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Community residential environments
for mentally retarded adults:
Staff attitudes and practices
regarding resident dependence and independence

by
Diane Conway

A thesis
submitted to the Dept. of Psychology
in partial fulfillment of the
requirements for the Degree
of Master of Arts

Wilfrid Laurier University
Waterloo, Ontario,
Canada
1981

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ABSTRACT

A study was conducted to investigate staff attitudes and everyday behaviors and their relationship to the independence of mentally retarded adults in four community residences. Questionnaires administered to 15 front-line staff persons measured their perceptions of the amount of external control (situations in which staff assume control over residents' environments), personal control (situations in which staff encourage or allow residents to exert control over their own environments), and shared control (situations in which staff encourage shared responsibility between staff and residents in exerting control over the environment). The questionnaires tapped staff perceptions of the degree to which each of these types of control were being encouraged in their respective settings (real), as well as how much staff thought they should be encouraged (ideal). Two types of questionnaire were used: a general questionnaire which measured staff attitudes in consideration of residents in general, and specific questionnaires which measured attitudes toward specific residents. The impact of staff variables (age, sex, education, and experience) on questionnaire responses was also considered. In addition, participant-observation was carried out in each of the residential settings and interviews were conducted with

the 15 staff members and the residential director of each of the four residences.

Questionnaire results pointed to direct relationships between the ideal and real levels of external control, and the ideal and real levels of personal control. No relationship, however, was found between ideal and real levels of shared control. In addition, there were inverse relationships found between external and personal control, and between external and shared control. There was a direct relationship between shared and personal control. Very little difference was found between responses on general and specific questionnaires. There was no impact of staff variables on questionnaire responses.

Results of the observations and interviews suggested that various strategies are used to implement the different types of control. External control strategies included positive reinforcement, negative reinforcement and punishment, nonverbal messages, teasing and put-downs, encouragement of emotional dependence, and the use of one's intellectual superiority. Personal control strategies included patience, treatment of residents as adults rather than as children, staff's relinquishment of decision-making power, laziness, phraseology, staff as models, physical arrangements of people, confidentiality maintained by staff, the use of natural consequences, and discouragement of emotional

dependence. Also discussed were external controls imposed upon staff. These included administrative policies and rules, and the location of the residences.

Introduction

Human management services for mentally retarded people in our culture have seen varying approaches and underlying ideologies (or lack thereof). An important basis for these differences is the values held by those who are responsible for planning and implementing these services. Such values reflect a belief that mentally retarded individuals are either nonhuman or subhuman organisms, or that they are human beings with a handicap. Wolfensberger (1972), for example, outlines major historic roles of deviant persons: the deviant is described as a subhuman organism, as a menace, as an unspeakable object of dread, as an object of ridicule, etc. He proposes an approach to services that reflects a more positive orientation, a belief in the integrity of a mentally retarded person as a human being with the potential to lead a life that approximates that of other human beings.

This research will reflect such an orientation: that the mentally retarded individual is a human being. The major focus will not be that we must curb and/or serve their deficiencies, but that we have to find ways to provide an optimal environment that can both recognize human rights and still meet the needs of the individual. The rights/needs issue is a paradoxical one in that they appear to be contradictory concepts. In

other words, it can often happen that to meet certain needs, some rights may have to be withdrawn. Rappaport (1980) proposes however, that we must confront the paradox that people have both rights and needs. His point is that the analysis of paradoxical relationships stimulates large varieties of solutions.

We ought not only expect, but welcome this, because the more different solutions to the same problem, the better, not the worse. (p. 12)

Rappaport sees that a preventive approach in services supports a view of dependent people as ones who have needs that cannot be met independently because of their deficit (viewing them as children). He sees advocacy as an approach supporting a rights model of social responsibility (viewing them as citizens). He points out that both these approaches are one-sided, and that:

both advocacy and prevention suggest professional experts as leaders who know the answers and provide them for their clients. (p. 24)

He proposes a different model based on "empowerment."

By empowerment, I mean that our aim should be to enhance the possibilities for people to control their own lives....Empowerment implies that many competencies are already present or at least possible, given niches and opportunities....Empowerment implies that what you see as poor functioning is a result of social structure and lack of resources which make it impossible for the existing competencies to operate. It implies that in those cases where new competencies need to be learned they are best learned in a context of living life, rather than in artificial programs where everyone, including the person learning, knows that it is really the expert who is in charge. (p. 22, 24)

The purpose of this particular research was to describe those characteristics of community residential environments for the mentally retarded that might affect the amount of control residents have over their own personal environments. Specifically, the focus was a description of the attitudes and practices of front-line staff working with these people.

Before discussing the research in detail, I will first consider some of its background components. The basic outline of the thesis will be as follows. The main philosophical approach used in services for mentally retarded people, the philosophy of normalization, will be discussed and it will be shown that it is an appropriate area for research in community psychology. Since the focus of the study was on the environmental context of the lives of retarded adults, I will first discuss the institutional environment and major criticisms of its operation. The deinstitutionalization process will then be considered especially as it relates to that process in the province of Ontario. One of the main goals of deinstitutionalization is to teach retarded individuals to be more independent than they have been able to be in an institution. The following section then, will elucidate the concepts of dependence and independence in terms of the way they have been studied in the past. An

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overview of the design of the study will be presented with the main question being: What are the characteristics of the environment of community residences for mentally retarded adults that might affect the development of dependence and independence in their residents? Specifically, what are the staff characteristics that might affect this development? Past methods of assessing psychosocial environments will be detailed and the one to be used in the present study will be outlined.

Community Psychology and Normalization

One way to conceptualize this work is to consider it within the framework of "Community Psychology." Some of the basic values underlying the practice of community psychology are "cultural diversity," "cultural relativity," and an emphasis on finding the right match between specific persons and specific environments (social ecology). Cultural diversity means that "every person has a right to be different without risk of material or psychological sanction" (Rappaport, 1977, p. 1). This would also apply to cultures and subcultures as well as individuals and is what is meant by cultural relativity. In Rappaport's conception of community psychology, every person in society also has a right to be equal. This would imply that retarded and nonretarded people should have equal access to available material, educational, and psychological resources

provided by the society. If differences among members of society are to be respected, and if resources are to be made available to all, then the accepted practice of judging people against a single standard of competence (i.e. here, intellectual standards) or else labelling them deviant, can no longer be accepted. Finally, an orientation based upon cultural relativity and diversity encourages an "ecological" approach to existing personal and social problems. Thus, certain problems are conceived as not necessarily a deficiency in an individual or an inadequacy with the environment, but as a relative discord in the fit between the two.

For the individual for whom there is a...discordant fit, the causes lie in the relationship between the person's requirements and the requirements of the social systems network. The results of such a discordant condition may be psychological discomfortpersons with more limited resources or more atypical problem management programs will have less choice of systems; there will be fewer systems that can provide them with good fits. (Murrell, 1973, p. 82)

The goal of community psychology, then, is to develop better match-ups between persons and their environments.

Residential services for the mentally handicapped are currently attempting to provide a wide range of services geared to meet the needs of the individual. In order to ensure maximum efficiency in the distribution of resources, an effort is made to provide an optimal fit between an individual with specific needs and an environment that can best meet them. Many of these

services are presently based on the "principle of normalization." This principle refers to the:

utilization of means which are as culturally normative as possible in order to establish and/or maintain behaviors and characteristics which are as culturally normative as possible. (Wolfensberger, 1972, p. 28)

The concept of normalization was initiated in the Scandinavian countries in the late 1950's and early 1960's. A new act legislated in Denmark "Act of 1959", stated that its objective was "to create an existence for the mentally retarded as close to normal living conditions as possible" (Bank-Mikkelsen, 1976, p. 243).

Meanwhile, conditions in U.S. institutions for mentally retarded people were described as dehumanizing (e.g., Blatt and Kaplan, 1966; Vail, 1967). The Scandinavian concept was introduced to the United States in a monograph published in 1969 by the President's Committee on Mental Retardation (Kugel and Wolfensberger, 1969). Nirje (1976) outlines the components of normalization that were articulated in this monograph. These components include:

- 1) the opportunity to have a normal rhythm of the day (e.g., getting out of bed, being involved in meaningful activity, going to bed at an age-appropriate time),
- 2) the opportunity to experience a normal weekly rhythm (e.g., live in one place, go to school or work in a different place, have week-ends off for

- leisure time),
- 3) the opportunity to experience a normal yearly rhythm (e.g., take summer vacation, participate in seasonal changes in sports, food, to observe annual events of personal significance),
 - 4) to partake in normal developmental experiences within the life cycle (e.g., to go to school, to go to work, and to retire, all at age-appropriate points in the life cycle),
 - 5) deserving the respect of personal choices, wishes and desires (e.g., consideration for personal belongings),
 - 6) the opportunity to live in a heterosexual world (e.g., desegregation of sexes into patterns of normal society), and
 - 7) the right to normal environmental standards of living (e.g., physical facilities should be modelled on those types used by ordinary citizens).

In an evaluation of then current issues in residential services, Roos (1970) indicated that:

the Principle of Normalization now seems generally accepted as a sound basis for residential services for the retarded (p. 12).

The details of the philosophy of the concept were finally published in a book by Wolf Wolfensberger in 1972.

The approach implied by his definition of

normalization however, seems to contradict the ideology underlying community psychology. Wolfensberger's definition implies that deviant behaviors must be adjusted to a norm. This would contradict community psychology values of cultural relativity and diversity. It seems that Wolfensberger realized the limitations of his perspective, however. In a short epilog to his book, he suggests that:

The normalization principle implies that we provide conditions which eventually permit a person to function as normally as possible unless he deliberately chooses to be deviant. If he chooses deviancy, we should practice as much tolerance as is possible in a well-ordered society. (p. 238)

Essentially then, the goal of normalization is to provide the mentally handicapped with an equal opportunity to lead as normal a life as possible. This assumes, however, that they lead dissatisfying lives and that more "normal" ones would be more satisfying. This may not always be the case but it shall later be seen that traditional approaches have not seemed to encourage positive life experiences for the mentally handicapped. Normalization is seen as a way to change this state of affairs for the better. Implied in a status of inequality is that those of lower status will tend to be dependent in some respects on those of upper status. An important consequence of normalization then, should be the widening range of choice it affords and the opportunity for a retarded person to be more independent

than s/he has been in the past. The most popular form of treatment for mentally retarded people has, historically, been placement in custodial institutions. With the introduction of the principle of normalization however, there has been a strong movement towards releasing institutional residents and teaching them to lead "normal" lives in the community. In the following section, I will discuss the institutional environment, criticisms of its operation, and the current alternative, deinstitutionalization.

Institutions and Deinstitutionalization

Through research demonstrating the variability of behavior across different settings (e.g., Endler & Hunt, 1968), it has become clear that an important component in the study of human behavior is a consideration of its environmental context. Moos (1974) has reviewed research that demonstrates the importance of the influence of treatment milieu on outcome. The impact of institutional treatment environments has received considerable attention.

Broom and Selznick (1973) have defined institutionalization as "the development of orderly, stable, socially integrating forms and structures out of unstable loosely patterned or merely technical types of action" (p. 232). With respect to residential institutions for the retarded, this definition suggests

that normally loosely patterned activities of living (e.g., eating, leisure time) become formalized and regimented. The development of a formal system means that the system acquires increased control and thus, residents lose a certain measure of control over their own lives. The loss of self-determination in certain areas of functioning may tend to unnecessarily discourage self-determination in other areas of functioning. This would especially be so because the mentally handicapped need more training than usual to reach "adequate" levels of functioning. This might go unrecognized because it is assumed to be easier to provide unnecessary services than to plan individual treatment programs on such a large scale. The result of this is that individual potential is rarely recognized or realized.

Much of the criticism of residential institutions is concerned with the effects of such an environment on its residents. Goffman (1961) has described a total institution as possessing an encompassing character "symbolized by a barrier to social intercourse with the outside, and to departure that is often built right into the physical plant" (p. 4). Barriers to social intercourse would contribute further to residents' dependence on physical and social resources that are within the boundaries of the institution itself. He also suggests that an institution represents a breakdown

of the barriers that separate the three main spheres of life (sleep, work, and leisure). While most people usually have different lines of authority that influence each of these spheres, this is not so with institutional residents. Instead, their life spheres are handled through only one line of authority, and thus, control becomes all-encompassing.

Goffman's analysis can be related to Sarason's (1974) main criticism of institutions. Sarason argues that they create a barrier to social intercourse resulting in an absence of a "psychological sense of community." Sarason refers to this as a "sense that one was part of a readily available, mutually supportive network of relationships upon which one could depend" (p. 1). He suggests that this absence has significant effects on a resident's life.

- 1) "Removal from family and community accentuates the patient's feeling of being different and rejected" (p. 177).
- 2) "The psychological sense of community that the family felt with the patient (....frequently fragile) is further attenuated" (p. 177).
- 3) Relationships between residents and professionals are affected because "the professionals...perceived by their colleagues as second-rate people...feel apart, rejected and the recipients of undeserved abuse" (p.178).

- 4) There is no relation between the institution and the community because the local community has no sense of responsibility for the institution and its residents.

Sarason then, also seems to be suggesting that residents become increasingly dependent on institutional resources because of their alienation from the community and its resources.

Another major factor contributing to dependence would be the process of deindividualization (Wolfensberger, 1972). Wolfensberger does not define this concept but outlines a number of corollary features.

- 1) The first is the existence of an environment that chooses the lowest common denominator through which to deal with its residents. Many capable residents would not be expected to achieve a higher level of performance and thus, would never learn to function more independently.
- 2) Residents are congregated into groups that are larger than most other groups in the surrounding community.
- 3) Regimentation is increased and residents lose autonomy.
- 4) Work, sleep, and play settings are fixed under one roof.

Wolfensberger seems to be suggesting that institutional life leads to a loss of personal identity because the individual is not given a chance to learn to separate his/her personal identity from the group identity (i.e., s/he is always doing the same thing as everyone else and performs at approximately the same level as everyone else).

The theme underlying each of these criticisms seems to be that institutions unnecessarily encourage dependence upon its resources. While institutional reform is being suggested (National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1974), deinstitutionalization is the overwhelmingly popular approach used today.

Deinstitutionalization encompassed three interrelated processes: 1) prevention of admission by finding and developing alternative community methods of care and training, 2) return to the community of all residents who have been prepared through programs of rehabilitation and training to function adequately in appropriate local settings, and 3) establishment and maintenance of a responsive residential environment which protects human and civil rights and which contributes to the expeditious return of the individual to normal community living whenever possible. (NASPRFMR, 1974, p. 4)

Scheerenberger (1976) suggests that such a process is one that would emphasize independence, individuality, mobility, and a high degree of interaction in a free society.

The process of deinstitutionalization in the province of Ontario was initiated 10 years ago by a

report to the Minister of Health (Williston, 1971). In his report, Williston described the level of care and quality of services offered to mentally retarded citizens of Ontario at that time. Of the many and varied observations he made, the following are exemplary.

- 1) Wards were large, overcrowded and residents' lives were monotonous and impersonal.
- 2) Emphasis was placed upon custody, not on training or rehabilitation.
- 3) Catchment areas were very large resulting in great distances between a given resident and his/her family (i.e., infrequent family contact).
- 4) Institutional locations were isolated.
- 5) There seemed to be a dearth of highly trained individuals willing to work under such institutional conditions.

In March, 1973, a new policy focus for community living was outlined (Welch, 1973). This "Green Paper" indicated that the government was considering ways to implement:

- 1) a special program of guardianship,
- 2) changes in the types of economic incentives offered to retarded persons,
- 3) provision of appropriate community residential services,
- 4) co-ordinating mechanisms to ensure the availability of a wide range of services.

Following the Green Paper, new government legislation was enacted, the Developmental Services Act, 1974. Its purpose was:

- 1) to effect the transfer of responsibilities for services to the mentally retarded in Ontario from the Ministry of Health to the Ministry of Community and Social Services (COMSOC);
- 2) to authorize COMSOC to operate and administer the program; and
- 3) to provide a legislative base,
 - a) to expand the program,
 - b) to reorient the program toward community living for the mentally retarded, and
 - c) to attract federal cost-sharing (Ontario Ministry of Community and Social Services, 1974).

And finally, in April 1974, a detailed program proposal was approved by the Ministry (Ontario Ministry of Community and Social Services, 1975). The stated long term objectives were to reduce the incidence and severity of mental retardation in Ontario and to increase the extent of normal living opportunities. The plans for the subsequent five years involved:

- 1) increasing the extent of community-based: a) accommodation options, b) work and training options, and c) support services, thereby allowing community living for those rehabilitatable retarded persons now in institutions, and for those now in the community who are not receiving appropriate service;
- 2) developing and implementing a range of community-based support programs for families of mentally retarded children, thereby reducing the need for placement in facilities (Ontario Ministry of Community and Social Services, 1975).

This and other later discussion papers (e.g., Ontario Ministry of Community and Social Services, 1977) outlined detailed standards that residences and services would have to meet.

To have as an ultimate goal that residents be returned to the community, implies that it is the most desirable place for mentally handicapped people to be. Unfortunately, while institutional critics have articulately outlined how these facilities foster dependence, proponents of deinstitutionalization have not been as specific about how community residential life necessarily leads to independence! It is crucial however, that if institutional residents are to be moved into the community, that the independence-promoting characteristics of community residential environments be identified and shown to be effective. Wolfensberger believes that to accomplish this task, deviants must actually become integrated both physically (location, physical context, access, and size) and socially (program features, labelling, and building perception) into the community. Presumably, he is suggesting that community life would reduce the barrier to social intercourse and would separate the three main spheres of life. Thus, the main source of dependence would be eliminated. But the mechanisms through which independence is to be encouraged are left unclear (i.e., what are the relevant components of the treatment environment that influence the development of independence in the mentally retarded?).

Given that retarded individuals have certain needs that they cannot meet themselves because of their

deficits, some may find it difficult to imagine that they could achieve a significant level of independence. To be dependent in at least one area of functioning points to the need for some form of caretaking. Where caretaking is provided, dependence tends to be exacerbated simply by the availability of other unneeded services, thus leading to institutional models of care. For example, if an individual cannot feed him/herself, then a staff person will feed him/her. If staff do it, then it must be done at their convenience (i.e., they will prepare the meal, it will consist of what is available, feeding will be done when there is time, etc.). Dependence on meal preparation and feeding would also create dependence in the area of decision-making: what, when, and where to eat. While this has tended to occur in the past, dependence in one area of functioning does not have to create dependence in other areas. The focus of this thesis will be to determine how some levels of independence might be encouraged. Before considering how independence might be encouraged, the concepts of independence and dependence themselves will first be discussed.

Dependence and Independence

Literature regarding the concepts of dependence and independence has been relatively sparse and inconsistent. Most of the work that has been done

focuses on children's relationships to their parents and significant others. An additional limitation to this research has been a primary consideration of dependence only rather than both dependence and independence (see Gewirtz, 1972; Hartup, 1963; Maccoby & Masters, 1970). These concepts have rarely been considered in the context of the mentally retarded.

Several attempts have been made to define these concepts as well as to consider the nature of their dimensionality. Heathers (1955a) suggests that:

A person is dependent on others to the extent that he has needs which require that others respond in particular ways if needs are to be satisfied.

A person is independent to the extent that he can satisfy his needs without requiring that others respond to him in particular ways. (p. 277)

Heathers further elaborates on these definitions by distinguishing two forms of dependence and independence: instrumental and emotional. "Instrumental dependence" refers to occasions in which an individual seeks help in order to achieve certain goals. "With emotional dependence, the responses of others are the the endgoals rather than the means of achieving them" (p. 278). Heathers suggests that three types of emotional dependence can be identified: need for reassurance, affection, and approval. In contrast, "instrumental independence" according to Heathers, refers to the "obverse of instrumental dependence" (p. 278), that is,

coping with problems without seeking help. "Emotional independence" refers to the "absence of needs for reassurance, affection, or approval" (p. 278). These distinctions have been popular since their articulation in 1955 (e.g., see Marcus, 1972). It is surprising then, that in another paper published in the same volume, Heathers (1955b) suggests that dependence and independence are not endpoints of a bipolar continuum even though he defined them that way earlier. He offers evidence, however, to suggest that correlations between emotional dependence and independence could be positive, zero, or negative, depending on the specific patterns being studied (i.e., patterns of behavior reflecting emotional dependence and independence).

Beller (1955, 1957) supports Heathers' findings with evidence suggesting that the relationship between dependence and independence is moderately but not perfectly negative. He suggests that this evidence supports the hypothesis that dependence and independence are not endpoints of a bipolar continuum. In his work with parents and children, he proposes that

In order to encourage the child in his early attempts to explore and manipulate the environment on his own, the parent may help and praise the child. Moreover, certain aspects of dependency are constructive and are continually reinforced even in the adult and self-sufficient individual. (Beller, 1955, p. 27)

Beller's conclusions, however, might be questioned on

the basis of the measures used to obtain his results. His measures do not reflect a distinction between the emotional and instrumental forms of dependence and independence. In other words, his measure for dependence reflects an emotional type while the measure for independence is of an instrumental type. That his results do not suggest the existence of a bipolar continuum is not surprising since two different types were being examined.

In reviewing these and other works, Hartup (1963) supports this conclusion:

Although empirical evidence suggests that dependence and independence are orthogonal factors, this evidence may be in one sense artifactual. That is, dependence and independence may or may not be overlapping concepts depending on how definitions are formulated and measures are constructed. (p. 338)

In the context of normalization, reference to independence is meant to refer to the potential for the individual to exert control over his/her own environment and to be able to manipulate it effectively. This would match the concept of an instrumental form of independence. Thus, it could be thought that institutions foster instrumental dependence through the imposition of external controls over which the individual has no influence. Deinstitutionalization is being advocated to reduce the necessity for these controls, thereby increasing the opportunity for individuals to exert more influence over their personal

environments.

Langer and Rodin (1976) investigated the effects of differential amounts of perceived personal control over the institutional environments of the elderly and found strong evidence for the importance of this factor. With what was described as a very subtle manipulation, one group of elderly adults were given the opportunity to make choices in their lives and were encouraged to do so. In addition, they were encouraged to take a small amount of responsibility (caring for a plant). Members of the other group were not encouraged to make choices and plants were cared for by staff. Over a three week period, 93% of participants in the experimental group showed overall improvement (more active, happier, more mentally alert, increased involvement in activities). In contrast, 71% of the members of the control group actually showed debilitation. Langer and Rodin concluded by stressing the importance of establishing mechanisms for changing situational factors that reduce real or perceived responsibility in the elderly.

Langer and Rodin's study demonstrates the necessity for changing treatment environments. With respect to community environments for the mentally retarded however, it would first be important to know what it is that must be changed. The next section then, will deal with the assessment of psychosocial environments.

Assessment of Psychosocial Environments

Jordan (1972) has noted a rapid increase in the attention being paid to the study of human behavior in the context of the surrounding environment. This area of research has been called "social ecology" and has been defined as the "multidisciplinary study of the impacts on human beings of physical and social environments" (Moos, 1974, p. 20). In one study, Lamb and Goertzel (1971) measured the impact of community residential environments on discharged mental patients. Subjects were randomly assigned to one of two community settings. In one setting, expectations of residents were high: there were demands for mobility, planning, and for accepting responsibility. In the low expectation setting, docility was valued and little initiative was expected. Results suggested that while the high expectation group had a higher rehospitalization rate, members of this group spent longer periods out of the hospital, had a higher level of instrumental performance, were less stigmatized, and were less likely to be labelled deviant. This study suggests that mere placement in the community will not automatically facilitate change, but rather, that institutional characteristics can be infused into noninstitutional settings. The point to be made again, is that while proponents of deinstitutionalization have encouraged community residential programs, they have not

been very explicit about what it is about community programs that is superior.

Moos (1974) has outlined six major methods of characterizing relevant features of the environment.

These include:

- 1) ecological dimensions (i.e., geographical-meteorological and architectural-physical design variables).
- 2) behavior settings (i.e., analysis of specific behaviors demanded by the setting, their effects on other behaviors, and on individuals' experiences).
- 3) dimensions of organizational structure.
- 4) dimensions of personal and behavioral characteristics of milieu inhabitants.
- 5) psychosocial characteristics and organizational climate.
- 6) functional or reinforcement analysis of environments.

Of these, the assessment of the psychosocial characteristics of treatment environments has been of primary focus. There have been several questionnaires that have been constructed to serve this purpose and these have measured such dimensions as:

- 1) physical facilities, services, and management and discipline (Ward Evaluation Scale developed by Rice, Berger, Klett, Sewall, & Lemkau, 1963).
- 2) active treatment, socio-emotional activity, patient self-management, behavior modification, and instrumental activity (Characteristics of the Treat-

ment Environment developed by Jackson, 1969).

- 3) Staff measures: motivated professional staff, nursing team as involved participants, dominant professional staff, and praise for work. Patient measures: inaccessible staff, involvement in ward management, satisfaction with wards, receptive involved staff, and expectation for patient autonomy (Perception Of Ward scale developed by Ellsworth, Maroney, Klett, Gordon, and Gunn, 1971)
- 4) involvement, support, spontaneity, autonomy, practical orientation, anger and aggression, order and organization, program clarity, staff control (Community Oriented Programs Environment Scale developed by Moos, 1972).

In order to assess the applicability of such scales to residences for the mentally handicapped, the COPES was modified to measure this type of psychosocial environment (Pancratz, 1975). Of special interest were the results from subscales of autonomy and staff control. Pancratz found that in the residences studied, staff control was perceived by both staff and residents as being three standard deviations above the norms established on residences for the mentally disturbed. Autonomy was found to be one standard deviation below the norm. Thus, while the COPES was generally considered to be an appropriate measure for assessing programs for the mentally retarded, it was suggested

that the staff control subscale would probably not discriminate between these particular types of programs. Since these factors (staff control and autonomy) will be of primary focus in the study to be proposed, it was seen as necessary to use a form of research that would be sensitive to these particular characteristics of the psychosocial environment.

Overview and Issues Related to Design

The present study is intended to investigate the nature of staff attitudes towards dependence or independence of residents with the degree of control staff think residents should have over their environment as the variable of interest. Attitudes will then be compared to actual behaviors, that is, the extent to which staff actually encourage residents to assume personal control over their environment. Degree of control has been broken down into three dimensions. "Personal Control" has been defined as situations in which staff encourage or allow residents to exert control over their own environment. "Shared Control" is defined as situations in which staff encourage shared responsibility between staff and residents in exerting control over the environment. Finally, "external control" is defined as situations in which staff assumes control over residents' environment.

In this investigation, both quantitative and qualitative methods of research were used. The quantitative method was an attitude scale administered to staff. Edelson and Paul (1976) suggest that attitude and atmosphere scales frequently leave several variables uncontrolled, often confounding the results of the research. Specifically, they review considerable literature suggesting that staff age, sex, level and nature of education, and experience significantly affect scale scores. Bordeleau, Pelletei, Pannacio, and Tetrealt (1970) and Middleton (1953), for example, found positive relationships between level of education and attitudinal scores associated with treatment effectiveness. Clark and Binks (1966) found that individuals who were younger and who had higher educational levels tended to have more humanistic attitudes toward mental illness (that residents are capable of responsible behavior, that they should not be unnecessarily restricted, that they are likely to recover, etc.). Middleton reported that staff attitudes changed favorably with increased exposure to mental patients. A number of studies also suggest that females, in contrast to males, tend to score "in the direction of those profiles associated with effectiveness" (Edelson & Paul, 1976, p. 252). In the present study then, the relationship between age, sex, education, and experience of staff, and staff attitudes towards control of the environment were investigated, as well as the relationship between these variables and staff behaviors.

Several researchers, however, have begun to question the strength of the relationship between attitudes and behaviors (e.g., McGuire, 1969). Ajzen and Fishbein (1973) propose a theory that suggests that attitudes are relevant but insufficient measures needed to predict behavior. The theory deals with the "prediction of specific behavior under a given set of conditions" (p. 42). A more accurate predictor of behavior then, was thought to be one's "behavioral intention." They propose that these intentions are mathematical functions of one's attitude, and the perceived normative expectations of reference groups multiplied by the individual's motivation to comply with these. Wilson and Rappaport (1974) measured the difference between generalized and specific expectancies for personal self-disclosure in a group of college students. They found that individuals' responses to given situations were a function of an interaction between generalized expectations and specific expectations.

In the proposed study, I felt that if staff were asked to fill out questionnaires concerning their residents, a common complaint would be that "It depends on the resident." In other words, in order to fill out the questionnaire, staff would feel that they require an outline of more specific conditions than those provided in most general attitude questionnaires. This factor was taken into account in this study. Staff filled out

questionnaires concerning their general attitudes towards control. In addition, they filled out one questionnaire for each resident (i.e., their attitudes applied to given residents were measured). Logically, these questionnaires should measure their intention to perform specific behaviors as well. The demand characteristics that such a procedure would afford in this particular study, however, would seriously reduce its validity. (By asking people if they intend to do something, it would increase the probability that they would do it. They might not have done so had they not been reminded). What were measured then, were staff attitudes concerning the degree of control they believe residents should have in general. This, in turn, was compared to the degree of control they believe specific residents should have. These were compared to the amount of control they actually do encourage residents to have in their daily practice.

In assessing social environments, one step has been to study the congruence between conceptions of the ideal environment and perceptions of how it actually is (Moos, 1974). As was mentioned earlier, the current thrust of the movement towards community care for mentally retarded adults is to "normalize" their lives as much as possible. Such an approach would include training in conducting more independent lifestyles. This then, is the literature's "ideal." One important point of consideration then, was to determine whether the "ideal" of the direct-care workers

was consistent with such a philosophy. After all, they are the ones that are supposed to be implementing it. If staff ideals are consistent with the principle of normalization, it should also be important to determine the relationship between their ideals and their perceptions of how things actually are. The quantitative methodological component to this study then, included a focus on measurement of staff's perceptions of ideal levels of external, shared, and personal control that should be encouraged in their respective settings, and their perceptions of how much of each there actually is encouraged.

The qualitative component to the research method was a naturalistic observation carried out by two observers. Participant-observations were made of staff behaviors relating to external or personal controls implemented in each setting. Specifically, strategies that staff use to implement the various controls were noted. Also, staff and residential directors were interviewed in order to discuss staff communication patterns, and the impact of controls upon staff which may prohibit them from encouraging personal controls in certain instances.

Purpose and Hypotheses

The purpose of this particular research was to describe those characteristics of community residential environments for the mentally retarded that affect the

amount of control residents have over their personal environments. Specifically, the focus was a description of the attitudes and practices of front-line staff working with these people. This study will attempt to answer the following questions:

1) STAFF ATTITUDES

- a) What is the relationship between staff attitudes towards different dimensions of control? In other words, are attitudes towards "external control" (E) and "personal control" (P) related inversely, directly, or are they independent of one another? Similarly, how are "shared control" (S) and P related, and how are S and E related? Following Beller's (1955) conclusions, it was expected that there would be a moderate inverse relationship between the E and P categories of staff attitudes. No predictions were made about shared control categories.
- b) Do staff members' attitudes toward the needs of residents reflect the ideal of a need for external, shared, or personal control over residents' environments? If residences are attempting to implement the current philosophy of normalization, it would be expected that staff attitudes reflect a belief in the need for personal control over resident environments.
- c) Are staff's conceptions of the ideal type of control

to be encouraged with residents consistent with the types they believe are being used in the settings in which they work? No predictions were made.

- d) Do staff's general attitudes match the average of their individual attitudes towards specific residents?

Based on research investigating the differences between general vs specific expectancies (e.g., Wilson & Rappaport, 1974), it was expected that there would be a difference between staff's general attitudes and their attitudes towards specific residents. While staff may believe that personal control should be implemented, they may not find themselves doing so when they examine their own behaviors with specific clients. This difference should be seen in lower scores on personal control categories in the specific questionnaire than the general questionnaire.

- e) Do staff age, sex, education, or experience have any impact on these beliefs?

Based on research reviewed by Edelson and Paul (1976), it was expected that behaviours reflecting encouragement of personal control would be exhibited more by younger, female staff members with higher levels of education and more experience with residents.

2) STAFF BEHAVIORS

- a) What strategies are being used to implement external

control? shared control? personal control? No predictions were made.

- b) Do staff interactions with residents reflect a behavioral orientation towards encouragement of personal control, shared control, or external control of residents' environments? If residences are implementing the current philosophy of normalization, then it would be expected that staff behavior would reflect an environment that is personal control oriented.

METHOD

Settings

Four community residences for mentally handicapped individuals were studied. Each of them are core community residences (a transition point between an institution and a group home). The resident population in these settings ranged from 11 to 24 mentally retarded adults. These men and women varied greatly in their range of intellectual functioning (profoundly to mildly retarded) but the majority were in the moderate and mild ranges.

Each of these residences is run by a local Association for the Mentally Retarded. These associations may be responsible not only for a core residence but for smaller group homes and an apartment program as well. In addition, each association is

responsible for a sheltered workshop for their clients. Other programs in some agencies include developmental centres for children, infant programs, etc. In other words, the Associations are umbrella agencies for various services provided to mentally retarded citizens of their respective catchment areas. Within each association, one person, the Director of Residential Services, is responsible for the core residence, apartment program, and any group homes the agency sponsors. Within the core residence, there are full-time residential counsellors who are each responsible for client caseloads ranging from three to six. In some residences, the position of staff supervisor is an independent one, whereas in others, the supervisor carries a reduced caseload. While the residences also employ day staff, night staff, and part-time week-end staff, the focus of this study was on the prime residential counsellors: those who most often work evening shifts during the week (i.e., 1-9 p.m., 2-10 p.m., 3-11 p.m., or 4-12 p.m.) and some week-ends. These are the people who are responsible for designing and implementing individual program plans (IPP) for each client in their respective caseloads.

Subjects

The total full-time complement of residential counsellors at each residence were included in this

research. This means that 15 front-line staff members, 11 females and four males (one male in each of the four residences) filled out questionnaires, were observed and interviewed. In addition, four residential directors and a staff supervisor who did not have a caseload were interviewed.

Measures

Attitude questionnaire. To measure the extent to which staff believe residents should have control over their personal environments, an attitude questionnaire was developed. The development of this scale was borrowed from an earlier version constructed by Reid (1974). This scale was originally developed by Bennett (1969) for use in school environments. Reid (1974) modified it for use in residential environments for retarded adults. Reid's scale includes 40 items which are divided into seven categories: environmental mastery, submissive control, shared relating, dominant relating, psychological existence, physical existence, and other. The subscales of interest to this study were environmental mastery and submissive control. The subscale entitled environmental mastery was changed to "personal control." The subscale "submissive control" was changed to "external control." Two items were added to this category. To reduce the extremes of the control items, another subscale, shared control, was

added to the questionnaire and it included five items. To ensure the construct validity of the new subscale and new items, five graduate students were asked to sort all of the items into the eight categories (see procedure used by Reid, 1974). Each student did two sorts on consecutive days and only items sorted into the same category 90% of the time were to be retained for the questionnaire. Of the 47 items sorted, only 15 achieved at least 90% reliability.

To improve reliability, the scale was modified. In Reid's scale, three issues were of concern: existence, relating, and control. Thus, it was possible to sort certain items into more than one of these categories (e.g., one item could go both under a control category and an existence category). To reduce this ambiguity, only control items were used for the second sort. Items retained for this sort were ones that had achieved at least 80% reliability in the first sort. One item in the shared control category retained for the second sort had achieved only 60% reliability. Thus, 13 items from the first sort were retained for the second sort. In addition, eight new items were constructed. These 21 items were sorted by five graduate students. Again, each sorted the items twice on consecutive days. All items in the second sort achieved at least 90% reliability (i.e., they were sorted into the same category 90% of the time). Two forms of this

questionnaire were used in this study. The general form included items which refer only to residents in general (see Appendix A). The specific form included the same items worded in such a way as to refer to specific residents.

In addition to the two forms of questionnaire administered, they each contained two types of item, "ideal" and "real." The "ideal" form referred to how staff believe things ought to be (e.g., residents should be allowed to paint their own rooms). The "real" form referred to what staff believe is actually happening (e.g., residents are allowed to paint their own rooms).

Procedure

The main research approach in this investigation was both quantitative and qualitative. The first step taken in this study was to administer the general form of the questionnaire to each staff participant. Then, each staff member completed the specific forms of the questionnaire, one for each client in their assigned caseload (i.e., each staff person filled out one general and several specific questionnaires). These questionnaires were completed in one sitting.

The results of these questionnaires were then tabulated and the important dimensions identified. With this information, an observer (the investigator) visited each setting to participate in their daily activities on

an informal basis. She took detailed notes of occurrences in these settings that related to the control dimensions identified. The observer spent one to two hours with each staff person on each of the evening shifts visited. The observer rotated the times which she spent with the staff on different days. For example, if she observed one staff person's interactions with residents from 4-6 p.m. one day, then the next day she might observe that staff person from 6-8 p.m. or 8-10 p.m. This means that the observer not only observed mealtime activities and chores, but also went shopping, swimming, to baseball games, etc. During periods in which staff were involved in tasks unrelated to this research (e.g., paperwork) the observer would spend time interacting with residents or simply observing them.

In the beginning, the criteria for observation were not specified in detail. The intention was to observe staff's interactions with residents in terms of the various ways in which they would encourage external and personal control. As the research progressed and comparative analysis could be made between residences, the relevant dimensions became apparent (e.g., impact of location, patience of staff, use of nonverbal communication) (c.f., Schatzman & Strauss, 1973).

In the first residence visited, the observer spent four consecutive eight hour shifts in observation. At

the second residence, the observer observed for four eight hour shifts over a two week period. Then, the staff, supervisors, and residential directors at each of the two residences were interviewed. In these interviews, several types of information were discussed. Interviewees were first asked for their interpretations of the results of the questionnaires. Next, the interviewer asked the staff members to describe their own personal communication styles. And finally, they were asked to discuss the external controls imposed upon residents that they themselves had no control over (e.g., those imposed by family, administration). For the format of these interviews, see Appendix E.

To supplement the data collected in the first two residences, the observer spent an additional four four hour shifts in two other core residences. Again, the staff, supervisors, and residential directors of these two residences were interviewed. And finally, toward the end of the observation phase, a second observer went to two of the four residences for the purpose of checking the reliability of the first observer's data. While the first observer was female, the second was male. He spent two four hour shifts in each of two residences and, having finished the second shift in the second residence, he returned to the first residence and started again (i.e., two more four hour shifts in each residence). From the notes of the second observer, it

was possible to examine the consistency of the information obtained by the two observers.

RESULTS

Questionnaires

The first part of the analysis is a statistical consideration of the questionnaire data. It should be noted however, that due to the small sample size ($n = 15$) the results of this analysis can only be considered as tentative.

Data are coded such that "one" represents a low score on each of the control categories (external, shared, and personal control), while "seven" represents a high score on these categories.

Staff ratings were summed within each category (external, shared, and personal control) for both types of items (ideal, real) on each form of the questionnaire (general, specific). For each, there were three scores: external control (E), shared control (S), and personal control (P).

1a) WHAT IS THE RELATIONSHIP BETWEEN STAFF ATTITUDES TOWARDS DIFFERENT DIMENSIONS OF CONTROL? IT WAS EXPECTED THAT THERE WOULD BE A MODERATE NEGATIVE RELATIONSHIP BETWEEN THE EXTERNAL AND PERSONAL CATEGORIES OF STAFF ATTITUDES. NO PREDICTIONS WERE MADE ABOUT SHARED CONTROL CATEGORIES. A matrix of Pearson correlation coefficients was generated for each control

score (E, S, & P) on each type of item (ideal & real) (see Table 1). Several interesting relationships were found through this analysis. As expected, there were moderate inverse relationships between staff's attitudes toward levels of external and personal control exerted in the residential settings both in the ideal, $r = -.57$, $p < .005$, and the real, $r = -.65$, $p < .005$. In other words, the more external control staff felt there should be imposed (ideal), the less personal control staff felt should be encouraged. And in fact, the more external control staff felt there actually is (real), the less personal control staff felt there actually is. In addition, there were moderate inverse relationships between shared and external control categories for both the ideal, $r = -.59$, $p < .01$, and the real, $r = -.50$, $p < .03$. This means that the more shared control staff felt should be encouraged (and actually is), the less external control should be used or vice versa. In contrast, there was a moderately direct relationship between attitudes towards ideal levels of shared and personal control in these settings, $r = .51$, $p < .03$. The more staff felt shared control should be encouraged, the more they felt personal control should be encouraged (ideal). Interestingly, there was no significant relationship between real levels of shared and personal control exerted, $r = .25$, $p > .05$. Other significant relationships are presented in the correlation matrix in

Table 1. Thus, the hypothesis concerning the relationship between external and personal control categories was supported.

1b) DO STAFF ATTITUDES REFLECT THE IDEAL OF A NEED FOR EXTERNAL, FOR SHARED, OR FOR PERSONAL CONTROL TO BE ENCOURAGED IN RESIDENTIAL ENVIRONMENTS? IT WAS EXPECTED THAT STAFF ATTITUDES WOULD REFLECT A BELIEF IN THE NEED FOR PERSONAL CONTROL OVER RESIDENTIAL ENVIRONMENTS.

1c) ARE STAFF'S CONCEPTIONS OF THE IDEAL TYPE OF CONTROL TO BE ENCOURAGED WITH RESIDENTS CONSISTENT WITH THE TYPES THEY BELIEVE ARE BEING USED IN THE SETTINGS IN WHICH THEY WORK? NO PREDICTIONS WERE MADE.

1d) DO STAFF GENERAL ATTITUDES MATCH THE AVERAGE OF THEIR INDIVIDUAL ATTITUDES TOWARDS SPECIFIC RESIDENTS? IT WAS EXPECTED THAT THERE WOULD BE LOWER SCORES ON PERSONAL CONTROL CATEGORIES ON THE SPECIFIC QUESTIONNAIRES THAN ON THE GENERAL ONE.

In consideration of these questions, a repeated measures analysis of variance (ANOVA) was conducted. The first, a 2 x 2 x 3 x 4 factorial ANOVA, treated the two questionnaire forms (general vs specific), two item types (ideal vs real), and three control subscales (external, shared, personal) as within subject independent variables, and the four residences as a between subject variable (see Table 2).

A significant main effect of item type was found through this analysis. Specifically, scores for the

Table 1

Correlation Matrix for Ideal and Real
Item Types on Each Control Subscale

	External Ideal	External Real	Shared Ideal	Shared Real	Personal Ideal	Personal Real
External Ideal						
External Real	.72***					
Shared Ideal	-.59***	-.51**				
Shared Real	-.14	-.50*	.25			
Personal Ideal	-.56***	-.41	.51**	-.09		
Personal Real	-.66***	-.65***	.48*	.25	.55**	

* $p < .03$

** $p < .02$

*** $p < .01$

ANOVA Summary Table

Effects of Residence (A) by Questionnaire (B) by Item (C)
by Control Subscale (D) on Questionnaire Responses

Source	Sum of Squares	df	Mean Square	F
A	1.34	3	.45	.46
Error	10.66	11	.97	
B	.01	1	.01	.04
AB	.66	3	.22	.58
Error	4.18	11	.38	
C	6.35	1	6.35	31.91**
AC	.78	3	.26	1.30
Error	2.19	11	.20	
BC	.76	1	.76	4.89*
ABC	.65	3	.22	1.40
Error	1.70	11	.15	
D	45.77	2	22.89	20.52**
AD	52.88	6	8.81	7.90**
Error	24.53	22	1.12	
BD	.87	2	.43	2.98
ABD	1.81	6	.30	2.07
Error	3.20	22	.15	
CD	35.16	2	17.58	32.77**
ACD	1.76	6	.29	.55
Error	11.80	22	.54	
BCD	.36	2	.18	1.49
ABCD	.54	6	.09	.74
Error	2.63	22	.12	

* $p < .05$

** $p < .01$

ideal were generally higher than those for the real, $F(1, 11) = 31.91, p < .001$. Further, there was a small interaction between item type and the form of questionnaire used, $F(1, 11) = 4.89, p < .05$. As can be seen in Figure 1, there was a greater difference between the real and the ideal on specific questionnaires than there was on general questionnaires. A significant main effect of control subscales was also found, $F(2, 22) = 20.52, p < .001$. Figure 2, however, shows that there was a significant interaction between the types of items used in measuring these control subscales, $F(2, 22) = 32.77, p < .001$. It would seem that approximately equivalent amounts of each type of control (E, S, P) are being encouraged, but that ideally, staff believe that there should be less external and more shared and personal control encouraged in the residences. Thus, the second hypothesis, that staff believe there is a need for residents to have personal control, was supported. Staff conceptions of the ideal types of control to be encouraged are inconsistent with the types they believe are used in their respective settings. And finally, there was no difference between control scores on general and specific questionnaires although there was a difference between ideal and real situations on each of these questionnaires.

The analysis also suggested that residences differ significantly in the types of control they encouraged,

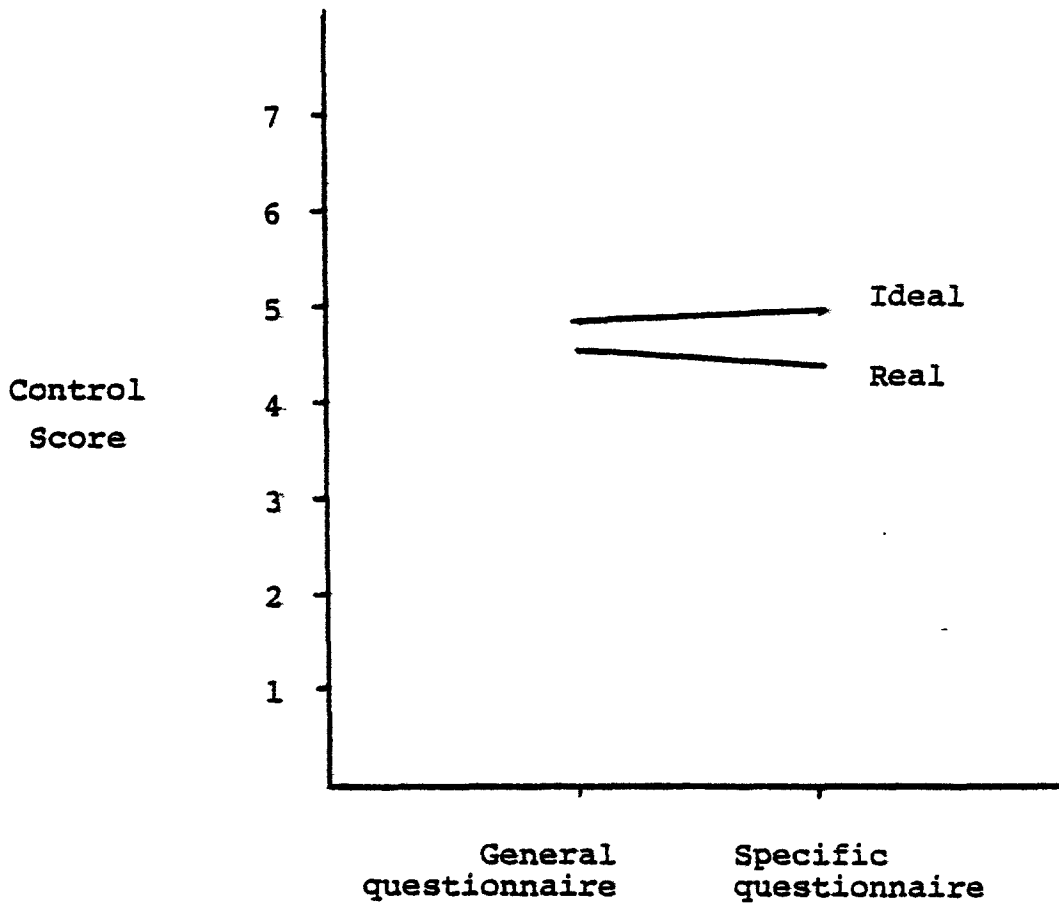


Figure 1. Mean response on general and specific questionnaires for each type of item.

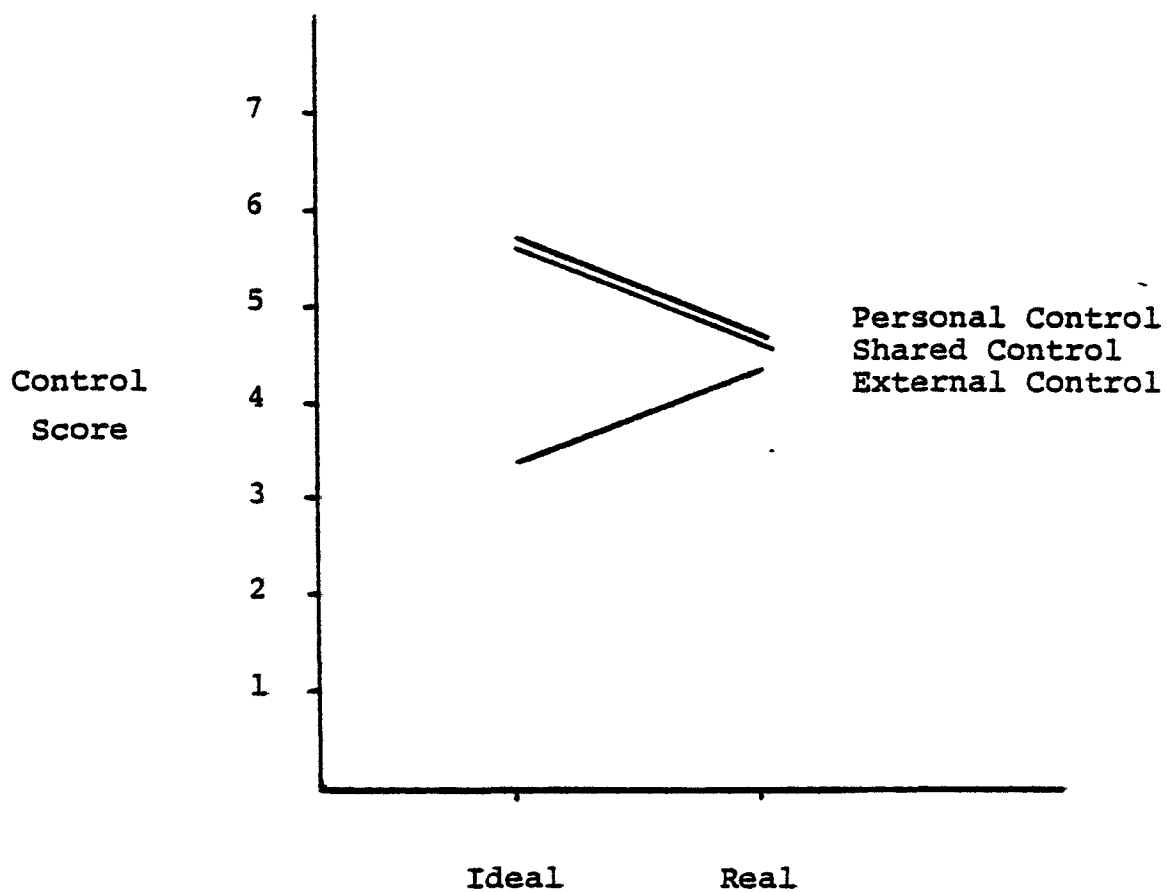


Figure 2. Mean responses for each type of item on each of the control subscales.

$F(6, 22) = 7.9, p < .001$. Consideration of Figure 3 would suggest that staff's perception in Residences Q, Z, and X are that they encourage more shared and personal than external control while staff in Residence K believe that they encourage about the same amount of each. Further examination of Figure 3 points to staff in Residence X as being the ones that exert the least external control and the most personal control (see Appendix F).

1e) DO STAFF AGE, SEX, EDUCATION, OR EXPERIENCE HAVE ANY IMPACT ON THEIR BELIEFS? IT WAS EXPECTED THAT ATTITUDES REFLECTING ENCOURAGEMENT OF PERSONAL CONTROL WOULD BE EXHIBITED BY YOUNGER, FEMALE STAFF MEMBERS WITH HIGHER LEVELS OF EDUCATION AND MORE EXPERIENCE WITH RESIDENTS.

A second repeated measures analysis included sex as the between group variable. Thus, the design was a $2 \times 2 \times 3 \times 2$ factorial with two questionnaire forms, two item types, three control categories, and two sexes. The respondents' gender did not appear to significantly influence the pattern of responses so this hypothesis was not supported.

To determine the relationships between the other staff variables and beliefs in external, shared, and personal types of control, another correlation matrix was generated. None of these relationships were statistically significant (see Appendix H).

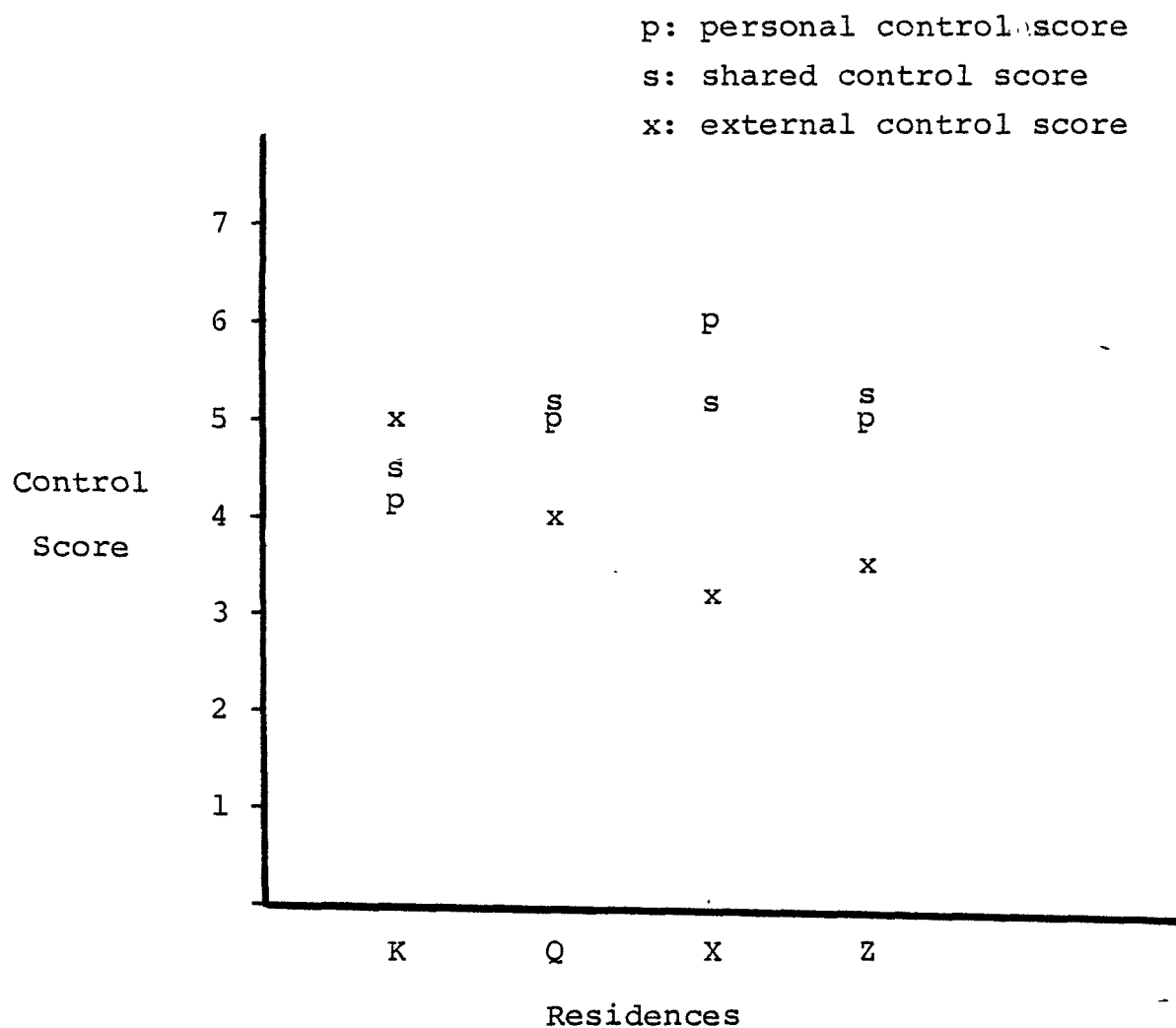


Figure 3. Comparison of the difference between the four residences on each of the three control subscales.

Observation and Interviews

Qualitative results were narrative descriptions of what was occurring in the residences. For the sake of clarity, results presented in the following pages will be from observation of daily activity in the residences unless it is explicitly stated that a particular segment is interview material.

2a) WHAT STRATEGIES ARE BEING USED TO IMPLEMENT EXTERNAL CONTROL? SHARED CONTROL? PERSONAL CONTROL? NO PREDICTIONS WERE MADE. The qualitative data can be considered as falling into two main areas: control strategies used by staff, and external controls imposed upon staff.

Control strategies used by staff. Two main types of control strategies were observed: external control and personal control. Shared control strategies were not identified. Reasons for this will be dealt with in the discussion section. The external control strategies included the following.

- 1) Positive reinforcement. This was seen as an external control strategy to the extent that staff controlled residents' behavior by controlling the immediate consequences of it. It should be noted however, that positive reinforcement can also be a means of teaching instrumental independence. In the context of the immediate consequences of behavior however, it was

seen as an external control strategy.

e.g., A resident is offered a token if s/he complies with a demand, and the tokens can later be "cashed in" for privileges.

- 2) Negative reinforcement and punishment. As with positive reinforcement, these were seen as external control strategies to the extent that staff controlled the immediate consequences of residents' behavior. e.g. of punishment, Resident's privileges are withdrawn when s/he performs an inappropriate behavior.
- 3) Nonverbal messages. Certain physical postures were seen as implying that external control was expected. e.g., A tall staff person may use his/her size to instill fear by straightening his/her back, standing with his/her legs about one foot apart and placing his/her hands on the hips. Facial characteristics may include tensing of the eyebrows, squinting the eyes, wrinkling the nose, frowning, gritting the teeth, contorting the mouth, staring, and making one's chin double.
- 4) Teasing, put-downs. These can be seen as external control strategies to the extent that if and when a resident takes such a comment seriously, it could reduce his/her confidence in the performance of a task. e.g., Staff: That dress looks terrible on you! Consequence was that the resident let the staff person choose the rest of the dresses she would try on, on her shopping trip.

- 5) Encouragement of emotional dependence. When a resident was highly emotionally dependent on his/her counsellor, s/he generally performed instrumental tasks to please the counsellor rather than to meet a personal goal. Occasionally, this was actually encouraged (though probably not intentionally). e.g., Staff: Come on Joe, eat your soup. Please? For me?
- 6) Use of intellectual superiority. When a resident wishes to do or not to do something, the staff person engages in a discussion of the issue with the resident, using logic to convince him/her of the point the staff person is trying to make. Because the staff person is generally more intelligent, and provides a better argument, the client ends up conceding far more often to the counsellor's logic than the counsellor to the clients' logic (though the latter does happen on occasion). While the use of intellectual superiority was the most subtle form of external control observed, it was by far the most prevalent.

e.g., Resident: I don't feel like doing my laundry tonight.

Staff: Do you want to go to work tomorrow in dirty clothes?

Resident: No.

Staff: Do you want to go to work in clothes that don't smell very good?

Resident: No.

Staff: Then how about if you do your laundry?

Resident: O.K.

Personal control strategies included the following.

1) Patience. This was demonstrated in various ways.

The speech pattern of retarded adults for example, seemed generally to be slower. Thus, if a staff person asked a question of a resident, the staff would act in one of several ways: a) answer the question for the resident as well, b) assist in an answer by offering multiple choice alternatives, c) prompt them on an average of every three to five seconds, or d) wait silently for an extended period of time (e.g., 45 seconds if necessary) and then ask the question again, possibly giving later occasional prompts.

Parallel situations are demonstrated in the performance of a task: a) staff may take over the activity for the client, b) s/he may immediately offer suggestions without giving the resident the opportunity to figure the problem out for him/herself, c) s/he may give repeated prompts, d) staff could question resident in such a way as to demonstrate a flat refusal to accept the responsibility that the resident is trying to give him/her, or e) staff may simply observe without comment to the extent that the staff person may actually see a mistake being made, but would allow the resident to try to work it through him/herself before offering assistance. The situation

described in item d is vague. An exemplary interaction might be as follows:

Resident: How do I make liver?

Staff: Well, how do you think you should do it?

Resident: I don't know.

Staff: Well, what do you think needs to be done first?

Resident: Get the pan out?

Staff: Sure. What next?

Resident: I don't know.

Staff: Well, are you going to fry, boil, or bake it?

Resident: Fry it.

Staff: So what do you need to fry liver?

Resident: Butter!

(etc.)

- 2) Treatment of mentally retarded adults as adults and not as children. Child-like treatment was seen in the counsellor's slowing down of his/her speech, an increase in the range of the voice pitch with a tendency to most often use a very high pitch, eyes widening, eyebrows raised, taughened facial muscles, and/or a tendency to "hover" over the individual to whom s/he is speaking. In contrast, adult-like treatment was seen in a more "matter-of-fact" tone of voice, a natural, as opposed to a high voice pitch, and a more relaxed physical posture (eyes, eyebrows, facial muscles, etc.).
- 3) Residents as decision-makers. Personal control is being encouraged when residents are allowed or encouraged

to make their own decisions. Two examples will be given here, one representing external control and the other, personal control. In one residence, clients and staff had agreed months earlier that Thursday night would be a night in which all the women would go swimming. Every week, the same client becomes very upset because she does not want to go swimming. The staff know that, as soon as she gets to the pool, she will be the one who enjoys herself more than anyone else. Thus, she is expected to go every week despite her vehement resistance. And she does enjoy herself every week. In this situation, the staff assume that they know better than the client and therefore impose an external control. In another residence, swim night was also on Thursday night, but on one occasion, staff asked the residents if they wished to go to a baseball game instead. All but one were eager to see the game. In this instance, the staff's attitude was not that external control needed to be exerted. Rather, the immediate consequence was that one of the staff members was very disappointed that s/he would have to miss the baseball game in order to take the resistor swimming. The resident could have gone swimming on his/her own and taken a cab back home, but house regulations stipulated that if a client is on the premises, then there must be a staff person on the premises as well. Since the swimmer would arrive home

long before the group would get back from the game, the staff person would at the very least have had to miss the game and stay back at the residence waiting for the swimmer to come in. In this situation, there was an implicit assumption on the part of staff that it was the resident who decided, not the staff. (Note: Both the resident and the staff person became involved in a lengthy negotiation process which ultimately resulted in a mutually satisfying solution for both parties).

- 4) Laziness. When staff intentionally play "lazy" and do not do anything, then it leaves more instrumental tasks that residents are expected to complete on their own.

e.g., While other staff tended to keep tight reins over their clients' money and dished it out as the need arose, one staff person left the responsibility of money management up to his/her clients, and let them deal with the natural consequences of how they spent it. This person's philosophy was "Why should I have to do something when they are supposed to learn how to do it anyway?"
- 5) Phraseology. Language used with residents could imply external or personal control depending upon the way it is used. An example will be used of a "cook's helper" who is making a salad for dinner. A direct command leaves little opportunity for a client to have even a small measure of personal control in a situation ("Put some

mayonnaise in the salad"). A request ("Would you put some mayonnaise in the salad, please?") gives the client the opportunity to say no. Of course, depending on the tone of voice used and the person who is making the request, such a statement could also reflect a direct verbal order. "Do you think you could put some mayonnaise..." or "How would you like to put some mayonnaise in the salad?" leaves the helper open to express a personal opinion about mayonnaise in the salad. "Do you think there might be something missing in the salad?" leaves the responsibility up to the resident to figure out what s/he wants. If this cook's helper has made salad before successfully, the counsellor may actually choose to allow the salad to go on the table, have the resident taste it, and let him/her detect for him/herself whether there may be something missing. Which of the above techniques would be used would generally depend on the situation, the client, but more than anything else, on the staff person's personal style of communication, (i.e., one who gives direct orders generally does so fairly consistently and so does the staff person who asks a resident what s/he thinks may be missing).

- 6) Staff as models. Staff may use themselves as models to teach residents appropriate behavior. This can be done through the use of comparisons.
e.g., Staff: Why are you wearing panty-hose? It is

so hot out you do not really need them. Do you see me wearing panty-hose? (shows bare leg)

Resident: No.

Staff: Do you see (her peer) or (another staff person) wearing panty-hose?

Resident: No.

Staff: Isn't it terribly hot to be wearing them?

Resident: Yes, I think I will go take them off. I really do not have to wear them, eh? It is O.K., huh?

Staff: Sure!

- 7) Physical arrangement of people. Staff can take authoritative physical positions with residents (external) or less conspicuous physical positions (personal control). e.g., In one residence, there were four rectangular tables. One staff person sat at the head of each table, the head being nearest the kitchen. In another residence, there were two oval tables and staff chose more inconspicuous places to sit.

	S			R
R		R		R
			R	
R		R		R
			R	S
				R

- 8) Degree of confidentiality maintained by staff. It seemed that the more confidentiality of clients' histories, programs and files that was being maintained, the more the staff held the attitude that clients had a right to their own private lives and staff were reluctant to share

information about these private lives with an outsider.

- 9) Natural consequences. Sometimes, rather than imposing a consequence for inappropriate behavior (e.g., a punishment), staff would allow the client to experience the natural consequence of it. It should be noted that such a technique can only be used when a natural consequence is available and obvious to the client.

e.g., If people are going swimming, and a resident has spent his/her money earlier on a hamburger, then s/he would have to sit and watch or not go at all.

- 10) Discouragement of emotional dependence. Staff discourage ingratiating performances of instrumental tasks.

e.g., Resident: Do you want me to make you a cup of coffee?

Staff: I could probably make my own coffee, but I appreciate the offer. Why don't you make a cup of coffee for yourself? (and a resident friend?)

External controls imposed upon staff. Unless otherwise indicated, the information in this section was acquired through the interviews with staff, supervisors, and residential directors.

- 1) Administration. Residential administrations impose some rules and regulations over which staff have no control to change or adapt to situations.

a) Physical maintenance of residents and facility.

Explicit rules may be imposed by administration concerning residents' health or personal grooming, or maintenance of the facility.

- b) Sexuality of residents. Some residential administrations impose rules and regulations concerning sexual behavior of residents. e.g., No sex.
- c) Resident use of alcohol. Some residential administrations impose rules concerning use of alcohol by residents. e.g., While they may visit a tavern, no alcohol is allowed on some residences' premises.
- d) Residents' finances. Financial matters are controlled by government as well as the agency administrations. e.g., Administrations may stipulate that staff control the bank accounts in which residents keep their disability pension.
- e) Curbing risk-taking. Administrative bodies sometimes impose rules which prevent clients from taking certain risks. e.g., They might not allow residents to own a bicycle if the residence is in a busy traffic area.
- f) Resident behavioral problems. When resident behavioral problems become extreme, administration might choose to become involved, generally in a consultative role.
- g) Location of residence. The geographical location of the building in which residents live affect the potential to learn independence. e.g., A country location could put restrictions on resident independence in that they become more or less dependent on staff for transportation.

2b) DO STAFF INTERACTIONS WITH RESIDENTS REFLECT A BEHAVIORAL ORIENTATION TOWARDS ENCOURAGEMENT OF PERSONAL

CONTROL, SHARED CONTROL, OR EXTERNAL CONTROL OF RESIDENTS' ENVIRONMENTS? IT WAS EXPECTED THAT STAFF BEHAVIOR WOULD REFLECT AN ENVIRONMENT THAT IS PERSONAL CONTROL ORIENTED. The behavioral orientation in Residence K was external control and in Residence Q to a lesser extent. The staff behaviors in Residence Z were oriented towards personal control. Residence X was even more personal control oriented than Residence Z (c.f., Figure 3).

Reliability

To provide a check on the reliability of the observer's observations, a second observer was sent out to visit two of the residences for short periods of time. Because of the nature of the observations, no reliability coefficients can be reported. Determination of the consistency of the information was available through study of the second observer's notes and discussions with him. In general, his observations were consistent with the first observer's. Control strategies he reported included nonverbal communication, influences on self-concept (put-downs), use of emotionally dependent relationships, and staff's use of their own intellectual superiority. Treatment of residents as adults or equals, phraseology of language, the physical arrangements of people, and relinquishment of decision-making power were also strategies he pointed

out. With respect to differences between residences in the levels of different types of control encouraged, the second observer's perceptions were in the same direction as the first observer's and the quantitative measures' (see Figure 3). The first observer however, tended to acquire a first impression of a setting which would change somewhat or substantially based upon additional information that was acquired. The second observer tended to retain evaluative first impressions. For this reason, there tended to be disagreement on the magnitude of difference between residences regarding the use of control strategies.

DISCUSSION

The combination of quantitative (questionnaires) and qualitative research methods (observation and interview) yielded a very rich source of data which would not have been possible had only one or the other been used. The quantitative data provided valuable, objective information about staff perceptions of what was occurring in the residences. The qualitative data offered supplementary data to support the quantitative as well as information describing how it was occurring and why.

Lofland (1971) discusses the importance of auxiliary conjecture:

Because of the quantitative researcher's typical distance from the phenomenon of his interest, and because, therefore, of his ignorance, he often finds himself turning to qualitative studies in order to

gain a sense of what the phenomenon is like and what variables he ought to look for.... The qualitative researcher has gotten close to people somewhere in the world. He may not have developed a fully correct and definitive depiction of variations and auxiliary causal accounts, but he has provided indispensable and useful foundations for quantitative research. (p. 63)

In this study, the quantitative data verified the existence of the different types of control in the residential settings and their relative importance in each. The relationships between external, shared, and personal control were outlined as well. The qualitative analysis served to elaborate on these by identifying the strategies that were being used to implement these different types of control. In addition, it served to point out that staff may not be the sole causal factors of the levels of control in the settings, but that there are also external controls imposed upon them that restrict their ability to reduce the gap between their personal ideals and the reality of what occurs in the settings. Thus, the two methods combined provided the potential for a broader understanding of the phenomenon in question. In a later discussion, it will be seen that further research in the area could include quantification of the qualitative data identified. Thus, a cyclical pattern of research, quantitative, qualitative, and back to quantitative, could be established thereby providing a forum in which to broaden understanding in the field as a whole. The

discussion section of this thesis will first consider the quantitative results. This will be followed by a discussion of the qualitative results, and finally, there will be a discussion of the relationship between the two.

Discussion of Quantitative Results

Quantitative analysis of the questionnaire data involved three main areas: the relationships between the control subscales; differences in staff's perceptions based on the residences they work in, the type of items responded to, the form of questionnaire administered, and the control subscales; and the impact of staff variables on their responses.

In discussion of these results, I will first consider the relationships between the ideal and the real for each of the control subscales. It seemed that for external control, there was a fairly strong positive relationship between how much staff felt there should be and how much they perceived that there actually is. For personal control, there was only a moderate relationship between how much there should be and how much there actually is. This was consistent with interview data which suggested that while most were generally satisfied with the control orientation in their settings, they wished there could be a little more personal control. This then, could explain the moderate relationship for personal control. As the reader will recall, there was

no relationship between how much shared control there should be and how much there actually is. One way to explain this might be that the extent to which one can encourage shared control is dependent upon how long it takes for a client to respond to it. For example, a staff member could be sitting in a restaurant with a client. S/he may ask the client what s/he wishes to eat for breakfast: cereal or eggs. This could be labelled shared control because the staff 1) suggested that the client make a decision, and 2) offered alternatives from which to choose (as opposed to letting him/her come up with his/her own alternatives). If the client says "Eggs" immediately, then they have shared in the decision-making process. If it takes five seconds to respond, there may still be sharing. If it takes a minute to respond, there is less of a probability that they share in the decision-making process because the staff may intervene to make the decision for him/her. If it takes five minutes to respond, the waitress may already be at the table. A decision would then be necessary and if the resident has not made one, then the staff person would most likely intervene at this point and make one for him/her. Thus, it would seem that the shared control was dependent upon the duration of the clients' response. While patience and use of natural consequences may be ways of dealing with such an issue, there may also be occasions in which practicality

overrules. In this case then, the lack of relationship between shared control in the ideal and in the real could be explained by the lack of control for a third variable, duration of response. This could prove to be a fruitful area for further quantitative research.

Discussions with staff and directors however, suggested that another reason for the lack of relationship may be that shared control is undefineable in actual practise. The reason they cite for this is that there are different interpretations of shared control and how and why it is used. For one thing, one may ask where the line is drawn between external and shared control, between personal and shared control? For example, if a staff is in a restaurant with a client and asks him/her what s/he wants to eat, is this encouragement of personal control because the staff is leaving the decision up to him/her, or is it shared because the staff person brought it up in the first place? More difficult to interpret however, is the difference between external and shared control. Often, what may appear to be shared control is actually a staff person's manipulating the client's decision-making process in order to agree with a predetermined decision, i.e., shared control could often be an illusion. In further support of this lack of definition, it should be pointed out that in constructing the questionnaires, it was the shared control items that raters had the most

difficulty sorting. The problem however, may be that the operational definition of shared control used in this study was inadequate. Clearly, further work needs to be done to elucidate the concept of shared control.

The finding that there was a moderate inverse relationship between encouragement of external and personal control (both in the ideal and in the real) supports earlier research (Beller, 1955). While the present study was directed at how staff attempt to influence dependence and independence (i.e., through encouragement of external or personal control) and the other study focused on the behavior of the residents themselves (dependent vs. independent), it would still seem that the results of both studies could be supportive of the hypothesis that independence and dependence are not necessarily endpoints of a bipolar continuum.

With an inverse relationship between external and personal control and between external and shared control, one might also have expected an inverse relationship between shared and personal control. In other words, if people are sharing control it would mean that residents must be using less personal control. This, in fact, was not the case. Shared control and personal control were directly related. These results may be related to the difficulty in defining shared control. One way to look at it might be to consider

shared and personal control as falling under a single dimension which might be better conceived of as "relinquishment of total external control." External control, of course, would form the other dimension. If shared and personal control fall under a single dimension then, it would follow that they relate positively. Following this argument, each of the components of the shared-personal dimension should relate negatively to the external dimension. This, in fact, was the case.

As was seen in Figure 1, the interaction between item type and questionnaire form was a very small one but it did point to a greater difference between the ideal and the real on specific questionnaires than there was on general questionnaires. One interpretation of this might be that the specific questionnaires were tapping a more realistic situation in that they asked about real people. General questionnaires, in contrast, may have been tapping more idealistic situations in that they asked about general attitudes. If this was the case then, the ideal and the real would ideally be closer (general questionnaires) than they are in reality (specific questionnaires). It should be pointed out however, that the interaction was determined in large part by the significant main effect of item type rather than by the questionnaire form. In addition, there were no other significant results related to questionnaire

form. Thus, which form staff responded to did not seem to have a strong influence on the results of this study as had earlier been anticipated.

In returning to focus on the ideal-real distinction, an interesting finding was the interaction between the item types and the control subscales. While there seemed to be little difference between how much external, shared, and personal control staff felt there actually is, there was a large difference between how much of each staff felt there should be, (i.e., more shared and personal control and less external). This suggests then, that staff attitudes are consistent with those ideologies expounded in current literature, that retarded people need to learn to be more independent. It may also suggest however, that whether this is, in fact, happening is questionable. The equivalent amounts of external, shared, and personal control in the real, however, could also be a function of the substantial differences found between residences. In other words, because there was so much difference between residences in their perceptions of the real situation, the extreme scores may have averaged out to a mean that does not accurately represent any of the scores of the individual residences. Because of the significant differences between these residences, generalization of the results of this research to other Ontario residences may not be possible.

Interestingly, the staff variables (sex, age, education, and experience) did not seem to affect staff responses to the questionnaires. While this is inconsistent with research cited earlier in this paper (e.g., Clark & Binks, 1966; Middleton, 1953), it is consistent with a study conducted by McLain, Silverstein, Hubbell, and Brown (1975). They measured two main factors through the use of questionnaires: "Activity" and "Autonomy." The measured demographic characteristics of staff included sex, age, length of employment at hospital, length of employment on current ward, shift worked, and professional affiliation. Only the two length of employment variables affected staff responses and these were related only to the "Activity" scale, not the "Autonomy" scale. Unfortunately, the results of the impact of staff variables in this study can only be considered tentative since the sample used was so small ($n = 15$). Of the 15 staff participants, only four were male. The age range was small (22 - 38), with the majority falling in their late twenties. Educational backgrounds were variable (high school diploma to master's degree) but more than half had completed at least a bachelor's degree.

Discussion of Qualitative Results

Qualitative results were simply narrative descriptions of what was occurring in the residences. In this section, I will consider some of the possible

consequences for residents that the various types of controls may elicit. Strategies used by staff to enforce external control or encourage personal control with retarded adults have not been extensively researched. Some research however, has been included.

External controls. It has been pointed out that positive reinforcement, negative reinforcement, and punishment can be considered as external controls used to train personal control of the environment. There has been considerable controversy though, concerning the use of behavior modification principles to impose social conformity. In a 1956 debate (Rogers & Skinner, 1956), Rogers outlines three types of control. External control refers to conditions that are created to modify behavior without obtaining consent of the person whose behavior is being modified. Influence is where these conditions are created with some degree of concurrence with the treatment recipient. Internal control is where a person creates conditions to manage his/her own behavior. Bandura (1969) however, argues that the distinction between external control and influence is illusory.

In many instances, certain conditions are imposed upon individuals without their agreement, knowledge, or understanding, to which they could later free themselves by willingly changing their behavior in a direction subtly prescribed by controlling agents. (p. 82)

He suggests then, that willing consent is an illusory

criterion and that the more important ethical principle to be considered is to determine to whose advantage the power to influence others is used, the controller or the controllee. He adds that self-monitoring is not independent of external influence but that a person can be "considered free in so far as he can partly influence future events by managing his behavior" (p. 88). Certainly, the use of behavior modification self-monitoring strategies have been used successfully with mentally retarded people (e.g., Bauman & Iwata, 1977), and have been found to be significantly more effective than standard behavior modification procedures in some instances (Matson, Marchetti, & Adkins, 1980).

In summary then, behavior modification techniques are usually external control oriented but they may be used in two different ways. They may be used as structured techniques to teach independence, or they may be used as techniques staff use to exert their own power and foster dependence. A critical factor to consider, however, is the relationship between the resident's behavior and the consequence for it. Staff will rationalize negative reinforcement or punishment by pointing out that "if this is not carried out, they must learn that there will be a consequence." In some cases, however, the spontaneity of the staff person's reaction to a situation and the influence of previous events may serve to blow an exchange out of proportion: "If you do

not do your running shoe up, you cannot go to the picnic tomorrow." The consequence of such an unbalance could be twofold. The retarded person may not learn a sense of balance between events, a sense of proportion between what is "bad" and what is really "bad." On the other hand, if they even have a little bit on the ball, they may recognize the bluff (i.e., knowing that there would be no way that s/he would not get to go to the picnic just because s/he did not have his/her running shoe done up). In this sense, if a staff person used this strategy consistently, the client might learn that this person is rarely to be taken seriously.

Staff nonverbal communication patterns and their relationship to external or personal control has rarely been considered in literature in the field of mental retardation. In one study, however, (Grant & Moores, 1977) resident characteristics were considered in relation to staff behavior. It was found that staff interactions with residents whose behavior was more adaptive and more independent were likely to be more positive and less non-verbal. Residents with higher assessed levels of social maladaptation received more nonverbal interactions. While not clearly defined as such, the nonverbal interactions in this study seemed to have negative connotations attached to them. Bailey, Tipton, and Taylor (1977) showed that a threatening stare significantly influenced resident avoidance and

aggressive responses. In an earlier study, Bailey, Caffrey, and Hartnett (1976) found that the use of body size was perceived as an implied threat.

The large object person increased his advantage over the subject as threat increased, while the opposite was true of the small object person. (p. 223)

Nonverbal communication then, can also be used effectively to implement controls over the environment.

Another important data point concerned the issue of teasing and put-downs. The point of teasing was generally to lighten the atmosphere, to enable people to laugh at themselves and, to this extent, could be seen as having a positive influence. At the same time, there is the question whether, because they are retarded, they always understood that the staff were teasing and not being serious. After all, teasing is a form of put-down that is not meant to be serious. But if clients perceived them as being serious, this could adversely affect self-concepts which, in turn, might undermine independent functioning. During observations, clients generally seemed to accept the teasing for what it was and even found situations in which to tease the staff people. There were a few occasions, however, in which staff were unaware that their clients had been unhappy about these interactions. Also, if one feels badly about some characteristic about themselves, even teasing intended to be light-hearted can be taken negatively.

In interviews with other staff people, however, it was learned that some teasing was intentionally used to increase self-concept. The type of teasing used here was as follows. The counsellor would find a way to distort reality for the client in such a way that the client would be able to pick up on it, correct the staff person and tease him/her back. An example of this might be that the staff person would respond to something a client had said by deliberately misunderstanding what s/he had said:

Staff: Did you say that that horse was GAY?!!!

Resident: No-o-o-o-o-o-o-!!! I said it was gray, silly!!

The client might then chase the counsellor down the road to give him/her a playful slap or nudge. In this type of situation, the teasing has been bi-directional: staff to client, then client to staff with the client having the last say. Such an approach reinforces the clients' perceptions that they know something, that they are not dumb. Such confidence in one's self would be an important prerequisite for an individual to make use of his/her independence.

Serious put-downs by staff could also adversely affect client self-concept. Certain situations arise in which clients may need to be told that something they have done is incorrect. Also, staff may simply wish to express a personal opinion. The way that this is done however, might positively or negatively influence self-concept. A staff person can say:

Staff: That dress looks terrible on you!

OR

Staff: That dress is a little tight. How about trying one on in a larger size?

The former really does happen, and with staff people who do not generally seem like ogres! Here is another situation.

Staff: That flower that you made at work is ugly! It is just so gawdy!

OR

Staff: That flower you made seems to be well-done, but personally it is not my style. Of course, people have different tastes. If you like it, then so much the better for your individuality.

In each example, the first part reflects a situation in which the person's self-concept would probably decrease momentarily. In the second, the same concept is being expressed but in a way that should not affect the client's self-concept adversely. Green and Zigler (1962) point out that mentally retarded people pay more attention to external cues than normal people do because they are learning what is appropriate and inappropriate. They pay a lot of attention to what staff say about what they themselves say and do. Thus, these types of interactions can be very important.

The use of emotional dependence as an external control strategy may best be exemplified by the

situation in one residence. Staff turnover there had been very low and emotional attachments between many of the clients and their counsellors were very close. At the same time, there appeared to be little interaction amongst residents. Thus, staff members became almost the only source of emotional support. It should be pointed out that attachments to staff (and vice versa) are not unusual in any of the residences. Good rapport between a client and his/her counsellor is essential. Retarded adults do have certain limitations which restrict their ability to form relationships with "normal" adults so attachments to staff members are not surprising. It is the use that is made of these relationships that is the key factor.

While never explicitly stated to them, residents in this particular setting recognized that withdrawal of affection was the most common form of discipline used by staff. Thus, residents do not do things for themselves, but for their counsellors. This may include such personal activities as laundry or clean-up, as well as ingratiating activities such as making coffee for one's counsellor, volunteering to do extra work, etc. Ingratiation in this residence was not discouraged. In fact, reinforcement sometimes turned out to involve extra attention from staff or staff members showing their pleasure, (e.g., "I am really proud of you for what you have done"). A more resident-oriented response

might be: "You must be really proud of yourself for what you have done."

When emotional dependence of a resident on a staff person becomes too strong, staff in some residences try to redirect the emotional focus to other channels (e.g., encourage them to engage in activity with other residents and make a friend, change counsellor, etc.). This has even been done in the residence under consideration. This is a post-hoc solution however, to an existing problem. Had they not been encouraged, these attachments may not have developed to their existing levels in the first place.

There has been very little research carried out that investigates the relationship between emotional dependence and independence, and interaction styles (e.g., teaching styles, parent-child interactions). Donoghue (1974), however, found that authoritarianism of parents was negatively related to the independence of their children and that restrictiveness was positively related to dependence. Contrary to his expectations, nonallowance for dependence was positively related to independence. In the present study, the residence in which the most external control seemed to be exerted was also the residence in which emotional dependence was used by staff as a control strategy.

Interestingly, one of the few sex differences observed in the study was related to emotional

dependence. Specifically, the emotionally dependent relationships were generally directed between clients and female counsellors. In interviews with the male counsellors, two of the four explicitly stated that they tried to avoid the "maternal" relationships that some of the women tended to get into with residents. Three of the four indicated that, because they were the only male in their respective settings, they tended to be the authority figures (they generally disliked this role) and that residents were a little scared of them (a stereotypical paternal role). Only three of the 11 females described themselves as authority figures. Even in these three cases however, they did not see themselves as "the" authority figure as the men did, but as "an" authority figure.

Personal controls. In describing patience in the results section, it was seen that if a staff person asked a question of a resident, s/he would: 1) answer the question for the resident as well, 2) assist in an answer by offering multiple choice alternatives, 3) prompt them on an average of every three to five seconds, or 4) wait silently for an extended period of time (e.g., 45 seconds if necessary) and then ask the question again possibly giving later occasional prompts.

In the first three situations, the client has not had the opportunity to think for him/herself and consequently comes to rely on the staff person to do the

thinking for him/her. Interestingly, this happens amongst clients as well. For example, while seated at a table with five clients, I asked questions of each of them but one of the clients answered all of the questions. This continued to the extent that when I had finished addressing a given question, the client would turn immediately to the other resident and wait expectantly for him/her to answer it for him/her. It is much easier to rely on another person, be it client or counsellor, to do one's own work than it is to do it one's self. In the fourth situation mentioned above, the counsellor has refused to allow a client to exploit him/her in this way, and has made a concerted effort to see that the individual tries to answer for him/herself before offering any needed assistance. Further, there was a tendency for staff using this pattern to use more non-directive, probing questions if there was no response, in order to continue to encourage the client to attempt to come up with his/her own response. Sarason (1971) discusses question-asking behavior in teachers, its importance for reciprocal question-asking behavior in students, and comments on the paucity of research literature in this area.

This issue may seem to be a minor point. But a given staff person is generally consistent in his/her interaction pattern. And thus, a given resident might rarely be given an opportunity to think for him/herself.

Or, in contrast, s/he may generally be expected to think for him/herself most of the time. Again, while there was some variation within residences (staff using one or another of these patterns), generally staff in a given residence were consistent in their patterns. This may be a function of the philosophy of the administrators or of the staff members themselves. For example, in the residence where all staff seemed to be very patient in the types of situations described above, interviews with staff suggested that their residential director had maintained the philosophy that "if it takes five hours to do something with a client, then take the five hours" (process orientation). Other residences were more task-oriented. ("There are a lot of things to do around here and we haven't got time to spend all day doing so-and-so. It's just impractical").

We have been considering patience in the context of speech interactions between staff and residents. Parallel situations in the performance of a task were also described in the results section. The example described earlier (making liver) was given as an example of a staff person being patient as a resident learned an instrumental task. Unfortunately, this very strategy could also produce another consequence. Such behavior could also turn out to be a reinforcement of emotional dependence rather than encouragement of instrumental independence. One must be able to determine whether the

resident's behavior in this situation was directed at making liver, or at seeking attention by playing dumb, when in fact s/he may already know how to make liver. This factor is what makes quantitative research on dependence and independence so difficult. Strict behavioral observation will not distinguish between the different types of dependence and independence. The staff person's task then must be to know his/her client well enough to understand the basis of the interaction. Many of the counsellors, in their interviews, did point out that they wished that they did not interfere so quickly and that they could let people make more mistakes and learn from them. Emotionally however, it was very difficult to watch a client's frustration continue. If the client's behavior is based more on a need for emotional dependence than the lack of ability for instrumental independence, then the staff person will not learn what his/her clients' potentials are.

Traditional attitudes toward mentally retarded adults have been to conceive of and treat them as children. But if Wolfensberger's suggestion to treat them "normally" is to be followed, then this would have to include the treatment of adults as adults and not children.

While this is one factor which differed almost as much between as within residences, there was one residence in which almost all staff spoke to their

clients as adults. An interesting point related to this was that many of the clients in that setting also behaved more like adults than did residents in other settings. It should be noted however, that one is not necessarily a consequence of the other. Is it because they are treated as adults that residents act like adults? Is it that residents act like adults making it easier for staff to treat them as adults? Is it that on the average, residents in this setting are at a higher level of intellectual functioning explaining both staff and resident behavior? While the first is certainly an intuitively appealing explanation, the second and third are equally plausible ones.

It should be pointed out here, that a single criterion such as communication to an adult or to a child does not distinguish between dependence or independence-fostering staff people. In one instance, for example, a staff person using child-like treatment was also very patient, waited for his/her clients to respond to him/her rather than try to figure out an answer for him/her, asked a lot of non-directive questions, etc. In contrast, another staff person spoke to clients as full adults but ones who were not very bright, and in fact, disrespectfully. Thus, a single factor was not enough to characterize a staff person as dependence or independence-fostering.

With respect to the locus of decision-making, it seemed that in two of the residences studied, staff made most decisions. In fact, at one place, residents rarely seemed to assert themselves at all. Their submissiveness seemed to advertise who the decision-makers were. In the other two residences, it seemed that it was the clients who made many of these such decisions. Interestingly, it would appear that these were also the settings in which clients made the most use of their independence. Often, in fact, if clients would turn to the staff person to assist him/her in a decision-making process, the staff would simply refuse to participate putting the responsibility on the client to make his/her own decision.

The importance of staff serving as models for their clients has been well-established. Early work on vicarious modelling (Bandura, Ross, & Ross, 1963) has shown us that one social learning process is imitation of others. Snyder, Appollini, and Cooke (1977) also found that retarded children will imitate their non-handicapped peers. In other research (Gibson, Lawrence, & Nelson, 1976), it was found that retarded adults learned peer interactive processes through modelling, instructions and feedback. While the combination of the three methods was the most effective procedure, it was found that modelling alone did significantly increase peer interactive responses.

Hirschbach (1976) points out that one of several essential roles for staff is to serve as models for their clients. While he was discussing child-care staff, the same would apply to staff working with adults who are still in the process of learning social behaviors and skill acquisition.

While it was seen that confidentiality was an indicator of personal control, the confidentiality of client data complicated the collection of the data, and it is thus difficult to validate this observation. Certainly, in research of this nature, it was important for me to have access to information about clients and important that I keep this information confidential. If a given resident seemed to have restrictions placed upon his/her life that seemed on the surface to be unnecessary, it was important to understand why these restrictions were necessary. In two of the residences however, it seemed that I had freer access to information than I did in two other residences. In the latter two, I sometimes felt intimidated about asking questions and felt that my physical presence in the setting was an intrusion, even though I had not done anything differently than in the former two residences. In fact, the residences in which I felt I was intruding, were also the residences in which the most independence seemed to be fostered. In other words, those that had a strong attitude that clients make their own decisions,

that they have a right to their own private lives, were the ones who were reluctant to share information about these private lives with an outsider. In contrast, in residences where residents had somewhat less autonomy in their lives, I had full access to information about those lives. Of course, I fully appreciated this information. I feel that my perceptions of these residences were far more in-depth while my perceptions of the other two were more superficial. Without the in-depth information from the first two residences, this research would not have been made possible. But it did seem to be the case that protection of privacy was related to the degree of resident independence fostered.

The concept of natural consequences (and its cousin, logical consequences) was popularized by Rudolf Dreikurs in his work with teachers, parents, and children. In a review of his life work, Turner and Pew (1978) define natural consequences as

a learning technique drawn from experiencing the results of behavior. The child quickly learns the inherent order and reality of the physical and social environment from the natural consequences of his acts: "If I touch the hot stove, it hurts"; "If I fail to get my dirty clothes into the hamper, they don't get washed." (p. 218)

Unfortunately, while the concept has been discussed widely in Dreikur's work and has been applied in training programs for parents (e.g., Parent Effectiveness Training, P.E.T.), very little research

has been done to substantiate the effectiveness of this technique with children. It has not been considered in relation to work with mentally retarded children or adults. But in working with them, it might be expected that if the client experiences the natural consequences of his/her actions and does not like them, then s/he may learn to take more responsibility for his/her own actions in the future. Thus, the staff do not really have to get involved in these situations. The counsellor may need to explain though, how the act relates to the consequence, and strategies to use to avoid it in the future. But out-and-out external control is not always necessary under such circumstances.

External controls imposed upon staff. Through the use of the interviews, it was learned that one area in which administration tend to exert control is in the physical maintenance of clients (e.g., ensure that they are properly dressed, no dandruff). The reason for the concern, according to those interviewed, is generally to preserve the image of the retarded adults in the community as their appearance reflects upon the residence and, more generally, the association itself. Staff have sometimes felt that this priority may interfere with programming, i.e., staff must be sure residents look alright every day (external staff control upon resident) rather than being able to take a little

more time to teach them "proper" grooming as well as to let them experience the natural consequences of improper grooming (e.g., "if their peers tell them that they smell, it will have far more impact than if I do as a staff person").

Interestingly, while not one of the front-line staff mentioned it in their interviews, three of the four residential directors pointed out the administrations' concern with the health of their residents. This may suggest that while administrations are concerned that health be maintained and medications administered, they may rarely try to exert influence in these areas so that staff do not feel a strong impact of this concern. In some residences, staff felt that administrations exerted their influence over what the clients eat. In three of the four residences, a cook was responsible for most of the food shopping and menu-planning. Thus, residents rarely had an opportunity to decide what they wished to eat, to plan and prepare balanced meals. Some staff members felt that these were not appropriate functions to be learned in a core residence (i.e., better learned in a group home) whereas others felt that a residence was an appropriate place to acquire these skills.

It was suggested that administration tried to maintain an influential role over moral issues which concern the community at large. One of these was in the area of sexuality, but there was considerable variation

on this issue. Interestingly, the residence which seemed to be encouraging the most independence in other areas, had the most restrictive policy on sexual behavior (i.e., no sex). In this instance however, it was not the administration that set the policy. It was a decision reached by group consensus amongst the staff.

In another residence, there was no policy at all on sexual behavior. The argument there was that, like it or not, sexual behavior is going to take place. It was felt that the best way to deal with it is to do so as the situation arises and consider the individual merits of the situation. It was felt that to ask the administration to set a policy would surely mean a very restrictive one which would be very difficult to carry out. Thus, with no policy at all, at least there was some leeway in how to deal with such situations. Unfortunately, this puts front-line staff in a difficult situation. They claim that they are not allowed to include sexual behavior as a programming priority and that counselling must be very informal. Yet if a negative incident concerning sexuality arises, staff believe that they will ultimately be held accountable. This, of course, inhibits their own decisions about how to deal with sexual behavior. The whole issue of sexuality in this residence then, is left highly ambiguous.

In another residence, policy set by administration states that sexual behavior amongst residents is not allowed. Here, staff attitudes seem to be that the reality of the situation is that residents will involve themselves in sexual behavior whether they are allowed to or not, and thus, it is this reality that must be dealt with. Information about policy on sexual behavior in the fourth residence was not acquired.

While discussion of administration policies as external controls upon staff has not been discussed in the mental retardation literature, Mulhern (1975) did study administrative policies in institutions as they relate to sexual behavior. He concludes his paper by suggesting that "a commitment to principles of normalization encounters severe strains in the area of sexual behavior" (p. 673). He points out that what is needed is conceptual clarity in defining normalization of behaviors and applying the principles to these.

The second "moral" issue concerned the use of alcohol. Again, residences varied on policy in this area. In one setting, alcohol was not allowed on the premises but clients were allowed to go for a drink in a tavern if they chose to do so. In a second setting, alcohol was not permitted on the premises, and clients were discouraged from any form of social drinking except possibly on special occasions under staff supervision. There seemed to be contradictions between some of those

interviewed in this residence about the use of alcohol, and I had a difficult time trying to understand what is actually practiced.

In a third setting, there was no policy on the use of alcohol but staff were encouraged to be as discrete as possible about residents' use of alcohol, the main concern being possible community reaction to a retarded person drinking alcohol. In a fourth setting, alcohol is allowed on the premises and residents are allowed (not encouraged or discouraged) to store a case of beer at the back of the fridge, or to keep a bottle in their room. In addition, these people may visit a tavern if they so choose.

One important consideration in discussion regarding the use of alcohol is the effect it may have in its interaction with medication. Most of the residents in these settings are on some form of medication (e.g., to control epileptic seizures, depression, congenital heart problems). The use of alcohol for some people can be dangerous and they usually know it and control their intake accordingly. One staff person pointed out that one resident who, while on medication, had been allowed to drink as much as he chose, had had a minor reaction the next day. The staff member indicated that the reaction had taught the resident far more than the staff person ever could have: that what the staff people had been saying about being careful not to elicit a reaction

had been true! S/he claimed that, dependent upon the type of medication and its effects in interaction with alcohol, s/he would condone this type of learning process. This is consistent with a "learning from mistakes" strategy.

The area of finance seemed to be the most controversial one for staff since there were so many different sources of control over it: government, agency administration, staff, client, clients' families, etc. Basically, it seems that retarded adults (i.e., over the age of 18 years) receive a monthly Family Benefit Allowance from the Ontario Ministry of Community and Social Services which amounts to \$397.00. Of this, all but \$61.00 goes to the agency for room and board. The \$61.00 is for the resident to spend on personal needs and entertainment. In addition, they earn a nominal amount in sheltered workshops where they are required to work. The resident may or may not see that money depending both on his/her level of intellectual functioning and the residence in which s/he lives. In one residence, the money is deposited to the residents' accounts by a staff member. When necessary, the staff person also withdraws money from the residents' accounts and gives them cash to buy particular items, or buys the items for the clients themselves. Staff here do not necessarily want this responsibility and often feel that their clients could benefit more by handling at least

some of their own funds, but this is a rule set by the administration and they cannot do anything about it.

Other residences, in contrast, encourage varying amounts of personal control over finances. In one setting, money is generally kept in a petty cash box, but residents are responsible for going to the bank to make deposits and withdrawals. When they return from the bank the money is returned to the petty cash box and it is handed out as the need arises. One staff member here, admits that his/her main personal characteristic is laziness and that s/he does not want to be bothered with the responsibility of managing his/her clients' finances. Thus, s/he lets them have their money a week in advance to do with as they choose. If they run out, they suffer the natural consequences.

It should be pointed out here that one of the main reasons for controlling finances like this is that some clients may not have any concept of what money is, or if they do know, they spend it all immediately. An argument against this would be that they will never learn to manage money if they are not given the chance. The counterargument to this would be that some people have higher programming priorities than money management (e.g., extreme behavioral problems, toileting, etc.). It is unnecessary however, to apply such rules across the board when some people ARE capable of handling their own money. Fortunately, money management is a programming priority for some clients.

In the other two residences, clients have varying degrees of control over their money depending upon their ability to manage it, i.e., for clients who are capable of managing it themselves, the responsibility is left entirely up to them; for clients who are at lower levels of intellectual functioning (e.g., no concept of money, cannot sign a deposit slip, etc.) the responsibility may actually be "shared" with his/her counsellor or fully controlled by him/her.

As could be expected, the subject of finance was a popular topic of conversation. Many felt that while the government claimed to be encouraging deinstitutionalization and more resident autonomy, the way in which they have set up the funding structure for retarded adults actually discourages independence.

The Family Benefit Allowance (FBA) is for mentally retarded adults who are permanently unemployable. They should be enrolled in a day program. The requirements are that to live in the residence, the client must also work at the workshop. If s/he wished to be competitively employed but does not have the skills to live outside the residence, then s/he would theoretically have to pay approximately \$336.00 per month to live in the residence (it varies from residence to residence). If however, they are not registered in an approved residential program (e.g., are living independently in an apartment under the supervision of a

Protective Service Worker) then they no longer receive the Family Benefit Allowance. Instead, they would receive a disability allowance of \$315.00 per month (i.e. less than the FBA). This is certainly no incentive to develop one's self towards greater independence.

Interestingly, because residents can only have a maximum of \$1500.00 in their bank accounts, clients in one setting are strongly discouraged from buying lottery tickets. The rationale is as follows. If a resident won \$10,000.00 and the money was banked, then the FBA cheque is immediately cut off. The \$10,000 would thus diminish rapidly. Reapplication for the FBA is not allowed until the banked amount has been reduced to \$1500.00. At this point, staff people claim that they can reapply but that it would take eight or nine months before the application is processed. To win and bank \$10,000 then, would actually be detrimental to a client. Two alternatives then, are left open. One way would be to spend the money immediately. This is not as easy for retarded adults to do as it may seem. They cannot buy a house or a car, and their personal interests are not often as diversified as the average man or woman on the street. The other alternative would be to put the money in someone else's account. Here again, there would be dependency on someone else, hopefully someone that could be trusted.

In another residence, a couple of people actually go to bingo quite regularly. While this research was in progress, one woman won \$250.00 and another \$50.00 the same night. In fact, the former spent her money immediately to buy "her own bed" for her planned apartment. Problems do not necessarily arise then, but residents have certainly been made aware that they must be cautious about having too much money (as if \$61.00 a month is too much!).

While it varies from residence to residence, spending money must usually be used for such things as cigarettes, entertainment (dinner, movies, swimming, etc.) educational activities (e.g., an evening class in reading and arithmetic skills, swimming lessons). In some places, personal care items such as soap, shampoo, deodorant, is bought in bulk by the agency and is sold to the client at a nominal sum (e.g., \$.50 for shampoo). In other places, they are expected to buy their own. Generally, this means that residents have been supplied with enough money to meet their basic needs. Some staff however, pine for the occasional luxury for their clients: a nice coat, a holiday out of town other than at a camp for retarded adults. One residence does use the "Ontario Tax credit" (approximately \$250.00 per year for each client) for this purpose. But if clients go on a trip, then it becomes their responsibility to pay part of the bill for the counsellor that must accompany him/her.

Another area in which the administration tend to exert their influence is in curbing risk-taking. As pointed out by one residential director, the issue here is a difficult one. S/he pointed out that Wolfensberger (1972) suggests that retarded people should be allowed the dignity to take their own risks as part of the developmental process. He also suggests, however, that they be protected from undue risk. In actual practice, it is very difficult to draw the line between the two. Staff, in general, felt that their administrative bodies were fairly conservative. They felt that it was important that their clients be able to take certain risks (e.g., a resident going on an outing by him/herself). Risk-taking according to staff, does not sit well with administrative bodies for two reasons. For one thing, the agency is ultimately responsible for what happens to their clients, and they do not want to risk any negative incidents. Secondly, the administration is apparently concerned about the success (or lack thereof) of the clients and how this might negatively affect the public image of the agency. Both are legitimate issues but at the same time another label that might be applied is over-protectiveness. Unfortunately, it is difficult to determine how far one can go to take a risk without going too far.

A variable that significantly affected resident independence was the physical or geographical location

of the building in which they live. In this study, two were located in country settings, three and seven miles outside of a small and a large urban centre, respectively. One was located in town, on a two mile commercial strip. A fourth residence was located on the inside boundary between a residential and a commercial area. Both of the city residences had public transportation that was available. Thus, two settings were located in country settings and two within city limits.

A country location put strong restrictions on resident independence in that they were more or less dependent on staff for transportation. The impact of this was not the same in the two residences, however. In one country residence, there was no public transportation in the nearby small community, so residents were driven to and from work either by residence or workshop staff. In the other, residents who were capable of doing so, were driven to the city outskirts in the morning and were expected to take public transportation to the workshop at the other end of the city. They were to be picked up again at a prespecified time at the end of the day. Such a practice had both benefits and drawbacks. On the one hand, they had learned to use the local public transit on at least one major route. Since this association's group homes were within city limits, this knowledge

would prove useful to those residents who might later be transferred there.

On the other hand, because residents were to be picked up at a specified time, they did not have the choice of stopping for a coffee or doing some shopping before coming home from work. Clients in city residences who walked home or took a bus did make use of this opportunity as was seen in their varied "estimated time of arrivals" (i.e., they arrived home anywhere from half an hour to one and a half hours after work, just in time for supper!).

This means then, that residents living in the country spent far more time at home than did city dwellers. After dinner, city residents would go shopping, out for coffee, out to bingo, for a walk, etc. While country residents were sometimes driven into town, this had to be dependent on how much time the staff had to do so. This meant that city residents were more familiar with wandering around on their own than were country dwellers. Community orientation was not only better, but it was sometimes self-initiated. They were experienced with the man/woman on the street, the clerk in the store, the tellers at the bank. This does not mean that country dwellers had no experience with these, only less.

These findings are consistent with research reported by Eyman, Demaine, and Lei (1979). They studied the

relationship between community environments and resident changes in adaptive behavior. Their measure of the community environment was the Program Analysis of Service Systems (PASS III). One factor in this system was location and it referred to access, local proximity to the community, and physical resources. Results indicated that location of services produced significant positive change on personal self-sufficiency and on community self-sufficiency.

Relationship between Quantitative and Qualitative Results

Basically, the questionnaire results were consistent with observations. Residence K was more external than personal control oriented as indicated by questionnaires, but observation suggested a greater distance between external and personal control than was indicated by questionnaire findings. Use of external and personal control in Residences X and Z are consistent with staff attitudes on questionnaires. It would have been expected however, that there was a slightly lower score on personal control in residence Q than was found through questionnaires (though the score on external control was consistent with questionnaire findings). The relative standing of external control would be as predicted from observations. Interestingly, staff in the residence with the highest score on external control, did admit that while there were certain inherent restrictions about the setting that

made encouragement of independence difficult, they felt that they might be using these restrictions as excuses to maintain control. For example, one person pointed out that they may be using their location as a crutch, to defend themselves against dependence-promoting strategies that could possibly be unnecessary.

With respect to staff variables, I did not note large differences in the way a given staff person handled individual clients. The only thing that was noted was that males tended to be more physical with their clients than females did (e.g., playfighting). Males also pointed out that in general, their clients were probably a little afraid of them, at least more so than they might be of females.

CONCLUSIONS

Theoretical Implications

One important issue that has not been taken into consideration in this paper to this point has been to distinguish the strategies that staff use according to whether or not the desired behavior is in the resident's repertoire. Consider a 2 x 2 matrix with control source (external, personal) and resident behavioral repertoire (behavior in repertoire, behavior not in repertoire) as the variables of interest (see Figure 4).

	External Control	Personal Control
Behavior in Repertoire	a	c
Behavior not in Repertoire	b	d

Figure 4. 2 x 2 matrix with relevant variables being control source (external, personal) and resident behavioral repertoire (behavior in repertoire, behavior not in repertoire).

Consider cell a. If a behavior, (e.g., making liver) is in the resident's repertoire, and if a staff person used an external control strategy, (telling him/her what to do) the interpretation would be different than if the behavior is not in a residents's repertoire (cell b). In the first situation, the staff person is discouraging independence without regard for the resident's rights. In the latter situation, where the behavior is not in the resident's repertoire, external control may be interpreted differently. A structured learning environment may be necessary for teaching independence. Within this cell however, it would also be important to consider certain ethical questions. Firstly, does the resident have the potential to learn the behavior? And secondly, does the resident want to learn to perform the behavior him/herself. Such questions would need to be considered before a staff chooses the external control strategy that s/he will use. In other words, if s/he is teaching, behavior modification might be the strategy chosen. If the resident does not have the capability or desire to learn the behavior, staff may reasonably choose to perform the task for the resident.

Cell c represents a situation where staff encourage residents to perform certain tasks for themselves because they are capable of doing them. Cell d would represent a situation in which staff give control away

to the residents in a type of "laissez-faire" manner. It represents an unstructured learning environment where residents may learn to perform a behavior by chance. Some might argue that this may occasionally be a strategy of choice as long as it is carried out in such a way that staff could supervise the learning experience. If staff are supervising however, then it really is not personal control.

The matrix described above clarifies certain issues of when it is appropriate to use external and personal control strategies. Certainly, there are occasions in which use of external control is appropriate and use of personal control is not.

The main thrust of this paper has been to consider the rights of the mentally retarded citizens of our community: the right to live as normally as possible, and more specifically, as independently as possible. But in allowing them to exercise these rights, we must also consider whether this might detract from the process of meeting the needs that they do have. In other words, when does encouraging people to exercise their rights interfere with ensuring that their basic needs are met? Take the hypothetical case of a mentally retarded adult who, despite lengthy explanation, does not understand the relationship between eating meals and his/her personal health. S/he decides that s/he does not wish to eat dinner. S/he should have the right to

make that decision, but do we let him/her continue to go without food for two weeks? Or, do we, at some point, intervene and force him/her to eat? At what point?

While this paper has indicated that a certain measure of personal control is encouraged in community residential settings for mentally retarded adults, it should be pointed out that in a sense it may be an esoteric concept in the context of the rights vs needs issue. Staff people have control over how much external control they impose and how much personal control they encourage. Moreover, they have the power to take away personal control in particular circumstances. In other words, they control how much personal control people have and so ultimately, they actually do own almost total external control. I say "almost" because, of course, there are administrative, governmental, and legal factors that impose external controls on the staff to ensure that staff are not using total external control. The point to be made, however, is that staff can, in many respects, withdraw personal control from residents (e.g., not allow resident to make certain decisions, treat them as children, use verbal commands rather than requests, etc.). In the present situation, staff encourage residents to exercise rights but only to the extent that residents' needs can continue to be met. When needs are not met, staff can and do withdraw personal control from a resident (i.e., personal control

really seems to be more of a privilege right now than a right). Until we know how to precisely define what they do need and what they do not, this will continue to be the case.

Implications for Future Research

In summary then, I have shown that staff believe that some external controls should be imposed in residential settings for mentally retarded adults and that some personal controls should be encouraged. Of course, these attitudes did differ significantly between residences. It was also seen that there was a negative relationship between external and personal control. Various strategies are used to impose external and to encourage personal control, but consideration must be given to choosing appropriate situations to apply each. One important area for future research would be to specifically outline such "appropriate" and "inappropriate" situations. This would have to be articulated simply and clearly enough that front-line staff workers with even minimal education could understand and use these outlines.

The research presented in this paper can be considered as a single step toward investigating staff-resident interactions. This particular study identified the categories of interaction (the control strategies) that might relate to resident dependence and independence. With this information, it would now be

possible to move into a longitudinal, quantitative analysis of the impact of these strategies on resident dependence and independence. Also, the impact of administrative, governmental, and legal controls on the development of resident dependence and independence should be measured. Both of these research efforts would certainly have to control for the residents' levels of intellectual and adaptive functioning.

It has been mentioned earlier that the concept of shared control was ambiguous either because it has not been adequately defined or because mitigating variables are involved. The duration of response hypothesis was one which could account for this ambiguity, and could suitably be quantified. It was suggested that the extent to which control is shared could be dependent upon the length of time it takes for the client to respond: the more time that it takes for the client to respond, the less probability there will be that control would be shared. Such an investigation would again have to control for clients' levels of intellectual as well as adaptive functioning.

Given that, in regard to the different levels of control in each of the residences, the questionnaires were validated concurrently with observations, one could use these scales to measure control differences in the social climates between various settings. A very important area for research would be to study the

effects of staff encouragement of independence on clients' success rates in the community. We assume that residences that encourage the most independence would be ones whose clients should best succeed in a community group home or independent apartment living. There is no evidence to substantiate this, however. It may also be the case that residences are offering more independence than clients are prepared to handle. Is there a revolving door syndrome? In other words, are residents who "graduate" to apartment programs returning to the core residence because they were not prepared for such autonomy? Are some core residences sending some of their clients back to institutions because the residents are not able to handle the social climate of the setting? If there is a revolving door syndrome, it would be important to know the characteristics of the clients that are not making it, how these characteristics relate to the ways in which staff had been encouraging dependence and independence, to find assessment tools that would measure readiness for more independent community living than they are currently involved in. Another important area for future research would be to find the optimal level of independence to be encouraged that would facilitate a retarded adult's integration into the community.

I feel however, that the most important contribution of this research has been in the area of the control

strategies outlined. Staff development programs for direct-care workers could be expanded to include conceptual and practical training in the use of these strategies. Before this can be done, however, it would be important to further define these strategies. More clear operational definitions should be outlined for each and then, their impact should be measured longitudinally on clients' intellectual and adaptive development. Once this is accomplished, it would mean significant advances in outlining clearly the means of implementation of the philosophy of normalization in services for retarded adults in our society.

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Appendix A
Sorting of the attitude questionnaire items

First Sort

Instructions: My research involves an investigation of the needs of retarded adults as perceived by the staff who work most closely with them. The names of categories of human needs and their descriptions are typed on white cards. Questionnaire items are typed on blue cards which are presented in random order. Please sort the items on the blue cards into one of the eight categories. When you have finished sorting please fasten the cards together and return them to me. Tomorrow you will be asked to sort the cards again in the same way that you did today. Each of five social scientists will sort the cards twice. Only items on which there is agreement 9 out of 10 times will be retained for the questionnaire.

(Definitions were provided for each of the eight categories and students sorted the set of items twice, on consecutive days.)

Second sort

Instructions for the second sort were exactly the same as for the first sort except that the word 'eight' was changed to 'three'. The number of categories for the second sort was reduced to three: 'personal control' (situations in which resident exerts control over his/her own environment), 'shared control' (situations in which both staff and resident share the responsibility of

controlling resident's activities/environment), and 'external control' (situations in which resident does not have any control over decisions that affect his/her life).

Of the 15 items achieving at least 80% reliability in the first sort, 13 fell into either the 'environmental mastery', 'external control', or 'shared control' categories. These 13 were used for the second sort. The 'environmental mastery' category's name was changed to 'personal control'. 8 new items were constructed:

- 1) If _____ loses his/her paycheque in the house, s/he should be able to expect that a staff will help look for it.
- 2) _____ should participate with staff in planning his/her behavioral program.
- 3) Both staff and residents such as _____ should be involved in planning recreational activities.
- 4) _____ should be able to go places without a staff member sometimes.
- 5) _____ should only be allowed to leave the residence with the permission of a staff member.
- 6) _____ should be able to decide for him/herself how to have his/her hair styled.
- 7) Staff should have the authority to forbid _____ from seeing certain movies.
- 8) Both staff and residents including _____ should have a voice in planning the daily menu.

All items in the second sort achieved at least 90% reliability. Below are the numbers of the items from the questionnaires (Appendices B and C) which fall into each category:

external control: 4, 8, 12, 18, 20, 24, 30

shared control: 2, 10, 14, 16, 32, 34, 42

personal control: 6, 22, 26, 28, 36, 38, 40

Appendix B
GENERAL questionnaire

The following questionnaire asks for your opinion about certain aspects related to this residence and the residents who live here. There are two types of questions. The first type asks about "how things should be" in YOUR opinion. The second type asks about "how things actually are" in YOUR opinion. Simply, circle the number above the phrase that best expresses your opinion. Please answer all the questions.

Sample questionnaire item

a) A resident should receive the staff's attention whenever s/he wants it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

b) A resident does receive the staff's attention whenever s/he wants it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

If you strongly agree with the statement, circle '1'; if you are not sure, circle '4'; if you disagree but only a little bit, circle '5'; and so on.

1a) Residents should participate with staff in planning their behavioral programs.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

1b) Residents do participate with staff in planning their behavioral programs.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

2a) Residents should accept the plans that the staff make.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

2b) Residents accept the plans that the staff make.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

3a) A resident should be allowed to go to school instead of workshop if s/he wants to continue his/her education.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

3b) A resident is allowed to go to school instead of work-shop when s/he wants to continue his/her education.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

4a) Residents should usually follow the staff's suggestions about how to spend money.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

4b) Residents usually follow the staff's suggestions about how to spend money.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

5a) Residents should be able to negotiate with staff, any changes in residence rules they are not happy with.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

5b) Residents negotiate with staff, any changes in residence rules they are not happy with.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

6a) Residents should trust their families to make the important decisions concerning their lives.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

6b) Residents trust their families to make the important decisions concerning their lives.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

7a) Both staff and residents should be involved in planning recreational activities.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

7b) Both staff and residents are involved in planning recreational activities.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

8a) The established curfew for a resident should be a mutual agreement between him/her and a staff member.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

8b) The established curfew for a resident is a mutual agreement between him/her and a staff member.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

9a) If two residents are quarrelling, they should accept the staff's solution to their problem.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

9b) If two residents were quarrelling, they would be expected to accept the staff's solution to their problem.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

10a) Residents should only be allowed to leave the residence with the permission of a staff member.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

10b) Residents are only allowed to leave the residence with the permission of a staff member.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

11a) Residents should have control over their own bank accounts.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

11b) Residents have control over their own bank accounts.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

12a) Residents should usually agree with staff.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

12b) Residents usually agree with staff.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

13a) Residents should be able to go places without a staff member sometimes.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

13b) Residents do go places without a staff member sometimes.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

14a) Residents should choose the clothing they buy.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

14b) Residents do choose the clothing they buy.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

15a) Staff should have the authority to forbid residents from seeing certain movies.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

15b) Staff have the authority to forbid residents from seeing certain movies.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

16a) Both staff and residents should have a voice in planning the daily menu.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

16b) Both staff and residents do have a voice in planning the daily menu.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

17a) It should be as much a responsibility for residents as it is for staff to ensure that the house is secure at night before going to bed (i.e., doors locked, burners and oven turned off, etc.).

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

17b) It is as much a responsibility for residents as it is for staff to ensure that the house is secure at night before going to bed (i.e., doors locked, burners and oven turned off, etc.)

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

18a) Residents should try things for themselves before seeking help.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

18b) Residents tend to try things for themselves before seeking help.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

19a) Residents should be able to decide for themselves how to have their hair styled.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

19b) Residents decide for themselves how to have their hair styled.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

20a) Residents should be allowed to paint their own rooms.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

20b) Residents are allowed to paint their own rooms.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

21a) If a resident loses his/her paycheque in the house,
 s/he should be able to expect that a staff person will
 help look for it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

21b) If a resident loses his/her paycheque in the house,
 s/he can expect that a staff person will help look
 for it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

Appendix C
SPECIFIC questionnaire

The following questionnaire asks for your opinion about certain aspects related to this residence and the residents who live here. In the previous questionnaire, you were asked for your opinion about residents in general. These types of questionnaires can often be difficult because certain items could be answered differently depending on the resident. For this reason, you will be asked to fill out one questionnaire for each resident. The blank in the sentence represents a space for the resident's name. Circle the number above the phrase that best expresses your opinion. Please answer all the questions.

Sample questionnaire item

a) _____ should receive the staff's attention whenever s/he wants it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

b) _____ does receive the staff's attention whenever s/he wants it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

If you strongly agree with the statement, circle '1'; if you are not sure, circle '4'; if you disagree, but only a little bit, circle '5'; and so on.

1a) _____ should participate with staff in planning his/her behavioral program.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

1b) _____ participates with staff in planning his/her behavioral program.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

2a) _____ should accept the plans that the staff make.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

2b) _____ accepts the plans that the staff make.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

3a) _____ should be allowed to go to school instead of workshop if s/he wants to continue his/her education.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

3b) _____ would be allowed to go to school instead of workshop if s/he wanted to continue his/her education.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

4a) _____ should usually follow the staff's suggestions about how to spend money.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

4b) _____ usually follows the staff's suggestions about how to spend money.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

5a) _____ should be able to negotiate with staff, any changes in residence rules s/he is not happy with.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

5b) _____ can negotiate with staff, any changes in residence rules s/he is not happy with.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

6a) _____ should trust his/her family to make the important decisions concerning his/her life.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

6b) _____ trusts his/her family to make the important decisions concerning his/her life.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

7a) Both staff and residents such as _____ should be involved in planning recreational activities.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

7b) Both staff and residents such as _____ are involved in planning recreational activities.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

8a) The established curfew for _____ should be a mutual agreement between him/her and a staff member.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

8b) The established curfew for _____ is a mutual agreement between him/her and a staff member.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

9a) If _____ is quarrelling with someone, they should accept the staff's solution to their problem.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

9b) If _____ was quarrelling with someone, they would be expected to accept the staff's solution to their problem.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

10a) _____ should only be allowed to leave the residence with the permission of a staff member.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

10b) _____ is only allowed to leave the residence with the permission of a staff member.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

11a) _____ should have control over his/her own bank account.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

11b) _____ has control over his/her own bank account.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

12a) _____ should usually agree with staff.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

12b) _____ usually agrees with staff.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

13a) _____ should be able to go places without a staff member sometimes.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

13b) _____ goes places without a staff member sometimes.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

14a) _____ should choose the clothing s/he buys.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

14b) _____ chooses the clothing s/he buys.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

15a) Staff should have the authority to forbid _____
from seeing certain movies.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

15b) Staff have the authority to forbid _____ from
seeing certain movies.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

16a) Both staff and residents including _____ should have
a voice in planning the daily menu.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

16b) Both staff and residents including _____ do have a voice in planning the daily menu.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

17a) It should be as much a responsibility for _____ and other residents as it is for staff to ensure that the house is secure at night before going to bed (i.e., doors locked, burners and oven turned off, etc.).

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

17b) It is as much a responsibility for _____ and other residents as it is for staff to ensure that the house is secure at night before going to bed (i.e., doors locked, burners and oven turned off, etc.)

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

18a) _____ should try things for him/herself before seeking help.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

18b) _____ tries things for him/herself before seeking help.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

19a) _____ should be able to decide for him/herself how to have his/her hair styled.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

19b) _____ decides for him/herself how to have his/her hair styled.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

20a) _____ should be allowed to paint his/her own room.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

20b) _____ is allowed to paint his/her own room.

1	2	3	4	5	6	7
strongly disagree	moderately disagree	slightly disagree	no opinion	slightly agree	moderately agree	strongly agree

21a) If _____ loses his/her paycheque in the house, s/he should be able to expect that a staff person will help look look for it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

21b) If _____ loses his/her paycheque in the house, s/he can expect that a staff person will help look for it.

1	2	3	4	5	6	7
strongly agree	moderately agree	slightly agree	no opinion	slightly disagree	moderately disagree	strongly disagree

Appendix D

Introduction of staff and residents to research

(Because of specific requests by the residence directors, some introduction meetings will take place with both staff and residents present, whereas others will be done separately. The following is a summary of what they will be told. Language will be modified in order to meet the needs of the particular audience being addressed.)

I am a graduate student at Wilfrid Laurier University in Waterloo. This summer, I worked at the Oxford Regional Center as a psychology intern. While I was there, I became interested in finding out what happens in community residences, and what makes them better than institutions. To finish my degree, I have to do a major research project so I decided to use this requirement as an opportunity to become familiar with community residences. In my thesis, I am specifically interested in seeing how staff relate to residents. In other words, what do staff do with them, how do they handle them, etc. I realize that this can put staff into a rather threatening position: having someone come in to see what they are doing. For this reason, I want to stress to you that this is NOT an evaluation. I am not collecting this information to provide feedback to administration about staff performance or resident behaviors. Instead, its purpose is to provide some scientific information about what happens in residences. When research is conducted, the goal is usually to implement some form of change. With this study that will

not be the case. Before a decision can be made about what might need to be changed and what is best left the way it is, one must first know what is happening. This study then, will be a description of what happens between staff and residents in a community residence. For this kind of research to be useful though, it is important for each individual to be as natural as possible. There will be some questionnaires to fill out, and there will also be somebody coming to visit periodically over the next few weeks just to see what is happening.

It is extremely important that your behavior towards residents be the same as it would be at any other time. I do not want you to try to give me a certain impression because that would defeat the purpose of the study. Besides, there are really no right or wrong answers. I mean, I have no intention of leaving here with a report indicating that the staff are doing this, this, and this that is good, and this, this, and this that is bad. I will leave here with a report indicating that they do this, this, and this, period.

I realize that you will probably want me to be more specific about what I am studying. At this point, I do not feel that I can do that. I am not trying to be dishonest with you, nor am I trying to deceive you. But, if I tell you exactly what I am studying, it will make it easier for you to inadvertently or unconsciously change the way you would normally be with residents.

To make it easier for you to be as honest as possible, I want to stress that information about specific individuals is going to be kept strictly confidential. As I mentioned earlier, there will be no feedback given to administration. The final report will be written in such a way that it will not be possible to identify any particular person. I should point out that I will be working in four community residences. This should make identification of individuals even more remote.

If, for any reason, you do not want to participate, please let me know.

After the study is completed, I would like to meet with you again as a group, both to present the results as well as to discuss them with you. I would like to consider your interpretations of the results as well as to discuss your opinions about how these results might be used.

Questions?

Appendix E
Interview Format

INTERVIEW FORMAT

As mentioned in the first meeting, I wanted to take this opportunity to discuss the results of the research with you and to give you some input into the interpretation. I have several kinds of questions: 1) information-seeking, 2) questions that are fairly general, i.e., standard ones that I will ask everybody, and 3) some more specific questions directed to you alone. You may sometimes feel as if you are being put on the defensive. None of the questions are meant to do that, i.e., if I ask you why you did something, I am not coming down on you I am asking you to explain something I did not understand, OK?

(Review the three control subscales and the two types of dependence and independence.)

SECTION A

- 1) I realize that you may not necessarily have a broad background of experience in this, but, based on anything you have heard or seen, how do you think that this residence differs from other residences in terms of the extent to which residents are being encouraged to be independent, to be dependent, the extent to which control is being exerted in the setting?

- 2) Explain Table 4. Please comment on why your residence

came out as it did.

(Review results of questionnaires: relationships between external, shared and personal control; relationships between ideal and real; impact of staff variables).

- 3a) Ask for interpretations of discrepancy between SP ideal and SP real.
 - b) Explain 'duration of response' hypothesis and ask for comments.
- 4) Why are staff variables unrelated to the three dimensions of control?

SECTION B

- 5) Explain emotional dependence (needs for reassurance, affection, and approval). Who are the most emotionally dependent residents in this setting?

SECTION C

- 6) How do you see your style of interaction with residents, i.e., are the ways in which you encourage independence? the ways in which you encourage dependence?
- (ADMINISTRATORS: How do you see the general pattern of interactions used by your staff with residents, i.e., what are the ways in which they encourage independence? the

ways in which they encourage dependence?)

- 7) How is your style different from others working in this setting? (ADMINISTRATORS: How do you think that this style might differ from the styles used in other residences?)
- 8) What do you like about how you treat your residents?
What don't you like?

SECTION D

- 9) Do you like your job? Why or why not? What is reinforcing about it that keeps you here?
- 10) How did you choose this job in the first place?

SECTION B

- 11) Who are the easiest persons to handle here? In other words, if you wanted someone to do something, who would do it most readily?

SECTION E

- 12) What strategies do you see residents using to control other residents?
- 13) Do you think that these are at all similar to the strategies that staff are using?

(ADMINISTRATORS: What are the criteria you use to hire people in this residence?)

SECTION F

14) What factors are 'controlling' residents' lives that you feel you have no control over?

15) What areas of residents' lives do the administration especially like to have control over?

16) What areas of their lives do they leave the decisions up to the staff members?

17) In what ways does the family's control affect the residents' independence?

18) What would you change around here if you had the choice?

SECTION G

19) Draw a picture of my perceptions of what was happening in that that particular residence, and ask for comments re: where they agree and disagree or wish to fill in the picture a little more.

(Personal Questions)

Appendix F

Consideration of data from Residence X

Appendix F

Consideration of data from Residence X

Unfortunately, before filling out the questionnaires, the staff in Residence X learned that this study was directed towards investigating staff control in residential settings. The means from this residence could have been inflated then, due to a tendency to respond in a socially desirable fashion. When the research was initially introduced to the staff in the residences, the design of the research was somewhat different than the final one presented in this thesis. Specifically, they were told that a systematic observation would be conducted. In other words, observers at the residence would stand in locations that were as inconspicuous as possible. They were to have stopwatches that they would use to record data at five second intervals. Staff at Residence X felt that such observations would interfere with their daily activities and decided that they did not wish to participate in the study. The researcher decided to change the nature of the observations to a more qualitative method. This had nothing to do with Residence X's refusal to participate however, as she was not aware of their decision at the time of the change. When the researcher called to inform Residence X of the changes, she was told of their decision not to participate. The researcher asked if they might change their minds given the new design of the research. They did. The director

indicated however, that because the staff had decided not to participate, s/he had already outlined the exact nature of the research to them. After careful consideration, the researcher decided to ask them to participate anyway, with the intention of being sensitive to this issue when it was time to analyze the data.

A separate analysis was conducted to determine whether Residence X differed significantly in their responses from other residences. This analysis was a 2 x 2 x 3 x 2 factorial ANOVA with two questionnaire forms, two item types and three control categories treated as repeated measures, and two "residences" (X vs. all others) treated as a between group variable (see Table F1). Unexpectedly, there was a three way interaction between questionnaire form, control category and residence, $F(2, 26) = 4.44, p < .05$ (see Figure F1). Such a finding is not interpretable. Separate analyses on each of the control subscales revealed that scores on the external control subscale were significantly lower (see Figure F2) than were scores from other residences, $F(1, 13) = 10.87, p < .006$ (see Figure F3). There was some concern that the data from this residence would somehow influence the pattern of correlation coefficients. Another analysis of the main data was conducted then, deleting the data of the five subjects in that particular residence. Interpretation of the results in the resulting correlation matrix is difficult as there are only 10 subjects left in the

Table F 1

ANOVA Summary Table: Effects of (A) Residence (x vs. other) by (B) Questionnaire by
(C) Item Type by (D) Control Subscale on Questionnaire Responses

Source	Sum of Squares	df	Mean Square	F
A (Res. X vs. other)	.003	1	.003	.004
Error	12.00	13	.92	
B (Questionnaire)	.23	1	.23	.68
AB	.38	1	.38	1.12
Error	4.46	13	.34	
C (Item)	7.56	1	7.56	36.95**
AC	.31	1	.31	1.50
Error	2.66	13	.20	
BC	.23	1	.23	1.48
ABC	.37	1	.37	2.42
Error	1.98	13	.15	
D (Control)	72.29	2	36.14	19.12**
AD	28.27	2	14.13	7.48**
Error	49.15	26	1.89	
BD	.17	2	.08	.58
ABD	1.27	2	.64	4.44*
Error	3.73	26	.14	
CD	38.03	2	19.01	38.89**
ACD	.85	2	.43	.87
Error	12.71	26	.49	
BCD	.28	2	.14	1.16
ABCD	.03	2	.02	.14
Error	3.14	26	.12	

* $p < .02$

** $p < .005$

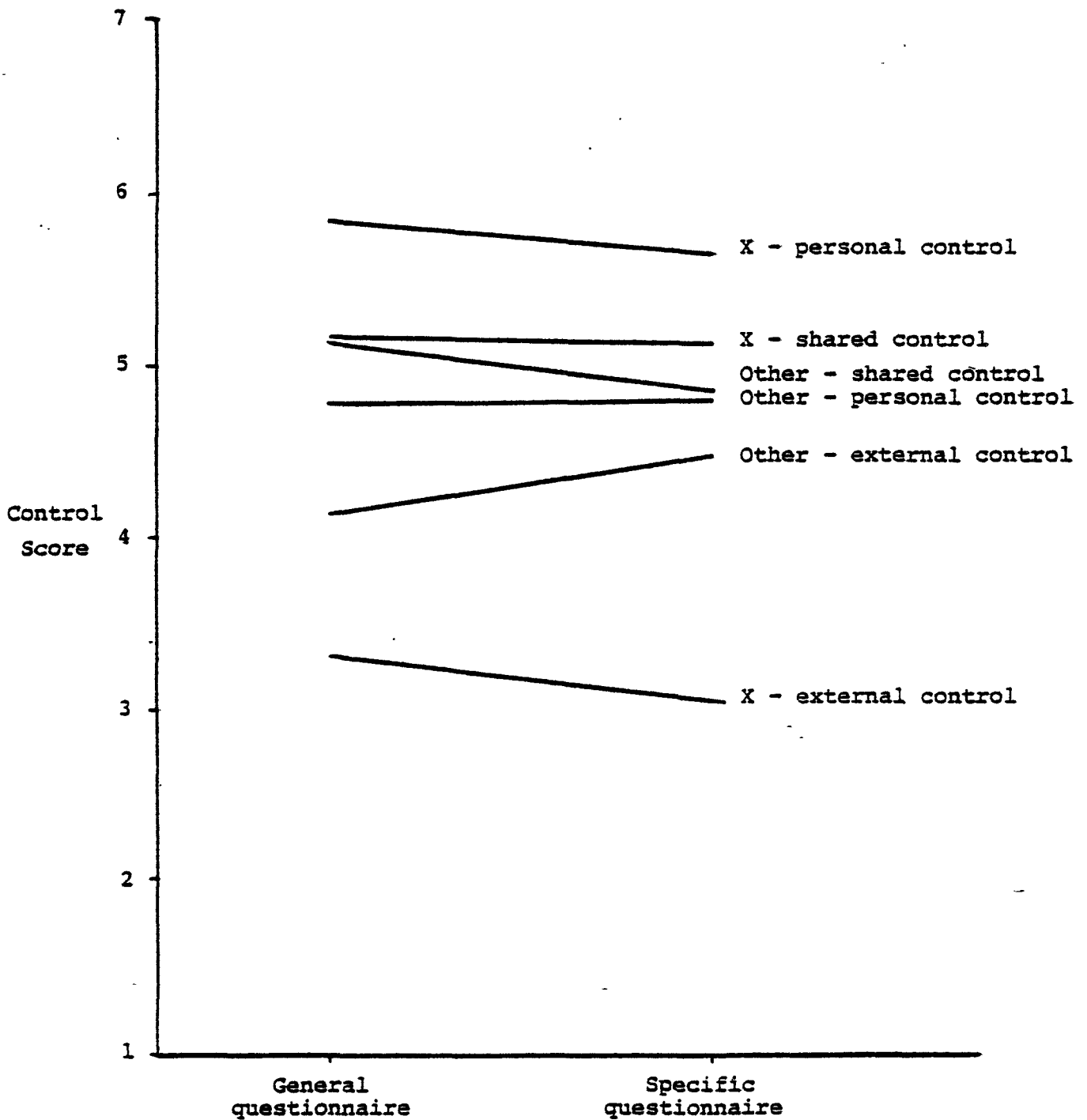


Figure F1 - Comparison of the difference between Residence X and other residences on the basis of the form of questionnaire administered and responses on each of the three control subscales.

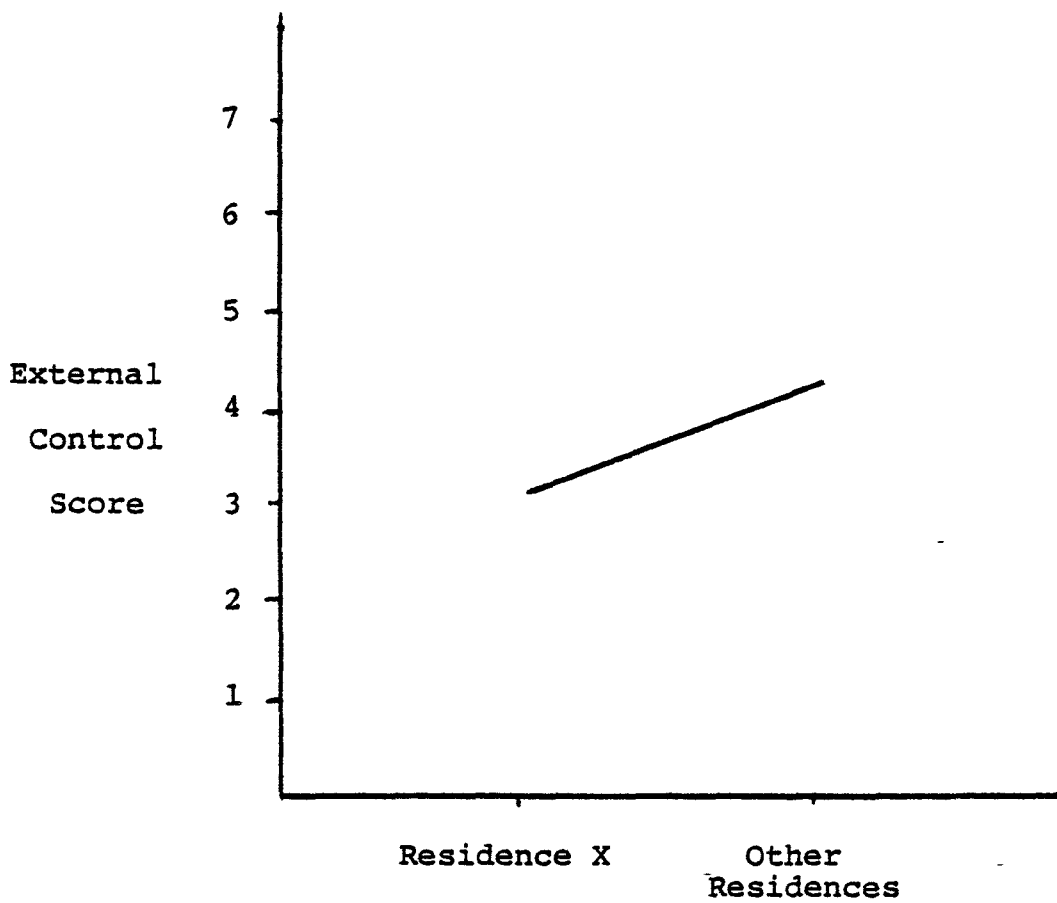


Figure F2. Mean responses on the external control subscale by staff in Residence X and staff in other residences.

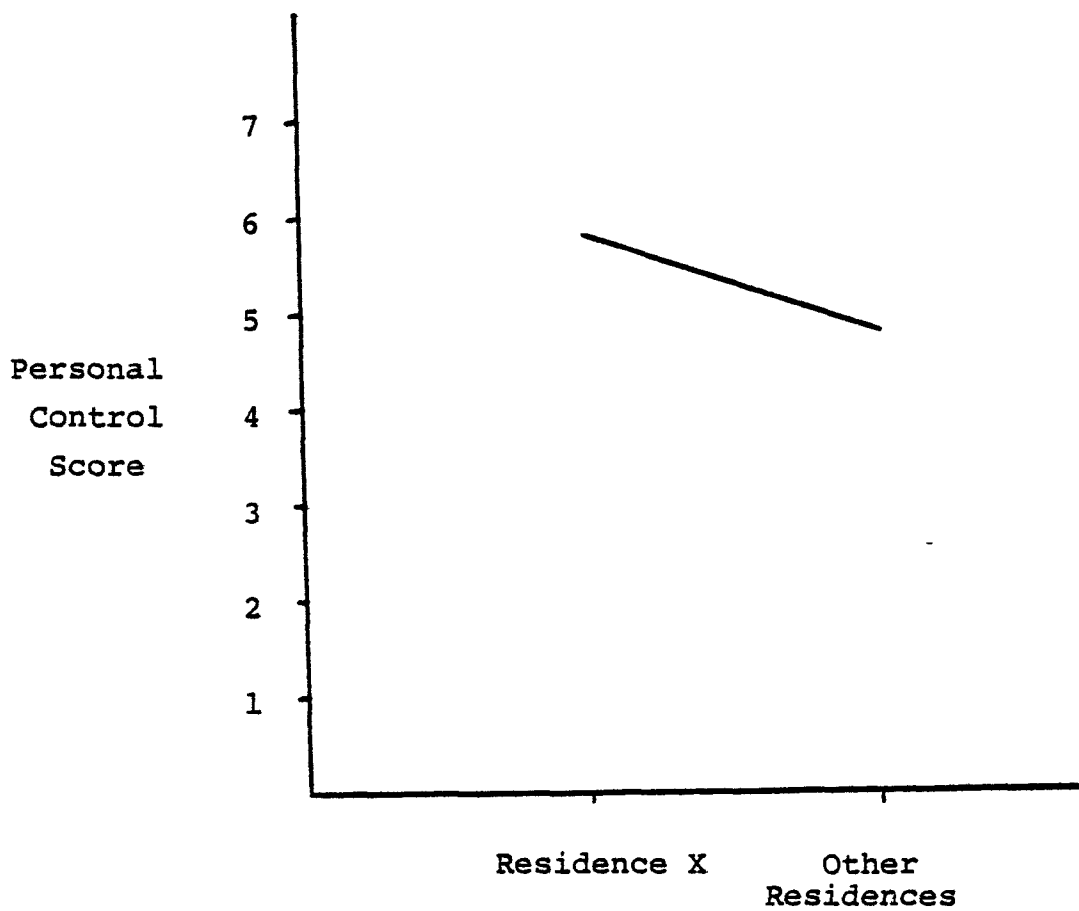


Figure F3. Mean responses on the personal control subscale by staff in Residence X and staff in other residences.

analysis. Examination of the matrix seemed to indicate however, that coefficients tended to be in the same direction (see Table F2).

Table F2

Correlation Matrix for Ideal and Real
Item Types on each Control Subscale
With Data from Residence X deleted

	External Ideal	External Real	Shared Ideal	Shared Real	Personal Ideal	Personal Real
External Ideal						
External Real	.80**					
Shared Ideal	-.50	-.38				
Shared Real	-.39	-.72	.44			
Personal Ideal	-.55*	-.40	.54	.41		
Personal Real	-.69**	-.54	.25	.46	.39	

* $p < .05$

** $p < .01$

Appendix G
Short form of proposal

This letter concerns a proposal for a research project to be carried out at four Ontario core residences for mentally retarded adults. Let me first introduce myself. My name is Diane Conway, and I am a graduate student at Wilfrid Laurier University in Waterloo. My master's thesis is going to involve a study of staff-resident interactions in residences for the mentally handicapped. The following is a brief summary of what the study is about.

The research literature seems to indicate that institutions tend to foster dependence in their residents. One of the reasons for the present push for deinstitutionalization is to facilitate and encourage the retarded individual to be more independent. It is not clear however, how 'encouragement of independence' is carried out. In my research project, I would like to determine what strategies are presently being used to foster independence or dependence.

More specifically, there will be three main areas of focus: 1) to what extent do staff ATTITUDES reflect a belief in the need to impose external controls vs personal controls over residents' environments, 2) to what extent do staff BEHAVIORS reflect an orientation towards external vs personal controls over the environment, and 3) to what extent do staff behaviors reflect their attitudes.

To answer these questions, several procedures will be carried out. Staff will be asked to complete a

questionnaire reflecting their general attitudes as well as several questionnaires relating to each resident (e.g. 'Residents should be able to go places without a staff member sometimes' vs 'Mary should be able to go places without a staff member sometimes').

For the next step, one of two individuals will visit the residence to observe staff-resident interactions. The observer will be present for approximately five to ten eight hour shifts over a period of three to four weeks. In addition, staff and supervisors will be interviewed once or twice during this period.

After the project is completed, all participants will be fully debriefed. The report of the results will be written up in the form of a master's thesis but it would be possible to write a shorter summary if both agencies would find this useful.

This is to advise you, in writing, of several changes in the proposal for research I submitted in March.

1) Questionnaires

- a) 21 "filler" items have been deleted from the questionnaires, i.e., every odd-numbered item.
- b) The remaining items are of two types: "ideal" and "real." For example, "Residents should be able to go places without a staff member sometimes" vs "Residents do go places without a staff member sometimes." Both questionnaire forms (general, specific) will still be administered.

2) Observation

- a) Rather than conducting a quantitative systematic observation at mealtime or during the laundry period, the intention will be to visit the residences on an informal basis where "casual" observation and discussion with staff will take place. In addition, I would like to interview each of the full-time staff members and possibly the supervisor and residential director as well. Then, a final observation will take place.

It is expected that the first observation would be for 3 - 5 eight hour shifts, the interviews one to two hours, and the final observations 2 - 3 eight hour shifts.

Appendix H

Correlation matrix of relationships between age, education, and experience of staff, and attitudes toward external, shared, and personal control

Table H1

Correlation Matrix of Relationships Between Age,
Education, and Experience of Staff, and Attitudes
Toward External, Shared, and Personal Control

	Age	Education	Experience
External Ideal	.20	.19	.24
External Real	.06	.09	.37
Shared Ideal	-.21	-.32	-.20
Shared Real	.01	-.01	-.19
Personal Ideal	-.08	.08	-.10
Age	1.00	.001	.43
Education		1.00	-.25
Experience			1.00