Interpersonal and Structural Factors in the Study of Mental Hospitals

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The youngest branch of organizational theory is the study of mental hospitals. Twenty years ago, when Rowland pioneered in the field, the major sources of information on the mental hospital were books written by former patients. Today there are a number of excellent studies of the organizational structure of the mental hospital. The new studies follow in the steps of organizational research in other areas, especially in the area of industrial relations. Such a transfer of ideas, concepts, and perspectives from one area of study to another benefits both the new other areas, especially in the area of industrial relation^. Such a transfer of ideas, the human-relations approach—from industrial relations theory, and applying those ideas to analysis of the structure of the mental hospital, without fully considering the implications of other aspects of the theory.

The study of industrial relations is more or less split into two camps. On one side are the advocates of the human-relations approach, including disciples of Elton Mayo and Kurt Lewin. On the other side are the scholars who object to the human-relations school, which they name "managerial sociology," and which they criticize for being manipulative, biased in favor of management—for example, earlier studies ignored the role of the trade unions—and unrealistic.

Another way of putting the difference is to say that the human-relations school is for "peace in industry," harmony, and "understanding" between the employer and employees, while the opponents emphasize the objective significance and positive function of industrial


†For a recent discussion and bibliography, see Amos H. Arenberg, and others, editors, Research: Industrial Human Relations; New York, Harper, 1967.

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4 For a recent outstanding review and analysis of organizational research, see James G. March and Herbert A. Simon, Organizations; New York, J. Wiley, 1958.

5 Charles K. Andrew, "Industrial Techniques Can Be Used," Modern Hospital (No. 6, 1955) 84:67-72.

6 Caudill finds "a very direct parallel" to his work in a study of a factory by Rice. William Caudill, "Psychiatric Hospital As a Small Society; Cambridge, Harvard Univ. Press, 1958. A. K. Rice, "The

7 See also Milton Greenblatt, Richard H. York, and Esther Lucile Brown, From Custodial to Therapeutic Care in Mental Hospitals; New York, Russell Sage Foundation, 1955, p. 21, n. 1.

conflict. The human-relations people emphasize two-way communication, while the opponents stress the role of the trade unions. The human-relations school suggests therapeutic interviews and participation in decision-making; the opponents point to economic, political, cultural, and other 'real' differences between workers and management.

Although it is difficult to integrate the two approaches on the ideological level, an unbiased examination of them reveals that in illuminating two aspects of industrial organization, both schools are vital to a better understanding of the organizational process. Interpersonal relations are better understood if structural factors are taken into account. The process of communication within small groups can be better analyzed when the outside communal and political ties of the workers and managers are considered. Structural analysis benefits from study of interpersonal relations, as shown, for example, by studies of informal relations. In short, a theoretical integration of the two approaches is possible.

Where do the new studies of the mental hospital fit into this picture? In general, many of these studies are inclined to accept the human-relations approach. Many studies of mental hospitals focus on the communication system among the personnel, emphasizing the importance of “understanding” among the various members and ranks of the staff. They see the mental hospital as a “therapeutic community” or “small society,” rather than as a large-scale organization and a work place. Finally, they favor conferences and wide participation in the process of decision-making. I shall examine all these points in detail subsequently.

One of the reasons why the human-relations approach is so readily accepted in the study of the mental hospital is that there is a high congruence between the ideas and techniques of psychotherapy and those of the human-relations orientation. Psychological insights in general and psychoanalysis in particular played an important role in the early development of the human-relations school. The ideas of increasing self-understanding by communication with a trained professional, and of solving or accepting conflicts by becoming aware of their existence, are very close to the idea of increasing understanding between worker and management by increasing communication between them with the help of the human-relations expert. Increased communication is expected to reduce industrial conflict, if not to abolish it altogether. From this it is only one step to the suggestion that the mental hospital staff has to be made more aware of the organizational process. “Being aware” is considered an important therapeutic factor or the organizational level. Not all studies of mental hospitals follow this line. One of the outstanding exceptions is the Stanton and Schwartz study. The authors combine an analysis of the communication system with an analysis of the power structure. Stanton and Schwartz, as well as a few other investigators, put much emphasis on the relation between formal and informal structures, on the lines of authority, and on the relation between “functional” and “scalar” status. But even in these studies many of the other structural factors are neglected, as important in our overlooked as discussed in other chapters.

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**Communication and Structural Factors**

The studies of mental hospitals examine two major channels of communication: between staff and patients, and among various staff members. The influence of objective factors on communication between staff and patients will not be discussed here because it would involve an evaluation of psychiatry which is far beyond the competence of the author.

Communication among various staff members is considered an essential mechanism for effective operation of the hospital. Cases of conflict and misunderstanding are attributed to lack of communication or to communication blocks among the staff. It is suggested that when sufficient avenues of communication are supplied, the blocks are removed and, as Stanton and Schwartz said in describing one such instance, "Misunderstanding after misunderstanding disappeared like magic." There is no doubt that some problems arise from communication blocks whose removal allows the problems to be solved. But it is necessary to specify more clearly which problems can be handled by increased communication and which cannot. In the case described by Stanton and Schwartz, the nurses complained that the soap supply was rationed and insufficient. In a conference with the administrator the nurses learned that no such rationing had been intended and that the amount of soap available was for all practical purposes unlimited. The nurses' complaint had resulted from an inquiry from the housekeeper about the amount of soap used, which had been misinterpreted to mean that soap would be rationed. There was no 'real' problem. Since the whole problem was created by distorted communication it is no wonder that it disappeared like magic once the block was removed. What would have happened if in the conference between the nurses and the administrator it had turned out that soap was really to be rationed because "too much" had been used? One wonders if communication would have been so helpful in such a situation.

Now soap is not of vital concern to the nurses—although it may, of course, acquire symbolic significance if it is seen as reflecting the attitude of the hospital toward patient health, or as expressing the money versus service conflict. But more vital conflicting interests may also be subject to similar exaggerated 'solutions.' For example, Caudill devotes a long analysis to the case of "the TV petition." The patients petitioned to be allowed to watch TV every evening of the week instead of one evening. When the petition was brought up in administrative conference, the nurses objected to the extension of TV "privileges." Actually they would have preferred to forbid watching TV altogether. The head of the hospital saw this as a problem of communication. First of all, he believed that there was insufficient information about the deeper, "psychodynamic" reasons which motivated the patients to hand in the petition. As the "meaning" of the petition was not clear, the head of the hospital felt that he was unable to decide how to react. Second, there seemed to him to be too little communication with the nurses about the therapeutic significance of the "other twenty-three hours," in which the social activities of the patients and presumably watching TV were included.

I doubt that the situation required so complicated an approach. The patients wanted to watch TV because they were bored and liked to watch fights. The nurses did not want the patients to watch TV because it meant that they would be late for the 11:15 bus and because it would interfere with the change of shifts. While "communication" brought these factors out during the administrative conference,
it seems that the training of the hospital head prevented him from seeing the significance of these simple facts. Moreover, it seems that no additional communication about these factors could change them. The issue was solved, typically, after the session was over, by a simple bargaining process; it was decided in a discussion between the hospital head, who sided with the patients, and the nurse supervisor to enable the patients to watch TV two nights a week but not to serve food after the program so that the nurses could catch their buses. Like so many conflicts of interests, this one was solved by bargaining and compromise and not by a sheer increase of communication.20

If the nurses, who often have no special training for work in mental hospitals, do not feel free to establish "warm" personal relations with patients, it is not because the information that this is necessary has not reached them, but because it does not fit into their professional image, which is based on long training, and is reinforced by interaction among the nurses and by other mechanisms. This cannot be greatly changed by communication sessions any more than psychiatrists can be changed, in the same or similar ways, from, for example, psychoanalysts to group therapists.

Many of the problems discussed in studies of state mental hospitals seem to be the result of objective conditions which no communication can overcome—such as questions of budget. Some of the problems seem related to establishing and maintaining working and social conditions which will secure enough people who are willing to work in the mental hospital. Other problems might be decreased if personnel were trained more specifically in accordance with the needs of the mental hospital. Still others might be minimized if the objective organizational structure were adapted to the special needs of the mental hospital. If these basic needs were satisfied, some of the remaining problems might be solved by better communication.

But even within these limits, the importance of better communication is much less than some of the studies of mental hospitals seem to assume. "Being aware" might decrease the emotional tension involved in a conflict, but it might also draw more clearly the line between management of the hospital—especially in profit-making organizations—and the employees, thus increasing tensions and potential conflicts. There is also the danger of a utopian approach to communication. Even if it can be shown that some difficulties disappear when communication is increased, it does not follow that all problems yield to this technique. The effect and flow of communication are limited and influenced by structural conditions. The demands on psychiatrists' time limit communication. A psychiatrist devotes a limited number of hours to a hospital, of which a considerable part is devoted to nonprofessional activities.21 An increase in communication, by writing and reading reports or by participating in administrative and "therapeutic team" conferences, would mean that even less time was available for therapy. Psychiatrists already seem to feel deprived because administration does not leave enough time for their professional activities, in which they do not usually include communication with lay personnel.

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mended for still another reason. It is advocated as a means of enhancing the identification of staff members with the organization. In order to feel that they are part of the "therapeutic community," everybody must know "all that is going on." It is easy to understand that certain information will give the personnel a feeling of participation and an increased understanding of their own roles and the roles of others. For example, staff members should understand the basic policy of the hospital, and should be informed about progress of the patients. Attempts to increase communication beyond that point means taking time from other activities, and arousing rather than satisfying an "inside-dopester" attitude which is harmful to the organization. Even with a daily orientation conference for each staff member, some people will be "uninformed," or at least will feel that they are, and thus will be left out of the group.

The assumption behind the suggestion that everybody should be informed about the organizational process in general is that the hospital staff constitutes one social group to which everyone wants to or should want to belong. This is obviously not the case. The hospital community is at best a group of groups. Most members can feel quite at home in the hospital if they are well-integrated members of one or two small groups and if they are informed about what their clique is doing. Only leaders of such groups usually have an interest and the need to be informed of a greater detail about what is going on in the hospital community in general and in other and higher cliques in particular. This brings up the question, "What is the nature of the social structure of the mental hospital?"

**The Hospital as a "Small Society"**

If the term society is used in a strictly sociological way, a hospital is not a small society, because societies have functional autonomy and hospitals do not. Functional autonomy means that all the basic functional needs of a social system are internally regulated. Since the hospital secures staff, patients, and facilities from the outside, and only partially controls their recruitment, it cannot technically be seen as a society.

But even if the term is defined more loosely, the assumptions and associations that such terms as "small society" and "therapeutic community" bring to mind are quite misleading. Use of the terms often indicates a tendency to neglect the influence of external factors on the internal process of the mental hospital, and also to oversimplify some aspects of the internal process.

This limited perspective is not accidental. It is one of the most important trademarks of the human-relations approach to the study of industry. Historically, it follows from the application of anthropological techniques to the study of large-scale organizations. The anthropologist tends to see each social unit as an isolated society. This approach often overlooks such factors as trade unions and professional associations; communal ties such as social groups, governing boards, political institutions, and other structures and attitudes which affect the organizational process; and such internal factors as the influence of multigroup membership.

**The Influence of Professional Associations**

The various professional and semiprofessional groups which interact in the mental hospital have clear images of their respective roles. Attempts to change these roles within a single hospital seem to be almost always doomed to failure because these role-images are created and reinforced by many factors which are external and beyond the control of each hospital. While the image is usually created during the training period, it is cons-
stantly reinforced by the professional associations and professional social groups. The professional associations also act as interest groups which support their members in the struggle to maintain or improve their professional image and position. At the same time these associations serve as reference groups in terms of standards and professional ethics, as well as prestige systems. One cannot expect basic changes in the techniques applied by hospital psychiatrists, for instance, or in the relationships between psychiatrists and clinical psychologists, without taking such factors into account.

With few exceptions, the influence of such associations is not analyzed. Often they are not even mentioned. I wonder if the scholars who have explored these issues have found those associations uninfluential, or have preferred to focus on other aspects of the material, or have been limited by their conceptual scheme to the study of what was going on in the "small society," to the neglect of influences on the behavior of the staff from outside the walls of the hospital.

The Influence of Communal Ties

The mental hospital is usually a "total institution" only for patients. The staff, as a rule, does not live on the premises. Even in cases where the lower-level staff lives in the hospital, most of the physicians and other professional personnel live outside. Studies of industries have found it fruitful to examine the social life and relationships of workers and various levels of management outside the factory. Similar studies of the off-the-job social relations of and among various staff groups of mental hospitals would be of much interest. Some studies of the social background and social ties of the patients are of great help. But if more were known about the social life of the physicians and nurses, better understanding might result of their conflicting aspirations and reference groups, and of the lack of common language, which have been described in several studies. Such data reveal, for example, some of the mechanisms which reinforce the professional image of the nurse and are responsible for the fact that she quite often prefers to work on the closed rather than on the open ward, and prefers to increase the patient's assurance by wearing a starched cap and handing the patient his medication rather than by smoking a cigarette and engaging in informal talk with him.

For a long time it was believed that the main primary relationships of workers were based on on-the-job relationships. But some recent studies cast doubt on this generalization. One study, for instance, reports that only 10 percent of the workers stated that their main primary relationships were based on work relationships. It seems now that other primary groups—such as families, neighbors, and so forth—have much influence on the aspirations and attitudes of the actors in organizational contexts.


For an outstanding study, see Elizabeth Bell, Family and Social Network, London, Tavistock Publications, 1957.
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...standing of aspirations and attitudes will be achieved only when the communal ties are taken into account.

There is another type of communal tie which seems to be of much importance but is only rarely analyzed by the scholars who study mental hospitals, perhaps because access to this aspect of the organizational structure is limited. Usually lower and middle levels of organizational authority are studied; sometimes the head of the organization is also covered. Almost no organizational study considers higher authorities—such as the board of trustees, the health department, the governor, and so forth—such expressions of the communal structures as the press and the local chamber of commerce. While higher and external authorities are of great significance in the study of all organizations, they are of special interest in the case of mental hospitals. Most mental hospitals are state hospitals and therefore more dependent on external authority than many other organizations. Also, the functioning of the mental hospital is highly influenced by the community "license"—that is, attitudes concerning what are right and wrong methods of care.

Community pressure can affect what is already a built-in strain in the mental hospital, the conflict between the therapeutic and custodial functions. To some degree, custodial activities are means for therapeutic goals. If the patients cannot be kept in the hospital, they cannot benefit from its service. Some suicide-prone patients have to be controlled for their own safety. But community pressure sometimes results in considerable expansion of custodial activities beyond the therapeutic needs. The community often does not want to be bothered by patients or is afraid of them. On the other hand, the community may also be the source of initiative and pressure to introduce more humane methods of treatment into the mental hospital. The internal conflict between custodial and therapeutic functions cannot be fully understood unless the community orientation and the channels of its expression are studied.

The Influence of Multigroup Membership

One of the most important early discoveries of industrial sociology was that workers act as group members and not always on rational grounds. Studies of the mental hospital have rediscovered this tendency. "Recent literature shows a refreshing new point of view. There is an awareness of the fact of interaction, of the importance of the group, ..." But with the rediscovery of the significance of small groups, some of Mayo's early mistakes in applying the human-relations approach to industrial theory have also been repeated. The assumption is often made that the patient or staff member is a member of one group at a time. While this may be true in some marginal cases, people are usually members of more than one group at a time. Consequently, adjustment problems develop, especially when these groups are competing for the loyalties and resources of the members. One of the most important characteristics of a person in modern society is that he knows how to adjust to...
multigroup membership, to be at the same time a trade union member and a factory worker, a member of two families—orientation and procreation—or an obedient soldier and a good buddy.

The patients in the mental hospitals quite often seem to have difficulties along this line. They tend to become overinvolved in one group and to reject their obligations to other groups. Part of the therapeutic process is the reconstruction of the ability to participate in multigroup situations. Several hospital practices, often pursued quite unwittingly, either help to satisfy or interfere with the need of the patient to maintain or to reconstruct his ability for multigroup participation. The widespread practice of sending patients on furloughs instead of giving them simple, direct discharges, seems to have positive effects, such as supplying the patient with an exercise in multigroup activity. On the other hand, the ambivalent, and if not hostile, attitude of the hospital staff toward a patient’s relatives endangers any ties that the patient may have to the external social life and tends to increase his investment in the hospital community. This may later make weaning from the hospital more difficult and block his recovery. Similarly, the objection of some personnel to transferring patients from room to room and ward to ward on the basis that it will weaken their group ties is not always justified. The patient may need these opportunities to become a member of two or more groups at the same time. Such movement might also provide the patient with more social permissiveness and some immunity from the group pressure to conformity. By learning to play his membership in one group against that in another group, the patient may gain some privacy and independence. Some patients seem to use various groups as a ladder on their way to convalescence. With improvement in their mental health, they climb to more ‘advanced’ patient groups. The hospital, it seems, should encourage such mobility, and support and create opportunities for multigroup membership for patients who are ready for it.

**Conferences and Participation in Decision-Making**

The human-relations school is in favor of conferences and group discussions between the superior and his subordinates where information about future activity is given and a group decision is made. That support of the subordinates for a new activity is enhanced in this way has been proved in a number of important experiments conducted by Lewin and others. These conferences, however, may be evaluated differently according to their purpose. If they are used to spread information in a way which diminishes unnecessary anxiety, they can certainly be of great help. One human-relations training movie shows a case in which tension is created among workers when new machines, which they believe will create unemployment, are brought into the factory. Once management explains that the new machines will be used for expansion of the factory and that new workers will be hired, anxiety is completely dispelled. The film does not deal with a case in which anxiety would be justified because the new machines mean that some workers will have to be fired. A conference of the type shown in the movie is just another channel of communication, which, if previously, can function in the structural conditions.

But conferences are not taken only as char or upward communication believed to offer an opportunity for the personnel, and even those ‘self-governing’ in a discussion by the hospital.

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communication, which, like those discussed previously, can function only under certain structural conditions.

But conferences are supposed to function not only as channels of downward or upward communication. They are also believed to offer an opportunity for the personnel, and even the patients, to participate in the process of decision-making, thus increasing their commitments to the decisions made. Democracy is believed to be a more efficient way of management. A study by Caudill, in which verbatim notes of 63 administrative conferences were taken, gives a different evaluation of "conferences" with groups of patients and of their "self-government," as shown in a discussion by the heads of the hospital:

Miss Nugent [Nurse] . . . Are you going to have a gripe session?
Dr. Scott: I'm personally against these gripe sessions.
Dr. Show: So am I, particularly if the patients feel that they are legislating at these sessions and find out later that they are not.
Dr. Scott: The only good that these gripe sessions do is that if you can get the patients as a group to scrutinize what is going on in their behavior. . . .

In other words, conferences with the patients, disguised as upward communication ("gripe sessions"), serve actually for downward communication and direction. Similarly, in some industries, human-relations techniques are applied to the extent that conferences with workers are used as the modern way of giving orders, but the direction of order-giving remains the same. Thus "participation" can be turned into a manipulative technique, not a way of sharing the power to decide.

What about the administrative conferences? Although patients are manipulated, does the staff really participate in the decision-making process? A detailed analysis of the material supplied by Caudill shows that these conferences are either manipulative or blocks to communication, and serve as a source of anxiety rather than as a positive influence. Stanton and Schwartz reach a similar conclusion in their discussion of staff conferences in another mental hospital. They state: "Conferences and discussions were regarded as a means of rationalizing hospital interference, and as discussions which might interfere with clear personal insight into the problem" (italics mine).

In one sense, the administrative conferences of mental hospitals seem to have gone even further than similar conferences in industry. In industrial conferences, usually only two levels of authority confer and there is only one representative of the higher level. These are conferences between a superior and his subordinates—that is, the people he works with. Special attention is paid to arranging conferences in a way which will not confuse the lines of authority. In the administrative conferences described in the studies of mental hospitals, the heads of hospitals, nurse supervisors, charge nurses, staff nurses, senior and junior physicians, and others participate. This creates several peculiar and unnecessary tensions: (1) Conflicts among superiors are acted out in front of those who ordinarily have to accept their orders. (2) Conflicts of superiors with their superiors are discussed in front of subordinates. (3) Subordinates' actions, which have been based on orders or general directions from superiors, are scrutinized by the superiors' colleagues in front of the subordinates. (4) Subordinates attempt to undermine directions to which they object by by-passing their immediate superior and asking the opinion of the conference about the action which should be taken.

The implicit assumption on which these conferences seem to rest is that since "we are all part of the therapeutic community," things can be discussed freely.

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45 See Caudill, footnote 4; p. 76.
with disregard of statuses and lines of authority. But this assumption is unrealistic, as indicated by the behavior of the participants in the conference. As Caudill shows, they tend to participate in the communication process according to their rank. Thus, the subordinates tend to be more passive. Also, much of the conference time is wasted on defensive behavior in response to the tensions described previously. Further, actors in the conference frequently do not transfer information upward, thus avoiding the possibility that it will be used against them. Subordinates in general tend not to pass upward information which is disadvantageous for them, but the conference aggravates this tendency.

Although the studies of mental hospitals indicate the helpfulness of transferring concepts and theorems from one area of organizational studies to another, they show that inappropriate and incomplete ideas can be transferred as well. In adopting the human-relations approach used in industrial theory, some studies of mental hospitals seem to overemphasize (1) the importance of communication, (2) the totality of the institution, and (3) the benefits of participation in decision-making conferences. In so doing, the studies neglect somewhat the study of structural factors, such as budget and time limitations; real differences in personnel; the influence of such external factors as professional associations, communal ties, and so forth; and the unchangeable locus of certain decisions. A balanced analysis of the influence of interpersonal and structural factors, of internal process and external ties, and of the origins of authority, will ensure a fruitful, realistic development of this young branch of organizational theory.

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