Observations from five groups lead to the inference that hostility and militancy contribute to the functional effectiveness and cohesiveness of local advisory groups composed of poor people.

THE ROLE OF HOSTILITY AND MILITANCY IN INDIGENOUS COMMUNITY HEALTH ADVISORY GROUPS

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Introduction

KINGSLEY DAVIS[1] and more recently Grusslin,[2] et al., indicated that there exists an affinity between the Protestant ethic and the concept of mental health found in mental hygiene publications. The "Mental Health Prototype" is characterized by attributes which are readily identifiable with middle-class culture. This prototype for mental health implies that adjustment to the prevailing norms of the culture is implicit to attainment of a meaningful role in society. Adjustment is regarded as the ability to get along well with others, being congenial, and nonaggressive. There is a similar affinity between the "Mental Health Prototype" and the middle-class health professional's concept of appropriate behavior in indigenous community health advisory groups.

There is a wide divergence between the norms of the middle-class culture and those of the lower class. The middle-class values competence and knowledge, security, and cooperative group behavior. Hostile and aggressive behavior are repressed, exceptions including group behavior at certain spectator sports. In contrast, the lower-class person gives direct expression to his aggressive feelings, does not strive to get along well with others because he is more willing to risk disapproval, and has little to lose from nonconformity.[3*]

The health educator has assumed the role of enabler and promoter of the consumer participation concept; however, his social and cultural bias of his experiences, knowledge, and education augur against an ability to contend with cultural norms of the lower class that constitute the consumer membership of most advisory boards representing "the poor." The socialization process of his culture insures that most health professionals either control their hostility or experience negative reinforcement from peers when it is vented. Furthermore, training in group process, an integral part of most academic programs in health education, includes introduction to the theories of group interaction which value the role of controlled group conflict.

There does not exist a theory of group process or criterion for analysis of group interaction which is applicable to the sociocultural symbols and communication mode of the lower class. The classical

* Unfortunately the absence of refined social-class categories means that some fine distinctions between the unstable poor and other groups of poor is lost. In this paper terms like: "the poor" and the lower class are used interchangeably, and refer to the group being contrasted with the middle class.

theories of group process were developed on multiple-goal, future-oriented, middle-class groups in controlled laboratory settings. Although Bales[4] has insisted that the common culture of a small group should serve as the norm for interpretation of present interaction, the conceptual framework for analysis of lower-class group interaction remains reflective of a middle-class prototype. The result is a search for unnatural behavior in a natural setting.

Hochbaum[5] said that there is an urgent need for objective investigation both of the concept of consumer participation and various operational systems based upon it. The purpose of this paper is to deal with the lower-class group as an operational unit in its natural setting, and examine some of the complex and countervailing forces which prevail. The findings from field data, collected by means of participant observation, should contribute to the development of theories that can be applied to the behavior of populations or social entities such as community health advisory groups. Field research of this type does not assume to control extraneous factors, nor allow the evaluation of interaction between variables. Perhaps it is more important at this stage of development of the consumer participation concept, to view the group without the demand characteristics of experimental design or the self-fulfilling prophecies in evaluator's behavior which introduce systematic biases in results.

Method

The need for current and meaningful field data for the author's students, who were studying participant-observation methodology, provided the impetus for this study. Rather than create artificial data for analysis the observer chose to become a full-fledged member of a neighborhood health care clinic's policy advisory group. The role of observer as participant was preferred to that of researcher incognito. The method, supported by Bruyn[6] was again adopted when opportunities for observation of subsequent groups occurred.

Data were collected in journal form from a total of five advisory boards located in three midwestern states, from 1967 to 1970. Four of the groups were composed of over 85 per cent indigenous "poor" consumers of the health or welfare services offered by the agency being advised. The fifth group was 88 per cent professional, with 12 per cent, or 2 of 16 members, actually residing in the target area. The racial composition, education level, means of attaining group membership, and group purpose, were recorded from reports of the groups themselves and supplemented with data from the advisee. A summary of this information is shown in Table 1.

Participant-observation techniques were used during approximately 300 hours of group meetings. Observations were recorded during group meetings and retrospectively. Minutes of meetings, and group notes to others were analyzed for content. The exigencies of the field prevented the collection of data in such a form as to meet the assumptions of statistical tests.

This report is objective in that it is an accurate protrayal of themes which emerged during the growth and development of four indigenous groups. "A theme is a cultural value tacitly approved throughout a culture which controls and guides activities of the members."[7] Each theme must confirm the expressed meanings of the group, directly or indirectly. The major problem of participant observation as a method is the identification of themes and their relationship to the time, place, social circumstance, and language of the group, while being cognizant of the degree of intimacy the observer develops with that group. Literature in the theory of participant-observation indicates that

Table 1—Characteristics of five advisory groups in participant-observation study, 1968-1970

Characteristics	Groups				
	I	II	III	IV	V
Total N group members					
m=male	—	9	6	4	8
f=female	11	15	10	14	8
Educational level average, last grade of school completed	8.5	8	10	10	16+
Employment					
employed	2	8	—	4	16
recipient of aid	9	14	16	12	
Average annual income per family	−$3,500	−$3,000	−$4,500	−$3,000	+$7,200
Group membership means of attainment*	A	E_a	A	E_a	E_i
Average group attendance at meetings	9	18.5	9	14	13
Group purpose†	a	a dm	a	dm	dm

* A=appointed by agency; E_a=elected from target area; E_i=elected from institutional and allied agency nominations.

† decision-making powers initially granted by agency=dm
decision-making powers assumed by group, no agency designation=a dm
advisory capacity only=a

it is not unusual for the observer to become acculturated to the group being observed. After 300 hours of active participation with advisory boards, the observer must say, using a phrase borrowed from Camile Jeffers[8]—"This study is objective but not impartial."

The foci of the study are two themes which the observer identified from the analysis of field data on the first two groups. The themes were then described and defined using a classification system adapted from Bales.[4] The themes are presented in Table 2 in two parts; concepts and relationship being observed. This construction facilitated empirical verification by the observer during work with three other groups.

Observations on Hostility

The indigenous advisory groups were initially characterized as a small group of "the poor," leaderless, and displaying hostility in a complex pattern of attitudes and behaviors. The frequency of hostility as a pattern was first recognized from analysis of the first five meetings of the groups. During the first five meetings, each of the four groups, with consumer membership, averaged from a maximum of 16 to a minimum of eight hostile episodes per session.

The number of episodes rose from the first meeting to the fifth, with the frequency of insulting and abusive comments between members accounting for the greatest increase between first and fifth meeting. Other categories of behavior contributing heavily to the episodic count were: table pounding, fist and finger pointing, cursing and harassing. An episode usually included at least two but most often four to six group members interacting, with accompanied general group disorder. The hos-

tility was between in-group members. (In-group members are consumers, i.e., "the poor"; out-group members include professionals and nonservice eligible group members.) An episode included from 4 to 34 exchanges between persons, lasting from approximately three to ten minutes or longer. Internal group reaction to hostility, in the form of any type of control measure, occurred only after the measures were effectively introduced by out-group members.

Table 2—Concepts and definitions of themes on hostility and militancy

Theme 1: Hostility
concept
Hostile behavior is an accepted norm for interaction in a lower-class group
relationship being observed
Lower-class groups are less functional when hostile behavior is controlled
definitions
Hostile Behavior
Physical acts: beckons, points, pulls, pushes, stomps, pounds.
Verbal attitude: assertive, overbearing, inconsiderate, insulting, severe, abusive, accusatory, dogmatic.
Verbal expression: shouts, curses, badgers, harasses, gripes, carps, nags, perturbs, annoys.
Functional Group
Identifies shared goals from within the group membership; formulates tasks on the basis of in-group goals; dismisses, ignores, subverts, goals imposed from out-group membership.
Control of Hostility
Physical acts: evicts, discharges, banishes; dismisses; ignores; changes position or location; grim appearance; fidgety.
Verbal attitude: smug, haughty; condescending.
Verbal expression: overides; interrupts; interferes; finishes sentences; stresses greater experience; implies inferiority or incompetence of group members; enforces rules of order, conduct, standards; arbitrarily settles disputes; defines power and authority.

Table 2—Continued

Theme 2: Militancy
concept
Shared goals are expressed as militant statements in lower-class groups
relationship being observed
Lower-class groups are less cohesive when militant expression of shared goals is controlled.
definitions
Militant Expression
Negative, defiant; nonconforming; insubordinate; rebellious, demanding; negating; anti; condemning.
Cohesive Group
Group with a high level of participation; attendance; proportion of group members interacting during a meeting; number of group confrontations with authority; number of group members in attendance at confrontation sessions.

In no instance, in any of the four indigenous groups did the in-group members initiate control of hostile behavior. Health professionals, including health educators, were observed to be the initiators and accounted for the greatest number of the total attempts to control group hostility.

The professional often initiated control measures under the rubric of "an educational experience" for the group. Insistence on the use of standard rules of order or the institution of formal organizational structure were the obvious initial measures of control. In one group, the professional devoted one evening to a lesson on "How to Conduct a Meeting." Subsequently, no in-group member was ever observed to impose the suggestions of this lesson on another in-group member, but it was used several times in attempts to control the professional. Another typical control measure introduced

by professionals was the use of an outside consultant. For example, an advisory group report to a health officer from a health educator included the following statement:

> "I have suggested, and the group agreed, to invite Dr. (a local psychologist) to the next meeting. He will speak on *Discipline*. I spoke with him and suggested that he include some strong suggestions on how adults should discipline themselves. I hope this has some carry-over effect on the lack of emotional control in our group."

Outside consultants were also used by out-group members to help identify tasks and goals for a group, or to assure that certain issues were "cooled." Group I was concerned about rumors of an urban renewal project. The agency representative invited a local official to talk with the group. He talked *at* them, and informed them that the city would do its best to "get rid of these slums." The agency representative dismissed the meeting rather abruptly when group members began cursing the official for his attitude toward their neighborhood. Other less obvious measures of control were also employed by out-group members.

When hostile episodes occurred the professional frequently resorted to negative reinforcement or other traditional group control measures. Examples of these methods included: referral of a controversial issue to a smaller "committee," with the most hostile in-group members excluded; interrupting shouting episodes with the statement, "This is a time-consuming discussion and the group has many things to do at this meeting." (It should be noted here that this professional obviously had a tight schedule of topics for the group to cover, and never stopped to consider the literature on orientation of time of the middle versus the lower class.) Negative reinforcement methods, which were more subtle, included physically moving the group—"the other room has better ventilation," serving coffee, asking for a recess so that he could make an "important phone call." Overt power plays usually included moving to the defense of a group member and giving them sanction, pointing out the inexperience of the group with "problems of medical ethics," or dismissing the issue because "the director, of course, makes the final decision on these matters, so let's move on to. . . ." If control measures were effective, the frequency of hostile episodes decreased over time. Group III, effectively controlled by a nondirective professional who manipulated group members masterfully, went from an average of 16 hostile episodes during the first six meetings, to less than one per session for the remaining 16. Group I averaged 8 hostile episodes per meeting up to the 12th meeting. An out-group member had managed to suppress an average of 6 episodes per session up to that time. During the 12th meeting the out-group member was excluded, at the group's request, and the number of episodes jumped to an average of 18.5 in subsequent meetings. Group IV was never effectively controlled by any out-group member, and held a consistently high average of hostile episodes; they were also observed to be the most functionally effective group.

Groups which were controlled and allowed to express minimal hostility were not functionally representative of the consumer. Groups I and II identified issues and problems which had emerged from the concerns of in-group members. Unity was usually achieved at the point of resolution of hostile interaction. Group III did not identify a single in-group goal after the sixth meeting. They assumed the role of listener for the professional who "tested" agency policy by exposing them to the advisory group. Groups which functioned as representatives of the consumer were often considered most uncooperative and impractical by the agency being advised. Content analysis of notes from agency staff meetings supports this observation.

Hostile groups functioned as effective representatives of the consumer and tended to identify goals and make decisions on subjects more sacred to the realm of the health professional. In Group III, after 20 meetings, the stated goals included: (1) helping the people understand the importance of keeping appointments; (2) promoting the use of service to neighborhood residents; (3) identifying the need of educational programs in nutrition and child-rearing practices; (4) interpreting the role of the advisory group to the broader community. In contrast the three other indigenous groups were demanding: (1) the right to determine eligibility requirements; (2) representation on personnel committees which hired professionals and nonprofessionals; (3) authority in financial matters, particularly in determining salaries; (4) final authority in decisions related to establishing new or extending old programs.

The professionally dominated Group V, was controlled, nonhostile, cooperative, and displayed traditional group interaction from its inception. The frequency of hostile episodes averaged less than one per meeting. The group chairman controlled the one group member who was responsible for over 80 per cent of the hostile interaction attempts. This group was a rubber-stamp mechanism for the decisions made by the agency director, with a few exceptions. Financial matters, particularly those involving requests for funds, invoked long, intense but polite discussion. The group suggested some modifications of procedures or amounts, at the discretion of the director. The group followed an agenda, established by the agency, and was never overtly against any agency goal suggested.

Observations on Militancy

An advisory board which "demanded that an agency not . . ." was typically a cohesive group. If an indigenous group consistently made statements to the advisee which were suggestions that policies be reviewed, revised, or reconsidered, it was an indication that they felt powerless, were controlled, and usually lacked interest in the consumer-participation concept. Analysis of meetings with the agency power structure, and reports to agency directors from advisory boards, empirically verify this conclusion.

Group I was a moderately cohesive advisory board; the average attendance was 9 out of 11 members. During group meetings usually 75 per cent of the ingroup participated in discussion. In four meetings with the agency staff, eight decisions were negatively stated motions for action, two were suggestions implying agency bias in treatment of neighborhood residents. Group II had ten confrontations with the agency power structure, with over 80 per cent of the ingroup represented at each session. They made 25 negatively stated *demands*, 12 statements of intent to boycott agency policy, and three statements directly condemnatory of agency personnel.

Group IV went through a critical period and was found to respond in any form only after the demise of a professional who insisted on strict enforcement of lines of authority, and only positive recommendations from his policy advisory group. This group was told, "The function of an advisory board is to make constructive suggestions for change, anybody can tell me what is wrong with *my program*, I need you to tell me how to make it better." "Don't worry yourselves about salaries, job qualifications, or grant renewal proposals, we can take care of things like that; they require the technical expertise of those of us who have worked on these problems for years." "We know how to get the most from the system."

Negative, demanding, condemning statements often provoked the agency de-

cision makers, and resulted in defensive confrontations. One group was finally given the responsibility for hiring and firing health aides when they demanded that all health aides who did not have financial need, or who did not live in the target area, be replaced by persons selected by the advisory group. The first hiring session was memorable to all. Two of the group members had never held a "paying job," but asked some very difficult questions of the persons they interviewed. Another group made the same demand, but was referred to the local civil service examiner who refused to see them because as he stated, "Those people couldn't even understand the tests we give, how could they decide how or whom to hire?" Group IV threatened to picket an institution because it closed its doors to a service program. The agency gave in to the threat, and the group responded with further demands. The institution decided to rescind its permission. The advisory group then "leaked some evidence on how the institution hoodwinked the poor." Working relationships between the institutions' professionals and the service agency were severely strained, but the advisory group attacked new issues with great energy and renewed militancy. Observations clearly support the conclusion that militant demands brought results and increased group cohesion.

There are many more specific examples of the functional role of hostility and militancy which are omitted because of the restraints of time and space, but some general observations are of particular relevance to this paper. Militancy was observed as most intense when group membership was mostly urban black or Chicano. Low-income white and American Indian members were less militant but more hostile in their interaction. Groups which succeeded in having their militant demands met by the advisee tended, with time and success experience, to produce more frequently recommendations in a positive form. Health professionals (there were 15 observed) who were younger and trained in the behavioral sciences were less controlling than those who were more experienced, older, and trained in allied medical fields.

Implications

Whether consumer participation is to be evaluated as a concept or further implemented as a means to improve health service, the health professional needs to reexamine his prototype for an indigenous health advisory group. As Grusslin[2] had suggested, and the observations reported here imply, the health educator is likely to discover, belatedly, that his purposive control of hostile and militant behavior produces a nonfunctional, less cohesive advisory group, a consequence antithetical to his intent. This assumes that health professionals actually want to hear what the consumer values, and will accept their beliefs and shared goals regardless of how they are developed or expressed. Although there are no immutable characteristics of all lower-class persons, or groups of "the poor," there is sufficient information in these data to construct some hypotheses concerning the indigenous policy advisory group.

The cultural norms of the indigenous advisory group, composed of lower-class members, do not favor or value controlled, ordered, polite interaction. The normative value is toughness,[9] and that is not expressed by submissive, conforming, non-aggressive behavior. When an issue is important, it provokes strong feelings, and most emotional reactions of the lower class are spontaneous and aggressive in the meeting room and on the street. Rousseau coined an expressive term which was later used by Reiss-

man,[10] and seems to typify the middle-class imaginary prototype of the lower-class group behavior. It refers to the "noble savage." How comforting it must be to some to dismiss the advice and abuse dealt out by the poor, by employing the norms of the middle class to their behavior, and labeling it as noble but inexperienced.

The health professional's problem with indigenous community advisory groups is not how to control the group's hostility, but how to allow the group to identify and express beliefs, needs, and values of the consumer it represents. Obviously, this author feels that the professional must forego his traditional expectancies of group process, his need to educate the group to the standards of group order, and his tendencies to impose "controlled conflict" as a value. The drowning man will grasp at straws; he does not have the strength to dive for pearls. It might also be helpful if agencies would alter their expectations and recognize that a group, which is for the first time having the opportunity to be heard, will not stop demanding just because it is now interacting with health agencies. Who is to assure that health agencies are going to react any differently than the rest of the "system"? "The strength of the poor arises out of their effort to cope with an essentially negative environment."[10]

Although it may be a heuristic value to anticipate that the poor will change; change may indeed occur. There were some indicators in these data that groups changed their behavior when they actually did share in the decision-making process. The changes observed were to the middle-class prototype. Just as likely, however, is a shift in the balance of power, so that the militant consumer determines the type of health service to be provided. For some health professionals a request to sit passively as one group member reduces another to humiliated tears, or listens submissively to the demand to fire a colleague, is too much to ask. This paper is not meant as an advocacy of one approach by all professionals, nor as an insistence that all advisory groups are always hostile and militant. It is a proposal for health educators, and other professionals who so desire, to attempt to gain as objectively as possible an understanding of the role of hostility and militancy in indigenous community health advisory groups and other groups that have culturally different norms which do not fit the middle-class prototype.

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Vigilance and Effort

It seems that just as the lessons of history are that the great political prizes of liberty and justice, comfort and learning are only gained at the price of constant vigilance and effort, so also are the scientific prizes of command over disease and early death.

Magnus Pyke: *The Science Century*, New York, Walker and Company, 1967, p. 32.