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AN EVALUATIVE STUDY OF A THERAPEUTIC COMMUNITY APPROACH TO TREATMENT

by

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Table of Contents

List of Tables

List of Figures

Introduction

The therapeutic community approach to the treatment of the mentally ill has been used with effectiveness in a variety of institutional settings (Jones, 1953; Wilmer, 1958; Gottesman, 1967). The major impetus for this approach resulted from the recognition of the fact that hospitalization in an institution structured along traditional lines was not only non-therapeutic, but was often anti-therapeutic (Devereux, 1944; Bettelheim, 1948; Gottesman, 1967). Therefore, one of the basic premises of the therapeutic community approach can be stated as follows; since all aspects of institutional life effect patients' psychological functioning, they must be carefully structured, to maximize the therapeutic impact of the hospital milieu (Main, 1946; Jones, 1953, 1968). Jones, who coined the term, argued that the distinctiveness of this new treatment approach, was that all the resources of the institution, both patients and staff, were self-consciously pooled to further treatment.

This approach also required a basic change in the status of patients. Patients were no longer seen as the passive recipients of treatment, but active participants in the therapeutic process; they also became more involved in the general activities of the life of the institution (Jones, 1968). The rationale for this change in patients' status had been stated earlier by Main (1946), who noted that if patients were to retain their status as human beings, and maintain their dignity and self-esteem, they had to play an active part in the development of their community. In a therapeutic community the traditional order was reversed, and the hospital became the patients' world, rather than the doctor's domain (Wilmer, 1958). Communication and social interaction between all members of the community became the vehicle through which

these changes were implemented (Jones, 1969).

The problems of the aged, suffering from chronic and degenerative diseases which require their hospitalization in a chronic disease facility, are not unlike those of the chronically mentally ill (Rosenstock & Kutner, 1966). Studies have indicated that their institutionalization in these facilities often leads to negative psychological effects (Abramson, et. al. 1963; Hefferin, 1968). With the rise in the number of aged people in the population, there is a need for developing new treatment modalities to combat these difficulties.

In a study done at Beth Abraham Hospital (a chronic disease facility in the Bronx, New York), Rosenstock and Kutner (1966), with the help of the hospital administration, reorganized two floors of the hospital, and operated these floors according to milieu therapy techniques. Their purpose was to demonstrate the feasibility of milieu therapy techniques for this kind of hospital population, and "to provide guidelines for the reorganization of other chronic care institutions from custodial to therapeutic facilities".

The purpose of the present research is to evaluate the effects of this treatment innovation upon the patients and staff living and working on these wards.

Definition of the term Therapeutic Community

While a number of authors use the term therapeutic community, it is difficult to define just what is meant by the term (Wilmer, 1958; Zeitlin, 1967). Part of the difficulty stems from the interchangeable use of terms like milieu therapy, social therapy and therapeutic community, without spelling out the particular determinants of the term (Zeitlin, 1967). It is also often difficult to know just what kinds of facilities comprise a therapeutic community (Wilmer, 1958). In spite of these

difficulties, and the many variants of the therapeutic community approach, there are certain commonalities which bind them all together (Rapoport, 1960).

For purposes of this study, we will define a therapeutic community as one which possesses the following set of beliefs proposed by Rapoport (1960), and utilized by Rosenstock and Kutner (1966).

1. The total social organization in which the patient is involved is seen as therapeutic.

2. The social organization is seen as a vital force that will maximize therapeutic effects, rather than as a routinized background to treatment.

3. The central element in the institutional context, is the provision that patients will have the opportunity to take an active part in the affairs of the institution.

4. All relationships within the institution, patient-patient, as well as staff-patient relationships, are regarded as potentially therapeutic.

5. The qualitative atmosphere, what may be called the "emotional climate" of the institution is considered therapeutic.

6. Finally, a high value is placed on communication per se.

In addition, in order to avoid confusion between terms like milieu therapy, and therapeutic community, following Jones (1968), we will use the term therapeutic community to define an organized system, whereas, milieu therapy will refer to a therapeutic process.

History of the Development of the Therapeutic Community Approach

Social scientists have long been interested in studying the relationship between the social structure of mental institutions and the behavior of patients residing in these institutions. Rowland (1938), a Sociologist, systematically studied two wards in

a state mental hospital, and described the informal organization of patient life, noting their modes of interacting, and methods of communication. He indicated the way in which the sub-culture of a particular ward could influence patient interactions. This was one of the first attempts to study patient interaction in a way that demonstrated its potential therapeutic significance.

Devereux (1944), another Sociologist, continued along the line of investigation initiated by Rowland. He explored the relationship between the social structure of a schizophrenic ward and its therapeutic fitness, and indicated some of the problems of institutional living. He pointed out that some adjustment to hospital routine was necessary for satisfactory recovery, but indicated that too good an adjustment might result in an "institutional cure" from which the patient might never recover. He explained that life on the ward was by its nature routinized and simplified for the convenience of staff, and made few demands upon the patients' latent energies. The dullness of this hospital routine therefore, often made it difficult, if not impossible, for a patient to adapt himself to the complexities of the world outside the hospital, where he had to make many personal decisions in order to function adequately. This was one of the first studies in which the detrimental effects of hospitalization were highlighted.

In England, Anna Freud (1943) working at the Hampstead Nursery modified the formal organization of the wards in an attempt to create "artificial families". She described dramatic changes in the children's behavior as a result of the modification in structure. Bettelheim and Sylvester (1948), working with disturbed children at the Orthogenic School in Chicago, reported the potentially deleterious effects of institutional life, presenting a syndrome which these authors labelled "Psychological institutionalism". They noted that a frame of reference composed of the institution's

impersonal rules and regulations led some children to become automatons in their passive adjustment to the institution. Like Devereux (1943), they pointed out that compliance with rules consisted of adequate institutional adjustment, but prevented individual spontaneity, and the development of inner resources. These findings led the authors to suggest that an understanding of the factors preventing psychological growth necessitated the construction of a therapeutic milieu which would foster rather than inhibit personality development.

In a later work, Bettelheim (1950) underscored the significance of studying the impact of daily normal activities on the individual. He, and his colleagues analyzed every group experience in order to maximize its therapeutic potential. The significance of Bettelheim's work was twofold. First, he demonstrated very clearly, the negative effects of some aspects of institutional existence. Second, he highlighted the therapeutic significance of the time between therapy sessions. Here the concept and the important implications of a therapeutic milieu became more clearly defined.

In England, following World War II, The Northfield Experiment was begun in order to determine whether a continuously changing population of patients and staff could develop its own type of community within the framework of a Military Psychiatric Hospital (Bridger, 1946). In the description of this experiment, Bridger stated that it would be misleading to describe any single facet of the experiment unless it were considered within the context of the entire operation. Patients were told upon admission to the hospital, that every activity was considered part of the treatment. As in the Orthogenic School, the therapeutic impact of the total milieu was emphasized. The most significant aspect of this experiment was the importance it attached to the patients' ability to modify and influence the hospital's organization

and staff by their actions. For example, a patient government was formed which discussed every aspect of the day-to-day problems of every hospital group whether patients or staff. Staff then attempted to modify the hospital environment according to the mutual agreement of all members of the community.

Unlike the situations in a hospital described by Caudill (1952), where the lack of communications between patients and staff led to their mutual isolation, the openness of communication between patient and staff at Northfield facilitated the development of a community spirit which fostered patient recovery and growth. For example, weekly ward meetings were held with staff to discuss issues related to ward problems. Broader hospital problems were discussed at meetings of ward representatives and senior hospital personnel. The effect of this sharing of ideas, was that patients developed a sense of belonging to, and responsibility for, the total community. They also felt that their individual contributions were significant to the community (Bridger, 1946).

The philosophy of treatment in the Northfield Experiment was most elequently stated by Main (1946), who was very actively involved in its development.

> "By tradition a hospital is a place wherein sick people may receive shelter from the stormy blasts of life, the care and attention of nursing and medical auxiliaries, and the individual attention of a skilled doctor. The concept of a hospital as a refuge too often means, however that patients are robbed of their status as responsible human beings....health and stability are too often bought at the excessive price of desocialization. Sooner or later the patient, alone and unsupported must face the difficult task of returning to the society in which he became unstable, and there regain social integration, and a daily sense of values and purpose. This task is no light one for a desocialized man, however healthy he may have become."
>
> (Main, 1946, p.66)

Attention was now clearly focused on the importance of making the daily life

of the community truly relevant to the needs of the micro-society within the hospital. Hospital organization and procedures could no longer be developed solely for the convenience of the staff, but had to be responsive and continually modified according to the needs and problems of all of its inhabitants.

It remained for Maxwell Jones (1953) to coin the term "therapeutic community", and to design an institution around the particular handicaps of its patients. In his pioneering work, Jones worked with a population of chronically unemployed neurotics. He envisioned the hospital ward as a community in which all patients and staff were actively involved. The primary therapeutic vehicle employed by Jones, was a daily community meeting attended by all patients and any staff members who could spare the time. The topics of discussion at these meetings were not only the personal problems of the patients, but problems relating to ward management as well. Like Main, Jones emphasized the need to have patients actively involved in their own treatment, and for staff members to allow patients to participate in the decision making process. Jones also integrated the community outside the hospital into the total treatment program, by developing employment opportunities for patients in the surrounding community. He noted that one of the difficulties he had observed in mental hospitals in the United States, was the failure to integrate the expectations of a patient's role within the hospital, with his role outside the hospital.

Following Jones (1953), there were a number of studies done to evaluate the effects of the therapeutic community approach to dealing with psychiatric and non-psychiatric problems (Gill, 1967; Gottesman, 1967; Wilmer, 1958).

A significant work by Stanton and Schwartz (1954) shifted the focus from specific wards or services, to the entire hospital as a social system. These authors pointed out

that the problems and techniques of psychotherapy with hospitalized patients could be discussed only in so far as they were relevant to the institution as a whole. Studying a private mental hospital, they highlighted the group life of both patients and staff, indicating the nature of the communications networks between and within the groups. They concluded that one of the hospital administrator's jobs was to treat patients by modifying the administration of the institution.

The negative effects of institutional life were further underscored by Goffman (1961), a Sociologist who worked as an aide in a mental hospital. He documented a vivid picture of the manner in which hospital rules and routines force a patient into a subordinate status, and lead to a more depersonalized self-image.

Thus, the focus on factors initially thought to be unrelated to, and incidental to the effective treatment of hospitalized patients, had indicated just how crucial, variables such as hospital organization, patient interactions, patient-staff interactions, and patient decision-making were to the therapeutic process. Further, an examination of these factors had indicated how anti-therapeutic many hospital procedures had been. These findings, and the success reported by Jones (1953; 1969) led many researchers to modify the structure of their own institutions along the lines of the therapeutic community approach.

Wilmer (1958), restructured the admission ward facilities at an Oakland, California, hospital along the lines of the therapeutic community approach, and reported positive results. He noted that the basic departures of the therapeutic community concept from more traditional concepts was the emphasis it placed on socio-environmental factors in a patient's hospital experience. Socialization, and a sense of belonging were as important as psychotherapy. More important, Wilmer added, self-control, dignity and trust supplanted excessive controls, restrictions,

regimentation, and tradition bound rituals.

In another study, Gottesman (1967) reported the results of research in milieu therapy done with aged patients who had been hospitalized for an average of 18 years. He noted that within a few days, many of the patients had abandoned sedentary and empty behaviors so characteristic of the mentally ill. The approach taken by Gottesman was to strengthen patients' ego functioning by giving them a series of normal social demands of increasing magnitude. For example, patients were started on simple workshop jobs, and upgraded continuously to more complex jobs as they mastered each step. Apart from the remarkable improvement shown by patients, there were significant effects on staff. Staff members developed a willingness to innovate in the hospital, and a sense of having the power to make decisions as therapists. They also became more satisfied with their jobs, as evidenced by their willingness to work overtime on several occasions without pay.

The Therapeutic Community in Rehabilitative Medicine

At the same time as research utilizing the therapeutic community approach proliferated in the mental health field, investigators in other health care fields noted the detrimental effects of hospital procedures and organization upon non-psychotic patients. (Kutner, 1958; Coser, 1960). In a sociological study of patients reaction to hospitalization, Coser (1960), described the loss of ego identity many patients felt upon entry into the hospital. Like Devereaux (1944) many years earlier, she found that for many patients, good adjustment to the hospital made it difficult to relinquish the "sick" role. Such patients often lost their initiative and motivation to recover from their illness.

A major step toward applying the therapeutic community concept to the

rehabilitation of disabled individuals was taken by Abramson, Kutner, et. al (1963). These authors proposed to modify what had been learned about therapeutic community techniques in the mental health field to deal with the difficulties encountered in rehabilitation services for the disabled. In their study, the authors described the psychological characteristics of patients in the hospital as a result of a disabling disease. Several of these are worth noting. In response to their illness, patients often become withdrawn and fail to develop adequate interpersonal relationships. Further, as a result of their being taken care of by the hospital staff, they lose the motivation to take care of themselves, and subsequently have difficulty meeting the normal demands of daily life. They then become reluctant to leave the hospital because they feel they cannot take care of themselves. Finally, they often become apathetic and listless, and have difficulty exerting even minimal energy to help themselves recover. The similarity of these characteristics to those exhibited by patients in mental hospitals led these authors to conclude that a modification of the therapeutic community techniques described in the psychiatric literature would be an effective means of counteracting the negative effect of hospitalization. A number of programs were started which were designed to actively involve both patients and staff in the rehabilitative process. Simultaneously, families were also actively involved in the treatment process, in order to prevent the patients' social isolation from their families and the community outside the hospital. The ward climate was carefully designed to create an atmosphere encouraging independence, social participation and community directed interest. The results indicated that the therapeutic community approach was effective in counteracting the negative effects of hospitalization.

The literature cited thus far has focused on the reorganization of ward or hospital

facilities designed for patients expected to be discharged from the hospital. Brudno and Seltzer (1968), investigated the efficacy of group techniques for resocializing geriatric patients. They hypothesized that the planning of services for patients hospitalized permanently in chronic disease facilities, or nursing homes for the aged, should be different than for patients awaiting discharge to the community. While they did not specifically state the nature of the changes that should be made, two aspects of the study are worth noting. First, their descriptions of the patients symptoms were like those cited in studies of the chronically mentally ill and physically disabled (Devereaux, 1944; Caudill, 1952; Goffman, 1961; Gottesman, 1967; Abramson, et. al 1963). It appears that symptoms like excessive dependency, withdrawal, social isolation, impoverished interpersonal relationships, lowered self-esteem and self-image, are universal psychological symptoms which cut across disabilities, and are related to the effects of hospitalization. Second, as one examines the nature of the therapeutic changes they instituted; such as involving nurses' aides more fully in the treatment planning; studying the impact of the total institution on the therapeutic process, and giving patients a greater control over decision making; it appears that what they described may be considered a variant of the therapeutic community approach. Their results indicated that a significant proportion of the patients in the study benefitted from such an approach, and showed marked improvement in a number of areas of psychological functioning, such as distortion of judgment and time, concentration, and reality testing. When one considers that the patients who participated in the study were initially diagnosed as senile, it becomes apparent that the therapeutic community approach has relevance for work in rehabilitating geriatric patients.

Other studies have also demonstrated the effectiveness of group or milieu therapy techniques with an aged population (Gottesman, 1967; Putter, 1967; Nervuz, 1967: Cohen and Kraft, 1968). In some of the studies, the patients had been hospitalized for an average of 18 to 19 years. Yet many of these patients improved significantly after the initiation of a new treatment program involving milieu therapy techniques. Thus, the literature indicates that like the mentally ill, the aged who were often chronically ill from physical disabilities, benefitted from milieu therapy experiences. This comparison seems to be further supported by recognition of the fact that physical debilitation in aged patients is often related to the emotional status of the patient. When the emotional tone is improved, so is the physical condition of the patient (Hefferin, 1968; Beck, Clagger & Strangle, 1968). It was similarly noted by Krupp (1968), that in rehabilitation, many of the successes depended on an adequate handling of the patient's emotional reactions.

Rosenstock and Kutner (1971), attempted to study just how effective a therapeutic community approach would be in altering the lives of patients in a chronic care institution. Their study was the first to attempt to apply therapeutic community techniques learned in a variety of other settings, to a population of chronically physically disabled patients, destined to be hospitalized for the remainder of their lives. These authors noted that within institutions for the chronically physically disabled, there had been few attempts to break away from the custodial approach to treatment, and that many of the patients exhibited symptoms like "abject dependency, egocentric preoccupation, and the decline of physical functioning and social competence".

They instituted a program of action research which took place over a three year period from April, 1967 to March, 1970, and found that during this period patient morale improved markedly, as did patient satisfaction with institution. There were also noteworthy increases in the amount of patient participation in activities outside

the institution. Further, although there were no quantifiable data collected, there was ample anecdotal evidence to suggest that the staff's job satisfaction had also increased.

The present study is an attempt to evaluate the psychological effects of the therapeutic community program developed at Beth Abraham Hospital by Kutner and Rosenstock (1966). In order to do this most effectively, it will be necessary to describe some of the techniques employed in the original study.

The major action components of the therapeutic community research project were as follows. First, there was a weekly meeting of all patients on the floor. Secondly, there was a weekly in-service seminar for the therapeutic community wards, which the entire professional and non-professional staff attended. Thirdly, there was a monthly meeting of the policy committee composed of research staff members, administrative and departmental heads, to review program policy and maintain lines of communication. During the course of the three years, the first two components grew and changed substantially. The third component did not develop as expected and meetings were held only sporadically.

The patients' program increased to include a number of committees which dealt with different aspects of patient life, which prior to the initiation of the therapeutic community had been handled only by administration. For example, a nursing committee formed to help advise the personnel department on plans for recruiting new staff members and utilizing existing staff more efficiently. Other committees included dietary and social-recreational committees. Each of these groups provided patients with the opportunity for developing their skills in communication, and facilitating interpersonal relationships. More important,

patients began to communicate their needs and demands to administration more directly, thereby increasing their sense of power in the decision making process.

Staff meetings gradually evolved from a weekly meeting in which staff attitudes about patients and each other were explored, to meetings in which problems of patient care as well as staff issues were explored. Staff members, particularly aides, were taught to perform their jobs in new ways. Instead of taking care of patients, they learned to help patients to take care of themselves. At the same time, full recognition was given to every staff member's (particularly the aides') contribution to the total treatment. Unfortunately, meetings between patients and staff did not develop as fully as expected. Patients and staff only began to meet together during the latter stages of the project. Following the termination of the action component of the study, several changes were made in the program. Some of the commitees disbanded, and one of the social group workers on the project resigned. Nevertheless, the two floors continued to be run according to the operating procedures established during the study's development.

Theoretical Considerations and Rationale for the Present Study

One of the issues raised by Wilmer (1958), in connection with his discussion of the changes occurring in therapeutic communities, was the question of just how much the success of any program depended upon the enthusiasm, optimism and interest of the staff. Similarly, Zeitlin (1967), pointed out that, " the act of examining the mental hospital as a social organization, or for that matter any other activity, if conducted with sufficient enthusiasm and vigor, will itself prove beneficial to its inmates, simply by bringing energy and interest to people long neglected ". (Zeitlin, 1967; p. 1084). The implication of these comments is that the results

reported in studies utilizing milieu therapy may be artifacts of the investigator's enthusiasm, rather than real measures of change. If this were true, then one would expect that the changes in patient and staff attitudes hypothesized by Rosenstock and Kutner (1966), would not be as evident sometime after the research staff had departed. It is now one year after the official termination of the therapeutic community research project at Beth Abraham Hospital. It follows, that if the effects of the research project were meaningful, they would be just as evident now, if patients and staff were again evaluated by an independent researcher. One would also expect, that if the therapeutic community approach produced more positive changes in patient and staff attitudes and behavior than more traditional approaches, the superior effects would be demonstrable if patients and staff involved in the therapeutic community program were compared to patients and staff not involved in such a program. Part of the evaluative procedure in the present study therefore, will be to compare and contrast the patients and staff in the original study, with *a post-hoc control group of patients and staff who did not participate in the original* study. This is particularly important, since as Fairweather (1969), pointed out, a totally new treatment program must be a demonstrated improvement over current practices, before it can be accepted.

One of the major emphasis of the study by Rosenstock and Kutner (1966), was on patient participation in group activities and the decision making process. The literature related to therapeutic community research suggests that patient participation is important for several reasons. First, as Clark (1967) found in a study of milieu therapy, patient participation is significantly related to, and precedes patient improvement. This finding, that patients' active participation in meaning-

ful group activities is related to improvements in patients' psychological and physical functioning, has been repeated in a number of other studies (Dubey, 1968; Krupp, 1968; Davis, 1967; Gottesman, 1967). It follows, that as patients begin to experience the emergence of their dormant capacities, and the sense of having some control over the conditions effecting their lives, their attitudes about themselves should improve. One would expect therefore, as Fairweather (1969) found earlier, that patient morale would improve, and self-esteem would increase.

Another effect of patient participation is that it facilitates patient interaction with others, so that he (the patient) has the opportunity to develop more meaningful interpersonal relationships (Schwartz, 1957). In contrast with the isolation experienced by many geriatric patients (Dubey, 1968; Hefferin, 1968), patients in therapeutic community settings report closer interpersonal relationships (Hink, 1967). (Significantly, these patients also report higher morale.) Thus, the therapeutic community patients participating in the study by Rosenstock and Kutner (1966) should interact more often with each other than patients on non-therapeutic community wards. Further, it is expected that these patients should know other patients on their floor very well.

Finally, and perhaps most important, patient participation in a therapeutic program should lead to a change in the roles the patient assigns to himself. Wilensky and Herz (1966), pointed out that the therapeutic community attempts to provide the patient with a more active role. In fact, some of the effectiveness of this approach depends on a change in roles (Wilensky and Herz, 1966). As patients become active, the staff has to withdraw gracefully, to allow patients more control (Kutner, 1967). Similarly, as Jones (1969) indicated, participation in the thera-

peutic process allows for more flexibility in the roles available to the members of the community.

The implication of this discussion is that patients involved in a therapeutic community should see themselves as capable of performing functions not usually attributed to patients. If the ward is the patients' world, as a number of investigators have indicated (Main, 1946; Wilmer, 1958, Jones, 1959), then patients in a therapeutic community should perceive themselves as capable of performing many helping functions normally attributed to staff.

As patients attitudes and roles change, staff attitudes and roles change. As patients participate in the decision making process, and demonstrate their capacity for increased social responsibility, staff's perception of patients should also change. However, this may not always be the case. Staff members may pay lip service to the ideals of a therapeutic community, while really feeling that patients are incapable. Other studies have indicated that staff members are often reluctant to share their responsibilities with patients (Herz, Wilensky and Earle, 1965; Cumming and Cumming, 1957). This is particularly true for nurses' aides, the people who have the most contact with patients, and are the most crucial agents for patient recovery, but who also have the least power. (Cumming and Cumming, 1957). Clark (1967), pointed out that lower level staff's ability to deal with patients could be enhanced by raising their status. This is usually done in a therapeutic community by increasing the importance attached the contributions of lower-level staff (Schwartz, 1957; Jones, 1959). Therefore, one manifestation of a real change in staff members attitudes toward patients would be their willingness to grant patients greater social responsibility. More specifically, staff members should perceive patients as capable of performing a number of staff roles.

The change in staff attitudes towards patients at Beth Abraham is complicated by the fact that most of the patients are severely physically disabled. Part of the attitude change therefore, must involve a change in staff members attitudes towards disabled people. If there has been a real shift in staff attitudes about patients, then staff members in the therapeutic community should have a more positive attitude toward disabled people and see them as capable of more independent functioning.

In addition to changes in staff attitudes towards patients, studies have also cited the change in staff attitudes toward their work, as a result of participation in therapeutic community programs (Volpe and Kastenbaum, 1967; Gottesman, 1967; Clark, 1967). As mentioned earlier, Clark (1967), noted that increased support for staff members resulted in higher morale. Similarly, Gottesman (1967), and Volpe and Kastenbaum (1967), found that as patients improved, staff's expectations of patients' performance increased, as did the staff's job satisfaction. In another study (Gottesman, 1967) staff members worked overtime without compensation. Job satisfaction therefore, should increase as staff members feel that they are contributing more to the therapeutic process. It should also increase if staff members experience the "sense of membership in a community", that Wilmer (1958) describes. Reasoning from the above, it follows that staff members working on therapeutic community wards at Beth Abraham Hospital, should experience greater job satisfaction than staff members employed on other wards.

Hypotheses

Hypotheses Related to Patient Morale and Self-Acceptance

1. Patients participating in a therapeutic community program, for at least 18 months, will report higher morale than patients who have not had that experience.
2. Patients participating in a therapeutic community program, for at least 18 months will report greater self-esteem than patients who have not had that experience.

Hypotheses Related to Patient Interaction

3. There will be greater patient interaction on floors which have an ongoing therapeutic community program, than on floors which do not have such a program.
4. Patients participating in a therapeutic community program for at least 18 months, will report that they know more patients on their floors, than will patients on floors which do not have such a program.
5. Patients participating in a therapeutic community program for at least 18 months, will perceive themselves as capable of performing more helping and organizing functions, normally attributed to staff, than patients on floors which do not have such a program.

Hypotheses Related to Staff Attitudes

6. Staff members who have participated in a therapeutic community program for at least 18 months will have more positive attitudes toward disabled

people than staff members who have not participated in such a program.

7. Staff members who have participated in a therapeutic community program for at least 18 months, will feel that disabled people are capable of more independent functioning than staff members who have not participated in such a program.

8. Staff members participating in a therapeutic community program for at least 18 months, will be more satisfied with their jobs than staff members working on floors which do not have such a program.

Method

A post-hoc control group of patients and staff roughly comparable to the group of patients and staff involved in the therapeutic community research project carried out by Rosenstock and Kutner (1971), was selected from two other floors of the same wing of Beth Abraham Hospital. Both groups of patients and staff were than asked to fill out a structured interview containing several scales and questionnaires (See Appendix A). The patient interviews were designed to assess morale, self-esteem and the extent to which patients saw themselves as capable of performing functions normally attributed to different staff members. Patients were also asked to identify the pictures of 10 other patients on the floor as a measure of how well patients knew other patients. In addition, behavioral ratings of patient interactions were made by a trained observer, to evaluate the quality of patient behavior on the different floors.

Staff interviews were designed to assess staff attitudes toward disabled people, job satisfaction, and the extent to which they saw patients as able to perform staff functions (see Appendix A).

The responses to these instruments were then compared in order to evaluate the differences between Ss on a floor run according to the therapeutic community approach, and Ss on a floor run according to more traditional institutional methods.

Subjects. The Ss for this study were 100 patients (31 males and 69 females) and 53 staff members (9 males and 42 females) at Beth Abraham Hospital, a chronic disease facility located in the Bronx, New York. Ss were drawn from

four floors of the hospital in the Baum-Rothschild Wing.[1] Two of the floors, floors 3BR and 4BR, participated in the original therapeutic community research project (Rosenstock & Kutner, 1966), and continued to be operated according to many of the milieu therapy techniques developed during that time. The other two floors, 6BR and 7BR, were selected as a post-hoc control population after numerous consultations with the medical and social service departments.[2, 2a]

Only those patients who had been on their present floors for a minimum of 18 months were included in the study. The reason for this criterion, was that research (to be reported below), had indicated that patients need a certain amount of time to develop a "sense of belongingness"; to feel as if they are part of a community; and for a real change in the perception of a patient and staff roles to take place. In an earlier study, Wilensky and Herz (1966), suggested that a year might be too short a time for attitude change to take place in a therapeutic community. Similarly, Gottesman (1967) noted that for the effects of milieu therapy to be more effective, the process should be in effect for more than six to twelve months. Therefore, eighteen months was selected as a time period during which the therapeutic

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[1] Patients located in the Baum-Rothschild Wing of Beth Abraham are considered to be the healtheir patients in the institution. In contracts to patients in other parts of the hospital, they are more alert, require less nursing care, and in general are better able to function on their own. This is generally agreed upon by the various disciplines, i.e. medicine, social service, nursing.

[2] In the judgment of the Director of Social Service, the Medical Director of the Baum-Rothchild Wing of Beth Abraham, the social workers on the floors involved, the charge nurses and their nursing supervisors, the patients on floors 6BR and 7BR, were as mentally alert as the patients on the therapeutic community floors. They were also considered to be similar in the degree of their physical impairment. It should be also noted that the original selection of patients for the therapeutic community project was based on a very loose set of criteria that would have been impossible to duplicate.

[2a] See Appendix C for a description of the floors involved in the study.

effects of hospitalization, either negative or positive should be demonstrable.

An additional criterion for patient selection was that patients be able to communicate effectively with other patients and staff members. Clark (1967), had found earlier that patient participation in a therapeutic community had preceded patient improvement. In part, a patient's ability to communicate determines the extent to which he may participate, and in turn profit, from a therapeutic community approach. Therefore, only those patients who demonstrated the mental capacity to communicate effectively, were included in the study sample.

The decision about each patient's ability to communicate effectively was determined by a joint rating of the two charge nurses from the day and evening shifts, using three questions from the "Stockton Geriatric Rating Scale" (1965). These questions were:

1. The patient does not understand others.
2. The patient does not make himself understood.
3. The patient does not know his name.

Patients were given a score of "0", "1", or "2", on each item. A score of "0" was given if the patient had trouble all or most of the time. A score of "1" was given if the patient had trouble intermittently; some of the time. A score of "2" was given if the patient had no difficulty, most if not all of the time. Only those patients who received a minimal score of "1" on the first two questions, and a score of "2" on the third question were considered mentally alert enough to be included in the study.[3]

There were two major subgroups of Ss involved in the study.

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[3] For the most part, only those patients with hearing or speech problems received a score of "1" on the first two questions.

Group I: Ss in this group were designated as either therapeutic community ("T.C") patients (N=50), or non-therapeutic community ("Non-T.C.") patients (N=50), based upon whether or not they had been living on a floor which had an ongoing therapeutic community program in operation.

The sex distribution of Ss in the "T.C." group(16 males and 34 females) approximates that of the "Non-T.C." group of Ss (15 males and 35 females). The majority of the Ss in both groups were Jewish, from middle-class backgrounds. An analysis of the age distribution of the patient Ss , however, reveals that the"T.C." Ss as a group are slightly younger than the "Non-T.C." Ss.[4] While only 53% of the "T.C." Ss are over the age of 65, 58% of the "Non-T.C." Ss are. Similarly, while the median age of the "T.C" is between 65 and 70 years of age, the median age for "Non-T.C." Ss is between 71 and 75 years of age.

However, since the therapeutic community approach has been used with success with both elderly mental patients (Cohen & Kraft, 1968), and with elderly (mean age = 85.2 years of age) patients in geriatric settings (Brudno & Seltzer, 1968), these age differences between the two patient groups should not have had significant effects upon the results of the present study. However, it was a factor that was taken into consideration in the analysis of the data.

Originally, variables such as type of physical disability, educational background, family background and length of stay in the hospital, were considered as

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[4] It should be noted that at the beginning of the therapeutic community project, the percentage of patients in the "T.C." group over 65 years of age was equal to that in the rest of the hospital. However, since that time a number of patients in this age group have died, and have been replaced by new admissions to the hospital, or transfers from other floors. While the inclusion of these new patients, many of whom are over 65 years of age, would make the age distribution in the two groups more equal, they did not meet the minimum criterion for length of stay in the hospital and were not included in the sample population.

important variables to be controlled for. However, a review of the literature, indicated that the therapeutic community approach has been used with success with a number of different kinds of populations, (Jones, 1953; Wilmer, 1958; Wilensky & Herz, 1966; Gottesman, 1967; Cohen & Kraft, 1968), and in a variety of settings. Thus its efficacy does not seem to be related to any particular constellation of subject variables. In fact, as Wilmer (1958) points out, it is often difficult to tease out the particular independent variables that define its success.

In addition, control of these kinds of variables is not practical (or possible) in a hospital setting since the hospital policy often sets very definite limits on the kinds of factors that can be controlled for. It may also be more fruitful in field research of this kind to study the phenomenon in its natural setting without the artificiality imposed by rigid experimental manipulation.[5] Further, it is the heterogeneity of both the "T.C." and "Non-T.C." patient groups which may permit the application of the research findings to a variety of other geriatric and institutional settings. It was therefore decided that the "Non-T.C." Ss from floors 6BR and 7BR, whose background was roughly comparable to that of the "T.C." Ss, but who had undergone a distinctly different hospital experience, was a reasonable solution to the problem of finding an adequate control population.

Group II: Ss in this group were designated as either "T.C." staff (N=27) or "Non-T.C." staff (N=26) depending upon whether or not they were regularly assigned to a

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[5] As mentioned earlier, the original patient sample was selected on the basis of very loose criteria. These were as follows: 1. Patients with serious physical and mental disturbances were ruled out. 2. Some patients who showed potential for growth. 3. Some patients who showed great difficulties in inter-personal relationships were included. 4. Finally some patients who showed potential for leadership were included.

floor that had an ongoing therapeutic community program in operation.[6] Ss in this group were further subdivided into those who had been working on their floor for a minimum of eighteen months and those who had been on their floor for a shorter time. Staff members in both groups came from a variety of backgrounds. They were however, similar on several dimensions. Most of them (90%) are members of minority groups (Black or Puerto Rican), and approximately 67% of the staff members in both categories are employed as nurses aides or orderlies. The remaining staff members are nurses (27%), and social workers (6%).

Measuring Instruments. To test the various hypotheses in this study, a number of scales and questionnaires were employed. The following scales and questionnaires were administered to the patient Ss.

The first of these, The Kutner Morale Scale was employed by Rosenstock and Kutner (1971) in the original research project as a measure of patient morale. It consists of five items, which using a Guttman Scalogram Analysis (1950), have a coefficient of reproducibility of over .90. Responses to each of the questions are scored either 1 or 0 yielding a maximum score of 5. Higher scores indicate higher morale.

Self-Esteem Scale. The scale employed as an index of self-esteem was a

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[6] Most of the staff members who were asked to participate in the study cooperated fully. Only four (4) staff members on the floors in the study refused to cooperate, or did not complete the questionnaires given to them. Two of these staff members on 7BR, could not be convinced that the questionnaire they filled out would not be used against them by the administration. While other staff members were fearful of possible reprisals from the administration, they nevertheless cooperated in the study. Another staff member on 3BR failed to bring in the questionnaires by the time the study was completed, although asked to do so on several occasions. He was described by his co-workers as "not a very enthusiastic participant in the therapeutic community". A fourth staff member had only started working on her floor two weeks before the study ended and it was decided not to include her in the staff sample.

modified version of the major subscale of Janis and Field's (1959) Field Personality Questionnaire. The modified version contained on 12 items, since it was found that 11 of the original questions were not appropriate for the life situation of the patients at Beth Abraham Hospital. (The original version had a split half coefficient of reliability of .89) Following Janis and Field, 12 filler items dealing with physical health and hospital life were interspersed throughout the scale.

All questions beginning with the phrases "How often do you ...?" and "Do you ever....?", have the following checklist of five answer categories: Very often, Fairly often, Sometimes, Rarely, Never. For example:

"How often do you have the feeling that there is nothing you can do well?"

Very often ___ Fairly often___ Sometimes___ Rarely___ Never___

Each response is given a score of 1 to 5, with a score of 5 given to the response "Never", and 1 given to the response "Very often". Thus total scores on the scale may range from 12 to 60, with the higher scores indicating higher self-esteem.

Patient Ss were also asked to fill out The Role Functions Questionnaire. Originally developed by Wilensky, Kornfeld and Herz (1969), the present version was modified and adapted to the patient population of a chronic disease facility. Ss were presented a list of 24 incidents such as:

> "Two patients were always arguing about the temperature of the air conditioning in their room. Which person or persons would help settle the argument?"

Ss were then asked to indicate the person or persons most likely to handle the situation in question, by checking the appropriate people in the following list: Nurse, Social Worker, Patient, Aide or Orderly, Doctor. Next to each of the

five names, there were a choice of five ratings. Ss were asked to check the rating which was most appropriate, and to rate each person independently. The ratings are as follows:

All _____ Most _____ Some_____ Rarely _____ Never _____

Ss were then instructed to check off the appropriate ratings according to the following instructions:

If the person would handle all such situations, check off the word All.

If the person would handle most such situations, check off the word Most.

If the person would handle some of these situations, check off the word Some.

If the person would handle these situations rarely, check off the word Rarely.

If the person would never handle situation, check off the word Never.

Thus Ss could give ratings to each of the five people above. The data was then analyzed by comparing the total scores given to each discipline (i.e. doctor, patient) listed. The results were then analyzed by means of analysis of variance (2 X 5), comparing "T.C." and "Non-T.C." Ss.

In addition to the scales and questionnaires already mentioned, Patient Ss were also asked to identify the pictures of 10 other patients on the floor. They were shown only pictures of patients who had been on the floor for a minimum of 18 months. If they were able to identify the picture of the patient in question, but could not remember their name after several minutes of trying, Ss were read the names of 5 persons from which to choose the correct name. Both the pictures shown to Ss and the names given to choose from, were selected randomly to insure against bias. If Ss could not select the correct name from the 5 names presented, Ss were then asked if they recognized the picture as someone from the floor, even though they could not remember the name (Ss were given sufficient time to remember the name of the

person in the picture to control for temporary memory loss). Finally each S was shown a picture of someone outside the hospital, whom they could not possibly recognize. This "dummy" picture was used to determine whether or not Ss were falsely reporting that they recognized the pictures.[7]

Ss were given a score of 4 if they recognized the picture with the correct name; a score of 3 if they could not remember the name but selected the correct name from the 5 presented; a score of 2 if they failed to select the correct name, but reported that they recognized the picture; and a score of 1 if they reported that they did not recognize the picture. Thus the range of possible scores was from 10 to 40.

The Location Activities Inventory (LAI), developed by Hunter, Schooler and Spohn (1962), was designed to provide a measure of the characteristic patterns of behavior of psychiatric patients. It was designed for use by a single observer. As the observer moves through the floor he checks off the category into which the various patient's behavior falls.[8] In this study the categories were as follows:

1. Sleeping
2. Social Interaction
3. Parasocial behavior, i.e. watching t.v. in a group.
4. Functional non-social behavior, i.e. reading a book, taking care of one's personal needs.
5. Null behavior, i.e. sitting, staring into space.

This data was collected by a research assistant who was experimentally naive

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[7] Only one patient S reported that he recognized the "dummy" picture. All of his responses were later discarded because his mental status had become very questionable. He was quite confused at times, and disoriented as to time and place.

[8] In this study only the activity dimension of the LAI was employed.

in order to prevent experimenter bias from influencing the behavior ratings. The same research assistant made the observations on each of the floors involved in the study.

The treatment of this data took two forms. First the total number of people on each floor at the same time provided one measure. Since patients have the opportunity to be off the floor in various activities during much of the day, their presence on the floor may be considered a measure of the inactivity of the ward as a whole.

Secondly, the data obtained from the two groups was compared in terms of the percentage of patients in each category, to distinguish between the "T.C." and "Non-T.C" Ss on the basis of social vs. non-social behavior.

The staff Ss were asked to complete The Role Functions Questionnaire, already described in the preceding section. Next, Ss were asked to complete The Attitude Toward Disabled People Scale (ATDP), developed by Yuker, Block and Campbell (1960). The ATDP is an instrument designed to measure the attitudes of both disabled and non-disabled people toward disabled people in general. The original form, a twenty item, Likert type scale ATDP-0, may be administered as either a group test or an individual test. (In this study we chose to administer it as an individual test since Ss could not complete the questionnaires at work and, took the instruments home and filled them out themselves). Ss were presented with 20 statements about disabled people. For example:

"Disabled people are easier to get along with than other people."

Ss were than asked to respond to each statement by indicating the extent of their agreement or disagreement, according to the following possible answers:

+ 3 1. I agree very much

+ 2 2. I agree pretty much

+ 1 3. I agree a little

- 1 4. I disagree a little

- 2 5. I disagree pretty much

- 3 6. I disagree very much

The total score for this scale ranges from 0 to 120, with higher scores reflecting more positive attitudes toward disabled people. The authors report that their studies have indicated that the scale (ATDP-0) has reliability coefficients ranging from +.75 to +.85. They also report that the ATDP-0 correlates well with other instruments of general attitudes towards disabled people (Yuker, Block & Young, 1970). One important finding cited by these authors was that there was no significant differences in the scores achieved by Ss answering the questions honestly, and those attempting to make a good impression. This finding is particularly important when one considers that staff members filling out the scale may have tried to make a good impression.

Finally, staff Ss completed a Job Satisfaction Scale. The scale used in this study was a modification of a scale developed by Decker (1959), to measure employee attitudes toward specific aspects of their jobs.

The 10 aspects of the job, rated in this study were as follows:

1. Amount of pay received.
2. Job Security.
3. Physical working conditions.
4. The opportunity for learning new skills that would make the job more meaningful.
5. The administration's attitude and responsiveness toward its employees.

6. Patients' attitudes toward staff members.

7. The personality and temperament of their immediate supervisor.

8. The way staff members are informed of their job performance.

9. The kind of work each employee does.

10. Relations with co-workers.

Each of the factors was rated on two dimensions by staff Ss. The first rating reflected the degree of satisfaction-dissatisfaction with each of these aspects on a 9 point scale. The second rating involved a rating of how important each of the 10 aspects of the job were, rated on a 5 point scale. Finally, each staff S was asked to rate his overall job satisfaction on a 9 point scale similar to the one used to rate each of the 10 aspects of the job. The sum of the ratings on each of these 10 aspects was also considered an additional measure of job satisfaction. Comparisons were then made between "T.C." Ss and "Non-T.C." Ss on these various dimensions.

Procedure. The experimenter was introduced to both patients and staff at Beth Abraham Hospital as someone who was interested in doing a study of "what life at Beth Abraham is like for patients and staff". It was made clear in a number of meetings with patients and staff on the various floors that the investigator was not a member of the Beth Abraham Staff, and was an objective observer, affiliated with the City University of New York, where he was working on his doctorate in Clinical Psychology. These meetings were usually held separately, that is with only staff members present, or only patients present, although on several occasions staff members were present during patient meetings. These contacts with patients and staff took place intermittently over a 9 month period before the actual data collection study was begun.

Appointments were made with staff members and they were asked to fill out a

questionnaire composed of the Role Functions Questionnaire, the ATDP-0, and the Job Satisfaction Scale already described. When staff Ss could not complete the questionnaire in one sitting, and few of the staff Ss were able to, they were asked to take the questionnaires home to complete. When this occurred, Ss were asked not to discuss the questionnaire with their co-workers; to guard against any contamination of their answers.

In order to be sure that staff Ss could read English well enough to fill out the questionnaire, the investigator asked all Ss who had had minimal educational background to read the first couple of questions aloud as they went over them with the investigator who presented himself as available to answer any questions. Ss were then told that if they had any difficulty with any of the questions, or had trouble understanding what was asked of them, they could consult with the investigator who was available for assistance. Several of the staff members whose principle language was Spanish initially refused to fill out the questionnaire. However, after learning that they would have help in answering the questions, they admitted their embarrassment and filled out the questionnaire with the investigator's assistance.

Staff Ss were told that their responses to the questionnaire were confidential, and that the anonymity of their responses would be assured. As an assurance of this, the only identifying data requested on the forms was age, sex, job title, marital status, and length of time working on their present floor.

Patients were also interviewed individually and asked to complete the Kutner Morale Scale, the Role Functions Questionnaire, and the Self-Esteem Scale drawn from Janis and Fields' (1959) inventory. For those patients who had trouble filling out the questionnaire on their own, because of physical difficulties, an interviewer was assigned to read the questions and fill in the answers. In these cases, someone,

other than the investigator, who was experimentally naive assisted the patient to fill out the various interview forms.[9] This was done in order to guard against experimenter bias. However, a small number of patient Ss (a total of nine) were assisted by the investigator, because the other interviewers had difficulty completing the interviews. Interviewers were also asked to write notes on each interview evaluating the Ss honesty and response style.

The scoring of the responses to the questionnaires and scales was also done by someone other than the investigator. Since all the questions were objective questions, there were no problems evaluating or scoring the responses.

Patient Ss were then asked to identify the pictures taken of other patients on the floor. (The procedure and scoring of Ss responses was described in an earlier section.)

Finally, a measure of patient interaction was made by use of the LAI (described earlier). In this case, a single observer (other than the investigator) walked through the four floors involved in the study and recorded the patient Ss activity on the floor at the time. Twenty such time samplings were made on each floor involved in the study. The times sampled were decided by a random sampling of the time periods when patients might be active on the floor (excluding Saturdays for religious reasons). The observer randomly varied the order in which she made the observations on the four floors. The average of all the time samplings was used for purposes of statistical analysis.

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[9] The researchers hired for study were trained for several hours by the investigator in order to familiarize them with the research procedure. They were asked to talk to Ss briefly to establish rapport. All Ss were introduced to the researchers by the investigator in order to insure as much cooperation as possible. They were kept as experimentally naive as possible.

Results

The first analysis concerned the hypothesized difference in patient morale. For purposes of this analysis, mean morale scores for "T.C." patients and "Non-T.C." patients were compared. This comparison is presented in Table 2.

Insert Table 1 about here

The morale hypothesis was strongly supported. The difference between the "T.C." and "Non-T.C." Ss was in the predicted direction, and was significant beyond the .001 level of significance.

An additional analysis of the morale data was done including only those Ss between 50 and 75 years of age. This was done in an attempt to minimize the effect of age differences between the two groups upon morale. Although there was a slight decrease in the difference in mean morale scores, this difference remained highly significant in the predicted direction (see Table 2). This finding suggests that age differences between the two groups did not contribute significantly to the differences in morale scores.

Insert Table 2 about here

Thus, both analyses of "T.C." and "Non-T.C." Ss morale scores confirmed the first hypothesis. This difference in morale becomes even more striking, when one compares the mean morale score of the "T.C." Ss in the present study, with the base-line data for "T.C." Ss reported by Rosenstock and Kutner (1971). The mean morale score for "T.C." patients was even lower than that for the "Non-T.C." patients in

Table 1

Differences in Mean Morale Scores for

"T.C." and "Non-T.C." Patients

Group	Mean	S.D.	Diff.	t-ratio
"T.C."	2.960	1.40		
			+ 1.246	4.267*
"Non-T.C."	1.714	1.37		

Note.- N=50 for each group

* $P < .001$

Note.- The mean morale score for "T.C." patients at the beginning of the Rosenstock & Kutner (1971) study, was 1.55.

Table 2

Differences in Mean Morale Scores for "T.C." and "Non-T.C." Patients Between 50 - 75 Years of Age

Group	N	Mean	S.D.	Diff.	t-ratio
"T.C."	35	2.89	1.45		
				+ 1.16	3.14*
"Non-T.C."	26	1.73	1.41		

* $P < .005$

Table 3

Distribution of Morale Scores for "T.C." Patients at Beginning of Therapeutic Community Project (Rosenstock and Kutner, 1971)

Level of Morale	Low (0 - 1)	Moderate (2 -3)	High (4 -5)
Per Cent of Patients in Each Category	63.1%	21.5%	15.4%

Note.- N = 72, Mean = 1.55

the present study. The baseline data for "T.C." patients is presented below (see Table 3).

Insert Table 3 about here

The second hypothesis concerned the differences in self-esteem between "T.C." and "Non-T.C." Ss . As can be seen from Table 4, the difference between the two groups was not significant, and the hypothesis was not confirmed.

Insert Table 4 about here

The next analysis dealt with the hypothesis about differences in patient interaction. Patient interaction may be thought of as a measure of patient involvement with the activities of the institution, and with other patients. Therefore, the data concerning patient behavior was analyzed in two ways. First, the number of patients off their floor at a given time provided a measure of the number of patient Ss who were involved in other activities of the institution. Second, the behavior patterns of those patient Ss remaining on their floors indicated the nature of the patient interaction taking place on the floor at that time. The results of this analysis are presented in Table 5.

Insert Table 5 about here

The results of this analysis are mixed. The difference in the mean percentage of patients on the "T.C." and "Non-T.C." floors was in the predicted direction and significant beyond the .001 level, suggesting that "T.C." patients were more involved in the activities of the institution. However, an examination of the differences in the various behaviors on the different floors, revealed that the only significant difference

Table 4

Differences in Mean Self- Esteem Scores for

"T.C." and "Non-T.C." Patients

Group	Mean	S.D.	Diff.	t-ratio
"T.C."	43.98	4.11		
			+1.77	.93
"Non-T.C."	42.21	12.54		

Note.- N=50 for each group

Table 5

Differences in Per Cent of Patients on "T.C." and "Non-T.C." Floors Involved in Different Behaviors on Their Floors

Behavior	Group	Mean %	S.D.	Diff.	t-ratio
Sleeping	"T.C."	5.58	1.63	-1.10	-1.00
	"Non-T.C."	6.68	1.47		
Social Interaction	"T.C."	14.88	1.06	- .75	-.298
	"Non-T.C."	15.63	1.19		
Para-Social Interaction	"T.C."	7.05	6.63	+1.10	.78
	"Non-T.C."	5.95	5.97		
Functional Non-Social	"T.C."	18.58	6.48	-5.87	-3.96*
	"Non-T.C."	24.45	6.79		
Null Behavior	"T.C."	9.75	6.77	-.55	-.37
	"Non-T.C."	10.30	6.56		
Total % of Pts. on Floors	"T.C."	55.83	15.84	-7.10	-3.82**
	"Non-T.C."	62.93	10.70		

Note.- N= 40 in each group

* $P < .05$

** $P < .001$

between the two groups was in Functional Non-Social Behavior. This difference was significant beyond the .05 level. The other differences, particularly the differences in social interaction, did not even approach significance. Thus, the hypothesis concerning differences in patient interaction on the "T.C." and "Non-T.C." floors was not confirmed. However, the significant difference in the mean percentage of patients off the floors, may reflect the fact that people who might normally have been involved in social interaction on the "T.C." floors, were not on the floor at that time.

The next analysis was concerned with differences in patients' ability to recognize other patients on their own floors. The extent to which patients know other patients on their floor may be seen as a measure of an individual patient's involvement with other people in his floor, and in a sense his involvement in the life of the floor. Patients were asked to identify the pictures of 10 other patients, on their floor. The sum of his responses to the 10 pictures provided a measure of each patient's capacity to recognize other patients on his floor. Mean picture recognition scores were then compared for the "T.C." and "Non-T.C." groups. The results for this analysis are presented in Table 6. As can be seen from this table, the difference in mean scores was in the predicted direction, and significant beyond the .001 level. This finding was all the more impressive when one considers the fact that only patients who had been on their floors together for 18 months participated in the study.

Insert Table 6 about here

The last hypothesis dealing with patient Ss was concerned with differences in the extent to which patients on "T.C." floors, saw themselves as capable of performing more staff functions, than patients on "Non-T.C." floors. For purposes of this

Table 6

Differences in Mean Picture Recognition Scores

for "T.C." and "Non-T.C." Patients

Group	N	Mean	S.D.	Diff.	t-ratio
"T.C."	47	39.15	2.34		
				+ 5.00	5.42*
"Non-T.C."	48	34.15	5.96		

Note.- Two patients from the "Non-T.C." group, and three patients from the "T.C." group were excluded because of Problems with their vision.

* $P < .001$

analysis patient S responses to the Role Functions Questionaire, were compared by means of a two by five analysis of variance with repeated measures, with treatment condtion against discipline. A summary of the results of this analysis is presented in Table 7.

Insert Table 7 about here

The summary reveals that the "T.C." and "Non-T.C." patients were significantly different in their responses to the Role Functions Questionnaire. This difference was significant beyond the .001 level. It is also evident there were highly significant ($P < .001$) differences between disciplines which points to specific discipline effects. However, these main effects must be qualified because of the significant ($P < .025$) interaction between treatment conditions and disciplines.

Therefore following Winer (1962), tests on simple main effects were performed to determine which treatment conditions remained significant after interaction effects had been accounted for. The analysis revealed that the difference between the disciplines (i.e. doctor, nurse, etc.) remained significant within the "T.C." and "Non-T.C." groups. (for both groups $P < .001$) However, a comparison of the differences between disciplines between groups reveals that only the differences between the scores given to patients, and doctors, are significant ($P < .01$) (see Table 8).

Insert Table 8 about here

Thus, while patients in both groups (T.C. and Non-T.C.) rate the disiplines in approximately the same order. That is, they give social workers, nurses, doctors the highest ratings in that order, patients in the "T.C." group rate themselves higher than aides and orderlies, while "Non-T.C" patients remain at the bottom of

Table 7

Summary of Analysis of Variance

Patient Responses to RFQ

Source	d.f.	MS	F
Between Groups	1	4,075.44	9.64**
Ss Within Groups	92	422.60	
Between Disciplines	4	16,934.26	164.36**
Groups X Disciplines	4	327.71	3.18*
Disciplines X Ss Within Groups	368	103.03	

Note.- There were 47 Ss in each group. Three Ss in each group were excluded because of difficulties in data collection.

* $P < .025$

** $P < .001$

Table 8

Mean Scores for "T.C." and "Non-T.C."

Patients for Each Discipline

Discipline	Group	Mean	df	MS	F
Nurse	"T.C."	53.61	1	533.73	3.197
	'Non-T.C."	48.85			
Social Worker	"T.C."	59.04	1	202.60	1.230
	"Non-T.C."	56.10			
Patient	"T.C."	34.36	1	3148.26	18.86*
	"Non-T.C."	22.78			
Aide	"T.C."	28.85	1	160.95	.964
	"Non-T.C."	26.23			
Doctor	"T.C."	42.29	1	1340.69	8.03*
	"Non-T.C."	34.74			

Note.- Error Term= MS within cells = SS within Groups+ SS_{BxSs} within groups $\div$ pq (n-1) = 166.94

* $P < .01$

the list. In addition, "T.C." patients also rate themselves and doctors significantly higher in helping functions, than "Non-T.C." patients do. This difference also accounts for the significant interaction effects, suggesting that the treatment conditions differentially effected patients and doctors, but not the other disciplines. The interaction effects of discipline scores with treatments are represented graphically in Figure 1.

Insert Figure 1 about here

Thus the hypothesis that "T.C." patients would see themselves as more capable of more of the helping and organizing functions normally attributed to staff members, than "Non-T.C." patients would, was confirmed.

There were three hypothesis about differences between staff members working on "T.C." and "Non-T.C." floors. The first of these hypotheses was concerned with differences in attitudes towards disabled people. This hypothesis was tested by comparing mean scores for the "T.C." and "Non-T.C." groups on the ATDP (Yuker, Block & Campbell, 1960). Higher scores on this instrument reflect more positive attitudes towards disabled people. As can be seen from Table 9, while the difference between the two groups is in the predicted direction, it is not significant. Thus, the hypothesis about differences in attitudes towards disabled people was not confirmed.

Insert Table 9 about here

However, an inspection of the data revealed some unexpected differences. When the mean ATDP scores for staff members working on "T.C." and "Non-T.C." floors for 18 months or longer were combined, and compared to the ATDP scores of staff members working on these floors for less than 18 months, the difference was

Figure 1

Interaction of Discipline Scores With

Treatments for Patient Data

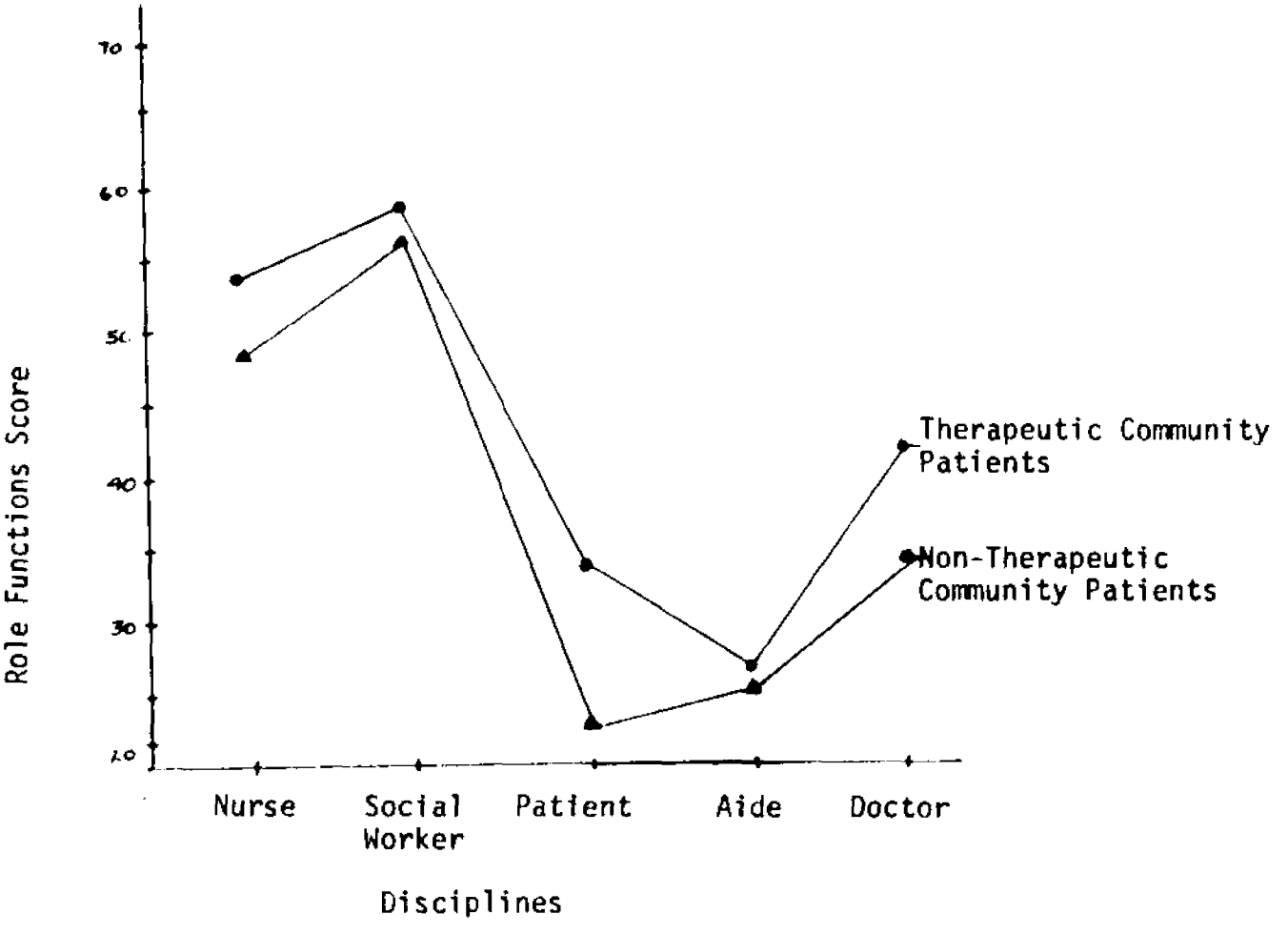

Table 9

Difference in Mean ATDP Scores Between Staff Members Working on a "T.C." Floor and Those Working on a "Non-T.C." Floor

Group	N	Mean	S.D.	Diff.	t-ratio
"T.C."	18	64.00	12.47		
				+4.19	.837
"Non-T.C."	16	59.81	13.29		

Note.- Only staff members working on their respective floors for a minimum of 18 months were included in this comparison.

Table 10

Difference in Mean ATDP Scores Between Staff Members Working on Their Respective Floors For 18 Months of More, and Those Working Less Than 18 Months

Group	N	Mean	S.D.	Diff.	t-ratio
Staff 18+	34	62.03	14.5		
				+8.20	1.83*
Staff 18-	18	53.83	17.09		

* $P < .05$

significant beyond the .05 level. Thus, it appears, that it may not be the nature of the therapeutic orientation of a particular floor which effects staff attitudes towards disabled people, but rather the length of time that staff are in intimate contact with disabled people. (see Table 10).

The next analysis was concerned with the hypothesis that staff members on "T.C." floors see patients as capable of more independent functioning than staff members on "Non-T.C." floors. As in the case of patient Ss, staff Ss were asked to fill out the Role Functions Questionnaire, and their responses to this instrument were analyzed by a two by five analysis of variance with repeated measures. A summary of the results of this analysis is presented in Table 11.

Insert Table 11 about here

As can be seen from this summary table, both main effects of the analysis were significant beyond the .01 level. However, the significance of the differences between these main effects must be qualified because of the significant ($P < .01$) interaction between treatment condition and discipline score.

Therefore, again following Winer (1962), tests on simple main effects were performed. The results of this analysis (as in the case of the two by five analysis of patients' response to RFQ) reveals that the differences in the effects of the disciplines remained significant within the "T.C." and "Non-T.C." groups (for both group $P < .001$). However a comparison of the differences between disciplines between groups reveals again that only the differences between patient and doctor disciplines were significant; at the .01 level. This data is presented in Table 12.

Insert Table 12 about here

Table 11

Summary of Analysis of Variance

Staff Responses to Role Functions Questionnaire

Source	df	MS	F
Between Groups	1	1,815.75	4.49*
Ss Within Groups	30	404.44	
Between Disciplines	4	9,058.80	110.99**
Groups X Disciplines	4	349.81	4.29**
Disciplines X Ss Within Groups	120	81.62	

Note.- There were 16 Ss in each group. Two Ss from the "T.C." group were excluded for statistical reasons.

* $P < .05$

** $P < .01$

Table 12

Mean Scores for "T.C." and "Non-T.C."

Staff for Each Discipline

Discipline	Group	Mean	df	MS	F
Nurse	"T.C."	67.75	1	132.03	.903
	"Non-T.C."	63.69			
Social Worker	"T.C."	64.44	1	84.50	.58
	"Non-T.C."	67.69			
Patient	"T.C."	34.06	1	1,378.13	9.426*
	"Non-T.C."	20.94			
Aide	"T.C."	42.94	1	504.03	3.447
	"Non-T.C."	35.00			
Doctor	"T.C."	55.81	1	1,168.28	7.635*
	"Non-T.C."	44.00			

Note.- Error Term = MS within groups = SS_{BXSs} within groups $\div$ 150 = 146.19

* $P < .01$

Thus, analysis of the data suggests that there are different treatment effects for the patient and doctor disciplines, than for the other three disciplines. The interaction effects of discipline scores with treatments are represented graphically in Figure 2.

Insert Figure 2 about here

"T.C." staff members give both patient and doctor higher role functions scores, than do "Non-T.C." staff members. This may be interpreted as seeing both "T.C." patients and "T.C." doctors as more capable of performing helping and organizing functions on the floor, than patients and doctors on other floors. Therefore, the results of the analysis confirmed the hypothesis concerned with staff members view of patients' functioning.

The final analysis concerned the hypothesized difference in job satisfaction between "T.C." staff, and "Non-T.C." staff. There were two measures of job satisfaction employed to test this hypothesis. The first was a rating of overall job satisfaction on a nine point scale, with lower scores reflecting greater job satisfaction. The second measure of job satisfaction, was the combined total of the ratings given to each of 10 aspects of the job by each staff member. Each of these ratings was also based on a nine point scale. As in the first measure, lower scores reflect greater job satisfaction. The results of these analyses are presented in Table 13.

Insert Table 13 about here

As can be seen from the table, neither the differences in single factor ratings nor the difference in the combined rating were significant, and the hypothesis was not confirmed. However, again there was an unexpected finding. When job

Figure 2

Interaction of Discipline Scores With

Treatments for Staff Data

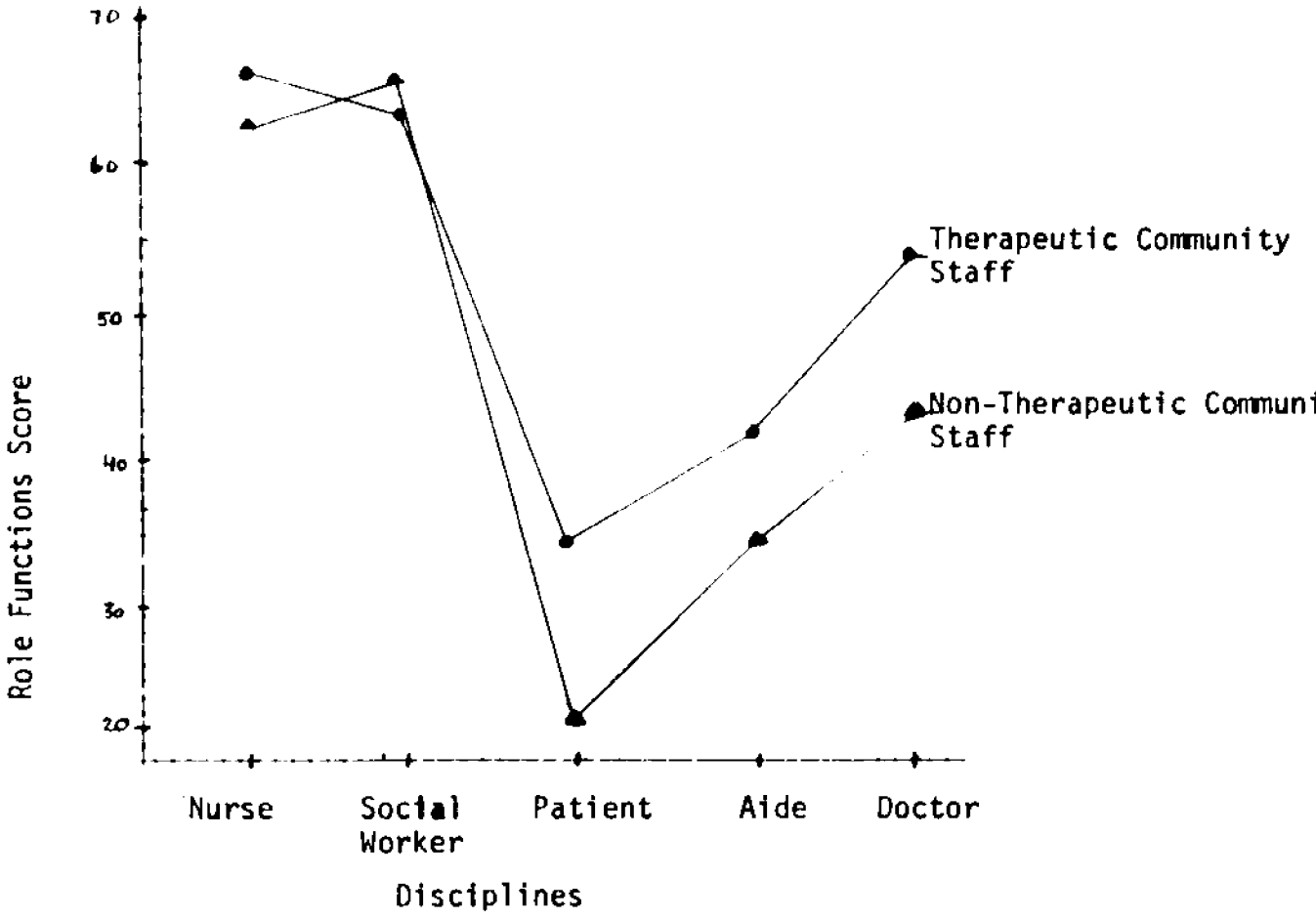

Table 13

Difference in Mean Job Satisfaction Scores

Between "T.C." and "Non-T.C." Staff Members

Single Factor Ratings

Group	N	Mean	S.D.	Diff.	t-ratio
"T.C."	18	4.11	.58		
				+.23	.96
"Non-T.C."	16	3.88	.81		

Combined Totals of 10 Aspects of Job

Group	N	Mean	S.D.	Diff.	t-ratio
"T.C."	18	40.56	4.45		
				-.69	n.s.
"Non-T.C."	16	41.25	9.53		

Note.- Only staff working on their floor for a minimum of 18 months were included in these analyses.

satisfaction scores for staff members working on their floors for 18 months (regardless of treatment category), were compared to scores for staff members working less than 18 months, it became apparent that the latter are more satisfied with their jobs than the former. This data is presented in Table 14.

Insert Table 14 about here

In summary, the results of the present study indicated that the hypotheses concerning patient improvement were in the main confirmed, except for the hypotheses related to self-esteem and patient interaction. "T.C." patients had significantly higher morale, recognized more of their fellow patients, and saw patients as capable of performing more of the functions traditionally performed by staff, than their "Non-T.C." counterparts. The hypothesis related to "T.C." staff's perception that patients could function more independently was also confirmed, although the hypotheses related to differences in staff attitudes toward disabled people, and job satisfaction were not.

Table 14

Differences in Mean Job Satisfaction Scores Between Staff Members Working on Their Floors More Than 18 Months, and Those Working Less Than 18 Months

Single Factor Rating

Group	N	Mean	S.D.	Diff.	t-ratio
Staff 18 +	34	4.00	.69		
				+ .44	1.48
Staff 18 -	18	3.56	1.15		

Combined Totals of 10 Aspects of Job

Group	N	Mean	S.D.	Diff.	t-ratio
Staff 18+	34	40.88	7.18		
				+4.71	2.32*
Staff 18 -	18	36.17	6.53		

* $P < .05$

Discussion

In general, the results of the present study supported the hypotheses that patients in a therapeutic community program would have higher morale, function more independently, and be more involved in the activities of the floor,[10] and the hospital, than patients living on floors run according to more traditional hospital procedures. As a group, "T.C." patients felt less isolated, were less depressed, and saw themselves as more actively involved in helping other patients, than their counterparts on the "Non-T.C." floors.

The significant difference in morale between "T.C." and "Non-T.C." patients was very impressive. This finding was all the more striking, when the morale scores of "T.C." patients in the present study were compared to the scores of patients at the beginning of the original research project by Rosenstock and Kutner (1971). It appears that the significant changes in patient morale reported by these authors have been supported by the results of the present study.

These findings are also consonant with the differences in responses elicited from patients in informal interviews. Whereas "T.C." patients commented most frequently on the struggle of maintaining the therapeutic community program now that "Einstein has pulled out", and "the administration is letting it die", patients on other floors were more preoccupied with their own personal problems, and talked at length about how difficult it was to get along with other patients. It was quite evident that the major focus of the complaints, was different for the two groups. As Davis (1967)

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[10] The patients at this institution were opposed to referring to it as a hospital. They preferred to call the institution a "home". For similar reasons, patients did not like anyone referring to the floors on which they lived as wards.

has pointed out, the stimulation provided by the mild frustrations of participating in a therapeutic community, helps patients to focus on the concrete reality and prevents them from getting lost in their own world.

On the other hand, there were no differences in self-esteem between patient Ss in the present study. The absence of any significant difference in this case, however, seems related to the use of an instrument more appropriately used to measure a person's long standing attitudes about himself, rather than the kinds of changes in attitude that can take place in a short time.

The isolation of "Non T.C." patients was, in part, reflected in their responses to pictures of other patients on their floor. One aspect of this isolation was reflected in their inability to recognize the pictures of patients who had been on the floor with them for a minimum of 18 months. In many cases, the unrecognizable patients lived only a few doors down the hall. Another aspect of this isolation was reflected in patients' feelings about being unable to recognize these pictures. Many "Non-T.C." Ss seemed indifferent, and commented that it wasn't important for them to know too many people on their floor, and "they didn't care about them anyway". One S reported that she hadn't learned a patient's name because he had never bothered to return any of her greetings. In striking contrast, even the quietest, most withdrawn "T.C." patients recognized a significant percentage of the pictures shown to them.

The differences in the responses of the two groups were even more remarkable when one considered the fact that almost all of the Ss involved in the study recognized the experimenter easily, and remembered his name after only a few brief meetings. Our findings therefore suggest that there is something about the "T.C." approach that makes patients more alert to each other, and makes patients interested enough in other patients to retain an internal image of them.

On the other hand, while patients on "T.C." floors knew more patients on their floor, they did not interact with them more during the course of the day. It was somewhat surprising that there were no differences in the observed interpersonal interactions on the two floors, because of the significant picture recognition differences. However, the difference in these findings may be due to the fact that the picture recognition tests and the behavioral observations of patients' behaviors were measuring two different things, i.e., recognition in the one instance and interaction in the other. These data suggest that there are many factors, other than recognition, which determine whether interaction takes place. It does not necessarily follow that if a patient recognizes another patient, he will interact with him. There is another possible explanation for this finding. Observations of patients' behavior involved the evaluation of the behaviors of all patients on the floor. On the other hand, the picture recognition test involved only those patients who had been on their floors for a minimum of 18 months. The results might have been different had the observer been assigned to rate only patients who had been on the floor for 18 months. It would have been interesting for example, to study the relationship between picture recognition scores, and the behavior pattern, of a particular patient.

There is a third possibility which seems the most plausible. This is related to the finding that there were fewer patients on the "T.C." floors than on the "Non-T.C." floors, at any given time. It is conceivable that the more active patients, who might have been involved with other patients on their floor, were engaged in different activities in other parts of the institution. In other words, the "T.C." patients were for the most part, more active, alert, and interested in the life of the home which took them off the floor where the interaction observations made. It was not possible physically to follow all patients and record their interaction as they meandered

throughout the building, and therefore this hypothesis could not be verified.

However, differences in patient interactions were reflected in the way in which "T.C." patients saw themselves as capable of performing a number of functions usually attributed to staff members. In this regard, "T.C." patients gave "Patients" significantly higher scores on the RFQ than did "Non-T.C." patients. Thus they saw themselves as capable of functioning in ways that would help other patients. In this sense, "T.C." patients were clearly more active participants in the life on their floor. In contrast to Non-T.C." patients remarks that difficulties between a patient and his family were "none of the other patients' business", or that "patients wouldn't interfere", patients on "T.C." floors reported that "patients on this floor are used to interfering in each other's business", or "a patient could talk to another patient about things like that".[11]

Similarly staff on "T.C." floors reported that patients had become more involved in helping each other in a mutual way. For example, an "Adjustment Committee" was formed which helped patients with personal problems that came up in relation to their roommates, other patients or staff members. Additional data from the social service department indicates that at the beginning of the therapeutic community project, patients were engrossed in their own personal concerns, and spent much of the time in group meetings talking about their own personal needs, i.e. changes in medication. They also commented disparagingly that it ("T.C.") wouldn't work. It was only after many meetings, and much hard work, that patients began to listen more attentively to what other patients had to say, and began to work with each other to deal with

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[11] These quotes are from individual patients, but reflect what appeared to represent the most frequent comments on a particular floor.

some of the realistic problems of their floor.[12] In many ways, the description of "T.C." patients at the beginning of the therapeutic community program, resembles that of the "Non-T.C." comparison group.

The patients' perception of themselves as capable of performing "Staff" functions was supported by the staff responses to the RFQ. The responses of staff may be seen as reflecting their attitudes and expectations about patients' functioning. As a number of authors (Davis, 1967; Volpe & Kastenbaum, 1967; Brudno & Seltzer, 1968) have indicated, the expectations of staff serve to reinforce the behavior of patients. Our results suggest that the effect was a positive one, and staff's favorable response to patients' activities may have served to encourage their increased participation. Klemes (1951) has also pointed out, that increased staff interest often leads to a favorable clinical response from patients.

The interest of the "T.C." staff was indicated in several ways. First, even after the official termination of the "T.C." project, staff members developed a new patient activity where patients were taken out shopping on a weekly basis. Secondly, this investigator noticed that during the time between staff shifts, when "Non-T.C." staff would often be sitting around the dining room waiting for the shifts to change, "T.C." staff remained more actively involved in continuing to work with patients. While this data was not collected in any systematic manner, and may reflect the biased observations of this investigator, it is suggestive of a more involved attitude on the part of "T.C." staff.

A somewhat surprising finding in the present study was the significant difference in the doctor's role in the two groups. The "T.C." doctor's own self-report

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[12] This information was obtained from group process records of the patient meetings.

(Rosenstock & Kutner, 1971) was that she functioned as somewhat of a "Handyman", and that she needed more time to do her medical work more effectively. It appears that the doctor's role in the therapeutic community program was an expansion of the role of the doctor on the more traditional floors. This finding was unexpected, since other studies had indicated that one of the results of the therapeutic community approach was a decreased dependence on doctors, and increased reliance upon other patients and staff members (Jones, 1953, 1968; Wilmer, 1958).

It is possible that the explanation for this finding lies in several factors. First, it may be difficult for patients to transfer trust from the doctor to other lower level staff members because of their anxiety about their physical disabilities. More specifically, patients may be so concerned about their physical condition that given the opportunity to do so, they expand the role of someone they already have trust in, and demand more from them, rather than develop trust in somebody else.

At the same time, one must consider the role of the doctor's personality in this matter. The doctor on the "T.C." project, was described as, and appears to be a hardworking woman who takes her work very seriously. As a result, she may have gotten more involved in the responsibilities of other departments, and thus unconsciously contributed to her feeling that she had functioned as more of a "handyman".

An equally surprising finding was that there were no differences in the scores given to "Aides" in the two groups of patients. Since "T.C." staff seemed to be more active, had continued their weekly meetings, as well as initiating several new patient activities, it was expected that this would have been reflected in higher scores on the RFQ. It may be that the kinds of activities measured on the RFQ, were not the kinds of activities that aides and orderlies were usually engaged in. However, there seem to be several alternative explanations. While "T.C." staff felt good about

their work with patients, they were frequently hampered by the lack of support given to them by administration and department heads. While on the one hand, the new "T.C." program taught them to be more innovative and understanding in their work with patients, administration required that they continue to do all of their usual custodial work with patients, and did not provide staff members with the time necessary to implement changes in staff functions which had developed out of "T.C.". Similarly, patients, who were still physically dependent upon staff, were now vocally demanding that staff provide either more or better treatment. Staff members negative reactions to these two factors may have contributed to their relucatnce to respond to patients in new ways that would have placed even greater demands on them.

A final possiblity may lie in the racial differences between patients and staff. The patient population at this institution is predominantly white, while most staff members are either Black or Puerto Rican. While there is no data available to support this hypothesis, it may be that the absence of significantly higher RFQ scores for "T.C." aides reflects the effects of long standing racial prejudices which have subtly effected the attitudes of both patients and staff. Whatever the reasons, the patients' attitudes about some of the aides and orderlies were reflected in their spontaneous comments to the RFQ.

Patients on the "T.C." floors commented frequently, as many of the "Non-T.C." patients did, that a particular incident described in the RFQ was "none of the aides' business", or that "most aides wouldn't interfere". The reason for these comments may lie in what this researcher considers one of the major shortcomings of the Rosenstock and Kutner (1971) project, and that is the absence of any sustained

patient - staff meetings on a regular basis. While Cumming and Cumming (1957) noted that the importance of staff-staff communications should not be overlooked, a number of other investigators (Jones, 1953; 1959; Wilmer, 1958; Rapoport, 1960) have indicated that the cornerstone of the therapeutic community approach is the regular meeting between patients and staff. It is through this meeting that the difficulties between patients and staff are continuously worked out.

In the present therapeutic community project these meetings were not held on a regular basis, in part because of the anxieties and mistrust of both groups (Rosenstock and Kutner, 1971). The patients were anxious about becoming involved in a problem solving situation with staff because it might produce a staff conflict, or result in some staff resignations. In informal interviews, patients reported to this investigator that they were very dependent upon staff, and worried that if they got staff angry they might not be taken care of in the same way, and some important services might be delayed.

The staff saw patients as "demanding", and felt too vulnerable to expose themselves to patient attacks in large meetings, particularly since they felt unsupported by their superiors.[13] It is surprising that during the time that patients and staff did meet regularly to plan a move to another location, they worked very well (Rosenstock and Kutner, 1971). However, these meetings were not continued.

Another reason that these meetings were not held, was that the administration was reluctant to grant more time for staff to go to meetings. While they were willing to have some patient-staff meetings take place on an ad hoc basis, as in the case of the meetings focused on the issue of patients moving from one building to another,

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[13] This information was obtained from group process notes of staff meetings, and from informal, confidential interviews with staff members.

they were unwilling to allow patient-staff meetings to take place on a regular basis because of time considerations (personal communication, B.Kutner, Oct. 1971).

Thus the absence of a regular meeting between patients and staff where issues and problems could have been worked out, and from which a mutual sense of trust and support could have developed, was one of the factors which prevented the therapeutic community project at Beth Abraham from realizing its full potential. It may also have prevented it from developing the foundation necessary to withstand "Einstein's pulling out", and the "administrations letting it die".

The absence of this joint meeting may also have resulted in staff members on "T.C." floors complaining, in staff meetings, that patients on their floors were asking questions about treatment Issues all the time, and giving staff " a hard time". Similarly, staff members on "Non-T.C." floors reported that they didn't like working on "T.C." floors because the patients were more of a "nuisance" there. These complaints are consistent with the findings of Lewis (1967) who reported that it is often harder for staff to tolerate the hostility of patients than to nurture them. It appears that staff are much more comfortable with pleasant, agreeable patients who do not try to challenge them about the kinds of treatment they are getting. Without a vehicle through which these feelings could be resolved, each group was left harboring negative feelings about the other.

As indicated earlier, staff members also complained (in informal interviews) that they felt a lack of support from administration. In the original study, Rosenstock and Kutner (1971) reported that one of the difficulties they encountered at the institution, was the absence of administration support for staff. They noted that this was either because of an unwillingness to do so, or because administration misunderstood what was expected of them. They hypothesized that this administration-staff conflict could be

seen as resulting from the absence of clear lines of communication between the different levels of staff (Rosenstock and Kutner ,1971). Their finding was consistent with the argument presented by Cumming and Cumming (1957), that it is always important in a therapeutic milieu, to lay down firm lines of communication, and to work as thoroughly as possible with administration and upper-level staff, since innovations are particularly threatening to senior staff members who authority is threatened most by these innovations.

This difficulty points to another shortcoming of the original project. This was the problem the researchers had in working effectively with upper-level staff and administration. It may be that the researchers should have worked with administration in a different way at the beginning of the project, to make them more comfortable with the demands a therapeutic community would make upon them. It might also have been important to involve the institution's staff more actively in the initial planning stages of the project. In this manner, the therapeutic community would have been a joint creation of the researchers and the institution, rather than a project of "Einstein" imposed upon the institution. It appears that part of the difficulty was due to the administration's expectation that "Einstein" was going to present them with a finished product which they could either accept or reject. In this sense they did not see the therapeutic community as a process which would continually be modified.

The present state of patient attitudes about the lack of administration support for "T.C."were reflected in the feelings of patients that since the financial support of "Einstein people" had been withdrawn, the administration had refused to supply the extra money necessary to maintain an effective program at the institution.

Staff attitudes about the lack of administration support, were reflected in their

complaints that they experienced difficulties in getting compensatory time to attend weekly meetings of staff, and that administration was cutting down on the time allotted for the meetings. The lack of trust was further reflected in the initial responses of staff members to the present study. Many staff were concerned that their responses might be used against them by administration ("T.C." staff was somewhat less concerned), and their jobs would be in jeopardy. The negative feelings of staff are a crucial factor, since the success of any therapeutic program depends most upon the manner in which it is implemented by staff, particularly lower-level staff (Cumming and Cumming, 1957; Lewis, 1967; Clark, 1967). These authors have also pointed to the necessity of providing adminstration support for the aides and orderlies who do the bulk of the work.

In spite of a number of very positive comments (obtained from staff in informal interviews) about how satisfying their jobs had become since the inception of "T.C.", there were no differences in job satisfaction on the measures used in the present study. This finding may have been due to staff attitudes about filling out the job satisfaction scale. Although a number of staff members on "Non-T.C." floors expressed negative feelings about their jobs in informal interviews, none of the staff in this group gave a lower score than five on the nine point scale. This was the rating of "balanced feelings". Thus in spite of some indications to the contrary, none of the staff expressed negative feelings about working at the institution. It may be that the underlying fear of retaliation by the administration, forced staff to restrict their answers to a very narrow range of responses.

It is also possible that the job satisfaction scale was measuring was something different for the two groups. While staff members (aides and orderlies) in both groups have the same job description, in reality their jobs are somewhat different.

Staff members on "T.C." floors attend weekly staff meetings; they are involved with patients in "O.T."; and they are more intimately involved in talking with patients about their problems. They are also expected to work closely with patients in their committee work, and planning special events. "Non-T.C." staff are not involved in these kinds of activities. In this sense, the jobs of aides and orderlies, as well as other staff members, are more demanding on "T.C." floors. It may be therefore, that the term "job satisfaction" has different meanings for the two groups of staff.

Another explanation is suggested by the finding that staff members working on their floors for less than 18 months were more satisfied with their jobs, than staff members working on their floors for more than 18 months. One of the aspects of work with the chronically physically disabled is that patients rarely get better. Rosenstock and Kutner (1971) for example, found that there was no improvement in the physical condition of patients participating in the study. At best their condition maintained a "status quo", and they did not deteriorate, but remained very dependent upon staff. It is therefore possible that the longer one works with patients of this kind, the more discouraging the work becomes in the sense that one does not see patients getting physically better, and this contributes to dissatisfaction with the job.

In addition, "T.C." staff may also have become frustrated, because while certain aspects of their jobs have become more satisfying, they are still faced with an intransigent administration, which often acts in a manner to undercut the gains made by staff.

While staff members working on their floors for more than 18 months reported less job satisfaction than their co-workers who had been there for a shorter time,

the results indicated that they had a more positive attitude toward disabled people. This may indicate that attitudes toward disabled people are more a function of prolonged, intimate contact with disabled people, rather than therapeutic orientation.

Limitations and implications of the present research

There are several important factors qualifying the results of the present study. The present study was basically concerned with comparing a group of patients and staff in a therapeutic community program, with a comparable of patients and staff from two floors run according to more traditional hospital procedures. However, this comparison involved a "post-hoc" control group, and as a result, it was not possible to match the two groups of Ss, or randomly distribute Ss into the two groups at the beginning of the original therapeutic community research project. Thus, the findings are by no means conclusive evidence of the advantages of the therapeutic community approach, although one can say that the data suggest positive trends.

Had there been comparable baseline data on the two groups involved in the study, the analysis of the data collected might have been more instructive. For example, had the level of morale of "T.C." patients been comparable to the morale of "Non-T.C." patients at the incpetion of the "T.C." project, the relative gains made in both groups could have been evaluated. It is also conceivable that both the positive effects of the therapeutic community approach, and the negative effects of the more traditional approach would have been demonstrated.

The findings of the present study must also be qualified because of the nature of the data collection in the original study. While it would have been instructive to compare morale scores for the "T.C." patients in the present study with their morale scores at the end of the original study, this could not be done because data on individual

patients could not be located. Further, since the morale data (the only measure that was replicated in the present study) presented by Rosenstock and Kutner (1971) was presented in terms of changes in categories, i.e. "low", "moderate" and "high", instead of mean scores, the results could not be directly compared. Nonetheless, one important point is worth noting. At the official end of the "T.C." project in March, 1970, patient had dropped off somewhat. One might have expected that it would have continued to drop if the gains reported were an artifact of the research project. Instead, our data indicates that 15 months later, "T.C." patients' morale had stabilized at a level twice as high as it was at the beginning of the project.

Even if one concludes that the therapeutic community approach was effective with the population of patients and staff in the present study, and this is one conclusion suggested by the data, what aspects of this approach were most effective? What innovations introduced in the study by Rosenstock and Kutner (1971) should be retained in the operation of the floors in question, and which aspects should be discarded? Which should be retained but modified? These are subjects for future research. For example, patients initially met in a weekly floor meeting of to discuss issues relevant to all patients. This meeting was subsequently changed to a monthly meeting after patients began to function effectively in committees. However, the functioning of these committees relied heavily on the work of several key floor leaders. After the termination of the research project in March, 1970, and the death of several of these leaders, a number of committees were disbanded. Thus, the primary vehicle for patient participation in the therapeutic community process was severely diminished. Wouldn't it have been better to have continued the larger meetings on a regular basis (once a week), allowing for both increased patient interaction in a group setting, and at the same time, encouraging some of the quieter withdrawn patients to develop more fully? As Stotsky and Margolin (1968) also pointed out, these larger meetings of patients

would also have been useful in dealing with the inevitable frictions which developed between sub-groups of patients.

Further, since the patients in the present study were considered to be among the healthier patients at this institution, there is a question as to which of the milieu therapy techniques could be utilized with the more seriously disabled patients requiring greater nursing care. It is clear that one cannot talk about independence for chronically disabled patients in the same manner as one talks about it for psychiatric patients whose major problem is an emotional one. Patients with severe physical disabilities will always be dependent upon staff for many vital services, i. e. assistance in going to the bathroom. Even patients who were leaders on their floor and quite outspoken, were afraid that their criticism of staff might result in the reduction of these vital services to them.

An additional limiting factor on patient independence within a therapeutic community is set by the policy of a particular hospital. As Fairweather (1969) pointed out, even the best of hospital administrations does not allow patients total freedom in decision making. In this case, the attitude of the administration towards "T.C." seems to be a mixed one. On the one hand they (the administration) are concerned about the expense of maintaining the "T.C." project. At the same time, they are in the process of starting a variant of "T.C." on one of the control floors in the present study. [14]

It is clear that one of the important innovations in the study by Rosenstock and Kutner, that should be retained is the weekly staff meeting. While the data collected

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[14] This information was obtained in informal meetings with administrative officials and department meetings.

in the present study, does not bear directly on the efficacy of this technique, there is ample anecdotal evidence from both patients and staff to suggest that one of the effects of this meeting has been to make life on the "T.C." floors more meaningful for patients and staff. Unfortunately, the time allotted for this meeting has already been reduced (personal communication, H. Reitman, Oct. 1971).

In conclusion, it appears that it is difficult to specify just what milieu therapy techniques were effective in the therapeutic community project at Beth Abraham. It may be as Wilmer (1958) pointed out that the important aspect of the therapeutic community approach is in the final analysis, an intangible factor called "atmosphere". Complaints about patients being "more demanding" and "asking questions about medication" may reflect one of the stresses that staff members experience in a therapeutic community. To an outside observer, they look like signs of life that should not be dampened. In contrast to the isolated, depressed existence many people in institutions experience (Brudno & Seltzer, 1968; Hefferin, 1968), a number of patients in the therapeutic community project at Beth Abraham Hospital have found "something" that has made their lives more meaningful.

Appendix A -- Material Used in this Study

1. ON THE WHOLE, HOW SATISFIED WOULD YOU SAY YOU ARE IN YOUR WAY OF LIFE TODAY? ARE YOU:

_____VERY SATISFIED _____FAIRLY SATISFIED _____NOT VERY SATISFIED

2. AS YOU GET OLDER, WOULD YOU SAY THINGS SEEM TO BE BETTER OR WORSE THAN YOU THOUGHT THEY WOULD BE?

_____BETTER _____WORSE _____SAME

3. ALL IN ALL, HOW MUCH UNHAPPINESS WOULD YOU SAY YOU FIND IN LIFE TODAY?

_____ALMOST NONE _____SOME, BUT NOT VERY MUCH_____A GOOD DEAL

4. HOW OFTEN DO YOU FEEL THERE'S JUST NO POINT IN LIVING?

_____OFTEN _____SOMETIMES _____HARDLY EVER _____ NEVER

5. DO YOU AGREE OR DISAGREE WITH THIS STATEMENT? THINGS JUST KEEP GETTING WORSE FOR ME, AS I GET OLDER?

_____AGREE _____DISAGREE

MORALE SCALE

THE FOLLOWING QUESTIONS ARE RELATED TO THINGS THAT YOU MIGHT BE CONCERNED ABOUT. UNDERNEATH EACH QUESTION, THERE ARE FIVE (5) POSSIBLE ANSWERS. YOU ARE TO CHECK OFF THE ANSWER THAT YOU BELIEVE BEST ANSWERS THE QUESTION.

1. HOW OFTEN ARE YOU TOLD ABOUT CHANGES IN YOUR MEDICAL TREATMENT?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

2. HOW OFTEN DO YOU HAVE THE FEELING THAT THERE IS NOTHING YOU CAN DO WELL?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

3. HOW OFTEN DO YOU FIND YOURSELF WORRYING ABOUT YOUR HEALTH?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

4. HOW MUCH DO YOU WORRY ABOUT HOW WELL YOU GET ALONG WITH OTHER PEOPLE?

   VERY MUCH___FAIRLY MUCH___SLIGHTLY MUCH___NOT VERY___NOT AT ALL___

5. DO YOU EVER FEEL SO DISCOURAGED WITH YOURSELF THAT YOU WONDER WHETHER ANYTHING IS WORTHWHILE?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

6. HOW OFTEN DO YOU FIND YOURSELF GETTING ANNOYED AT THE LIVING CONDITIONS AT BETH ABRAHAM?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

7. HOW OFTEN DO YOU FEEL THAT YOU DISLIKE YOURSELF?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

8. HOW MUCH OF THE TIME DOES YOUR BEING IN PAIN STOP YOU FROM DOING THE THINGS THAT YOU WOULD LIKE TO DO?

   VERY MUCH___FAIRLY MUCH___SOMETIMES___RARELY___NEVER___

9. HOW OFTEN DO YOU FEEL SELF-CONSCIOUS?

   VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

10. HOW MUCH OF THE TIME DO YOU FEEL THAT YOU ARE GETTING GOOD MEDICAL TREATMENT?

VERY MUCH___ FAIRLY MUCH___ SOMETIMES___ RARELY___ NEVER___

11. HOW OFTEN ARE YOU TROUBLED WITH SHYNESS?

VERY OFTEN___ FAIRLY OFTEN___ SOMETIMES___ RARELY___ NEVER___

12. WHEN IN A GROUP OF PEOPLE, DO YOU HAVE TROUBLE THINKING OF THE RIGHT THINGS TO TALK ABOUT?

VERY OFTEN___ FAIRLY OFTEN___ SOMETIMES___ RARELY___ NEVER___

13. HOW RESPONSIVE DO YOU FEEL THE STAFF AT THE HOSPITAL IS TO YOUR NEEDS?

VERY ___ FAIRLY ___ SLIGHTLY ___ NOT VERY ___ NOT AT ALL ___

14. HOW OFTEN DO YOU WORRY ABOUT WHETHER OTHER PEOPLE LIKE TO TO BE WITH YOU ?

VERY OFTEN___ FAIRLY OFTEN___ SOMETIMES___ RARELY___ NEVER___

15. HOW MUCH DO YOU FEEL THAT THE ADMINISTRATION OF BETH ABRAHAM LISTENS TO THE COMPLAINTS OF PATIENTS?

VERY MUCH___ FAIRLY MUCH___ SOMETIMES___ RARELY___ NEVER___

16. WHEN YOU ARE TRYING TO CONVINCE OTHER PEOPLE WHO DISAGREE WITH YOUR IDEAS, HOW WORRIED DO YOU USUALLY FEEL ABOUT THE IMPRESSION YOU ARE MAKING?

VERY ___ FAIRLY ___ SLIGHTLY ___ NOT VERY ___ NOT AT ALL___

17. HOW OFTEN DO YOU FEEL GOOD ABOUT YOURSELF?

VERY OFTEN___ FAIRLY OFTEN___ SOMETIMES___ RARELY___ NEVER___

18. HOW WELL DO YOU FEEL PATIENTS AND STAFF GET ALONG AT BETH ABRAHAM?

VERY WELL___ FAIRLY WELL___ SLIGHTLY WELL___ NOT VERY WELL___

NOT AT ALL ___

19. WHEN YOU HAVE DONE SOMETHING THAT MAKES YOU LOOK FOOLISH HOW LONG DO YOU USUALLY KEEP ON WORRYING ABOUT IT?

VERY LONG___ FAIRLY LONG___ SLIGHTLY___ NOT VERY LONG___

NOT AT ALL ____

20. HOW FREE DO YOU FEEL TO COMPLAIN ABOUT THINGS THAT YOU DON'T LIKE ON YOUR FLOOR AT THE HOSPITAL?

VERY____FAIRLY____SLIGHTLY____NOT VERY____NOT AT ALL____

21. WHEN YOU THINK ABOUT THE POSSIBILITY THAT SOME OF YOUR FRIENDS AND ACQUAINTANCES MIGHT NOT HAVE A GOOD OPINION OF YOU, HOW CONCERNED DO YOU FEEL ABOUT IT?

VERY____FAIRLY____SLIGHTLY____NOT VERY____NOT AT ALL____

22. HOW OFTEN DO YOU FEEL BOTHERED OR WORRIED ABOUT WHAT OTHERS THINK OF YOU?

VERY OFTEN____FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

23. HOW OFTEN DO YOU FEEL THAT YOU HAVE ALL THE FRIENDS YOU NEED AT BETH ABRAHAM?

VERY OFTEN___FAIRLY OFTEN___SOMETIMES___RARELY___NEVER___

INSTRUCTIONS

THE STATEMENTS ON THE NEXT PAGES ARE SHORT DESCRIPTIONS OF THINGS THAT HAPPEN ON THE FLOOR. FROM YOUR UNDERSTANDING OF HOW THE FLOOR OPERATES, INDICATE WHICH PERSON OR PERSONS YOU THINK WOULD HANDLE EACH SITUATION. OF COURSE MORE THAN ONE PERSON MIGHT HAVE HANDLED EACH INCIDENT. FOR EXAMPLE, TAKE THE FOLLOWING INCIDENT:

A PATIENT FELT SICK AND HAD HIS TEMPERATURE TAKEN. WHO IS LIKELY TO HAVE TAKEN HIS TEMPERATURE?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

CONSIDER EACH OF THE ABOVE PEOPLE SEPARATELY. HOW LIKELY WOULD EACH OF THESE PEOPLE BE TO HANDLE THE SITUATION? LET'S TAKE THE NURSE. WOULD SHE BE THE ONE TO TAKE THE PATIENT'S TEMPERATURE ALL OF THE TIME? MOST OF THE TIME? SOME OF THE TIME? RARELY? NEVER? THEN CONSIDER THE SOCIAL WORKER. WOULD THEY BE LIKELY TO TAKE THE PATIENT'S TEMPERATURE? ALL OF THE TIME? MOST OF THE TIME? SOME OF THE TIME? RARELY? NEVER? DO THE SAME FOR THE PATIENT, THEN FOR THE AIDE OR ORDERLY, AND FINALLY FOR THE DOCTOR. NEXT TO EACH PERSON THERE ARE FIVE CHOICES, CHECK OFF THE WORK THAT YOU BELIEVE INDICATES HOW LIKELY THAT PERSON WOULD BE TO HANDLE SUCH AN INCIDENT.

IF THE PERSON WOULD HANDLE ALL SUCH SITUATIONS CHECK OFF THE WORD ALL.

IF THE PERSON WOULD HANDLE MOST SUCH SITUATIONS CHECK OFF THE WORD MOST.

IF THE PERSON WOULD HANDLE SOME OF THESE SITUATIONS, CHECK OFF THE WORD SOME.

IF THE PERSON WOULD RARELY HANDLE SUCH SITUATIONS, CHECK OFF THE WORD RARELY.

IF THE PERSON WOULD NEVER HANDLE SUCH A SITUATION, CHECK OFF THE WORD NEVER.

LETS LOOK AT ANOTHER EXAMPLE:

A WITHDRAWN PATIENT WAS ENCOURAGED TO SOCIALIZE. WHO IS LIKELY TO HAVE ENCOURAGED HIM?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

NOW GO AHEAD TO THE STATEMENTS ON THE FOLLOWING PAGES. WORK QUICKLY, DON'T SPEND MUCH TIME THINKING ABOUT THE QUESTIONS. IF YOU HAVEN'T SEEN ANY SIMILAR INCIDENTS, GIVE YOUR OPINION. IT IS VERY IMPORTANT THAT YOU FILL IN EVERY ANSWER SPACE. IF YOU HAVE ANY QUESTIONS, PLEASE ASK FOR HELP.

1. TWO PATIENTS WERE ALWAYS ARGUING ABOUT THE TEMPERATURE OF THE AIR CONDITIONING IN THEIR ROOM. WHO WOULD HELP SETTLE THE ARGUMENT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

2. A FEW PATIENTS WANTED TO GO TO A MOVIE, SO SOMEBODY TRIED TO SET UP A TRIP. WHICH PERSON OR PERSONS WOULD SET UP THE TRIP?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

3. A PATIENT WAS UNDRESSING IN HIS ROOM WITH THE DOOR OPEN. THIS UPSET SOME OF THE PATIENTS. WHO WOULD TALK TO HIM ABOUT IT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

4. A PATIENT THREW SOME DISHES ON THE FLOOR, WHO WOULD TELL HER TO STOP ACTING LIKE A CHILD?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

5. A PATIENT WAS BECOMING CONFUSED AND FORGETFUL. WHO WOULD TELL HIM THAT HE WOULD BE TAKEN CARE OF?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

6. A RELATIVE WAS UPSETTING A PATIENT IN THE DINING ROOM. WHO MIGHT HAVE ASKED THE RELATIVE TO LEAVE?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

7. WHO MIGHT TELL A PATIENT THAT HIS PHYSICAL COMPLAINTS WERE REALLY RELATED TO HIS EMOTIONAL CONDITION?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

8. WHO WOULD LEAD A CURRENT EVENTS DISCUSSION GROUP ON THE FLOOR?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

9. WHO WOULD POINT OUT TO A PATIENT THAT OTHERS STAYED AWAY FROM HIM BECAUSE OF HIS WHINING AND COMPLAINING BEHAVIOR?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

10. A RELATIVE OF A PATIENT BECAME DEPRESSED AND ANXIOUS AS A RESULT OF THE PATIENT'S LONG STAY IN I.C.U. WHO WOULD DISCUSS THE PROBLEM WITH HER?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

11. SOMEONE REASSURED A TERRIBLY ANXIOUS PATIENT THAT MANY OTHERS WHO HAD HAD SIMILAR MEDICAL PROBLEMS HAD RETURNED FROM I.C.U.. WHO WOULD REASSURE THE PATIENT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

12. A PATIENT WAS DISTRESSED BECAUSE OF INFREQUENT VISITS FROM FAMILY MEMBERS. WHO MIGHT TALK TO HIM ABOUT IT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

13. A FEMALE PATIENT WAS ANNOYED BECAUSE A MALE PATIENT HAD TRIED TO KISS HER. WHO WOULD STEP IN AND HANDLE THE PROBLEM?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

14. A PATIENT'S RELATIVE WAS TOLD BY SOMEBODY THAT HE MUST STOP BELITTLING HER BECAUSE THIS MADE HER FEEL MORE UNHAPPY. WHO MIGHT DO THIS?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

15. A PATIENT CALLED A STAFF MEMBER A BAD NAME. WHO HELPED TO SETTLE THE ARGUMENT.

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

16. PATIENTS COMPLAINED THAT THE MEALS SERVED ON THE FLOOR HAD BEEN TOO SKIMPY, AND OF POOR QUALITY. WHO WOULD TRY TO DO SOMETHING ABOUT GETTING BETTER MEALS?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

17. A PATIENT ASKED FOR ADVICE CONCERNING HER FAMILY PROBLEMS. WHO WOULD TALK TO HER ABOUT IT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

18. THE PHONE WAS BEING USED ALL THE TIME BY ONE PATIENT, AND THE OTHER PATIENTS WERE VERY ANGRY ABOUT IT. WHO WOULD SETTLE THE ARGUMENT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

19. A PATIENT COMPLAINED THAT HE HAD NOTHING TO DO WITH HIS TIME DURING THE DAY. WHO WOULD TRY TO HELP HIM?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

20. A PATIENT REMAINED WITHDRAWN ALL DAY AND REFUSED TO TAKE PART IN ANY ACTIVITY THAT HAD BEEN PLANNED FOR HIM. WHO WOULD ENCOURAGE HIM TO STOP BEING SO WITHDRAWN?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

21. A PATIENT REFUSED TO COME TO THE FLOOR MEETING. HIS BEHAVIOR HAD BEEN VERY UPSETTING TO EVERYONE ON THE FLOOR. WHO WOULD SPEAK TO HIM ABOUT IT?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

22. A RELATIVE WAS TOLD NOT TO ASSIST IN TOILETTING A PATIENT BY SOMEONE. WHO WOULD TELL THE RELATIVE NOT TO HELP?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

23. A PATIENT BOUGHT ICE CREAM FOR A DIABETIC PATIENT WHO SHOULDN'T HAVE ANY ICE CREAM. WHO WOULD SPEAK TO HIM ABOUT THIS?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

24. A NEW PATIENT CAME TO THE FLOOR. WHO WELCOMED HER?

NURSE:	ALL____	MOST____	SOME____	RARELY____	NEVER____
SOCIAL WORKER:	ALL____	MOST____	SOME____	RARELY____	NEVER____
PATIENT:	ALL____	MOST____	SOME____	RARELY____	NEVER____
AIDE OR ORDERLY:	ALL____	MOST____	SOME____	RARELY____	NEVER____
DOCTOR:	ALL____	MOST____	SOME____	RARELY____	NEVER____

Picture Recognition Scoring Sheet

Number _____ Floor _____

Trial Number	Picture Number	Recall Na. w/ Pict.	Identifies Name	Fails to I. D. Name	No Recog.
Totals					

Behavior Observation Rating Sheet

Behavior	No. of Persons	% of Total
I: Sleeping		
II: Social Interaction. i.e. talking together or playing a game		
a. two or three person interaction		
b. four or more person interaction		
c. social interaction with staff member only if conversation.		
III: Parasocial Interaction i.e. watching T.V. in a group some comments but not conversation or, engaged in O.T. together, no real conversation.		
interaction with staff member re:med.		
IV: Functional Non-Social Behavior i.e. reading a book, or watching T.V. in one's own room, also taking care of, one's personal needs.		
V: Null Behavior. i.e. sitting alone staring in space, sleeping in chair.		
VI: Talks to rater spontaneously. Also included in category above.		
Totals: (all of above except VI)		

Floor _____ Date _____ Time _____

I would like to find out how much you agree or disagree with each statement below. Please indicate next to each statement how much you agree or disagree with it. You are to do this, by writing +1,+2,+3 or -1,-2,-3: depending on how you feel in each case.

+3: I AGREE VERY MUCH	-1: I DISAGREE A LITTLE
+2: I AGREE PRETTY MUCH	-2: I DISAGREE PRETTY MUCH
+3: I AGREE A LITTLE	-3: I DISAGREE VERY MUCH

_____ 1. Parents of disabled children should be less strict than other parents.

_____ 2. Physically disabled persons are just as intelligent as non-disabled ones.

_____ 3. Disabled people are usually easier to get along with than other people.

_____ 4. Most disabled people feel sorry for themselves.

_____ 5. Disabled people are the same as anyone else.

_____ 6. There shouldn't be special schools for disabled children.

_____ 7. It would be best for disabled persons to live and work in special communities.

_____ 8. It is up to the government to take care of disabled persons.

_____ 9. Most disabled people worry a great deal.

_____ 10. Disabled people should not be expected to meet the same standards as non-disabled people.

_____ 11. Disabled people are as happy as non-disabled ones.

_____ 12. Severely disabled people are no harder to get along with than those with minor disabilities.

_____ 13. It is almost impossible for a disabled person to lead a normal life.

_____ 14. You should not expect too much from disabled people.

_____ 15. Disabled people tend to keep to themselves much of the time.

_____ 16. Disabled people are more easily upset than non-disabled people.

_____ 17. Disabled persons cannot have a normal social life.

_____ 18. Most disabled people feel that they are not as good as other people.

_____ 19. You have to be careful of what you say when you are with disabled people.

_____ 20. Disabled people are often grouchy.

THE FOLLOWING LIST OF QUESTIONS ARE RELATED TO HOW YOU FEEL ABOUT YOUR JOB. EACH OF THE QUESTIONS REFERS TO A DIFFERENT ASPECT OF YOUR JOB. PLEASE INDICATE HOW YOU FEEL ABOUT THIS ASPECT OF YOUR JOB BY FILLING IN THE APPROPRIATE NUMBER IN THE LEFT HAND MARGIN NEXT TO THE QUESTION. THESE NUMBERS ARE INDICATED IN THE FOLLOWING KEY:

1. COMPLETELY SATISFIED: I couldn't reasonably desire more.
2. VERY SATISFIED: I don't think things could be improved a great deal.
3. QUITE SATISFIED: I like the situation as it is pretty well - I can't really complain.
4. FAIRLY SATISFIED: Things could be better, but I'm still a little more satisfied than dissatisfied.
5. BALANCED FEELINGS: My feelings toward this are about even. It's not good, but it's not bad. I'm about as satisfied as dissatisfied.
6. SLIGHTLY DISSATISFIED: I tend to be a little more dissatisfied than satisfied.
7. QUITE DISSATISFIED: I am definitely not satisfied with this.
8. VERY DISSATISFIED: I feel very dissatisfied with this.
9. EXTREMELY DISSATISFIED: I am extremely dissatisfied and displeased with this.

_____ 1. HOW DO YOU FEEL ABOUT THE AMOUNT OF PAY YOU RECEIVE ON YOUR JOB?

_____ 2. HOW DO YOU FEEL ABOUT THE JOB SECURITY OF YOUR JOB?

_____ 3. HOW DO YOU FEEL ABOUT THE PHYSICAL WORKING CONDITIONS OF YOUR JOB?

_____ 4. HOW DO YOU FEEL ABOUT THE OPPORTUNITY FOR LEARNING NEW SKILLS THAT WOULD MAKE YOUR JOB MORE MEANINGFUL?

_____ 5. HOW DO YOU FEEL ABOUT THE ADMINISTRATION'S ATTITUDE TOWARD STAFF MEMBERS?

_____ 6. HOW DO YOU FEEL ABOUT THE PATIENTS' ATTITUDE TOWARD STAFF MEMBERS?

_____ 7. HOW DO YOU FEEL ABOUT THE PERSONALITY AND TEMPERAMENT OF YOUR IMMEDIATE SUPERVISOR?

_____ 8. HOW DO YOU FEEL ABOUT THE WAY STAFF MEMBERS ARE INFORMED OF THEIR JOB PERFORMANCE?

_____ 9. HOW DO YOU FEEL ABOUT THE KIND OF WORK YOU DO?

_____ 10. HOW DO YOU FEEL ABOUT YOUR RELATIONS WITH YOUR CO-WORKERS?

FOR QUESTIONS 10 - 20, WE ARE INTERESTED IN FINDING OUT HOW IMPORTANT DIFFERENT ASPECTS OF YOUR JOB ARE TO YOU. INDICATE HOW IMPORTANT THIS ASPECT OF YOUR JOB IS BY FILLING IN THE APPROPRIATE NUMBER IN THE LEFT HAND MARGIN NEXT TO THE QUESTION. THESE NUMBERS ARE INDICATED IN THE KEY (KEY II) BELOW:

1. OF NO IMPORTANCE: THIS ASPECT HAS NO REAL IMPORTANCE TO ME.
2. OF LITTLE IMPORTANCE: I WOULD ONLY BE SLIGHTLY BOTHERED OR ANNOYED IF I WERE NOT SATISFIED WITH THIS.
3. OF SOME IMPORTANCE: THIS FACTOR IS IMPORTANT ENOUGH THAT I WOULD BE FAIRLY UNHAPPY IF NOT SATISFIED WITH IT.
4. VERY IMPORTANT: IF I WERE NOT SATISFIED WITH THIS I MIGHT NOT LEAVE MY JOB, BUT I WOULD BE EXTREMELY UNHAPPY.
5. EXTREMELY IMPORTANT: I WOULD PROBABLY LOOK FOR ANOTHER JOB IF I WERE NOT REASONABLY SATISFIED WITH THIS.

QUESTIONS:

_____11. HOW IMPORTANT IS THE AMOUNT OF PAY YOU RECEIVE?

_____12. HOW IMPORTANT IS YOUR JOB SECURITY?

_____13. HOW IMPORTANT TO YOU ARE THE PHYSICAL WORKING CONDITIONS?

_____14. HOW IMPORTANT TO YOU IS THE OPPORTUNITY FOR LEARNING NEW SKILLS THAT WOULD MAKE YOUR JOB MORE MEANINGFUL?

_____15. HOW IMPORTANT TO YOU IS THE ADMINISTRATION'S ATTITUDE AND RESPONSIVENESS TO ITS EMPLOYEES?

_____16. HOW IMPORTANT TO YOU IS THE PATIENT'S ATTITUDE TOWARD STAFF MEMBERS?

_____17. HOW IMPORTANT TO YOU IS THE PERSONALITY AND TEMPERAMENT OF YOUR IMMEDIATE SUPERVISOR?

_____18. HOW IMPORTANT TO YOU IS THE WAY STAFF MEMBERS ARE INFORMED OF THEIR JOB PERFORMANCE?

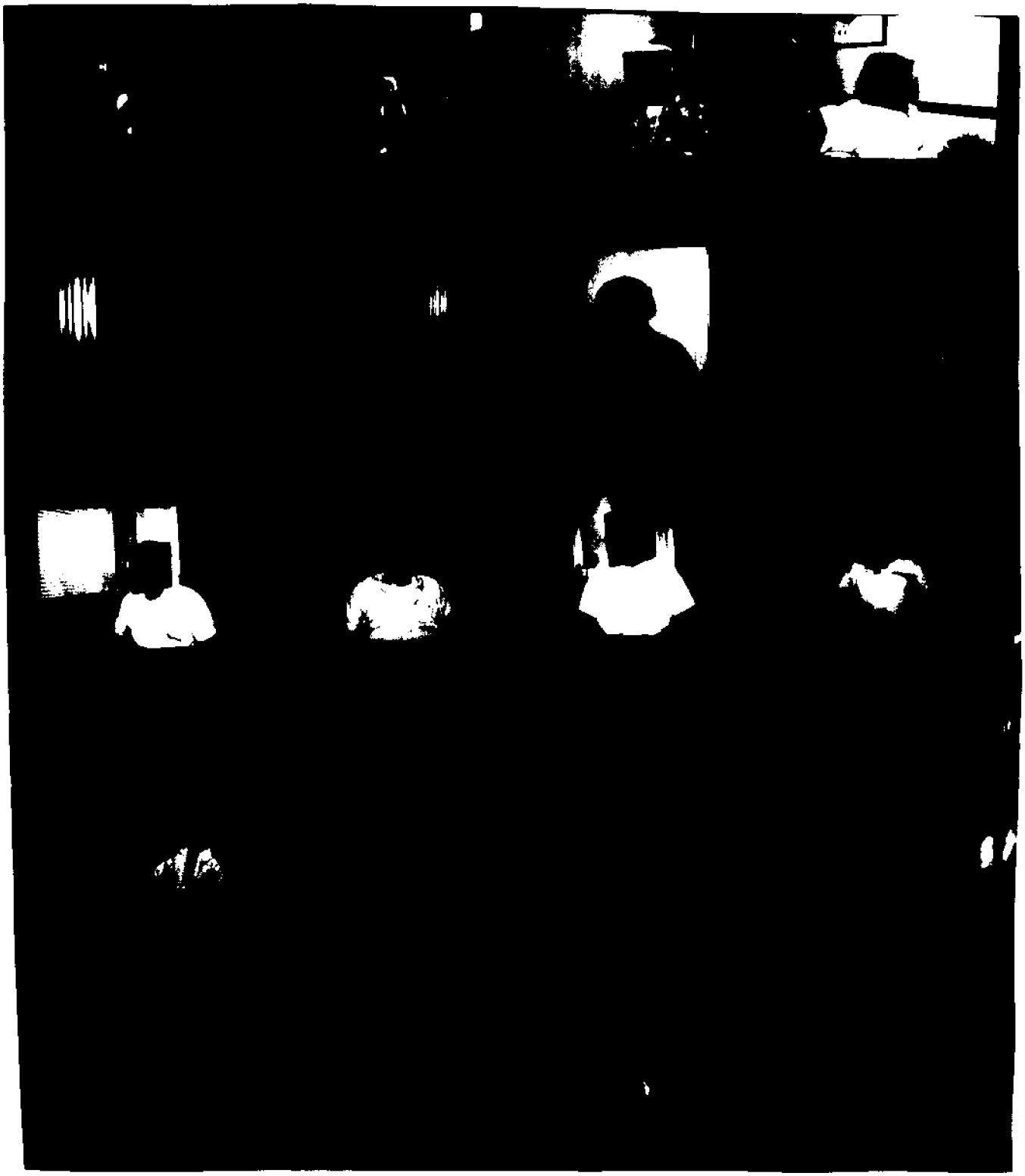
_____19. HOW IMPORTANT TO YOU IS THE KIND OF WORK YOU DO?

_____20. HOW IMPORTANT TO YOU ARE YOUR RELATIONS WITH YOUR FELLOW STAFF MEMBERS?

NOW PLEASE RATE YOUR OVERALL ATTITUDE TOWARD YOUR JOB BY CIRCLING ONE OF THE FOLLOWING:

1. COMPLETELY SATISFIED: I FEEL THAT MY PRESENT JOB OFFERS ME EVERYTHING I COULD REASONABLY DESIRE.
2. VERY SATISFIED: I LIKE MY JOB VERY MUCH AND FEEL THAT THERE ARE FEW PLACES IN WHICH I COULD DO BETTER.
3. QUITE SATISFIED: I LIKE MY JOB REASONABLY WELL, I HAVE NO REAL COMPLAINTS.
4. FAIRLY SATISFIED: I AM FAIRLY SATISFIED WITH MY JOB. THERE ARE A FEW THINGS I DON'T LIKE ABOUT IT, BUT I'M STILL A LITTLE MORE SATISFIED THAN DISSATISFIED.
5. BALANCED FEELINGS: THERE ARE AS MANY THINGS THAT I LIKE ABOUT MY JOB AS THERE ARE THAT I DISLIKE - MY FEELINGS ARE ABOUT EQUAL IN BOTH DIRECTIONS.
6. SLIGHTLY DISSATISFIED: I TEND TO BE A LITTLE MORE DISSATISFIED THAN SATISFIED WITH MY JOB.
7. QUITE DISSATISFIED: I'M DIS PLEASED WITH MY JOB. I PROBABLY WON'T QUIT, BUT I'M DEFINITELY NOT SATISFIED.
8. VERY DISSATISFIED: I AM VERY DISPLEASED WITH MY JOB. THERE HAVE BEEN TIMES WHEN I HAVE THOUGHT ABOUT FINDING ANOTHER JOB.
9. EXTREMELY DISSATISFIED: I AM EXTREMELY DISSATISFIED WITH MY JOB. I AM THINKING OF QUITTING OR AT LEAST OF SERIOUSLY LOOKING AROUND FOR ANOTHER.

These are samples of the pictures used in the study. It should be noted that the original pictures were both bigger (3 1/2" by 5") and brighter. Approximately 90% of the Ss participating in the study allowed E to photograph them.



Appendix B

Appendix C

Description of "T.C." and "Non-T.C." Floors

The basic physical layouts of the "T.C." and "Non-T.C." floors are identical. There are 36 or 37 patients on each floor in either single or double rooms, and approximately the same number of staff members on each floor.

There are, however, a number of differences in the way the floors are run. "T.C." staff members attend a weekly staff meeting, where they are often asked to put their knowledge of patients on the line. There is also the clear expectation that they are to talk to patients on a personal level, and about problems related to their floor. When necessary this information is to be communicated to other members of the professional staff. Staff members also work with patients in "O.T."; in preparing special events; as well as conducting a "walk program" where patients are taken out on a weekly shopping trip. They also have to relate to the executive officers of the floor; work with whatever committees are functioning; and facilitate the orientation of new patients to the floor, working out problems between patients where possible. This is not true for staff members on the "Non-T.C." floors.

During the "T.C." project, patients had a number of committees in operation. The executive committee, dietary committee, social recreation committee, nursing committee, adjustment committee, and the Baum-Rothschild committee, were some of the committees operating during the official project, and there were as many as two or three committee meetings a week. Floors 6BR and 7BR ("Non-T.C." floors) have never had committees in operation. While "T.C." floors have long had a sunshine club to buy presents for needy patients, floor 6BR is only now beginning one. While "T.C." floors have a monthly meeting of all patients, 6BR and 7BR have bi-weekly meetings.

Since the official termination of the therapeutic community program in March, 1970, a number of the patient committees have been disbanded, and patient activity on the committees has dropped off somewhat. Staff activity, apart from a reduction in the time allotted for the weekly staff meeting, has not dropped off significantly. It is also interesting to note that in the past several months the patients on 6BR have been talking to some of the patients on 3BR and 4BR to try to get some information about "T.C." which they can apply to their own floor.

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