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The Ohio State University, Ph.D., 1976
Social Work

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AN EVALUATION OF A
GROUP LEVEL INTERVENTION Training PROGRAM
FOR CAREGIVERS WITHIN A COMMUNITY MENTAL CONTEXT

DISSERTATION

Presented in Partial Fulfillment of the
Requirements for the Degree Doctor of Philosophy
in the Graduate School of
The Ohio State University

By
James P. Perry, B.A., M.S.W.

******

The Ohio State University

1976

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I wish to express my gratitude to the School of Social Work for the encouragement and learning experience which enabled me to enhance and broaden my own interventive focus, scope and repertoire. This study was an attempt to participate in an effort designed to give others what was given to me.

I appreciate the cooperation of Mental Health Services for Clark County, Incorporated. Their assistance and support was vital to completing this evaluative task.

A special thanks is due to the caregivers of Clark County, Ohio, who participated in this study.
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CHAPTER ONE: INTRODUCTION

This chapter seeks to provide an overview of the study. It consists of a statement of the problem upon which the research was directed, a background of the problem, the objectives of the study, research strategies employed, the significance as well as the limitations of the study, and the general organization of the dissertation.

The Problem:

This study evaluated, described and documented a community mental health based training program designed to broaden and expand the interventive scope and focus of community caregivers. This was accomplished by providing a T-group laboratory experience in group level intervention for selected delegates and then measuring certain attitudinal and ideological changes which resulted from participation in the T-group.

Caregivers, for the purposes of the study, were defined similarly to Caplan's (1964) notion of caregivers, namely, that they were community agents designated by elements of the power structure from a certain geo-political area, who facilitated the well-being of citizens and helped persons deal with hazardous, unfavorable or special circumstances.
A T-group laboratory is defined for the purposes of this study, as a learning strategy which makes use of structured and unstructured group experiences in which theory sessions are conducted in designated subject areas, but more importantly, the data for learning are the transactions of group members, their own behaviors as they struggle to create a productive spirit of inquiry and viable organization.

Group level intervention is defined as the activity of caregivers which is directed toward networks of reciprocal social roles within complex transactional systems with the purpose of inducing change within the systems.

Stating the problem as concretely as possible, an answer was sought to the following question: Does caregivers' participation in a group intervention training program within a community mental health context effect changes in the participants' self esteem, adherence to community mental health ideology, familiarity with and attitudes toward group intervention?

For more than a decade, community mental health has been both a belief about and a service delivery system for mental health. It emphasizes population foci, prevention, social treatment goals, comprehensive continuity of care, and total involvement (the belief that the mental health specialist is only one member of a group of community agents and thus he can extend his effectiveness by working with and through other people). Caplan (1964:31) commits the community mental health movement to the development of continual 'supplies' commensurate
with a person's current stage of growth and development. These supplies can be specified and classified into three groups: physical, psychosocial and sociocultural. Essentially Caplan directs community mental health toward efforts at maximizing resources and increasing institutional provision. Boehm (1958:16-17) indicates that educational intervention is useful when a maximization of social resources is required.

Community mental health programs have developed educational interventions so as to enhance and maximize institutional provision. Broadening the scope and focus of caregiver's interventions is a part of such enhancing and maximizing activities and is certainly an appropriate interventive target for the community mental health movement.

Background of the Problem:

The implications of a study, which evaluates a group level intervention training program designed to broaden, expand and enhance the scope and focus of community caregivers intervention, are many. One obvious implication is that, caregivers probably are lacking to some extent in group intervention skills. Still another, and maybe as important, is that caregivers' scope and focus are too narrow and unclear; and yet another implication, is that certain phenomena may be operating which either further narrows the scope and focus of their intervention activities or that opportunity for enhancement of these activities are not available or utilized.
It is suggested here, that the problem of caregiver's scope and focus is related casually to obsolete conceptualizations of social functioning. Schneiderman (1969) suggests that the conceptualizations of social functioning were too limited and narrow. In the past, social functioning was viewed as expressions of the intrinsic properties or attributes of individual actors. Intervention of caregivers based upon such conceptualizations were directed at individuals rather than the group; furthermore it was based upon the mistaken notion that the individual can be comprehended apart from the network of social roles which he or she occupies. Current conceptualizations of social functioning indicate that all social functioning must concern itself with people in groups and that all interventions are at the group level. It is, then, the obsolescent conceptualization of social functioning and obsolete prescriptive notions for intervention that contribute substantially to caregiver problems of scope and focus.

Other phenomena and societal forces have also contributed to the aforementioned problem. The knowledge explosion, as documented by Toffler (1971), is very quickly rendering some extant knowledge obsolete; this is particularly true of the knowledge base of those engaged in helping activities. The problem of the expanding quantity of knowledge and securing implementation of such knowledge is further complicated by knowledge diffusion problems within the human sciences. As
new knowledge is developed within the helping professions, standard educational strategies are not always sufficient to secure the transfer of the new knowledge from the learning centers to those engaged in practice. Since many caregivers don't hold membership in any particular profession, the transmission of new knowledge to these caregivers is fraught with even more difficulties. This "educational lag", between new knowledge developed, and new knowledge diffused to community caregivers, seems to be a contributing force to the identified problem, namely, that some caregivers are operating upon obsolete conceptualizations of social functioning which in turn renders their interventive repertoires as incomplete and obsolete.

In addition, many community caregivers function within social welfare organizations which are experiencing increasing specialization and bureaucratization. These two major societal forces have produced increased organizational efficiency but also have contributed to delimiting caregivers' focus and scope. The two phenomena combine to produce a delimiting atmosphere by defining, in a narrow sense, the division of labor and reducing the size of the task assigned to those within the organization. In such an atmosphere, it is very easy for the caregiver to go along with the trend, by further narrowing and delimiting his own focus and interventive repertoire.
Objectives of the Study:

The overall objective of this dissertation is to contribute to the understanding of changing caregivers interventive activities through a review of the literature and reporting upon a T-group experiment in group level intervention training within a community mental health context.

The objectives of the literature review were to place the T-group laboratory in proper perspective, moving in a telescopic fashion, from broad concerns about learning and re-education to a specific understanding of the T-group approach which included a history of the T-group, to survey learning theories of the T-group, dynamic issues such as controversies about T-group models and designs, to consider previous research studies which are related to or thought important to this study and to review prior attempts of the community mental health movement to train caregivers.

The major objective of the experiment was to see whether a T-group laboratory could change certain attitudes and interventive ideologies. Very specifically, the experiment sought to determine whether a T-group laboratory would effect changes in participants self-esteem, secure greater adherence to community mental health ideology and produce more positive attitudes toward group level intervention.
Research Strategies

The subjects of this study were drawn from applicants for a group level intervention training program for community caregivers sponsored by Mental Health Services of Clark County, Ohio, Inc. The caregivers for the study represented the broad spectrum of community caregivers and included physicians, nurses, social workers, psychologists, social agency executives, policemen, probation officers, indigenous workers in poverty and alcohol programs and others designated as caregivers by the community.

A classic pre-test-post-test design was employed. Subjects for this study were randomly selected from applicants to the T-group laboratory and then randomly assigned to experimental and control groups. The experimental group attended the T-group laboratory in group level intervention, while the control group received no such formal training.

This author hypothesized that there would be greater changes in the experimental group, receiving the training as to their self esteem, adherence to community mental health ideology and attitudes toward group level intervention than the pretest experimental group and the pretest and posttest control group.

The Significance and Limitations of the Study:

This study seeks to evaluate a T-group laboratory, designed to update the skills, broaden and enhance the
interventive repertoire of community caregivers. The need to enhance caregiver's abilities shall remain a problem for the foreseeable future. This study can contribute some understanding regarding the usefulness of the T-group laboratory, as an educational interventive strategy with caregivers. In addition, the findings contribute to the overall literature of the T-group laboratory and the community mental health movement. The study reports whether the T-group laboratory was useful in effecting global changes within individual's self-esteem and adherence to a particular ideology as well as specific attitudes toward group level intervention. The issue as to the power of the T-group, in effecting global and specific changes within individuals and their work adaptation, is a matter of controversy in the literature. This study then contributes its findings toward an understanding of the strengths and limitations of the T-group laboratory; furthermore, it provides outcome data on a particular educational interventive strategy which should provoke strong heuristic notions about how best to intervene with community caregivers.

The limitations of the study should be considered in light of the context of the study and the T-group laboratory. This study consisted of a specific set of actors, including the delegates to the T-group, T-group leaders, lectures in the theory sessions and others involved in carrying out the program; and while there is nothing in particular about the set of actors involved in this study that might contaminate its
results, one should approach the results with the afore-
mentioned awareness. Furthermore, the study was conducted
within a community mental health setting and another kind of
setting might produce different results. The study was also
conducted within the context of a medium sized city with a
given social welfare structure and one might have difficulty
generalizing these results to caregivers in other social
welfare structures who work with a different kind of popu-
lation.

Substantial discretion is allowed as to the design of
the T-group laboratory. It very well could be that a dif-
ferent T-group laboratory design could generate different
results. There is a need for further evaluation of the
various laboratory designs.

Organization of the Dissertation:

The study was divided into five chapters and each chap-
ter subdivided into several sections. Chapter one outlined
the problem being studied and set down the overall objectives
of the study. Definitions of community caregivers, T-group
laboratory and group level intervention were offered. This
chapter also considered certain factors crucial to the prob-
lem including citing an educational lag as to the diffusion
of new technology and the influence of major structural forces
such as bureaucratization and specialization.
Chapter Two gives some initial considerations to how learning and re-learning occur. The utilization of group phenomena as a learning tool is also discussed, as well as how group level interventive skills have been diffused in the past. Importance was given to the T-group laboratory as a learning strategy since it was the core design of the training program and was the independent variable in this study. The history of the T-group laboratory was reviewed; the variable designs of T-group laboratory were analyzed. Significant attention was directed toward T-group research as to internal and external criteria for outcome evaluation of T-group laboratories. Lastly, community mental health educational intervention programs were considered in light of contributions to the field of training caregivers.

Chapter Three focused upon the research methodology utilized in the study. In particular, the rationale for the conceptual design and a model of the design were presented. The hypotheses for the study were posited and an elaboration of the research design was put forward. The context and sample of the study were described and general explanations of the instruments and statistical tools to analyze the date were given.

Chapter Four presented the results of the study with a strong focus upon group comparisons. A discussion of the
results and the implications of the group comparisons accompanied this chapter.

Chapter Five is an attempt to summarize this study as well as state the implications of the study for future social work practice.
CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction:

Since the problem being considered seems to require educational intervention designed to provide a learning and re-learning experience for caregivers, this chapter considers factors thought to be significant in learning group processes. The literature of learning tended to recommend T-group laboratories as a viable vehicle of educational intervention; significant attention was directed toward elucidating how learning occurs in a T-group laboratory, T-group designs and research outcomes of T-groups. Additional consideration was devoted to documented efforts of educational intervention conducted within community mental health programs.

Two major theories dominate an understanding of learning, S-R (stimulus-response) and field or cognitive theories (Garrison and Magoon 1972). According to Garrison and Magoon, (1972) S-R theory emphasizes contiguity, practice, reinforcement, repetition and shaping, while cognitive theories consider, insight, structure and goals as more important to learning. For the S-R theorist, learning is the product of maturational readiness and sensory experience, whereas field theory suggests, that new learning occurs as the learner draws upon patterns and configurations of the past, to give insight to the new experience.
Clearly for the caregivers of this study, the T-group laboratory to enhance and broaden interventive scope and focus, is a new learning experience but essentially is a re-educative experience in intervention. Lewin and Grabbe (1945) suggest that:

the re-educative process involves changes in the cognitive structure, modification of valances and values and motoric actions (the degree of control over one's physical and social movements).

Lewin thought that changes in cognitive structure could not be brought about by rational education alone, he suggests that rational education refers to rather abstract measures of transmitting knowledge such as lecturing. Nor does Lewin believe that first-hand experience alone changes the cognitive structure in value experiences. Lewin and Grabbe (1945) state very simply that:

the basic task of re-education is one of changing the individual’s social perception. Only by this change in social perception can changes in the individual’s social actions be realized.

Neither the possession of correct knowledge nor changes in sentiment preclude a rectification of false perceptions or produce changes in cognitive structure. Lewin and Grabbe (1945) postulate that:

the individual accepts a new system of values and beliefs by accepting belongingness in a group.

For the authors a change in action-ideology, a real acceptance of a changed set of facts and values, a change in the perceived social world are all difference expressions of the same process, namely, re-education through group membership.
Learning and the Group:

The attempt to change the perception of caregiver's practice so as to develop an understanding and utilization of group phenomena in their practice is a complex task. Such a change would require a strong impact upon caregivers' cognitive elements (changed attitudes about group intervention) and behavioral elements (changed competence). Lewin (1952) found empirically that certain methods of group process prove to be superior to lecturing as a means of re-educating and changing behavior. Lewin described the group learning process as one consisting of 1) unfreezing of old attitudes, knowledge and behaviors, 2) change, 3) refreezing new knowledge and behaviors. From his study of home nurses' dietary practices with patients, he concluded that it was more effective to produce changes in their nursing dietary practice through group participation training than lecturing or individual instruction. The home nurses were volunteers and tended to prepare foods for their clients, much like the food they prepared in their own kitchen. The conditions of those being served by home nurses were such, that although certain foods which were alien to and viewed as somewhat undesirable to the home nurses, these foods were more beneficial for the patients. The home nurses were subdivided randomly so that some received individual instruction, another group received lecturing and still another received group participation in dietary planning. All were then evaluated as to which group altered their dietary practices.
Gordon (1950) found that group participation accelerated "psychological growth", brought about changes in self concept and seemed to encourage the individual participant to take responsibility for his or her own learning. Gordon found that such group learning which involved free discussion in atmosphere of permissiveness seemed to generate a reorganization of previously held concepts in light of new ideas gained from the group. Utilizing group participation as a learning vehicle isn't new; some would argue that most knowledge, the wisdom of the ages and the folklore of the culture have been passed on through group participation. Efforts at teaching public health concepts and the old settlement house socialization approach have utilized group participation for quite some time. Tregant Burrows had begun the use of a group in psychotherapy in the first quarter of this century. It wasn't until the late forties and early fifties that there developed a substantial interest in the study and the impact of the group upon the individual's learning process.

Lewin and Gordon seem to emphasize the group as an effective vehicle for learning and change. Behavior change seems to be the chief parameter for measuring a successful teacher-learner transaction. This is consistent with previous conceptualizations as to how learning occurs. The question arises as to what has been the problem with traditional teaching-learning transactions which don't bring about all the desired behavior changes. Bradford (1958) cites that a
teaching-learning transaction should be based upon two assumptions:

that the teaching-learning process is a human transaction involving the teacher, the learner and the learning group in a set of dynamic inter-relationships. Teaching is a human relational problem. Teachers and learners engage together in a complex process of exploration and diagnosis of needs for and resistances to learning and change; of experimentation and fact finding; of testing and planning for utilization of learning and change in the life of the individual...

Secondly, again the target of education is growth and change in the individual and his behavior... This is a deeper and broader goal than cognitive learning only.

One could say that the sine qua non of the teacher-learner transaction is some kind of interaction. Interactions are always influenced by the limitations which the participants bring to the interactional situation. Bradford implies that learning is acquired through dynamic group membership rather than passive learning or membership in an audience. Bradford suggests that the learners bring certain resistances to the learning situation; he contends that cognitive learning alone provides the learner with the opportunity of resisting new learning through compartmentalizing is so as to avoid integrating the new knowledge into his external behavior. In addition, new knowledge which may psychologically threaten or attack the self-esteem of a person will somehow be perceptually screened out by the learner. Lewin and Grabbe (1945) suggest that resistance to new knowledge may be partially influenced by conscience structure or super-ego, in that a sense
of loyalty to old knowledge is developed and to embrace new 
and possibly threatening knowledge is disloyal to old knowledge 
and the self. They stress that only in an atmosphere of free-
dom of choice, spontaneity of expression and self decision-
making can re-education occur. Zander (1950) indicates that:

resistance will be prevented to the degree that the 
"changer" helps "changee" to develop their own under-
standings of the need for change, and an explicit 
awareness of how they feel about it and what can be 
done about those feelings.

The literature suggests not only problems of resistance to 
new learning, but also the maintenance of new knowledge and 
the transfer of that new knowledge to other situations. 

Bradford (1958) contends that:

if maintenance of change and utilization of learning 
is a necessary part of a theory of teaching-learning, 
then efforts must be made during the process of formal 
teaching-learning to prepare for the problem of main-
tenance.

Bradford (1958) calls upon those in teaching capacities 
to recognize recent research which indicates how powerful group 
forces are in individual productivity, learning and the main-
tenance of new learning. The issue which Bradford seems to be 
raising is, whether teachers have given attention to exploiting 
group membership for learning, by helping the group to form, 
organize, grow and keep in good repair. The teacher needs to 
assume some type of facilitating role by assisting in the 
establishing of relationships which reduce anxiety or threats 
to self esteem, and open the learner to the utilization of 
new knowledge. Bradford (1958) lists six conditions which 
foster learning and change:
1. Revealing thoughts, feelings and behavior
2. Seeking reactions to revealed ideas and behavior
3. A supportive climate for learning
4. Information seeking and receiving
5. Experimentation and practice with new ways of thinking and doing
6. Application of change into the learning situation of the individual

Bradford seems to be suggesting that some type of carthesis in a supportive environment is helpful in unfreezing old knowledge, attitudes and behaviors. Information giving and receiving together with opportunity for experimenting and applying new knowledge seem to complete a learning cycle and closely resemble the aforementioned Lewinian way of learning.

The Way it Was:

Up until this point, we have considered the concept of learning from various definitional points of view, various theoretical approaches; some specific points of teacher-learner interaction, resistance and the most effective strategies for re-education. It would be of value here to review previous learning approaches that were geared to prepare caregivers to intervene at the group level.

Basically group intervention skills are taught within professional graduate schools according to discipline and there is substantial variance in training approaches according to profession.
Some disciplines emphasize the therapy aspects of groups while still others approach groups in the Gestalt. Some of the problems of group intervention training are probably related to separate conceptualizations of practice for those who deal with individuals or those who intervene in groups, thus intervention in groups have been conceptualized differently in psychiatry, psychology and social work. Historically, all three professions viewed group intervention with some degree of suspicion, reluctant acceptance and as having relatively low status among interventional strategies. For caregivers lacking professional membership, group level intervention training is even more fragmented and underdeveloped. None of the professions have taken full advantage of learning theory especially as it applies to group intervention. Lefton (1961) recommends the following elements of training for intervention at the group level 1) course work in personality theory, semantics, verbal communication, human behavior, role theory, counseling skills 2) supervised practicum 3) group leadership or membership experiences. Sadock and Kaplan (1971) summarize group intervention training in terms of classroom lectures in psychopathology, group observation, seminars in basic group intervention skills, group supervision and an intern experience as a group leader. The foregoing approaches exemplify traditional long-standing approaches to training caregivers to intervene at the group level. Yalom (1970), Papell (1972) and Toren (1972) indicate a failure to utilize new insights gained from learning
theory especially as has been evidenced in T-group training. Yalom suggests that T-group training for group intervention is unavailable to many and has not been fully incorporated into professional training for caregivers. Toren (1972) and Papell (1972) commend the value of the Laboratory Training Movement for the social work profession. Toren (1972) contends that social work has not taken full advantage of insights from recent developments in learning theory. If the laboratory training model is purported to be a useful method of transmitting learning and this has been somewhat neglected as a training strategy for group level intervention, it seems useful to consider the T-group laboratory as a learning device and its potentiality for training group level interventionists.

A Brief History of the T-Group Laboratory

Since 1947, the National Training Laboratory has been utilizing a learning approach involving group process and cyclical learning experiences. Bradford et al (1964) point out that such laboratories have:

continued to work most broadly with the growing population of professional helpers. These professional helpers function in a wide variety of community educational governmental and industrial organizations.

Like many inventions, the T-group approach was invented somewhat accidentally. Three groups of educational administrators had gathered to discuss problems of implementing new fair
employment practices legislation. The program had been sponsored by the Connecticut Department of Education and the Research Center for Group Dynamics. The groups focused upon an analysis of problems brought from home regarding equal employment. There were lecture sessions, group discussion and role playing activities. Research observers were attached to the group discussions to record interactions among the group. Kurt Lewin arranged evening meetings for the staff to provide feedback from the research observers to the training staff regarding their groups, and by happenstance, some group participants asked if they could also attend. Very soon these evening meetings developed into a free flowing, give and take behavioral analysis of what went on in the training sessions. Both staff and training participants felt a substantial learning breakthrough had occurred in terms of deriving important understandings of their behavior. It proved to be a significant heuristic device and gave impetus to further exploration of the newly discovered learning process.

After the initial quasi-laboratory experience a BST (Basic Skills Training) Group was initiated at Bethel, Maine, for the purpose of providing a place for learning change-agent skills and concepts as well as a place to understand group growth and development. The early goals of the BST were multiple and conceptually somewhat vague. It was expected that the participant would internalize the skills of a change-agent, practice
those skills at all levels of human organization while at the same time learning more about themselves, develop a clearer understanding of democratic values and be able to be a trainer for human relations. The staff of the BST realized that their objectives were too generalized and too non-specific. The "inner circle" of the BST staff reads as a "who's who" in the behavior sciences with people such as Kurt Lewin, Alvin Zander, Gordon Hearn, Kenneth Benne, Leleand Bradford, etc., involved in its establishment. In keeping with the democratic spirit of the movement, the power of the "inner circle" was distributed as new members joined the training staff. Bradford et al (1964) suggests two phases in the laboratory movement; the first phase went from 1949 through 1955 and is characterized by a variety of experimental attempts to create training formats and technologies to serve learning objectives some of which are now seen as extraneous to the province of the T-group. This led at times to virtual segregation of T-group activities from other learning strategies. Separate groupings were formed for skill practice, for application of laboratory learnings and for the study of change.

Bradford et al (1964) remarks that:

the second period, roughly from 1956 to the present, is marked by efforts to reintegrate T-group experiences into the designs of laboratories. Experimentation with new designs and with new uses of T-groups continues. This second period is harder to deal with historically than the first. It is difficult, particularly for one actively participating in laboratory and T-group developments to get perspective on these more recent events.
Another part of the difficulty comes from the proliferation in numbers and kinds of laboratories. It is during this time that numerous occupational laboratories developed while the more traditional cross-occupational laboratories continued. Regional and other laboratory programs also developed under auspices other than NTL. I have not had time to study the records of regional laboratories with the same care I have given to laboratories under NTL auspices. Many "errors" of omission may inadvertently have entered into my account. Yet my hypothesis concerning the direction of evolution in T-group utilization during the past seven years seems generally correct. Of necessity, it takes me into a treatment of various parts of laboratory designs which have both conditioned and been conditioned by staff provisions for collateral groupings and activities supportive of T-group experiences.

Laboratory Training Movements began to develop all over the country with some degree of rapidity. Bradford et al (1964) confirms that Laboratories utilizing a T-group approach spread to the Mid-West, Far West and Southwest; laboratories were also begun in several Western European countries. In yet a related development the middle 1960's saw encounter groups and sensitivity groups mushrooming throughout the country. In some instances there were significant similarities between T-group laboratories and sensitivity groups, while in others there seemed little connection between the two group phenomena. Gottschalk and Davidson (1971) distinguished the two by viewing a laboratory training group as an educational procedure that mobilizes initiative control with access to new knowledge and skilled professional leadership so as to develop some new attitudes and behaviors. A sensitivity group according to these authors was a more general non-specific set of experiences which attempted to help each participant recognize and face
his own behaviors and others at various levels of functioning (i.e. emotions, values) so as to further integrate these levels into a more effective perceptive self.

The brief history of T-group training seems to reflect a growing awareness of the strengths and limitations of a new re-educative medium. The movement has been typified by a great deal of experimentation and empirical exploration into laboratory phenomena. From such planned and unplanned experiments, it is now thought that the T-group can be matched with other learning strategies but must be woven and integrated as closely as possible to the entire training experience. Within limits, the T-group is a medium for change-agent training, it is not a total replacement for other learning approaches but can be utilized as a central focus with other educational strategies. Schein and Bennis (1965) confirm that the T-group laboratory has not been a monolithic entity; it has been an intellectual movement, developing unevenly, sometimes erratically accepting and ejecting ideas as to the best use of the T-group approach. Today, laboratory training is a rapidly changing endeavor practiced by social scientists and certain professionals who share common beliefs and values as to how people learn. Schein and Bennis (1965) warn that T-group training is relatively new, that it doesn't fit conventional categories of learnings, and since it is experience-based, we are bothered by problems of matching symbols with experience and difficulty in fully understanding outcomes and processes.
They warn that one should not construe, however that laboratory training is such a unique entity that it defies understanding or analysis. As we shall see later, T-group laboratory training has been a rather heavily evaluated learning endeavor.

What is a T-Group Laboratory

Bradford, et al (1964) indicate that a:

"T-group" is a relatively unstructured group in which individuals participate as learners. The date for learning is not outside the T-group or remote from their immediate experience within the T-group. The data are the transactions among members, their own behavior in a group, as they struggle to create a productive and viable organization....

In some sense, the learning comes from the T-group itself (the experiences), the group members make their own learning experience from their behaviors. To accomplish such learning, behaviors need to be collected and analyzed. Behaviors then can be tested and retested in light of interactions that occur; learning about one's own feelings, motives, attitudes and patterns toward others are the central focus. Bradford et al (1964) suggest that from interactional confrontations of intentions and effects, barriers to full and autonomous functioning relations with others are located. Through the T-group experience, new images of self-potentialities develop and from group experience, the T-group delegate seeks help in maximizing those potentialities into actualities. Golembiewski and Blumberg (1970)
point out several factors about the T-group laboratory which help to distinguish it from other group approaches. They indicate that the T-group laboratory is above all a learning laboratory, which focuses in part on learning how to learn and deals principally with the here and now. As a learning laboratory it differs from therapy in many ways. Group therapy is a reactive healing response to some problem of functioning, and is designed to restore balance or wholeness in functioning. The T-group is pro-active educative endeavor to enhance extant functioning by removing blockages to self-realization. T-groups utilize present behavior rather than past behavior and are not concerned with genetic causes of behavior. No importance is attached to any unconscious behavioral motivation; and the assumption underlying the T-group is that the delegates are emotionally healthy rather than ill.

Like most groups, the T-group is a society in the miniature thus providing a learning experience that has the potentiality of being generalized to a substantial part of the delegate's functioning. In particular the T-group is distinguished by its emphasis upon inquiry and creating the psychologically safe atmosphere to learn. T-group theorists such as Golembiewski and Blumberg (1970) cite their dissatisfactions with aspects of past learning approaches. Criticism is especially directed toward the rote learning approaches which according to Benne et al (1964) develop plastic learners
lacking information and skill to successfully negotiate the environment. T-group advocates stress that often traditional learning is deductive in nature and rather authority bound. The learner is not able to adapt the learning to suit situational demands.

The T-group approach utilizes a group leader, called a trainer, who provides guidance and direction yet promotes a democratic spirit and a collaborative notion of authority. Freed from an authority bound learning approach and enhanced by democratic value preferences, a spirit of inquiry fosters behavioral exploration and experimentation. Schein and Bennis (1965:31) comment:

the first meta-goal or value (of T-group laboratories) is an attitude of inquiry most often associated with science. It is a complex of human behavior and adjustment that has been summed up as the spirit of inquiry and includes many elements, only two of which are considered here. The first may be called the hypothetical spirit, the feeling for tentativeness and caution, the respect for probable error. The second ingredient is experimentalism, the willingness to expose ideas to empirical testing, to procedures, to actions.

In essence, Schein and Bennis seem to develop a concept of learning how-to-learn. A spirit of inquiry or learning how-to-learn seem to be the sine-qua-non of a productive T-group laboratory; the trainer's use of self seems vital to developing the sense of inquiry. It is only with an extant spirit of inquiry can the learning how-to-learn process be successfully completed. Schein and Bennis conclude that the learning how-to-learn cycle is successful when the delegate achieves
expanded consciousness, wider recognition of available choices and authenticity in interpersonal relations.

The literature seems to confirm three distinguishing elements of a T-group.

1. The T-group is a learning laboratory

2. The T-group emphasizes learning how-to-learn process

3. T-group focuses on the "here and now: as opposed to the "there and then"

Golembiewski and Blumberg (1970) considered the focus upon the here and now as basic to the learning how-to-learn process in a T-group. Schein and Bennis (1965) view the here and now focus as the heart of laboratory training.

Benne et al (1964:46) state:

Immediate experiences of participants furnish the basic ingredients for laboratory training. The struggles of groups to achieve satisfactory organization and forward movement, the strivings by members to find a place in the formation and functioning of the groups, the efforts of members to integrate discrepant demands stemming from multiple memberships, within and without the laboratory - all of these experiences yield vivid and personal content for learning."

In short the focus of the T-group can possibly take place in a vacuum uninfluenced by events external to the group since the delegates to a T-group hold membership in a variety of organizations and institutions and in formal and informal groups. Members possess a variety of social and value perspectives and when issues external to the common experience (the context of inquiry) of delegates surface, the topic is changed in some way so as to make it relevant for the group.
Schein et al (1970) explain the here and now focus as follows: Here and now learning is based upon shared immediate, direct, first-hand experiences rather than the vicarious, detached, incomplete and overly protective learning found in traditional settings. Such a learning experience enables the delegate to accept responsibility for one's own continued learning and growth. When problem-solving skills are developed so as to reduce internal barriers to learning and help is both received and given in processes of change, learning can then be transferred from the tiny societal microcasum of the T-group to other social systems of which the delegate is a part. The delegate develops a beginning identity as a potential change agent.

It would be foolish to assert that the T-group is a smooth struggle-free experience and to assume such would be inconsistent with empirical findings. The task of expanding one's own consciousness is a vague ambiguous one, the ambiguity of which can help to create substantial anxiety and tension for the delegate. In prior learning experiences, delegates learned to underestimate the value of peer-input and over-estimate the teacher input. Within the T-group, the teacher is seen as any member of the group who can provide data for learning. Prior socialization experiences often makes the shifting teacher role difficult to accept; and when the trainer assumes a non-teacher trainer role, it is often upsetting to the delegates. Learning in a T-group setting can be "an emotionally loaded" experience and delegates
have different reactions to emotion-laden experiences. For some delegates, the T-group experience fosters an identity crisis. Identity is thought by T-group theorists to be achieved partially in relationship to others and partially in differentiation to others. The issue of achieving one's identity through differentiation is an issue of conflict for T-group learning. The T-group situation tends to mobilize defenses of delegates because prior traditional learning experiences provided greater situational predictability as to power and status relationships, gaining rewards and avoiding punishments, direction and goals. Perhaps Bradford et al (1964:198) sums it up best:

people generally approach learning and change with ambivalence. They would like to improve provided change is not too threatening.

Models of T-group Laboratory Learning

The T-group laboratory learning strategy, as learning strategies go, is a historically young one. Seemingly endless heuristic possibilities exist as to the T-group approach. Much research and study has already been done, but as to theoretical development, much remains to be developed. Three models of the T-group learning process have been put forward and seem important. Blake (1960) suggests a dilemma-invention-feedback-generalization model to explain how delegates learn in a T-group. T-group participants initially confront a dilemma and
then delegates engage in a variety of problem-solving behaviors i.e. experimenting, inventing, discovering, etc.; the delegates then get feedback regarding their problem-solving behavior from one another. There then follows a period of time (not defined or structured in any sense) when delegates and trainer generalize, theorize test and retest their new problem-solving behaviors before proceeding into a new learning phase. Blake's model suggests that the main energy source for the group is from the problem or dilemma in situation and that in the nature of man there exists some need to confront and solve problems.

Miles (1960) suggests a dynamic interchange between personality factors, situational influences and the T-group process. Miles' model is sequential in nature and one, which presumes, that the delegate comes to the T-group with some desire for change. This desire for change allows for a potential unfreezing of old behaviors when coupled with involvement in T-group and feedback from the group. Miles' notions about T-group learning somewhat approximates Lewinian field theory as to how learning occurs. Miles has high regard for the outcome possibilities of the T-group and contends that the best predictor of delegate learning change is its subsequent effect on work performance. Empirically, Miles has concerned himself with the degree of change occurring within the T-group laboratory rather than work performance changes.
Hampden-Turner's (1966) McGregor Award winning article regarding a model of T-group training posits a cyclic-existential theory of learning for the T-group. This model contends that the learner comes to the laboratory with a particular cognitive map, level of self-esteem, and sense of identity; the delegate then takes the risk of investing some of his experienced competence in relation to an "other". The response by the other will determine some move toward synergy or conflict; the learner will then modify his expectations. Hampden-Turner's existential theory of learning is self-perpetuating in nature and is heavily influenced by the learner's cognitive state, identity and self-esteem. All three factors are ordered in some purposeful synthesis of experienced and anticipated consequences which the subject invests in his environment by risking a portion of his experienced competence. Through the risky investment, some type of self-confirmation is sought; the result of the investment is feedback from each group member which further enhances or reduces his own perceived confidence. The final stage of Hampden-Turner's learning cycle is one in which the feedback, gained from the investment, is integrated with the synthesis of cognition, self-esteem and identity resulting in some change in the synthesis. The cycle of learning can begin once again. Hampden-Turner's point seems to be that integrated feedback from one successful investment will speed further investments and a series of successful investments will cause every segment of the cycle
to enhance itself. For Hampden-Turner, the T-group learning cycle becomes spiral in nature, beginning with a rather immature, sometimes neurotic synthesis, and a developing learning spiral so as to move or grow to a mature or integrated condition. The author reaches his conclusions regarding the T-group learning cycle by organizing research data and the literature of T-group laboratories in such a fashion so as to prove his point, namely, that learning in a T-group occurs in cyclical spires requiring investment of self and feedback; the integration of such feedback leads to further investment.

Energy Sources for the T-Group

The sources of energy for learning or the dynamic forces which promote learning in T-groups are a topic of disagreement in the literature. Schein and Bennis' (1965) counsel that the energy for learning springs from the tension in the T-group situation. In particular they affirm a struggle of dependence and independence, regarding group participation, as the cause of tension. Benne (1964) does not agree with Bennis' learning energy notions and he (Benne) would argue that polarization and divorce conflicts among T-group delegates is the source of energy for learning. Gibb (1964) proposes that defense reduction and trust formation is the learning energy source, while Bradford et al. (1964) contends that it is the constant seeking and maintaining of group membership. Blake (1964)
argues for a centrality of the trainer-delegate-member relationship as a catalyst for learning but Shepherd focuses upon the training milieu itself. Whitman (1964) believes the dynamics of focal conflict are the true energy source but Horwitz (1964) senses that the need for legitimation of behavior is an energizer because of the lack of authoritarian sanction. As one can readily observe there is substantial disagreement and variance among T-group theorists and to learning energy sources but all confirm it is intra-T-group in nature.

T-Group Learning: Putting it Altogether

Schein and Bennis (1975:50) summarize certain factors which they think to be highly influential in the learning process for T-groups. First, they intimate that there is a sequence of learning steps or phasing to T-group learning which move from an unfreezing of old cognitive knowledge to some cognitive mastery of new knowledge. Second, there is both cognitive and affective feedback induced by the situation and the integration of this feedback is probably what is meant by insight. It is an integration of the intellectual and emotional functions of man; and as a learning strategy, it is carried in that sense. Schein and Bennis also take note of the amount of "unlearning" especially as to interpersonal matters in which the delegates perceive things about themselves
which are distasteful or disconfirming to a sense of ideal self. They stress that feedback is involved; that is, systems of data exchange about interpersonal phenomena are developed and employed in the groups. The data are generated and analyzed by the delegates. Lastly there is a self-generated momentum to training. Once the momentum is begun it seems to have a life of its own, generated by the complexities of the experience. Schein and Bennis (1965:275-276) summarize their model of learning theory for the T-group follows:

Essentially the model specified that the attitude change consists of three stages which correspond closely to what Lewin identified as the stages of learning (1) unfreezing (2) changing and (3) re-freezing. The first of these stages are necessary conditions of change, the third is concerned with the stability of whatever change occurs. Under each of these stages we can identify certain key mechanisms as follows:

Stage 1. Unfreezing

1. Lack of confirmation of disconfirmation
2. Induction of guilt-anxiety
3. Creation of psychological safety by reduction of threat or removal of barriers of change

Stage 2. Changing

1. Scanning the interpersonal environment
2. Identifying with a model

Stage 3. Refreezing

1. Personal-integrating new responses into the rest of the personality and attitude system
2. Relation-integrating new responses into ongoing significant relationships
Basically, they seem to be suggesting that attitude change begins with a disequilibrium, usually receiving some information from a person that leaves the delegate uncomfortable because it is unexpected or violates an ideal sense of self. Such discomforting information leaves the delegate feeling anxious or guilty and in need to make some type of change in order to rectify the discomfort. For such change to occur, however, some psychological safety must be present in the situation or else the person will simply further insulate old learning. Though this process sounds somewhat cognitive, it should be emphasized that the emotional components for learning to become unfrozen are crucial. Again Schein and Bennis (1975:277) suggest:

if a person comes to feel safe he will begin to seek some new information about himself which will allow him cognitively to redefine some beliefs about himself or his relationships to others; much new information will be obtained by one of two basic mechanisms:

1. Scanning the available interpersonal environment for relevant cues.

2. Identifying with some particular other person whose beliefs seem to be more viable.

The delegate may begin to try to view himself from the perspective of another person or from the perspective of an array of others. As his perspective changes his frame or reference shifts, he develops new beliefs about himself which, in turn, lead to new feelings and behavioral responses. If these new feelings and responses fit well with the rest of the person, and personality and attitudes and/or if they are confirmed or reinforced by others, a new cycle of unfreezing and changing is initiated until the person finds attitudes (feelings, beliefs and responses) which do fit and which are reinforced.
Schein and Bennis' (1965) theory of learning for the T-group closely approximates Lewin's field theories of learning. The two dominant tracks of learning theories, stimulus-response (S-R) and field theories, have been previously considered within this study. Both seem to have captured an understanding of how human learning occurs. Learning theories provide cognitive road maps to those desiring to understand how learning occurs or for those designing situations where learning needs to occur. The processual, field-like theory involving cyclical steps of unfreezing old learning, change and refreezing seems to dominate T-group learning theory and there seems to exist a highly relevant match between T-group learning theory and cognitive field theories. Because of such a match, T-group learning theory and the T-group approach gains sanction and legitimacy. The T-group is not a passing fad; but rather is rooted in firm theory base with strong heuristic possibilities.

The Design of a T-Group Laboratory

The design of a T-group is an attempt to operationalize an idea about learning and to instrumentalize a preference as to how learning should occur. There are problems in operationalizing an idea as Schein and Bennis (1965) have pointed out. They assert that since laboratory training is
new and does not fit conventional categories of education or therapy, problems exist in effecting a match between symbols and experience; there also exist a lack of clear cause and effect as to processes or outcomes. While newness can be a handicap, it sometimes has the benefit of flexibility and pliability. Learning, as any other repetitive social process, has tended to become highly patterned and institutionalized, leaving the learner to fit himself or herself into the process rather than shaping the process to fit the needs of the person. Regarding the design of the T-group, the literature has concerned itself with serving the target populations according to their needs. (Balchelder and Hardy (1968), Lubin and Eddy (1970), Bradford, et al (1964), Schein and Bennis (1965). The T-group laboratory staff assists units of human organization assess its need for change, and then supports that unit through re-education, invention and experimentation. The T-group laboratory design becomes a facilitating vehicle or more accurately a vehicle, through which, some opportunity for maximization of change occurs.

Benne et al (1964:45) suggest that the laboratory design grows out of general principles, an orientation to T-group theory and any limiting factors such as number of staff, participants, time, physical facilities and resources. Each laboratory design is somewhat of a unique invention. For Schein and Bennis (1965) the design of the laboratory is a blueprint regarding major decisions in the life of the
laboratory. It encompasses such decisions as the sequence of activities, the amount of time spent in T-group as well as cognitive input, exercises, size of groups, composition of groups and staffing patterns. The culture of the laboratory is shaped very consciously by its design. Bennis (1964) cites three types of laboratory designs:

1. Cousin labs - labs for individuals with a similar organizational rank but from different functional groups (i.e. supervisors, foreman, caseworkers, etc.)

2. Diagonal slices: The T-group is composed of members from the same organization but having different rank levels and from different areas in the same organization.

3. "Family" or Functional Groups: A group that already exists for a purpose within an organization (i.e. supervisor and "the work group").

While Bennis' T-group design typology is dominated by the kind of people who attend or more particularly the work role they occupy, Batchelder and Hardy (1968:106) see the design of a laboratory in seven sequential steps:

1. Clarify the goals of the total learning programs for the particular constituting.

2. Determine which of the learning goals can be best achieved through the laboratory method and which can be best achieved by other methods.

3. Work out a sequence of experiences...

4. Review the learning goals with a qualified trainer...

5. Recruit competent trainers...

6. Make arrangements for physical facilities...
7. (provide) adequate pre-information for participants...provision for evaluation, provision for application of laboratory learnings back home...

The conceptual design of a T-group experience is highly influenced by the delegates attending (i.e. learning needs, type of work done by delegates, skill levels, etc.) and the task environment (i.e. physical facilities). The impinging task environment and the learning needs are, sometimes, not separate issues but rather interrelated and interdependent and therefore influencing one another. The early and somewhat standardized T-group laboratory design consisted of a two week period of time with delegates living away from home and work. This design does not meet the learning needs of some potential delegates. The notion of the T-group being responsive to the delegates learning needs is "the golden thread" running through the literature regarding the construction of laboratory design. Thus Bradford et al (1964) and Schein and Bennis (1965) consider substantial benefit in developing variations upon the standard, two week residence laboratory. Miles (1964) cites the adaptation of laboratory methods for the classrooms. Bradford et al (1964) suggest promising beginnings in exporting T-groups education into a variety of settings by modifying the standard resident laboratory to meet situational demands.

Perhaps, however, Schein and Bennis (1965) are the most enthusiastic supporters of variations in T-group educational designs. Historically T-groups began in an isolated location
of some distance from the delegate's family and work. The
length of time varied but generally began to evolve to one
or two week time periods. The actual schedule and content
of the laboratory (i.e. the time given to T-group sessions,
theory sessions, etc.) varied according to laboratory goals,
characteristics of delegates and nature of sponsorship.
Schein and Bennis (1965) suggest that the laboratory method
of human relations is a philosophy of learning and not limited
to certain settings or populations. Being a belief as to how
people learn, it also is not limited to a particular type of
location or time frame. Major variations in design seemed
to have occurred in three areas 1) time 2) location (degree
isolation residential, non residential) 3) content. Much
experimentation has occurred with the time variable but the
literature does not confirm one time span better than another.
The training needs and life-situational limitations of the
delegates seem prominent. Schein and Bennis (1965) hypothesize
that the longer, the laboratory the greater the likelihood
that delegates' previous learning is unfrozen and that new
learning will be more successfully acquired, refrozen and
integrated.

Another variable that has generated a great deal of
experimentation and conflict as well, is that of residency.
Bradford et al (1964) subtly suggests that when the isolation
factor is removed and a non residential laboratory is con-
ducted, in essence, it ceases to be a laboratory and becomes
an example of when T-group educational strategies are exported. Their opinions are however in the minority and the notion that the laboratory is truly a philosophy of learning not tied to place of context is more widely accepted in the literature. Schein and Bennis (1965:72) outline four types of residency designs:

1. Total residential-delegate is removed from job and family
2. Partial residential-delegate is removed from job but not necessarily from family
3. Non residential, full-time delegates attend laboratory during working hours, but lives at home and maintains work contacts
4. Non residential part-time delegate attends training sessions for several hours several days per week but maintains normal work routine at other times

The authors hypothesize that the greater the degree of isolation of the laboratory the greater the likelihood of delegates' previous learning being unfrozen, increased learning through identification and the more likelihood that learning will be refrozen especially in a back home situation. While orthodox T-group constituents still prefer the isolated laboratory experiences, the literature suggests that experimentation with the design has showed the effectiveness of the non residential laboratory. The literature contends that the greater the isolation factor, the more that can be accomplished, but that there is a place for the laboratory with very limited isolation.
Research on T-Group Laboratory Outcomes

Campbell and Dunnette (1968) contend that T-group laboratories have received substantial attention as to their empirical outcomes. They propose that as a management development tool, no other single management development approach has received more evaluative attention. In a review of the empirical literature they (Campbell and Dunnette) comment that effectiveness studies have been rather dichotomous, in that they concern themselves either with internal or external criteria, as to how much impact, the T-group has had. Cooper and Mangham (1971:25) define internal criteria for T-group effectiveness as:

measures linked directly to the content and processes of the training programs. External criteria are those linked directly with job behavior.

Campbell and Dunnette (1968) state that examples of internal criteria include measurements of attitude change, performance in simulated problem-solving situations and opinions of trainees toward what they thought they had learned. Cooper and Mangham (1971) define external criteria as those linked with job criteria behavior, i.e. increased problem solving in job situation, increased productivity and improved decision making.

There has been much more empirical evaluation done regarding internal criteria for T-group effects upon participating leaders and delegates than external evaluative measures of changes in job behavior. One particular area, which measures
the internal "happenings" of T-group that has received a great deal of research attention, has been that of changes in self-perception and perceptual changes toward others. Burke and Bennis (1961) found that self-perceptions changed to be more consistent with other delegate's perceptions of them. The authors' study and results are weakened by the absence of a control group. Gassner, Gold and Snadowsky (1964) conducted a well controlled study of phenomenal self changes and both the T-group (experimental group) and the control group decreased the discrepancy between their own self-perceptions and others' perception of them. Carson and Laken (1963) and Link (1972) studied similar phenomena and these studies were equally inconclusive. Stock (1964) found that those making the most change in regard to their self-perception actually began to experience anxiety as to what kind of people they were, as the result of T-group membership. Brooks (1974) hypothesized that a T-group experience would reduce self-concept problems and enhance supervisor-rated interpersonal skills of graduate social work students, but the data did not confirm these hypotheses. Brooks' control group also decreased self-concept problems and increased interpersonal skill ratings. Brooks' experimental group did demonstrate greater affective authenticity. The students involved, reported an impressionistic increase in self-confidence. Brooks used the Tennessee Self-Concept Scale to measure difference. Minter (1970) and Norton (1973) provided human relations
training to student teachers and utilized the Tennessee Self-Concept attempt to measure changes in the student teacher's self-concept. Again there were no significant differences in self-concept between the experimental group who received the human relations training and those in the control group who did not. Santucci (1972) found that a T-group experience did increase the confidence of college freshman when compared with study skill training. In a similar vein, Lee (1972) found sensitivity training to be superior in promoting positive changes in self-concept when compared with other educative interventions. By and large, one would have to concur with Cooper and Mangham (1971) regarding the evidence, as to the T-group's effect on self-perception. They contend that the evidence is vague, uncertain and even contradictory. In light of the lack of clarity as to the results using the Tennessee Self-Concept Scale one might surmise that there has been problems of instrumentation or that simply the T-group laboratory doesn't influence self-concept.

It has long been surmised that T-group laboratories increase the sensitivity and knowledge level as to feelings and thoughts of others. In particular the T-group experience is thought to increase the functioning-predictor skills of delegates. Argyris (1965) did confirm such an increase in predictor skills, but beyond increasing the predicator
abilities of the delegates toward their fellow-delegates, there were no generalized increases in the ability to predict feelings or the behaviors of others outside of the T-group. Gage and Exline (1953) conducted a study, as to how well T-group participants could predict questionnaire responses of other group members, but in contrast to Argyris' findings, the group's scores did not significantly change in the before and after measures which were taken. Other studies regarding predictor skills have either been equally contradictory or unclear as to significance.

In addition to increasing behavioral predictor skills, the T-group laboratory is thought to produce demonstrable attitude changes of delegates. Campbell and Dunnette (1968) in summarizing Smith's 1964 study of the T-group's influence over managerial attitudes, suggest that the disparity, between delegate's own behavioral tendencies and those behaviors they would expect or find desirable in others, could be reduced. The greatest changes occurred for those in the experimental group, who initially showed strong control and weak affection tendencies and those who desired low control and high affection from others in the group. These changes are thought to be consistent with T-group expectations.

Keenan (1964), despite some methodological weaknesses, found that attitudes of engineers were positively influenced toward authority as a result of T-group membership. Carron (1964) found that T-group members significantly decreased
authoritarianism, as expressed in the need for rigid structure, among a group of research and development managers; but Carron's methodology left some question as to the permanence of the attitudinal change. Schult and Allen (1966) found that the certain negative attitudes of delegates from varying backgrounds and attending different T-groups, experienced attitudinal changes greater than control groups, with which they were compared.

There have been several attempts to measure personality change among T-group members but no significant changes have been recorded. Campbell and Dunnette (1968) explain that, perhaps it is expecting too much to change basic personality variables due to relatively short period of time which T-groups last and the degree of impact necessary to attain major personality changes.

Since the T-group is thought to be more than an intrapersonal enrichment experience and more than a vehicle whereby interpersonal interactional skills can be improved, considerable research and study has been devoted to the effectiveness of T-groups in producing on-the-job changes. Miles (1965) utilizing a T-group experience for elementary principals, found them to have made more changes as to increased job sensitivity to others, egalitarian attitudes, skills of communication and leadership, group task and maintenance skills, than a control group of principals not receiving the T-group experiences. To test Miles' findings, Bunker (1965:42) tested delegates from several T-groups and
developed a more rigorous rating system. His findings "muddied the waters" somewhat by suggesting that outcomes varied among delegates rather substantially and there was "no standard learning outcome". Moscow (1969) conducted a study among British managers and tended to substantiate Bunker's findings. Valiquet (1968) built upon Bunker's work and found that T-group members were more effective group members and their acceptance of change was greater than a comparable control group. Valiquet infers that these behaviors are easily transferable to a job situation. Several studies have been done using pre and post measurements regarding changes in managerial attitudes toward McGregor's Theory X and Theory Y notions. T-group theory would suggest that managers would become less control oriented, attain a better integration of individual and work goals and embrace Theory Y. However, Zand et al (1967) found that his groups didn't change much as the result of the T-group experiences but they were already rather positively oriented to a Thory Y position.

There has been a significant quantity of research done in the area of T-group outcomes. With some reservations, it can be said that T-group training does positively induce behavioral changes in an on-the-job setting. The evidence regarding intra-personal changes is less conclusive especially in the area of self-perception. The T-group does seem to positively influence self-confidence levels of delegates.
Perhaps Stock (1964:435) summarizes T-group research best when she states:

Research about T-groups suggest a large checkerboard, incompletely and unevenly filled in. Some areas show a considerable concentration of work; others are nearly empty. In some other areas, the questions have been asked and answered. In others the questions are clear, but methodology or relevant theory is not yet fully developed. In still other areas, even the questions are not yet well defined. To complicate the analogy, the checkerboard is expanding and issues which previously did not exist are constantly emerging in response to new applications and modifications of the T-group.

Community Mental Programs to Train Caregivers

By and large the Community Mental Health literature does not reflect strong usage of T-group educational strategies to train Community caregivers. The community mental health movement has conducted training of many caregivers without employing T-group approaches. One exception to this notion was Hommen's (1972) study of laboratory training for parish clergymen in bereavement ministry. Hommen's study focused upon before and after changes in clergymen as they performed their bereavement ministry, their attitudes toward mental health and their orientation to the community mental health movement. He assumed that clergy are key caregivers in the community and their effectiveness as caregivers could be augmented by training; these assumptions are consistent with community mental health ideology. Hommen hypothesized that
his experimental group which received the laboratory training, would show greater improvement in the affective aspects of their bereavement ministry, greater change in their ideological orientation toward community mental health and more positive mental health attitudes than a comparable control group. He utilized a basic information questionnaire, the Baker-Schulberg Community Mental Health Ideology Scale and Mackey's Semantic Differential Mental Health Attitude Scale. Homen found that the experimental subjects improved more than control subjects in the bereavement ministry. No difference was found between the experimental and control groups as to their orientations to community mental health ideology or in positive mental health attitudes.

Margo Pines, reporting in Harper's Bazaar magazine, states that a National Mental Health project of training housewives as psychotherapists seems to have a very positive evaluation. Geis and Tenney (1968) evaluated a training program for the Juvenile Court judges at the agency level. The authors, utilizing a classic experimental research design, evaluated the training using four criteria: 1) judges own assessment of their change in courtroom practice; 2) the judges' attitudes toward ethnocentrism; 3) the judges' feelings of anomie; and 4) the judges' views on law and order issues. The evaluation left the notion that training outcomes with this type of personnel are somewhat in doubt. The judges expected to change a great deal as a result of the training
program, yet they believe they changed very little. In terms of attitudes, the judges became more politically conservative with greater interest in social control. Andrews (1954 conducted a training program for schoolteachers in order to enable the teachers to learn mental health principles which would enhance the psycho-social growth of the children whom they taught. The research data suggested that the educational program was of little consequence and indicated little or no change occurred in teacher knowledge levels. Hammer (1965) provided community mental training to ministers consisting of seminars, case presentations and visits to institutions. Hammer's impressions were that the seminars were beneficial but he collected no data. Shapiro (1967) trained ministers in a similar fashion to Hammer and again reported positive impressionistic notions about the training.

Like other programs of social intervention, community mental health began to train some consumers of their services and selected other groups to become interveners so as to expand their manpower capacity. Dellworth et al (1974) trained student volunteers in specific counseling duties. While no data was collected, the authors surmised that training student volunteers was effective and that it freed the professionals to develop new programs. Neleigh et al (1970) reports upon a five year New Mexico program to train non-professionals to render mental health services. They provided three different
kinds of training: 1) didactic approach; 2) group sensitivity; 3) spending time in observation and a general orientation to sensitivity groups. The professionals and the trainees differ significantly in their opinions of the training. Trainees preferred the didactic approach and those receiving the didactic approach felt more prepared to perform mental health tasks. In general, all trainees preferred classes, demonstrative observation, individual conferences and on-the-job training to the group laboratory approach. Those conducting the training sessions preferred the laboratory approach. The authors did not report upon the work effectiveness of the separate training approaches and this would be extremely useful to know.

Rioch (1967) trained middle class women to do therapy through didactic, observational and case-study approaches. Expert opinions were utilized as an evaluation of the women’s output; the evaluation was positive. Vander Kolk (1973) compared two similar groups of psychiatric attendants given mental health training with purpose of increasing their effectiveness in interpersonal functioning, improving counseling skills and on the job behaviors. One training approach was labeled as integrated-didactic and experiential and consisted of listening to counseling tapes, responding to the tapes, rating the tapes for "empathy levels" and role playing. The second training approach was labeled as traditional, and consisted of lecture and classroom-style
training. The group receiving the integrated-didactic experiential approach made the greatest gains in counselor skills and empathy, as might have been expected.

As the foregoing illustrates, community mental health literature is not resplendent in data regarding educational interventions with community caregivers. The literature reflects a strong trend to expand manpower resources through indirect educational interventions training consumers and other groups in community mental health principles. Yet this author suspects that the community mental health movement has intervened educationally with a variety of caregivers such as public welfare workers, schoolteachers, and police, but it is not well evaluated or reported in the literature.
Rational

Growing bureaucratization and specialization phenomena are thought to influence the interventive strategies and activities of community caregivers. More particularly, it is thought that bureaucratization and specialization have narrowed the focus and world-view of caregivers so that they are lacking in group level intervention skills; this renders their interventive repertoires insufficient and/or obsolete. Extant re-educational resources are not always available or accessible to caregivers, or if they are, the resources are not as effective as they might be. This study first considered, how it is, that learning occurs for the human organism. Two tracks of learning theory were considered as to how knowledge was imparted; the literature suggests that group participation facilitates learning and that learning is more effectively instrumentalized through group processes. The literature recommended that a T-group laboratory, in particular, was an effective vehicle to facilitate learning and to develop group intervention skills. It was established that theoretical notions, as to how learning occurred in a T-group laboratory, were legitimate and consistent with cognitive or field theories of learning.
Likewise, it was noted that the community mental health movement saw as its responsibility, the continued provision of supplies necessary for self-realization and maximization. These supplies are multi-faceted and one part of those supplies could be the availability of caregivers whose interventive repertoires are adequate, technologically current and commensurate with needs. The community mental health movement is interested in extending its effectiveness through working with community caregivers in varied direct and indirect interventive activities. Thus, the community mental health movement provides the situational opportunity for such group level intervention training of community caregivers.

How to Evaluate the Caregivers Training:

The literature of learning contends that the learner approaches a learning situation with a synthesis of previously gained knowledge, self-esteem and identity. Another way of understanding this synthesis is to view it as an accumulation of insights. The synthesis of knowledge, self-esteem and identity are invested by the learner at substantial emotional risk with the expectation that feedback will result in some positive change in the synthesis. Any evaluation of the effectiveness of the T-group approach must necessarily contend with some way of measuring change or the lack of change in the synthesis. The issue becomes simply, what is the most
effective manner in which old sets of knowledge, identity and self-esteem are unfrozen, learning occurs, and a new synthesis is refrozen? The needs of the delegates, the context of the training and the goals of the training seem to provide direction to responding to the aforementioned question. Measuring change in self-esteem can be best accomplished by taking some measurement of self-esteem before and after the training in order to determine change. To measure knowledge and identity change is somewhat more difficult. Again, the needs of the delegates and the context of the study seem to offer solutions to the dilemma. The needs or problems of the delegates (community caregivers lack group level intervention skills) have been previously delineated. Their identity as practitioners intervening at a group level, as well as, their knowledge of group intervention can best be measured by some attitude change in the knowledge of and confidence in group intervention. The literature attests to the fact that changes in confidence levels of T-group members can be expected as the results of participating in a T-group laboratory, and in effect, is a measure of T-group effectiveness.

The context of the study offers further help with measuring the degree of change as to knowledge and identity. The training is a part of the community mental health movement and is an attempt to expand the effectiveness of that movement by working through others. In this particular situation, it is training caregivers in group interventive skills so as
to expand the movement's effectiveness. The community mental health movement has vastly broadened its own interventive scope and repertoire, if the movement is compared with traditional mental health delivery systems. Community mental health's intervention activities are group-level in nature, and based upon a belief of cause and effect which demands group intervention. Community mental health's population focus, its emphasis upon primary prevention, social treatment goals, continuity of care and total community involvement are useful concepts for all caregivers. Identification with such concepts facilitates the work of the community caregivers and because these concepts of intervention are not limited to one kind of social problem, but are based upon recent insights provided by the social sciences; they enhance the effectiveness of all caregivers. In addition, the sharing of interventive concepts has the effect of uniting caregivers into a common social network. Therefore, assessing adherence to community mental health ideology measures to some degree, an identity with certain interventive strategies, as well as an identity with a social network of caregivers.

Conceptual Design of the Study

It was suggested within the literature review of this study that caregivers could benefit from acquiring increased group level interventive skills. It has also been established
in this study that a T-group laboratory may be a preferred educational interventive strategy to train caregivers in group intervention skills and that the community mental health movement provided the context for such training. It was further recommended that evaluation of such training concern itself with any changes in self-esteem, adherence to community mental health ideology and attitudes toward group intervention. Having stated then the premises for this study, the following conceptual design of the study is put forward:
CONCEPTUAL DESIGN OF THE STUDY

Caregiver Participants

Attitudes of Group Intervention

Adherence to Community Mental Health Ideology

Assessment of Self-Esteem

Change

Modified T-Group Training

Training

(Modal Health Context

Program in Group

Intervention in Community

Caregiver Participants

Attitudes of Group Intervention

Adherence to Community Mental Health Ideology

Assessment of Self-Esteem

Change

(Independent Variable)

(Independent Variables)
Hypotheses

$H_1$ The post experimental group would have higher self-esteem scores than either the pre-experimental group and the post control group.

$H_2$ The post experimental group would demonstrate greater adherence to community mental health ideology than either the pre-experimental group and the post control group.

$H_3$ The post experimental group would have more positive attitudes toward group intervention than either the pre-experimental group and the post control group.

Research Design

The research design for this study is a pretest-posttest control group design (Campbell and Stanley (1969). The design employs both pretest and posttest measures for the experimental group and the control group. As described by Campbell and Stanley (1969), this design is one of the true experimental designs as opposed to a quasi-experimental design, and is useful to insure internal validity. Campbell and Stanley (1969) suggest that such a design enables some discernment as to whether the experimental treatment or in this instance the T-group laboratory makes a difference.
The above design was modified in two ways. First, the experimental and control groups were split randomly so that one-half of the experimental and one-half of the control group (E₁ and C₁) were given the pretest and the remaining half of each group (E₂ and C₂) were given the posttest. The random splitting of the groups allows different sub-groups of the experimental and control group to receive pretest and posttest measures thus reducing test-retest reactivity. With the first modification, the design is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Training</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>0</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>Control Group</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 2

The second modification has to do with a retest of the experimental group. It would be useful to know whether gains made during training are sustained over time. The literature does indicate that retests of delegates attending T-group laboratories have occurred from time to time, both to test whether delegates have integrated knowledge learned in T-group laboratories to their work competencies, and to test
the permanence of changes made. This author concurs that re-
tests for these purposes are useful and puts forward the notion
that such retests can also partially control for the effects of
serendipity. The laboratory situation, by its very nature, is
a simulated experience and as Raser (1969) points out, simulated
experiences can be prone to serendipity. Raser (1969:91) explains
serendipity as a "gift from the Gods" and that human relations
training is a rich experience, complex in nature. Such rich
experiences are relatively uncontrolled as to some prescribed
type of generated outcome. The experience may be extremely
intense for the moment but would not hold up over time and
thus creating a serendipity effect. The retest some three
months later would re-evaluate learning after the serendipity
effect has had time to dissipate.

The research design then including the provision for a
retest is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Training</th>
<th>Posttest</th>
<th>Retest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>$E_1$</td>
<td>$X$</td>
<td>$E_2$</td>
<td>$R_1$</td>
</tr>
<tr>
<td>Control Group</td>
<td>$C_1$</td>
<td></td>
<td></td>
<td>$R_2$</td>
</tr>
</tbody>
</table>

Figure 4
The Context and Sample of the Study

The subjects for this study were drawn from Clark County caregivers who applied for Group Intervention Training, a modified T-group laboratory sponsored by the Clark County Mental Health Program. Applicants for the training were recruited through the media, brochures, mailings and other recruiting methods. Applicants who applied represented a broad spectrum of caregivers including health care professionals, criminal justice system workers, school personnel, such as school psychologists and social workers, child welfare and child care workers, indigenous workers and agency executives.

Since caregiver is a rather broad category of people, one might expect substantial variance among participants as to their age, educational backgrounds, income levels and years of experience; this expectation proved to be correct for the participants of this study. While an analysis of demographic findings will be presented more fully in chapter four of this study, the following description of the participants seems useful. The participants were relatively young with more than one-half of them under forty years of age. Two-thirds of the participants were women. There was substantial differences in their education levels as the aforementioned description of their caregiving jobs might
suggest. The educational range for participants was from high school dropout to those with doctoral degrees and physicians. Within the above groups, there was also considerable differences such as policemen who were high school graduates, bachelor degree level caseworkers and still others at the master degree level.

Rather impressionistically, the sponsors of the laboratory thought that the dominant annual income range of the participants was from ten to twenty thousand dollars. Sponsors were aware of a few participants whose incomes were at or below the poverty level and a few whose annual incomes exceeded twenty-five thousand dollars. Their years of experience as formal caregivers were likewise very mixed.

Perhaps the most single influential factor regarding the context of the study was T-group laboratory design. The sponsors of the T-group laboratory impressionistically concluded from their collateral and consultative contacts with caregivers in their catchment area (Clark County, Ohio) that nearly all the community caregivers lacked group interventive skills. As such, the sponsors desired to train a large number of caregivers, but limitations of space and trainer- manpower resources required that the training laboratory be limited to twenty-six delegates. Perhaps the most influential limiting factor was the size of the actual T-group. The literature suggests that with two leaders or trainers the actual T-group should contain no more than twelve to sixteen members; and the number of available T-group trained leaders were limited to staff two groups.
The sponsors designed the T-group laboratory to run a twelve week span of time meeting four hours, one day each week. The T-group experience and theory sessions regarding group intervention training shared the laboratory time equally. Two breaks of an informal nature were scheduled within the sessions. Delegates were assigned randomly to their T-groups with thirteen delegates to each T-group. T-group trainers had previous T-group training and once the T-group trainers were assigned to their respective groups they remained with the same group. The trainers did observe in the theory sessions but did not function or participate in any thing resembling a teacher role because the sponsors thought this would be a role contradiction and a source of confusion to delegates. Their observation during theory sessions occurred at their own suggestion so that they might obtain a sense integration and be exposed to the same experiences as the delegates. The focus of the T-group was upon the here and now. The T-groups were conducted in such a manner as to be consistent with current T-group thought and strategies.

The content for the theory sessions was rather broad in nature focusing upon group intervention training as it relates to community mental health principles, the group in the realm of social functioning, group dynamics, group role behaviors, group type (i.e. natural versus formal, mechanical versus
phenomenological), how to intervene in existing groups and how to establish new groups of varying types. Extensive use of audio-visual material and equipment were utilized to enhance theory sessions.

Procedures Utilized in Doing the Study

Sixty four (64) caregivers applied for the T-group laboratory; from these applicants, fifty-two (52) were selected randomly as participants in this study. One-half of the fifty-two (52) participants were randomly assigned to the experimental group and received the training, while the other half became the control group and were not delegates to the T-group laboratory. Although random assignment usually is thought to guarantee group comparability, significant demographic information such as age, sex, educational level and years of employment in the human services were gathered through an information sheet in order to assess the degree of comparability between groups.

The pretest assessment of the experimental and control were administered immediately prior to the starting of the first T-group session. As previously mentioned, random assignment to the two T-groups occurred so as not to jeopardize validity of the assessment due to some unusual positive or negative experience occurring in one or other
of the T-groups and so as not to load one of the other groups with subjectivity of the sponsors. The pretest group was chosen randomly from both T-groups.

<table>
<thead>
<tr>
<th></th>
<th>Pretest Group</th>
<th>Posttest Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-Group A</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>T-Group B</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 5

Upon completion of the twelve week group intervention program the posttests were administered to the previously untested experimental and control groups within the same time frame. As was discussed earlier, in order to reduce serendipity effects and measure to see whether T-group gains stood some test of time, the entire experimental group was retested, using the same instruments, three months after the completion of the training program.

Instruments Used in the Study

Three instruments to assess change were employed in this study: 1) The Rosenberg Self-Esteem Scale (R.S.E. Scale), 2) The Baker-Schulberg Community Mental Health Ideology Scale (C.M.H.I. Scale), 3) Attitude Toward Group Intervention Scale (A.G.I. Scale).

The self-esteem of delegates was measured by the R.S.E. Scale, a Guttman scale, of ten alternating positive and negative stems about oneself. The scale was initially developed in 1953, and later modified in 1965 and while the scale was standardized upon an adolescent population it has
been further utilized successfully upon college students and adults. Using the Guttman procedure, the reproducibility of the R.S.E. Scale was .92 and its scalability was .72. The scale was designed to measure attitudes toward the self along a favorable-to-unfavorable dimension. (Rosenberg 1965 and Wylee 1961, Coopersmith 1964). The Baker-Schulberg C.M.H.I. Scale is a Likert type scale of thirty-eight items developed in 1967 which measures adherence to community mental health ideology. It has been utilized successfully with mental health professionals, para-professionals and lay groups. It was standardized on the basis of 484 respondents from nine criteria groups of mental health professionals. Its construct validity is supported by significant correlations to two other measures of community mental health orientation (r = .55 p < .001 and 4 = .41, p < .001). Reliability for all respondents was .94, split half reliability was .95, and test-retest reliability was .92. (Baker-Schulberg 1967).

The Attitudes Toward Group Intervention Scale (A.G.I.) was developed for this study by this writer. The scale was originally a fourteen item Likert type scale which attempted to measure respondents' attitudes toward group intervention and their own assessment of their familiarity with group interventive strategies. Before administering the scale to the experimental and control group, it was pretested upon nineteen credentialed (Master's Degree or above) professionals,
Ten of the instrument-pretest group were mental health professionals experienced in group intervention while nine were caregivers who have little training or experience in the strategies of group intervention. Upon analysis of the instrument pretest, two items were dropped as one set of responses were not considered unidimensional while the other item did not correlate highly with the total score higher than .80. The results of the pretest analysis indicate that all individual items and the total score distinguishes between the two pretest groups. (p < .005).

The A.G.I. scale was developed to measure the specific task of the T-group laboratory, while it was thought that the R.S.E. scale and C.M.H.I. scale might measure more global changes within the individual and his work adaptation. In constructing the A.G.I. scale, this writer thought that there were three important components in measuring attitudes toward group level intervention: 1) attitudes toward what they thought they knew about group intervention, 2) their attitudes about their own confidence in intervening at the group level, 3) their willingness to intervene at the group level. Items were then constructed to elicit attitudes toward these three components.

How the Data Were Analyzed

Differences between the experimental and the control group were computed; the differences between the premeasures
postmeasures of the experimental group were assessed by $t$ tests. A series of $t$ tests were also conducted on the posttest scores of the experimental and control group. In addition, $t$ tests were conducted between the pretest scores of the experimental and control group. It is expected that there would be no significant differences between these groups; however, this analysis was conducted to determine the comparability of the two groups. Furthermore, $t$ tests were conducted between the experimental group's original scores and their retest scores; the retest scores of the experimental group were compared with the pretest and posttest scores to gain some understanding of the effects of time upon the T-group delegates.

Figure 6
Winer (1962) indicates that the $t$ test is a robust statistical device with respect to the sample size, normality of distribution and homogeneity of variance. In addition, however, non-parametric analyses were conducted in order to further analyze these data in the event that the aforementioned assumptions about the $t$ test are violated. A Mann Whitney $U$ was computed between the pretest and posttest scores of the experimental and control groups, and between the post scores of the experimental and control groups.

To assure comparability of the experimental and control groups, certain demographic variables, such as age, and years of training were analyzed by means of $t$ tests to determine if these variables might have affected the outcome. Sex distribution among the groups was analyzed by computing a chi-square comparing the proportion of men and women in the subgroups of the experimental and control groups.

A great number of $t$ tests were conducted, four $t$ tests ($E_1$ to $E_2$, $E_2$ to $C_2$, $E_2$ to $R$ and $C_2$ to $R$) to measure the experimental hypotheses, namely, did the T-group laboratory have any effects. In addition $t$ tests were conducted to determine the comparability of groups as to certain demographic influences. Conducting a great number of $t$ tests increasing the probability of finding significant $t$ values (Winer 1971)

In order to correct this potential source of error, an analysis of covariance was conducted so as to control for increased probability of statistical significance and
furthermore such an analyses would serve to statistically match certain demographic variables that might differ between groups, and thereby interact with the training in a manner so as to alter results.
CHAPTER FOUR

THE FINDINGS

Introduction

Although random assignment to the experimental and control groups should guarantee that no group differences existed as to age, sex, income, length of employment and years of education, tests were conducted between the experimental and control groups to check this assumption. Comparisons were made between \( E_1 \) and \( E_2 \) in order to determine whether training had any effect upon the T-group delegates, comparisons were also made between \( E_2 \) and \( C_2 \) for training effect. In addition, tests were conducted between \( C_1 \) and \( C_2 \) to see if by chance there were any differences between these two groups. The entire experimental group was retested after twelve (12) weeks, and then, scores were compared to both pretest and posttest measures of the experimental and control groups; this was done to determine whether training effects lasted over time.
Of secondary importance, comparisons were made between E₁ and C₂ to test the assumption that E₁ and C₂, neither of whom were exposed to training, were comparable. In order to gain greater familiarity with those who participated in the study, comparisons were made between E₂ and C₁. These scores also were compared with the experimental retest scores.

As previously mentioned within the context of this study, three measures of the primary dependent variable were used, The Baker-Schulberg Community Mental Health Ideology Test (C.M.H.I.), The Rosenberg Self Esteem (R.S.E.) Scale and an attitude scale especially constructed for this study to measure attitudes in group intervention (A.G.I.).
Comparison of Groups for Demographic Differences

Sex

Fourteen (14) men and thirty-one (31) women participated in this study indicating that 31.1% of subjects were men (see table one). To determine whether any one group differed significantly in composition of men to women, it was expected that each group (experimental and control) would be made up of 31.1% men. Chi-square analyses were conducted to ascertain whether any sub-group differed significantly from the 31.1% expected proportion of men. No significant differences in any of the groups were found.

\( \chi^2 \) for E₁ = .360; df = 1; p = .50. \( \chi^2 \) for E₂ = .009; df = 1; p = .90. \( \chi^2 \) for C₁ = .080; df = 1; p = .95. \( \chi^2 \) for C₂ = .494; df = 1; p = .30. See table two.
Table 1

FREQUENCY OF MEN AND WOMEN PARTICIPANTS IN EACH GROUP

<table>
<thead>
<tr>
<th>Group</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td>2</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>E₂</td>
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</tr>
<tr>
<td>C₁</td>
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<tr>
<td>C₂</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>
Table 2

CHI-SQUARE ANALYSIS OF SEX COMPOSITION OF GROUPS

<table>
<thead>
<tr>
<th>Group</th>
<th>$x^2$ Value</th>
<th>$p$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$</td>
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</tr>
<tr>
<td>$E_2$</td>
<td>.009</td>
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<td>$p = .95$</td>
</tr>
<tr>
<td>$C_2$</td>
<td>.494</td>
<td>$p = .30$</td>
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</tbody>
</table>

Age

The age range of the 45 participants in this study was from twenty-two years to sixty-three years. All possible comparisons were conducted between the sub-groups of the experimental group and control groups, and as can be seen in tables three and four, no significant differences in age were found on any of these comparisons.
Table 3

**MEAN AGE OF GROUPS**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$</td>
<td>37.6</td>
</tr>
<tr>
<td>$E_2$</td>
<td>38.3</td>
</tr>
<tr>
<td>$C_1$</td>
<td>40.3</td>
</tr>
<tr>
<td>$C_2$</td>
<td>37.0</td>
</tr>
</tbody>
</table>
Table 4

_t_ TESTS ON GROUP COMPARISONS OF AGE

<table>
<thead>
<tr>
<th>Comparison</th>
<th><em>t</em> value</th>
<th><em>p</em> value</th>
</tr>
</thead>
<tbody>
<tr>
<td>_E_1 to _E_2</td>
<td>- .129</td>
<td>.899</td>
</tr>
<tr>
<td>_E_1 to _C_1</td>
<td>- .450</td>
<td>.657</td>
</tr>
<tr>
<td>_E_1 to _C_2</td>
<td>.121</td>
<td>.905</td>
</tr>
<tr>
<td>_E_2 to _C_1</td>
<td>- .337</td>
<td>.739</td>
</tr>
<tr>
<td>_E_2 to _C_2</td>
<td>.236</td>
<td>.816</td>
</tr>
<tr>
<td>_C_1 to _C_2</td>
<td>.525</td>
<td>.605</td>
</tr>
</tbody>
</table>

Education

Although one might assume that random assignment to experimental and control sub-groups would preclude educational differences among groups, this was not found to be the case. Contrary to expectations (see tables five and six), significant differences were found, namely, that the posttest
experimental group (E₂) was better educated than the pretest experimental group (E₁) (t = -2.37; p = .014). In addition, it was also found that the posttest control group (C₂) was significantly better educated than the pretest experimental and the pretest control groups (t = -2.80; p = .001; t = -3.27; p = .004). As expected no significant differences were found between the experimental and control pretest group (t = -2.23, p = .826) nor between the experiment and control posttest groups (t = -1.05, p = .306).

Table 5

MEAN EDUCATION LEVEL OF GROUPS

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td>14.7</td>
</tr>
<tr>
<td>E₂</td>
<td>17.0</td>
</tr>
<tr>
<td>C₁</td>
<td>14.9</td>
</tr>
<tr>
<td>C₂</td>
<td>17.3</td>
</tr>
</tbody>
</table>
### Table 6

**t TESTS ON GROUP COMPARISONS OF EDUCATION**

<table>
<thead>
<tr>
<th>Comparison</th>
<th>t value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ to $E_2$</td>
<td>-2.37</td>
<td>.028</td>
</tr>
<tr>
<td>$E_1$ to $C_1$</td>
<td>.223</td>
<td>.826</td>
</tr>
<tr>
<td>$E_1$ to $C_2$</td>
<td>2.80</td>
<td>.011</td>
</tr>
<tr>
<td>$E_2$ to $C_1$</td>
<td>2.67</td>
<td>.014</td>
</tr>
<tr>
<td>$E_2$ to $C_2$</td>
<td>-1.05</td>
<td>.306</td>
</tr>
<tr>
<td>$C_1$ to $C_2$</td>
<td>-3.27</td>
<td>.004</td>
</tr>
</tbody>
</table>

**Missing Data**

Fifty-two subjects participated in the training experiment. Of the twenty-six members of the experimental group, four did not complete any of the instruments. The four delegates, who did not complete the instruments, had different reasons for not doing so, but the reasons seem to indicate
some kind of trust factor. Of the twenty-six members of the
control group, three participants did not return any of the
questionnaires. It is thought that the return rate of com-
pleted data was adequate.

Due to either problems of instrumentation or some ex-
plained reluctance among participants, employment and income
data were not able to be gathered. However, considering the
other demographic data gained, this author thinks that these
variables are perhaps the least important in terms of influ-
encing outcome of this study.

Analysis of Demographic Data

Demographic data collected, confirmed that no signifi-
cant differences existed between the experimental and control
groups as to sex and age. Contrary to expectations, both
posttest groups were significantly higher in educational
achievement levels. Data was not obtained upon income level
and years of work experience well enough to report. While
no significant differences were found between the groups as
to age and sex types, certain remarks regarding the age and
sex of the participants can be made. Generally, the partic-
cipants tended to be women and relatively young. As tables
one (1) and two (2) suggest both posttest groups had a higher
proportion of men than the pretest groups but this difference
was not found to be statistically significant. Tables three
(3) and four (4) indicate that the mean ages of all four
groups were quite close; that there was a spread of no more than three years between the means, and group comparisons as to age differences between the groups were not statistically significant. Twenty-five of the forty-five respondents were under forty years of age. One might venture an opinion that often a community's network of caregivers are relatively youthful women, then if this is the case, this particular group of caregivers are fairly representative of a caregiving network. One can push the age-sex role stereotyping too far, but one could argue that, historically, early occupational opportunities for women existed in caregiving work. Except for certain professions, or work which usually emphasize social control or for some other reason traditionally assigned to males, community caregiving has been a female dominated task. Although some change has occurred in recent decades, the preponderant influences of women in caregiving occupations still exists and is reflected in the population of this study. That these women might be young rather than middle aged might reflect, in part, the recent manpower explosion and societal investment in caregiving activities. Thus, in an area that requires increased manpower, one could comment that, such an area would lure those entering the job market (usually the young adult) rather than those who have been in the labor market a number of years.

Unlike age and sex, significant differences between the groups were found as to their educational achievement levels
despite the random selection process. Table 5 suggests that on the average, the posttest experimental and control groups had achieved two (2) to three (3) more years of formal education than the pretest groups. Stated another way, the two posttest groups had enough years of education to have completed four (4) years of college and attended a year or so of graduate or professional school while the pretest groups, on the average had enough years of education to be college sophomores.

Table six indicates that the educational differences between the pretest and posttest experimental group were significant at the .028 level and the differences between the pretest and posttest control groups were significant at the .004 level. Likewise the posttest experimental group had significantly more years of education than the pretest control group (p = .014) and the posttest control group had significantly more years of education than pretest experimental group (p = .011). While it isn't possible to explain the failure of random sampling to assure equality of groups as to their educational levels except for the small size of the sample, one could comment upon the educational differences and their potential influences. This varied group of participants reflects both the educational levels necessary to obtain their caregiving jobs and the varied educational levels of caregivers now found in a community. Stated another way, the hazardous situations, which require the activity of
caregivers are sufficiently diverse so as to require quite different knowledge and skill levels. Extant knowledge, confidence and interventive repertoire as to group interventional vary greatly with educational levels. A delegate with more years of educational training might also come to the laboratory with greater self-esteem and familiarity with community mental health ideology and group level intervention skills; educational level then could interact with the training and distort the results. This author shall point out somewhat later in this part of the study that this was probably not the case in this experiment.

ANALYSIS OF THE PRIMARY DEPENDENT VARIABLES

Self Esteem Findings

No significant differences were found between the pretest and posttest measures of the experimental group (E1 to E2) on the R.S.E. Scale (\(t = -0.958, p = 0.349\)). See tables seven (7) and eight (8) for mean values, \(t\) values and \(p\) values of the R.S.E. Scale. Comparing the same groups utilizing non-parametric statistical analysis, no significant differences were found. (\(U = 43, p \leq 0.05\)). See table nine for \(U\) values and \(p\) values of the R.S.E. Scale.

No significant differences were found between the experimental group pretest scores and the control group pretest
(E₁ to C₁) scores on the R.S.E. Scale (t = .668, p = .511). Comparing the same groups utilizing non-parametric statistical analysis, no significant differences were found (U = 87, p .05).

Contrary to the expectations of this author, no significant differences were found between the experimental group posttest measures (E₂ to C₂) on the R.S.E. Scale (t = .105, p = .918). Non-parametric analysis of the same groups and the same data confirmed that no significant group differences existed. (U = 67, p .05).

No significant differences were found between the experimental group pretest scores and the control group posttest scores (E₁ to C₂) on the R.S.E. Scale (t = 1.29, p = .221). Comparing the same groups utilizing non-parametric statistical analysis, no significant differences were found (U = 33, p .05).

No significant differences were found between the experimental group posttest scores and the control group pretest scores (E₂ to C₁) on the R.S.E. Scale (t = .330, p = .774). Comparing the same groups utilizing non-parametric statistical analysis, no significant differences were found (U = 75, p .05).

No significant differences were found between the pretest and posttest control group measures (C₁ to C₂) on the R.S.E. Scale (t = .399, p = .694). Comparing the same groups utilizing non-parametric statistical analysis revealed similar nonsignificant findings (U = 62, p .05).
Table 7

GROUP MEANS ON THE ROSENBERG SELF-ESTEEM SCALE

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>3.13</td>
</tr>
<tr>
<td>E2</td>
<td>3.34</td>
</tr>
<tr>
<td>C1</td>
<td>3.26</td>
</tr>
<tr>
<td>C2</td>
<td>3.32</td>
</tr>
<tr>
<td>R</td>
<td>3.54</td>
</tr>
</tbody>
</table>
## Table 8

**t TESTS ON GROUP COMPARISONS OF THE ROSENBERG SELF-ESTEEM SCALE**

<table>
<thead>
<tr>
<th>Comparisons</th>
<th>t value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ to E₂</td>
<td>-.958</td>
<td>.349</td>
</tr>
<tr>
<td>E₁ to C₁</td>
<td>-.668</td>
<td>.513</td>
</tr>
<tr>
<td>E₂ to C₂</td>
<td>.105</td>
<td>.918</td>
</tr>
<tr>
<td>E₁ to C₂</td>
<td>1.29</td>
<td>.221</td>
</tr>
<tr>
<td>E₂ to C₁</td>
<td>-.330</td>
<td>.774</td>
</tr>
<tr>
<td>C₁ to C₂</td>
<td>-.399</td>
<td>.694</td>
</tr>
<tr>
<td>E₁ to R</td>
<td>.585</td>
<td>.563</td>
</tr>
<tr>
<td>E₂ to R</td>
<td>.817</td>
<td>.420</td>
</tr>
<tr>
<td>C₁ to R</td>
<td>-.330</td>
<td>.744</td>
</tr>
<tr>
<td>C₂ to R</td>
<td>.903</td>
<td>.374</td>
</tr>
</tbody>
</table>
Table 9

NON-PARAMETRIC STATISTICAL ANALYSIS
OF GROUP COMPARISONS ON THE
ROSENBERG SELF ESTEEM SCALE

<table>
<thead>
<tr>
<th>Group Comparison</th>
<th>U value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ to E₂</td>
<td>43</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₁ to C₁</td>
<td>87</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₂ to C₂</td>
<td>67</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₁ to C₂</td>
<td>33</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₂ to C₁</td>
<td>75</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>C₁ to C₂</td>
<td>66</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₁ to R</td>
<td>96</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>E₂ to R</td>
<td>126</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>C₁ to R</td>
<td>145</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>C₂ to R</td>
<td>141</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>
No significant differences were found between the experimental pretest and the experimental retest groups (E1 to R) on the R.S.E. Scale ($t = .585, p = .563$). Comparing the same groups utilizing non-parametric statistical analysis revealed similar non-significant findings ($U = 96, p = .05$).

No significant differences were found between the experimental posttest group scores and the experimental retest group scores (E2 to R) on the R.S.E. Scale ($t = .817, p = .420$). Comparing the same groups utilizing non-parametric statistical analysis confirmed the aforementioned results ($U = 126, p = .05$).

No significant differences were found between the control group pretest scores and the experimental retest group scores (C1 to R) on the R.S.E. Scale ($t = .330, p = .744$). Comparing the same groups utilizing non-parametric statistical analysis revealed that no significant differences existed between the groups on the R.S.E. Scale ($U = 145, p = .05$).

Contrary to the expectations of this author, no significant differences were found between the control posttest group scores and the experimental retest groups scores (C2 to R) on the R.S.E. Scale ($t = -.903, p = .374$). Comparing the same groups utilizing non-parametric statistical analysis, no significant differences were found on the R.S.E. Scale ($U = 141, p = .05$).
An analysis was conducted to determine if the differences on the R.S.E. Scale between $E_1$ and $E_2$ were greater than the differences between $C_1$ and $C_2$ as to enhanced self-esteem due to attending the T-group laboratory. Since independent groups were used, a gain score analysis could not be conducted. Consequently, the mean differences between $E_1$ and $E_2$ were compared to the mean differences between $C_1$ and $C_2$ and a $t$ test conducted. No significant differences were found ($t = .487$, $p = ns.$).

Discussion Concerning the Self-Esteem Findings

This writer hypothesized that the posttest experimental group would have higher self-esteem scores than either the pre-experimental group and the post control group. Both parametric and non-parametric analysis of the data suggest that there were no significant differences between the groups as to their scores on the R.S.E. Scale. Significance was accepted at the $p = .05$ level. Since the scores of the experimental posttest group were not significantly higher in terms of self-esteem than either the experimental pretest group or the control posttest group, the first hypotheses of this study must be rejected. Overall, it was found that the self-esteem of all groups involved in the study were quite high. Table seven (7) suggests that the group mean scores for the R.S.E. Scale were 3.13 or better, and since the R.S.E. Scale is a four point Scale, one could
comment that the participants came to the laboratory with rather positive attitudes toward their own self-esteem. Given the instrument used, there just wasn't much self-esteem enhancement possibilities. There are indications from the group mean scores as found in table seven (7) that the experimental group gained more self-esteem enhancement than the control group; that self-esteem increased to the highest point at the time of the retest, however, none of these group differences were statistically significant.

While the aforementioned discussion of self-esteem findings are the most salient, some additional discussion is useful. The findings in regard to self-esteem in this study are rather consistent with other T-group findings which were detailed in the literature review of this study. In other studies, where the Tennessee Self-Concept Scale was utilized, there seemed little significant changes as to self-esteem enhancement. Using a different instrument in this study did not alter the findings. It very well could be that the accumulation of findings in the T-group literature may be indicating the T-group laboratories do not significantly alter self-esteem. In addition, there may be indications that T-group experiences do not effect global changes within the individual.

Certainly the results do not indicate any decrease in self-esteem and this is especially confirmed in the
retest of the experimental group some three months after the laboratory. While the "no harm done" issue is not the most important, it is still worth noting.

Some speculation seems called for to explain how it is that the participants came to the laboratory with positive opinions of their self-esteem. First, these participants were community caregivers which is a relatively important position in the community. Caregiving activities in Gesellschaft communities seem to be growing in importance as the society seems to realize the high level of interdependence that exists in such communities. Caregiving is a relatively complex activity which requires a certain amount of personal strengths, inter-personal skills and knowledge bases. The prerequisites then for the assumption of membership in the network of community caregivers suggests some kind of synthesis of qualities which might be reflected in a rather positive self-image. Second, there may have been some influence upon the caregiver to present a semblance of strength, an emphasis on a healthy personality and positive self-esteem since the training program was taking place in a mental health environment, "their own" community mental health program. Third, these participants maintained multiple role relationships with the sponsors of the laboratory and this factor could have influenced delegates to put his or her "best foot forward".
Community Mental Health Ideology Findings

No significant differences were found between the experimental pretest group scores and the experimental post-test scores (E₁ to E₂) on the C.M.H.I. Scale. (t = -1.36, p = 1.89.). See Tables ten (10) and eleven (11) for t values and p values. Comparing the same groups utilizing non-parametric statistical analysis revealed similar findings. (U = 42, p = .05) See table twelve (12) for U values.
### Table 10

**GROUP MEANS ON THE COMMUNITY MENTAL HEALTH IDEOLOGY SCALE**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$</td>
<td>4.55</td>
</tr>
<tr>
<td>$E_2$</td>
<td>4.87</td>
</tr>
<tr>
<td>$C_1$</td>
<td>5.00</td>
</tr>
<tr>
<td>$C_2$</td>
<td>4.95</td>
</tr>
<tr>
<td>R</td>
<td>4.89</td>
</tr>
</tbody>
</table>
Table 11

**t** TESTS ON GROUP COMPARISONS OF THE COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

<table>
<thead>
<tr>
<th>Group Comparison</th>
<th>t value</th>
<th>p values</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ to E₂</td>
<td>-1.36</td>
<td>.189</td>
</tr>
<tr>
<td>E₁ to C₁</td>
<td>2.30</td>
<td>.032</td>
</tr>
<tr>
<td>E₂ to C₂</td>
<td>.377</td>
<td>.710</td>
</tr>
<tr>
<td>E₁ to C₂</td>
<td>1.67</td>
<td>.109</td>
</tr>
<tr>
<td>E₂ to C₁</td>
<td>- .458</td>
<td>.650</td>
</tr>
<tr>
<td>C₁ to C₂</td>
<td>.303</td>
<td>.765</td>
</tr>
<tr>
<td>E₁ to R</td>
<td>1.34</td>
<td>.190</td>
</tr>
<tr>
<td>E₂ to R</td>
<td>.882</td>
<td>.300</td>
</tr>
<tr>
<td>C₁ to R</td>
<td>- .458</td>
<td>.650</td>
</tr>
<tr>
<td>C₂ to R</td>
<td>- .235</td>
<td>.816</td>
</tr>
</tbody>
</table>
Table 12

NON-PARAMETRIC STATISTICAL ANALYSIS OF GROUP COMPARISONS ON THE COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

<table>
<thead>
<tr>
<th>Group Comparisons</th>
<th>U value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$ to $E_2$</td>
<td>42</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$E_1$ to $C_1$</td>
<td>33</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>$E_2$ to $C_2$</td>
<td>63</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$E_1$ to $C_2$</td>
<td>34</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$E_2$ to $C_1$</td>
<td>93</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$C_1$ to $C_2$</td>
<td>66</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$E_1$ to $R$</td>
<td>84</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$E_2$ to $R$</td>
<td>118</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$C_1$ to $R$</td>
<td>141</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>$C_2$ to $R$</td>
<td>123</td>
<td>&gt; .05</td>
</tr>
</tbody>
</table>
Contrary to the expectations of this author significant differences were found between the experimental pretest group measures and the control pretest group measures (E₁ to C₁) on the C.M.H.I. Scale. The scores of the control pretest group were significantly higher than the scores of the experimental pretest group (t = 2.31, p = .032.). Non-parametric statistical analysis comparing the same groups confirmed the above findings, namely, that the pretest control group scores were significantly higher than the experimental group scores on the C.M.H.I. Scale (U = 33, p < .05.).

Contrary to the expectations of this author no significant differences were found between the experimental posttest group scores and the control posttest group scores (E₂ to C₂) on the C.M.H.I. Scale (t = .377, p = .710.). Non-parametric statistical analysis of the data confirmed that no significant differences existed between the two groups (U = 67, p > .05).

No significant differences were found between the experimental pretest group scores and the control group posttest scores (E₁ to C₂) on the C.M.H.I. Scale (t = 1.67, p = .109.). Non-parametric statistical analysis of the same groups revealed similar findings (U = 34, p > .05).

No significant differences were found between the experimental posttest group scores and the control group pretest scores (E₂ to C₁) on the C.M.H.I. Scale (t = -.458,
£  « . 6 5 0 . ) .  C o m p a r i n g  t h e  s a m e  g r o u p s  u t i l i z i n g  n o n - p a r a - m e t r i c  s t a t i s t i c a l  a n a l y s i s ,  n o  s i g n i f i c a n t  d i f f e r e n c e s  w e r e found  b e t w e e n  t h e  s a m e  g r o u p s  o n  t h e  C . M . H . I .  S c a l e  (U = 93, 
£  . 0 5 ) .

No  s i g n i f i c a n t  d i f f e r e n c e s  w e r e  f o u n d  b e t w e e n  t h e  c o n - t r o l  p r e t e s t  g r o u p  s c o r e s  a n d  t h e  c o n t r o l  g r o u p  p o s t t e s t scores  (C _ { 1 }  t o  C _ { 2 } )  o n  t h e  C . M . H . I .  S c a l e  ( t = .3 0 3 ,  p = .1 9 0 ) . Comparing  t h e  s a m e  g r o u p s  u t i l i z i n g  n o n - p a r a m e t r i c  s t a t i s t i -

c a l  a n a l y s i s ,  n o  s i g n i f i c a n t  d i f f e r e n c e s  w e r e  f o u n d  o n  t h e C . M . H . I .  S c a l e  (U = 8 4 ,  p  . 0 5 . ) .

No  s i g n i f i c a n t  d i f f e r e n c e s  w e r e  f o u n d  b e t w e e n  t h e  c o n - t r o l  p r e t e s t  g r o u p  s c o r e s  a n d  t h e  e x p e r i m e n t a l  r e t e s t  g r o u p scores  (C _ { 1 }  t o  R )  o n  t h e  C . M . H . I .  S c a l e  ( t = -.4 5 8 ,  p = .6 5 0 . ) . Comparing  t h e  s a m e  g r o u p s  u t i l i z i n g  n o n - p a r a m e t r i c  s t a t i s t i -
c a l  a n a l y s i s  r e v e a l e d  s i m i l a r  f i n d i n g s  (U = 1 4 1 ,  p  . 0 5 . ) .

No  s i g n i f i c a n t  d i f f e r e n c e s  w e r e  f o u n d  b e t w e e n  t h e  c o n - t r o l  p o s t t e s t  g r o u p  s c o r e s  a n d  t h e  e x p e r i m e n t a l  r e t e s t  g r o u p scores  (C _ { 2 }  t o  R )  o n  t h e  C . M . H . I .  S c a l e  ( t = -.2 3 5 ,  p = .8 1 6 . ) . Comparing  t h e  s a m e  g r o u p s  a n d  u t i l i z i n g  n o n - p a r a m e t r i c  s t a t i s -
t i c a l  a n a l y s i s  n o  s i g n i f i c a n t  d i f f e r e n c e s  w e r e  f o u n d  (U = 1 2 3 , 
£  . 0 5 . ) .

An  a n a l y s i s  w a s  c o n d u c t e d  t o  d e t e r m i n e ,  i f ,  t h e  d i f -
f e r e n c e s  i n  t h e  C . M . H . I .  S c a l e  b e t w e e n  C _ { 1 }  a n d  C _ { 2 }  a s  t o s t r o n g e r  a d h e r e n c e  t o  c o m m u n i t y  m e n t a l  h e a l t h  i d e o l o g y  d u e to  a t t e n d i n g  t h e  T - g r o u p  l a b o r a t o r y .  S i n c e  i n d e p e n d e n t
groups were used, a gain score analysis could not be conducted. Consequently, the mean differences between $E_1$ and $E_2$ were compared to the mean differences between $C_1$ and $C_2$ and a $t$ test conducted. No significant differences were found ($t = .841, p = ns.$).

Discussion Concerning the Community Mental Health Ideology Findings

Table eleven (11) indicates that the only significant differences between the groups existed between the experimental pretest group and the control pretest group on the C.M.H.I. Scale ($p = .032$). This was a rather unexpected finding since one would presume that since neither of the groups were exposed to the training that they would come to the T-group laboratory with similar adherence to community mental health ideology. Table ten (10) further suggests that both control groups were higher than the pretest and posttest experimental groups and was even higher than the experimental group when retested. None of these differences (except $E_1$ to $C_1$) were considered as statistically significant. However given the above finding, the second hypothesis of this study, which contends that the experimental posttest group would have significantly greater adherence to community mental health ideology than the experimental pretest and control posttest groups, must be rejected. While the hypothesis regarding adherence to
community mental health ideology cannot be accepted, it should be noted that the posttest experimental group had greater adherence to community mental health ideology than the experimental pretest group and the experimental retest group was higher than either the experimental pretest or posttest groups (differences were not statistically significant).

It is difficult to explain the one statistically significant finding (control pretest score greater than experimental pretest score). It is suggested that such a finding is not considered important since this trend did not continue among any other inter-group comparisons. In addition, no significant differences were found in the comparison of the pretest control group with the retest of the experimental group (C₁ to E₂ and C₁ to R). More importantly, no significant differences on the C.M.H.I. Scale were found between the experimental posttest groups (E₂ and C₂); furthermore, no significant differences were found between the pretest experimental group and the posttest experimental group on the C.M.H.I Scale. In addition, no significant differences were found when the scores of the experimental group retest are compared with other sub-groups.

As with the findings regarding participants self-esteem, participants came to the laboratory with rather strong adherence to community mental health ideology. The C.M.H.I. Scale is a six point scale and the group mean scores (see table 10) were nearly five. If the participants already
strongly adhered to community mental health principles, then the laboratory would not have influenced stronger adherence in a measurable way, given the instrument being used.

While the aforementioned explanations of the results are perhaps the most salient points in considering the results, certain other points might be put forward. Certainly the results do not indicate any decrease in adherence to community mental health ideology; and this seems confirmed in the retest of the experimental group some three months after the laboratory. In addition, the community mental health national delivery system is now more than a decade old. This particular community mental health program has been a part of the caregiving network for quite sometime. One could argue that perhaps through working together in the same caregiving network, community mental health principles have "rubbed off" on other caregivers. In addition, it could also be argued that the participants were responding positively to community mental health issues just to give the sponsors what they wanted to hear. In still another vein, something must be said about the very fact participants applied to a community mental health program which offered a laboratory in group level intervention. The decision to attend the training may suggest some expression of confidence and positive attitude toward community mental health and would also account for strong adherence attitudes to the movement's ideology.
The results found with the C.M.H.I. Scale tend to confirm earlier findings regarding the T-group laboratory. Hommen (1972), in training ministers in bereavement ministry did not find measurable change in mental health attitudes. This same study, also, did not find measurable changes in the self-esteem, as the result of T-group training.

Attitudes Toward Group Intervention Findings

The experimental posttest group scores ($E_2$) were significantly higher than the experimental pretest scores ($E_1$) on the A.G.I. Scale ($t = -4.04, p = .001$). See tables thirteen (13) and fourteen (14) for mean values, $t$ values and $p$ values of the A.G.I. Scale. Non-parametric analysis of the same data and the same groups confirmed that the experimental posttest group scores were significantly higher than the experimental pretest group scores ($U = 12, p = .001$). (see table fifteen (15) for $U$ values and $p$ values)
Table 13

GROUP MEANS ON THE ATTITUDE TOWARD GROUP INTERVENTION

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>$E_1$</td>
<td>2.57</td>
</tr>
<tr>
<td>$E_2$</td>
<td>3.60</td>
</tr>
<tr>
<td>$C_1$</td>
<td>2.71</td>
</tr>
<tr>
<td>$C_2$</td>
<td>3.58</td>
</tr>
<tr>
<td>$R$</td>
<td>3.21</td>
</tr>
</tbody>
</table>
Table 14

**t TESTS ON GROUP COMPARISONS OF THE ATTITUDE TOWARD GROUP INTERVENTION**

<table>
<thead>
<tr>
<th>Group Comparison</th>
<th>t value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ to E₂</td>
<td>-4.04</td>
<td>.001</td>
</tr>
<tr>
<td>E₁ to C₁</td>
<td>-0.480</td>
<td>.636</td>
</tr>
<tr>
<td>E₂ to C₂</td>
<td>0.538</td>
<td>.950</td>
</tr>
<tr>
<td>E₁ to C₂</td>
<td>3.08</td>
<td>.006</td>
</tr>
<tr>
<td>E₂ to C₁</td>
<td>3.39</td>
<td>.003</td>
</tr>
<tr>
<td>C₁ to C₂</td>
<td>-2.76</td>
<td>.012</td>
</tr>
<tr>
<td>E₁ to R</td>
<td>4.38</td>
<td>.001</td>
</tr>
<tr>
<td>E₂ to R</td>
<td>0.306</td>
<td>.762</td>
</tr>
<tr>
<td>C₁ to R</td>
<td>3.72</td>
<td>.001</td>
</tr>
</tbody>
</table>
Table 15

NON-PARAMETRIC STATISTICAL ANALYSIS OF GROUP COMPARISONS ON THE ATTITUDE TOWARD GROUP INTERVENTION SCALE

<table>
<thead>
<tr>
<th>Group Comparison</th>
<th>U value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁ to E₂</td>
<td>12</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>E₁ to C₁</td>
<td>60</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>E₂ to C₂</td>
<td>69</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>E₁ to C₂</td>
<td>19</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>E₂ to C₁</td>
<td>20</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>C₁ to C₂</td>
<td>22</td>
<td>&lt; .02</td>
</tr>
<tr>
<td>E₁ to R</td>
<td>27</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>E₂ to R</td>
<td>34</td>
<td>&gt; .05</td>
</tr>
<tr>
<td>C₁ to R</td>
<td>44</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>C₂ to R</td>
<td>135</td>
<td>&gt; .05</td>
</tr>
</tbody>
</table>
No significant differences were found between the experimental pretest group scores and the control group pretest group scores ($E_1$ to $C_1$) on the A.G.I. Scale ($t = -4.80, p = .636$). Non-parametric statistical analysis of the same groups was consistent with the above findings ($U = 60, p = .05$).

Contrary to the expectations of this author, no significant differences were found between the experimental posttest group and the control posttest group ($E_2$ to $C_2$) on the A.G.I. Scale ($t = .538, p = .951$). Comparing the same groups utilizing non-parametric statistical analysis no significant differences were found between the groups. ($U = 60, p = .05$).

Contrary to the expectations of this writer, the control posttest group scores ($C_2$) were significantly higher than the experimental pretest group scores ($E_1$) on the A.G.I. Scale ($t = 3.08, p = .006$). Non-parametric statistical analysis of the same data and groups confirmed the significant findings ($U = 19, p = .05$).

As expected the experimental posttest group scores ($E_2$) were significantly greater than the control pretest group scores ($C_1$) on the A.G.I. Scale ($t = 3.72, p = .001$). Significant differences among the same groups were also confirmed by non-parametric statistical analysis ($U = 20, p = .01$).

Contrary to the expected findings of this author, the control posttest group scores ($C_2$) were significantly greater than the control pretest group scores ($C_1$) on the A.G.I. Scale.
Non-parametric statistical analysis confirmed the significant finding between the aforementioned groups \((U = 22, \ p = .012).\)

The experimental retest group scores \((R)\) were significantly higher than the experimental pretest group scores \((E_1)\) on the A.G.I. Scale \((t = 2.76, \ p = .012).\) Comparing the same groups utilizing non-parametric statistical analysis revealed similar significant findings \((U = 27, \ p = .001).\)

No significant differences were found between the experimental posttest group scores and the experimental retest group scores \((E_2 \text{ to } R)\) on the A.G.I. Scale \((t = 4.38, \ p = .001).\) Non-parametric statistical analysis of the same groups and data produced similar findings \((U = 27, \ p = .001).\)

The experimental retest group scores \((R)\) were significantly higher than the control pretest scores \((C_1)\) on the A.G.I. Scale \((t = 3.72, \ p = .001).\) Non-parametric statistical analysis revealed similar significant finding between the two groups \((U = 27, \ p = .001).\)

Contrary to the expectations of this author no significant differences were found between the control posttest group scores and the experimental retest group scores \((C_2 \text{ to } R)\) on the A.G.I. Scale \((t = -.192, \ p = .849).\) Non-parametric statistical analysis of the same data and groups revealed similar non-significant findings \((U = 135, \ p = .05).\)
An analysis was conducted to determine if, the differences on the A.G.I. Scale between $E_1$ and $E_2$ were greater than the differences between $C_1$ and $C_2$ as to more positive attitudes toward group laboratory. Since independent groups were used, a gain score analysis could not be conducted. Consequently, the mean differences between $E_1$ and $E_2$ were compared to the mean differences between $C_1$ and $C_2$ and a $t$ test conducted. No significant differences were found ($t = .291, p = ns.$).

Further Analysis of A.G.I. Data

Since differences were found between pretest and post-test groups as to educational levels and since education could possibly have interacted with the training to produce inflated test scores, an analysis of co-variance was conducted on the A.G.I. scores which was the only dependent variable to demonstrate change. The analysis of co-variance can help to accomplish "a match between groups," as to educational level, to determine the effects the T-group training with the education variable held constant.

The experimental hypothesis of an interaction between the trained group versus the control group (factor A) and the time of testing (factor B) on the A.G.I. was not found, see Table 16 for summary of analysis of co-variance. However, significant effect was found ($f = 17.5493; df = 1.40; p < .01$), indicating that time two was higher than time one. As previously mentioned $t$ tests revealed that $C_2$ was
### Table 16

**SUMMARY OF ANALYSIS OF CO-VARIANCE ON THE ATTITUDE TOWARD GROUP INTERVENTION SCALE**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Squares</th>
<th>F values</th>
<th>p values</th>
</tr>
</thead>
<tbody>
<tr>
<td>A(Groups)</td>
<td>.0253</td>
<td>1</td>
<td>.0253</td>
<td>.0611</td>
<td>ns</td>
</tr>
<tr>
<td>B(Time of Testing)</td>
<td>7.2619</td>
<td>1</td>
<td>7.2619</td>
<td>17.5493</td>
<td>.01</td>
</tr>
<tr>
<td>AB(Groups x Time of Testing)</td>
<td>.0076</td>
<td>1</td>
<td>.0076</td>
<td>.0818</td>
<td>ns</td>
</tr>
<tr>
<td>Error</td>
<td>16.5538</td>
<td>40</td>
<td>.4138</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
significantly greater than $C_1$ and $E_2$ was significantly greater than $E_1$.

Discussion Regarding the Attitudes Toward Group Intervention Findings

While little or no significant differences were found between groups on the R.S.E. Scale and the C.M.H.I. Scale, significant differences were found on the A.G.I. Scale. The analysis of data does not explain the fact that two of the instruments revealed no significant differences and one did reveal significant difference between the groups. Perhaps the literature of the T-group laboratory is the place to begin to look for answers to such a dilemma. The literature suggests that the needs of the T-group delegate are paramount. In fact, by applying for the laboratory training, there was some expression of need, namely, the need for acquiring group level intervention skills. Such a need is rather concise and has a sense of boundaries. No request was made by the participants for increased self-esteem or adherence to community mental health ideology. The acquisition of enhanced self-esteem and greater adherence to community mental health ideology were thought to be secondary gains from the laboratory rather than an expression of delegate needs.

Certain other factors also seem relevant to the dilemma. The A.G.I. Scale was specifically tailored for this study and it reflects perceived knowledge of group level intervention,
self-confidence reporting in doing group level intervention and willingness to do group level intervention. In essence then, the A.G.I. was measuring attitude change toward a very specific phenomena whereas self-esteem and ideological issues can be rather global in nature. Perhaps major ideological shifts and changes in the perception of self should also not be expected in outcomes from T-group laboratories because of their global nature.

That there were significant differences between groups as to their positive attitudes toward group level intervention is reflected in the results of the data. Significance was accepted at the \( p < .05 \) level. That the posttest experimental group would have more positive attitudes toward group intervention than either pretest experimental group and the posttest control group is not reflected in the results and therefore in the strictest sense hypothesis three \((H_3)\) must also be rejected.

In analyzing the data of the A.G.I. Scale, there was no instances in which significance was found using the parametric statistic and significance was not found using the non-parametric statistic; likewise, there were no instances when significance was found using a non-parametric statistic and was not found using a parametric statistic. There was then consistency between the two statistical analytic tools as to the existence of significant difference between groups.
At first glance, the data seems to support that the laboratory training had a positive effect on the attitude toward group level intervention in that the posttest experimental group scores were significantly higher than the pretest experimental group scores and pretest control group scores (see Tables 14 and 15 for $p$ values). In addition, the experimental group seemed to maintain their gains after three months in that the experimental retest scores was significantly greater than either the experimental or control groups' pretest scores. However, the posttest control group scores were higher than the pretest control or the pretest experimental group. There were no significant differences between the posttest control group and the posttest experimental group; even the retest scores of the experimental group failed to demonstrate significantly higher scores than the control group posttest scores. To fully accept a training effect in an unequivocal sense, the posttest experimental group would have to have been significantly higher scores than the posttest control group. For a positive training effect to stand the test of time and guard against serendipity effect, the retest scores of the experimental group should also have remained significantly higher than the posttest control group as well as pretest experimental and control groups.
One might suggest that the reason a training effect was not found may be due to educational achievement level differences between the groups. Both the experimental and control posttest groups were significantly higher as to their educational achievement levels than either of the pretest groups (see Table 6). An analysis of co-variance was conducted, to determine if educational achievement level did effect the posttest group scores on the A.G.I. Scale. The analysis of co-variance parceled out the effects of education and found no significant differences as to groups on the A.G.I., therefore, statistically eliminating the concern that different educational achievement levels accounted for the higher scores of both posttest groups. The crucial test of the experimental hypotheses would be reflected by significant interaction between groups and time of testing, with the posttest experimental group having higher scores than the posttest control and pretest experimental groups. No significant differences were found when groups and time of testing were considered together. However, significant differences were found between time one (T₁ the pretest) and time two (T₂ the posttest). Table sixteen (16) indicates a highly significant p value for time of testing.

While the time factor seems to have heavily influenced whether a training effect occurred, the higher scores of the posttest groups provoke some additional discussion. It is
true that it just might have been that at $T_2$, those in the posttest groups for some unexplainable reason had more positive attitudes about their knowledge of confidence in and willingness to intervene at the group level. Campbell and Stanley (1966) offer several possibilities relating to the passage of time that influence test scores other than the training itself. They suggest that history and maturation factors are operative as time passes. For this study, the maturation factor doesn't seem reasonable since that the participants are adults and the length of time over which the study was conducted did not allow for drastic enhancement of intervention skills without training. Campbell and Stanley (1966) indicate further that the pretest-posttest control group design does not ensure internal validity when some unique intra-session historical event occurs. It becomes, at this point, a matter of speculation, but one could conjecture as to the possible effects of rejection and loss phenomena that might have influenced the posttest control group response rather positively as to group level intervention. The interpretation being put forward suggests that the responses by the posttest control group might have been motivated by a unique kind of anger expressed through a denial of needing the laboratory because they were not chosen as a delegate. While the pretest control group was also rejected in the sense that they were not selected for the laboratory and they too would have had similar rejection
feelings, the sponsors thought there was resentment among some not accepted as delegates. The nature of the laboratory design being such and the random selection of the delegates meant that delegate and non-delegate participants in the study continued to work together during the training in a common community caregiving network and sometimes within the same caregiving institutions. It was the impression of the sponsors of the laboratory that, some strong negative feelings about not being accepted as a delegate to the laboratory grew among participants who were not delegates during the life of the laboratory.

The possibilities of conjecture about the results of posttest group seem very great. Despite $T_1$ and $T_2$ differences, something positive seemed to happen within the experimental group. The posttest experimental group did have significantly more positive attitudes toward group level intervention than the pretest experimental group. These gains were not lost some three months later, when the retest of the experimental group took place. The sustained gains of the experimental group seems to rule out a serendipity effect, and in addition, when considered as a whole, the retest scores of the experimental groups are significantly higher than the pretest experimental group. While any claims that the gains were caused by training are not strongly supported by rigorous statistical analysis, there does exist limited indications, that training did effect the attitudes
of the delegates toward group level intervention. The sponsors and this author thought that something positive occurred in delegates' attitudes toward group intervention and these research hunches and intuitions should be pursued through further research.
CHAPTER FIVE

CONCLUDING SUMMARY

This study chose to evaluate the effectiveness of a community level training program which undertook to broaden and enhance the scope and interventive repertoire of caregivers. Such an activity was construed to be a provisional activity whereby "supplies" were being developed so as to be commensurate to anticipated needs of individuals encountering hazardous or risk situations. In the larger sense, such a development of supplies is really a maximazation of extant resources and the literature suggests an educational interventive strategy to accomplish the task.

The underlying need for such training was thought to be precipitated by three prominent structural trends which are considered as rather pervasive in our society, 1) an explosion in the quantity of knowledge, 2) bureaucratization, 3) specialization. These societal forces are not seen as exclusive of one another, but are rather highly interrelated and interdependent. The tendencies of knowledge explosions, increasing bureaucrati-

zation and specialization tend to fuel one another; the effect such interlocking phenomena upon community caregivers and their activity were duly noted. It was thought that the very nature of such phenomena limited the scope of caregivers so that
caregivers direct their interventions at ever narrowing role clusters of individuals rather than the group which is thought to be a crucial element of man's social functioning.

The notion that caregivers' intervention need always to be at the group level was recognized to be a rather recent theoretical insight. Such recent insights are thought to be shared by some caregiving professions and not by others; while those doing caregiving activities but not having membership in a caregiving profession get new theoretical insights in some kind of a "helter-skelter" fashion or simply don't get them at all. In any case, it was thought that there were community caregivers who lacked recent theoretical insights regarding groups.

The community mental health movement has been interested in providing "continual supplies" commensurate with needs and has also been interested in extending their own effectiveness through working with other community caregivers. The community mental health movement utilized multiple cause problem-definitions and multi-level intervention strategies. The notion of enhancing interventive repertoires of caregivers effects a significant match with community mental health goals and objectives. In short, the community mental health movement provides both the situation and setting for the implementation of an educational interventive strategies.

In considering the literature relevant to the problem, certain elements crucial to the implementation of educational
interventions were considered. First, attention was given to how learning and re-learning occurred. Second, if the concept of group is crucial to man's social functioning and learning is a major repetitive social process then the group itself would be central to man's learning. Third, various approaches for teaching group interventive skills were considered with the T-group laboratory being highly recommended by certain scholars in the field.

Cognitive or field theories of learning, one of the two dominant tracks of learning theories, contends that all knowledge is interrelated and that man has a unique mental organization capable of understanding himself and his environment. This understanding of himself and his environment requires, that learning experience consists of insights, goals, structure, and come when the individual accepts a new system of values and beliefs through group membership. Lewin (1952) described a sequential learning process including 1) unfreezing of old attitudes, knowledge and behaviors, 2) change, 3) refreezing new attitudes, knowledge and behaviors.

Ironically, traditional training in group level intervention did not fully exploit or take advantage of the power found within the group to accomplish learning tasks. Recent literature in the field of training group level interventionists suggested the utilization of T-group laboratory strategies.

The T-group laboratory was considered from its historical development the variance in models of learning found with the
literature, definitional understandings of the T-group, its energy sources, design, research outcomes and its relationship to the community mental health movement.

The T-group approach is now about a quarter of a century old. Its beginnings, like many other social inventions were somewhat accidental. Some of the finest social scientists contributed to the T-group laboratory development and from small beginnings, it has become a driving force in educational interventive strategies.

The T-group laboratory is first and above all, a learning laboratory. Its focus is upon the how to learn process by making use of here and now phenomena. Through a collaborative effort between trainer and delegate, a spirit of inquiring evolves through emphasizing the democratic nature of learning rather than a teacher-centered didactic approach. T-group learning theory was described as highly consistent with overall cognitive theories of learning in that delegates come to the laboratory with a "frozen" synthesis of cognitive state, self-esteem and identity. Through involvement in the T-group, past competencies are risked and some type of self-confirmation is sought. Feedback from other delegates and trainers is the result of the investment; the investment then is integrated with the existing synthesis of cognition, self-esteem and identity, resulting in some changed condition of learning.

The energy source for learning in the T-group comes entirely from within the group itself. The design of the T-group laboratory is highly determined by the needs of the delegate.
Generally speaking there has been no shortage of research done on the T-group as a management development approach. There is a shortage of research done in other areas which attempt to utilize the T-group as an educational interventional strategy. Two trends in researching T-group outcomes seem to emerge within the literature: 1) to consider measures linked directly to the content and processes of the training program, 2) to measure the effect of the training program upon delegates work behaviors. Problems of measuring various aspects of training were cited, especially that of how T-group laboratories might effect self-esteem. It was felt that Stock (1964) best summoned up T-group laboratory research when she described it as a large and incompletely filled-in checkerboard.

The community mental health movement like other social welfare programs has recently trained a large number of varying kinds of individuals as caregivers within their programs, but the results of the training seem poorly reported in the literature and more importantly there seems little reported usage of the laboratory approach.

Three parameters were chosen to evaluate the effectiveness of the T-group laboratory designed to train community caregivers in group level intervention skills: 1) changes in self-esteem, 2) greater or lesser adherence to community mental health ideology, 3) more positive or negative attitudes toward group level intervention. These three parameters were chosen in relationship to how learning occurs within the T-group; namely,
that the synthesis of knowledge, self-esteem and identity is risked as with the expectation of feedback from other delegates and trainers. The abovementioned parameters seem, in part, to operationalize the synthesis.

Three major hypotheses were posited for purposes of research in this study. In essence the hypotheses suggested that the post experimental group would have higher self-esteem, demonstrate greater adherence to community mental ideology and have more positive attitudes toward group level intervention than either the pre-experimental group and the post control group.

The research design was a pretest posttest control group classic design. The subjects for the study were caregivers in Clark County, Ohio who applied for group intervention training. Delegates were chosen on a random basis from applicants; the first twenty-six applicants became delegates while the second twenty-six randomly selected became the control groups. The experimental and control groups were split randomly so that one-half of each group was given the pretest while the remaining half of each group was given the posttest. A retest of the entire experimental group was conducted to see whether, any gains which were made, stood some test of time and were not the result of some serendipity effect.

The laboratory was a combination of theory sessions and T-group with each receiving an equal amount of time. Instruments used in the study included a basic information sheet, the Rosenberg Self-Esteem Scale, the Baker-Schulberg Community
Mental Ideology Scale and the Attitudes Toward Group Intervention Scale which especially designed for this study. The data collected was analyzed in terms of group differences through parametric and non-parametric statistical analysis. Demographic data was analyzed so as to make conclusions as to the comparability of the groups.

It was thought that random selection of delegates would assure no differences between the groups as to age, sex and education but by chance both the posttest control groups were significantly more educated than the pretest groups.

No significant differences were found between the groups as to having greater self-esteem or greater adherence to community mental health ideology thus indicating that the laboratory had little effect on the delegates' self-esteem and belief in community mental health ideology. It should be noted that delegates came to the laboratory feeling rather positive about their self-esteem and already strongly adhering to community mental health ideology. Hence given the instruments used, there was little chance to measure enhancement.

The data on the A.G.I. Scale did demonstrate significant differences between the groups, but not in such a manner so as to confirm the hypotheses. The posttest experimental group did score significantly better than the pretest experimental and control group, however the posttest control group scores were also significantly higher than either pretest groups scores and equally important no significant differences were
found between the A.G.I. Scale scores of the posttest experimental and posttest control groups. A concern had been expressed that perhaps the educational level had influenced the outcome of the data, since, of the major social variables considered in this study, educational achievement levels differed significantly among the groups. Yet further statistical analysis did not confirm the outcome to be influenced by educational levels but did indicate that some differences as to the time of testing existed.

The experimental group retest seemed to confirm, that gains made stood the test of time and in addition seemed to minimize any concern as to serendipity effects. In addition the analysis of the retest scores indicated that there may have been 'some positive training effects as to the participants' attitudes toward intervening at the group level in that the retest experimental group scores were significantly higher than either of the pretest group scores.

Implications for the Future

The results found in this study are not unlike those reported in other aspects of T-group literature. This study seems to suggest that the T-group laboratory analyzed within this study did not effect participants' self-esteem and adherence to community mental health ideology. In a rigorous sense, it must also be said that it didn't significantly
change attitudes toward group intervention; without time differences perhaps the results could have been more conclusive. In any case, the doubt that is left, as a result of this study, suggests yet further attempts to utilize the T-group approach at teaching group level intervention skills and further research.

The ongoing societal trends of bureaucratization, specialization and "creeping" technological obsolescence upon community caregivers remain a problem as will educational diffusion problems. Educational interventions will be one strategy to cope with the aforementioned problems. The need to intervene in such a way so as to enhance and update caregivers skills is an ongoing task and must be accomplished through methods consistent with recent theoretical insights from learning theory. Those planning and conducting educational interventions need to consider the fixed synthesis of knowledge, self-esteem and identity that caregivers bring to the learning situation. The impact of the learning experience must be sufficient to un-freeze the syntheses, promote risk taking, provide opportunity for change, and insight so as to effect new learning within the caregiver. Such new learning can then be refrozen and utilized in work situations.

Yalom (1972) and Toren (1972) are among those who call for extensive usage of T-group laboratories in training caregivers. This study was not able to confirm the usefulness of T-group strategies in influencing self-esteem and ideological
perspectives. It seems to confirm other findings in the literature that suggest that the T-group experience does not produce global changes in delegates; therefore, these limitations must be taken into consideration as to expected outcomes and benefits when educational intervention is planned. Either global changes shouldn't be attempted or such large changes should be partialized in sequentially ordered steps so as to gradually achieve the desired effect. The results of this study did not conclusively establish that T-group experiences produced more positive attitudes toward group level intervention largely because of time testing problems; the results obtained point to the need of further experimental research. That the delegates' attitudes toward group intervention seemed to change and stay positive over time suggests that some successful unfreezing of old knowledge occurred. The delegates seemed to have integrated this same knowledge some three months after the study. However, it would be rash for practitioners to wholeheartedly embrace T-group strategies without reservation following this study and what the literature seems to suggest. Neither the limitations nor the strengths of the T-group laboratory are fully known and therefore, need to be employed with caution and subdued expectations as to outcome.

With further research, the T-group educational strategy may be highly useful for updating caregivers' skills. This may be especially true when the nature of the knowledge being imparted or skills being taught may be particularly threatening
to the learner, require the acquisition of new beliefs, new ideologies, or the relinquishment of old skill related behaviors. It is especially useful to utilize T-group strategies when some kind of educational impact is necessary to unfreeze old knowledge and behaviors. There are, of course, other ways of achieving impact including the full time educational curriculum found in institutions of learning; the T-group approach increases the educational alternatives, choices, and strategies. The literature reflects the broad spectrum of consumers of T-group laboratories, the implication therefore, is that the T-group can be adapted to a variety of persons in a variety of situations. Further study will clarify its usefulness to the broad category of caregivers with the various mixes of work activities and educational backgrounds.

Therefore, to fully determine T-group benefits in educating community caregivers, more experience with the T-group is needed in a variety of community situations. Thus the particular mix of Clark County caregivers and the local community mental health program may have influenced the outcome of this study. Yet the T-group approach remains a viable alternative interventive possibility for practitioners to utilize when there is a need for educational intervention.
ROSENBERG SELF-ESTEEM SCALE

Place a check mark on the line which most accurately describes your current feelings.

1) I feel that I'm a person of worth, at least an equal plane with others.

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2) I feel that I have a number of good qualities.

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3) All in all, I am inclined to feel that I am a failure.

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4) I am able to do things as well as most people.

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5) I feel I do not have much to be proud of.

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6) I take a positive attitude toward myself.

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7) On the whole, I am satisfied with myself.

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8) I wish I could have more respect for myself.

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9) I certainly feel useless at times.

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10) At times I think I am no good at all.

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ATTITUDES TOWARD

GROUP INTERVENTION SCALE

Please read each of the statements below and for each item make the response which most appropriately corresponds to your own personal opinion or feeling.

1) I have an adequate understanding of group dynamics.

_____Very definitely
_____Yes
_____Uncertain
_____No
_____Definitely not

2) I do not know how to form a counseling group.

_____Strongly agree
_____Agree
_____Undecided
_____Disagree
_____Strongly disagree

3) I have a poor comprehension of the responsibilities of a group facilitator/leader.

_____Very definitely
_____Yes
_____Uncertain
_____No
_____Definitely not

4) I feel confident in my knowledge of group dynamics.

_____Very definitely
_____Yes
_____Uncertain
_____No
_____Definitely not
5) The responsibilities of being a group facilitator/leader do not seem overwhelming.

______Strongly agree
______Agree
______Undecided
______Disagree
______Strongly disagree

6) I clearly understand what it is that a group facilitator/leader does.

______Very definitely
______Yes
______Uncertain
______No
______Definitely not

7) I am comfortable in regard to having a general overview as to the theories of group counseling and group interventive strategies.

______Strongly agree
______Agree
______Undecided
______Disagree
______Strongly disagree

8) I have been exposed to and have sufficient understanding of the theories of group counseling/intervention, so as to be effective in a group leadership position.

______Very definitely
______Yes
______Uncertain
______No
______Definitely not

9) If the situation demanded, my knowledge of family group functioning would be adequate to intervene appropriately.

______Strongly agree
______Agree
______Undecided
______Disagree
______Strongly disagree
10) Doing family group interview raises concerns in me as to my competency to be effective.

- ______ Very definitely
- ______ Yes
- ______ Uncertain
- ______ No
- ______ Definitely not

11) Even with adequate resources and appropriate situations, I would be afraid to be a group facilitator/leader with children's or adolescent groups.

- ______ Very definitely
- ______ Yes
- ______ Uncertain
- ______ NO
- ______ Definitely not

12) I have a clear understanding of group dynamics, structure and information of children's and adolescents' groups.

- ______ Strongly agree
- ______ Agree
- ______ Undecided
- ______ Disagree
- ______ Strongly disagree
BAKER-SCHULBERG CMHI SCALE

Instructions: Please read each of the statements carefully, in the order in which it appears, and for each one indicate to what extent you personally agree or disagree with it. You should do this by circling next to each statement the one of the six symbols which best represents your own feeling about the statement.

Circle AAA, if you strongly agree
Circle AA, if you moderately agree
Circle A, if you slightly agree
Circle D, if you moderately disagree
Circle DD, if you strongly disagree
Circle DDD, if you strongly disagree

1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.

2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.

3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.

4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.

5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.

6. Such public health programs as primary preventive services are still of little value to the mental health field.

7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.

© 1976 by J. A. L. Publications, Inc. All rights reserved. Addres to inquiries to Columbus, Ohio, 43202. New York, NY 10019.
5. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.

6. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.

7. The mental health specialist should seek to extend his effectiveness by working through other people.

8. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.

9. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.

10. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.

11. The control of mental illness is a goal that can only be attained through psychiatric treatment.

12. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.

13. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for solving a community's total psychiatric problem.

14. Our professional mandate is to treat individual patients and not the harmful influences in society.

15. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.
19. The focus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.

20. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.

21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.

22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.

23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.

24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.

25. The mental health center is only one part of a comprehensive community mental health program.

26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.

27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.

28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in balancing his ability to cope with it.

29. It is a poor treatment policy to allow nonpsychiatrists to perform traditional psychiatric functions.
38. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.

39. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.

40. Social action is required to insure the success of mental health programs.

41. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.

42. Each mental health center should join the health and welfare council of each community it serves.

43. The responsible mental health professional should become an agent for social change.

44. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indifferently with many patients.

45. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.

46. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.
**IDENTIFYING INFORMATION**
(Confidential – For Research Purposes Only)

1. Date of Birth: ___________________________ / ___________________________
   (month) (year)

2. Sex: ___________________________
   — male
   — female

3. Place of Birth:
   — City ___________________________
   — State ___________________________
   — County ___________________________

4. Race: ___________________________
   — Black
   — White
   — Other (Specify) ___________________________

5. Marital Status: ___________________________

6. Education: (Check highest level completed)
   — less than 6th grade
   — 6th grade
   — 7th grade
   — 8th grade
   — 9th grade
   — 10th grade
   — 11th grade
   — 12th grade
   — College or Other Post High School:
     — 1 year
     — 2 years
     — 3 years
     — 4 years
     — Graduate or Professional: ___________________________ years

7. What is the title of your position at the agency? ___________________________

8. Family Income Range:
   — $0 - $22,000
   — $22,000 - $24,000
   — $24,000 - $26,000
   — $26,000 - $28,000
   — $28,000 - $30,000
   — $30,000 - $32,000
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   — $94,000 - $96,000
   — $96,000 - $98,000
   — $98,000 - $100,000
   — Over $100,000
9. Would you identify your agency as: County... State___ Fed. 
___ City___ None___ Private___ Other
10. How long have you been employed by your agency?___ Years___ Months
11. How many years of experience have you had (employed or not) in the health and welfare field?___ years
BIBLIOGRAPHY

Books


Unpublished Papers


Articles in Journals and Magazines


