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STAFF COHESION IN RESIDENTIAL TREATMENT

by

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ABSTRACT

This thesis attempts to examine the effect of varying levels of staff cohesion, a key process variable in the residential treatment of disturbed adolescents, on the quality of treatment environment.

In order to do this the staff from each of the three residential cottages which constitute the Easton residential unit were given the Seashore Index of Group Cohesiveness (1954). It was then possible to delineate three levels of staff coehsion, high, medium, and low.

The same staff groups also completed a treatment environment scale, namely the Community Orientated Programs Environment Scale (Moos, 1974), Forms R (real) and I (ideal). The hypothesis here was that as staff cohesion rose so the perceived quality of the treatment environment would rise. The clients from the cottages also completed the environment scale, the hypothesis being that their perceptions of the environment would be more positive in the cottage containing the most cohesive staff group. Client behaviours in the low, medium and high cohesion cottages were also observed.

The study showed that there were no significant differences between the staff groups concerning their view of the ideal treatment environment, but the level of cohesion did have an effect on the real treatment environment, as perceived by the staff, specifically on the variables Support, Personal Problem Orientation, Autonomy, Practical Orientation and Staff Control. The number of locked room hours for clients and the number of violent incidents also seemed to follow the cohesion factor pattern. However, the clients' perceptions of their environment did not vary sig-

nificantly according to cohesion level. Some descriptive data comparing the factors in the Easton treatment environment to the norms for such programs were also included.

Implications for the planning and evaluation of such treatment programs have been outlined as well as suggestions for further research.

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INTRODUCTION

The critical demand for services in child mental health has been reflected in the marked growth of residential treatment facilities for disturbed children during the last two decades, (Durkin and Durkin, 1975). At the same time there has also been growing criticism of the theory and practice of residential treatment itself. For example, the Joint Commission on the Mental Health of Children (1970) reports that the present institutional arrangements for the residential care of disturbed children are "inadequate in many ways, requiring a critical appraisal of both assumptions and procedures." The task of describing, analysing, and evaluating such programs, however, is a complex and difficult one. The first step in this task would appear to be the delineation of the significant process variables in residential treatment and their effect on the treatment environment and, consequently, on treatment outcome.

Easton, a residential treatment facility located in a major Canadian city, and the subject of this study, is at present facing the imminent prospect of a substantial expansion of its treatment program. The task of outlining the effects of variables believed by the Easton staff to be of crucial significance in the present Easton program is then a particularly urgent one, in view of the massive planning procedures necessary before such an expansion can take place.

The most significant variable in the process of residential treatment is considered by this unit and by other practitioners (Easson, 1969; Bettelheim, 1974) to be staff cohesion. This study, then, is an attempt to

look at this variable and determine its effects on the Easton treatment environment as perceived by the Easton staff and clients.

The purposes of such a study are: to provide process evaluation to the Easton unit, which will serve as a basis for future planning and priority setting; to lay the foundation for a meaningful outcome evaluation of such a treatment centre; and to add to the general theory of residential treatment, by clarifying relationships between the significant variables operating in such a setting.

This study consists of an overview of residential treatment and an examination of the group cohesion factor, a description of the Easton program, an outline of the study itself, and an analysis and discussion of results.

CHAPTER I

BACKGROUND OF THE STUDY

Section 1 -- Residential Treatment

Introduction

This section consists of a discussion of residential treatment. It begins with some definitions of residential treatment, followed by a short history, continuing with an overview of the general models of treatment, the structure of residence and treatment methods. Residential treatment as it pertains particularly to adolescents is then reviewed, and finally there is a synopsis of evaluations and evaluative techniques in this area.

Some Definitions of Residential Treatment

Residential treatment, as employed in this study, refers to a complex, full time, twenty-four hours a day therapeutic process provided within a setting specialized for, and adapted to, the needs of clients in the early and middle periods of adolescence (ages 12 through 17 years). The therapeutic process in such a setting is designed to be comprehensive and addressed to the adolescent whose problems are of such a degree that they warrant removal from his family and social environments and admission into full time residential care.

Rinsley (1965) states that in such treatment there are two basic ingredients: first, understanding and treatment of the client's problem; and, secondly, cognitive and emotional growth experiences appropriate for the client's age and development. Both of these, "curing" and "raising," exploring the disorder and socializing or educating the client through the

intact aspects of his functioning, are necessary for a program to be justly entitled residential treatment.

In a more general context, although there is no accepted definition of residential treatment, it has some general characteristics which have been defined by Adler (1968) as:

1. Structured, planned living.
2. Authority and opportunities for clients to work out their feelings about it.
3. Focus on health rather than pathology of personality.
4. Group living.
5. Individualization of treatment.
6. Identification, through opportunities for significant relationships.
7. Child-staff interaction.
8. A sense of community.
9. Integration, joint planning of treatment programs by all staff.

Lourie (1952) has described residential treatment as follows:

We would define residential treatment as therapeutically directed institutional or group care for emotionally disturbed children in which all possible ways of helping -- casework, education, recreation, planned group life, and psychotherapy, are utilized and integrated into a clinically oriented and directed treatment plan for the individual child. It is not merely the removal of the child to a benign environment where he is available for psychotherapeutic interviews. The essence of residential treatment lies in the milieu -- in the complement of adult-child relationships and experiences which can be clinically manipulated and controlled in the interests of therapy (p. 801).

All facets of the client's life in residence are seen as providing opportunities for learning and growth. The milieu itself is seen as the primary and most powerful method of intervention.

Mayer (1955) makes the point that residential treatment is not an entity in itself but a link in a total treatment process which includes pre-institutional and post-institutional care. The fact that in reality this is not always so, but that there is a need for such continuity of care, is a common theme in the literature (Whittaker, 1979; Children in Canada in Residential Care Report 1971; Celdic Report 1970). Such literature emphasizes the dangers inherent in the isolation of residential treatment from the community, and the need for a comprehensive, coordinated community based network of treatment resources that will meet the varied needs of disturbed children.

History of Residential Treatment

Before 1900, residential treatment consisted of orphanage type institutions, mostly religious institutions, offering custodial care. After this date, however, group living experiences, education, and psychotherapy for the child or adolescent began to replace custodial care. Shelter and training began to give way to treatment. The outstanding pioneers in this field have been Aichhorn (1954), Bettelheim (1950), and Redl (1952).

The number of residential treatment units grew slowly over the years, but a marked increase occurred, in the United States at least, between 1945 and 1965 (Pappenfort and Dinwoodie, 1970). Pappenfort and Dinwoodie also note that those institutions existing in 1966 were deluged with applicants. Whether this is due to an increased incidence of psychological disturbance in young people, improved diagnostic systems, or a tendency to redefine many types of deviant behaviour in a mental health context is not known. Hylton (1964) states that in the United States, for every 100,000 people under age 18, 135 are in inpatient care, and 355 in outpatient care. In recent epidemiological studies (Langer et al., 1969), large numbers of

children were found in the community showing marked psychiatric impairment, with disproportionate numbers coming from families on welfare and from low income groups. Where in the network of social services do these children go? Some are likely to be placed as delinquents in training schools, some in homes for the retarded, some in psychiatric wards in state hospitals, some in multiple foster homes, and some in residential treatment facilities, the need for which seems to be critical and increasing.

Models of Residential Treatment

The field of residential treatment has now developed in a variety of directions, the main models reflecting different theories of child development. Psychoanalysis and learning theory provide significant foundations for two polarities of treatment approaches between which various mixtures are to be found.

Lewis and Solnit (1975) break down the recent history of residential treatment into three parts. First, the early view described by Nospitz (1962) that the goal of residence was simply to make the child available for individual psychotherapy, this therapy being isolated from the rest of the client's environment. The therapist did not reveal his work with the client to other staff, who were reduced to the role of custodians. In more recent variations of this model, the power of the milieu may be recognized as a context or integrating force, but individual psychotherapy, which attempts to resolve intrapsychic conflicts, is seen as the core of treatment.

Another view regarded the experience of living in a structured environment with healthy role models as all the client needed. The group living experience was regarded as a corrective emotional experience. This view culminated in the behaviour modification and educationally focussed approaches using such techniques as token economy. In this model, the focus

is on behaviour, not inner personality traits. The "symptom" is seen as the entire problem to be treated by creating a systematic environment which reinforces desired responses and extinguishes negative responses. Achievement Place, in Kansas, (Phillips and Phillips, 1973) is an example of this model. Hobbs' Project Re-ed (Hobbs, 1967), is also significant here.

The third view of residential treatment regards the whole residential experience, group living, individual counselling and psychotherapy, the power of the environment and the client's interaction with it as constituting the client's therapy. Whittaker (1979) states that the major ingredients of a therapeutic milieu are: rules which create a helping culture, routines, program activities, group sessions, individual psychotherapy for clients who can develop and act on the basis of insight, life space interviews (Redl and Wineman, 1952), incentive systems, special education, conjoint family treatment, parent education groups, and individual behaviour modification programs. In this view, staff communication is emphasized as they deal in a consistent therapeutic way with the client, his treatment environment, and his family. Here, combined treatment methods are used, including individual psychotherapy, behaviour modification, milieu therapy, and special education. The Therapeutic Community Model (Jones, 1968) and the ecological model of emotional disturbance have contributed to this third and most recent model for residential treatment.

The ecological model (Rhodes and Tracy, 1977) has augmented and validated this third approach to residential treatment. Ecology is the study of the interaction between organism and environment. In this model, emotional disturbance is seen as a dysfunction interaction between the individual and his unique environment. Key concepts in this model are: the necessity of taking into account the whole "eco-system" of a client,

that is his home, school, community and treatment environment; treating behaviour in the here and now, in its natural context; and the "fit" and interaction of environment and client. Ecological concepts such as "life-space" (Lewin, 1951) are reflected in the writings of residential treatment practitioners. Fritz Redl (Redl and Wineman, 1952), for example, named one of his intervention techniques, life-space interview. This model tends to foster an eclectic and multidisciplinary approach to treatment.

The Therapeutic Community Model (Jones, 1953) is also one of the more significant in relation to this third view of residential treatment. The words "therapeutic community" appear frequently in the literature of residential treatment. This model is the basis for the idea that the total social structure of the treatment unit is involved as part of the helping process; all of the social and interpersonal processes are seen as relevant to the treatment of the individual. The model grew from the psychoanalytic approach but was also a reaction to that approach. The ideal of such a community is to create an environment which heals (the Greek word *therapeuein* means to heal) and nourishes. The basic principles of the Therapeutic Community (Jones, 1953) are: first, the client assumes as much responsibility as possible for his own, his peers and the community's growth. Second, the staff are unified into a team rather than separated into distinct roles, and authority is shared. Third, there is open communication between staff and client, staff and staff, and client and client, enhancing the relationships which are the "primary source of therapeutic change." Fourth, the social environment is as normal as possible. Fifth, there is considerable emphasis placed on "group interaction," the process of interaction as well as content is stressed. Sixth, all facets of life are opportunities for living-learning experiences. And seventh, an emotional climate of warmth and acceptance is desirable. The most powerful factor

in the creation of such a community is the staff who, according to Jones, must be constantly examining their role relationships and must remain open to criticism and feedback, thus forming a therapeutic culture which manifests a consistent attitude towards clients.

This final view of residential treatment, influenced as it is by the ecological and therapeutic community models, is the view favoured by most modern writers on this subject. Whittaker (1979) states, "Psychoanalytically oriented therapy as the treatment of choice is slowly giving way to therapeutic intervention in the life-space." (p. 11) Even programs which focussed on behaviour modification as the prime treatment modality are becoming aware of the power of interactions between staff and client and the effect of the peer culture (Phillips and Phillips, 1973).

These models of residential care also tend to lose their clarity in the process of implementation. Some writers speak of the psychoanalytic model in this field but, in fact, classical psychoanalysis with its focus on regression does not seem, at present, to be widely applied to the treatment of disturbed children or adolescents. Psychotherapy, grounded in interpersonal theory and ego psychology, however, is used. It is difficult as far as concrete implementation is concerned to separate the psychotherapy practices of building relationships and learning new ways of coping or ego strengths from more behaviourally orientated models which also emphasize these elements, but with a different theoretical justification. The behaviour therapists often also focus on the client and therapist relationship, but for its reinforcing and modelling potentialities. Mayer (1977) makes the point that there are more similarities than differences between the different approaches. He compares the twelve concepts Hobbs stresses as underlying Project Re-ed and the twelve items that Redl suggests in his article on the therapeutic milieu. In many ways these concepts overlap.

Redl's "The Impact of the Group Process" and Hobbs' "The Group is Important," are just one example. Most practitioners, no matter what their theoretical background, also speak of the importance of ego development and its growth through a graded set of expectations and responsibilities.

Appendix F contains a description of some of the terms used in these models of residential treatment.

Organizational Structure of Residential Treatment

The staffing pattern includes various combinations of child care workers, teachers, social workers, nurses, psychologists and pediatricians, making the cost of residential treatment very high (Hylton, 1964). The roles and levels of training of these professionals will vary from unit to unit. In some centres the child care staff are the primary therapists, teachers and custodians, while in others these functions may be broken up and assigned to different professionals. The present trend (Mayer, 1977) seems to be to recognize more and more the crucial role of the child care staff. In recent years the French model of training for the "educateur" has been advocated as a model for child care training in the United States and Canada. The emphasis in this model is on a total life education and on helping the child to manage and integrate daily living and learning experiences in all areas, cognitive, emotional and interpersonal.

The ratio of staff to client in residential care is usually very high. Hylton reports a rate of slightly less than one for one to be most common, and the average turnover among staff to be very high, two-thirds of the line staff in some institutions leaving every year. Increased professionalization of the child care staff is noted, but training will vary considerably from institution to institution, as will administrative structures.

The Joint Commission on the Mental Health of Children (1970) made the recommendation that residential facilities be small, allowing children and adolescents to live in small groups, and the institutions should be open, locked buildings or rooms being only rarely required. Also, the guiding principle should be that children be removed as little as possible in space, time and life experience, from their normal setting.

This general theme, that the institution should be as "normalizing" as possible is consistent with recent developments in the institutional care of other groups such as the retarded and the physically handicapped. Wolfensberger's book (1972) expounds the rationale surrounding this concept which is that treatment should be in the "least restrictive environment possible."

Fritz Redl (Redl and Wineman, 1952) also speaks of the need for "a house that smiles, props which invite, and space which allows," meaning that the physical setting and emotional climate must be one where the client's acting out problems and behaviours can emerge and be safely dealt with. Bettelheim (1974), talking of his Orthogenic School, states that the community should be like a "well appointed home."

Client Population

The clients for whom residential treatment is designed are children or adolescents exhibiting a variety of problems such as aggressive impulse disorders, depressed or suicidal behaviours, or various forms of bizarre or psychotic behaviour. The clients will vary according to the focus of the treatment centre. Some centres specialize, for example Pioneer House in Detroit (Redl and Wineman, 1952) which focussed primarily on aggressive impulse disorders. Others have a more general admissions policy.

Whittaker (1979) suggests that clients recommended for residential

treatment commonly share the following traits: poor impulse control as a result of faulty ego development (that is, an inability to channel instinctual impulses into socially acceptable forms of expression); low self-image; poorly developed modulation of emotion; relationship deficits resulting in isolated autistic-like behaviour or clinging over-dependence; family pain and strain; limited play skills; and special learning disabilities.

Whittaker then sees the residential environment as consisting of a series of "teaching formats" to teach competence in these basic life skills.

Institutions seeking to help the emotionally disturbed client differentiate between these emotionally disturbed clients, hard-core delinquent, chronic psychotic, and retarded clients. In fact, when confronted with the individual these lines may be difficult to draw. The causes of emotional disturbance are varied and include possible genetic factors (such as epilepsy and a related emotional or behavioral disorder), disruptions in the life process which impede normal development (such as multiple foster home placements), developmental delay or traumatic experiences (such as physical abuse, incest, parental psychosis, maternal deprivation and loss), or dysfunctional families which produce bizarre or inappropriate coping mechanisms in the child or adolescent.

Clients are generally referred by mental health professionals, such as school psychologists or state welfare agency workers; and previous attempts at treatment, such as foster home placement, usually precede residential placement. The age range varies from institution to institution, but boys are generally referred more frequently than girls.

The needs of the client, skills of the staff, limitations of the setting, balance of the patient population and estimates of prognosis are some of the variables to be weighed when a client is being considered for admission (Lewis and Solnit, 1975).

Elements of Treatment

The implementation of treatment displays some general characteristics which are common to most institutions.

Most institutions focus on the group interaction aspect of residential treatment as a powerful therapeutic force. Polsky and Claster (1968) in their studies of residence emphasized the power of the peer group in residence to undermine or create a therapeutic environment. Redl (1966) states, "Residential treatment in a therapeutic milieu means group therapy."

The therapeutic effect of a structured environment with its rules, routines, expectations, sanctions and incentives, all implemented in a clear and consistent way, is emphasized by most residential treatment facilities (Redl, 1959; Bettelheim, 1974; Trieschman, 1969). Easson (1969) states that the teenager's daily living in the residence is the main treatment tool.

In addition, the child or adolescent's relationship with key staff members who are his chief therapists is recognized, whether this is through the medium of a transference reaction (psychoanalytic model) where the child expresses his feelings towards his parents through this relationship, or through a life-space interview (Redl, 1959) where the working through of daily conflicts and problems is used to build insight and new coping mechanisms. Whittaker (1979) attempts to define the therapeutic relationship between client and staff as containing the elements of social reinforcement, communication, and modelling, each of these elements fostering a different kind of learning, reward and punishment, insight and identification-imitation learning, respectively.

Treatment is individualized, requiring generally high client to staff ratio and most residential centres emphasize the need for free and regular staff communication and team work. Bettelheim (1974) speaks of

the "social solidarity" which is necessary among the staff to support them in their relationships with their clients. The importance of the personal qualities of the staff, their interaction with each other and their ability to form a therapeutic culture is accepted as a basic building block in residential treatment.

It is Easson's (1969) view, echoed by many others such as Bettelheim, and Redl, that

the final therapeutic effect of a residential treatment unit is totally dependent on the quality and the effectiveness of the treatment personnel who must be able to live constructively with their own emotional potentials and their own personal limitations. (p. 28)

Education and recreation seem to be given a high priority in most residential units, as providing age-appropriate tasks through which the child or adolescent can learn competence in life skills.

Traditional modes of psychotherapy are used in most residential facilities, except those operating under strict behaviour modification, token economy systems. Such modes include individual and group psychotherapy and, in some cases, family therapy. The general use of these techniques, however, and of others such as medication, will vary not only from centre to centre, but also from individual to individual.

There has been a general recognition that stages of treatment are identifiable in such settings (Masterson, 1972; Rinsley, 1965). In the first stage, the client displays anxiety which is followed by a honeymoon period where the client is anxious to please, finally lapsing, however, into his characteristic behaviour patterns and resisting treatment. This resistance takes the form of frequent limit testing. The second stage is where the client has formed relationships in the community and begins to work through his or her problems and learn new coping mechanisms. The third, or final stage, is discharge and termination, which often involves

feelings of loss in the client, creating a temporary regression in behaviour. Length of treatment varies from five years (Rinsley, 1965) to five or six months (Hobbs, 1967).

Treatment goals

The goals of residential treatment are stated in terms of the philosophy and theoretical orientation of each unit. However, in general, the goals can be stated as: first, the control of problem behavioural patterns, hopefully at the end of treatment, by means of self control on the part of the client; second, the maximizing of the client's potential for a normal and fulfilling life in the outside community. Whittaker (1979) states the goal of residential treatment to be "education for living." Bettelheim (1974) defines the goal of treatment to be "self esteem" for the client, and that a prerequisite to this is for the client to be backed in his attempts to form satisfying human relationships, and gain "mastery over inner and outer forces." The milieu must, therefore, be structured so that the client can master it, be competent in it, and thereby learn the tools to master the reality of society. The goals of residential treatment are also often stated in terms of ego strength. Some of the specific ego strengths that are mentioned again and again are impulse control, the ability to cope with emotions positively, the ability to see reality without projection or distortion, and the ability to form trusting relationships with others.

The Residential Treatment of Adolescents

How is the residential treatment of adolescents different from the residential treatment of children and adults? What are the special needs of adolescents to which such treatment must respond?

The adolescent client is in a transitional stage of life psycho-

logically, psysiologicaly and socially. The issues and objectives of therapy will naturally reflect the themes and tasks of these years.

Tanner (1962) and Young (1971) have reviewed the physical changes associated with puberty. Cognitive changes emerge in the form of what Piaget called the beginning of formal operational thinking (Elkind, 1968). Here children become increasingly able to generate and explore hypotheses, make deductions and derive higher level abstractions. They now have an awareness of how things might be as opposed to how they are, and this becomes increasingly significant in the formation of their self concept. Erikson (1965) described adolescence as the period in which the main psychological task is to establish a personal identity, and this is tied to separating from parents. It is possible to view all adolescent problems as basically those of separation-individuation (Masterson, 1971). Blos (1970) speaks of adolescence as "a second stage in individuation", the first one having occurred toward the end of the second year when the child experiences the distinction between "self" and "non-self". The leaving of elementary school for high school also underlines a new social role, one in which performance and peer approval becomes increasingly important.

In summary, the tasks of adolescence, as defined by Shields (1973) are: (1) the establishment of healthy sexuality; (2) the achievement of adult intimate relationships; and (3) a firm sense of self and independence.

When does the adolescent require residential treatment? Easson (1969) states that only when the disturbed adolescent shows "a profound deficit in ego strength", therefore not being able to handle his inner drives, and a "deficit in relationship ability", therefore not being able to form meaningful, stable relationships to use as a support system, should the adolescent be admitted to residence. In residential treatment, the adolescent receives the maximal environmental support and control as he

reveals his problematic behaviour patterns and is taught new methods of coping.

The treatment goals, then, that especially relate to the adolescent client are:

1. Promoting an understanding of, and ability to cope with, emerging sexuality.
2. Improving social skills and the ability to form peer relationships and relationships with adults.
3. Increasing self esteem by teaching new coping skills through graded tasks, duties and responsibilities.
4. Helping the adolescent separate from his family and become independent; aiding the emancipatory process.
5. Reinforcing of any individual strengths and confidence the client possesses by making the client's behaviour his responsibility and struggle (Easson, 1969).

Easson (1969) states that the total treatment program for the disturbed adolescent must be geared towards promoting "trust, self-awareness, self-control, and self-confidence."

The implications for the implementation of treatment are many. Meeks (1975) states that adequate treatment of many adolescent problems requires "the flexible application of a variety of approaches," which are designed to match the individual's needs and abilities. This requires consistency in approach and particularly close collaboration and communication between therapists, what Bettelheim (1948) calls an "inner cohesiveness" or the necessary integration of control, support, direction and gratification for each client.

Most residential treatment facilities for adolescents recognize a

particular need to develop a "protherapy" group culture among the adolescents who tend to be particularly peer orientated, as well as an especially clear system of limitations and privileges designed to control the adolescent tendency to live out problems rather than discuss them (Holmes, 1964). Easson (1969) emphasizes that these controls must be "human based", happening in the context of a therapeutic relationship. Most programs also recognize the importance of parental involvement, and offer parents groups and family therapy as a part of their program.

Forming a relationship with an adolescent client is a different process from engaging a child or adult client. The therapist may be seen as a authority figure, or a surrogate parent. Interpretation and insight may not be relevant or acceptable to the client, and the main influence that the therapist has on the client may be that of a healthy role model. Easson talks of "acceptance and alliance" as the key words in the therapeutic relationship between staff and client. The treatment team has "to be respected as secure, meaningful, dependable adults who can then be used as consistent identification models" (p. 71).

Authors such as Easson also talk of the need for space and safety in the environment for the adolescent to express himself and his feelings, and to take a more and more responsible role in his own treatment, and in the community in general. The client has to be allowed to move from dependence to independence.

Many authors emphasize the need for clarity and consistency in daily routines and expectations, since the adolescent will need to test and retest these structures to discover if they are certain and dependable. Acceptable and unacceptable patterns of interacting must be definitely delineated, the focus of treatment being the day to day living and the problem of coping with this present reality.

The use of various treatment modalities must be adapted to the needs and limits of the adolescent. Most disturbed adolescents, as Easson points out, find close relationships very threatening and do not have the ego strength necessary to benefit from a classical uncovering analytic psychotherapy process. Instead, the need is to strengthen the emotional defenses the client already has, while attempting to make his reaction patterns less maladaptive. Often the use of group counselling, if a pro-treatment culture can be created, is one of the more acceptable treatment modalities for the adolescent client.

The Evaluation of Residential Treatment

Numerous serious methodological problems plague research in this area. Criteria for diagnosis, treatment and outcome are not sufficiently well defined for research purposes, and the intervening variables make controlled studies virtually impossible. Client groups also tend to be small and heterogeneous so it becomes difficult to compare them. Many studies are conducted without benefit of controls, so although a change in the dependent variable may occur, the precise nature of independent variables responsible for the change cannot be specified.

The importance of evaluation is emphasized firstly by the powerful nature of residential treatment which may actually be harmful to the disturbed client. Easson stresses this point by stating that

the firm external imposition of such structuring as occurs in the residential setting can act directly counter to the adolescent emancipation-individuation process... and perpetuate emotional dependence... (p. 6).

The first effect of admission, in fact, is usually to further undermine the teenager's emotional competence since it can be seen as a judgement by society and family. In this case the adolescent may see admission to residence as a confirmation of his "craziness" or "badness". Writers such as Goffman (1961)

have also specified the dangers of institutional life, such as depersonalization and iatrogenic disturbance (where disturbance is an adaption to the culture of the hospital), and these dangers could be seen as even more critical in relation to adolescent clients.

The report, "Children in Residential Care," (1971) states that often there is a lack of continuity of care, such as little specific discharge planning, and thus there is a danger that the child will adapt to the needs of the institution while ties in the outside community are allowed to wither. This then results in a traumatic separation at discharge and the creation, since the client has great difficulty adapting now to the general community, of another failure experience. This danger is increased further if the values and expectations of the residential unit deviate dramatically from those of society in general or the client's family in particular.

The second factor that emphasizes the importance of evaluation is the complexity and expensive nature of residential treatment. "The Children in Canada, Residential Care Report" (1971) makes the point that residential programs are cannibalistic of scarce professional staff, especially since they give great amounts of time and energy to very small numbers of individuals. In 1978/79 the cost of keeping a client at Easton, the unit that is the subject of this study, was approximately one hundred and twenty-five dollars per day. Such questions as the effectiveness of treatment as a whole, the differential effects (what works best, when, and for whom), and the transferability of learning to the outside environment, are therefore very pertinent. The question of transferability is particularly so, since studies such as the "Bellefaire Follow-up Study" (Allerhand et al, 1966) and the Taylor and Alpert study (1973) suggest that positive adaption to the institution does not forecast adequacy in the post-treatment environment.

Durkin and Durkin (1975) identify four different types of research in this area: descriptive studies; follow-up and outcome studies; process evaluations; and system analyses. Of the descriptive studies that have been done, most are extremely subjective. For example, Easson's "impressions" (1969) that four out of five severely neurotic teenagers at the Menninger Foundation grow in the treatment process to "some level of acceptable social adaptation." The clearest point in his evaluation is the judgement, shared by other clinicians, that the more psychotic the client's behaviour pattern, the worse the prognosis. Redl and Wineman (1952) attempted a follow-up study of the clients who were in treatment at Pioneer House, but again there is a lack of empirical data. He states only that he observed a diminution of major symptomatology and an increased ability to relate to adults and cope with rules, in the eight months following the closing of the school. However, he also states that many clients later regressed, but suggests that this may be the result of re-exposure to traumatic life situations.

Most follow-up studies display the methodological problems common to this area. Treffert (1969) estimated that forty-eight percent of the clients admitted improved. However, it is not clear how much of this improvement was due to treatment, and how much due to maturation, spontaneous recovery or other factors. It is also not clear in this study exactly what "treatment" consisted of. The main conclusion drawn from studies of this type seem to be that poor outcome is associated with a psychotic diagnosis, the early onset of problems (King, 1970) or low I.Q. (Levy, 1969). Not surprisingly, healthier clients do better after discharge. Most follow-up studies also emphasize the crucial importance of after-care and discharge planning (Mora et al., 1969). In general, outcome or follow-up studies, as Durkin and Durkin (1975) point out, usually disregard the intramural functioning

of the program, provide very delayed feedback, do not delineate the relative contributions of the various components of the program, and do not differentiate between formal and informal, or unrecognized goals.

An example of process evaluation is the book, "A Milieu Therapy Program for Behaviourally Disturbed Children" (Monkman, 1972). Here a thorough going application of behaviourist principles lead to meaningful comparisons over time of behaviour checklists, punishment records, a daily mark sheet and samples of the client's behaviour. This kind of process evaluation would only be possible, however, in a centre organized on behaviourist principles, and does not address itself to long term outcome.

One of the newest approaches to evaluating such treatment programs is goal attainment scaling. Austin (1976) used this approach to compare two day hospitals, one using behaviour therapy and one implementing milieu therapy based on group interaction. The subjects were randomly distributed to treatment units. In a six month follow-up, significantly more subjects who had received the behavioural therapy had attained their treatment goals (93% versus 79%). Another goal attainment study by Goldenburg (1971) analyzed changes in attitude (such as alienation, authoritarianism, trust for others, and positiveness of world view) and changes in arrests and work performance of an experimental group of delinquent boys in residential treatment and a control group. Pre and post measure of attitudes and behaviour were taken. Randomization was not possible, but the most difficult twenty-five boys were taken into the experimental group, and the next most difficult were taken into the control group. This sampling poses obvious problems. The results, favouring significantly the experimental group, may have been the result of a Hawthorne effect or a regression-from-the-mean phenomenon (the most troublesome boys could only improve). The authors did relate attitudinal measures to behavioural ones however. This approach to evaluation

seems to have considerable potential, as well as problems.

The last type of evaluation is the analysis of the residential centre as a social system. System analyses are evaluative in the sense that they examine functional and dysfunctional aspects of programs. The Polsky and Claster study (1968) is such a study. In this study, the authors use the concept of role to examine staff and peer group structures, and to analyze the social and cultural processes in residential treatment cottages. Unfortunately, the lack of reliability in the collecting of the data mars the study. Henry (1957) employs a systems approach to contrast two types of social structures characteristic of residential treatment centres. He contrasts the structure characteristic of the Sonia Shankman Orthogenic School with a more traditional psychiatric model. The Orthogenic School is seen as an example of simple, undifferentiated subordination. There is one director with a staff that is responsible for all phases of the operation. The staff are responsible for the child care and individual psychotherapy, and have an intense involvement in all phases of the child's life. Contrasted with this is a system of multiple differentiated subordination. In this system, therapeutic tasks are broken down into child care custodians, teachers, therapists, recreational staff, and so on. Henry suggests the first model is much more efficient in achieving the organizational goals of residential treatment. Pilivian (1963) examined the relationships between child care staff who were given the role of "raising" the clients, and caseworkers who were "treating" the clients, and suggested that the integration of such functions was crucial.

There are also many studies which attempt to examine the inter-relationship between process variables in mental hospitals and residential treatment settings. These variables are usually grouped under the heading "environment" (Jackson, 1964; Moos, 1974; Rice et al., 1963; Eilsworth et al., 1969). These studies ask questions such as: Which setting characteristics

relate to which indices of treatment outcome? or What type of milieu program is best for what type of patient? Moos (1972), for example, found large size was associated with low scores on such factors as Spontaneity, Personal Problem Orientation and Anger shown in the environment, and high scores in Staff Control as perceived by patients. Moos (1974) also found a correlation between high dropout rates in a psychiatric hospital program, and factors such as low Involvement Support, Order and Organization, and Program Clarity. Wards that were successful at keeping patients out of the hospital emphasized Autonomy, Practical Orientation, Order and Organization, and a reasonable degree of Staff Control.

Durkin and Durkin (1975) emphasize the virtues of this last model of evaluation in residential treatment over the other models mentioned. They suggest examining goals in relation to inputs, sub and supra systems, and the functional processes of residence such as communication patterns, accountability, decision-making, coordination, and staff support. Outcome variables can then be related to institutional characteristics and processes which are amenable to change, such as the composition of staff.

The evaluation of residential treatment remains, however, a difficult but increasingly necessary task.

Section 2 -- Role of Staff Cohesion in Residential Treatment

This section consists of a discussion of the significance of staff relationships in residential treatment, and the perspective of the Easton residential centre concerning this variable. A general discussion of the group cohesion concept is then followed by a statement of hypotheses.

In the literature of residential treatment the significance of the quality of the milieu is emphasized continually. Moos (1974) makes the point that,

various authors have differed in their feelings about the effectiveness of psychiatric treatment, but they all agree on one point: that the immediate psychosocial environment in which patients function determines their attitudes, behaviour, and symptoms, and that this environment can be the most critical factor in determining the outcome of the treatment. (p. 8)

The Significance of Staff Relationships

What are the factors that facilitate the creation of an effective therapeutic milieu? The consensus appears to be that the main factor here is the residential staff, their individual characteristics, and how that staff operates as a group. The staff must form a cohesive team if they are to create an effective treatment environment. Staton and Schwartz (1954) clearly illustrate the relationship between client symptoms and the social environment, specifically between the collective disturbance of a psychiatric ward and low staff morale occurring as a result of conflict and lack of communication.

Matsushima (1972) states,

any collection of individuals living together develops relationships of influence toward one another, cliques spring into being, unstated expectations of sanctioned and unsanctioned behaviour arise, subtle power relationships become apparent, all quite apart from the formal institutional organization, functioning for or against its treatment purposes. The staff is part of this network of relationships, so that tensions in one element inevitably affect the others. (p. 176).

Wessen (1961) also stresses that staff conflict undermines treatment goals,

where misperceptions, disagreement and conflict about authority relations among staff create barriers to communication and autistic hostility, the total amount of staff time and energy allocated to maintenance or the solution of the expressive-integrative problem of the system will be disproportionately large, and relatively little staff time and energy will be available for accomplishment (p. 42).

The literature further emphasizes the necessity of an integrated team approach to treatment so that a health promoting consistent culture

or network of norms and values will form the basis for a therapeutic culture set up among the client peer group. Weber (1972) emphasizes that adolescents in particular,

know about conflict and inconsistency in their homes, and develop devious means of satisfying their needs. They evaluate social situations very well and exploit and manipulate any weakness in the staff group (p. 283).

To create a therapeutic culture, capable of dealing with such adolescents requires "consensus" and "cooperation" (Dean, 1976).

The literature also emphasizes the importance of the staff as role models for the clients, modelling effective positive ways of interacting with others. Dean states that the therapeutic social system teaches relationship skills by making a wide variety of relationships available, and by examining the processes of the relationships as they take place. Also that the quality of the interpersonal relationships among staff shapes the work output by influencing the process of communication and individual commitment to the task.

Maxwell Jones (1968) stresses that in a therapeutic community, open communication, feedback and free expression of feeling in the staff group is a prerequisite to the creation of a therapeutic community consisting of clients and staff. This parallels Bettelheim's concept (1974) of staff solidarity, which he sees as essential to provide the staff with the reassurance and security necessary to cope with the personal risks and strains involved in their role. He also emphasizes that the staff group must have a common commitment to a clear treatment philosophy. His concept of integration perhaps sums up his view of the significance of staff interaction in residential treatment. He sees inner integration as the goal of therapy, the achievement of this goal being dependent in turn on the integration of all features of the environment, routines, groups, rules, etc., which is in turn dependent on the inner integration of the staff themselves, and their integration into

a supportive staff team. He states,

a therapeutic milieu must provide the right emotional climate for its patients so that they can regain mental health. It will succeed in doing this to the extent that it is able to create a human and social environment which promotes the social solidarity of the staff (p. 320).

Staff Relationships at Easton

This concept that staff interaction and teamwork is one of the most if not the most significant building block in the implementation of residential treatment is a clear and generally accepted assumption at Easton, the residential treatment centre described in this study. A close and supportive staff group has always, since the units inception, been seen as a prerequisite for the creation of the desired therapeutic community. The assumption is that only when a staff has close, open, and positive relationships with his peers will he then be secure and confident enough to be honest, authentic and communicative with residents.

In the unit's early years, this belief in the importance of the relationships between staff was reflected in the emphasis placed on staff "process", which is the ongoing examination of feelings, relationships, and interactions between staff as they are in the process of developing. This priority was reflected in the content of training days and marathon group sessions. Here the staff engaged in extensive sensitivity training, encounter groups, and general group therapy techniques as suggested by Polsky and Claster (1968).

For the last few years, the value placed on staff relationships has been further formalized in that the first half of the daily cottage shift change meeting is set aside for such "process". During this time, the focus is on "feelings" rather than "business" or "issues", that is, on clarifying

the relationships and interaction patterns between staff and staff, staff and clients, and staff and job expectations or tensions. A familiar pattern is to discuss the events of the day and their effect on the shift team, also to give resentments, appreciations and demands to other members of the team. Staff may share their personal feeling state, and examine how this is likely to affect their interaction with staff and clients at this particular time. Conflict around treatment issues is also examined. The goals here are to promote the personal and professional growth of staff and to create a cohesive and supportive staff team. The assumption is that this will then facilitate the completion of tasks and enable the counsellors to relate consistently and authentically with their clients, thus creating a healing culture in the cottages. If the exposure and resolution of tension and conflict is the basic dynamic in a therapeutic community, then this process must logically begin with the staff group.

To summarize, one of the chief assumptions affecting the implementation of residential treatment at Easton is that the cohesiveness of the staff group exerts a powerful influence on the treatment environment, and thus on client behaviour and treatment outcome. Fritz Redl (1959) has stated that an examination of the impact of variables, assumed to be critical in residential treatment, is an "urgent job". In order to further examine the significance of the variable, staff cohesion, it is necessary to further define and examine this concept.

The Concept of Cohesiveness: Some Definitions

A number of authors have emphasized the theoretical and practical importance of the concept of group cohesion.

For example, Golembiewski (1962) states,

The concept of cohesiveness occupies a particularly prominent place in small group analysis. This prominence is a result of several contributing factors, theoretical, experimental, and practical. Theoretically, cohesiveness is the essential small-group characteristic. This "stick-togetherness" or member attraction at once characterizes a small group and differentiates it from other social units. Further, cohesiveness can be induced in laboratory situations by straightforward means. Moreover, early small group studies of productivity and opinion formation demonstrated the importance of the concept. The simultaneous impact of these factors led to the frequent use of the concept, to its conceptual and operational development and to a growing literature. In a real sense then, the study of cohesiveness is small group analysis at its best (pp. 149-50).

What, then, is group cohesion? Seashore (1954) makes the point that in common parlance the term encompasses such ideas as "group pride", "group solidarity", "group loyalty", "integration", "team spirit", and "teamwork". Several operational definitions have been used, such as the relative frequency of friendship choices within and outside the group, the frequency of "we" versus "I" references in conversation, the degree to which norms are shared, the strength of desire to continue relations as a group, and the perception of the group as being better than others in various respects.

Cartwright and Zander (1960) distinguish three different commonly used meanings of the term: attraction to the group, including resistance to leaving it; morale, or the level of motivation of the members to attack their tasks with zeal; and, the coordination of the efforts of members. For the purposes of this study, group cohesiveness is defined as attraction to the group and resistance to leaving, and this is the most common definition used in recent research studies.

There have been several attempts to further delineate this attraction to group. Mikalachki (1969) in his study defined group attractiveness as consisting of members' identification with their group; members' positive evaluation of their group as compared to others; high within group friendship choices; few expressions of open conflict or antagonisms among members; and

refusals of transfers to other groups. Golembiewski (1962) states that individuals' attraction-to-group is a function of two classes of factors: group properties and the properties of group members, such as the motivational states of the persons involved, which are a function of personal needs and characteristics. Newcomb (1960) divided interpersonal attraction into five subclasses: respect, admiration, reciprocation (judged favorability of another toward self), role support, and value support. Of these, a combination of the last three forms of attraction was found to be the most stable.

Mikalachki (1969) also specified some of the behaviours and feelings characteristic of the highly cohesive groups in his study. The definition of cohesion was, as above, attraction to group. He found that the high cohesive group members joined in more voluntary joint activities, were distinguished by their cooperative behaviour, lack of interactional sub-grouping, and a stability of interactional patterns when newcomers entered the group, as well as more egalitarian mode of interacting.

Conditions Facilitating Group Cohesion

The first condition that has been noted as likely to facilitate high levels of cohesion is the opportunity for interaction. Homans (1950) contends that a high frequency of interaction between individuals will result in a high degree of attraction or positive sentiments between these individuals. It seems self-evident that the rewards and deprivations associated with group membership are determined and realised through interaction. For example, consensual validation of attitudes occurs through interaction. Studies have also generally shown that interaction is more equal and more intense in highly cohesive groups.

Certain kinds of similarity among members may also strengthen the cohesiveness of a group. In an experimental study, Zander and Havelin (1960)

observed that persons preferred to associate with those close to them in ability. The result of the tendency for like to join like in group association, as Cartwright (1960) points out, is an eventual increase in similarity among members.

Deutsch (1960) in his study found that a situation in which group members are in a cooperative relationship is more attractive than one in which they are competing. Raven and Rietsema (1957) reveal that a member is more strongly attracted to his group when he is clear as to the goal of the group, and the path it is following toward the goal, as well as how his own task fits into the goal and path, than when he is not clear about these matters.

Mikalachki (1969) suggests that interdependent roles and a climate of concern for each other foster high cohesion. He also adds that a high degree of identification with formal group goals, as well as a high degree of success in attaining these goals, facilitates cohesion. The absence of the last two conditions concerning goals tends to shift a cohesive group from a task orientation to a social one. Cartwright and Zander (1960) also emphasize success in goal attainment as a factor which increases cohesion, suggesting that this results from the realization that membership in the group enhances personal prestige. When a group is attacked, an increase of cohesiveness can occur, if the group is seen to be a source of security.

Cartwright and Zander (1960) sum up the conditions which facilitate cohesion thus;

the attractiveness of a group may be increased by making it better serve the needs of people. A group will be more attractive the more it provides status and recognition, the more cooperative the relations, the freer the interaction, and the greater security it provides for members (p. 83).

The main condition Cartwright and Zander identify as damaging to cohesion is members' disagreement over the way to solve a problem.

Consequences of Group Cohesion

Back (1951) attempted to answer the question, Does the source of attraction create differential effects? In his study, groups were established on three bases: personal attraction, task attraction, and possible prestige gains from membership. The conclusions were that the style of communication and influence was different for each source of attraction, but a similar increase of attraction on each of the bases led to a similar increase in the power of the group to influence its members. With respect to power to influence, then, it appears probable that different sources of attraction have the same effect. This power of the group to influence its members, or members' willingness to accept influence, has been identified as one of the main results of group cohesion.

Cartwright and Zander (1960) state that the power of a group over its members is proportional to the cohesiveness of that group, and that pressures toward uniformity are stronger in a more cohesive group because of the value attached to the group. Schachter (1951) also found that members of a cohesive group more readily try to influence others, perhaps because members who are strongly attracted to a group place greater value on the group goals, and adhere more closely to the group's standards.

In summary, the research suggests that in a highly cohesive group there is more interpersonal influence and, thus, usually a greater similarity in values and conformity in behaviour (Lott, and Lott, 1961).

Another consequence of high cohesion that has been identified is a lack of anxiety, or sense of security among members. Seashore (1954) suggests that this arises because being an accepted member of such a group gives the individual added control over his environment and a defense against any threat arising in his environment. In addition to this support, the direct satisfaction of being a member of a cohesive group can also be surmised to be

anxiety reducing. Mikalachki (1969) suggests that the tension characteristic of uncohesive groups is a result of the disconcerting interpersonal relations found in such a group.

The main thrust of research concerning the consequences of group cohesion, however, has been towards the relationship between this variable and productivity or goal attainment. The relationship between these two variables has been shown to be a complex one. Seashore (1954) found that highly cohesive groups show less variation in productivity (more effective group standards), but the direction of productivity, up or down, depends on the norms of the group which are influenced by the support and reward structure set up by the larger organization. Shaw (1976) states that,

it seems evident that the empirical data supports the hypothesis that high-cohesive groups are more effective than low-cohesive groups in achieving their goals. The cohesive group does whatever it tries to do better than the noncohesive group (p. 207).

Thus, if the cohesive group's priority is production, then it tends to be more efficient, but if, for example, social interaction is the priority, then this may conflict with task orientated production goals. There is also evidence that the members of highly cohesive groups more often take on responsibilities for the organization, participate more readily in meetings (Back, 1951), persist longer in working towards difficult goals (Horwitz, 1953), attend meetings more faithfully (Libo, 1953), and remain members longer (Sagi et al., 1955). Also, because there is a higher degree of interpersonal influence in a cohesive group, if the group attempts to influence its members towards increased production, a cohesive group should be more successful in this respect (Berkowitz, 1954).

There has been no direct study examining the "productivity" or success of residential treatment units in relation to group cohesion. However, some research has been done on the desirability of cohesion in therapy groups.

Truax (1961) found significant relationships between group cohesiveness and both the degree of patient self-exploration and the degree of patient insight. Bettelheim (1974) sees both self-exploration and insight into self as necessary processes for residential treatment staff. The research of Truax suggests that this process will be more effective in a highly cohesive staff group. Yalom (1975) states, "Members of cohesive groups are more accepting of one another, more supportive, and more inclined to form meaningful relationships in the group" (p. 67). This would suggest that members of a cohesive staff team would be more therapeutic as role models than members of a less cohesive staff team.

The Measurement of Group Cohesion

One very prevalent method is to use a sociometric status measurement. The main objections here are that such an instrument measures only each individual's attraction to the group, one part of the group, and the precise relation to the cohesiveness of a total group is unclear, and that such instruments are often difficult to interpret (Golembiewski, 1962).

A second kind of measure is an operational measure sometimes called a "locomotion measure". Libo (1953), for example, allowed people to vote with their feet concerning the attractiveness of their group. His subjects were given a choice: they could enter one door and thus remain in the group; or enter another and leave. Libo also devised a projective test, a Group Picture Impressions Test, which correlated significantly with the locomotion measure.

A third kind of measure is a questionnaire, perhaps consisting of only one question, Do you wish to remain in this group? or a scale, such as the Seashore Cohesion Index (1954) which was the instrument used in this study and which will be discussed in the next chapter.

Summary

Cartwright and Zander (1960) state that "the theoretical and practical importance of cohesiveness as a determinant of other group properties is now well established" (p. 91). It seems then an especially significant variable to examine in a milieu such as a residential treatment centre, which purports to be a therapeutic community, where the group relationships and living situation are the basis of treatment. Yalom (1975) suggests that cohesiveness in group therapy is the analogue of relationship in individual therapy. Here relationship is valued for its curative powers and is seen as a goal in itself. In this setting then, group cohesion is not only deemed a necessary condition for goal attainment, it can be seen as part of the treatment goal itself. The cohesiveness of staff being viewed as a prerequisite for the integration, or cohesiveness, of the whole community of staff and clients.

The hypothesis of this thesis is that as the staff cohesion in the residential cottages at the Easton residential treatment centre varies so the treatment environment, or atmosphere, as perceived by clients and staff will vary. Specifically, as staff cohesion increases, the gap between the perceived real treatment environment and the staff's conception of an ideal treatment environment will decrease. Also, as staff cohesiveness increases, the clients' perception of cottage atmosphere will become more positive, and this will be reflected in less client runaways and acting-out necessitating confinement to a locked room.

CHAPTER II

SETTING: EASTON RESIDENTIAL TREATMENT CENTRE

This section consists of a physical description of the residential treatment centre, Easton, together with a short history and synopsis of the unit's social organization. A description of the unit's design and intent, client population, staff, and client organization will follow. Lastly, there will be a discussion of the general philosophy of residential treatment operating at Easton, and how this philosophy fits into the general context of residential treatment, followed by an overview of the program and its implementation.

Physical Description

The residential treatment centre for emotionally disturbed adolescents, known as Easton in this study, has been in operation since August, 1969. The unit is part of a larger Mental Health Centre which includes a Psychological Education Clinic and a Family and Children's Clinic. The adolescent treatment centre also includes a day centre program for adolescents not requiring residential treatment. This study, however, is concerned only with the residential unit.

Easton is a Provincial Government Mental Health Institution situated in a mixed commercial-residential area of a major Canadian city.

The Easton residential unit consists of three cottages, each accommodating up to twelve "emotionally disturbed adolescents, boys and girls." The age of the clients ranges from twelve to seventeen years. The residential unit has access to a swimming pool, gymnasium, tennis courts, an outdoor sports

and play area, an arts and crafts centre, and a schoolroom in the school complex. The administration building for the residence is separate from the cottages, located in the centre of the complex (see Figure 1).

The unit grounds are landscaped with well maintained lawns, shrubs, and trees. For an urban area it is relatively quiet and peaceful.

The residential cottages were designed in the interests of indestructibility, being made of brown brick and furniture built into the walls. Any movable furniture is made of very heavy materials. The living room floors are carpeted and lighting is indirect, behind inaccessible valances. The walls, however, are brightened considerably by painted, coloured geometric designs and an occasional art print. The woodwork is also painted bright colours and this, with the general lighting, including big windows and skylights, creates a cheerful interior. The living rooms have fireplaces and contain plants and art work which have been donated by the staff and previous residents.

There are certain features necessary to satisfy the health and safety requirements of an institution, such as exit lights, fire alarms, fire extinguishers, etc. Each cottage also has a room especially designed for the safe containment of adolescents. Such a room is necessarily rather bare, has immovable windows and elaborate locks on the door. Each cottage contains eight bedrooms (six double rooms and two single rooms); four double rooms in one wing accommodating boys, and the rest in another wing accommodating girls. The main staff office is centrally located near the front door, with the walls consisting mostly of glass to facilitate the staff being able to see out into the cottage community.

Design and Intent

Easton was designed to fill the needs primarily of non-delinquent and non-psychotic adolescents who did not require a closed institution. However,

Figure I: EASTON COMPLEX

SCALE 1" = 100'

small numbers of psychotic or delinquent youths could be admitted. The "open door" character of this institution was, and is, consistent with a therapeutic community model which forms one of the basic theoretical frameworks for the implementation of treatment at Easton, although this model and other significant concepts have necessarily been adapted to the needs of adolescent clients and the bureaucratic structure imposed by the Provincial Government Mental Health Branch.

Client Population

Each cottage at Easton can contain as many as twelve adolescents, but the numbers fluctuate because of discharge and admission timing and the client runaways or "splits". At the time of this study, July, 1979, there were ten residents in cottage one, ten in cottage two with an impending admission, and eleven in cottage three.

The age range of the residents varies from twelve to seventeen years. The average age of Easton residents at the time of this study was fifteen years and three months.

The number of boys and girls in a cottage at any one time can vary slightly. At the time of the study there were six boys and four girls in cottage one, five boys and five girls in cottage two, and five boys and six girls in cottage three.

It is reasonable to assume that the Easton clients would fall in the average range as far as I.Q. is concerned, since part of the admission criteria is that the client has been tested and found to be at least in the normal or dull-normal range.

The adolescents are referred by mental health teams, psychiatrists, physicians, counsellors, probation officers, social workers, and assessed by the Easton assessment team. This assessment process consists of an interview

of the family by the social worker, an interview of the client by a child care counsellor and a psychiatric assessment followed by a day visit to one of the cottages. If admitted, the first month is also an assessment period, during which the cottage assesses the nature of the client's disturbance and the treatment goals to be achieved. Easton clients come from all over the Province but by far the largest proportion are admitted from the surrounding urban area.

In 1978, Easton received 183 referrals. Of these referrals, 97 were recommended for admission after the assessment procedure; and of these, 57 were actually admitted in that year. There are various reasons for the lower number actually admitted: the limited number of beds available at Easton, clients on the waiting list (there are usually 30 to 40 on this list) may find alternative placement, or parents may refuse placement.

The average length of stay at Easton is approximately eight to nine months, although this is a somewhat artificially low figure influenced by some clients who repeatedly run away during the first months of treatment and are then discharged. A more realistic figure would perhaps be ten to eleven months.

Staff (Figure 2)

The importance of the quality of the residential staff is emphasized by most authorities on residential treatment. Easson (1969) states, "The final therapeutic effect of a residential treatment unit is totally dependent on the quality and effectiveness of the treatment personnel" (p. 28). At Easton, the child care counsellors are considered the primary therapists for the Easton clients. They are supported in each cottage by a social worker, a ward aid (who sees to household duties), and a consultant psychiatrist. These counsellors have an intense involvement in all phases of the client's life. This differs from many other institutions where tasks are usually

broken down and assigned to different staff with different professional orientations. At Easton, the counsellor is responsible for basic child care, milieu management, and the planning and implementation of individual, group, and family therapy for their particular client or cottage. Thus, there is no division of staff roles between those who do "therapy" and those who put children through daily routines.

Redl's life-space interview technique (1959) was an attempt to break down such divisions which have proved problematic in many institutions (Pilivian, 1963) and encourage "the clinical exploitation of life events." This concept of the child care role which integrates management and treatment is similar to the European concept of the "educateur" who is a professional mental health specialist trained in child care, education, and clinical management. This model is the one recommended for residential unit staffing in "The Children in Canada, Residential Care Report," (1971).

The staff to client ratio is necessarily high in residential treatment, and at Easton there are fifteen child care counsellors in each cottage, consisting of one cottage supervisor (child care counsellor 4), four shiftheads (child care counsellor 3), and ten child care counsellors (child care counsellor 2). The policy of Easton is to balance male and female staff in the cottages. However, at the time of this study, the staffing pattern as far as sex was concerned was that cottage one had eight men and seven women, cottage two and three had nine men and five women. The staff are all required to hold a B.A. degree in Child Care or the Behavioural Sciences. Most have had previous experience with disturbed young people and all, once hired, take part in a two-year in-service training program consisting of two days training per month. The training program covers the following areas: the counsellor role expectations, Easton philosophy of treatment, communication skills, human

FIGURE 2
RESIDENTIAL UNIT ORGANIZATION CHART
1978

Consulting Psychiatrists
(Sessional) -- 3

Director -- Psychiatrist
(Sessional)

Psychologist

CCC 6 -- 22989
Chief CCC

Psychiatric
Social Worker 4 - 229674

Training Coord.
CCC 5 - 229948

Program Coord.
CCC 3 - 229534

CCC 4 - 23001
Admin. Asst.

Education Program
CCC 3 - 2220476

Psyc.Soc.Wkr. 3 - 229435
Psyc.Soc.Wkr. 3 - 229351
Psyc.Soc.Wkr. 3 - 229732
Psyc.Soc.Wkr. 3 - 229864

CCC 2 - 229559
CCC 2 - 229583

Ck.St. 3 - 229708
Ck.Typ.2 - 229880
Ck.Typ.1 - 229344

CCC 2 - 229393
CCC 2 - 229823

Day Care Unit
CCC 4 - 230003

Cottage No. 1
CCC 4 - 229831

Cottage No. 2
CCC 4 - 229815

Cottage No. 3
CCC 4 - 229633

CCC 2 - 229369
CCC 2 - 229500
CCC 2 - 229807
W/Asst. 229799

CCC 3 - 220856
CCC 3 - 229666
CCC 3 - 229781
CCC 3 - 440156
CCC 2 - 229484
CCC 2 - 229609
CCC 2 - 229526
CCC 2 - 229930
CCC 2 - 229955
CCC 2 - 229542
CCC 2 - 229625
CCC 2 - 229443
CCC 2 - 229872
CCC 2 - 229658
W/Asst. 229849

CCC 3 - 229724
CCC 3 - 440149
CCC 3 - 440131
CCC 3 - 229740
CCC 2 - 229690
CCC 2 - 229682
CCC 2 - 440164
CCC 2 - 229419
CCC 2 - 229997
CCC 2 - 229427
CCC 2 - 229575
CCC 2 - 229567
CCC 2 - 229385
CCC 2 - 229468
W/Asst. 229914

CCC 3 - 229898
CCC 3 - 229906
CCC 3 - 229757
CCC 3 - 229971
CCC 2 - 229963
CCC 2 - 229773
CCC 2 - 229518
CCC 2 - 229591
CCC 2 - 229922
CCC 2 - 229641
CCC 2 - 229377
CCC 2 - 229492
CCC 2 - 229450
CCC 2 - 229401
W/Asst. 229617

CCC = Child Care
Counsellor

growth and development, basic child care skills, and an introduction to treatment techniques. There is also a supervisor training program focussing on supervisory skills.

The personal characteristics that are sought by the Easton supervisory team when hiring staff are "genuineness", "openness", "energy", "flexibility", "warmth", "appropriate aggression", and a "desire to grow". These qualities then create the "ability to form effective interpersonal relations with other staff," that is, to help form a cohesive team. The presence of these qualities is determined through the subjective judgement of the hiring team during several interviews, and feedback from the cottage staff observing the potential employee on a trial shift. This high value placed on certain personal characteristics in staff and their general ability to relate to each other and their clients is paralleled in the writings of Bettelheim (1974), who stresses the psychological and social development of staff, stating that such staff must be "true to themselves" and have a basically strong ego as well as a personal desire to grow and become more integrated. Easson (1969) also states,

In the diagnostic and treatment process, therapeutic personnel are obliged to use their own reactions and intuitions as valid diagnostic clues. Such total treatment involvement requires a high level of individual integrity and personal strength in every member of the treatment personnel (p. 60).

Also pertinent here are the three personal characteristics which Traux and Mitchell (1971) consider to be essential in any effective therapist. These are genuineness, the ability to accept the client and so create trust, and the ability to empathize with the client.

The total cottage staff are spread over three shifts per day, with an hour overlap of day and evening shifts to facilitate daily group meetings. There are usually three to four staff members on the day and evening shifts, and one on the night shift.

Each child care counsellor is assigned a supervisor who conducts regular supervising sessions with the supervisee. The cottage supervisors are in turn supervised by the chief child care counsellor who reports directly to the Director of the unit, a position held by a psychiatrist. The supervision of staff at Easton has as its ultimate goal not just the monitoring of staff job performance in task and interpersonal functioning, but the growth and training of the staff towards their highest potential.

The staff at Easton have been relatively constant for the last few years. In July, 1979, the mean for Easton child care staff, as far as length of stay at Easton was concerned, was approximately three and a half years (See Table 21, Appendix C). The shift workers at Easton work seven and a half hour shifts on a modified four day - five day rotation schedule (four days on, two days off, and five on, and three off) with some changes including four or five days off after five midnights. The cottage supervisor works a regular day shift. This shift pattern can result in treatment disruption and inconsistency due to absences of key staff at crucial times. This factor makes the cohesion and teamwork of the staff group and good communications patterns even more essential. Staff are occasionally moved from cottage to cottage to complete staffing lines or balance team strengths and weaknesses.

The administration and decision making process in the unit operates on a hierarchical accountability model in keeping with the bureaucratic demands of the civil service. However, the nature of the task obligates staff to find "efficient, effective, and humane ways of relating in the organization" (Clarke et al., 1977). As a result, there is a value placed on participation, feedback and group consensus in the decision making process at Easton.

The creation of a therapeutic environment is seen as the mutual responsibility of all members of the staff team, who engage in peer supervision

and feedback. The underlying belief here is that the use of arbitrary authority causes "resentment, rigidity, and undermining" (Clark et al., 1977). Thus, there is a great emphasis at Easton on including all people affected by decisions in the decision making process, and valuing peoples' personal feelings, ideas, and preferences. A decision such as a staff move from one cottage to another (which happens fairly regularly), for example, will be discussed in a meeting of all the unit supervisors, discussed with the staff to be moved and the cottage shifthead group before being recommended to the administration group (consisting of area supervisors, the Director, and social work supervisor) for ratification.

Client Organization: Admission Criteria

The factors operating in the decision to admit or not to admit an adolescent to Easton are listed below. It should be understood that Easton is a "last resort" resource. Community resources such as mental health centres, therapeutic foster and group homes, and psychiatric consultation have first been tried and found insufficient. All avenues possible are tried before taking the serious step of placing the client in a residential institution.

There are two general principles concerning admission to Easton. First, does the client need the Easton program? Specifically, is the client at risk in the community? Is he hurting others or himself, and have all the community resources been exhausted? Second, can the client benefit from the Easton program? Such factors as I.Q. and motivation must be considered here. Easton is a relatively sophisticated program demanding a certain verbal and conceptual ability, and for this reason Easton does not accept clients below the dull-normal range of I.Q. (a score of at least 80 on the Weschler Intelligence Scale for Children) and prefers I.Q. to be in the normal range. Environmental factors and possible deprivation that may lead to lowered I.Q.

scores are factors that are taken into account. The client's motivation has to be at least at the level where there is some recognition of his or her problem. Some clients do not complete the assessment due to their unwillingness or that of their family. Other clients continually run away in the first month, making treatment impossible.

It seems appropriate here to quote directly from the Easton referral form, which states that Easton is

"geared to treat severely emotionally disturbed adolescents, including those who are depressed, potentially suicidal, psychotic, borderline psychotic, suffer significant arrested emotional development, display confusion in sexual identity, suffer impaired interpersonal relationships, act out as a manifestation of an emotional disorder, or exhibit symptoms related to situational crises during adolescence. We do not treat those who suffer gross intellectual impairment, are deemed hard-core delinquents or anti-social characters, or those who have displayed repeated patterns of law breaking or running away. This is due to the fact that the treatment cottages are open with little facilities for containment."

Privileges, Rules, and Penalties in the Cottage

For a period of two weeks after admission the client is not allowed phone privileges, outings, or contact with his or her family. The client is assigned a "treatment team" of two or three "key" workers who assess his needs and formulate a treatment program, which is presented to the rest of the staff group for discussion and approval (A sample treatment sheet is included in Appendix E). These key workers work with the client in one-to-one psychotherapy, and with the family in family counselling sessions. As the client gradually progresses, he or she is included into more group sessions, progressing from planning groups (to plan the day) to asking groups (to ask for privileges, feedback, etc.) to group therapy sessions.

The client can also lose or gain privileges such as "on grounds" that is being able to walk around the complex grounds unsupervised; "off

grounds", that is being able to walk to a store, etc.; and "six hour walks" where the client can leave the grounds unsupervised for six hours. Attending a certain group can be a privilege, as can being able to leave your room during the daily staff meeting (3:00 p.m. to 4:00 p.m.). The details of this privilege structure may vary slightly from cottage to cottage, but the concept, that of the client moving towards more self-control, freedom and responsibility, is the same.

The basic rules of the cottage are:

1. No drugs or alcohol allowed on the premises.
2. No sexual activity to take place between residents.
3. Physical violence is not acceptable in the cottage, either to self, others, or community property.
4. No admission to the wing of the building designated for the opposite sex.
5. The residents are expected to complete regular clean-up and community maintenance duties.
6. No smoking in the bedroom wings.
7. No running away (perhaps the most basic rule in an "open door" setting).

The penalties employed in the cottages are:

1. Room confinement for certain periods of time.
2. Loss of privileges or fines from the client's allowance.
3. Locked room placement.
4. Drugs (used as little as possible).
5. Physical restraint (used briefly for crisis management).
6. Discharge (for infractions such as constant running away).

The emphasis in the program, however, is on confrontation by the staff and by the rest of the community rather than automatic consequences and rewards. The general focus is on the client taking more and more responsibility as he moves towards discharge, for instance, participating in drawing up his own treatment proposals (which are regularly reviewed) and discharge planning. Generally, the client is seen by the Easton staff as moving through three phases: resistance to treatment, working through of problems, and separation from Easton.

The use of drugs at Easton is kept as minimal as possible, and used only to control violent behaviour or very high anxiety. In July, 1979, five out of 30 clients were being administered drugs as part of their treatment program. Four of the clients were on major tranquillizers, and one on anti-psychotic medication. Two of these clients were in cottage one, two in cottage three, and one in cottage two (not included in these figures are two clients in cottage one taking long-term medication to control epilepsy).

General Philosophy of Residential Treatment Operating at Easton

The main threads in the ideology of the Easton unit since the beginning has been the concept of the therapeutic community (Jones, 1953) and the belief as stated here by the first Director that "the basis of therapy is good individual relationships between the counsellors and children within a therapeutic milieu which caters to adolescent needs" (Mental Health Branch Report, 1969). The influence of the therapeutic community model can be seen in the emphasis on community, group process, and interaction among kids and staff as the main therapeutic tool, and among staff as a unit management modality; in the focus on consensus and participation in the decision making process; in the emphasis on "open communication" between staff and client, staff and staff, and client and client; the focus on responsibility, both in

clients' treatment and in staff development; the twenty-four hour a day nature of the Easton therapy program; and the constant attempt to create an emotional climate of warmth and acceptance.

The therapeutic community model springs out of the psychoanalytic tradition. This can be seen in the primary emphasis placed on relationship as a therapeutic tool, in the significance given to the dynamics underlying behavioural patterns, and in the value attached to the gaining of insight. However, this model is also a reaction to psychoanalytic tradition in that it focusses on the healthy functioning part of the client, emphasizing the client's responsibility for his behaviour patterns and the therapeutic significance of his social interactions.

Another offspring of the psychoanalytic tradition, ego psychology, is significant in the whole field of residential treatment and is particularly pertinent to adolescent clients who can be viewed as engaging in the process of trying to build an ego, that is, a set of functions, coping mechanisms, and defenses to cope with inner drives and outer realities. In discussing the life-space interview, a technique used extensively at Easton, Wineman (1959) refers constantly to the ego building goal of such intervention.

The treatment philosophy of Easton has also been influenced by learning theory with its emphasis on modelling and social reinforcement, and by the ecological model with its focus on the creation of a supportive milieu, and treatment techniques such as family therapy.

The treatment goals and direction are encapsulated in part of the introduction to the assessment form thus:

"Treatment is designed to reverse psychopathology, promote interpersonal relationships, personal growth, life skills and responsibility. These goals are achieved by living in a consistent, supportive, and caring milieu where staff serve as healthy role models and where adolescents are encouraged to participate in age appropriate activities.

The staff work towards improved relationships between peers and involve the adolescents in individual, group, and family therapy aimed at resolving the client's underlying problems. Much emphasis is placed on personal hygiene, daily chores and other responsibilities and skills necessary for the client's return to the community."

The key words here are "growth", "Milieu", "relationships", and "underlying problems". These concepts place Easton in the context of Whittaker's (1979) third model of residential treatment, which is essentially a merging of the more modern ego-orientated psychotherapeutic tradition and learning theory, with some input from the ecological and therapeutic community models. The strong emphasis on staff, and the interaction between the staff is more unique to Easton, but reflects similar values found in the work of Bettelheim (1974) and Jones (1968).

The high priority given to the training program reflects the high value which the unit places on the personal growth and development of the staff which will then, in the context of the Easton philosophy, be reflected in and passed on to the clients with which the staff work. The focus on relationship, interaction with peers, and personal responsibility begins with the staff group. The chief child care counsellor gave her view of Easton's philosophy as, "treatment based on staff growth and communication."

The shift change meeting, which is held every day in the cottages, is divided into two sections. The first section is dedicated to staff emotive communication and feedback or "process", and the second section to business issues. This "process" is seen as crucial to the forming of cohesive, supportive staff teams which can then create a therapeutic environment. One of the goals here is, as the Child Welfare League of America (1972) suggests, to make sure issues are openly worked through among staff, and not "worked out upon and through the patients." Here the staff attempt to practise skills which they hope to role model for their clients. These

include self-awareness, emotional honesty, the ability to hear and give feedback openly, and to relate to others supportively, together with the taking of personal responsibility for one's life-style and circumstances.

Program and Daily Routines

The primary therapeutic agents in the unit are seen to be the following:

- a. Residential living itself with its duties, problem sharing, conflict resolutions, and day to day interaction with adults and peers.
- b. Community meetings and therapy groups with their emphasis on interpersonal communication, social interaction, and insights into the dynamics of behaviour.
- c. The one-to-one relationships with key staff involved in creating awareness of problem areas, working through conflict resolution, creating emotional catharsis and teaching alternate behaviours.
- d. The family counselling sessions which, hopefully, allow the client to re-examine the family relationships and reassess his position as part of the family.
- e. The learning experiences encountered in the arts and crafts, recreation, and school programs.

During the five weekdays, residents are awakened by one of their members (chosen by roster) and come to breakfast at 8:30 a.m., beds being made immediately after breakfast. The residents then meet for a planning group to set up the day's events. In the morning, there will be either a group of some kind or an activity such as school, arts and crafts time, pool or gym activities, etc. In addition, in the afternoon, there may also

be family conferences or individual therapy sessions, as well as shopping trips, etc. During the shift meeting from 3:00 p.m. to 4:00 p.m., the adolescents are in their rooms where they do homework, play games, etc. Supper is at 5:00 p.m. and the evening time if no group is scheduled, is free for relaxation, T.V., games, discussion, etc., except for one hour of school homework time supervised by the staff. Bedtime is set for 10:00 p.m. with lights out at 10:30 p.m. The weekends are more flexible. Wakeup and bedtimes are later. Some residents leave Easton for home visits, others go on outings with the staff, or simply relax in the cottage.

The staff are assigned to recreation and arts and crafts programming. This includes individual gym programs, a skiing program, summer camping programs, arts and crafts classes, and art therapy sessions once or twice a week for selected clients.

Three staff are also assigned to the school program. Until 1974, the basic policy of Easton concerning education was, to quote a report (1972) to the Mental Health Branch, that "the child is so involved in the process of therapy as to make cognitive achievement out of place." Since that time, the school program has grown to the point where all clients at Easton are given an educational assessment and placed on an individualized educational program. However the staff to client ratio, and thus the quantity of schooling given, is seriously inadequate (for some clients as little as three hours per week) especially since most of the Easton clients have experienced considerable difficulty in school and are in need of intensive individualized, often one-to-one teaching.

To be effective, the school approach also has to be closely integrated with the cottage's general treatment plan for a particular client. As Whittaker (1979) points out, a low priority is frequently given to formal education in residential treatment centres. The reasons for this are complex.

Perhaps the most obvious is that such centres usually come under the auspices of Health rather than Education. Professional divisions can also create very real problems in the integration of such elements as formal education into a unified treatment plan. If the client is to function adequately in the community after discharge, however, a full creative educational program geared to the client's individualized learning style would appear to be essential.

Additional therapeutic services at Easton include music therapy sessions once a week for a selected number of clients, and an alumni group held once a week for discharged clients or those close to discharge, to help these latter clients deal with the problems of separating from Easton and reintegrating back into the community.

There is also an aftercare program which is extended to most clients who complete their treatment at Easton, if they are staying in the surrounding area. This consists of a number of conferences with the client and his guardians over a period of three months. They are conducted by the counselors or social worker with a view to helping the client reintegrate successfully into the community.

CHAPTER III

THE STUDY

Definition of Terms

Emotional Disturbance:

William Rhodes (1977) points out that each theory in the behavioural sciences defines "emotional disturbance" differently. For example, it can be seen as a disability, or as deviance, as a lack of fit between individual and environment, or as a dysfunctional set of learned habits. He states, however, that all the models speak of "a human system in distress" and a "disrupted pattern of human-environmental exchanges."

The California Department of Education (1959) state that children may be considered emotionally disturbed when they usually exhibit such primary symptoms as:

1. Inability to have effective relationships with peers and adults.
2. Inappropriate behaviour or feelings under ordinary conditions.
3. A general pervasive mood of unhappiness or depression.
4. A very poor self-concept.
5. Inability to face reality.
6. Inability to cope with the learning situation in spite of educational remedial measures.
7. A tendency to develop physical symptoms, speech problems, pains or fears associated with personal problems.

In addition, Kirk (1972) states that emotional disturbance is a "deviation from age appropriate behaviour which significantly interferes

with the child's growth and development and/or the lives of others" (p.389).

These definitions are all congruent with the concept of emotional disturbance operating at Easton, the residential unit in this study.

Specifically, for the purposes of this study, emotional disturbance is a pattern of behaviour, abnormal or destructive enough (to staff and others) to have caused concern among parents, social workers, and other mental health professionals to the extent that the client in question was considered in need of residential treatment, and thus referred to Easton. The specific symptom patterns labelled emotional disturbance in this context include: bizarre or psychotic behaviours such as wrist slashing; anti-social behaviours such as fire-setting or violence to others; and developmental problems, such as learning disabilities resulting in truancy, confusion as to sexual identity or school phobia.

Adolescent

For the purposes of this study, an adolescent is a person between the ages of twelve and seventeen years.

Treatment Environment or Cottage Atmosphere

For the purposes of this study, cottage atmosphere is defined as those aspects of the environment measured by the Community Orientated Program Environment Scale (Moos, 1974) hereafter referred to as the COPES. There are three dimensions in this instrument: the Relationship dimension, including the subscales, Involvement, Support, and Spontaneity; the Program dimension, which includes the subscales, Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression; and the System Maintenance dimension, which includes the subscales, Order and Organization, Program Clarity, and Staff Control. Definitions of these variables are given in Appendix A.

Cohesion

For the purposes of this study, cohesiveness is conceptually defined as attraction to the group or resistance to leaving. This is the definition upon which the index of cohesion used in this study is based. Operationally, in the Seashore Cohesion Index (Seashore, 1954) a group will be said to have a high degree of cohesiveness if its members:

1. perceive themselves to be a part of a group,
2. prefer to remain in the group rather than leave,
3. perceive their group to be better than other groups with respect to the way members get along together, help each other and stick together.

Residential Treatment

In this study, residential treatment can be defined as the Easton program which consists of a full time, twenty-four hour a day, therapeutic process, in a community specialized to the needs of the clients, and integrating various modes of intervention, such as group therapy, family therapy, and individual psychotherapy, into an individualized treatment plan. All facets of the client's life in residence are seen as providing opportunities for learning and growth; the milieu itself, and the relationships therein are the primary sources of intervention.

Population

The subjects in this study consist of two groups, clients and staff, living or working at the residential treatment centre, Easton, in July, 1979.

Clients

This group consisted of 31 emotionally disturbed adolescents displaying various symptoms (see Chapter II). In July, 1979, there were ten clients in residence in Cottage One (officially eleven, but one client was

a prolonged runaway case), ten in Cottage Two, and eleven in Cottage Three, one of whom was omitted from the study since she was on the point of discharge, and also too psychotic to complete the test given to the clients. Cottage Two contained five boys and five girls, whereas Cottages One and Three each contained six boys and four girls.

The average age of these clients was 15 years, 3 months. The ages of the clients differed slightly from cottage unit to cottage unit as follows: In Cottage One the average age of clients was 15 years, 8 months; in Cottage Two, 14 years, 9 months; in Cottage Three, 15 years, 1 month. The clients in residence in Cottage One at the time of the study were then slightly older than in the other two cottages (see Table 26). The average length of stay in residence for the Easton clients at the time of the study was 6-7 months. In Cottage One the average length of stay was slightly higher (7.9 months) than in the other cottages (see Table 25). The clients were admitted from group homes and foster home placements as well as from their own home setting (see Table 23).

In terms of severity of disturbance, the only two categories that seem clearly defined in the literature with predictive value as far as outcome is concerned are a psychotic/non-psychotic diagnosis, formulated before or on admission to residence. At the time of this study, Cottage Two contained one client so diagnosed, while Cottages One and Three each contained two psychotic clients.

The most frequent official diagnosis given on admission to Easton clients is "adjustment reaction of adolescence". This and other such diagnostic categories were not considered specific enough to be useful in this study. The social workers in each cottage, however, were asked to subjectively rate their clients as to poor, fair and good prognosis.

The results can be found in Appendix C, Table 24.

On an individual level the severity of disturbance of the clients in the cottages seems similar, albeit that this is a difficult factor to delineate.

The socio-economic status (SES) of the Easton clients is difficult to calculate due to the variability of placement before admission, SES usually being calculated on the parents' education or occupation. However, in a previous study (Neill, 1976) the client population at Easton was generally described, based on father's occupational category, as approximately "one half lower class, one quarter middle class, and one quarter upper class."

Easton does not accept clients below the normal range of I.Q. (a score of at least 80 on the Weschler Intelligence Scale for Children) although other factors that may lower I.Q. scores, such as environmental deprivation, are taken into account. As far as school performance is concerned, at the end of the 1979 school year, a rough estimate of clients' educational level in the Easton school program calculated that approximately 20% of the population were performing at their age-appropriate grade level; 20% on the other hand were remedial, that is at least two grades behind their age-appropriate grade level in English and Math; and the remaining 60% were clients for whom behavioural and emotional problems seemed to block consistent academic achievement. These three categories of clients seemed to be distributed fairly evenly over the three treatment cottages.

The pattern that seems to emerge here is a similar one for each cottage group. No one cottage seemed at the time of the study to vary greatly with respect to the number, gender, age, and length of time in residence of its client population, or with respect to the severity or kind of disturbance in that population.

The chief factor in the assignment of clients to cottages is the availability of beds. However, there is some attempt to avoid placing more than two clients who have been diagnosed psychotic in any one cottage at any one time.

The Staff

The Easton staff consists of 45 child care counsellors, with support staff consisting of social workers, administrators, consulting psychiatrists, and specific program staff. The cottage team of child care counsellors are the primary therapists and the creators of the therapeutic environment. This study, therefore, has focussed on these teams. The staff in the three cottages, 15 in each, were similar with respect to professional training (see Chapter II), length of time employed at Easton, and length of time spent in their present cottage (see Tables 21, 22).

The fact that they were selected for employment at Easton and have generally remained there for a considerable amount of time (average length of stay in July, 1979, was 3.5 years) suggests that they possess certain similarities as far as the personality traits that are required from and valued by the Easton staff as a whole.

The role expectations, supervisory structure and job routines for these staff members are standardized across the unit as a whole. The similarity concerning treatment philosophy between the staff in all three cottages is reflected by the lack of a significant difference between these groups as measured by the COPES Scale, Form I, which measures the group's perception of an ideal treatment environment (Moos, 1974).

If the staff as individuals and as counsellors shared many similarities, however, there was one significant difference between the staff groups as perceived by the Easton supervisory team. This difference was in

relation to the cohesiveness of the staff teams. For some time before July 1979, the consensus of the supervisory team was that Cottage Three staff formed a highly cohesive team, whereas the Cottage Two staff were experiencing considerable difficulty in this area. Concern was frequently expressed in the weekly supervisory meetings about this state of affairs and its perceived effect on the capacity of the Cottage to offer effective treatment to its residents.

Administrative steps were taken shortly after July, 1979, to change the configuration of staff in Cottage Two and to provide more support to the Cottage Two supervisors, with the hope of increasing the perceived effectiveness of the cottage team. The supervisor of Cottage Two described the situation for the year leading up to the time of this study as being one in which unresolved staff conflicts, poor communication, the formation of subgroups and cliques, and a general climate of lack of trust regarding the expression of feelings and individual differences in the staff group led to a low level of treatment effectiveness. This supervisor stated to the researcher that, in his opinion, the standard of staff interaction had improved somewhat during the year but was still inadequate, and thus the cottage was only able to provide a relatively low level of treatment. The specific ways in which this lack of cohesiveness among the staff affected the treatment environment were not completely clear, however, the consensus among cottage staff and supervisory staff was that it did indeed do so.

Instruments

Cohesion

The instrument used to measure staff cohesion was the Seashore Group Cohesiveness Index (1954). This index measures group cohesiveness, defined as attraction to the group or resistance to leaving, and morale, or percep-

tion of the group in relation to other groups. The measure consists of three questions:

1. Do you feel that you are really a part of your work group?
2. How would you feel about moving to another work group?
3. How does your group compare to other groups on each of the following points: The way in which people get along together; the way in which people stick together; and the way in which people help each other on the job.

The first two questions can be answered by one of five choices, and the three items in the third question can each be answered by one of three choices (see Appendix A).

The original study using this instrument was a study of 228 section shift groups in a company manufacturing heavy machinery, and attempted to relate group cohesion to productivity level. This instrument is the instrument of choice in modern research concerning the group cohesion variable (Mikalachk, 1969; and Wheaton, 1974).

Seashore states (1954) concerning the validity of the instrument,

The first two criteria appear to be relatively pure translations from the formal definition of cohesiveness as attraction to group. The third criterion is in two respects less satisfactory. The definition requires an 'objective' (i.e. not self-evaluational) measure of the degree of attractiveness. The available measures, however, appear to include kinds of relationship among group members other than those implied by mutual attractiveness. In addition, since the available measures are in terms of self-evaluation of the group, they contain an element of general satisfaction with the group, perhaps properly called 'morale'. These instrument problems could not be avoided without impaired reliability and without omission of an aspect of the definition of the variable to be measured. It is not possible to determine the extent to which the cohesiveness measure is thus contaminated. However, the possible presence of these extraneous elements suggests a degree of caution in interpreting an obtained relationship between the cohesiveness measure and measures of effect (p. 36).

The variance found between groups on this scale in this study was significant beyond the .001 level.

Table 31 shows the degree of intercorrelations among the responses to the questions in this index. Seashore (1954) states, "These correlations are judged to be sufficiently high to justify the conclusion that there is a common element in the responses to the five questions. This lends support to their combination into a single index of cohesiveness." The intercorrelations among mean scale values for the groups on scales comprising the index of cohesiveness ranged from .15 to .70 in Seashore's study. Mikalachki (1969) reports that he tested the reliability of the Seashore Scale for his sample by means of an item-test correlation described by Guilford (1950). The reliability of the Seashore Scale in this case was .979, which was significant at the .001 level of confidence.

Environment Scale

The instrument used to measure Treatment Environment was the Community Orientated Programs Environment Scale compiled by Moos (1974), Forms R (real) and I (ideal). This instrument will be referred to as COPES. The measure contains three dimensions: Relationship, Treatment Program, and System Maintenance. There are three subscales measuring the Relationship dimension. These are Involvement, Support, and Spontaneity. There are four subscales measuring the Treatment Program dimension. These are Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression. Lastly, there are three subscales measuring the System Maintenance dimension: Order and Organization, Program Clarity, and Staff Control. A definition of these subscales and the test itself can be found in Appendix A. The COPES items are to be answered true, if an individual believes they are generally characteristic of his program, and false, if he believes they are not generally characteristic of the program.

The COPES instrument was developed directly from the Ward Atmosphere Scale compiled by Moos (1974) and is conceptually identical and methodologically very similar to this instrument. Moos, in his book, Evaluating Treatment Environments (1974) states, concerning the formulation of the Ward Atmosphere Scale (WAS) that,

the choice of items was guided by the overall concept of environmental press (Pace and Stern, 1958) that is, an item had to identify characteristics of an environment which could exert a press toward Involvement, towards Autonomy, and so on. For example, an emphasis on Involvement is inferred from the following items: 'Members put a lot of energy into what they do around here,' and 'This is a lively place.' (p. 37).

He also states concerning the formulation of the COPES instrument that "some of the items were direct translations from similar items in the WAS, others were worded somewhat differently to obtain better item splits in community programs" (p. 228). Moos states that the criteria by which he derived the COPES were: First, reliability and validity; second, not more than 80% nor less than 20% of subjects should answer an item in one direction, (this criterion was established to avoid items that were characteristic only of extreme programs); third, there should be approximately the same number of items scored true as scored false, within each subscale, to control for acquiescence response set; and fourth, items should not correlate significantly with the Halo Response Set Scale, which assessed both positive and negative halo in the program perceptions.

The COPES manual states that a broad range of American and British programs were included in the normative sample, which currently numbers 54 programs. These programs include adolescent residential centres, the subject of this study, halfway houses, and day care centres. Some could be classed as transitional residences for former mental patients, some as alternatives to hospitalization.

Table 27 gives the means and standard deviations of Form R subscales over the 54 programs, separately for members and staff. The logic of having separate member and staff norms was derived from results with the WAS on which the COPES scale was based. Here there was often a considerable discrepancy between patient and staff perceptions of hospital based treatment programs. Moos points out that this "two subculture" notion has proved in COPES results to be less applicable to community based programs, although the directions of the differences which do exist are consistent with those found on wards, i.e. staff see treatment programs more positively than do members.

Table 28 gives the internal consistencies (Kuder-Richardson Formula 20) and average item subscale correlations for each of the ten subscales for members and staff, on Form R, in the initial group of 21 programs. Internal consistencies were calculated following Stern (1970) using average within-program item variances. The subscales have acceptable internal consistency and moderate to high average item to subscale correlations.

Table 29 gives the intercorrelations of the 10 subscale scores for the same 21 programs. The highest intercorrelation is .50, and the only cluster of subscales which show even moderate intercorrelations in both member and staff samples was composed of the Relationship dimensions of Involvement, Support, and Spontaneity. It thus appears, as Moos states, that the 10 subscales measure distinct, albeit correlated characteristics of member and staff perceptions of program atmosphere.

The results of one-way analysis of variance indicated that all 10 subscales significantly differentiated among the 21 programs for both member and staff responses. The COPES manual states that the proportion of subscale variances accounted for by the differences among these programs varied from a low of 5 percent on the Practical Orientation subscale for staff, to a

high of over 50 percent on both Autonomy and Order and Organization subscales for staff, indicating that the percentages of variance accounted for by differences among programs may be quite substantial.

Test-retest reliability, profile stability and the relationships of the subscales to the background variables of the respondents and to social desirability scales have been generalized from the WAS where these factors were all found to be satisfactory. Moos states in the COPES manual (1974),

Since the content and structure of the ten COPES and ten WAS subscales are directly parallel, and since patient and staff characteristics in these two types of programs are closely comparable, these results may be generalized as applicable to COPES (p. 8).

In Form I of the COPES, the Form R items and instructions have been reworded so that members and staff can answer them for the type of program they would ideally like. The means and standard deviations for the American normative sample are found in Table 30. The average item to subscale correlations for the ten subscales varied from .35 to .55. The subscale internal consistencies varied from a low of .70 for Program Clarity to a high of .88 for Personal Problem Orientation, and thus were quite substantial for both member and staff samples. Moos states that Form I has "adequate psychometric characteristics" (COPES manual, 1974). As to the uses of Form I, Moos suggests that it may be used in conjunction with Form R to identify specific areas in which members and staff feel change should occur, or by itself to assess the general value orientations of members and staff in a program. Form I is directly parallel to Form R, i.e. the scoring keys for the two forms are identical.

Other Measures

In addition to the cohesion and environment measures, two sociometric questions concerning preferred work partners and social friendships

were included with the cohesion scale. A questionnaire was also given to the social workers of each cottage concerning the clients' diagnosis on admission, prognosis, social skills, and length of stay in the cottage. The files and records at Easton were used to ascertain for the cottage staff groups duration of Easton employment and present cottage placement. The files were also used to specify the average length of stay, at the time of measurement, for the clients in each cottage group. The amount of time clients spent in the locked room during July, and the number of client run-aways, and acts of violence in each cottage during this time were also taken from Easton records.

Data Collection Procedures

Data collection took place in July-August, 1979. The cohesion index sociometric questions, and COPES Form R were given as a packet to each staff on July 4th. A covering letter was included (see Appendix B). Before this time the researcher had attended staff meetings and supervisory meetings to acquaint the staff with the study requirements. The nature of the study was not discussed; the main topics were, first, the need for the quick completion of the instruments by the entire staff, and second, the absolute necessity for complete independence, lack of collaboration and discussion among staff concerning these instruments during the study period.

A small number of the staff were on vacation at this time. These staff were contacted previously, and the tests were mailed to their homes, completed and returned when they resumed work.

Confidentiality was also a priority. The measures were numbered by a secretary and returned to her. She then forwarded the completed measures to the researcher. The COPES Form I was distributed to the staff three weeks later in the same manner.

The COPES Form R was also taped (tape recordings were used in the norming sample) and given to each client group in the same setting on the 18th of July. The answer sheet was deemed too confusing for client use, so a larger ditto format was used, and answers were indicated by T or F rather than with ticks in boxes as in the published answer sheet. The instructions used in the tape recording can be found in Appendix B. Moos himself suggests such modifications in the test manual.

The social workers also received their questionnaires at this time, and other relevant information was taken from files and records.

The staff and clients were extremely cooperative throughout the study. Only one staff neglected to return the measure, reducing the number of staff subjects in Cottage Three to 14. Three staff in each cottage also refused to answer the sociometric questions, and the researcher received considerable feedback that these questions were objected to by a considerable number of those who did in fact complete them. The researcher was assured by the supervisory staff that no collaboration or discussion concerning the measures was taking place.

All test scoring was checked for errors. One error was found and corrected.

The computer programs used in the analyses were: S.P.S.S. (Nie et al., 1975), MULTIVAR (Finn, 1972), LERTAP (Nelson, 1974) and ANOVA 11 (Carlson and Hazlett, 1971).

Data Analysis Procedures

The data analysis was divided into three stages. The preliminary analysis consisted of an item analysis of the Seashore Group Cohesiveness Index and the Community Oriented Programs Environment Scale (COPES) to ascertain the reliability and the validity of the above instruments. Also

a one-way analysis of variance (ANOVA) was used to ascertain if there were significant difference between the cottage staff groups on the factor, group cohesion.

The effect of levels of Cohesion on the staff's perception of the treatment environment as reflected in the COPES instrument, Forms R and I was then analyzed using multivariate analysis of variance (levels of cohesion by subscales in COPES). The effect of levels of staff cohesion on the client perception of the environment was analyzed, using a one-way analysis of variance and related to the frequency of such behaviour as client runaways.

The third stage of the analysis consisted of an examination of the profile of the Easton program as it is perceived by clients and staff in relation to the COPES normative sample and the stated philosophy and focus of the Easton centre.

Hypotheses were tested allowing a Type I error probability of .05. Differences among levels for a particular factor were examined, using Tukey's procedure (Glass and Stanley, 1970).

The sociometric scores obtained from the staff were discarded due to a lack of complete returns and ethical objections made by those staff who did in fact complete them.

Assumptions and Limitations

The design of this study is properly regarded as a quasi-experimental design (Campbell and Stanley, 1963) since the cottage groups constitute naturally assembled rather than randomly selected collectives, in which pre-experimental sampling equivalence can be assumed. The examination of factors such as the length of staff work experience at Easton and quality of client prognosis for each cottage, is an attempt to limit the effects of major significant variables other than staff cohesion, and ensure that the cottages were in fact genuinely comparable.

The quasi-experimental nature of the design, however, does qualify the external validity of the study; Thus generalising the results of this study to another residential treatment centre would be questionable, especially since the field of residential treatment contains such a diversity of models and patterns of program implementation, including the selection of clients for particular settings.

The question of the effect of reactive arrangements also limits the external validity of the study. It was assumed that the respondents answered the questions with candor, and did not give answers calculated to create a certain impression of their treatment cottage. The answers on the cohesion index did follow the pattern predicted by the Easton supervisory group, which suggests that on this instrument at least the responses were candid. The standardised format and instructions, and the assurance of anonymity were designed to facilitate honest responses.

CHAPTER IV

RESULTS AND DATA ANALYSIS

Stage 1: Preliminary Item and Test Analysis

The first part of the preliminary analysis consisted of an item analysis on the Seashore Cohesion Index (Seashore, 1954) and the COPES (Moos, 1974) using the LERTAP computer program (Nelson, 1974).

The means, standard deviations and reliabilities for the Cohesion Index are presented in Table 1.

Reliabilities were calculated using Hoyt's ANOVA (internal consistency) method, the reliability for the Cohesion Index being calculated at .87. However, the Cohesion Index was repeated after a period of three weeks, so that a coefficient of stability was also calculated. The value of this coefficient was .73.

Each item on this instrument correlated at a positive and adequate level with the other test items. Thus each item can be said to be performing correctly.

TABLE I
COHESION INDEX: TEST STATISTICS

	Cohesion Time 1	Cohesion Time 2	(n = 44)
Mean	15	15.64	
Standard Deviation	3.40	2.94	
Reliability (Hoyt Internal Consistency)	.87	.85	
Test-Retest		.73	

The means, standard deviations and reliabilities for the COPES Form R and Form I are presented in Tables II and IV respectively. Again reliabilities were calculated using Hoyt's ANOVA (internal consistency) method and Cronbach's alpha for the composite, here calculated at .75 for COPES, Form R, and .65 for COPES, Form I. The reliabilities of some of the subscales, especially the COPES, Form R, subscales numbered 3, 7, and 10, that is, Spontaneity, Anger and Aggression, and Staff Control, are low. However, the standard deviations for these subscales are also low, suggesting that the reliability estimate was lowered by a lack of variance.

Considering the sample as a whole, the subtest means are all relatively high. This implies that there were many items which staff answered similarly. These items, then, do not contribute to the test's ability to discriminate between individuals, thus lowering the reliability estimates.

This is to be expected in a centre such as Easton, where there is a certain homogeneity among staff and much emphasis on team work. For example, the expression of Anger and Aggression is valued highly at Easton as a cathartic force and is consistently used as such in the cottages (this is reflected in this variable's high mean value), thus a lack of variance is to be expected on such a subscale.

This phenomenon also occurs on the COPES, Form I. For example, the subtest 1, Involvement, has a low reliability and a small standard deviation.

The COPES, Form R, and Form I, subtest correlations are given in Tables III and V respectively. Again, the negative or minimal correlations occur on COPES variables, such as Anger and Aggression (variable 7) which have a very small amount of variability in their scores. However, the general lack of high correlation between subscales implies that they measure distinct but correlated program characteristics, as perceived by the staff.

TABLE II
COPEs FORM R: TEST STATISTICS, EASTON SAMPLE

Subtests	1	2	3	4	5	6	7	8	9	10	Total
Mean	17.66	17.50	17.11	15.02	15.93	18.86	19.30	14.80	17.43	16.27	169.89
Standard Deviation	1.70	1.91	1.35	1.70	1.90	1.46	.85	1.80	2.24	1.55	9.38
Reliability (Hoyt, Internal Consistency)	.53	.65	.33	.45	.55	.60	.18	.44	.72	.33	.75*

(n = 44)

NOTES: Number of Items = 100.

Raw Scores have 10 added.

*Cronbach's Alpha For Composite.

TABLE III
 COPES FORM R: TEST STATISTICS, SUBTEST CORRELATIONS

	1	2	3	4	5	6	7	8	9	10
1	--	.513	.312	.493	.556	.235	-.009	.312	.322	-.327
2		--	.275	.489	.670	.393	-.036	.497	.558	-.315
3			--	.322	.239	.032	-.009	.211	.284	-.071
4				--	.626	.254	.044	.146	.278	-.338
5					--	.325	-.045	.459	.572	-.192
6						--	.352	.140	.119	-.179
7							--	-.035	-.154	-.133
8								--	.705	.054
9									--	-.015
10										--

(n = 44)

TABLE IV
 COPES FORM I: TEST STATISTICS, EASTON SAMPLE

Subtests	1	2	3	4	5	6	7	8	9	10	Total
Mean	19.20	19.27	18.52	16.82	17.89	19.43	18.70	15.95	18.82	14.64	179.25
Standard Deviation	.90	1.26	1.02	1.50	1.87	.95	1.21	2.56	1.59	2.11	7.81
Reliability (Hoyt, Internal Consistency)	.32	.65	.37	.44	.65	.47	.45	.78	.69	.63	.65*

(n = 44)

NOTES: Number of Items = 100

Raw Scores have 10 added.

*Cronbach's Alpha For Composite.

TABLE V
 COPEs FORM I: TEST STATISTICS, SUBTEST CORRELATIONS

	1	2	3	4	5	6	7	8	9	10
1	--	.540	.335	.354	.647	.193	-.304	.456	.496	.052
2		--	.373	.309	.466	-.003	.069	.363	.454	.003
3			--	.504	.263	.074	-.229	-.044	.289	-.319
4				--	.341	-.025	-.005	-.245	.132	-.271
5					--	.277	-.066	.470	.502	.254
6						--	-.068	.209	-.101	-.024
7							--	-.484	-.306	.021
8								--	.610	.431
9									--	.340
10										--

(n = 44)

Delineation of Cohesion Levels

The final part of the preliminary analysis consisted of a one-way analysis of variance (Cohesion by the three cottage groups) using the SPSS computer program (Nie et al., 1975). Table VI shows the means and standard deviations for the cohesion factor and a summary ANOVA table is presented in Table VII.

As shown in Table VII, there was a significant difference between the cottage groups on this factor. Table VIII gives the post hoc comparisons using Tukey's procedure to determine which contrasts between cottages were significant for the cohesion variable. As can be seen from the Table, there were significant group mean differences on the factor cohesion between Cottage One and Two, and Cottage Two and Three. The contrast between Cottage One and Three, however, failed to reach the desired ($p < .05$) level of significance.

At this point the possibility of pooling Cottages One and Three to obtain just two levels of cohesion was considered. However, it is usual before pooling to test for significant differences at a relaxed alpha level of .20 (Winer, 1971), thus preventing a Type II error. But in this case, even if alpha is set at an alpha level of .10, there is a significant difference between Cottages One and Three ($.90 \text{ } q_{3, 42} = 2.99$). As a result pooling was not considered legitimate, and it was decided to consider all three cottages separately. Cottage One became synonymous with the Middle level of the factor Cohesion; Cottage Two with the Low level of Cohesion; and Cottage Three with the High level of Cohesion.

These three levels of the factor Cohesion now became the independent variables in the next stage of the analysis.

TABLE VI
COHESION INDEX -- MEANS AND STANDARD DEVIATIONS

Cottage	One	Two	Three
Means	15.87	11.53	17.79
Standard Deviation	2.36	2.69	1.18

TABLE VII
SUMMARY ANOVA -- COHESION INDEX

Sources of Variation	SS	MS	D.F.	F
Between	300.17	150.09	2	31.11*
Within	197.82	4.83	41	

* $p < .05$; .95 F 2, 41, = 3.23

TABLE VIII
COHESION INDEX: POST HOC COMPARISONS

Contrast Ψ	Observed Value $\bar{\Psi}$
$\Psi_1 = \mu_{.1.} = \mu_{.2.}$	7.65*
$\Psi_2 = \mu_{.1.} = \mu_{.3.}$	3.38
$\Psi_3 = \mu_{.2.} = \mu_{.3.}$	11.04*

NOTES:

$\mu_{.1.}$ = population mean corresponding to Cottage One.

$\mu_{.2.}$ = population mean corresponding to Cottage Two.

$\mu_{.3.}$ = population mean corresponding to Cottage Three.

$\bar{\Psi}$ = observed values at Ψ using corresponding sample means.

* $p > .05$; $.95 q_{3, 42} = 3.44$

Stage 2

Effects of Staff Cohesion Level on Treatment Environment

The effect of the levels of Cohesion on the staff's perception of the treatment environment as reflected in the COPES instrument, Forms R and I, was analysed using a multivariate analysis of variance (MANOVA).

The means and standard deviations for COPES, Form R, and COPES, Form I, are presented in Tables IX and X, respectively. Table XI shows the summary MANOVA table for COPES, Form R. Table XII gives the summary MANOVA table for COPES, Form I.

As shown in Table XI, there was a significant cohesion effect ($p < .05$) on the staff perception of the real treatment environment, as reflected in the scores on the COPES, Form R. The univariate F statistics for the subscales are also shown in Table XI. The subscales: Support (2), Autonomy (4), Practical Orientation (5), Personal Problem Orientation (6), and Staff Control (10) showed a significant cohesion effect.

Table XIII shows the post hoc comparisons for the effect of levels of cohesion on the COPES Form R subscales, using Tukey's procedure. These comparisons yielded the following results:

1. On the variables, Support and Personal Problem Orientation, Cottage Two (low cohesion) is significantly lower than the other cottages.
2. On the variable, Autonomy, Cottages One and Two are significantly lower than Cottage Three.
3. On the variable, Practical Orientation, Cottage Two is significantly lower than Cottage Three.
4. On the variable, Staff Control, Cottage Two is significantly higher than Cottage Three (high cohesion).

TABLE IX
OBSERVED CELL MEANS AND STANDARD DEVIATIONS
COPEs FORM R

Variables		1 Involv.	2 Supp.	3 Spon.	4 Auto.	5 Pract.	6 Pers.	7 Anger	8 Order	9 Clarity	10 Control
Cottage Groups	1 (MID.CO.H.)	17.80 1.57	18.33 1.35	17.13 1.06	14.73 1.91	16.00 1.65	19.60 .63	19.60 .74	15.07 1.98	17.67 2.09	16.27 .96
	2 (LOW COH.)	16.93 1.83	16.13 1.99	16.60 1.24	14.20 1.42	14.87 1.96	17.93 1.75	19.13 .83	14.40 2.03	17.07 2.91	17.27 1.58
	3 (HIGH COH.)	18.28 1.49	18.07 1.59	17.64 1.59	16.21 1.05	17.00 1.52	19.07 1.27	19.14 .95	14.93 1.33	17.57 1.55	15.21 1.37
	Program Means	17.7	17.5	17.1	15.0	15.9	18.9	19.3	14.8	17.4	16.3

Mean

Stand.
Deviation

TABLE X
OBSERVED CELL MEANS AND STANDARD DEVIATIONS
COPEs FORM I

Variables		1 Involv.	2 Supp.	3 Spon.	4 Auto	5 Pract.	6 Pers.	7 Anger	8 Order	9 Clarity	10 Control
Cottage Groups	1 (MID.CO.H.)	19.00 1.07	18.73 1.91	18.33 1.35	17.27 2.05	17.73 2.19	19.40 .91	18.80 1.01	15.13 2.67	18.53 1.77	14.87 2.13
	2 (LOW COH.)	19.47 .64	19.67 .49	18.60 .74	16.60 1.29	18.27 1.79	19.40 1.18	18.00 1.31	17.60 2.03	19.60 .74	14.87 2.39
	3 (HIGH COH.)	19.14 .95	19.42 .76	18.64 .93	16.57 .85	17.64 1.65	19.50 .75	19.36 .93	15.07 2.20	18.29 1.82	14.14 1.83
	Program Means	19.2	19.3	18.5	16.8	17.9	19.4	18.7	15.9	18.8	14.6

Mean
Standard
Deviation

TABLE XI
MULTIVARIATE ANALYSIS OF VARIANCE
COPEs FORM R (REAL)

Source	Multivariate Test		Univariate	Univariate F Statistics									
	df	F	df	1	2	3	4	5	6	7	8	9	10
Between	20	2.83*	2	2.55	7.73*	2.29	6.85*	5.57*	6.41*	1.49	.56	.30	8.67*
Within	64		41	2.69	2.78	1.72	2.29	2.97	1.69	.71	3.30	5.16	1.76

* $p < .05$; .95 F 2, 41 = 3.23

TABLE XII
MULTIVARIATE ANALYSIS OF VARIANCE
COPEs FORM I (IDEAL)

Source	Multivariate Test		Univariates	Univariate F Statistics									
	df	F	df	1	2	3	4	5	6	7	8	9	10
Between	20	1.3406	2	1.05	2.34	.39	1.02	.47	.05	5.59	5.74	3.12	.55
Within	64		41	.82	1.50	1.08	2.24	3.59	.94	1.21	5.37	2.29	4.57

.95 F 2, 41 = 3.23

TABLE XIII
POST HOC COMPARISONS FOR COHESION EFFECT

Dependent Variables	Contrast Ψ	Observed Value ψ
2 Support	$\Psi_1 = \mu_{.1.} - \mu_{.2.}$	4.7*
	$\Psi_2 = \mu_{.1.} - \mu_{.3.}$	.6
	$\Psi_3 = \mu_{.2.} - \mu_{.3.}$	4.51*
4 Autonomy	$\Psi_1 = \mu_{.1.} - \mu_{.2.}$	1.36
	$\Psi_2 = \mu_{.1.} - \mu_{.3.}$	3.87*
	$\Psi_3 = \mu_{.2.} - \mu_{.3.}$	5.15*
5 Practical Orientation	$\Psi_1 = \mu_{.1.} - \mu_{.2.}$	2.56
	$\Psi_2 = \mu_{.1.} - \mu_{.3.}$	2.25
	$\Psi_3 = \mu_{.2.} - \mu_{.3.}$	4.79*
6 Personal Problem Orientation	$\Psi_1 = \mu_{.1.} - \mu_{.2.}$	4.91*
	$\Psi_2 = \mu_{.1.} - \mu_{.3.}$	1.56
	$\Psi_3 = \mu_{.2.} - \mu_{.3.}$	3.53*
10 Staff Control	$\Psi_1 = \mu_{.1.} - \mu_{.2.}$	2.94
	$\Psi_2 = \mu_{.1.} - \mu_{.3.}$	3.00
	$\Psi_3 = \mu_{.2.} - \mu_{.3.}$	5.86*

NOTES:

M_1 .. = population mean for Cottage One (Medium Cohesion)

M_2 .. = population mean for Cottage Two (Low Cohesion)

M_3 .. = population mean for Cottage Three (High Cohesion)

ψ = observed values of Ψ using corresponding sample means.

* $p < .05: .95q_{3, 42} = 3.44$

FIGURE 3
STAFF: COPES, FORM R. -- SUBSCALE PROFILES

----- Cottage 1 (Mid Cohesion).
 Cottage 2 (Low Cohesion).
 ——— Cottage 3 (High Cohesion).

Figure 3 shows the COPES subscale means for all cottages. As can be seen from Table XII, a multivariate analysis of variance revealed no significant differences between the cottages on the scores of the COPES, Form I, the probability for a Type I error being set at $p < .05$. This result corresponded with the result of a preliminary one-way ANOVA which also revealed no differences between cottages on this variable. The significant univariate F statistics found on variables 7 and 8 in Table XII are examples of Type I errors. Therefore, since there was no significant variation between cottages in the COPES, Form I, scores (the staff's perception of an Ideal treatment environment), the COPES, Form R (staff perception of the Real treatment environment) was taken as the dependent variable rather than the difference between COPES, Form R, and COPES, Form I.

A one-way analysis of variance using the ANOV11 computer program (Carlson and Hazlett, 1971) was used to analyze the clients' perception of the real treatment environment in the different cottages, as measured by the COPES, Form R. These means and standard deviations are shown in Table XIV and Table XV.

A summary ANOVA in Table XVI shows that there is a significant group mean difference between the client groups and their perception of the treatment environment. Table XVII gives the post hoc comparisons, using Tukey's procedure to determine which contrasts between cottages were significant as regards the perception of real treatment environment. As Table XVII shows, the only significant group mean difference on this factor was between Cottages One (medium level cohesion) and Two (low level cohesion). The Cottage One mean was the lowest.

The researcher, who observed the testing situation, noted at that time that the Cottage One group of clients were particularly rebellious,

TABLE XV
MEANS AND STANDARD DEVIATIONS: COPEs FORM R
EASTON CLIENTS

Cottage	One	Two	Three
Means	50.7	61.7	58.1
Standard Deviation	9.13	7.92	11.15

TABLE XVI
SUMMARY ANOVA: COPEs FORM R, CLIENTS

Sources of Variation	S.S.	M.S.	O.F.	F
Between	624.06	314.53	2	3.49*
Within	2433.13	90.12	27	

* $p < .05$; .95 F s, 27 = 3.35

TABLE XVII
CLIENTS: POST HOC COMPARISONS FOR COHESION EFFECT

Contrast ψ	Observed Value ψ
$\psi_1 = \mu_{1.} - \mu_{2.}$	3.66*
$\psi_2 = \mu_{1.} - \mu_{3.}$	2.47
$\psi_3 = \mu_{2.} - \mu_{3.}$	1.19

NOTES: M_1 ... = Client population mean for Cottage One (Medium Cohesion)
 M_2 ... = Client population mean for Cottage Two (Low Cohesion)
 M_3 ... = Client population mean for Cottage Three (High Cohesion)
 = Observed Values of using corresponding sample means.
 * $p < .05$; .95 $q_{3, 27} = 3.56$

TABLE XVIII
COTTAGE OBSERVATIONS FOR THE MONTH OF JULY 1979

Cottage	One	Two	Three
$n =$	10	10	10
Locked Room Hours	52 (involving 3 subjects)	98 (involving 6 subjects)	16.5 (involving 3 subjects)
Number of Runaways	12	6	3
Violent Incidents (directed towards staff)	2	3	0

The last part of the second stage of the analysis was to examine the cottage locked room hours, runaways and documented "special occurrences" or violent incidents. These are shown in Table XVIII. The amount of locked room time followed the same pattern as the variable staff cohesiveness. That is, the amount of locked room time was appreciably higher in Cottage Two, the cottage with the lowest staff group cohesion, lower in Cottage One, and very low in Cottage Three, the cottage with the highest level of staff cohesion.

The number of violent incidents also appear to have increased as staff cohesion decreased. These two observations appear to suggest that the cohesiveness of staff does have some influence upon client acting-out behaviour, or perhaps the methods by which staff deal with such behaviour.

The number of client runaways was highest in Cottage One, which at this time was involved in a highly delinquent client sub-culture, one client in particular tending to precipitate large group runaways.

These data, because of the small number of groups involved (three cottages), cannot form the basis for any decisive conclusions concerning the relationship between client behaviour and other variables. It can only suggest the nature of such relationships, if indeed they do exist.

Stage 3

Stage 3 of the analysis is more descriptive in nature and consists first of converting the clients' and staff's subscale mean raw scores on the COPES Form R into standard scores based on the normative samples for the COPES instrument, which contained programs similar to Easton, and calculating the overall standard score program mean from these scores. These standard scores are given in Tables XIX (staff) and XX (clients).

It is then possible to create a program profile which describes Easton in relation to the average score obtained by members in the American Normative Sample (Figure 4), and in relation to that institution's own stated goals and values (Figure 6) and which also delineates such factors as possible differences between staff perceptions of the program and client perceptions of the same program (Figure 5).

Figure 4 suggests that the Easton program as perceived by the staff is only below average on the factors, Autonomy, Order and Organization, and Practical Orientation, the highest variable being Staff Control.

The clients' perceptions (Figure 5) seem to differ from those of the staff, particularly on the variables, Involvement, Support, Personal Problem Orientation, and Program Clarity. A further discussion of these profiles can be found in the following chapter. It is, of course, not possible to draw clear conclusions from these profiles without testing the apparent differences which appear on the graphs for statistical significance. They must be viewed from a purely descriptive perspective.

TABLE XIX
STAFF: COPES FORM R, SUBSCALE. MEANS - STANDARD SCORES

Subscales:	1	2	3	4	5	6	7	8	9	10
Cottage One n = 16	63 60	65 62	62 60	42 34	54 40	79 69	77 66	34 45	59 51	61 71
Cottage Two n = 15	56 54	43 37	58 51	33 27	45 29	70 61	74 63	30 42	54 47	65 75
Cottage Three n = 14	71 66	65 62	71 67	56 45	66 56	82 71	79 68	34 45	64 55	53 64
Program Mean for Easton	63 60	58 54	64 61	44 35	55 42	77 67	77 66	33 44	59 51	60 70

On
client norms

on
staff norms

TABLE XX
 CLIENTS: COPES FORM R, SUBSCALE. MEANS - STANDARD SCORES

Subscales	1	2	3	4	5	6	7	8	9	10
Cottage One	33	26	42	38	33	60	72	26	26	65
Cottage Two	41	39	54	51	62	60	69	34	45	69
Cottage Three	37	35	62	42	50	63	74	19	36	65
Program Mean for Easton	37	33	53	44	48	61	72	26	36	66

FIGURE 4

COPES FORM R -- EASTON PROGRAM PROFILE
(BASED ON STAFF NORMS)

* Mean for American Normative Sample.

FIGURE 5
EASTON PROFILE -- CLIENTS AND STAFF
(BASED ON CLIENT NORMS)

* Mean for American Normative Sample.

----- Clients (N=30)

— Staff (N=44)

FIGURE 6
COPES: REAL AND IDEAL SCORES FOR EASTON PROGRAM
(STAFF ONLY)

CHAPTER V

DISCUSSION OF THE RESULTS

Effects of Staff Cohesion Level

The overall pattern of results coincided with the expectations and clinical judgement of the Easton supervisory team, which was that the three cottages varied in the cohesiveness of the staff group, Cottage Three being the most cohesive and Cottage Two the least cohesive, and that these levels of cohesion affected the treatment environment and, by implication, treatment outcome. In general the empirical data appear to validate the conviction of the Easton unit that staff cohesion is related to the quality of the residential treatment environment, as perceived by the staff.

The COPES instrument identified specific variables (definitions of which are given in Appendix A) which the staff perceived as being significantly influenced by cohesion level. For example, Autonomy was more in evidence in the highly cohesive cottage. This appears logical when related to the variable, Staff Control, which was higher in the low cohesion cottage. One would expect Autonomy to vary inversely with the variable, Staff Control. Staff Control has a negative connotation at Easton, as is illustrated by the means for the COPES Form I (Table VIII) in that the ability to take responsibility and become independent are seen as one of the main goals of a therapeutic community, and one of the prime tasks of adolescence.

These two variables, then, are closely related to the treatment goals of an adolescent residential unit. These two variables would also appear to relate to the number of locked room hours, which were consider-

ably higher in the low cohesion cottage. It is possible to deduce from these facts that client autonomy is perhaps only possible when the staff experience the "social solidarity" which Bettelheim (1974) constantly refers to, and which he suggests gives the staff a sense of security which enables them to interact in a more open and non-authoritarian manner with their clients. The lack of staff cohesion, on the other hand, would appear to raise the need for structure, rule enforcement and staff control in general.

Practical Orientation was also significantly affected by both high and low levels of cohesion. It seems plausible that a cottage environment which is promoting client autonomy and does not feel the need for stringent staff control is also a place where plans for the future seem relevant, and where concrete skills can be taught and solutions to practical problems can be explored.

The COPES Subscales, Support and Personal Problem Orientation, are two variables which express aspects of treatment that are very highly valued at Easton, where much emphasis is placed on caring for others, validating and sharing individual feelings, and learning to understand one's problems and behaviours. Cottages One and Three did not differ on these variables, but the variables did appear to be negatively affected by the low level of staff cohesion present in Cottage Two. The fact that these two variables are the highest scoring variables on the COPES, Form I. (staff's view of the Ideal treatment environment) speaks to their significance in the Easton philosophy of treatment, and suggests that staff cohesion very much affects the ability of the staff to implement the Easton treatment philosophy. Bettelheim's (1974) point that the staff in such a centre need team cohesiveness in order to relate openly and therapeutically with their clients again seems relevant here. It would seem logical that these variables are

also negatively affected by a high level of Staff Control.

It now seems pertinent to consider the variables which showed no significant cohesion effect. First, Order and Organization were uniformly below average in all cottages. The low value placed on this variable is illustrated by the relatively low Order and Organization mean value in the staff COPES, Form I. This area appears to be considered relatively unimportant regardless of the level of staff cohesion. Five of the questions out of the ten which go to make up this subscale, however, concern neatness and tidiness in the environment. These may not seem like the most significant of variables to staff in a cottage dealing with seriously disturbed adolescents and their behaviour patterns.

The expression of anger and aggression, on the other hand, is highly valued at Easton, and the variable so named has the highest mean value of all the variables in the COPES, Form R (completed by the staff), and is uniformly high regardless of the level of staff cohesion. The expression of anger may have a different quality, however, in a cottage with high staff control and low client autonomy as compared with a cottage which had relatively low staff control and high client autonomy. In any event, the general value which is placed on the ventilation of negative feelings and assertion of individual needs in the Easton program would appear to be strong enough to override any cohesion effect.

There were no significant differences between the cottages on the variable, Spontaneity. This is a little surprising in that such a variable would appear to tie in with the variables, Personal Problem Orientation and Support. It may be that the general values of the unit are again operating here since Spontaneity (expressing yourself and your feeling), like Anger and Aggression, is seen as a positive value at Easton.

The lack of a cohesion effect for the variable, Program Clarity, would seem to be related to the standardization of the program structure throughout the unit, which is perhaps clearer to the staff than to the clients. Rules, routines and expectations are made explicit to the staff and follow a similar general structure in all cottages. The staff also seem to share a common treatment philosophy (see following section). It is interesting to note that the clients did not agree with the staff concerning the level of Program Clarity operating at Easton (see Figure 5). The lack of a cohesion effect for the variable, Involvement, can be seen in the context of the staff's overview of the Easton program activities, such as school, arts and crafts, art therapy, and recreation. To the staff, it may appear that the environment is very stimulating and that the clients are relatively busy and involved in the program.

Staff Perceptions of Ideal Treatment Environment (COPES, Form I)

The finding of no significant differences between the three cottages on the COPES, Form I, or Ideal Program Environment Scale, requires comment.

Originally, the researcher had planned to use the difference score between COPES, Form R, and COPES, Form I, as the measure of the quality of the perceived treatment environment. However, since there were no significant difference between the cottages on this test, and thus any variance reflected in such difference scores would simply be a reflection of the variance in the COPES, Form R, scores, it was decided to simply use the COPES, Form R, score for this purpose. Obviously, if the difference scores were used, Cottage Three, the highly cohesive cottage with the highest scores on the COPES, Form R, would be closest to the Ideal.

However, the fact itself that there were no cottage differences measured on this instrument suggests that Easton as a unit has a uniform,

clear and consistent set of treatment ideals that are subscribed to by the majority of the staff. Bettelheim (1974) states that a clear commitment to a consistent treatment philosophy is essential in residential treatment. These results suggest that Easton has exactly this.

What are the ideals which the Easton staff adhere to? According to the results of this test (Figure 6), the highest value is placed on the Relationship Dimension variables of Support, Involvement, and Spontaneity, on the Treatment Program Dimension variables of Personal Problem Orientation, and Anger and Aggression, and on the System Maintenance Dimension variable of Program Clarity. Order and Organization and Staff Control are seen by the Easton staff as being relatively unimportant in the Ideal treatment environment. The variables valued here would appear to be those which support an interaction orientated milieu where there is considerable freedom of expression, sharing of personal problems and an attempt to understand or gain insight into the dynamics of such problems.

The use of COPES, Form I, also makes possible a comparison between Real and Ideal scores (Figure 6) which could be then used as a form of process evaluation for the Easton unit, giving the Easton staff specific information as to which variables the majority of their peers appear to value and see as needing improvement.

Clients' Perceptions of Real Treatment Environment (COPES, FORM R)

One significant difference between cottages was found on this test. Cottage One (average cohesion) clients had a significantly more negative perception of their treatment environment than the clients in Cottage Two. It was the consensus of the Easton supervisory group and the Cottage One staff that a formidable peer group delinquent culture existed in the Cottage at this time. The number of client runaways for the month of July

also reflects the existence of such a culture. It is suggested that this peer group delinquent culture negatively biased the results of the COPEs in Cottage One.

As to the reasons for the uniformity of client perceptions of the environment in cottages with low and high staff cohesion levels, many conjectures can be made. The results may have been influenced by the fact that the test itself is a little long (100 items) for clients who tend as a group to be distractible and easily frustrated. Clients, too, may genuinely not be able to discriminate clearly concerning the treatment variables in their environment.

Goffman (1961) proposes that in an institution two different social and cultural worlds develop, one of the clients and one of the staff, and that there is in fact little contact between them. If in fact this was so, the client perceptions of their environment would be made from a totally different perspective than that of the staff. Moos (1974) states that staff are generally more positive about treatment programs than clients. Observations of the Easton Alumni group meetings, which clients attend just before discharge, suggest to the researcher that while in the program the peer culture pressures the client to view the Easton program negatively. However, upon leaving the program, the client often appears to change his perspective to a more positive one. This observation may be biased, however, since clients who continued to view the program in a very negative light would not be likely to attend the Alumni group meetings.

Client Behaviours

Moos (1974) states, "moderate to substantial relationships exist between average patient behavioural characteristics (i.e. disturbed behaviour) and treatment environment" (p. 143). Examining the recorded client behaviours

in the cottages for the month of July, one finds that two of these behaviours do decrease as staff cohesion rises. It is not clear, however, if these figures reflect the frequency and severity of client acting out or simply the staff methods of dealing with such crises. A staff who is part of a highly cohesive team, working in a cottage which focusses on autonomy and minimises staff control, may not use the locked room to control acting out behaviour, or may be more easily able to defuse a potentially violent situation. Whether these observations are a reflection of client behaviour or staff reactions to that behaviour, or both, they remain interesting and suggest the kind of link which treatment environment may have with treatment outcome in that frequent violence or other behaviours which necessitate many hours in the locked room are often preludes to premature discharge from the Easton program.

Discussion of Program Profiles

Easton in Relation to Other Programs

Moos (1974) states that,

"wards that are successful in keeping patients out of the hospital emphasise Autonomy and Independence, a Practical Orientation, Order and Organization, and a reasonable degree of Staff Control. They also emphasise Personal Problem Orientation and the free and open expression of Anger" (p. 196).

Taking the first three variables (see Figure 4), one would not predict long community tenure for Easton clients after discharge. The last two, however, are very much part of the Easton program. It is difficult to compare such programs. Easton is not a "ward", and is orientated towards a special kind of client.

Nevertheless, the COPES profile enables Easton to compare the environment variables operating in their program to those of other programs and to consider outcome studies such as the one above in the light of the

Easton program. The significance and interrelationship of the environmental variables have been already discussed. It is worth noting again, perhaps, that the staff perceives the Easton Program to be above average on all COPES variables, except Autonomy, Order and Organization and Practical Orientation.

Client and Staff Perceptions of the Easton Program

The perceptions of the clients and staff concerning the Easton environment appear to differ considerably (see Figure 5) especially on the variables Program Clarity, Involvement and Support and somewhat on Personal Problem Orientation. Moos in the COPES manual states that members and staff generally perceive a relatively similar emphasis on Relationship (variables 1, 2, 3) and System Maintenance (variables 8, 9, 10) dimensions. This suggests that a discrepancy as wide as the one found is not a generally expected occurrence. This poses many questions. Is this, as was suggested concerning the clients COPES, Form R, scores, a reflection of a two-culture split at Easton? Are the staff misjudging the effect of the program on the clients in these areas of relationship and program clarity? The clients seemingly are not perceiving the program rules, procedures and expectations as clearly as the staff believe. This variable is an area where the staff ideal is somewhat higher than the present reality (Figure 6), which suggests that the staff recognise the need for improvement in this area.

The clients apparently also perceive themselves as less involved in the day to day programming and less supported by other clients and staff than the staff perspective would suggest. The majority of staff seem to believe that there is an above average degree of sharing and encouragement in the program. The clients appear to disagree. What may be viewed as support from the point of view of the staff culture perhaps may not be seen in the same light by the adolescent client. The staff and clients agree,

however, that there is relatively little encouragement for the clients to be autonomous and independent, and that order and organization are low, while staff control seems to be above average. They also agree concerning the main focus of the program, namely, the variables Personal Problem Orientation and Anger and Aggression.

It is not possible to draw clear conclusions from this data without testing the apparent differences for statistical significance.

Staff Perceptions of the Real versus the Ideal Environment

The COPEs profiles show discrepancies in the Real and Ideal treatment environments (see Figure 6) which could be used as descriptive data in an ongoing process evaluation. The Anger and Aggression score is the only Real score which appears higher than its corresponding Ideal score. The Easton staff seem to believe that there is a little too much expression of negative feelings in the cottages. The Staff Control score is the only Ideal score that is lower than its Real counterpart. This seems to imply that ideally the Easton staff would like to play a less parental and authoritarian role.

The profile seems to suggest that the Easton staff particularly feel the need to improve the program in the relationship dimension and in the area of client autonomy, to help their clients find more solutions to practical problems, and to create more clarity regarding the expectations and goals of the program for the clients, while reducing the level of staff control.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Summary of the Study

In 1959, Fritz Redl, one of the pioneers of residential treatment in North America, emphasised the need for the clinical assessment of the relative impact of the identified key variables which constitute a residential "therapeutic milieu". He saw this as an "urgent" task. Since that time, the number of residential treatment centres has continued to grow (Pappenfort and Dinwoodie, 1970) and the cost of such treatment, always high, has continued to rise. In addition, the issue of accountability has come more and more to the forefront in this field, as in education and the social sciences in general. It appears, then, that the task outlined by Fritz Redl has become even more urgent. This point is stressed by Durkin and Durkin (1975) who emphasise the need for process evaluation of residential treatment programs and suggest that an approach which relates treatment process variables to functional and dysfunctional aspects of such programs are generally more useful than the more usual but difficult outcome studies.

What, then, are the key process variables involved in a residential therapeutic milieu? Many such variables have been identified, but the factor that is stressed in the literature as being the most crucial is the treatment staff and their ability to work together as a cohesive team (Easson, 1969; Bettelheim, 1974). The pertinent question is, then, which specific variables in a treatment environment are influenced by a factor such as staff cohesion?

To turn from the general to the particular, the Easton residential treatment program, the subject of this study, is in 1980 on the verge of a substantial expansion, and also taking the first steps towards recognising the need for process evaluation of the program. The Easton program has focussed particularly on staff cohesion as the main building block in residential treatment. It appears, then, that this setting is a particularly appropriate one to use in an attempt to begin to tackle the urgent task outlined by Redl, more specifically, to look at the cohesiveness of staff teams and to attempt to assess the impact of this variable on the treatment environment.

In order to do this, the staff in the three residential cottages at Easton were given the Seashore Group Cohesiveness Index (Seashore, 1954) to determine if different levels of this factor were indeed present. The Easton supervisory team believed that such levels did indeed exist at this time. An analysis of the Cohesiveness Index resulted in the delineation of three levels of cohesion: high, average or medium, and low.

These staff groups were then assessed as to their perceptions of the real treatment environment and the ideal treatment environment, as assessed by the COPES, Forms R and I (Moos, 1974), the hypothesis being that the more cohesive the staff group the higher the quality of the perceived treatment environment. The cottage client groups were also asked to evaluate their treatment environment, the hypothesis being that the more cohesive the staff group the more positive the client perception of the environment would be. The incidence of client acting out behaviour was also examined, the expectation being that there would be less acting out on the part of clients as the level of staff cohesion rose.

Finally, a program profile of Easton was constructed using standard scores on the COPES, Form R, instrument in order to describe Easton in relation to other similar programs and in relation to the aims and goals of

Easton itself.

Conclusions of the Study

1. The level of staff group cohesion is related to the quality of the treatment environment as perceived by the staff. Specifically, a significant cohesion effect was found on the following environmental variables (see Appendix A for definitions of these variables):

- a) Support and Personal Problem Orientation were significantly lower in the cottage where the staff group exhibited a low cohesion level.
- b) Autonomy was significantly higher in the cottage where staff exhibited a high cohesion level.
- c) Practical Orientation was significantly lower in the cottage with low staff cohesiveness as compared to the cottage with high staff cohesiveness.
- d) Staff Control was significantly higher in the cottage with low staff cohesiveness.
- e) The variables that did not appear to be significantly influenced by levels of staff cohesion were: Involvement, Spontaneity, Anger and Aggression, Order and Organization, and Program Clarity.

2. The client perception of the treatment environment did not appear to be affected by the level of staff cohesion. The cottage with an average level of cohesion, however, was associated with the most negative client perception of the environment, perhaps reflecting the strong peer group delinquent culture present in the cottage. The client locked room hours and number of violent incidents, however, did correspond with the pattern of staff cohesiveness in the cottages.

3. There appears to be a high level of consensus concerning the Ideal treatment environment among the Easton staff.

4. The program profiles suggest that the Easton Program as perceived by the staff is above average on all the COPES environmental variables except Autonomy, and Order and Organization, and Practical Orientation, and that client perceptions appear to differ from those of the staff particularly with respect to the variables, Involvement, Support, Personal Problem Orientation, and Program Clarity.

Implications of the Study

The main implications of this study would appear to be that:

1. Staff cohesion is a significant variable in relation to the quality of a treatment environment, and thus should be facilitated and fostered by systematic means.
2. The COPES, Forms R and I, have considerable value in the description and process evaluation of residential treatment centres.
3. Other variables such as group values and judgements, and client peer group pressure also need to be delineated and taken into account in the evaluation of residential treatment.
4. Clients such as those in residence at Easton may perceive their environment from a different perspective than that of the staff.

Suggestions for Further Research

There are other process variables, such as those mentioned above, which could provide fruitful areas of enquiry and new perspectives on the mechanisms of residential treatment. However, the outstanding need in the field at the moment is for a study which combines process variables such as

staff cohesion, peer group culture and program value structure with measures of treatment outcome. In such a study, it is feasible to relate process variables to treatment environment, and treatment environment to specific indices of treatment outcome. Thus it should be possible to determine not only if residential treatment works, for whom and under what circumstances, but also how specific elements of such treatment programs affect treatment outcome, that is, how residential treatment works. Only then can successful treatment strategies be duplicated and generalized. The methodological constraints which confront such a study are severe. However, studies which outline the effect of process variables are the ground on which such an outcome study should logically be based.

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APPENDIX A

INSTRUMENTS USED IN THE STUDY

WORK GROUP QUESTIONNAIRE

No. _____

Date _____

1. Do you feel that you are really a part of your work group?

- (1) _____ Really a part of my work group.
- (2) _____ Included in most ways.
- (3) _____ Included in some ways, but not in others.
- (4) _____ Don't feel I really belong.
- (5) _____ Don't work with any one group of people.

2. If you had a chance to do the same kind of work for the same pay, in another work group, how would you feel about moving?

- (1) _____ Would want very much to move.
- (2) _____ Would rather move than stay where I am.
- (3) _____ Would make no difference to me.
- (4) _____ Would rather stay where I am than move.
- (5) _____ Would want very much to stay where I am.

3. How does your work group compare with other work groups at Easton in the way the people get along?

- (1) _____ Better than most.
- (2) _____ About the same as most.
- (3) _____ Not as good as most.

4. How does your work group compare with other work groups at Easton when it comes to sticking together to get what the group wants?

- (1) _____ Better than most.
- (2) _____ About the same as most.
- (3) _____ Not as good as most.

5. How does your work group compare with other work groups at Easton in the way the people help each other on the job?

- (1) _____ Better than most.
- (2) _____ About the same as most.
- (3) _____ Not as good as most.

6. What three people in the cottage do you see most of socially (both during and after working hours)?

- (1) _____
- (2) _____
- (3) _____

7. What three people in the cottage do you most like to work with?

(1) _____

(2) _____

(3) _____

NOTE: The first five items of this questionnaire constitute the Seashore Index of Group Cohesiveness. The last two items are Sociometric questions.

COPEs SUBSCALES AND DEFINITIONS

Relationship Dimension	1. Involvement	measures how active members are in the day-to-day functioning of their programs, i.e., spending time constructively, being enthusiastic, doing things on their own initiative.
	2. Support	measures the extent to which members are encouraged to be helpful and supportive towards other members, and how supportive the staff is towards members.
	3. Spontaneity	measures the extent to which the program encourages members to act openly and express their feelings openly.
Treatment Program Dimension	4. Autonomy	assesses how self-sufficient and independent members are encouraged to be in making their own decisions about their personal affairs (what they wear, where they go) and in their relationships with the staff.
	5. Practical Orientation	assesses the extent to which the member's environment orients him towards preparing himself for release from the program. Such things as training for new kinds of jobs, looking to the future, and setting and working towards goals are considered.
	6. Person Problem Orientation	measures the extent to which members are encouraged to be concerned with their personal problems and feelings and to seek to understand them.
	7. Anger and Aggression	measures the extent to which a member is allowed and encouraged to argue with members and staff, to become openly angry and to display other aggressive behaviour.
System Maintenance Dimension	8. Order and Organization	measures how important order and organization is in the program, in terms of members (how do they look), staff (what they do to encourage order) and the house itself (how well is it kept).
	9. Program Clarity	measures the extent to which the member knows what to expect in the day-to-day routine of his program and how explicit the program rules and procedures are.
	10. Staff Control	assesses the extent to which the staff use measures to keep members under necessary controls, i.e., in the formulation of rules, the scheduling of activities, and in the relationships between members and staff.

COMMUNITY ORIENTED PROGRAMS
ENVIRONMENT SCALE
FORM R

Rudolf H. Moos, Phd.

Instructions

There are 100 short statements in this booklet. There are statements about programs. Please decide which statements are true of your program and which are not. On the separate answer sheet, mark under T (True) when you think the statement is true, or mostly true of your program; mark under F (False) when you think the statement is false, or mostly false. Please be sure to answer every statement and to fill in your name and the other information requested.

Do not make any marks on this booklet.

CONSULTING PSYCHOLOGISTS PRESS, INC.
527 College Avenue, Palo Alto, California, 94306.

1. Members put a lot of energy into what they do around here.
2. The healthier members here help take care of the less healthy ones.
3. Members tend to hide their feelings from one another.
4. There is no membership government in this program.
5. This program emphasizes training for new kinds of jobs.
6. Members hardly ever discuss their sexual lives.
7. It's hard to get people to argue around here.
8. Members' activities are carefully planned.
9. If a member breaks a rule, he knows what the consequences will be.
10. Once a schedule is arranged for a member, the member must follow it.
11. This is a lively place.
12. Staff have relatively little time to encourage members.
13. Members say anything they want to the staff.
14. Members can leave here anytime without saying where they are going.
15. There is relatively little emphasis on teaching members solutions to practical problems.
16. Personal problems are openly talked about.
17. Members often criticize or joke about the staff.
18. This is a very well organized program.
19. If a member's program is changed, staff always tell him why.
20. The staff very rarely punish members by taking away their privileges.
21. The members are proud of this program.
22. Members seldom help each other.
23. It is hard to tell how members are feeling here.
24. Members are expected to take leadership here.
25. Members are expected to make detailed, specific plans for the future.
26. Members are rarely asked personal questions by the staff.
27. Members here rarely argue.
28. The staff make sure that this place is always neat.
29. Staff rarely give members a detailed explanation of what the program is about.
30. Members who break the rules are punished for it.
31. There is very little group spirit in this program.
32. Staff are very interested in following up members once they leave the program.
33. Members are careful about what they say when staff are around.
34. The staff tend to discourage criticism from members.
35. There is relatively little discussion about exactly what members will be doing after they leave the program.
36. Members are expected to share their personal problems with each other.
37. Staff sometimes argue openly with each other.

38. This place usually looks a little messy.
39. The program rules are clearly understood by the members.
40. If a member fights with another member, he will get into real trouble with the staff.
41. Very few members ever volunteer around here.
42. Staff always compliment a member who does something well.
43. Members are strongly encouraged to express themselves freely here.
44. Members can leave the program whenever they want to.
45. There is relatively little emphasis on making specific plans for leaving this program.
46. Members talk relatively little about their past.
47. Members sometimes play practical jokes on each other.
48. Members here follow a regular schedule every day.
49. Members never know when staff will ask to see them.
50. Staff don't order the members around.
51. A lot of members just seem to be passing time here.
52. The staff know what the members want.
53. Members spontaneously set up their own activities here.
54. Members can wear whatever they want.
55. Most members are more concerned with the past than with the future.
56. Members tell each other about their intimate personal problems.
57. Staff encourage members to express their anger openly here.
58. Some members look messy.
59. The members always know when the staff will be around.
60. It is important to carefully follow the program rules here.
61. This program has very few social activities.
62. Staff sometimes don't show up for their appointments with members.
63. When members disagree with each other, they keep it to themselves.
64. The staff almost always act on members' suggestions.
65. Members here are expected to demonstrate continued concrete progress toward their goals.
66. Staff are mainly interested in learning about members' feelings.
67. Staff here never start arguments.
68. Things are sometimes very disorganized around here.
69. Everyone knows who's in charge here.
70. Members can call staff by their first names.
71. Members are pretty busy all of the time.
72. There is relatively little sharing among the members.
73. Members can generally do whatever they feel like here.

(Continued)

74. Very few members have any responsibility for the program here.
75. Members are taught specific new skills in this program.
76. The members rarely talk with each other about their personal problems.
77. Members often gripe.
78. The dayroom or living room is often untidy.
79. People are always changing their minds here.
80. Members may interrupt staff when they are talking.
81. Discussions are very interesting here.
82. Members are given a great deal of individual attention here.
83. Members tend to hide their feelings from the staff.
84. Members here are very strongly encouraged to be independent.
85. Staff care more about how members feel than about their practical problems.
86. Members are rarely encouraged to discuss their personal problems here.
87. Staff here think it is a healthy thing to argue.
88. Members are rarely kept waiting when they have appointments with staff.
89. Members never quite know when they will be considered ready to leave this program.
90. Members will be transferred or discharged from this program if they don't obey the rules.
91. Members often do things together on weekends.
92. The staff go out of their way to help new members get acquainted here.
93. Members are strongly encouraged to express their feelings.
94. Staff rarely give in to pressure from members.
95. Members must make detailed plans before leaving this program.
96. Staff strongly encourage members to talk about their pasts.
97. Members rarely become angry here.
98. The staff strongly encourages members to be neat and orderly here.
99. There are often changes in the rules here.
100. The staff make and enforce all the rules here.

COMMUNITY ORIENTED PROGRAMS

ENVIRONMENT SCALE

(COPEs FORM I)

(Moos, R. H., 1974)

There are 100 statements in this booklet. They are statements about programs. They ask you what you think an Ideal Program would be like. You are to decide which of these statement would be true of an Ideal Program and which would be false.

True -- Mark beside the T if you think the statement is TRUE, or mostly true, of an Ideal Program.

False -- Mark beside the F if you think the statement is FALSE or mostly false, of an Ideal Program.

Please be sure to answer every statement.

1. Members will put a lot of energy into what they do.
2. The healthier members will help take care of the less healthy ones.
3. Members will tend to hide their feelings from one another.
4. There will be no membership government in the program.
5. The program will emphasize training for new kinds of jobs.
6. Members will hardly ever discuss their sexual lives.
7. It will be hard to get people to argue.
8. Members' activities will be carefully planned.
9. If a member breaks a rule, he will know what the consequences will be.
10. Once a schedule is arranged for a member, the member will have to follow it.
11. It will be a lively place.
12. Staff will have relatively little time to encourage members.
13. Members will say anything they want to the staff.
14. Members will be able to leave anytime without saying where they are going.

15. There will be relatively little emphasis on teaching members solutions to practical problems.
16. Personal problems will be openly talked about.
17. Members will often criticize or joke about the staff.
18. It will be a very well organized program.
19. If a member's program is changed, staff will always tell him why.
20. The staff will very rarely punish members by taking away their privileges.
21. The members will be proud of the program.
22. Members will seldom help each other.
23. It will be hard to tell how members are feeling.
24. Members will be expected to take leadership.
25. Members will be expected to make detailed specific plans for the future.
26. Members rarely will be asked personal questions by the staff.
27. Members will rarely argue.
28. The staff will make sure that the place is always neat.
29. Staff will rarely give members a detailed explanation of what the program is about.
30. Members who break the rules will be punished for it.
31. There will be very little group spirit in the program.
32. Staff will be very interested in following up members once they leave the program.
33. Members will be careful about what they say when staff are around.
34. The staff will tend to discourage criticism from members.
35. There will be relatively little discussion about exactly what members will be doing after they leave the program.
36. Members will be expected to share their personal problems with each other.
37. Staff will sometimes argue openly with each other.
38. The place will usually look a little messy.
39. The program rules will be clearly understood by the members.
40. If a member fights with another member, he will get into real trouble with the staff.
41. Very few members will ever volunteer.
42. Staff will always compliment a member who does something well.
43. Members will be strongly encouraged to express themselves freely.
44. Members will be able to leave the program whenever they want to.
45. There will be relatively little emphasis on making specific plans for leaving the program.

46. Members will talk relatively little about their past.
47. Members will sometimes play practical jokes on each other.
48. Members will follow a regular schedule every day.
49. Members will never know when staff will ask to see them.
50. Staff won't order the members around.
51. A lot of members will just seem to be passing time.
52. The staff will know what the members want.
53. Members will spontaneously set up their own activities.
54. Members will be able to wear whatever they want.
55. Most members will be more concerned with the past than with the future.
56. Members will tell each other about their intimate personal problems.
57. Staff will encourage members to express their anger openly.
58. Some members will look messy.
59. The members will always know when the staff will be around.
60. It will be important to carefully follow the program rules.
61. The program will have very few social activities.
62. Staff sometimes will not show up for their appointments with members.
63. When members disagree with each other, they will keep it to themselves.
64. The staff will almost always act on members' suggestions.
65. Members will be expected to demonstrate continued concrete progress toward their goals.
66. Staff will be mainly interested in learning about members' feelings.
67. Staff will never start arguments.
68. Things will sometimes be very disorganized.
69. Everyone will know who's in charge.
70. Members will call staff by their first names.
71. Members will be pretty busy all of the time.
72. There will be relatively little sharing among the members.
73. Members will generally do whatever they feel like.
74. Very few members will have any responsibility for the program.
75. Members will be taught specific new skills in the program.
76. The members will rarely talk with each other about their personal problems.
77. Members will often gripe.
78. The dayroom or livingroom will often be untidy.

79. People will always be changing their minds.
80. Members will be able to interrupt staff when they are talking.
81. Discussions will be very interesting.
82. Members will be given a great deal of individual attention.
83. Members will tend to hide their feelings from the staff.
84. Members will be very strongly encouraged to be independent.
85. Staff will care more about how members feel than about their practical problems.
86. Members will rarely be encouraged to discuss their personal problems.
87. Staff will think it is a healthy thing to argue.
88. Members will rarely be kept waiting when they have appointments with staff.
89. Members will never quite know when they will be considered ready to leave the program.
90. Members will be transferred or discharged from the program if they don't obey the rules.
91. Members will often do things together on the weekends.
92. The staff will go out of their way to help new members get acquainted.
93. Members will be strongly encouraged to express their feelings.
94. Staff will rarely give in to pressure from members.
95. Members will have to make detailed plans before leaving the program.
96. Staff will strongly encourage members to talk about their past.
97. Members will rarely become angry.
98. The staff will strongly encourage members to be neat and orderly.
99. There will often be changes in the rules.
100. The staff will make and enforce all the rules.

QUESTIONNAIRE RE EASTON CLIENTS

Please tick appropriate answer:

A. Is this person diagnosed psychotic on admission?

1. Yes _____ 2. No _____

B. How long has this person been in residence (number of months)?

C. What in your opinion is the prognosis for this person?

1. Poor _____ 2. Fair _____ 3. Good _____

D. Would you say this person adds positively to the cottage atmosphere?

1. Often _____ 2. Sometimes _____ 3. Never _____

Please answer each question for each client:

Client I A. _____
 B. _____
 C. _____
 D. _____

Client VII A. _____
 B. _____
 C. _____
 D. _____

Client II A. _____
 B. _____
 C. _____
 D. _____

Client VIII A. _____
 B. _____
 C. _____
 D. _____

Client III A. _____
 B. _____
 C. _____
 D. _____

Client IX A. _____
 B. _____
 C. _____
 D. _____

Client IV A. _____
 B. _____
 C. _____
 D. _____

Client X A. _____
 B. _____
 C. _____
 D. _____

Client V A. _____
 B. _____
 C. _____
 D. _____

Client XI A. _____
 B. _____
 C. _____
 D. _____

Client VI A. _____
 B. _____
 C. _____
 D. _____

Client XII A. _____
 B. _____
 C. _____
 D. _____

APPENDIX B

LETTERS AND INTRODUCTORY REMARKS USED IN THE STUDY

TAPED INTRODUCTORY STATEMENT FOR COPEs FORM R
FOR ADMINISTRATION TO ADOLESCENT CLIENTS

I am going to read some statements about programs like Easton. Listen carefully and decide which statements are true of your cottage and which statements are false.

Your name is not on the sheets I have given you, so no one except you will ever know how you respond.

After you hear each statement, make your decision: Is the statement you have heard true, or mostly true; false, or mostly false, for your cottage?

If it is true, put a T for true in the box marked with the statement number. If it is false, put an F for false in the box marked with the statement number. For example, if you believe statement one is true in your cottage, put a T in box one. If you believe statement one is false for your cottage, put an F in box one. T for true, and F for false.

Please mark T or F for every statement. I will repeat every statement once.

Here is the first statement.

NOTE: On the board in the Administration Room is written:

T = True

F = False

July 1979.

Dear Staff Member:

Enclosed are two questionnaires that I would like you to complete. They are part of a study that I am doing on the Maples. One questionnaire is a Cottage Atmosphere Scale and one a Work Group Scale. They take about fifteen minutes to fill in altogether. When these questionnaires are returned, there will be one more to complete the study.

It is very important to have all the questionnaires filled in at approximately the same time so I would appreciate it if you could complete them as soon as possible. It is also important for them to be filled in independently; that is, without discussion with others.

I would like not to discuss the details of the study at this point as it may influence the results, but I will make the data available to the cottage and discuss it fully once the analysis is completed.

All information on the questionnaires will be strictly confidential. I will not know who has completed each questionnaire, only the number assigned to it. The secretary will assign the numbers, but will not read the questionnaires. This is to encourage people to answer the questions as frankly and honestly as possible.

I really appreciate your time and energy invested in completing these questionnaires. Completed questionnaires should be returned to the administration secretary as soon as possible, at the latest two or three days after the questionnaire was received.

Thank you very much.

Encls.

SIGNED "Sue Johnson"

July 1979

Dear Staff:

Thank you for filling in the first questionnaire for me. Enclosed is the final questionnaire which asks about your view of the IDEAL Treatment Environment, and a repeat of the Work Group questionnaire.

It is important that it is filled out independently, without discussion, and returned to the administration secretary as soon as possible, at the latest within two or three days of receiving the questionnaire.

Thank you so much.

Encl.

SIGNED "Sue Johnson"

APPENDIX C

EASTON DEMOGRAPHIC DATA

TABLE XXI
STAFF: LENGTH OF EMPLOYMENT AT EASTON

Cottages	One	Two	Three
Months	4	82	94
	100	34	13
	86	49	42
	54	27	3
	80	36	46
	62	3	24
	54	32	34
	56	26	32
	34	44	20
	48	56	32
	50	30	37
	24	2	38
	16	48	54
	12	72	62
	42	45	92
Means	48	39	41.5
Grand Mean = 43 months.			
Under 6 months Employment	1	2	1
Over 2 years	11	13	11
Over 6 years	3	2	2

TABLE XXII
STAFF: LENGTH OF EMPLOYMENT IN COTTAGE
AT TIME OF STUDY

Cottage	One	Two	Three
Months	4	12	11
	10	12	13
	18	30	16
	12	27	3
	48	36	7
	12	3	1
	24	15	34
	1	4	32
	34	17	20
	48	21	2
	34	30	37
	16	2	34
	16	4	12
	4	12	44
	12	45	13
Means	19.5	18	18.6

TABLE XXIII
PLACEMENT OF CLIENTS BEFORE ADMISSION
TO EASTON

Cottages	One	Two	Three
From Group Homes and Psychiatric Care	3	5	3
From Foster Parents	1	0	2
From Family of Origin	6	5	4

TABLE XXIV
PROGNOSIS ASSIGNED TO CLIENTS
BY COTTAGE SOCIAL WORKERS

Cottages	One	Two	Three
Poor Prognosis	2	3	2
Fair Prognosis	6	5	5
Good Prognosis	2	2	3

TABLE XXV
 CLIENTS: LENGTH OF RESIDENCE IN COTTAGES
 AT TIME OF STUDY

Cottages	One	Two	Three	
Months	4	4	8	
	6	9	10	
	7	2	8	
	18	9	5	
	12	2	8	
	1	5	6	
	2	9	5	
	12	12	4	
	9	5	4	
	8	4	10	
Means	7.9	6.1	6.8	Months

TABLE XXVI
AGE OF CLIENTS AT TIME OF STUDY

Cottages:	One	Two	Three
	15 years, 4 mos	13 years, 8 mos.	16 years, 8 mos.
	16 years, 0	16 years, 0	17 years, 5
	15 years, 6	13 years, 0	14 years, 9
	16 years, 0	14 years, 8	12 years, 10
	17 years, 0	15 years, 0	14 years, 10
	17 years, 1	13 years, 6	15 years, 9
	15 years, 2	17 years, 1	17 years, 2
	14 years, 0	14 years, 2	13 years, 0
	16 years, 10	17 years, 0	15 years, 0
	15 years, 4	15 years, 4	14 years, 4
Means:	15 years, 8 mos.	14 years, 9 mos.	15 years, 1 mo.

APPENDIX D

COPEs NORMATIVE DATA AND OTHER STATISTICS

SEASHORE COHESION INDEX STATISTICS

TABLE XXVII
 COPEs: MEANS AND STANDARD DEVIATIONS OF FORM R SUBSCALES
 FOR AMERICAN NORMATIVE SAMPLE

Subscale	No. of Items	MEMBERS			STAFF		
		(N = 54 Programs) Mean S.D.		(N = 779 Members) S.D.	(N = 32 Programs) Mean S.D.		(N = 357 Staff) S.D.
Involvement	10	6.22	1.32	(2.53)	6.37	1.61	(2.72)
Support	10	6.77	1.15	(2.08)	7.30	0.97	(2.03)
Spontaneity	10	5.50	1.21	(2.15)	5.54	1.44	(2.27)
Autonomy	10	5.87	1.11	(1.86)	7.25	1.41	(2.35)
Practical Orientation	10	5.56	1.21	(2.19)	6.92	0.91	(1.92)
Personal Problem Orientation	10	4.90	1.57	(2.55)	6.06	1.84	(2.53)
Anger & Aggression	10	4.16	1.98	(2.56)	6.48	1.92	(2.67)
Order & Organization	10	7.13	1.32	(2.28)	5.87	1.65	(2.41)
Program Clarity	10	6.55	1.07	(2.03)	7.38	1.13	(1.99)
Staff Control	10	5.13	1.25	(1.99)	3.60	1.38	(2.20)

TABLE XXVIII
 COPES: INTERNAL CONSISTENCIES AND AVERAGE ITEM-SUBSCALE
 CORRELATIONS FOR FORM R SUBSCALES

	Internal Consistency		Average Item-Subscale Correlation	
	<u>Members</u>	<u>Staff</u>	<u>Members</u>	<u>Staff</u>
Involvement	.79	.82	.48	.46
Support	.67	.64	.44	.42
Spontaneity	.63	.75	.43	.46
Autonomy	.62	.89	.38	.49
Practical Orientation	.64	.64	.44	.43
Personal Problem Orientation	.78	.84	.52	.50
Anger and Aggression	.82	.86	.51	.52
Order and Organization	.81	.87	.53	.53
Program Clarity	.68	.77	.45	.44
Staff Control	.67	.76	.40	.45
Mean	.79	.78	.41	.47

TABLE XXIX
 COPES: FORM R SUBSCALE INTERCORRELATIONS
 MEMBERS (N = 373) and STAFF (N = 203)

Subscales	Involvement	Support	Spontaneity	Autonomy	Practical Orientation	Personal Problem Orientation	Anger & Aggression	Order and Organization	Program Clarity	Staff Control
Involvement		50	34	13	44	27	-08	49	32	06
Support	39		44	31	39	27	-12	44	47	-08
Spontaneity	43	40		28	21	39	13	17	34	-27
Autonomy	19	28	24		16	25	00	04	34	-27
Practical Orientation	30	34	14	19		14	01	26	27	04
Personal Problem Orientation	36	27	42	46	22		30	03	19	00
Anger & Aggression	10	-12	11	24	02	46		-47	18	04
Order & Organization	07	29	01	-30	16	-29	-49		38	10
Program Clarity	28	32	23	20	25	06	-21	37		-01
Staff Control	-12	-19	-26	-40	-06	-30	-13	28	07	

NOTE: Member correlations are above the diagonal,
 and staff correlations below (decimals omitted).

TABLE XXX
 COPEs: MEANS AND STANDARD DEVIATIONS OF FORM I SUBSCALES
 FOR AMERICAN NORMATIVE SAMPLE

Subscale	No. of Items	MEMBERS			STAFF		
		(N = 47 Programs)	(N = 618 Members)	(N = 26 Programs)	(N = 252 Staff)		
		Mean	S.D.	S.D.	Mean	S.D.	S.D.
Involvement	10	7.82	1.24	(2.02)	8.51	0.73	(1.38)
Support	10	7.78	0.90	(1.92)	8.35	0.65	(1.51)
Spontaneity	10	6.37	1.21	(2.17)	7.91	0.87	(1.57)
Autonomy	10	6.53	1.10	(1.86)	7.56	0.93	(1.67)
Practical Orientation	10	6.85	0.99	(2.12)	8.22	0.63	(1.25)
Personal Problem Orientation	10	5.44	1.56	(2.81)	6.91	1.09	(2.30)
Anger & Aggression	10	3.69	1.54	(2.52)	6.36	1.24	(2.69)
Order & Organization	10	8.04	0.88	(1.87)	7.26	1.19	(2.19)
Program clarity	10	7.87	0.94	(1.92)	8.39	0.61	(1.24)
Staff Control	10	5.00	1.37	(2.07)	3.59	1.29	(2.12)

TABLE XXXI
 INTERCORRELATIONS AMONG MEAN SCALE VALUES
 FOR SECTION SHIFT GROUPS ON SCALES
 COMPRISING THE SEASHORE INDEX OF COHESIVENESS

	Q.50	Q.52	Q.50a	Q.50f	Q.50g
Q.51 Really part of group	--	.30	.15	.21	.32
Q.52 Want to stay in group	--	--	.37	.38	.34
Q.50a Way men get along	--	--	--	.64	.62
Q/50f Way men stick together	--	--	--	--	.70
Q.50g Way men help each other	--	--	--	--	--

Mean tetrachoric correlation for two or more
 alternative breaks on each scale. N = 228 groups.

APPENDIX E

EASTON SAMPLE TREATMENT SHEET

TREATMENT SUMMARY
(Sample No. 1)

NAME D.

DATE _____

1. Privileges, Limits and Program

Program on grounds
Groups
Planning
Sunday, Tuesday, Thursday - community
School - Thursday 10:45 - 12:00 noon
 1:15 - 2:30 p.m.
 Friday 10:45 - 12:00 noon

Life skills - learn bus routes,
run errands for the cottage/June.

Fitness - 3 times a week at pool, gym - living room and outside activities.

Pool - aquametrics for 15 minutes nonstop

Living room - warm up for 5 - 7 minutes followed by activities at the gym or pool or running in the field

2. Medication

Discourage her 222 and ASA intake. Give her time in her room (10 min.) then talk to her about how she is feeling before giving her her medication.

3. Family Contact

Conferences once every three weeks
During Christmas vacation.

4. Projected Duration of Treatment

Four to eight months

5. Treatment goals

1. Improve family relationships
2. Improve self-worth (I make my family angry, therefore I am no good)
3. Narrow the gap between how she sees herself and how she is seen by others, i.e., she sees herself as plain, slow and unattractive.
4. Improve her social skills.
5. To help her get in touch with the love and rage she has for her family.

6. Proposed Methods of Treatment

1. Confront sexual manipulation
2. Encourage her to get physical contacts from peers and staff through wrestling.
3. Improve relationships with family through family conferences and one-to-one psychotherapy with George.
4. Encourage her to get her privileges
5. Discourage alcohol dependency by examining family situations which led to this dependency
6. Support her to get clear with people re manipulation and avoidance of her feelings, especially sexual and depressive feelings
7. Give her positive strokes
8. Encourage physical activities through fitness
9. Support her with mathematical problems from school.

TREATMENT SUMMARY
(Sample No. 2)

NAME D.

DATE _____

1. Privileges, Limits and Program

1. All privileges except off-shift change, all groups, therapy group on Thursday evenings.
2. School - Tuesday.
3. Life skills.
4. Skiing - Tuesday until 7, after skiing, gym and pool activities.
5. Art therapy two times a week.

2. Medication

Discourage 222 and ASA intake. Get her to take some time out to relax and talk to her about how she is feeling. Try neck massages - she gets tense on neck and shoulder area.

3. Family Contact

Conferences every three weeks and home visits every second weekend as arranged with treatment team.

4. Projected Duration of Treatment

Two to three months - beginning of June discharge?

5. Treatment Goals

1. Improve family relationships.
2. Improve self-worth.
3. Improve self-awareness (narrow gap between how others see her and how she sees herself).
4. Improve social skills.
5. To reach an agreement with her family on where she will go upon discharge.

6. Proposed Methods of Treatment

1. Family conferences and home visits.
2. Psychotherapy.
3. Life skills - encourage use of her privileges.
4. Art therapy.
5. Continue to share thoughts and feelings with kids and staff.
6. Positive strokes and VALIDATION.
7. Extended home visit - 10 days.

APPENDIX F

SOME DEFINITIONS OF TERMS AND TREATMENT METHODS USED IN RESIDENTIAL TREATMENT

SOME DEFINITIONS OF TERMS AND TREATMENT METHODS
COMMONLY USED IN RESIDENTIAL TREATMENT

1. Life-Space Interview: (Wineman, 1959). This is an intervention technique developed by Fritz Redl with reference to the residential treatment situation. A similar concept called the "marginal" interview is found in the work of Bettelheim. "Life-Space" is a term taken from the ecological model, referring to all the various inner and outer forces that impinge upon an individual at any one time. The concept developed in response to client problem behaviours in a residential setting which required on-the-spot handling of an interview type nature. The life-space interview is conducted by any professional who is in the situation, in the process of interacting with the child or adolescent. Redl defines two kinds of interview: one he calls "emotional first-aid on the spot," and the second he terms "the clinical exploitation of life events." The first kind of life-space interview speaks for itself; the second can contain various components such as "reality rub-in," "symptom estrangement" or gaining the allegiance of the healthy part of the client to look critically at his pathological behaviours and their secondary gains, new tool salesmanship, and manipulation of the boundaries of the self or helping the client learn where he ends and other people's rights and processes begin. The context of this technique is that of ego psychology; Wineman talks of the "ego-disturbed child" who, for example, has a marked impoverishment of reaction techniques, thereby needing the counsellor or therapist to engage in "new tool salesmanship."

2. Ego Development: The ego is defined in conventional psychoanalytic theory as a set of functions which mediate between the instincts and the outside world. There are many models of ego development. Perhaps the most well known is that of Erickson (1950), who sees the child progressing through a sequential series of conflicts or crises, beginning with the Trust versus Mistrust conflict, and ending with Ego Integrity versus Despair. The development of a healthy ego is usually seen mainly as the result of stable consistent, positive, interpersonal and intrafamilial relations, in particular with the mothering figure. Instances of ego weakness would be impaired ego functions, namely perception, cognition, affect and action; constant instinctual anxiety; persistence of primitive defense mechanisms with reliance or denial, projection and regression; lack of basic trust; inability to relate to others; lack of impulse control; and primary process thinking, such as megalomania. All the main authorities on residential treatment (Bettleheim, Redl, and Whittaker) use this concept as providing a useful perspective from which to look at and plan interventions for emotionally disturbed children and adolescents.
3. Psychotherapy: The American Psychiatric Association Manual for 1975 defines psychotherapy as "the treatment of mental and emotional disorders based primarily on verbal and nonverbal communications with the patient." It thus encompasses many particular techniques, such as hypnosis or gestalt therapy, and many situations such as group or one-to-one psychotherapy. Psychotherapy is always done in the context of a meaningful relationship and the goal is to resolve intrapsychic conflicts and/or build ego strength. Psychotherapy can be distinguished from psychoanalysis in that psychoanalysis emphasizes the necessity for regression on the part of the client,

and the relationship between the therapist and the client is seen mainly in terms of transference. Psychotherapy, on the other hand, is more of a cooperative situation where there is a real, as well as a transference, relationship between the therapist and the client. Less regression is fostered, and the therapist may concentrate on supportive techniques, helping the client to build up his ego resources, or expressive techniques, helping the client to express and thus understand his conflicts and the dynamics of his life situation (Wolberg, 1967). Psychotherapy can be viewed as a re-education process, a means of learning about patterns of thinking, feeling and behaving. Psychotherapy is usually, then, a shorter process and much more suitable for children or adolescents who do not generally have the ego strength necessary for psychoanalysis. The aim of both modes is to produce catharsis and change through insight; in psychotherapy, however, the healthy part of the client is focussed on, whereas in psychoanalysis the focus tends to be more on the client's pathology. In the residential treatment literature, the crucial issue around psychotherapy, which differs from a life-space interview or crisis intervention, is that whatever form it takes, it must be integrated into the general treatment planning and milieu management of the treatment centre.

4. Family Counselling/Therapy: This perspective on emotional disturbance emphasizes the family interaction process as a necessary condition for disturbance. In the pathological families studied by Vogel and Bell (1960), for example, it was found that a particular child had become involved in the tensions existing between the parents. The child is then used as a scapegoat. Haley (1963) gives more emphasis to the family unit

as a system, and stresses the point that to treat a malfunctioning child in the absence of the system which his malfunctioning reflects is essentially futile. The goal of family therapy, then, is to examine the roles, communication patterns, and underlying dynamics of the family system in relation to the disturbance of the client. Most recent literature on residential treatment stresses the importance of family contact, education, and counselling.