implicitly— is to place extreme constraints on flexible utilization of manpower. At best such constraints represent luxuries which we can no longer afford.

THE ROLE OF THE NON-TRADITIONALLY TRAINED MENTAL HEALTH WORKER

What about the acceptance of non-traditionally trained persons in mental health work? The reactions of colleagues of the MHCs are certainly supportive on this point. It is interesting to note, however, that the colleagues tend to be positive in the concrete (i.e. reactions to the MHC with whom they work), but more tentative in the abstract (i.e. non-traditionally trained MHCs in general). Similarly, our studies of the perceived employability of non-traditionally trained MHCs yield interesting data regarding this point. The question appears to produce rather polarized reactions among our national samples of psychologists, social workers, psychiatrists, and school counselors. Relatively few respondents were uncertain in their reactions. This is true for both the samples of employers and of the educators. Suffice to say, there are substantial numbers of employers of mental health workers who are favorably inclined toward employment of persons so trained. These reactions are important for two reasons. First, they are important because there must be an anticipation of employment outlets for persons so trained; otherwise the usefulness of such programs and their graduates is an academic question. Second, the value of having the mental health agencies actively involved in training programs is forcefully underscored.

What can be said as to the commitment or stability of persons who are attracted into non-traditional training programs? Our three years of study offer a number of conclusions regarding these MHCs. These conclusions suggest very real commitment. For example, there has been no attrition in the group, either in training or over three years of employment. There has been some job mobility and this has been relevant to their training and opportunities for growth and advancement. Finally, a number of these women have taken further coursework to advance their knowledge and skills. Indeed, two of the women have been accepted for the two-year program in group psychotherapy conducted by the Washington School of Psychiatry.

QUESTIONS

Can programs of this type be conducted on a scale that would contribute to easing the mental health manpower problem? Several issues are involved in this question:

(a) To the extent that selectivity contributed to the success of this program, we might ask how many women possessing the characteristics described as maturity, sensitivity, and psychological mindedness, would be interested in this type of training and work?

It appears that a large number of mature women would be interested, especially in urban and suburban areas. For example, among a number of programs, the Women's Continuing Education Program at the University of Minnesota reported an enrollment of 1297 mature women during their initial three years of opera-

tion (Schletzer, 1963). Many of these women were interested in social sciences, especially psychology. The demographic characteristics of these students are similar to those of the women who applied for the MHC training program.

Furthermore, consider the relatively recent emergence of various social service programs (Peace Corps, Project Cause, Job Corps, Vista, Operation Headstart, etc.). These programs call for varied talents and for social service motivation. Responsiveness of large numbers of males and females to work in, or to be trained and then use their training in a working capacity, has indeed been impressive.

It is noteworthy that the percentage of married women who are working has more than doubled since 1941 (from 15 per cent in 1941 to 33 per cent in 1961; see Johnson, 1965). A substantial number of this percentage are mature women who are re-entering the working force.

(b) Does a non-traditional program such as this increase the manpower pool, or does it provide training to women who would otherwise obtain mental health training elsewhere?

This question is similar to one raised by Albee (1963), when he said that he was "...not completely convinced, as yet, that these women (the eight MHCs) would not have found their way into mental health work of some kind in the absence of the program described."

We did survey the applicants who were not accepted for the MHC program to gain whatever information we could on this matter. It appeared that very few of the "semi-finalists" either had entered traditional

training programs or were providing services in the mental health area.

While these individuals represent a rather weak form of control group, we would suspect that the vocational aspirations found among the MHCs were induced partly, if not largely, by experience in the training program. The training set high standards for these women which, in turn, encouraged them to hold vocational aspirations of significant substance.

(c) Would we, in fact, be more certain of increasing available manpower if we invested the additional time and money involved in established traditional programs instead of into programs such as this?

This question is one that has been raised a number of times, often by social workers with whom we have discussed the program. Our impression would be "No." At the present time, we would make *less* contribution to mental health manpower by attempting to reroute time and money that might go to special programs, into established training programs. Many academic departments have been hesitant to admit mature women, particularly as part-time students. The curriculum in many departments does not acknowledge and utilize the life experience of mature women. Graduate and professional school departments frequently confront them with rigid sequences of courses and requirements more suitable for engineering the education of large numbers of post-teenagers and young adults.

We might hope that the emergence of non-traditional training programs would have a stimulating influence upon traditional educational programs in the mental health fields. While this is a hope, we would be less than candid if we did not temper reader enthusiasm in

this regard. Perhaps the influence of non-traditional programs will contribute most to accelerating the rate at which technician and sub-professional curricula are supported and developed in graduate and professional schools.

It is interesting to note that the age of prospective trainees has implications for work as well as for eligibility for training. There is some evidence that if we are to effect the current manpower picture, we would probably do better to train the mature woman whose family responsibilities are lessening, than the younger woman whose major family commitments probably will come in the near future. A survey of 117 female graduates of the School of Social Service Administration of the University of Chicago (Thatcher *et al.*, 1963) tends to confirm this. The survey included the graduates over the 20 year span from 1938 to 1958. Those surveyed were married and had one or more children. Of these 117 Social Workers, only 20 were employed full time and only 25 part-time. It was noted that "on the basis of employment contributions to the field, older women applicants with children represent a good educational investment" since they tend to work consistently and full time while the younger women have a high probability of dropping out of the working force. The fact that traditional degree programs are hesitant to accept such women and that there are real limitations to the feasibility of expansion among traditional programs must weigh heavily here. It hardly appears judicious to divert the relatively small amounts of non-traditional training funds available to such programs.

(d) Is there an inherent problem with any non-traditional training program, namely one of

the ambiguous vocational identity of the person so trained?

The answer to this question is largely dependent upon the flexibility of views in the particular field of employment. The world of work in American society is a highly structured world. An individual is known by what he does and knowing the nature of his work leads to stereotypic views—valid or invalid—as to the kind of person he is. The structuredness of vocational life is most noticeable among occupations regarded as professions. Indeed, some of the hallmarks of professions tend to preserve and strengthen this structure. Several of these are particularly evident: compartmentalization of graduate and professional school education; the quest for statutory and non-statutory forms of regulating practice of the vocation; and the more subtle emergence of belief systems suggesting that if occupation X performs Y functions, then for Y functions to be performed an individual must be an X.

The structuredness of vocational life is a very real issue when considering practitioners of a function with non-traditional educational preparation for providing that function. In the case of non-traditionally prepared counselor/psychotherapists, the basic questions are ones of: (a) Vocational identity (i.e., "Who are you if you are not an X, Y, or Z?"); and (2) organizational structure (i.e., "Our organization's budget authorizes so many X, Y, and Zs. How could we employ you unless you qualify as an X, Y, or Z?")

The MHCs have been employed in professional mental health settings where traditional educational backgrounds are the rule. Two factors seem to have prevented the identity problem from becoming a major issue. First, the supervisors and co-workers of the

MHCs have accepted them personally and professionally. Put another way, the supervisors and co-workers are more positive to these MHCs than they are to the more abstract concept of non-traditionally trained MHCs-in-general. Second, it must be remembered that the MHCs are mature women who have long standing investment in a primary role of wife-mother-responsible community member. Their counselor role is a recently acquired one and undoubtedly secondary to their primary role. This difference presents quite a contrast to the picture of the traditionally trained mental health professional who emerges from training at a relatively early age and for whom the matter of vocational identity is primary.

CONCLUSION

After two years of employment, this small group of non-traditionally trained Mental Health Counselors have compiled a productive, stable and competent record of performance. They are evaluated as providing quite creditable mental health services in the judgment of their supervisors and co-workers. Their training and subsequent performance suggest one avenue for effecting change in the area of mental health manpower.

Who can be trained to provide effectively such services? What kind of training programs and under whose auspices should training take place? These are challenging questions. The results of this project should encourage many individuals and organizations to consider investment in these issues. Perhaps the greatest determinant of future activity in this direction will be

the capacity of mental health professionals and their educators to overcome traditional attitudinal sets regarding vocational functions in mental health work.

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APPENDIX A

A COMPARISON OF THERAPIST CHARACTERISTICS SORT ITEMS OF FIRST YEAR SUPERVISORS WITH A NATIONAL SAMPLE* OF OUT-PATIENT CLINIC DIRECTORS

First Year Supervisors** (also employers) of MHCs	Item Agreement		Total Item Agreement	Percent Agreement
	"above average"	"below average"		
A	40	39	79	96
B	38	38	76	93
C	40	39	79	96
First Year Supervisors (not employers) of MHCs				
D	39	32	71	86
E	40	39	79	96
F	39	41	80	98
G	41	32	73	89
H	38	39	77	94

*The selection of Directors of Psychiatric Out-patient Clinics is described more fully in Appendix B. The ratings on which the data above is based were sent to every other agency in a mailing to 52 agencies Sixteen out of 26 replied.

We were interested in the comparability of the MHCs' employers and directors of agencies elsewhere. We had ratings by a national sample on the Therapist Characteristics Sort in another connection (cf. Appendix M) and also ratings from the MHCs' supervisors on this same measure. We used agreement of ¾ of the Out-patient Directors which produced eighty-two items. The MHCs' supervisors' responses were then compared with these eighty-two items.

**The first three supervisors were most comparable to the national sample since they were also Directors of their agencies. The remaining five were included as a point of comparison.

APPENDIX B

The Inventory of Job Functions (IJF): Development and Item Characteristics

The steps in the development of the Inventory of Job Functions were as follows:

(a) A pool of 175 items describing job functions which might be performed by staff members in mental health agencies was written. Sources included job descriptions, and collection of functions from a variety of mental health professionals.

(b) Items were retained which were applicable to a range of mental health service agencies and at the same time not overly ambiguous. This procedure left 125 items.

(c) The directors of eight different mental health agencies, including educational, hospital, and out-patient settings, who were the initial employers of the MHCs were asked to modify these items and suggest additional items. They considered the functions listed to be representative of those performed at their respective agencies.

(d) Two judges independently classified each item into one of the following eight content categories:

(1) *Educating:* Providing supervision, training or consultation at any level within the agency.

(2) *Maintaining:* All levels of administration, as well as all clerical and secretarial functions.

(3) *Community-Professional:* Primarily *outside* of agency functions. Community relationships such as speaking engagements, committee work; professional duties such as professional association business.

(4) *Professional Growth:* Receiving supervision of training; self-improvement through reading, courses, workshops, etc.

(5) *Scientific:* All levels of research activity.

(6) *Direct Client Services Evaluative:* Direct service of an evaluative, diagnostic, or judgmental nature.

(7) *Direct Client Services Helping:* Direct service designed to be of a helping nature.

(8) *Indirect Client Services:* Services designed to be in the interest of the client, but not directly administered to him.

(e) The two judgments were compared. Items where disagreement occurred were discussed and reworded until consensus was reached.

(f) On the revised pool of items, four different judges, all Ph.D. psychologists experienced in mental health agencies and services, performed the same classifications, each working independently.

(g) The 108 items retained in the final form had been placed in the same category by the first two judges and by at least three of the four new judges.

(h) The 108 remaining items were sent to a national sample composed of 26 Psychologists who were Directors of University Counseling Centers, 24 Social Workers who were Directors of Family Services Agencies and 26 Psychiatrists who were Directors of Out-patient Psychiatric Clinics. The composition of the three samples is as follows:

The Directors of Family Service Associations were selected from the *1963 Directory of Member Agencies of the*

Family Service Association of America. To be listed, the agency "must offer family or family and children's casework, and be active in the improvement of social conditions in the community that affect family life. In addition, it must have an autonomous board and a minimum of two professionally qualified staff members. . .". Selecting one agency from the listing of each state by use of a table of random numbers provided 43 agencies; 5 more were selected at random from the directory, to reach a total of 48 Family Service Agencies.

The Directors of the Psychiatric Out-patient Clinics were selected from the *1961 Directory of Out-patient Psychiatric Clinics* published by the National Association for Mental Health in collaboration with the National Institute of Mental Health. This Directory "is not to be regarded in any sense as an accredited list of clinics, and no endorsement of a particular clinic is implied by including it." The definition of an out-patient psychiatric clinic employed in the directory is: "a psychiatric out-patient service for ambulatory patients, where a psychiatrist is in attendance at regularly scheduled hours and *takes the medical responsibility for all patients in the clinic.*" In addition to the criteria for inclusion in the Directory, the following criteria were used in selecting the sample from the Directory: (1) at least one full time, or two half-time psychiatrists on staff; (2) five day a week clinic; (3) other mental health personnel (psychologists and/or social workers on the staff); (4) services *not* limited to special groups (veterans, alcoholics, mentally retarded, delinquents, post-hospitalized patients). With these criteria, one agency was selected from each continental state by use of a table of random numbers and four others were drawn from the directory at large for a total of 52 agencies.

The University Counseling Centers were selected from a list of participants in the 1962 Annual Counseling Directors' Conference. Fifty-two centers were selected representing 30 states.

Only half of the agency Directors selected received the Inventory of Job Functions and were asked to judge the professional responsibility of each function. The remaining directors received a different form which was also being de-

veloped. Once the total samples had been selected the IJF was included in every other out-going envelope.

These 76 agency directors who did receive the IJF were asked to judge the level of professional responsibility (PR) connoted by each job function. For each job function, they checked a 4 point scale: 4 = high PR; 3 = more high than low PR; 2 = more low than high PR; and 1 = low PR.

Completed usable returns were received from 87% of the directors (96% of the Counseling Centers, 83% of the Family Service Agencies, 81% of the Out-patient Clinics). It should be noted that the distribution of PR among the 108 items is highly skewed. A mean response of "low" PR (mean = 2.50) was obtained on only 14 of the 108 functions. The mean PR value for each of the 108 items follows:

Mean Professional Responsibility (PR) for the 108 Job Functions Computed from the Responses of 66 Agency Directors to a 4 Point Scale

Item No.	PR	Item No.	PR	Item No.	PR	Item No.	PR
1	3.62	18	3.14	35	3.00	52	2.79
2	3.27	19	1.46	36	3.21	53	3.48
3	3.63	20	1.88	37	3.16	54	3.35
4	3.03	21	1.62	38	3.05	55	3.44
5	3.31	22	2.26	39	2.97	56	3.46
6	3.70	23	2.83	40	2.94	57	3.56
7	3.82	24	1.31	41	3.16	58	3.14
8	3.14	25	1.94	42	2.97	59	3.59
9	2.80	26	1.27	43	2.89	60	2.59
10	2.05	27	2.70	44	3.00	61	2.95
11	3.11	28	1.35	45	3.55	62	3.54
12	2.86	29	2.50	46	3.18	63	3.21
13	3.14	30	3.66	47	3.40	64	2.97
14	2.91	31	3.56	48	3.17	65	1.65
15	3.37	32	3.33	49	3.33	66	2.42
16	3.27	33	3.56	50	3.46	67	1.74
17	3.39	34	3.23	51	2.94	68	3.27

Item No.	PR	Item No.	PR	Item No.	PR	Item No.	PR
69	2.16	79	3.49	89	3.53	99	3.21
70	3.42	80	3.60	90	3.34	100	3.03
71	3.41	81	3.56	91	3.66	101	3.11
72	3.46	82	3.39	92	3.63	102	3.11
73	3.55	83	3.62	93	3.66	103	3.32
74	3.67	84	3.52	94	3.08	104	3.29
75	3.63	85	3.52	95	3.55	105	2.88
76	3.60	86	3.46	96	3.80	106	3.12
77	3.71	87	3.52	97	3.41	107	2.72
78	3.62	88	3.46	98	3.27	108	2.83

Agreement among these 66 agency directors was high in regard to a function connoting high or low levels of PR. Responses to the four point scale were converted into a high-low dichotomy. This revealed median agreement of 91% for functions which had a mean PR response of "high" and 83% for those which had a mean PR response of "low". Agreement of less than 75% was obtained on 15 of the 108 items. The percentage of agreement among the 66 judges for each of the functions using a high-low dichotomy follows:

Percentage of Agreement on PR of Each Job Function
Among 66 Agency Directors

(Computed after converting their judgments on a 4 point scale to a "high" — "low" dichotomy where points 3 and 4 = high, points 1 and 2 = low.)

Mean Rating of Low PR			
Item No.	% Agreement	Item No.	% Agreement
10	80	26	97
19	91	28	92
20	73	29	53
21	90	65	87
22	58	66	53
24	97	67	85
25	72	69	61

Percentage of Agreement on PR of Each Job Function
Among 66 Agency Directors.
(continued)

Mean Rating of High PR

Item No.	% Agreement	Item No.	% Agreement	Item No.	% Agreement
1	95	43	78	78	97
2	81	44	77	79	97
3	98	45	92	80	99
4	76	46	81	81	96
5	94	47	91	82	89
6	98	48	86	83	96
7	97	49	94	84	94
8	83	50	90	85	95
9	70	51	73	86	91
11	76	52	65	87	95
12	68	53	97	88	94
13	79	54	91	89	95
14	76	55	95	90	86
15	93	56	99	91	95
16	83	57	99	92	94
17	92	58	78	93	96
18	88	59	91	94	81
23	73	60	55	95	98
27	65	61	78	96	98
30	96	62	96	97	90
31	100	63	94	98	92
32	97	64	75	99	94
33	96	68	91	100	80
34	84	70	95	101	79
35	77	71	92	102	86
36	89	72	94	103	92
37	90	73	92	104	89
38	81	74	97	105	77
39	80	75	97	106	86
40	77	76	96	107	63
41	82	77	92	108	70
42	77				

APPENDIX C

Inventory of Job Functions (IJF): Items and Administration

The IJF was administered to the MHCs and their supervisors as an evaluation measure. The MHCs were administered the IJF each year, responding each year to three questions typed in on the form. The first was: "What functions do your training and experience qualify you to perform at the present time?"* The second was: "What functions have you been performing at *(name of agency)* during the last two months?"† The third was: "What functions would you like to be performing .... years from now?"‡ The number of years changed each year for the third question. In Year I it was three years, Year II it was two years, and in Year III, one year.

Two questions were asked of the supervisors each year. The first was: "Indicate which functions Mrs. *(name of MHC)* has been performing at *(name of agency)* during the last two months.

The second question was: "In your opinion, what functions would you think Mrs. *(name of MHC)* will be qualified to perform years from now?" The date was three years for Year I and two years from Year II to keep it consistent with the MHCs self-ratings.

The level of supervision for each function was to be checked and a description of the degrees of supervision in on the IJF form.

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*Referred to in the text as "functions qualified to perform".

†Referred to in the text as "functions performed".

‡Referred to in the text as "functions aspired to or vocational aspirations".

INVENTORY OF JOB FUNCTIONS

Administered by .... to ....

at ....Date ....

Instructions: This questionnaire contains a wide range of job functions likely to be performed in most "mental health" facilities. General terms have been employed — e.g. "client" refers to the individual who might be referred to as the "patient," "counselee" or "student" in your agency.

A. Please read the question written below.

B. Please answer the question by marking the appropriate column ("No" or "Yes") for each job function.
C. For functions answered "Yes", you will be asked to indicate the degree of supervision accompanying your answer to the question using a 4 point scale.

The 4 points correspond to the following degrees of supervision:

1 = *No supervision* (for that particular function).

2 = *Minimal supervision* (little, if any, scheduled supervisory time required, supervision or suggestions requested when and if needed).

3 = *Moderate supervision* (scheduled supervisory time maintained, questions and work regularly discussed, suggestions made, additional help also available when needed).

4 = *Close supervision* (weekly scheduled supervisory time maintained, instruction and teaching provided in addition to discussion, suggestions, etc.).

Section 1

		No	Yes	Supervision	
1.	Provide on-the-job training for new agency personnel.	1	2	3	4
2.	Explain what led to your opinion about a client to other agency personnel.	1	2	3	4
3.	Supervise students working in the agency.	1	2	3	4
4.	Supervise volunteer workers.	1	2	3	4
5.	Review and suggest improvements in reports about clients written by others.	1	2	3	4
6.	Serve as consultant to related staff members (nurses, aides, teachers, etc.).	1	2	3	4
7.	Supervise others in their work with clients.	1	2	3	4
8.	Train volunteers to work with clients.	1	2	3	4
9.	Provide in-service training to non professional agency personnel.	1	2	3	4
10.	Train clerical staff use of record forms.	1	2	3	4

Section 2

		No	Yes	Supervision	
11.	Regulate the assignment of cases to agency staff.	1	2	3	4

		No	Yes		Supervision
12.	Serve on committee made up of agency personnel.	1	2	3	4
13.	Meet with agency director(s) to discuss matters such as duties, agency policy, as they affect you.	1	2	3	4
14.	Express views to fellow staff members on professional issues such as promotion, duties, etc.	1	2	3	4
15.	Attempt to improve interpersonal relationships of the staff within the agency.	1	2	3	4
16.	Agency administration (funds, budget, staffing).	1	2	3	4
17.	Make merit evaluations of agency staff.	1	2	3	4
18.	Plan staff conferences.	1	2	3	4
19.	Keep count of the number of clinics served by the agency.	1	2	3	4
20.	Score objective paper and pencil psychological tests.	1	2	3	4
21.	Arrange appointments for clients of other staff.	1	2	3	4
22.	Participate in staff business meetings.	1	2	3	4
23.	Determine what fee the client should pay.	1	2	3	4
24.	Collect fee payments from clients.	1	2	3	4
25.	Fill out a record form for your contacts with client.	1	2	3	4
26.	Type reports prepared by other agency personnel.	1	2	3	4
27.	Assign the clients one will see.	1	2	3	4
28.	Keep inventory and order supplies.	1	2	3	4
29.	Formulate personnel practices for clerical staff.	1	2	3	4
30.	Develop methods of improving the agency's services to clients.	1	2	3	4

Section 3

		No	Yes		Supervision
31.	Participate in consultation to community groups.	1	2	3	4
32.	Interpret the work of the agency to lay or professional individuals (other than client's relatives).	1	2	3	4
33.	Serve as consultant to community groups and agencies.	1	2	3	4
34.	Give lectures on mental health to community groups.	1	2	3	4
35.	Represent the agency at a convention.	1	2	3	4
36.	Represent the agency at a meeting with other agencies.	1	2	3	4
37.	Participate in programs for the public concerned with mental illness and health.	1	2	3	4

Section 4

		No	Yes		Supervision
38.	Attend professional convention to keep up with new ideas.	1	2	3	4
39.	Attend special workshop(s) or seminar(s).	1	2	3	4
40.	Get further training in mental health area.	1	2	3	4
41.	Read professional materials.	1	2	3	4
42.	Ask another staff member to explain how he came to his opinion about a client.	1	2	3	4
43.	Sit in as observer in client groups to learn about group interactions and dynamics.	1	2	3	4

Section 5

		No	Yes	Supervision	
44.	Cooperate as subject, judge, data collector in research studies of agency colleagues.	1	2	3	4
45.	Plan research programs.	1	2	3	4
46.	Prepare research reports.	1	2	3	4
47.	Analyze research data.	1	2	3	4
48.	Do research on areas of personal interest.	1	2	3	4
49.	Do research studies on issues of agency interest.	1	2	3	4
50.	Formulate a grant request for a study within the agency.	1	2	3	4
51.	Review the research literature on a topic.	1	2	3	4
52.	Abstract research articles.	1	2	3	4

Section 6

		No	Yes	Supervision	
53.	Assess client's motivation and desire for help.	1	2	3	4
54.	Make decision regarding client's need for this agency's service.	1	2	3	4
55.	Assess the client's adjustment after agency service is terminated.	1	2	3	4
56.	Determine what type of problem the client has.	1	2	3	4
57.	Determine which psychological tests are appropriate for a client.	1	2	3	4
58.	Administer psychological tests.	1	2	3	4
59.	Evaluate and interpret client's psychological test performance.	1	2	3	4
60.	Obtain educational and vocational history from client.	1	2	3	4
61.	Obtain social history information from client.	1	2	3	4

Section 7

		No	Yes	Supervision	
62.	Discuss the treatment plans with the client.	1	2	3	4
63.	Aid the client to understand what services the counselor can offer him.	1	2	3	4
64.	Give educational or vocational advice to client.	1	2	3	4
65.	Chat informally, play cards, walk, etc. with the client.	1	2	3	4
66.	Teach skills to the client.	1	2	3	4
67.	Participate in leisure activities with clients.	1	2	3	4
68.	Conduct groups where clients discuss their problems.	1	2	3	4
69.	Tell the client what you would do in his position.	1	2	3	4
70.	Talk with children about their problems.	1	2	3	4
71.	Talk with adult clients about their problems.	1	2	3	4
72.	Talk with adolescents about their problems.	1	2	3	4
73.	Conduct play therapy sessions with children.	1	2	3	4
74.	Work with clients for an extensive number (more than 24) of interviews.	1	2	3	4
75.	Work with clients for a limited number (3-24) of interviews.	1	2	3	4
76.	Work with clients for a few (1-2) interviews.	1	2	3	4
77.	Attempt basic personality change in clients.	1	2	3	4
78.	Attempt to enhance client's self understanding and self acceptance.	1	2	3	4
79.	Discuss those test results with a client which might help him.	1	2	3	4
80.	Help client clarify his problem and what can be done about it.	1	2	3	4
81.	Interview clients with intent to modify attitudes and behavior.	1	2	3	4

Section 7 (cont.)

		No	Yes		Supervision
82.	Interview clients with intent to provide emotional support.	1	2	3	4
83.	Interview clients with intent to modify the client's defenses.	1	2	3	4
84.	Work for realistic decision making on client's part through interviews.	1	2	3	4
85.	Discuss interpersonal problems with the client.	1	2	3	4
86.	Discuss childhood events with the client.	1	2	3	4
87.	Discuss current life stresses with the client.	1	2	3	4
88.	Discuss future plans and problems with the client.	1	2	3	4
89.	Discuss the client's feelings toward the therapist with him.	1	2	3	4
90.	Discuss with the client one's feelings towards him.	1	2	3	4
91.	Aid the client to re-experience currently unconscious memories.	1	2	3	4
92.	Utilize the client's dreams in the interviews.	1	2	3	4
93.	Utilize the technique of free association in the interviews.	1	2	3	4
94.	Interview clients with relatively simple problems.	1	2	3	4
95.	Interview clients with somewhat complex problems.	1	2	3	4
96.	Interview clients with extremely complex problems.	1	2	3	4
97.	Terminate one's interactions with client.	1	2	3	4

Section 8

		No	Yes	Supervision	
98.	Discuss the treatment plan with relatives of the client.	1	2	3	4
99.	Cooperate with representatives of other agencies also providing services to client.	1	2	3	4
100.	Arrange for referral of client to appropriate outside agency or person.	1	2	3	4
101.	Contact other professional staff within the agency so as to provide for effective transition of the client between different services.	1	2	3	4
102.	Present progress of a case at a staff conference.	1	2	3	4
103.	Attempt to modify the behavior of client's relatives through interview(s).	1	2	3	4
104.	Participate with other staff in developing plan for amelioration of client's problems.	1	2	3	4
105.	Interview client's relatives to gain information about the client.	1	2	3	4
106.	Interview client's relatives to help them understand the client's problems.	1	2	3	4
107.	Communicate by telephone or letter with client's relatives.	1	2	3	4
108.	Aid other staff in providing a more suitable environment (home, school or job) for clients.	1	2	3	4

If there are other functions that occur to you as answers to the question, please list below.

	No	Yes	Supervision	
	1	2	3	4
	1	2	3	4
	1	2	3	4
	1	2	3	4
	1	2	3	4

APPENDIX D

ITEMS FROM IJF WHICH ALL MHCs RESPONDED TO SIMILARLY ALL THREE YEARS

Items All MHCs Answered:

Category	Yes	No
1. Educating	2	10
2. Maintaining		11, 20, 21, 24
3. Community-Professional		
4. Professional Growth	39, 40, 41, 42	
5. Scientific		
6. Direct client services-evaluative	53, 56	58, 59
7. Direct client services-helping	71, 72, 74, 75, 78, 81, 83, 84, 85, 86, 87, 88, 89, 90, 92, 95, 97,	
8. Indirect client services	98, 104, 106	

APPENDIX E

MHCs' Time Distribution Among Job Functions

The form reproduced here was administered to the MHCs at the end of their third year of employment in conjunction with the administration of the Inventory of Job Functions. The form was used to record the MHCs' estimated percentage of time in a week which they spent on the several types of job functions.

NAME	AGENCY	DATE

Below is a list of 8 categories which include the functions on the Functions Questionnaire. In the column "per cent (%) of time per week" estimate the per cent of time you spend in the agency working in each category.

Section	Category	Description of Category	Per cent (%) time per week
1	Educating	Providing supervision, training, or consultation within the agency	
2	Maintaining	Administrative and clerical	
3	Community-Professional	Community relationships (speaking engagements, committee work)	
4	Professional Growth	Further training, workshops, conventions	
5	Scientific	Research	
6	Direct Client Services - Evaluative	Direct service to clients of an evaluative, diagnostic or judgmental nature	
7	Direct Client Services - Helping	Direct service to clients designed to be of a helping nature	
8	Indirect Client Services	Services designed to be in the interest of the client but not directly administered to him	
	TOTAL		100% *

* The 100% would refer to the time you work in the agency. Please put the amount of time you work each week (in days) ....

APPENDIX F

Monthly Report and Client Termination Form

The form was submitted at the end of each month by each MHC throughout the second and third year.

M H Counselor .... Agency .... Month of .... 196......

1. # of days worked this month ....
2. # of different patients seen this month: Individually ....; Group ....; Total ....
3. # of individual "hour" interviews this month ....
4. # of group sessions this month ....
5. # other interviews this month ....
6. # of hours of individual supervision received this month ....
7. Comments/other ....

....

8. Clients terminated this month

Termination Date	Age	Sex	Educ.	Total # individual "hours"	Other Contact	Total # group sessions	Description

APPENDIX G

Brief Descriptive Listing of Range of Problems Among MHCs' Clients

This array is presented to give some impressions of the clients with whom the MHCs were working. The listing is derived from the MHCs' Monthly Report Forms of Terminated Clients for the period May 1, 1964 to April 30, 1965. The descriptions are not all in traditional terminology; when they are, they are generally the agencies' diagnosis.

Schizophrenic reaction — borderline
Schizophrenic reaction — upon graduation from high school
Schizophrenic acute — reaction to decisions re: marriage and career choices
Schizophrenic reaction — acutely psychotic and self-destructive
Schizophrenic paranoid

Depression — depressive reaction, suicidal
Depression — depression bordering on catatonic withdrawal
Depression — depressive reaction, passive dependent personality
Depression — depressive reaction, psychoneurotic
Depression — depressive housewife, woman
Depression — depression and school difficulty

Adolescent adjustment reaction
Acting out angry adolescent
Childhood adjustment reaction (learning disability, negativism, underachievement)

Anxiety — anxiety reaction, in passive dependent personality
Anxiety — anxiety attacks, school difficulty
Anxiety — Anorexia Nervosa, socially withdrawn

Parents of child in treatment
Father of child with adolescent adjustment reaction
Psychoneurotic reaction
Mother of child referred for childhood adjustment reaction
Underachieving boy with poor peer relations
Academic difficulty
Difficulty with school roommate
Compulsion to work
Character disorder
Sado-masochistic relationship
Phobic child
Passive, aggressive personality — passive dependent type

APPENDIX H

CHARACTERISTICS OF THE SUPERVISORS WHO PROVIDED RATINGS OF THE MHCs' PERFORMANCE DURING THE THREE-YEAR FOLLOW-UP STUDY.

Total N=20

Profession		Psychotherapeutic Orientation	
Psychiatry	17	Psychoanalytic	11
Psychology	1	Eclectic	5
Social Work	1	Neo-Freudian	1
School Counselor	1	Other	3

Experience

Psychiatrists	Years Since M.D. Degree
4	15 or more
6	10 - 14
5	5 - 9
2	less than 5

Social Worker:	More Than 15 Years Post MSW
Psychologist:	10 - 14 Years Post M.A.
School Counselor:	10 - 14 Years Post M.A.

APPENDIX I

Supervisors' Rating Scale

This rating scale was administered to the MHCs' supervisors during the first and second years of follow-up. The scale was used the third year as a part of the Supervisor's Final Report described in Appendix J. The three ratings which compared the MHCs' psychotherapy performance each year with that of specified reference groups are reproduced here as they were administered.

Reliability. It was not possible to conduct studies of the interrater or repeat reliability of this instrument.

Validity. It was not possible to conduct experimental studies of the validity of this instrument. Global ratings of this type have a high degree of intrinsic validity or face validity. The evaluations which this scale called for are of a type commonly made in mental health agencies for purposes of employment, evaluation of trainees and staff, and promotion.

Rating Scale on Quality of Mental Health
Counselor's Interactions with Clients

Administered by:.......................... Date:.................

To:..

MHC: ....

Instructions

This scale is designed for use by the supervisor of the Mental Health Counselor to aid in evaluating the *quality of her ther-*

apeutic or counseling work with clients. "Client" is being used as a general label for the individuals who in any one agency might be called patients, students, counselees, etc. The information you give will be treated as confidential and will not be revealed to the MHC.

I. First give your general or global evaluation of the quality of...................... performance.

As compared with new therapists or counselors (independent of discipline) starting their first professional position, the quality of ....performance with clients was (circle the number of your choice):

1 = Far above average (about top 10%)

2 = Above average (about top 30%)

3 = Average

4 = Below average (about lower 30%)

5 = Far below average (about lower 10%)

II. Next, please give some additional global ratings of the quality of.........................counseling or therapeutic performance but this time as compared to more specific reference groups.

A. First check the reference group whose counseling or therapy you are most familiar with:

.... Psychiatrists, having completed more than 2 years of residency, starting their first post-resident position.

............Psychiatrists, having completed less than 2 years of residency.

............Clinical Psychologists (Ph.D.) starting their first post-doctoral position.

............Clinical Psychology Interns.

.... Social Caseworkers (MSW) starting their first post-masters position.

............School Counselors.

III. Next, compare the quality of .... performance with that of the reference group you have checked (circle the number of your choice):

1 = Far above average (about top 10%)
2 = Above average (about top 30%)
3 = Average
4 = Below average (about lower 30%)
5 = Far below average (about lower 10%)

IV. Last, compare the quality of .... performance with that of the Social Worker (MSW) starting her first post-masters position (circle the number of your choice):

1 = Far above average (about top 10%)
2 = Above average (about top 30%)
3 = Average
4 = Below average (about lower 30%)
5 = Far below average (about lower 10%)

APPENDIX J

THE SUPERVISORS' FINAL REPORT

This final evaluation form was completed by MHCs' supervisors toward the end of the third year of employment. It included and supplemented the Supervisors' Rating Scale described in Appendix I. The Supervisors' Final Report is reproduced as it was administered.

Final Report
Mental Health Counselor Evaluation

This Form represents the end of our three-year follow-up study of eight mental health counselors (MHCs).

Your considered opinions are of great importance since you number among the few psychiatrists who have had direct contact with a MHC in the working situation.

(1) a. Name of Supervisor ....
b. Name of MHC described on the form ....
(Please complete one form for each MHC you have supervised.)

(2) Please list other types of professional or sub-professional mental health workers whose work you have supervised.

(3) For how many months have you supervised the MHC?........

(4) Did you observe any actual interviews conducted by the MHC? Yes .... No ....

If yes, about how many? ....

(5) Did you listen to interviews taped by the MHC? Yes .... No...........If yes, about how many? ....

(6) Which of the following best describes the typical amount of scheduled supervision you provided the MHC?

............Less than 1 hour a month
............About 1 hour a month
............About 1 hour every two weeks
............About 1 hour a week
.... More than 1 hour a week

(7) Did you select the patients that the MHC would subsequently see? Always ....Usually............ Occasionally........... Never............

(8) If you did select or help select the MHCs' patients, what "criteria" did you use?

(9) Were there certain types of patients that you preferred the MHC to work with?

Yes .... No .... If yes, what types?

(10) Were there certain types of patients whom you thought the MHC *should not* work with?

Yes........... No ....If yes, what types?

(11) Did the MHC herself select patients that she would subsequently see?

Always .... Usually ....

Occasionally .... Never ....

(12) If she did select or help select her patient how would you describe the appropriateness of her selections?

............Apropriate selections .... More appropriate than inappropriate .... More inappropriate than appropriate ....Inappropriate selections

(13) Were there certain types of patients that the MHC *preferred* to work with?

Yes ....No...........If yes, what types?

(14) Were there certain types of patients that the MHC preferred *not* to work with? Yes .... No .... If yes, what types?

(15) In her *work with patients*, what types of things would you have liked the MHC to do that she was often *unable* to do?

(16) In her *other work in the agency*, what types of things would you have liked the MHC to do that she was often *unable* to do?

(17) Were there certain things in her *work with patients* in which the MHC was particularly effective?

(18) Were there certain things in her *other agency work* in which the MHC was particularly effective?

(19) Describe any personal attributes of the MHC that seemed different from other new staff members in your agency.

Questions 20, 21, and 22 concern your evaluation of the *quality of* the MHC's *therapeutic or counseling work* with her patients or clients.

(20) Please give your *general* or *global* evaluation of the quality of the MHCs performance with patients as *compared with new therapists* or counselors (independent of discipline) starting their first professional position (check one).

.... Far above average (about top 10%)
.... Above average (about top 30%)
.... Average
.... Below average (about lower 30%)
.... Far below average (about lower 10%)

(21) a. Please check the one reference group whose counseling or therapy you are most familiar with:

.... Psychiatrists, having completed more than 2 years of residency, starting their first post-resident position.
.... Psychiatrists, having completed less than 2 years of residency.
.... Clinical Psychologists (Ph.D.) starting their first post-doctoral position.
.... Clinical Psychology Interns
.... Social Caseworkers (MSW) starting their first post-masters position.
.... School Counselors
.... Other (specify) ....

b. Compare the quality of the MHC's performance with that of the reference group you have checked. (Check one)

.... Far above average (about top 10%)
.... Above average (about top 30%)
.... Average
.... Below average (about lower 30%)
.... Far below average (about lower 10%)

(22) Please compare the quality of the MHC's performance with that of the Social Worker (MSW) starting her first post-masters position. (Check one)

.... Far above average (about top 10%)
.... Above average (about top 30%)
.... Average
.... Below average (about lower 30%)
.... Far below average (about lower 10%)

(23) The comprehensive community mental health center (in its ideal future form) may be composed of a wide range of programs and services.

How well do a MHC's training and skills equip her to work in these various programs and services? How useful might she be?

	Very Useful	Useful	Of Doubtful Use	Of No Use	In what ways might she best be used (if at all)?
A. Hospitals for long-term care					
B. Psychiatric units in General Hospital					
C. Day Hospitals					
D. Night Hospitals					
E. 24 hour "walk-in" out-patient Service					
F. Out-patient Clinic					
G. Diagnostic and referral Service					
H. Rehabilitation Services					
I. Mental Health Consultation Services					

	Very Useful	Useful	Of Doubtful Use	Of No Use	In what ways might she be used (if at all)
J. Community Mental Health Education Services					
K. Other:					
L. Other:					

(24) a. If more mental health counselors were trained in the next three or four years, how many, if any, would you request budget support for? In other words, how many MHCs would you want to employ?

.... None
.... One
.... Two or Three
.... Four or Five
.... More than Five

b. Please describe the main factors which lead to your choice in 24 A.

APPENDIX K

Co-Worker Interview Forms

(Initial and Post-Termination)*

The following two forms were used during the first and second years to guide the project interviewers in questions asked and information required. They were not administered as written questionnaires although they read that way. The order in which questions were asked and the techniques of further questioning and inquiry were determined by the interviewer. The interviews were semi-structured in nature and much freedom was allowed both the interviewer and the respondent in the framing and answering of questions.

The introductory material for both interviews was as follows:

As you know, Mrs. .... is one of a group of women recently trained at N.I.H. as Mental Health Counselors. Their employment in several agencies is currently being studied so as to aid in planning for future programs. This form contains several questions to be answered by each of the professional staff she has been working with. We would appreciate your answering these questions in as objective a manner as possible. Your cooperation is very much appreciated.

All responses are confidential.

---

*Initial form was used each year while the Post-Termination form was used only when an MHC left the agency during the project period.

The Initial Co-Worker Interview

(1) Respondent's profession:

(2) Respondent's years of experience since degree:

(3) a. Respondent's length of time in agency:
b. Kind of contact:

(4) What is your professional opinion of Mrs. ....
and her work in your agency?

(*5) What, in your opinion, is her greatest professional strength or asset?

(*6) What, in your opinion, is her greatest professional weakness or fault?

(7) How could her training have been modified to make her more useful in your agency?

(8) How does her contribution to the agency compare to that of the traditionally trained new staff members?

(9) a. How would you feel about having Mrs. ....
as a colleague for the next five years?

.... Very positively .... Positively
.... Uncertain .... Negatively
.... Very Negatively

b. What are the reasons for the above response?

The Post-Termination
Co-Worker Interview

Date..........

(1) Respondent's profession:

(2) Respondent's years of experience since degree:

(3) Respondent's length of time in agency:

---

*Please note that questions 5 and 6 call for a relative response. For example, you might feel that she has no major professional weakness, but describe that which she is weakest at relative to her other skills.

(4) a. What do you think about Mrs. .... leaving the agency?

b. Have you seen any effect of her leaving on the agency?

(5) What is your professional opinion of the work Mrs. .... did here?

(6) a. Did Mrs. .... 's professional work change during the period of her employment? If so in what ways?

b. Did she seem to change?

(7) Why do you think she left? (If you had to guess, what would you say was the main factor?)

(8) If there was another woman available for employment, who had been trained in a way similar to Mrs. .... (i.e. non-traditionally), what would be your recommendation toward hiring her?

(9) There has been some talk in the past of starting other programs to provide similar training as did the MHC program.

a. What do you think about training more professional mental health workers like the MHC's?

b. How would you feel about spending your own time to train such workers?

c. How do you think they could be used most effectively in an agency like this one?

APPENDIX L

THE CO-WORKER FINAL QUESTIONNAIRE

The Co-Worker Final Questionnaire is reproduced here. It was administered to the co-workers of the MHCs toward the completion of the third year of follow up. It was not administered as an interview but instead was completed as a written questionnaire.

Final

Co-Worker Questionnaire 1965

This form represents the end of our three-year follow-up study of eight mental health counselors (MHC).

Your considered opinions are of great importance since you number among the few mental health professionals who have had direct working contact with an MHC.

Section I

1. Respondent's Name ....
2. MHC's Name ....
3. Respondent's Profession ....
4. For how many months have you worked in the same agency as the MHC? ....
5. Describe any work experiences whereby you and the MHC

worked in actual collaboration: (co-therapists in a group; teen contact)

6. Describe any work experiences where you provided direct supervision or training to the MHC.

7. How frequently did you determine what work the MHC would (or would not) perform?

Always .... Usually ....
Occasionally .... Never ....

8. If you did determine, or help determine, what work the MHC would (or would not) do, please describe the bases you used for making such determinations.

9. Were there certain types of work that you thought the MHC should do more of?
Yes .... No .... If yes, what types?

10. Were there certain types of work that you thought the MHC should do less of?
Yes .... No .... If yes, what types?

Section II

The next several questions focus on the MHC's work with patients or clients

11. Did you select or help select the patients that the MHC would subsequently see?

    Always .... Usually ....
    Occasionally .... Never ....

12. Were there certain things in her work with patients in which the MHC was highly effective?

    Yes .... No .... If yes, please elaborate.

13. Were there certain things in her work with patients in which the MHC was highly ineffective?

    Yes .... No .... If yes, please elaborate.

14. Please give your general or global evaluation of the quality of the MHC's performance with patients as compared with new therapists or counselors (independent of discipline) starting their first professional position (check one).

    .... Far above average (about top 10 per cent)
    .... Above average (about top 30 per cent)
    .... Average
    .... Below average (about lower 30 per cent)
    .... Far below average (about lower 10 per cent

15. a. Please check the one reference group whose counseling or therapy you are most familiar with:

    .... Psychiatrists, having completed more than 2 years of residency, starting their first post-resident position.

.... Psychiatrists, having completed less than 2 years of residency.

.... Clinical Psychologists (Ph.D.) starting their first post-doctoral position.

.... Clinical Psychology interns

.... Social caseworkers (MSW) starting their first post-masters position.

.... School Counselors

Others (specify) ....

b. Compare the quality of the MHC's performance with that of the reference group you have checked. (Check one)

.... Far above average (about top 10 per cent)
.... Above average (about top 30 per cent)
.... Average
.... Below average (about lower 30 per cent)
.... Far below average (about lower 10 per cent)

16. Did the MHC *ask you* for your opinion or advice regarding her work with a patient?

Yes .... No .... If yes, about how often?

.... Less than once a month
.... About once a month
.... About once a week
.... More than once a week

17. Did *you ask* the MHC for her opinion or advice regarding your work with a patient or patients?

Yes .... No .... If yes, about how often.

.... Less than once a month
.... About once a month
.... About once a week
.... More than once a week

Section III

The remaining questions also concern the MHC's work in the agency but are not limited to her work with patients.

18. Were there certain things in her other agency work in which the MHC was highly effective?

    Yes .... No .... If yes, please elaborate.

19. Were there certain things in her other agency work in which the MHC was highly ineffective?

    Yes .... No .... If yes, please elaborate.

20. Did the MHC *ask* for *your* opinion or advice regarding other professional or agency business?

    Yes .... No .... If yes, about how often?

    .... Less than once a month
    .... About once a month
    .... About once a week
    .... More than once a week

21. Did *you ask* the MHC for her opinion or advice regarding other professional or agency business?

    Yes .... No .... If yes, about how often?

    .... Less than once a month
    .... About once a month
    .... About once a week
    .... More than once a week

22. Describe any personal attributes of the MHC that seemed different from other new staff members in your agency?

23. Please compare the MHC with the traditionally trained staff member along the following dimensions:

	More Than Average	About Average	Less Than Average
A. Identification with the agency			
B. Effort and work output			
C. Contribution to case discussions			
D. Contribution to morale			
E. Source of new ideas			
F. Openness to new ideas			
G. Co-operativeness			
H. Friendliness			
I. Job satisfaction obtained			
J. Role definition achieved (know what you should do in the professional setting.)			
K. Overall contribution to the agency			

24. How well does an MHC's training and skills equip her to work in these various programs and services? How useful might she be?

	Very Useful	Useful	Of Doubtful use	Of No Use	In what ways might she best be used (if at all)?
A. Hospitals for long-term care					
B. Psychiatric units in General Hospitals					
C. Day Hospitals					
D. Night Hospitals					
E. 24 Hour "walk-in" out-patient Service					
F. Out-patient Clinic					
G. Diagnostic and referral Service					
H. Rehabilitation Services					
I. Mental Health Consultation Services					
J. Community Mental Health Education Services					
K. Other:					
L. Other:					

25. If more mental health counselors were trained in the next three or four years, how many, if any, would you want the agency director to hire?

    .... None
    .... One
    .... Two or three
    .... Four or five
    .... More than five

26. How would you feel about having the one MHC as a colleague for the next five years?

    .... Very positive
    .... Positive
    .... Uncertain
    .... Negative
    .... Very negative

Please describe the main reasons for your answers in 25 and 26.

APPENDIX M

THE THERAPIST CHARACTERISTICS SORT

The Therapist Characteristic Sort is reproduced here. This instrument was administered twice the first year and twice the second. The first page is the head sheet used for the first administration to the MHCs' supervisors during the first and second years. The second page is the head sheet for the second administration. The remaining pages were identical for both forms.

A number of these items were taken or adapted from an experimental psychotherapists' Q-Sort which was being developed by Drs. Ronald Fox and Hans Strupp of the University of North Carolina. Their assistance in providing these materials is gratefully acknowledged.

Therapist Characteristics Sort

Administered by .... to ....

at .... Date ....

Instructions

Each of the items on the list describes a trait or technique that therapists or counselors often differ on. On the basis of your experience with Mrs. ...., please give your opinion (or your best inference) whether each of the items tends to be either:

A. Presently *characteristic* of her performance and work with clients, or

B. Presently *uncharacteristic* of her performance and work with clients.

For each items, please mark under either "A" for Characteristic, or "B" for Uncharacteristic.

	A	B
1. Is firm in dealings with client.		
2. Is permissive in dealings with client.		
3. Behaves in an assertive fashion.		
4. Seems strict with the client.		
5. Has a self-critical capacity.		
6. Genuinely submissive; accepts domination comfortably.		

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Instructions

Please provide the following background Information:

Your Name ....

Agency ....

Years of experience since degree: .... less than 5; ...... 5-9; .... 10-14; .... more than 14.

Primary theoretical orientation ....

Each of the items on this list describes a trait or technique that therapists or counselors often differ on. Terms such as "patient" and "client" "counseling or psychotherapy" are intended to be interchangeable for the purposes of this inventory. Also, any judgments of quality might vary depending upon theoretical orientation and treatment goals. You are asked to resolve these differences as best you can in arriving at your opinion as described below.

Please give your opinion (or your educated best guess) whether each of the items tends to be *more characteristic* of either:

A. The *"above average"* therapist or counselor (independent of discipline) starting his or her first professional position, or

B. The *"below average"* therapist or counselor (independent of discipline) starting his or her first professional position.

For *each* item, please mark under either "A" for above average or "B" for below average.

	A	B
1. Is firm in dealings with client.		
2. Is permissive in dealings with client.		
3. Behaves in an assertive fashion.		
4. Seems strict with the client.		
5. Has a self-critical capacity.		
6. Genuinely submissive; accepts domination comfortably.		
7. Argues with the client.		
8. Acts and speaks like an authority.		
9. Uses the client's frame of reference.		
10. Redirects the interview.		
11. Reflects the client's feelings.		
12. Gives advice to the client.		
13. Interrupts long pauses.		
14. Interrupts client's flow of speech.		
15. Mostly nods and says "uh huh".		
16. His (or her) questions are "probing."		
17. Understands and responds to client's feelings on many levels.		
18. Uses clarification as an interview technique.		
19. Restates the content of the client's statement.		

	A	B
20. Attempts to make connections (elucidates themes, etc.).		
21. His comments seem to "hit the nail on the head."		
22. Focuses on motivational factors.		
23. Suggests relation between what is said and client's feelings toward him (or her).		
24. Strives to correct misunderstandings.		
25. Tries to elicit affect from the client.		
26. Tends to be intellectual and analytical.		
27. Responds to the feeling tone of what is said.		
28. Responds primarily to the manifest content of what is said.		
29. Shows respect for client as a person.		
30. Seems accepting of the client.		
31. Completely dominates the client.		
32. Conducts interview in perfunctory disinterested fashion.		
33. Uses a common sense approach to the client's problems.		
34. His attitude seems cold or distant.		
35. It is virtually impossible to form an opinion about the therapist's or counselor's attitude.		
36. Tends to arouse liking and acceptance in people.		
37. Has warmth; the capacity for close relationships.		
38. Is socially perceptive of a wide range of interpersonal cues.		
39. Is not misled by the client.		
40. Seems critical of the client.		
41. Gets tied up in details.		
42. Judges the client in terms of conventional morality.		

	A	B
43. Conveys reassurance during interviews.		
44. Builds client's self-confidence.		
45. Shows condescending behavior in relations with the client.		
46. Is tactful.		
47. Structures the interview(s) for the client.		
48. Gives evidence of carefully listening to the client.		
49. Lack of closure (leaves client in "mid air").		
50. Communicates to the client an understanding that emotional problems exist.		
51. Appears empathic.		
52. Behaves in a giving way toward the client.		
53. Encourages client to seek his own solutions.		
54. Interview communications are brief.		
55. Is talkative during the interviews.		
56. Says very little in any one utterance.		
57. Responses seem obscure or meaningless.		
58. Uses clear and simple language.		
59. Is verbally fluent; can express ideas well.		
60. Speaks hesitantly (is tentative — manner encourages client to continue developing the subject).		
61. Comments are creative and original.		
62. Comments convey a dull, flat feeling.		
63. Favors conservative values in a variety of areas.		
64. Uses humor during interviews.		
65. Is flexible in work with clients.		
66. Is an interesting, arresting person.		
67. Has capacity to tolerate client's affects and tensions.		

	A	B
68. One gets the impression that the client is learning something about himself in the interview.		
69. His (or her) manner seems natural and spontaneous.		
70. Appears to have a high degree of intellectual capacity.		
71. Seems aware of own stimulus value.		
72. Is calm, relaxed in manner during the interviews.		
73. Is uncomfortable with uncertainty and complexities.		
74. Has a rapid personal tempo; behaves and acts quickly.		
75. Seeks gratification from the client.		
76. Identifies with the client.		
77. Is defensive (thin skinned).		
78. Puts the client on the defensive or embarrasses him.		
79. Is highly involved in what is going on.		
80. Shows signs of hostility toward the client.		
81. Seeks reassurance from the client.		
82. Treats the interview like a social situation.		
83. Misinterprets what the client says.		
84. Expresses own feelings and reactions during interviews.		
85. Remains essentially anonymous during interviews.		
86. Reacts with doubt and incredulity to elements of the client's account that do not make good common sense.		
87. Seems to look to the client for guidance.		
88. Approaches the client very intellectually.		

	A	B
89. Recognizes the client's discomfort, fears, concerns.		
90. Seems highly interested in work with clients.		
91. Seems to grope and fumble.		
92. Is mainly interested in collecting "facts" or data from the client's life history.		
93. Asks a good many questions.		
94. His attitude toward the client seems friendly.		
95. Obviously tries to put the client at ease.		
96. Seems eager to "make friends" with the client.		
97. Doesn't depart from one orientation toward work with clients.		
98. Seems anxious and ill-at-ease.		
99. Becomes emotionally involved in regard to the client's troubles.		
100. Seems highly experienced as an interviewer.		
101. Utilizes supervision or consultation effectively.		
102. Clients terminate by simply not returning.		
103. Work with clients is carefully planned.		
104. Clients tend to resist terminating the relationship.		

APPENDIX N

THERAPIST ORIENTATION QUESTIONNAIRE

The 1962 (revised) form of the Therapist Orientation Questionnaire is reproduced here. The development of this instrument is reported in an article entitled "The Orientations of Psychotherapists" published in the *Journal of Consulting Psychology*, 1962, **26**, 201-212, by Donald M. Sundland and Edwin N. Barker.

Therapist's Orientation Questionnaire, Form 1962

Name: .... Date: ....

Please indicate your *agreement* or *disagreement* with the following statements.

Circle one of the following:

SA Strongly agree
A Agree
UN Undecided or "it depends."
D Disagree
SD Strongly disagree

SA A UN D SD 1. With most patients I do analytic dream interpretation.

SA A UN D SD 2. A treatment plan is *not* important for successful therapy.

SA A UN D SD 3. A therapist should have long-range goals for his patients.

SA A UN D SD 4. It is necessary that a patient learn how early childhood experiences have left their mark on him.

SA A UN D SD 5. The major cause of neurotic behavior consists of internalized, overly-restrictive inhibitions of personal desires.

SA A UN D SD 6. No matter how emotionally mature and sensitive a person is, he cannot be a good therapist without training in psychopathology.

SA A UN D SD 7. I am a fairly active, talkative therapist, compared to most therapists.

SA A UN D SD 8. A good therapist will "interpret" his patient's behavior, in the sense of telling him its real significance — meanings of which he is unaware.

SA A UN D SD 9. My own attitudes toward some of the things my patients say or do, stop me from really understanding them.

SA A UN D SD 10. The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling that is right.

SA A UN D SD 11. The wise therapist will never try to advise a patient about the best way of coping with a life-situation.

SA A UN D SD 12. The most important learning in therapy is verbal and conceptual in nature.

SA A UN D SD 13. A mature, mentally healthy person will necessarily move in the direction of society's goals.

SA A UN D SD 14. In the therapy hour the therapist should act reserved, uninvolved, and impersonal.

SA A UN D SD 15. People can be understood without recourse to the concept "unconscious determinants of behavior."

SA A UN D SD 16. The most important variables in the outcome of therapy are the therapist's professional training in therapy techniques and his expert use of these techniques.

SA A UN D SD 17. I would *not* interrupt a patient during a therapy session as I might if we were having merely a social conversation.

SA A UN D SD 18. The most beneficial outcome of therapy is the patient's becoming more open to his feelings.

SA A UN D SD 19. It is *not* helpful to formulate for myself the psychodynamics of the patient's relationship with me.

SA A UN D SD 20. It is always unhealthy for a person to feel free-floating anxiety.

SA A UN D SD 21. Inherent in human beings is a natural propensity toward health, both physical and mental.

SA A UN D SD 22. Frequently, strong advice or actual commands by the therapist are indicated.

SA A UN D SD 23. Understanding why one does things is the most effective factor in correcting one's behavior.

SA A UN D SD 24. I am a fairly passive silent therapist, compared to most therapists.

SA A UN D SD 25. It is all right for a therapist, during the session, to experience strong emotional feelings concerning a patient.

SA A UN D SD 26. With most patients I instruct them to free associate.

SA A UN D SD 27. Therapists should make an overall treatment plan for each case.

SA A UN D SD 28. The most important learning in therapy is affective, non-verbal, and non-conceptual in nature.

SA A UN D SD 29. For a patient to improve his current way of life, he must come to understand his early childhood relationships.

SA A UN D SD 30. A too strict super-ego is more often associated with neurotic behavior than is a too-lenient super-ego.

SA A UN D SD 31. It is usually unwise for the therapist to deliberately influence a patient toward certain behaviors and attitudes.

SA A UN D SD 32. A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him.

SA A UN D SD 33. The patient's coming to experience his feeling more fully is *not* the most important therapeutic result.

SA A UN D SD 34. I point out connections between behaviors and attitudes, both those expressed in therapy and those described from present and past life situations.

SA A UN D SD 35. It is *unwise* for a therapist's remarks and reactions to a patient to be unplanned, spontaneous, not thought-through.

SA A UN D SD 36. A good therapist expresses to his patients a sense of personal involvement and concern.

SA A UN D SD 37. A successful adjustment to the social environment is *not* an important goal of therapy.

SA A UN DASD 38. The most beneficial outcome of therapy is for the patient to know the reasons for his behavior.

SA A UN D SD 39. It is possible to make sense of a patient's behavior without assuming motives of which he is unaware.

SA A UN D SD 40. Patients get better more because their therapists are the kinds of persons they are than because of their therapist's professional training.

SA A UN D SD 41. It is quite acceptable to interrupt a patient while he is talking.

SA A UN D SD 42. Deliberately expressing approval of desirable patient-behavior is *not* a good therapeutic policy.

SA A UN D SD 43. The crucial learning process in therapy is an emotional, visceral, and non-verbal process.

SA A UN D SD 44. It is very important for a therapist to conceptualize, think through, how a patient is relating to him.

SA A UN D SD 45. Regression (returning to a more primitive mode of behavior) is always undesirable.

SA A UN D SD 46. People do *not* have any inherent "drive toward health."

SA A UN D SD 47. It is preferable for the therapist to feel impersonal in the therapy relationship.

SA A UN D SD 48. It is important to analyze the transference reactions of the patient.

SA A UN D SD 49. Good therapists do a lot of talking during the therapeutic hour.

SA A UN D SD 50. Effective therapists almost always know what they are doing, and why, and where they are heading.

SA A UN D SD 51. The patient's greater knowledge of the reasons for his behavior is *not* the most important therapeutic result.

SA A UN D SD 52. Good therapists often strongly urge their patients to "try out" certain behaviors which are intitially frightening to them.

SA A UN D SD 53. It is *unnecessary* for a patient to learn how early childhood experiences have left their mark on him.

SA A UN D SD 54. The therapist sets the broad goals of therapy and attempts to influence the patient's behavior and feelings in that direction.

SA A UN D SD 55. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist.

SA A UN D SD 56. It is sometimes all right to take a walk with a patient during the therapy hour.

SA A UN D SD 57. The therapist should *not* act as though he were personally or emotionally involved with the patient.

SA A UN D SD 58. As a therapist, I avoid asking probing questions.

SA A UN D SD 59. The more effective therapists spontaneously express their thoughts about the relationship during the therapy hour.

SA A UN D SD 60. Neurotic behavior is usually associated with undeveloped weak super-egos.

SA A UN D SD 61. At times, I feel contempt for a patient.

SA A UN D SD 62. It is important for a patient to be helped to make a social adjustment.

SA A UN D SD 63. Medications are valuable as a part of psychotherapy to lower anxiety or to help "uncover" material.

SA A UN D SD 64. It is never all right to offer the patient a ride, or ask him for one.

SA A UN D SD 65. Understanding why one does things is *not* the major factor in correcting one's behavior.

SA A UN D SD 66. I interrupt a patient while he is talking.

SA A UN D SD 67. Whatever the intensity or nature of the patient's emotional expression, the therapist is most effective when he feels detached, objective, and impersonal.

SA A UN D SD 68. A good therapist constantly and deliberately uses his thorough knowledge of psychopathology and his training in psychotherapeutic techniques.

SA A UN D SD 69. Without a concept like "unconscious determinants of behavior," people could not be understood.

SA A UN D SD 70. The crucial learning process in therapy is a verbal and conceptual process.

SA A UN D SD 71. Ideally, a person should never consciously have psychotic-like thoughts or feelings.

SA A UN D SD 72. The therapist's personality is more important to the outcome of therapy than his professional training.

SA A UN D SD 73. I always (with proper timing) analyze the resistance.

SA A UN D SD 74. Electroshock is a necessary part of therapy with certain types of patients.

SA A UN D SD 75. The most important results of therapy are the new feelings and emotions that the patient comes to experience.

SA A UN D SD 76. Neither a thorough case history nor a proper diagnosis is important to treat a case effectively.

SA A UN D SD 77. The therapist should *not* try to act anonymous, impersonal or uninvolved with the patient.

SA A UN D SD 78. In all human beings there is a sort of "life force," a striving for perfection.

SA A UN D SD 79. The overall goals of therapy should be set by the patient only.

SA A UN D SD 80. It is never all right for the therapist to walk about the therapy room during the therapy hour.

SA A UN D SD 81. Good therapists are mostly silent during the therapeutic hour.

SA A UN D SD 82. Neurotic behavior is usually associated with a lack of awareness of super-ego demands and with a disregarding of these demands.

SA A UN D SD 83. It is *unwise* for a therapist to respond overtly to patients as he feels, i.e., without thought and without censoring his spontaneous internal reactions.

SA A UN D SD 84. For a patient to improve his current way of life, he does *not* necessarily have to come to understand his early childhood relationships.

SA A UN D SD 85. It is never all right for the therapist and patient to have refreshments together during the therapy hour.

SA A UN D SD 86. Hypnosis is a valuable part of psychotherapy with certain types of patients.

SA A UN D SD 87. In effective therapy, the patient learns mostly through the affective and unverbalized relationship between himself and the therapist.

SA A UN D SD 88. It is important for the therapist to feel a deep personal and emotional involvement with his patient.

SA A UN D SD 89. Having the patient move in the direction of the goals of society is *not* an important therapeutic aim.

SA A UN D SD 90. A therapist should never interrupt a patient while he is talking.

SA A UN D SD 91. To make sense of a patient's behavior one must assume motives of which he is unaware.

SA A UN D SD 92. The patient's coming to accept and experience his feelings is *not* the primary gain he derives from therapy.

SA A UN D SD 93. It is *not* important for the therapist to conceptualize the psychodynamics of the patient.

SA A UN D SD 94. There is *not* an innate tendency in human beings toward emotional health.

SA A UN D SD 95. Irrational types of experiences ("mystic", "oceanic", "religious", etc.) are

always unhealthy and undesirable in mature adults.

SA A UN D SD 96. It is important to analyze symptomatic behavior, such as, slips of the tongue, mannerisms, etc.

SA A UN D SD 97. A good therapist acts personally and emotionally involved and concerned with his patient.

SA A UN D SD 98. I am very secure and comfortable in my relationships with my patients.

SA A UN D SD 99. It is necessary for a psychotherapist to be a physician himself or to be supervised by one.

APPENDIX O

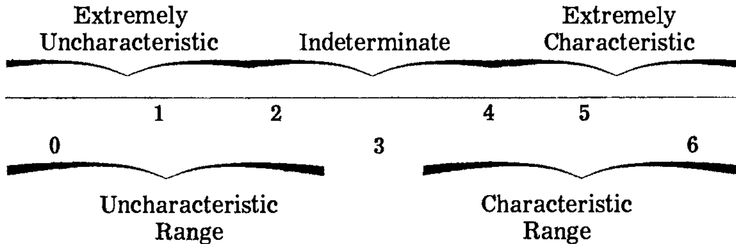
Filmed Interview Rating Form

The items accompanying the filmed interview of "Mrs. B" provided by Geertsma and Stoller are reproduced here. The item numbers are arranged for entry into IBM cards.

The development of this instrument can be found in such articles as Geertsma, R. H., and Stoller, R. J., The Objective Assessment of Clinical Judgment in Psychiatry. *Archives of General Psychiatry,* 1960, 2, 278-285.

Instructions

Give your clinical impression of the patient to be described in terms of the statements which follow. This is accomplished by assigning a number from 0 to 6 to each statement in the space provided at the left margin. The numbers represent a continuum from extreme *un*characteristicness (category 0) to extreme characteristicness (category 6) with the middle category (3) representing indeterminism (i.e. either the statement doesn't apply positively or negatively or you cannot decide whether it is more or less characteristic). Generally, the categories 0, 1 and 2 mean the statement is *not* characteristic of the patient, and categories 4, 5 and 6 mean that it is characteristic. The figure below sums up the rating continuum.



NO: *NAME:*

SORT: *DATE:*

Card I

...... 12. Generally alert and attentive to the interviewer.
...... 14. Train of thought is orderly and appropriately logical during interview.
...... 16. Afraid of being caught; fears external control or punishment.
...... 18. Very intelligent.
...... 20. Shrewd.
...... 22. Completely frank in speaking to interviewer.
...... 24. Delusional material is close to being expressed during interview.
...... 26. Capable of forming strong, permanent attachments to others.
...... 28. Sees herself as a feminine person.
...... 30. Charming and somewhat seductive in interview.
...... 32. Likely to be trustworthy.
...... 34. Enjoys being interviewed.
...... 36. Identifies primarily with father.
...... 38. Identifies primarily with mother.
...... 40. Impulsive behavior a primary defense against or reaction to anxiety.
...... 42. Likely to benefit from electroshock treatments.
...... 44. Likely to feel her problems would be solved by others changing.
...... 46. Sensitive to what the interviewer is trying to get at.
...... 48. Straightforward, forthright, candid in dealing with others.
...... 50. Tends to be rebellious and non-conforming.
...... 52. An expressive, colorful person.
...... 54. Strong self-destructive tendencies.
...... 56. Emphasizes being accepted by others.
...... 58. Easily becomes sarcastic and cynical.
...... 60. Irritable and over-responsive to frustrations.
...... 62. Tends to transfer blame from herself to others.
...... 64. Delays gratification unnecessarily; overcontrolled.
...... 66. Frequently self-aware; concerned with self as an object.

...... 68. Readily dominated by others; submissive.
...... 70. Not easily impressed; skeptical and critical.
...... 72. Satisfied with self.
...... 74. Likely to stretch limits to find out what can be gotten away with.
...... 76. Bizarre thought processes.
...... 78. Hostile toward others.
...... 80. Self-dramatizing; exaggerates in interview.

Card II

...... 12. Feminine in style and manner of behavior.
...... 14. Generally is poised and socially at ease.
...... 16. Projects own feelings and wishes onto others.
...... 18. Likely to make many different contexts sexually relevant.
...... 20. Unable to delay gratification; acts out.
...... 22. Generally distrustful of others.
...... 24. Prone to give up and withdraw in the face of frustration or adversity.
...... 26. Has a good sense of humor.
...... 28. Evidences oedipal conflicts and defenses against these.
...... 30. Past and present sexual feelings toward father lead to jealously of mother.
...... 32. Wishes to become a man in order to possess mother.
...... 34. Her problems largely influenced by lack of love from parents when a child.
...... 36. Self-esteem is adequate.
...... 38. Implicitly or directly blames mother for having deprived her in various ways.
...... 40. When disappointed is likely to turn to father figures.
...... 42. Essentially ambivalent toward others.
...... 44. Likely to be polymorphous perverse in sexual life.
...... 46. Tends to hold others off at a distance.
...... 48. Readily obstinate and stubborn.
...... 50. Feelings of having been mistreated make patient feel entitled to do what she wants without consideration for anyone else.
...... 52. Some of the patient's actions and attitudes are exaggerated because they are denials of contradictory attitudes.
...... 54. Chronic brain syndrome is prominent and significant.

...... 56. Psychotic.
...... 58. Identification with a lost person is significant.
...... 60. Frustration induces withdrawal from others.
...... 62. Inclined to deny her symptoms are related to emotional problems.
...... 64. Feels forced to perform certain actions at times or will be overwhelmed in some way.
...... 66. Hyperemotional.
...... 68. Alert to forestall criticism from others.
...... 70. Rebellious toward convention and authority.
...... 72. Has high moral standards and values.
...... 74. Patient could probably benefit from short-term psychotherapy.
...... 76. Afraid will not be given what she wants.
...... 78. Feels in danger.
...... 80. Has had more than her share of painful experiences.

Card III

...... 12. Sets goals high.
...... 14. Makes up stories and experiences to supply romance and drama to a life lacking in emotional satisfactions.
...... 16. If she would pay consistent attention to her appearance and way of presenting herself to others, patient's difficulties would diminish considerably.
..... 18. Artistically sensitive and possibly creative.
...... 20. Becomes upset when no one is willing to help her.
...... 22. Paranoid suspiciousness.
...... 24. Expresses self poorly in interview.
...... 26. Behavior and attitudes suggest an appropriate sexual identification.
...... 28. Angry impulses are threatening.
...... 30. Troubled over the death or loss of a significant person to her.
...... 32. No significant emotional pathology.
...... 34. Withdrawn and hypoactive.
...... 36. Under stress acts to reduce tensions without proper consideration for consequences.
...... 38. Runs away from troubling situations.
...... 40. Expects to be emotionally hurt and rejected by others.
...... 42. Feelings dominate thinking so as to hinder good judgment.

...... 44. Organic impairment is prominent.
...... 46. Likely to suffer from disturbances of the sensorium, e.g. fugue states, blackouts, etc.
...... 48. Manipulates and exploits others.
...... 50. Obtains gratification from her symptoms, defenses or complaints.
...... 52. Excessively concerned about trivial matters.
...... 54. Excitable and ineffective under even minor stresses.
...... 56. Lack of real loyalties to any person, group or code.
...... 58. Inability to profit from experience.
...... 60. Lacks a sense of responsibility; fixated on own pleasure and comfort.
...... 62. Retaliation toward others, e.g. parents, accomplished by self-punishment or self-degradation.
...... 64. Disregards social canons.
...... 66. Easily hurt.
...... 68. Impulsive, unstable in reaction to usual life stimuli.
...... 70. Fantasies experiences as painful.
...... 72. Overconventional.
...... 74. Undervaluates self; low level of aspiration.
...... 76. Undirected flight of attention in interview.
...... 78. Feelings focused on painful, punishing, suicidal tendencies.
...... 80. Excessive concrete thinking, with loss of abstraction and concept formation.

Card IV

...... 12. Erotic gratifications abnormal and regressive.
...... 14. Potentialities for pleasure and learning hindered.
...... 16. Inattentive and distractible.
...... 18. Much intrusion of irrelevant material, associatively, in interview.

APPENDIX P

Employability Survey: Samples Used

The Directors of Family Service Associations were selected from the 1963 *Directory of Member Agencies of the Family Service Association of America.* To be listed the agency "must offer family or family and children's casework, and be active in the improvement of social conditions in the community that affect family life. In addition, it must have an autonomous board and a minimum of two professionally qualified staff members . . ." Selecting one agency from the listing of each state by use of a table of random numbers provided 43 agencies; 5 more were selected at random from the directory, to reach a total of 48 Family Service Agencies.

The Directors of the Psychiatric Out-Patient Clinics were selected from the *1961 Directory of Out-Patient Psychiatric Clinics* published by The National Association for Mental Health in collaboration with the National Institute of Mental Health. This Directory "is not to be regarded in any sense as an accredited list of clinics, and no endorsement of a particular clinic is implied by including it." The definition of an out-patient psychiatric clinic employed in the Directory is: "a psychiatric out-patient service for ambulatory patients, where a psychiatrist is in attendance at regularly scheduled hours and *takes the medical responsibility for all patients in the clinic.*" In addition to the criteria for inclusion in the Directory the following criteria were used in selecting the sample from the Directory: 1) *at least* one full time, or two half-time psychiatrists on staff; 2) five day week clinic; 3) other mental health personnel (psychologists and/or social workers on the staff); 4) services *not* limited to special groups (veterans, alcoholics, mentally retarded, delinquents,

post-hospitalized patients). With these criteria, one agency was selected from each continental state by use of a table of random numbers and four others were drawn from the Directory at large for a total of fifty-two agencies.

The University Counseling Centers were selected from a list of participants in the 1962 Counseling Directors' Conference. Fifty-two Centers were selected representing thirty states.

The fifty-eight Directors of Clinical Psychology training programs constitute the 1961-1962 list of graduate programs in clinical psychology approved by the Education and Training Board of the American Psychological Association.

The sixty-one Deans of Schools of Social Work constitute the 1962 list of those Schools within the United States which were accredited by the Commission on Accreditation of the Council on Social Work Education.

The fifty-two Chairmen of Departments of Psychiatry were selected randomly from the 1962 list of Approved Medical Schools: Deans and Chairmen/Heads, Departments of Psychiatry, published by the American Psychiatric Association.

The fifty-three counselor educators were selected from the *1962 Directory of Counselor Educators,* published by the United States Office of Education. For purposes of the Directory, the counselor educator is defined as "a person who has been appointed for at least one academic year as a full time member of a college or university faculty, recognized by the State Department of Education, and who has met one or both of the following criteria:

> 1. One-half or more of the courses consistituting the teaching lead of the faculty member were courses for which graduate credit was given and which were accepted by the institution as a part of a program of studies leading to a degree in the field of guidance or meeting State certification requirements.
> 2. The senior faculty member responsible for administering, supervising, or conducting a program for the preparation of counselors.

Those selected were primarily from the second category. They were chairmen, directors, coordinators or the senior mem-

ber in counselor education. Persons also listed as holding academic rank in Departments of Psychology were excluded.

The fifty directors of state guidance programs were selected from the *1963 Directory of State Department of Education Personnel for Guidance, Counseling, and Testing,* published by the United States Office of Education. The one person who was selected from the listing for each State was the chief, director or supervisor of the State's Guidance Service or Bureau of Pupil Personnel Services.

APPENDIX Q

Employability Survey: Instruction Form and Response Form

Reproduced are the forms used in the Employability Survey. The instruction form was the one used for all eight respondent groups. The response form was the one which was sent to all directors of mental health agencies and to the chairmen of Departments of Psychiatry. The response form sent to the directors of training was modified so that the first question read: "If consulted by the director of a *(specified agency)* would you recommend the hiring of people such as those described on the attached sheet?" The remainder of the form was identical to that which is reproduced.

Instruction Sheet

We would appreciate your professional opinion regarding the usefulness and employability of the type of person described below. Enclosed is a brief description of a selection and training program and a sheet on which you may record your own reactions.

Our study is concerned with individuals with intensive, but non-traditional, professional training. There appear to be many different opinions concerning the employability of such people. This is one of several on-going studies to evaluate the performance and acceptance of Mental Health Counselors (non-traditionally trained counselor-psychotherapists).

Following a brief description of a Mental Health Counselor in terms of selection, background, training, and performance there are several questions you can answer by checking the appropriate box. Your co-operation is highly appreciated.

Selection: The stages were as follows: (1) 1500 word autobiography; (2) a day of group tests and group interviews; (3) individual interviews, tests, and observations. The selection panel, composed of eight highly qualified Psychiatrists and Psychologists, were looking for mature, bright, sensitive and psychologically minded middle-aged women who had successfully completed most of their child rearing duties and were motivated to learn to use their talents in work settings helping others.

Background: Women selected in the manner described had the following background: (1) age, 40-44; (2) married, living with husband who is a professional or executive, about 2-3 children; (3) at least a B.A. or B.S. degree; (4) no previous professional training in psychiatry, clinical psychology or social work: (5) a large proportion of those selected had had personal psychotherapy or psychoanalysis.

Training: The length of training was approximately 2/3 time over a two-year period, or the equivalent of 18 months full time. The training was focused on the performance of counseling-psychotherapy. The training is summarized in the table on the following page.

Evaluation: A variety of evaluation procedures were applied at the end of the first and at the end of the second year. The net results of these evaluations were quite favorable. Currently a three year follow-up evaluation is in progress. Please assume for the purpose of this questionnaire that successive evaluations are positive. More specifically, assume that the Mental Health Counselors' performance with her clients or patients is seen by experienced psychiatrists who supervise them as comparing favorably with traditionally trained individuals starting their first post-degree professional position. In short, that they have been judged to do satisfactory work with clients.

On the basis of this information, please answer the questions on the colored response sheet.

	Training Experience	Average Hours per Week* 1st Year	2nd Year	Approximate Total Hours
1.	Interviewing of normal subjects, and referred patients; group therapy with adolescents and parents; individual and group supervision including listening to playbacks of interviews.	14	7	798
2.	Observing experienced professionals conduct individual, group, and family interviews.	2	1	114
3.	Lectures and seminar discussions.	8	10	684
4.	Outside reading and report writing.	4	10	532
5.	Work-placement experience in a community mental health agency, non-paid, part-time.	4	10	532

*Based on a 38 week year.

Response Sheet

1. As director of your agency, would you recommend the hiring of such a person to work with your clients? (Assume funds are available.)

...... Very likely
...... Likely
...... Undecided
...... Doubtful
...... Very doubtful

If undecided, please explain as best you can: a) what the contingencies contributing to the indecision are, and b) what types of information would you consider most useful to help you to reach an opinion.

a. ______________________________

b. ______________________________

2. In what types of settings do you think such people would be most useful? (mark one for the type of setting you think they would be most useful in, and check any other settings you think they would be useful in).

...... State Neuro-psychiatric Hospitals
...... Child Guidance Clinics
...... Residential Treatment Centers
...... Day Care Centers
...... Private In-patient Neuro-psychiatric Facilities
...... Out-patient Mental Health Clinic Services
...... Family Service Agencies
...... High School Counseling Services
...... University Counseling Centers
...... Other (please specify)
...... Other (please specify)

3. On the basis of the information provided, at approximately what 12 month salary level would you place the full time Mental Health Counselor:

...... Less than 4,000
...... 4,000-5,000
...... 5,000-6,000
...... 6,000-7,000
...... 7,000-8,000
...... More than 8,000

4. I would like to receive the results of this survey.

Name ______________________________

Mailing address ______________________________

APPENDIX R

MHC Final Questionnaire

The MHC Final Questionnaire is reproduced here. It was administered to each MHC at the end of the third year. It was not administered in interview form, but as a questionnaire which the MHCs themselves completed.

MHC Final Questionnaire

Looking over these past three years since you finished your training at NIH:

1. What would you say were the high points in your professional work as an MHC?
   What do you point to with *most* pride?
2. What would you say were the stress points in your professional work as an MHC?
   a. Selection period
   b. Training period — 1st year
   c. Training period — 2nd year
   d. First year at work
   e. Second year at work
   f. This year at work
3. What do you anticipate doing in the:
   a. Next 5 years?
   b. Next 10 years?
4. Describe the attitudes and reactions of family and friends to your job as a MHC.

5. Please compare yourself with the traditionally trained staff members along the following dimensions:

	More Than Average	About Average	Less Than Average
A. Identification with the agency			
B. Effort and work output			
C. Contribution to case discussions			
D. Contribution to morale			
E. Source of new ideas			
F. Openness to new ideas			
G. Co-operativeness			
H. Friendliness			
I. Job satisfaction obtained			
J. Role definition achieved (Knows who she is and what she should do in the professional setting.)			
K. Overall contribution to the agency			

6. How well does your training and skills equip you to work in these various programs and services? How useful might you be?

	Very Useful	Useful	Of Doubtful Use	Of No Use	In what ways might you best be used (if at all)?
A. Hospitals for long-term care					
B. Psychiatric units in General Hospitals					
C. Day Hospitals					
D. Night Hospitals					
E. 24 hour "walk-in" Out-patient Service					
F. Out-patient Clinic					
G. Diagnostic and Referral Service					
H. Rehabilitation Services					
I. Mental Health Consultation Services					
J. Community Mental Health Education Services					
K. Other:					
L. Other:					

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