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# CHILDREN IN INSTITUTIONAL SETTINGS:

# PRIVACY, SOCIAL INTERACTION, AND SELF-ESTEEM

by

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# Chapter I

## OVERVIEW OF THE RESEARCH

The present investigation will study privacy for children and adolescents living in a residential psychiatric treatment center. There have been some theoretical assumptions and descriptive accounts written about the nature of privacy and its significance to people living in non-institutional settings and studies of adult and children's psychiatric facilities have suggested the importance of privacy to the living experiences of residents; the opportunity for privacy is one ingredient in the move towards normalization, a treatment approach popular in psychiatric care today.

However, the research on privacy in relation to psychiatric settings is limited. The little empirical work done in the area is based on aggregate data and either 1) has used "privacy" as a post hoc concept to explain behavioral data or 2) has studied privacy directly, but has focused on concepts of privacy using these data to make inferences to behavior (Wolfe & Golan, 1976). Equally important, privacy itself is a concept which needs further clarification: the systematic study of privacy and its impact on the individual has been ignored until recently. The present investigation, then, will study two broad areas:

1. the significance of privacy for children and adolescents living in a residential treatment setting and,
2. the contextual nature of privacy, considering the interface between environment, experience, and behavior.

In the present investigation, privacy will be conceptualized in terms of chosen physical aloneness. It has been suggested that this form of privacy is relevant to the goals of our culture and, in fact, is critical

to the development of self-esteem and culturally appropriate social interactive behaviors (Plant, 1930, Lee, 1959; Bates, 1964; Jourand, 1966; Westin, 1967; Laufer & Wolfe, 1978).

Two residential psychiatric treatment settings were selected for study. Briefly, the two settings were alike in many respects, including children and adolescents serviced, treatment approaches, therapeutic philosophy, and much of the physical design. However, differences in the two settings help to emphasize how environment relates to privacy and, ultimately, how privacy as chosen aloneness is related to the individual and social development of children and adolescents.

Several hypotheses were developed and tested. One set of hypotheses deals primarily with the relationship between the sociophysical environment and residents' reported privacy experiences. Another group focuses on the relationship between residents' use of privacy opportunities within the environment, social behaviors, and measured levels of self-esteem. Finally, a last set explores the relationship between residents' reported concepts of privacy and privacy behaviors. Considering results connected to each of the hypotheses, the investigator will explore the role of privacy as chosen aloneness in the institutional setting and understand its significance to human experience and behavior. It will be argued that privacy as chosen physical aloneness is instrumental to the development of appropriate individual and social interactive behaviors of residents.

# Chapter II

## PSYCHIATRIC TREATMENT ENVIRONMENTS

### Background

Much has been written about psychiatric treatment environments over the past several years. One can trace a history of attitudes with respect to treatment environments, beginning with Pinel's "moral treatment" in the eighteenth century, to the concept of custodial care in the nineteenth and early twentieth centuries, and now to the competing concepts of the traditional medical model of treatment vs. an holistic view of the person considered in a sociocultural context (see Bloom, 1963; Moos, 1974 for more complete historical perspectives on Western psyciatric treatment).

Clearly, the dominant attitudes towards the psychiatric care of people during a particular era are reflected in the physical design of treatment facilities (Scheff, 1973; Nauhaus, 1976). And taking this one step further, treatment goals can be facilitated by physical design, as well as by therapeutic philosophy and policy. A problem with many treatment facilities today is that physical plants are often the products of past attitudes. Thus, newer prevailing philosophies are often in conflict with outdated physical plants and little is done to change them.

Interestingly, the problem does not end here: many modern practitioners who have input into the total design of new facilities espouse the importance of the physical environment in theory, but in practice negate the critical role played by the physical environment. Much of the work dealing with adults in psychiatric treatment facilities ultimately considers only social structure as part of the therapeutic milieu (see, for example, Jones, 1953; Stanton & Schwartz, 1954; Caudill, 1958). Even Moos' (1974) ecological approach to treatment environments is disappointing: while Moos initially stated that patient and staff behavior of

treatment settings are a function of both physical design and psychological factors, he later discussed the physical environment only briefly, while he fully explored the effects of social climate, program, and organizational components.

The major work on children and psychiatric institutionalization has been a bit more specific in pointing out the role of the physical environment in the treatment of children. Bettelheim (1955, 1974), who initially dismissed the physical environment as important only during the initial period of adjustment of the disturbed child to his or her surroundings, eventually presented the physical environment as significant to the total treatment of the child; Bettelheim (1974) has provided arguments which deal with issues as private vs. shared bedrooms, a ward vs. cottage system, geographic location of a setting, and scale of setting. And Redl and Wineman (1952) list the design of the total environment as one of the four techniques to be used in strengthening ego supports of the disturbed child. However, Redl and Wineman quickly dismissed talk of the physical environment in favor of discussions of administrative policy and daily regime. This seems to be the trend among other practitioners who deal with children and institutionalization as well (Whittaker & Trieschman, 1972).

Clearly, the social environment is critical to the treatment of individuals living in settings used for psychiatric treatment. However, there is growing evidence that the physical environment is equally important to successful treatment.

Some controlled empirical studies lend support to this: in particular, physical changes have been shown to have differential effects on children with varying clinical diagnoses. For example, Hutt and Vaizey (1966) varied levels of social density with groups of brain-damaged, autistic,

and normally-diagnosed children, and found group differences in observed social interaction, aggression, and withdrawal kinds of behavior. And in a study of territoriality among psychiatrically hospitalized male adolescents, it was found that autistic and severely brain-damaged adolescents differed in space use from those adolescents with behavior disorders (Esser, 1970).

Other studies have shown that children and adolescents with severe pathologies are responsive to physical environmental changes. A study of autistic children before and after renovation of a play space indicated that changes in physical environment related significantly to behaviors of this particular group of children (Richer & Nicholl, 1971). A study conducted in a residential treatment center for retarded children and adults showed that residents were responsive to physical and policy changes made in their bedroom areas (Zimring, Knight & Weitzer, 1977). And a study of male adolescents in a juvenile treatment center suggests that the nature of "behavior settings" may encourage a varying range of behaviors for the same boys across different settings (Hahn, 1973).

The relationship between therapy and environment was introduced most clearly by Bayes in 1967. Bayes' opening question was this: Is there more to designing treatment environments than meeting just functional needs and aesthetics? Bayes answered this question in the affirmative by presenting a comprehensive review of planning, form, and color, and their potential effects on the institutionalized child.

In a later work, Bayes & Francklin (1971) continued to express a sensitivity to the physical components of environment and additionally, asked for continued interaction between: goals, functional and physical planning, design, evaluation, improvement, and feedback. An awareness of these interactions has been shown by others as well (Banner, 1970;

Lindheim, Glaser & Coffin, 1972; Pollowy & Hart, 1973).

These relationships lead back to some basic assumptions of environmental psychology: patterns of space use are intricately connected to the physical, social, and administrative structures that define a total setting (Proshansky, Ittelson, Rivlin, 1970). And, ultimately, the nature of the total setting is at the core of human experience and behavior (Proshansky, 1974). These assumptions have been the focus of a number of studies conducted in adult and children's psychiatric facilities over the past several years (Rivlin, Proshansky & Ittelson, 1969; Ittelson, Proshansky & Rivlin, 1970; Holahan & Saegert, 1973; Rivlin & Wolfe, 1972; Rivlin, Wolfe & Beyda, 1973; Wolfe, 1975; Wolfe & Golan, 1976; Rivlin, 1976; Wolfe, 1977). Findings of these studies continue to support these assumptions and, at the same time, have helped to explain the complexities of the institutional setting in relation to therapeutic goals and user experience and behavior.

This is best described in examples of studies which have examined the effects of physical and related policy changes on individual experience and behavior. In some cases, these changes are the result of planned intervention (e.g., Holahan & Saegert, 1973; McCarthy, in preparation); in others, they are changes made by the administration and/or users themselves, independent of the investigators (e.g., Rivlin & Wolfe, 1972; Churchman, Rivlin & Wolfe, 1975).

Occupants' patterns of space use and activity were examined from the initial period of occupancy of a new building to four months later (Rivlin & Wolfe, 1972). Findings indicate a clear change over time in the kinds of activities in which children engaged. At the beginning, only a small percentage of children were observed in isolated passive behavior. Four months later, isolated passive behaviors ranked first among all ob-

served behaviors, with this pattern stabilizing. The investigators followed physical and functional changes during this period and suggested that many environmental factors figured into this dramatic change. For example, the increased structuring of the program from the initial occupancy to several months later may have helped foster increasing isolated behaviors. Similarly, initially residents were free to travel to most parts of the hospital by themselves, but were later restrained from this; this change may have influenced perceived freedom of choice and, subsequently, behaviors.

In another study of an adult psychiatric ward, the effects of a physical environmental change on behaviors and attitudes were examined (Holahan & Saegert, 1973). Predictions of increased social interaction and less isolated passive behavior as a result of the change were confirmed.

The implications of this body of work are striking. As Holahan and Saegert (1973) suggested, results point to the role of the physical environment in "the transactional perspective of personality." Individual behavior reflects not only pathologies or internal processes, but the total milieu (Rivlin & Wolfe, 1972). Several other investigators acknowledged that the behavior of "disturbed" institutionalized patients may be attributable to the nature of the institutional environment as much as to internal processes. A review of studies reporting perceptual differences between "psychotics" and "normals" introduced the possibility that "psychotic perceptions can be induced under appropriate conditions in normal individuals (Ittelson, 1960, Sect. 5, p. 11)." And another analysis reported that in order to accurately describe the "mentally ill person," one must describe the <u>environmental conditions under which that person has been observed</u> (Zusman, 1973).

Here again, one can see the relevance of the transactional approach to environment: individual experience and behavior in treatment environments are intricately related to physical design, therapeutic philosophy, treatment goals, and characteristics of the users. This approach is central to the proposed investigation and speaks to the importance of "situationality" as a basis for understanding human experience and behavior.

The Nature of Institutionalization

Few would deny the impact the institutional structure has on its residents. While one must be cautious in the use of the label "institutional structure," there is enough evidence which suggests that certain qualities of psychiatric institutionalization persist across settings, despite variations in treatment philosophies. In fact, Goffman (1961), in a sensitive analysis of institutionalization, depicted the experiences of the psychiatrically hospitalized person much in the same way as those of an imprisoned person: each is an "inmate".

Goffman's participant-observer account vividly described the experience of total institutionalization, which is briefly outlined as follows: 1. all aspects of life occur in the same physical place, under one authortiy; 2. almost all of a person's activities are carried on in the presence of many other people, accompanied by requirements to conform to the same activity; 3. a day's activities are tightly scheduled, based on prearranged administrative rules; and 4. activities are connected by a singular rational plan, which ostensibly satisfies the stated goals of the institution. While the lives of people outside an institution conform to some of these features at different times, for most, these experiences are not overriding, ever-present qualities of living (see Rivlin, 1976 for the institutional qualities of everyday life).

Other investigators have since elaborated on Goffman's description of institutionalization, helping to provide a more complete picture of the experience. In one work (Osmond, 1970), a striking irony was pointed out: the choices given to and limitations of persons living in an institution are the reverse of the choices and limitations of persons living in ordinary settings. That is, the institutionalized person is forced to select companions from among a group of nonconstant strangers, is forced to adapt to inadequate physical surroundings which often change (e.g., patients are regularly moved from one ward to another), but is limited in the simple choices of what to eat, wear, and do. Conversely, the person living in an ordinary setting seldom has to choose companionship from among strangers, has few major changes in dwelling place, and is able to make choices, regarding day-to-day activities.

What is the impact of the institutional structure on human experience and behavior? Several investigators have focused on this critical issue. There is consensus among them that people ultimately adapt to the institutional structure in ways that meet their needs while in the particular system. Goffman (1961) spoke of the "underlife" networks within an institution. Braginsky & Braginsky (1971) provided evidence that institutionalized retardates use manipulation as a means to their goals. And Wolfe (1975; and Golan, 1976) described how children and adolescents in a residential psychiatric setting devise strategies to be physically alone, despite this behavior being negatively sanctioned.

A number of empirical studies show the contrast between institutional and ordinary home living. A behavioral study of the same boy at home and in a residential psychiatric facility revealed that the hospital structure (including daily regime, role of adults, continual presence of other people) was related to the boy's behavior in the institution and made it

different from his behavior at home (Tars & Appelby, 1973). For example, despite there being more people with whom the boy could potentially interact in the institution than at home, the boy interacted with others less in the institution than at home. Results of an interview study conducted in another children's residential psychiatric facility indicated that some residents perceived the facility as a "jailhouse" compared to the freedom of their homes (Wolfe & Golan, 1976).

Even more extreme adaptations to institutional life have been noted: the term "institutional neurosis" has been used to describe a syndrome characterized, in part, by apathy, submisiveness, and loss of individuality; the syndrome is associated with environmental factors of institutionalization, including locked doors and hospital regimen (Barton, 1959). And irreparable psychological withdrawal has also been cited as a reprecussion of the present system of institutionalization (Osmond, 1970; Wolfe & Golan, 1976).

This awareness has invited a healthy skepticism about the institutional process as it presently exists, accompanied by a readiness for change. Some of the change suggested is extreme, and assumes that institutionalization is the outcome of a society which is intolerant of people who deviate markedly from a predetermined range of normality (Schatzman, 1971; Braginsky & Braginsky, 1971; Scheff, 1973). Braginsky and Braginsky, for example, argued that clinicians erroneously assume the validity of labelling the "disturbed" and added that those so labelled are treated as if there was a "real internal pathological process." Others believe that there is a deliberately misplaced focus on psychopathology used to divert people's attention away from political oppression, and this is used as a form of social control (Statman, 1971). These views argue against the existence of psychiatric institutions for specialized care

and offer, instead, solutions which range from rustic country hospices (Braginsky & Braginsky, 1971) to more radical social and political change (Angel, 1971).

Most practitioners, however, have chosen to respond to the reported ills of the institutional structure by promoting change from within. That is, there is a widespread movement to "deinstitutionalize" psychiatric settings by making program and policy changes which are still compatible with the specialized psychiatric structures which exist today. One of the ways this challenge is being met is through the "normalization principle."

Normalization. One of the goals in today's treatment philosophies is the move towards normalization, which is the view that those labelled emotionally or physically handicapped be permitted to lead as ordinary a life as possible, even if it must be within an institution (Nirje, 1972). The significance of the normalization principle in relation to the care of children and adolescents in residential treatment facilities is the emphasis that all children, including those in treatment, have developmental needs which must be satisfied.

One aspect of development involves motoric and cognitive growth of the child. The significance of the social and physical environment to the "normal" child's development in these areas is well-known (White, 1959; Piaget, 1970). In keeping with the normalization principle, children in residential treatment should also be given environmental opportunities which allow for cognitive development (Bayes, 1967; Bayes & Francklin, 1971; Wolfe, 1977).

Another aspect of development deals with the psychological requirements of the child or adolescent. How does the child or adolescent develop a positive image of an independent self? And how does she or he

learn to live in a social world? In an ordinary home environment, the child or adolescent is given many opportunities to explore herself or himself in relation to other people. And she/he is given a chance to reflect on this. An interview study revealed that noninstitutionalized children and adolescents often used alone time to think and collect their thoughts (Wolfe & Laufer, 1974). Following the normalization principle, the institutionalized child and adolescent should be given the same opportunity to be alone to reflect if she/he chooses. For while the development of a positive self image and culturally appropriate social behavior is important for the noninstitutionalized child, the development of these patterns is even more crucial for the institutionalized child; often, the child is institutionalized precisely because of a rupture in the normal course of development of self and of appropriate social behavior.

This opportunity for chosen physical aloneness has most often been conceptualized under the rubric of "privacy." Several investigators have suggested the importance of privacy as chosen physical aloneness for both adults and children living in treatment settings (Cumming & Cumming, 1963; Osmond, 1970; Bayes & Francklin, 1971; Architectural Research Construction, 1975). Their conclusions, however, have little or no supporting empirical evidence.

The present investigation will study the meanings and functions of privacy within the institutional treatment setting. The value of this focus will be supported in the discussion of a number of issues related to privacy, including: 1. the behavioral and experiential forms of privacy assuming their meanings from the structure of a particular context or setting; 2. the relevance of <u>privacy as chosen physical aloneness</u> given the values of Western culture, and 3. the significance of privacy to individual experience and behavior, particularly with regard to self-

esteem and the development of positive social interactions.

These issues will be considered in the next chapter, to be followed by a chapter which integrates privacy as chosen physical aloneness and the prevailing goals of the institutional treatment setting.

# Chapter III

# PRIVACY

## Background

In recent years, privacy as a behavioral and experiential phenomenon has been of increasing interest to social scientists, architects, and designers. Privacy, however, is not a simple concept. Recent theoretical approaches describe its complexity and recognize that it is not a unidimensional concept, but rather one whose meaning varies with person, situation, and setting (Laufer, Proshansky & Wolfe, 1974; Margulis, 1974; Golan & Justa, 1976; Laufer & Wolfe, 1978). That is, privacy can be understood only in relation to the total environment. "Environment" will be considered in the broadest sense of the word: it is the complex system which takes shape through people, their values, and the subsequent design, organization, content, and meaning of place (Proshansky, Ittelson & Rivlin, 1970; Proshansky, 1974). Privacy will be shown to be an emergent experience/behavior based on the transactional process of person and place.

This approach introduces a major question which merits attention: is privacy to be treated as an experience or as a behavior? The question is one of both theoretical and methodological significance: in asking <u>what privacy is</u>, one is also asking <u>how privacy can be studied</u>. This direction of privacy is reasonable in light of existing theoretical statements and empirical research on privacy.

Recent theoretical frameworks have pointed to the intricate relationship between privacy as both experience and behavior: they suggest that behavior and/or environmental conditions maximize the privacy experience (Proshansky, Ittelson & Rivlin, 1970; Altman, 1975; Golan & Justa, 1976; Laufer & Wolfe, 1978).

While these theoretical positions easily deal with the relationship between privacy as experience and privacy as behavior, a problem still exists with the empirical investigators' attempts to substantiate such a relationship. The problem is one of construct validity: can it be assumed that reported concepts and observable behaviors--the two major indices used in privacy research--reflect a privacy experience? Concepts and behaviors as indices of the privacy experience will be handled separately and in an interrelated fashion as follows:

1. Reported privacy concepts reveal one level of understanding of the world (Werner, 1948, in Wolfe & Laufer, 1974). For example, Wolfe & Laufer (1974) found that reported concepts of privacy among children became more complex with age (in terms of numbers of discrete definitions reported). The investigators concluded that the complexity of privacy parallels the developmental theory of experience. Thus, reported privacy concepts will be seen as one way of studying privacy experience.

2. The behavioral basis of privacy is somewhat more complicated. The few behavioral studies dealing with privacy cannot clearly connect privacy as experience to an observed set of behaviors. As examples, Ittelson, Proshansky and Rivlin (1970) and Wolfe (1975) observed behaviors of adults and children, respectively, in two residential treatment centers. The researchers surmised that alone behaviors of residents <u>might</u> be reflections of privacy as physical aloneness, but indicated there was not enough physical evidence to confirm such a relationship. Later investigations of both institutionalized and noninstitutionalized groups of children showed that reported experiences with privacy were, in fact, often connected with reports of aloneness (Wolfe & Laufer, 1974; Wolfe & Golan, 1976; Wolfe, Schearer & Laufer, 1976).

It is still premature at this stage for investigators to assume uncon-

ditionally that certain behaviors are manifestations of the privacy experience, particularly when the relationship between privacy concepts and behavior has never been directly explored. Thus, the several investigations which suggest that certain observable behaviors are, in fact, privacy-seeking behaviors or reflections of a privacy experience need to be reviewed in light of new information resulting from direct studies of the relationship between privacy as experience and behavior.

The present investigation will study the relationship between privacy as reported experience and observed behaviors, in an attempt to add to a body of theory and practice. Using existing theoretical and empirical work, privacy will be treated as an experience made possible through behaviors and/or environmental conditions.

There is yet another major question which must be considered. That is, can one specifically describe the all-inclusive privacy experience and its related behaviors? To answer in the affirmative would be a simplistic response to the question. Rather, privacy will be treated as a situationally relevant concept, which can be best understood in relation to the total environment and experiences of the individuals within that environment.

Several theoretical positions have supported the importance of situationality and individual experience to the meanings and forms of privacy (Westin, 1967; Simmel, 1971; Laufer, Wolfe & Proshansky, 1973; Johnson, 1974; Golan & Justa, 1976; Laufer & Wolfe, 1978). For example, Laufer and Wolfe (1978) posited that individuals' concepts of privacy are connected to concrete situations that could be described in terms of three dimensions (self-ego, environmental and interpersonal). Golan and Justa (1976) elaborated on this point, focusing on the importance of the normative structures of situations as contributing factors to a pri-

vacy experience and to the behavioral forms of privacy.

There is some evidence which substantiates this perspective. On the broadest level of analysis, one could draw from cross-cultural documentation, which suggests that the meanings and forms of privacy are, indeed, related to the complexities of person and environment (including physical structures, norms/rules, cultural values). (For extensive reviews of cross-cultural surveys of privacy, see Hall, 1966; Westin, 1967; Roberts and Gregor, 1971; and Altman, 1975).

Several empirical investigations also provide evidence supporting privacy as a situationally relevant concept. One significant effort is a comprehensive interview study of 1,000 children and adolescents (Wolfe & Laufer, 1974). In this study, children's and adolescents' reported definitions of privacy generally reflected experienced qualities of their social and physical environments. For example, children who had their own bedroom were more likely to connect privacy with aloneness than were children who shared a bedroom. In other studies, reported privacy concepts and behaviors were shown to be connected to the features of a dwelling unit, for example, number of rooms in the house (Parke & Sawin, 1975; Wolfe, Schearer & Laufer, 1976).

Finally, other studies have shown the meanings and forms of privacy to be related to other person/environment variables, including: sex-type roles (Smith, Downer, Lynch & Winter, 1969); occupation-status roles (Coser, 1961; Simmons, 1968; Golan & Justa, 1976); age-related needs (Ladd, 1970; Talmon, 1972); and, socioeconomic levels and related needs (Krieger, 1971).

The body of theoretical and empirical work on privacy is valuable in its contribution of the idea that privacy is a multifaceted concept. Privacy can be conceptualized in a variety of ways, including privacy as:

controlling access over information, limiting interpersonal interaction, limiting access to spaces, intimacy, and the use of psychological reserve.

Privacy as Chosen Physical Aloneness

It is impossible to study all aspects of privacy at one time. Rather, in any one piece of research, one would hope to study that aspect of privacy which seems most germane to the goals of a particular setting and the broader culture of which that setting is a part. The present investigation will approach privacy in terms of interaction, where privacy is the management of social interactions with others. At its simplest level, privacy becomes a state of nonchosen aloneness for the individual. Privacy can also apply to two or more people who chose to separate themselves from a larger group. While this form of privacy-called intimacy-will be discussed when it occurs, the main focus of the present investigation will be on privacy as chosen aloneness for the individual person. Empirical studies have indicated the relevance of this form of privacy (Smith, Downer, Lynch & Winter, 1969; Marshall, 1972; Wolfe & Laufer, 1974). As importantly, privacy as chosen physical aloneness has been assumed to be instrumental to appropriate individual development (Plant, 1930; Bates, 1964; Jourard, 1966; Westin, 1967; Schwartz, 1968).

Following a general discussion of the relevance of privacy as chosen aloneness in our culture, the present investigation will study privacy as chosen physical aloneness in a psychiatric residential treatment setting for children and adolescents. It will be argued that privacy as chosen aloneness is at least as important to children and adolescents in residential treatment settings as it is to people living in ordinary environments.

Given the goals of our culture, it is understandable that the focus of privacy is often on the individual and on privacy forms which emphasize separation of self from others, rather than on other forms of privacy.

for example, privacy of the group or collective. Thus, as Lee (1959) suggested, the "need" for privacy as aloneness in Western culture is, in fact, a value which becomes significant with respect to our goals towards individualism. Privacy as physical aloneness is an end to these goals. As Lee illustrated, children in the American tradition grow up with certain privacy needs/values; the satisfaction of such needs--in the form of privacy as physical aloneness or separation--allows them to be the self-dependent beings that their culture has demanded. (The functions of privacy in relation to self will be treated in the following sections).

The goals of individualism are deeply rooted in our culture. This helps to explain why the current focus on privacy has been on physical aloneness. Specifically, several empirical investigations have treated privacy as physical separation or isolation (Madge, 1950; Grootenboer, 1962; Hedley, 1966; Kira, 1966; Atkins, 1970, Kuper, 1970).

A number of descriptive accounts lend support to the significance of privacy as physical aloneness in Western culture. Much of this work describes the outcomes resulting from limitations on privacy as physical aloneness (Plant, 1930; Lewis, 1970; Hackett & Sun, 1972). For example, despite attempts by a group of communards to foster social interaction through physical design and social policy and to eliminate physical and social isolation among group members, individual group members gradually created spaces for themselves and their families, away from others (Hackett & Sun, 1972).

Often when privacy as physical aloneness is impossible to achieve, other strategies are employed to create a privacy experience; often psychological aloneness or psychological reserve is a substitute for absence of opportunities for physical aloneness (Goffman, 1962; Lawton & Bader, 1970;

Pastalan, 1970; Osmond, 1970). Thus, the person who does not have the options to be physically away from other people may withdraw psychologically, for example, by staring into space (Lawton & Bader, 1970). Interviews with staff in a children's psychiatric facility (Wolfe & Golan, 1976) suggested that idiosyncratic behaviors as rocking represent an extreme form of psychological reserve, used by patients to create privacy as aloneness for themselves.

Yet, most of the work on privacy as physical aloneness reported thus far is limited in its failure to describe the many conditions which make physical aloneness or separation synonymous with a privacy experience. Rather, physical aloneness is sometimes treated as the one necessary and sufficient condition in defining such an experience as a privacy experience. It is premature to assume that physical aloneness, taken by itself as an operational definition of privacy, is an adequate and independent description of a privacy experience.

This issue has been addressed by Proshansky, Ittelson and Rivlin (1970), who focused on the role of physical structures in creating a privacy experience, but, as importantly, used freedom of choice as an organizing concept helpful to understanding privacy. Thus, place becomes connected to a privacy experience when it allows the individual to be free from the social constraints of others (also see Shils, 1966; Westin, 1967; Kelvin, 1973; Johnson, 1974; Altman, 1975).

More recently Laufer and Wolfe (1978) have presented a theoretical perspective which deals with choice and its relationship to the privacy experience. This perspective is derived from earlier work of the authors and their colleagues (Proshansky, Ittelson & Rivlin, 1970; Proshansky, 1974; Laufer, Proshansky & Wolfe, 1974; Laufer & Wolfe, 1974; Golan & Justa, 1976).

Portions of Laufer and Wolfe's presentation deal particularly with privacy and physical aloneness, where privacy as physical aloneness is an aspect of "interaction management." The authors go on to describe the criteria which render a physical aloneness experience a privacy-as-physical aloneness experience as well. Successful interaction management and, more specifically, aloneness which becomes experienced as privacy, involves the ability of the individual to 1) choose if and how she/he will relate to others, 2) to control to what extent and the ways in which others are a part of a person's spatial and/or psychological experience, and 3) to be able to regulate physical and social stimuli.

The present investigation assumes control over choice and over access to be critical to a privacy as physical aloneness experience, but questions control over stimulation as a discrete category. Rather it will treat other people (as a source of stimulation) as part of control over access. Physical stimuli such as non-human noise, temperature, luminous or olfactory sensation, etc., will not be considered as part of a privacy experience.

The decision to omit control over stimulation as part of a privacy experience is based partly on the qualities of the particular psychiatric settings being studied: for the most part, ordinary physical sources of stimulation are absent from these settings (e.g., street noises). In addition, in a previous study of children living in treatment settings, privacy was seldom described in terms of control over physical stimulation (Wolfe & Golan, 1976).

It has been shown that privacy involves individual choice as well as control over access. Thus, privacy with regard to physical aloneness will now be referred to as "privacy as <u>chosen</u> physical aloneness," with the understanding that this qualifier includes control over choice and

control over access.

Privacy: Its Significance to Human Experience and Behavior

The significance of privacy to human experience and behavior is underscored in several areas of inquiry. The notion of privacy and invasion of privacy has been a legal issue for years (Brandeis & Warren, 1890; in Laufer & Wolfe, 1978; Westin, 1967; Levin et al., 1971). Architects and planners have often used privacy as a variable in design decisions in housing (Madge, 1950; Grootenboer, 1962; Chermayeff & Alexander, 1963; Madge, 1965). And privacy has been seen as critical to appropriate development in children (Plant, 1930; Atkins, 1970; Wolfe & Laufer, 1974; Wolfe & Golan, 1976). In particular, recent discussions about privacy's functions and subsequent importance focus on privacy in relation to self-esteem and social interactive behaviors. This will be treated in the proposed investigation.

Privacy and self-esteem. Among almost all discussions of privacy, there is a consensus that privacy is critical to the development of self (Bates, 1964; Jourard, 1966; Schwartz, 1968; Laufer & Wolfe, 1977). In particular, frequent reference has been made to the relationship between privacy and self-esteem. This direction represents a clear departure from work done on self-esteem in the past. Traditional psychology had virtually ignored the physical environment as a factor in self-esteem; research in privacy assumes the significance of the physical environment, as well as the social environment, to the concept of self-esteem.

A brief review of some of the traditional work on self-esteem will serve as background to the later discussions of the relationship of privacy to self-esteem. The works of Coopersmith (1967) and Rosenberg (1965) represent efforts to elaborate on conceptualizations of self-esteem

presented in the past and, as importantly, to empirically test them. Both Coopersmith and Rosenberg introduced the topic by citing earlier self-theorists, including William James (1890) and George Herbert Mead (1934). In addition, the work of several personality theorists were presented (for example, Adler, 1927; Horney, 1945, 1950; Sullivan, 1947; Fromm, 1941; Erikson, 1968).

Rosenberg (1965) treated self-esteem as the self-respect or feeling of self-worthiness the individual has towards herself or himself. This self-judgement is based on the individual's comparison of herself or himself to other people: that is, the person views herself or himself as better than, equal to, or worse than other people. Rosenberg carefully pointed out that his conceptualization of a person with high self-esteem meant that the individual respects herself or himself and does not view herself or himself as being any better or worse than other people. In a survey study of adolescents, Rosenberg illustrated the relationship between self-esteem and social context, which included socioeconomic categories, religion and ethnic grouping.

The interpretations of the Rosenberg findings suggest that the child's immediate surrounds--including parental attitudes (which may be related to the broader social context)--accounted for distinct levels of self-esteem among the adolescents studied. This was supported in the Coopersmith study (1967) conducted a short time later with preadolescents.

Coopersmith defined self-esteem as "the evaluation which the individual makes and customarily maintains with regard to himself" (Coopersmith, 1967). In an empirical investigation, he proceeded to correlate the subjective and teacher-rated self-esteem of preadolescent children with clinical tests and behaviors in laboratory situations (e.g., bean bag toss). A focus of the research was to understand the conditions which were con-

nected to children's varying levels of measured self-esteem. Significant among those conditions were parental attitudes and individual history/experiences, including birth and infant experiences and sibling/peer relationships.

The implications of these studies are far-reaching: they suggest that high self-esteem is, indeed, desirable. According to Coopersmith's findings, high self-esteem is significantly correlated to: self-reliance, independence, leadership, a healthy non-conformity, positive social participation, initiative, creativity, and self-respect. All these are positive qualities, given our cultural goals, and all may be seen as related to goals of individualism described earlier.

Yet the work of Coopersmith and Rosenberg, as well as discussions by others in the field, have clearly ignored the role of both the physical and social environment in relation to levels of self-esteem; social context was focused on without any mention of the physical environment.

Recent work on privacy has begun to shed light on the connection between the social and physical environment and psychological constructs such as self-esteem. Privacy can be used as a concept which can help describe the connection between self-esteem and the social and physical aspects of environment. On a theoretical level, at least, privacy--a concept related to the social and physical environment--is associated with self-esteem.

Laufer and Wolfe (1978) have suggested that experiences with privacy "feed into the individual's sense of self-esteem (and) as one's identity and self-esteem develop . . . the individual acts differently and is likely to be perceived and reacted to differently" (Laufer and Wolfe, 1978, p. 9). Others have also suggested that privacy enhances levels of self-esteem (Goffman, 1961; Bates, 1964; Aloia, 1973; Berado, 1974). For instance, one study of the marriage partnership as a unit, described

how that unit needs to be away from the rest of the world in order to both play out roles they don't ordinarily do in public and to recoup from social pressures; privacy serves to restore levels of self-esteem (Berado, 1974). A study with institutionalized and noninstitutionalized elderly people reported a correlation between perceived privacy options and self-esteem (Aloia, 1973).

Other investigations have mentioned privacy as important to more general aspects of the self which, according to Coopersmith's findings, are connected to self-esteem. For example, some researchers see privacy as critical to self-evaluation (Westin, 1967; Proshansky, Ittelson & Rivlin, 1970; Lawton & Bader, 1970; Pastalan, 1970). Others have suggested privacy is critical to the development of personal autonomy and self-identity (Plant, 1930; Rossiter, 1958; in Westin, 1967; Jourard, 1966; Schwartz, 1968; Simmel, 1971). And others have suggested privacy is important for introspection, also related to development of the self (Chermayeff & Alexander, 1963; Kira, 1966).

How is self related to privacy as chosen physical aloneness? The investigations just cited vary in their conceptualizations of privacy. Thus, "privacy" in relation to self-identity may refer to both control/choice over interaction and over information (Laufer & Wolfe, 1974). However, often in discussions of privacy and aspects of self-esteem, "privacy" is assumed to be a form and experience of chosen aloneness. This form of privacy is positively valued, while psychological separation is not. For instance, many investigations, in their discussion about the functions of privacy, point to the need for individuals to limit their interactions with other people (Schwartz, 1968; Shils, 1966; Simmel, 1971, Johnson, 1974). Some go further and specifically cite the need for a physical space away from other people (Jourard, 1966;

Madge, 1965; Osmond, 1970; Talmon, 1972; Smith, Downer, Lynch & Winter, 1969; Kira, 1966; Kuper, 1970; Atkins, 1970). In any event, most of this work, having almost no empirical base, supports further investigation on the relationship between privacy and self-esteem, and specifically, between privacy as chosen physical aloneness and self-esteem.

Privacy and social interactive behaviors. The functions of privacy are believed to be connected to patterns of social interactive behaviors. However, what was true about privacy and self-esteem is also true about privacy and social interactive behaviors: inferences have been made about the importance of privacy to the development of appropriate social behaviors, yet little empirical research has been done to substantiate these speculations. As with self-esteem, these inferences are reasonable ones to pursue.

In connecting the functions of privacy to social interactive behaviors, investigators have been fairly specific in what is meant by privacy. In these discussions, privacy has been operationally defined as the absence of unwanted interaction; generally, these definitions include a clear spatial referent, e.g., a room/place away from other people. Central to this privacy experience is the control over interaction.

Most discussion about the role of privacy in social interactive behaviors has appeared in research on housing (Madge, 1950; Chapin, 1951; Rosow, 1961; Scho r, 1970; Rappaport, 1975). For instance, Madge (1950), believed that society's conflicts can be resolved through expressions in physical construction. He argued that the layout and demarcation of spaces in a dwelling unit set the pattern for social behavior of its occupants in the present and in the future. Others have added that the absence of private spaces within a dwelling unit for individual family members contributes to negative social interactions among family members

(Grootenboer, 1962; Atkins, 1970).

In addition, there has been some research which, although not always dealing directly with privacy, lends support to the idea that non-chosen social interaction has negative effects on the individual's future interactions when in social situations. Specifically, research has indicated that being in the continual presence of others (non-chosen) does not support positive social interaction (e.g., amicable talking, other cooperative behaviors), but, in fact, may encourage severe psychological withdrawal, aggressive behaviors, or other inappropriate social behaviors (Loring, 1956; Hutt & Vaizey, 1966; Osmond, 1970; Murray, 1974; Wolfe & Golan, 1976). In a now-classic work, Plant (1930) identified several developmental outcomes resulting from little opportunity for chosen physical aloneness in the home. These were: 1. lack of self-perception; 2. destruction of necessary illusions children should have about parent/heroes; 3. sexual maladjustment; 4. no chance to look objectively at their world (always being a part of it).

It is evident from this brief review that the physical environment is acknowledged as a factor contributing to people's social interactive behaviors, while having been ignored in studies of self-esteem; privacy has often been used as an explanatory concept in discussions of social interaction, but not in those of self-esteem. Yet there may be a strong connection among all three: privacy as chosen aloneness, self-esteem, and positive social interaction. That is, children with high levels of self-esteem have been found to be facile in social situations, particularly with regard to: ease of making friends and not being overly self-conscious, thus allowing them to focus on the world around them (Coopersmith, 1967). Children who grow up in homes which allow for little

opportunity for privacy as chosen aloneness lack these qualities (Plant, 1930; Atkins, 1970). Likewise, children with low levels of self-esteem are likely to show psychosomatic symptoms, internalize their anxiety (perhaps manifested as psychological withdrawal), and (at young ages) show aggressiveness towards inanimate objects, more so than children with high levels of self-esteem (Coopersmith, 1967). Again, these characteristics are in line with those qualities attributed to children who had few opportunities for privacy as chosen aloneness in the home (Plant, 1930).

In summary, it is reasonable to assume that privacy as chosen physical aloneness is related to both: 1. levels of self-esteem and, 2. kinds of social interactions when an individual is in social situations (positive, cooperative social interaction vs. aggression, withdrawal, or other inappropriate social behaviors). This area merits further investigation and will be fruitful to the further conceptualization of privacy and to physical design and clinical policies of therapeutic settings.

# Chapter IV

## PRIVAC AND THE INSTITUTIONAL SETTING

Recent investigations have begun to underscore the importance of privacy for people in a variety of settings. Most of this research illustrates the limitations on privacy. Descriptions about the lack of privacy has been reported for residents living in high density housing (Bracy, 1964; Schorr, 1966; Kuper, 1970; Lewis, 1970), for people in their work environments (Manning, 1965; Brookes & Kaplan, 1970; Golan & Justa, 1970) and for children in classroom situations (Rothenberg, 1972, in Wolfe & Laufer, 1974).

The significance of privacy can be best understood by focusing on the reprecussions brought on by the absence of different forms of privacy. There is evidence that people often create alternative forms of privacy for themselves, in the absence of environmental conditions conducive to other forms of privacy. Yet, at times the alternatives themselves may not be possible to achieve, and even if possible, may incur high costs (e.g., a person may manage to create physical aloneness for him/herself, even though physical aloneness may be negatively sanctioned within a setting; conceivably, the conflict between sanctioned and sought behavior/experience can be stressful on the person). In either event, there may be enduring consequences.

As was cited earlier, there are indications among noninstitutionalized groups that the continual presence of other people (to be taken as the absence of privacy as chosen physical aloneness) has several consequences, particularly in terms of self-development (Plant, 1930; Atkins, 1970; Talmon, 1972).

In a psychiatric facility, limitations on privacy and the potential consequences are even more pronounced. The continual surveillance of

patients allows them little control over aspects of their lives. Goffman (1961), in an essay on adult psychiatric facilities, described how limitations on privacy threaten the patients' sense of self and inhibit their return to mental health.

The issue of limitations on privacy becomes even more complex when one considers psychiatric facilities for children. Privacy is considered critical to children's social development; in fact, lack of privacy has been cited as a factor contributing to children's developmental disorders (Plant, 1930; Desor, 1972; Laufer, Proshansky & Wolfe, 1974). Children in psychiatric facilities have frequently been institutionalized precisely because of these disorders. Thus, if one assumes that privacy is important to development, children in psychiatric facilities should be provided with privacy as part of treatment. Ironically, limitations on privacy are greater for institutionalized children than they are for other groups. Children in general are limited in the opportunities they have for privacy; institutionalized children, because of the nature of the setting in which they live, are even more limited in the opportunities they have for privacy (Bettelheim, 1975; Wolfe & Golan, 1976).

This presents a strong argument in favor of the need for privacy opportunities for the institutionalized child or adolescent, assuming privacy does, in fact, contribute to the development of positive self-esteem and appropriate social behaviors, outlined in Chapter III. And assuming that the child or adolescent will eventually live outside of an institution, where individual independence is positively sanctioned, then privacy as chosen aloneness becomes significant, again, as outlined in Chapter III.

Privacy as Chosen Physical Aloneness in a Psychiatric Setting

It is important to evaluate the benefits of chosen physical aloneness in residential psychiatric facilities. Until recently, it was believed that time spent alone was not only dangerous to the physical security of patients, but counterproductive to the administrative goal of positive social interaction among patients. However, recent research has indicated that being in the continual presence of other people does not facilitate social interaction and, in fact, encourages psychological withdrawal and even aggression (Hutt & Vaizey, 1966; Murray, 1974). Chosen physical aloneness is beginning to be seen as a positive experience for psychiatric residents, one that, in fact, encourages positive social interaction and positive self image.

Some investigators have suggested that if residents are not provide with opportunities for chosen physical aloneness, they will devise strategies to achieve psychological aloneness, including psychological reserve and idiosyncratic behavior; these behaviors may be detrimental to patients' well-being, specifically with regard to development of self and patterns of positive social interaction (Goffman, 1961; Jourard, 1966; Schwartz, 1968; Osmond, 1970; Wolfe & Golan, 1976). Osmond, for instance, specifically stated that if a patient does not have the option for physical aloneness, she or he will withdraw psychologically; this psychological withdrawal, Osmond suggested, has more far-reaching negative consequences for the patient than does physical withdrawal or aloneness. Others have also indicated that if the institutionalized individual is not directly provided with options for physical aloneness, he or she will devise other means to achieve a state of aloneness, most notably psychological reserve (Goffman, 196 ; Lawton & Bader, 1969; Pastalan, 1970).

A group of studies of one children's psychiatric facility also support the importance of chosen physical aloneness. Staff who worked with children reported that children resorted to "bizarre" behaviors, including rocking, when they were deprived of privacy as physical aloneness; and children themselves reported that they occasionally feigned emotional upset in order to be placed alone in the seclusion room (Wolfe & Golan, 1976). And a behavioral study of room size, group size, and density, showed that regardless of how many children were assigned to a bedroom, there was seldom more than one child found in a bedroom at any one time (Wolfe, 1975). These studies suggest that these children work out strategies to create physical aloneness for themselves even when not directly provided with physical aloneness.

However, at this point, it cannot be assumed that these observed "alone" behaviors can be accepted at face value as equivalent to the experience of privacy as chosen aloneness. As Laufer, Proshansky & Wolfe (1974) suggested, control over <u>choice</u> of behavior and over access to spaces are necessary components for aloneness to be considered a privacy experience. Thus, while a resident may manage to be alone in a seclusion room (Wolfe & Golan, 1976), there are limits on the kinds of behavior she/he may exhibit in order to be placed and remain in the seclusion room; in this case, then, control over choice is absent (one might additionally ask about the consequences of having to feign certain kinds of behavior in order to be placed in the seclusion room; see Wolfe & Golan, 1976 for a discussion of this). Likewise, while residents manage to be alone for a while in their bedrooms (Wolfe, 1975), there is always the possibility of interruption or intrusion by other people, because residents do not have total control over access to spaces. The proposed research will explore aloneness in a children's psychiatric

facility, specifically studying aloneness as it relates to choice. In this way, physical aloneness will, indeed, be a reflection of a privacy experience, i.e., chosen physical aloneness as privacy.

Taken together, the investigations presented in these last pages as well as the work of others (see, for example, Cumming & Cumming, 1963; Lawton & Bader, 1970; Schwartz & Proppe, 1969; Ittelson, Proshansky & Rivlin, 1970; Pastalan, 1970; Architecture Research Construction, 1975) suggest the importance of privacy as chosen physical aloneness to both children and adults living in institutional settings, regarding development of a positive self and positive social interactive behaviors. At this point, however, this conclusion has been more inferred, rather than having been directly studied as a research issue in its own right. The present investigation, as part of its focus, will study the purported benefits of privacy as chosen aloneness for children and adolescents living in a psychiatric treatment center. Attention will be given to privacy as chosen physical aloneness as it relates to these children's and adolescents' self-esteem and social interactive behaviors. A study in this context is particularly meaningful, as children and adolescents placed here face problems of appropriate development with respect to positive self image and social behaviors. And, ironically, opportunities for privacy as chosen aloneness had been previously limited in these settings. The current move towards normalization in institutional settings--which includes the view that residents be given opportunities for privacy--gives even more cause for a study of this nature. Privacy as chosen physical aloneness is one part of normalization; an empirical study of the benefits of this aspect of privacy can speak to the process of normalization and its influence on the living experiences of the institutionalized person.

It must be pointed out that in all settings and even more so in the total institution, privacy as chosen physical aloneness depends on more than just the presence of a physical space. A physical space or absence of visibility does not guarantee privacy (Schwartz, 1968). Attitudes of staff, therapeutic philosophy, programming, and treatment are other factors in the resident's ability to regulate his or her social interactions. If, for example, a facility's design provides a physical space, but physical withdrawal is negatively sanctioned by the administration and direct staff, the resident would be unable to choose to retreat to a seemingly available space in order to regulate his or her social interactions. If, on the other hand, a facility provides no place specifically for physical withdrawal, but the staff is sympathetic to the need for physical withdrawal of the resident, programming and space may be manipulated in order to provide a situation for the resident to choose to be away from others. Thus, the opportunity for or provision for privacy as chosen physical aloneness in the psychiatric facility refers to: design, therapeutic philosophy, attitudes of staff, and programming.

# Chapter V

## THE SETTINGS/THE PREDICTIONS

Selection of the two settings for study was based on specific details in those environments in relation to privacy as chosen physical aloneness. A review of the literature on privacy revealed that there are features of environments which reflect experiences with privacy and observed privacy behavior. Thus, in a study of the contextual nature of privacy, it is useful to focus on settings which can provide a contrast in the provision of and opportunities for privacy. At the same time, it is important that the settings selected for study be alike in many respects. This makes a comparison of findings across settings meaningful, and helps strengthen the generalizability of findings in terms of the psychiatric institutional structure and, perhaps, even to noninstitutional groups.

On the basis of a preliminary study of four potentially suitable settings, two were selected for the final study (see checklist of criteria for setting selection, Appendix A). One of those settings is the one in which the researcher conducted previous investigations, to be referred to as "Setting 1." The second is a facility to which the researcher had made frequent visits and conducted interviews and informal observations, to be referred to as "Setting 2." The two settings, which are both state facilities located in New York City, are similar in the children and adolescents they service, but vary in the opportunities they provide for privacy as chosen physical aloneness.

A description of each of the two settings will be presented, followed by a summary comparison of the privacy-related aspects of both settings. This description will show the ways in which the physical and social en-

vironemnts create a context in which patterns and concepts of privacy are developed and maintained. Then, in the last section of this chapter, predictions central to the present investigation will be introduced. These predictions will be based on the privacy-related aspects of the two settings in relationship to the theoretical framework on privacy and environment discussed earlier.

The description of each of the two settings will be organized around: physical design, therapeutic philosophy, attitudes of direct care staff, and daily program.

Setting 1

This description is drawn from an earlier six-year longitudinal study of Setting 1; the study involved extensive interviews and observations of residents and staff, tracing people's experiences and behaviors in relation to physical design and functional changes over time. In addition, the investigators of the longitudinal study met regularly with administrative staff and attended policy meetings in order to understand the hospital system (Rivlin & Wolfe, 1972;Rivlin, Wolfe & Beyda, 1973).

Physical design. This facility is located on a tract of land, shared with a larger adult psychiatric center and a recently completed residential center for the mentally retarded. The three complexes are located in a tucked-away corner in the northeast part of New York City, directly adjacent to a major parkway, factories, and an elevated railroad. Access to the facility is difficult; there is one bus route running between a shopping district one and a half miles away and each of the facilities.

The children's facility services children and adolescents who range in age from six to 16 and who are generally diagnosed as having "childhood schizophrenia" or "behavior problems." There are also a number of day-

care clients who, during school hours, are integrated into the same program as full-care residents.

The children's psychiatric facility is made up of recreation areas, living units, school areas, an infirmary, and an administrative area, all housed in a one-and-a-half story building and connected by a series of corridors. These areas are deliberately apart from one another in order to suggest a separation of the spheres of life's activities, called for by the normalization principle (Nirje, 1972; Wolfensberger, 1977); yet, at the same time children and adolescents need not go outside in order to go from one activity to another. Nor do they need to use any community facilities for recreational or educative purposes (see Figure 1 for floor plan of facility, p. 38).

There are eight living units called "houses", each accomodating 24 people. (Over the years, only four of the eight houses have been used by the facility's clients; the remaining four are used as either business offices or for state programs which are not related to the children's facility [see Figure 2 for floor plan of a typical house, p. 39]).

Each house has a variety of spaces which vary in degree of group or individual use. The most public spaces of each house are the dayroom and the internal corridor/bench area. As one stands at the entry area (which is locked), one can see the dayroom to the right and the internal corridor straight ahead. The dayroom has a television set and enough seating to accommodate all residents. The internal corridor can seat up to ten or 12 people. The dayroom and internal corridor are in view of the nurse's station, which is itself a small room enclosed with panels that are largely glass. Off the internal corridor is a laundry room with a door and another room, whose function has varied over the seven years of occupancy, ranging from a staff office to a seclusion room to its

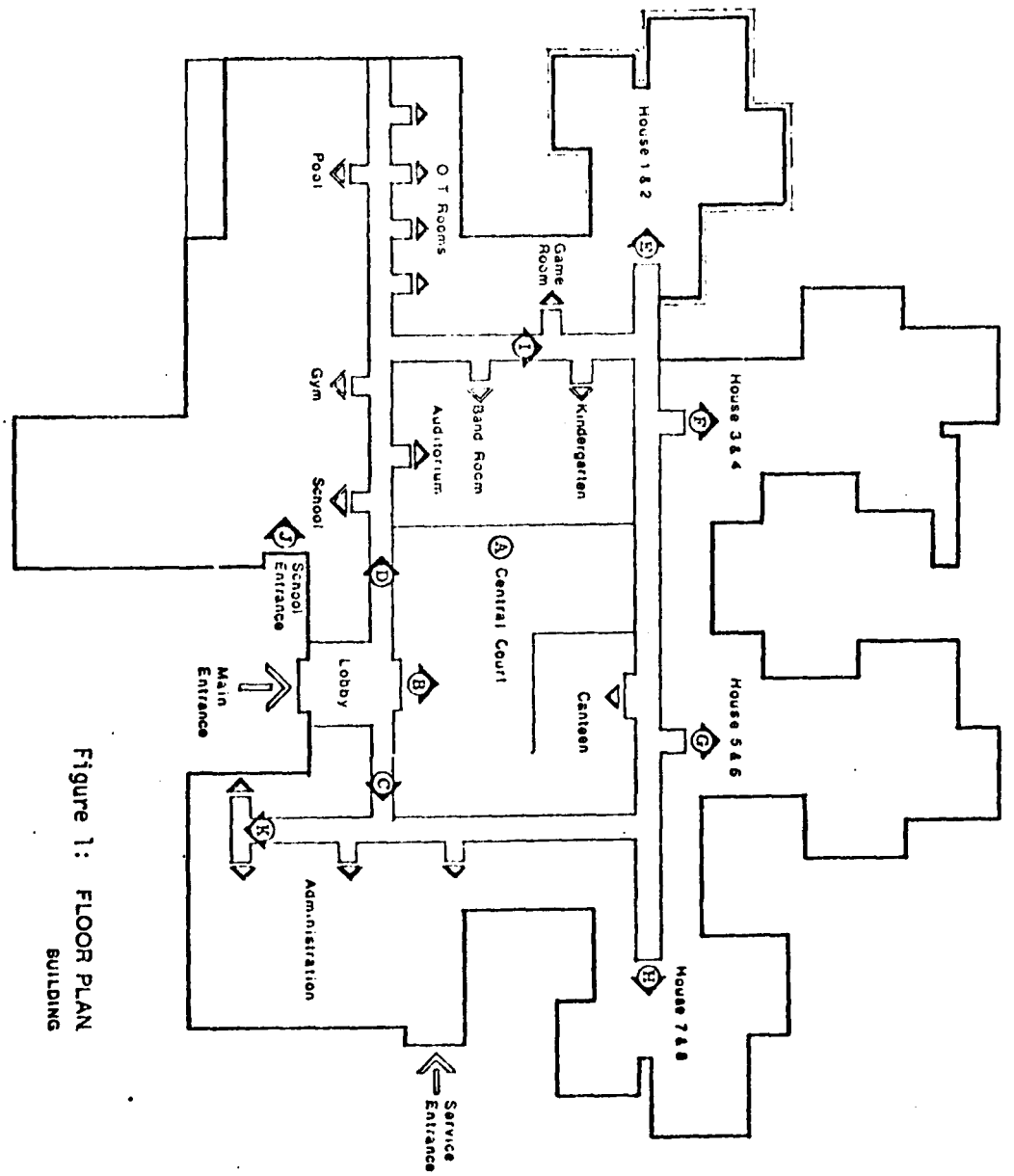



Figure 1: Floor Plan of Setting 1.

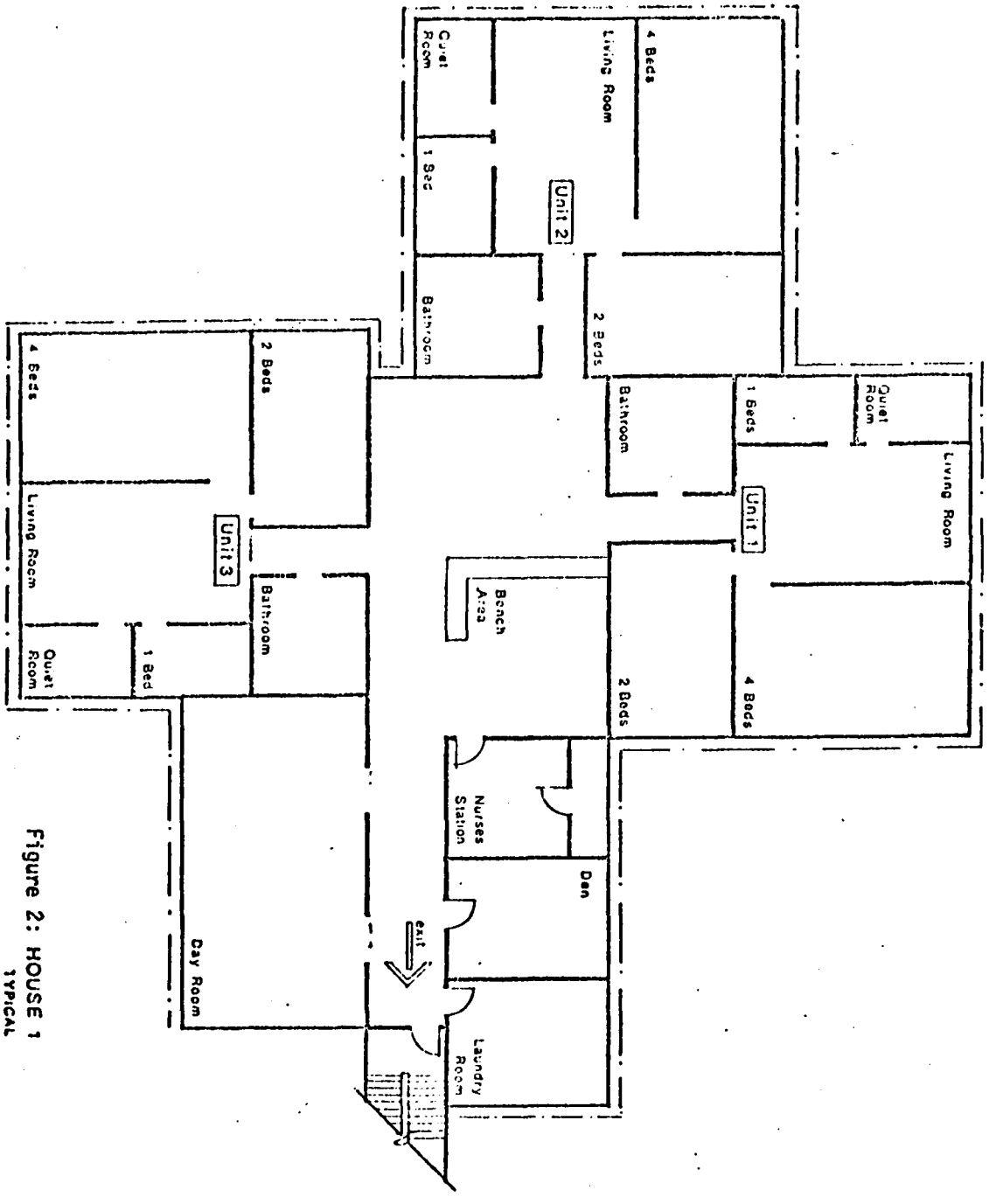



Figure 2: HOUSE 1 TYPICAL

Figure 2: Floor Plan of a Typical House in Setting 1.

present use as a client den/lounge area.

Clustered around the internal corridor of each house are three "apartments" or living areas. As one stands at the nurse's station, one could see into the "foyer" and "living room" of each apartment through a glass-paneled door, although there are some parts of the living room that are out of view of one looking in.

Off the foyer and living room of each living area are a bathroom, a combination shower/bathtub, a community closet and four rooms designated as bedrooms (one four-bedded room, one two-bedded room, and two one-bedded rooms). At the time of the proposed investigation, one of the one-bedded rooms of each apartment was being used as a seclusion room: when children and adolescents are perceived as out of control, they are sent here with a staff person.

The bathroom is similar to the community-style bathrooms found in many institutions: there are several sinks in line with one another (located beneath one large mirror) and two toilet stalls. Doors to each of the toilet stalls are recent additions, put up four years after the occupancy of the building. Bedrooms are sparsely furnished, containing a bed and one free-standing closet unit per resident. Doors to the bedrooms were installed around the same time as the bathroom stall doors.

Of the three houses used as living quarters for residents, one is used by adolescent boys, another by adolescent girls, and the third by younger boys and girls. At one time, adolescent boys and girls shared one house, occupying separate "apartment" or living areas. However, staff perceived problems in this arrangement, thus accounting for the present situation.

Also, at the time of the present investigation, adolescent girls lived in a house which varied somewhat from the typical house described

above, this due to a fire in their usual quarters. The temporary quarters of the adolescent girls' did not have demarcated one-person, two-person, and four-person bedrooms, but rather had two dormitory-style bedrooms, each accomodating up to six girls. (The dormitory-style bedrooms were originally designed for autistic children.). Also, the client/den lounge was absent with a seclusion room in its place. Moving the adolescent girls into that particular house was based solely on what was available, until the time the girls could return to their usual quarters. In total, the adolescent girls used the "temporary" quarters for one and a half years.

The major recreation areas used are located away from the living units, at the other end of the building. These areas include a gym, a swimming pool, an auditorium, a series of hobby or meeting rooms, a canteen, a library, a gameroom, a hair salon, a music room, an arts and crafts wing, and the main lobby with vending machines for snacks. The school wing is made up of classrooms. The administrative wing, not far from the houses, contains the offices of administrative staff and the social workers and psychologists who work with children and adolescents. There is also an infirmary where residents receive minor medical care. And finally, there is a dining room for every pair of houses where residents eat their daily meals, located only steps away from the houses. (The dayroom of each house has a kitchenette, used occasionally for evening snacks.).

The outdoor areas are alternately grass and concrete and have play equipment, including swings, seesaws, etc. However, observations over the years revealed that these areas are seldom used; almost all client activity takes place indoors.

The <u>therapeutic philosophy</u> of Setting 1 was initially determined

through interviews with administrative staff, including interviews with the facility's first and still-current director (see Rivlin & Wolfe, 1972). Evolution of therapeutic philosophy has been followed over the years by attending policy meetings and through formal and informal interviews and observations.

Normalization--with resident's eventual return to their communities--has been cited as the overriding philosophy of this setting, as well as for others like it. The director's early attempts to foster a normalized setting were somewhat hampered by the actual design of the facility: the creation of a multi-purpose unit tends to discourage the use of services in the surrounding community. But there were also deliberate policy decisions which seemed to run counter to the nonrestrictive environment prescribed by normalization. One specific change, instituted only months after the initial occupancy of the facility, was the installation of locks on the doors of the houses. The consistent use of these locks has since limited children's and adolescents' free access to the corridors which lead to other areas of the facility.

The director was specific in outlining goals relating to privacy. In particular, he argued that all children need interactional privacy and that this privacy is best met through the provision of one-person bedrooms, which allow residents to be away from others and explore themselves.

However, the director's unstated goals were at odds with the reported goals of other administrative staff, many of whom are more involved in day-to-day decision-making and whose responsibility is direct care staff. For example, in one interview, the chief psychiatrist of adolescent services voiced his opposition to one-person bedrooms, adding that children and adolescents must always be in a group situation in order for treatment

to be effective. The director of nursing, when relating privacy to staff supervision, agreed that privacy as physical aloneness was important, but felt that staff's need to know residents' activities took priority over any form of privacy (see Wolfe & Golan, 1976 for a more complete analysis of therapeutic philosophy and privacy in "Setting 1").

The administration's views about privacy are probably best expressed in a 1976 memorandum sent to direct care staff:

> On privacy in general: "There are times when children need privacy from either their peers or staff. However, staff must be aware at all times of where children are and what they are doing. This is to prevent a depressed child from hurting himself, an angry child from hurting someone else, prevent sexual acting out, horseplay, and teasing. Frequent checks must be made by staff (at) five to ten minute intervals at these times."
>
> On showering: "It has been our experience that undressing, showering, and general preparations for sleep encourage attempts of children to act out sexually. In view of the fact that normal children do a certain amount of examining and experimenting to find their own sexuality, it is often difficult for staff to understand our constant attempts to control it here. Although normal children frequently have homosexual-like experiences in search of their own male-female identity and handle them well, our children, who are already in emotional turmoil, cannot deal with these added conflicts. We have, therefore, tried to prevent situations where sexual acting out frequently happens. At shower time, a group leader must remain in the area and supervise. Only one child is allowed in the bathroom while showers are being taken. Although there are two showers, only one may be used. Children using toilets at those times must be supervised. Masturbation is a private thing and children found doing it in the presence of others or in public areas should be spoken to. We emphasize the fact that there is nothing wrong with it, but it must be done in private."

Attitudes of direct care staff are in line with the practiced philosophy described above. While there is concern about residents' needs for privacy as aloneness, there is also an expressed fear about residents' doing harm to themselves or others if left alone (Wolfe & Golan, 1976).

There is no clear-cut solution to such a conflict. In practice, children and adolescents are most often in program and in supervised areas, with a limited amount of free time where they may be away from the group; this is described in a brief outline of daily program.

Daily program was examined according to the amount of structured and free time provided daily for residents and according to the number of other people residents must be with over the course of a day. Children and adolescents are wakened by 7:00 AM, eat breakfast at about 8:00 AM, and are in the school wing from 9:00 AM to 3:00 PM, with a one hour lunch break in between. Most of the lunch hour is spent in the house, where children and adolescents have some free time, in addition to access to their bedrooms. From 3:00 PM to 4:30 PM and from 6:00 PM to 9:00 PM, children and adolescents are involved in the evening recreation program. There is some free time between 4:30 PM and 6:00 PM, where again children have access to their bedrooms. However, for the most part, residents are confined to the house area and during free time. During the afternoon free time, children and adolescents satisfy their weekly or twice weekly one-to-one meeting with the social workers or psychologist they work with. Dinner is served for a brief ten-minute interval at 5:00 PM. At 9:00 PM, showers begin and snacks are given out. Bedtime is about 10:30 PM. Taking into account daytime and nighttime preparation, children and adolescents have a maximum of two hours during which time they have some choice over what they do and with whom they spend their time.

Setting 2

This account is based on a year-long contact the investigator established with the facility, and included regular attendance at meetings, access to archival data, informal observations, and informal and formal

interviews with administrative and direct care staff (see Appendices B and C for staff interview schedules).

Physical design. This facility is located on an island which is technically part of New York City, but in reality, is quite a distance from the communities from which it draws its clients. Also on the island is a drug rehabilitation center, and a park created for use by New York City community residents. Access to the island is achieved by use of a public bus or a pedestrian bridge connected to part of New York City. Staff in Setting 2 have complained of security problems brought on by the community people's use of the bridge and park. (Staff did not complain about residents' trying to escape from facility by the bridge.).

Made up of five one-story and two-story buildings, the children's psychiatric facility is dwarfed by the adult psychiatric complex situated on a neighboring tract of land. Children and adolescents serviced range in age from six to 16 and are diagnosed as having the same problems as the children in Setting 1: "childhood schizophrenia" or "behavior problems". There are several day-care clients who are integrated into the same program as full-care residents.

As was true of Setting 1, this facility is a "total institution" which meets all of its clients' daily needs. The four one-story buildings make up the living units or "cottages" for each of four different age groups of children adolescents. The main building, a two-story structure, accommodates most recreation areas, the school areas, an infirmary, and the administrative wing. Each cottage is several hundred feet away from the main building. In total, the five buildings occupy over 200,000 square feet of land, much of which is used to travel to different parts of the facility and for outdoor recreation (see Figure 3 for plan of facility, p. 46).

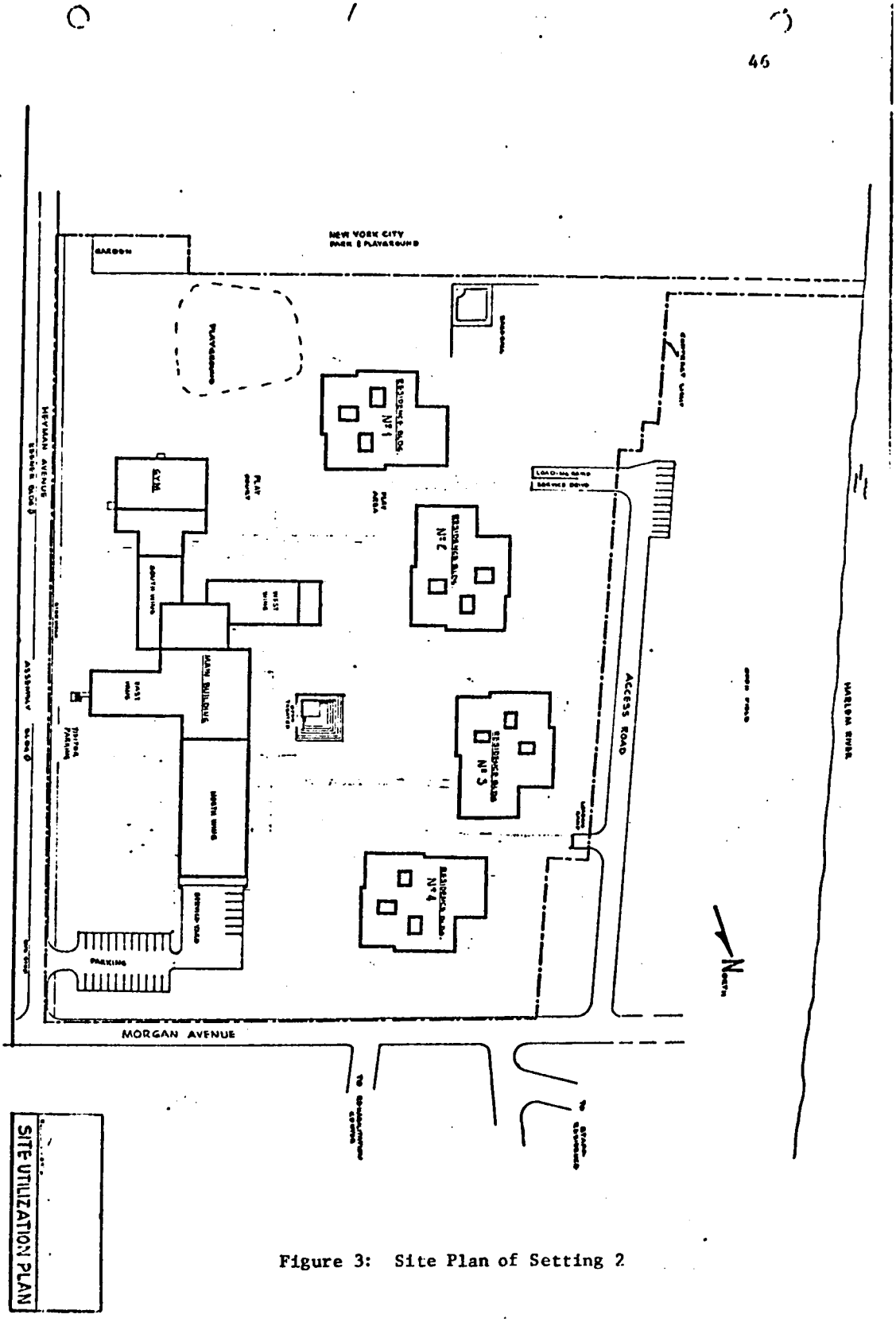



Figure 3: Site Plan of Setting 2

Each of the four cottages accomodates 24 people. The entry area of any one of the identical cottages is a small, tiled mudroom, which has a three-person bench secured to the floor. One wall of the mudroom is made entirely of glass, allowing full visual access to the outdoors. However, a person in the mudroom is out of view of people who are in inner areas of the cottage. An interior door from the mudroom leads to the visitors' alcove, which is adjacent to the food service area and two dining rooms, where residents eat their daily meals. The dayroom (recreation room) is a large interior space, which has tables and chairs, couch seating, a small kitchenette, and a television set. Off the dayroom is a laundry room, two small bathrooms each with a toilet and sink, a staff lounge, and a nurse's station/interview room. The glass-enclosed nurse's station allows full visual access to the dayroom and some other areas. The two bathrooms are used by children during the day.

Clustered around the dayroom are three "apartments", each accommodating eight residents. Each apartment consists of a living room, an encircled outdoor court, a community-style bathroom, a shower room, and five bedrooms (one four-person bedroom and four one-person bedrooms). The court and part of the living room wall are glass-paneled, providing partial visual access for a person located in either the dayroom or nurse's station. As with Setting 1, the bathroom in each of the living room areas is community-style, with two toilet stalls with doors, several sinks, and one mirror across a wall. Bedrooms contain a bed, a bureau, and a desk for each resident, and have doors on them. At the time of the present investigation, one out of the three living rooms of each cottage was used as a recreation area and had a billiard table and ping-pong table. Also, at one time, one of the one-person bedrooms was used as a seclusion room, but was unused during the present investigation (see

Figure 4 for floor plan of a typical cottage, p. 49).

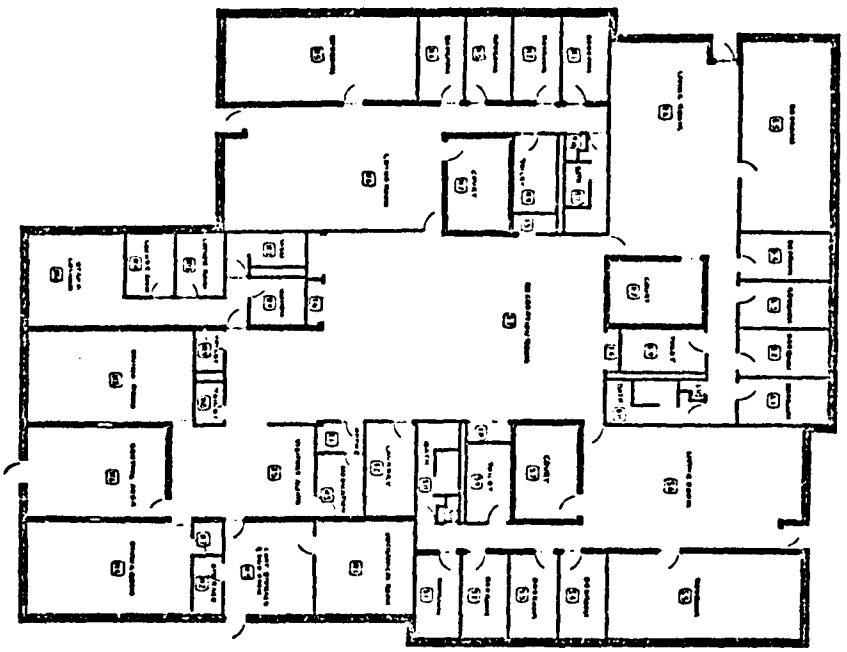
The four cottages are age-segregated, but each cottage has children of both sexes with apartments or living areas being sex-segregated. Thus, boys and girls have the opportunity to interact with one another in the dayroom and other public areas of each cottage.

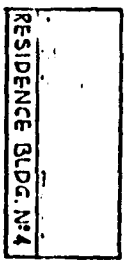
The major recreation areas of the facility are located on the first floor of the main building and includes a gym, a swimming pool, crafts rooms, an auditorium, a canteen with vending machines, a gameroom, a hair salon, and a music room. The school area, also on the first floor of the main building, consists of classrooms, a time-out room, and a seclusion room. The time-out room is used when children or adolescents pose a behavior problem seen as too disruptive to deal with in class: here, children and adolescents often do written assignments as punishment. When a child or adolescent is seen as being out of control, she/he is placed in the seclusion room with a staff person.

The administrative wing, located on the second floor of the main building, contains the offices of administrative staff and of the social workers and psychologists who work with children and adolescents. The infirmary is also on this floor.

The outdoor areas, made up of grass, concrete, and asphalt, consist of a basketball court and play equipment for young children. Informal observations revealed that outdoor areas are frequently used during after-school hours, as well as for travel during the day.

The <u>therapeutic philosophy</u> of Setting 2 was mandated, in part, by the New York State Department of Mental Hygiene, where normalization and eventual return to community life is a major goal. (This mandate applies to Setting 1 as well.). However, in Setting 2, therapeutic philosophy is also closely connected to the physical design or what is





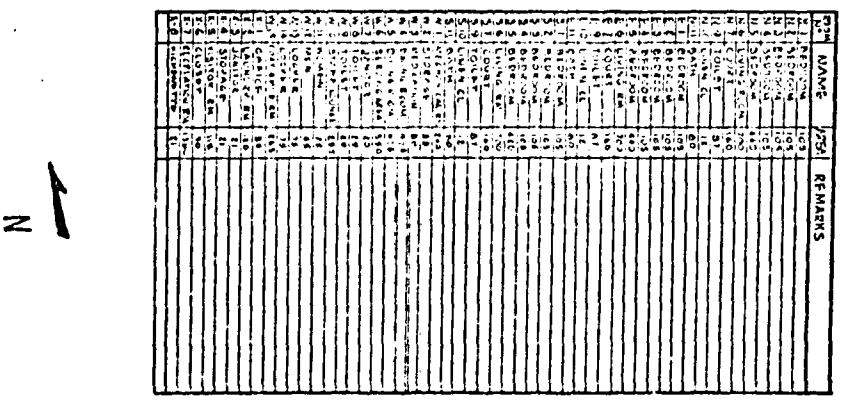




Figure 4: Floor Plan of a Typical Cottage in Setting 2

known as the "open setting". In an open setting, all activities do not occur under one roof and residents must travel outdoors to go from one activity to the next. In addition, according to staff, the open setting implies noncontainment, "no locked doors," and some freedom of choice in terms of residents being able to be on their own.

Yet, many staff saw the "open setting" as too unstructured for the children and adolescents the facility services. Ironically, the freedoms that the open setting potentially provides for residents has been countered by the staff belief that <u>because</u> of the setting, staff must "be more observant (of residents) or at least more cognizant" than they would be otherwise. And, interestingly, there are now locks on cottage doors, which were installed in the past year, about four years after the initial occupancy of Setting 2. (At the time of the present investigation, locks were seldom used.).

The functional program of Setting 2, written up prior to completion of the physical plant, acknowledged residents' needs for aloneness and freedom of choice:

> It is also important that each child have some free time each day to select his own activity or do nothing if he so wishes . . . Children will be permitted to use their rooms for quiet activities when they wish to be alone.

The difficulties this directive presents are reflected in the attitudes of direct care staff towards residents' freedom of choice and alone time, described below.

<u>Attitudes</u> of direct care staff in Setting 2 towards privacy are in line with those of staff of Setting 1. While aloneness is seen as somewhat important, most staff think that children should spend the day in structured activity and that staff must always know the whereabouts of children and adolescents. As one staff person said, "If they (children

and adolescents) had free time, they'd be doing something destructive." This is not to say that there is no free time away from staff during a day, but rather that free time is fit into a scheduled day.

Daily program is similar to the program in Setting 1, with the exception that children and adolescents have a bit more "free time" after school, usually from 3:00 PM to 6:00 PM. And because there is a commitment to the "open setting" despite the conflicts presented, children and adolescents are able to use outdoor spaces during these times, away from the direct watch of staff.

Summary Comparison of the Settings/Hypotheses

A comparison of the two settings will serve as a summary of the descriptions presented and will help clarify how social and physical environments can create a context which supports particular privacy-related experiences and behaviors. A point-by-point account of the similarities of and differences between the two settings will provide the basis for the hypotheses of the present investigation.

The physical design of each setting was examined, with a focus on the availability of spaces which allows for chosen alone time for children. Since both facilities are under the auspices of the New York State Department of Mental Hygiene, the same philosophical rationale was followed in building each facility. In fact, the design of Setting 2 was based on the same plans of those used in Setting 1, built one year earlier. The result is two very similar physical plants. For example, the physical layout of spaces is comparable for both facilities: living areas (also called houses), recreation areas, and school areas are clustered similarly.

Equally important, each facility has a similar distribution of single-person and multiple-person bedrooms: this variable is critical to the proposed investigation. Past studies in institutional settings have shown that bedrooms tend to be used by one person at a time, despite the number of residents assigned to them (Ittelson, Proshansky and Rivlin, 1970; Wolfe, 1975). Bedrooms marked as single-person rooms had the broadest range of activities occurring in them, while those designated as multiple-person rooms had more isolated passive kinds of behaviors occurring in them (Ittelson, Proshansky & Rivlin, 1970). Based on these

results, the proposed investigation posits that bedroom occupancy is important in residents' perceived and real choice. Specifically, it is predicted that residents occupying single-person bedrooms will have more choice and more opportunities for privacy as chosen aloneness than will residents occupying multiple-person bedrooms.

Returning to a general comparison of the two settings, there are some differences in physical design, functional use of space, and policy, across settings. In Setting 1, recreation areas, living areas, and school areas are housed in one building and are connected by a series of corridors making it possible to use indoor spaces without going outside and removing the outdoors from free use. Results of formal observations of the facility reveal that outdoor spaces are almost never used; corridors are used by children only for supervised travel to and from other spaces. In contrast, the same living areas, recreation areas, and school areas of Setting 2 are spread across a grassy campus (i.e., the "open setting"). Thus, children in Setting 2 must use outdoor areas for travel. In fact, informal observations of that setting show that children are often outdoors alone during nonschool hours, usually sitting or traveling. And outdoor space was often used during after-school hours. Thus, the use of the outdoors allows children and adolescents to be away from direct supervision by staff.

The separation of the administrative areas from the living areas in Setting 2 as compared to the physical proximity of these areas in Setting 1 may contribute to differences with respect to residents' relationship to other people (i.e., intimacy), in particular, regarding residents' visits with their assigned social workers. In both facilities individual therapy sessions with social workers take place in the social worker's office. However, in Setting 1 social workers are often seen with individual

residents in informal situations in residents' living areas. Similarly, residents in Setting 1 can easily stop by a social worker's office and engage in casual conversation with a social worker. There are less frequent occurrences in Setting 2 where social workers and children must travel from one building to another to visit with each other formally. The varied ease or difficulty in meeting with social workers may relate to reported experiential differences of residents across settings with regard to privacy with another person. Data of an earlier study reveal that residents in Setting 1 did, in fact, cite times spent with their social workers as a "privacy" situation (Wolfe & Golan, 1976).

In each setting, there have been both physical design and policy changes over time. Most notable are the recent design and policy changes with regard to the seclusion rooms in the living areas of both Setting 1 and Setting 2. In the adolescent boys' house of Setting 1 where there used to be only one quiet room per living area or house, there are now three, one near each cluster of four bedrooms. The adolescent girls make use of the one seclusion room in their temporary quarters. In Setting 2, on the other hand, the one seclusion room in each living area or cottage has been used so sporadically to the point where it is seldom used; in one unit, the seclusion room had even been closed off for a while.

In Setting 1, there has been another physical design change. Two years ago, provisions were made which gave residents in each living area a small lounge to which they could retreat to be alone with one or two other people. Investigators of the City University of New York research team have closely followed policy decisions and space use of this room. The room is, indeed, used by children most often to be alone or with one or two other residents or social workers (McCarthy, forthcoming). The availability of such a room in Setting 1 as compared to its absence in

Setting 2 may additionally contribute to differences in privacy experiences.

Finally, in Setting 1 there has been a change in the shared use of house areas by adolescent boys and girls. Where adolescent boys and girls once occupied the same house (having separate sleeping areas), they are now in separate houses altogether, thus having little contact with one another during free time. By contrast, in Setting 2 cottages are sex-integrated, which allows boys and girls to spend time together if they wish.

Therapeutic philosophies and goals were explored in each setting. For the most part, philosophy and goals were similar in each facility, with an emphasis on normalization. In addition, children's services and treatment approaches were alike.

The major difference in approach was in the use of the "open setting" approach in Setting 2 (dictated in part by the physical environment), compared to its absence in Setting 1. While administrative staff in Setting 2 questioned the appropriateness of the open setting for clients, they were, nonetheless, committed to a nonrestrictive environment. This was revealed in policy and space use related to privacy--and sometimes in sharp contrast to Setting 1.

Relevant to the present investigation, the "open setting" approach carries with it notions about containment of residents by locked doors. At the time of the present investigation, locks in Setting 2 were new additions on cottage doors and the use of a locked door was sporadic. Thus, residents may have perceived themselves as being able to move freely between the indoors and outdoors; in fact, informal observations revealed this movement to be the case. In Setting 1, on the other hand, doors to the houses were always locked and residents were not free to

go from the house areas to other areas.

Attitudes of staff who work directly with residents have been examined through formal interviews. Attitudes about children spending time in chosen physical aloneness are similar across settings. Staff are generally concerned with supervision, but at the same time see the importance of aloneness for residents; the result is a continual re-evaluation of supervision with respect to chosen aloneness.

Daily program was examined according to the amount of programmed and free time provided daily for children and according to the number of other children a child must be with over the course of a day. Programming was similar across the two facilities: children were in school from the morning until 3:00 PM, given some free time in the late afternoon and were in structured group recreation in the evening. However, where residents of Setting 1 were generally confined to the house areas during free time, residents of Setting 2 were given a broader range of movement.

In summary, Settings 1 and 2 are similar in the children they service, general philosophy and treatment, daily programming, and many aspects of the physical design. However, there are some variations in physical design and policy which may contribute to differing experiences with privacy as chosen aloneness for residents across settings. These variations are:

1) The "open setting design"of Setting 2 as compared to the physical containment of Setting 1; residents in Setting 2 use the outdoors more than do residents of Setting 1. Consequently, residents of Setting 2 may see the outdoors as a place allowing for privacy as chosen aloneness.
2) The policy of keeping doors unlocked in the cottages of

Setting 2 compared to the constant use of locked doors to house areas in Setting 1. This is still connected to the "open setting" approach described. As a result of this practice, residents of Setting 2 are able to move freely from the cottage areas to outdoor areas, a situation which residents may connect to the freedom to choose physical aloneness, related to privacy.

3) The geographic proximity of administrative areas to living areas in Setting 1 allows for easy contact between residents and their social workers, a situation which may be perceived by residents as a privacy situation (i.e., privacy as intimacy, a situation of privacy between two or three people). In Setting 2, administrative areas are located quite apart from living areas.

4) The lounge/den area in Setting 1 compared to the absence of a comparable space in Setting 2; such an area potentially allows for privacy as chosen aloneness and/or privacy as intimacy.

5) The increased importance of the seclusion rooms in Setting 1 compared to the decreasing and sporadic use of the seclusion rooms in Setting 2. Policy regarding seclusion room use may relate to the association of privacy as aloneness with emotional upset for residents in Setting 1, while such as association may not hold for children in Setting 2.

6) The separation of adolescent boys and girls in the house areas in Setting 1, compared to the cottages being shared by boys and girls in Setting 2. The usual concern adolescents express about heterosexual relationships may show up in the privacy

concepts reported by residents in Setting 2, but not for residents in Setting 1.

And finally, there is a variation within each of the two settings which may account for differing experiences of privacy as chosen aloneness for residents within settings. That is:

7) The presence of single-person bedrooms and multiple-person bedrooms (2-person or 4-person bedrooms) in each setting. Residents who occupy single-person bedrooms may see themselves as having more choice in privacy situations than do residents who share a bedroom with others.

Hypotheses

Taking setting of residence into account, one can predict that reported experiences of privacy as chosen aloneness will vary across settings. For while there seem to be opportunities for privacy as chosen aloneness in both settings, the nature of the places used to achieve privacy as chosen aloneness differ. Based on these differences, it is expected that residents' reported experiences with privacy will vary across settings. A number of hypotheses related to this will be tested, including:

Hypothesis I. As compared to residents of Setting 1, residents of Setting 2 will more often cite outdoor spaces as a private place.

Hypothesis II. Residents of Setting 2 will more often include "choice" in their concepts of privacy than will residents in Setting 1.

Hypothesis III. Residents of Setting 1 will more often describe privacy in terms of intimate situations as compared to resident of Setting 2 (an intimate situation being two or more people separating themselves from a larger group).

Hypothesis IV. Residents of Setting 1 will more often describe

privacy as chosen aloneness in relation to emotional upset than will residents of Setting 2.

Hypothesis V. Compared with residents of Setting 1, residents of Setting 2 will more frequently cite heterosexual experiences in relation to privacy.

And considering bedroom occupancy, another hypothesis will be explored.

Hypothesis VI. Reported privacy concepts of residents occupying single-person bedrooms will reflect "chosen aloneness" more often than will reported privacy concepts of children in multiple-person bedrooms.

These hypotheses are only part of the proposed investigation. Central to the research is the notion that residents will create experiences of privacy as chosen aloneness for themselves, sometimes regardless of setting of residence and bedroom occupancy and that these experiences would be significant to individual behavior and other experiences. Thus, another set of hypotheses assumes that individual residents' experiences with privacy as chosen aloneness are related to reported concepts, behaviors when in social situations, and measured levels of self-esteem. These are as follows:

Hypothesis VII. Residents who involve themselves in privacy as chosen aloneness will, when in social situations, be more involved in positive social interactions than in aggressive or isolated behaviors; residents who have experiences with privacy as chosen aloneness less often will more often be invloved in aggressive or isolated behaviors than in positive social interactions when in social situations.

Hypothesis VIII. Residents who involve themselves in privacy as chosen aloneness will exhibit higher levels of self-esteem than will residents who have fewer such experiences.

Hypothesis IX. Residents who involve themselves in privacy as chosen alonenss will more often report "chosen aloneness" in their concepts of privacy than will residents who have such experiences less frequently.

Where applicable, these same predictions will be examined with respect to nonchosen aloneness, although it is unlikely that the relationships will be the same under these conditions.

# Chapter VI

## METHODS AND PROCEDURE

### Overview of Methodology

A study with 35 adolescents living in one of two residential psychiatric facilities was conducted. The two facilities were similar in patient population and general goals, but varied in the opportunities each provided for privacy as chosen aloneness.

Observational data were collected on the 35 adolescents as a way of understanding their experiences with privacy as chosen aloneness and their behaviors when in social situations.

Interviews which dealt with concepts of privacy were administered to the same 35 adolescents.

Log data were collected to supplement observational data, with particular focus on medication schedules and inappropriate behaviors of residents as reported by the staff.

A self-esteem scale was administered to the study population.

Finally, various staff people were asked to rate severity of illness, behavior and prognosis for each individual in the study sample.

Data were collected by use of: 1) time-sampling observations; 2) event sampling observation; 3) interviews; 4) a self-esteem scale; 5) a staff perception of client scale; 6) log notes; and, 7) census data.

### Techniques

1) A time-sampling technique was used to describe and quantify behavior patterns and use of space of the 35 residents selected in the two settings. The list of behaviors used was derived from previous studies of a children's psychiatric facility (see Rivlin & Wolfe, 1972), and has been adapted to include more subtle activities of aloneness and social

interaction (see Appendix D for listing of behaviors). For purposes of data analysis, these activities will be grouped into one of four categories: 1) positive social interactions; 2) aggression; 3) isolated active behaviors; and, 4) isolated passive behaviors. Some activities clearly fall into only one of the four categories; for example, reading is distinctly an isolated active behavior. Other activities may fall into one category or another, depending on a person's involvement with other people. For example, if a person is playing alone, that activity falls under isolated active behavior. But if a person is playing with other people, the behavior is categorized as positive social interaction.

In each setting, observations were conducted in the mornings before the start of the school day, during the lunch hour, and after school hours on Tuesdays, Wednesdays, and Thursdays. These hours represent the least structured time of day in each setting; they are nonschool hours, where residents have the most choice in selecting their activities and with whom they engage. Similarly, residents can select, within limits, where they want to be.

Observations were conducted in one setting at a time. During each week of observations, behaviors of each of five residents were recorded. This number allowed observers to identify chosen residents easily, avoiding the problem of observers having to remember too many people and becoming confused. Residents were assigned identification numbers for use by observers.

This set of behavioral data was obtained by having a trained observer follow a predetermined route of specific locations in each facility. When the observer came across one of the five particular residents, she/he recorded the following information: identification number of the resident; location of resident; door position of room (where appropriate);

activity of resident; number and sex of other children with whom the resident was interacting; number and sex of children in that space not involved with the resident; number of staff with whom the resident was interacting; and, number of staff in the space not involved with the resident (see Appendix E for time-sampling observation form).

These observations were conducted every 10 minutes over four hours per day for a total of 24 observations per day per resident. At the end of one day, each of five residents was recorded at 24 activities (a resident was recorded only once per 10-minute interval, even if she/he were seen more than once during that interval). Thus, at the end of the first week, a total of 72 activities were recorded for each of five residents. During the second week of observations, another set of five residents were observed. Weekly observations were alternated between facilities, so that by the end of the eighth week, all 35 residents were observed.

2) An event sampling technique was used to obtain information about the nature of time spent physically alone by each of the 35 residents. During each time-sampling observational period just described, a second observer was stationed in an area where she/he was in view of or could easily locate the five residents being observed during a week. The observer recorded: 1) initiation of the particular resident's alone period (distinguishing if the alone period is self-initiated or not); 2) location; 3) duration of the alone period; 4) door position; 5) frequency and nature of interruptions; and 6) termination of the alone period. Items 1) and 6), in particular, reflect the choice and control aspects of privacy as chosen aloneness, respectively. When required, the observer asked for staff assistance to find out the nature of a particular resident's period of aloneness. Event sampling was conducted of no more

than five residents at any one time (see Appendix F for the event sampling observation form to be used).

Taken together, the time-sampling and event sampling techniques yielded data about selected residents on: 1) amount and nature of time spent in chosen physical aloneness and 2) when in social situations, proportion of time spent in either positive social interaction (e.g., talking, cooperative games), aggression (e.g., physical or verbal abuse towards others, disruptive activities), isolated active behaviors (e.g., reading, watching an activity), and isolated passive behaviors (e.g., sitting, staring into space, pacing).

3) Interviews were conducted with 32 of the 35 clients observed: in Setting 1, 17 clients were interviewed and in Setting 2, 15 clients were interviewed.[1] Interviews covered: 1) residents' concepts about privacy; 2) residents' perceptions about the opportunities the physical and social environment provides for privacy as chosen aloneness; 3) reports of the strategies used by residents to create privacy as chosen aloneness for themselves; and, 4) residents' perceptions about the possibility of interruption by others when they have chosen to be alone. This last item reflects the control dimension of privacy as chosen aloneness (see Appendix G for interview schedule).

A total of 32 residents were interviewed: 17 in Setting 1 and 15 in Setting 2.

4) A measure of self-esteem was obtained by use of a self-esteem scale (Rosenberg, 1965) (see Appendix H for scale). This measure will be compared to behavioral and interview data and is a critical measure of the predicted benefits of the opportunity for privacy as chosen

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[1] Three clients (one boy and one girl in Setting 1 and one boy in Setting 2) refused to participate in the interview situation.

aloneness described. Again, 32 residents were given the scale after the interview.

5) A staff perception of client scale was created and administered to various staff (including, teachers, recreational staff, and cottage staff). Each staff person was asked to individually rate clients selected for the study in the following areas: source of problems; severity of illness; frequency of social, aggressive, and withdrawal kinds of behavior; and, probability of successful return to the community (see Appendix I for scale). This measure was used for comparability of staff perceptions across settings. Additionally, it was used to help determine whether bedroom occupancy was related to staff perceptions of residents.

In each setting, six teachers, nine cottage workers, and two recreation workers were asked to rate each of five residents with whom they worked; each resident was rated by a total of four staff.

6) Log notes were collected to provide an additional measure of the reported behavior of residents. These data were collected by an investigator who reviewed notes recorded by staff about daily incidents which occurred in a given two week period which was not among those weeks of observation. Since incidents of aggression by residents are most commonly recorded in these notes, the log notes will serve as an independent measure of residents' aggressive behaviors.

During observation days, daily log notes were examined with regard to residents who are being observed. Focus was on recorded inappropirate behaviors, restrictions (including use of the seclusion rooms), and medication schedules (see Appendices J and K for forms).

7) Census data were collected during observation days regarding: 1) number of residents in treatment; 2) bedroom occupancy of all residents; 3) dates of birth of all residents; 4) dates of admission of all

residents. The first two measures were used to understand the conditions under which aloneness occurs; the second two measures were used in documenting comparability across settings (see Appendix L for recording forms).

The Study Population

Thirty-five full-care residents were selected for the study. Initially, it was hoped that 20 residents would be drawn from each setting for a total of 40 residents. However, criteria for selection, coupled with the limited number of full-care residents in treatment, contributed to the reduction in the sample size. Thus, the study population was selected as follows:

Setting 1: At the time of the study, there were 19 adolescent boys in treatment, 16 full-care (living in) and three day-care. Of the full-care boys, two went to public schools in the community (thus having different daily experiences from other residents), one boy was diagnosed as autistic, and another one was eliminated from selection on advice of staff that he should not participate in an interview situation. Thus, 12 boys from Setting 1 were selected for the final study.

There were 10 full-care girls and one day-care girl in the adolescent unit in Setting 1 at the time of the study. Of the 10 full-care girls, two went to public school and one was diagnosed as autistic. Thus, 7 girls from Setting 1 were selected for the final study.

Setting 2: At the time of the study, there were 34 boys in treatment, 11 full-care boys and 23 day-care boys. Of the full-care residents, one went to public school and one was diagnosed as autistic. Nine boys from Setting 2 were selected for the final study.

There were 11 full-care girls and 10 day-care girls in treatment in

Setting 2 at the time of the study. Of the 11 girls, one went to public school, one was on a special program of increased home visits during the week, and two were eliminated from selection on advice by staff that they should not participate in an interview situation. Thus seven girls from Setting 2 were selected for the final study.

It might mentioned that despite the larger number of day-care clients in treatment in Setting 2 over Setting 1, in both settings day-care clients were at the facilities only during school hours. They seldom used living quarters and were not on the grounds during scheduled free time. Also space accommodations were provided for the additional day-care clients in Setting 2 (e.g., more classrooms were in active use), thus avoiding problems in comparability of density across settings.

The composition of the two samples selected from each setting was similar along several dimensions.

Residents in both settings were most often diagnosed as having "behavioral disorders of childhood and adolescence" or some form of schizophrenia (e.g., childhood, chronic undifferentiated). Most residents' problems were seen as moderate or severe by staff clinicians, with present hospitalization projected at two years or greater. These pieces of information were obtained from individual client records, categorized in standardized charts which were used equally by both Setting 1 and 2 (see Appendices M and N for these charts). Most residents in both settings were on a daily schedule of psychotropic drugs (e.g., thorazine, stelazine); a few residents in each setting received these drugs only on an as-needed basis.

The mean ages for residents selected for study were 14.8 years and 14.3 years in Setting 1 and Setting 2, respectively. The average length of present hospitalization was 11.6 months for residents of Setting 1 and

11.0 months for residents of Setting 2. Table 1 shows these figures by setting of residence and sex.

The ethnic makeup of the two groups was similar: for the most part, residents were black or of Hispanic origin. The slightly greater Hispanic population of Setting 1 and slightly greater black population of Setting 2 reflect the ethnic composition of the different parts of New York City from which the samples were drawn. Table 2 shows ethnic composition by setting of residence and sex.

The one major difference in residents across settings was in bedroom occupancy. In Setting 1, 10 of the 12 boys occupied multiple-person bedrooms, with the remaining two boys occupying single-person bedrooms. In Setting 1, all the girls occupied multiple-person bedrooms. In Setting 2, the distribution was more even: five boys and three girls occupied single-person bedrooms; four boys and four girls occupied multiple-person bedrooms. Figures are shown in Table 3.

Preparation. Preparation for data collection of the present investigation was begun in January, 1977. At this time, the investigator arranged a meeting with residents and staff to introduce herself and the research. She explained that she and her colleagues were interested in the use of space in that particular facility and that this information could be helpful in the planning of treatment settings. She described the procedures to be used in the investigation (observations and interviews) and stressed that she was not interested in names of people, nor in evaluating people and situations in any way. Questions of staff and residents were answered at this time.

Training and reliability. Prior to the formal observations, the investigator and observers practiced observational techniques at each of the two settings. This was useful for piloting instruments and obtaining

Table 1. Mean Ages and Length of Present Hospitalization by Setting of Residence and Sex

| Source | N[a] | Age (in years) | Length of Hospitalization (mos.) |
|---|---|---|---|
| Setting 1 | 19 | 14.8 | 11.6 |
| Boys | 12 | 14.9 | 10.3 |
| Girls | 7 | 14.9 | 14.0 |
| Setting 2 | 16 | 14.3 | 11.0 |
| Boys | 9 | 14.0 | 11.2 |
| Girls | 7 | 14.7 | 10.8 |

[a]number of residents

Table 2. Ethnic Composition by Setting of Residence and Sex

| Source | Hispanic | | Black | | White | | Group Totals |
|---|---|---|---|---|---|---|---|
| | n[a] | %[b] | n[a] | %[b] | n[a] | %[b] | N[a] |
| Setting 1 | 6 | 31.6 | 10 | 52.6 | 3 | 15.8 | 19 |
| Boys | 2 | 16.6 | 8 | 66.7 | 2 | 16.6 | 12 |
| Girls | 4 | 57.1 | 2 | 28.6 | 1 | 14.9 | 7 |
| Setting 2 | 3 | 18.8 | 11 | 68.8 | 2 | 12.5 | 16 |
| Boys | 2 | 22.2 | 6 | 66.3 | 1 | 11.1 | 9 |
| Girls | 1 | 14.9 | 5 | 71.4 | 1 | 14.9 | 7 |

[a]number of residents

[b]based on group totals

Table 3. Bedroom Occupancy by Setting of Residence and Sex

| Source | Single Bedroom | | Multiple Bedroom | | Group Totals |
|---|---|---|---|---|---|
| | n[a] | %[b] | n[a] | %[b] | N[a] |
| Setting 1 | 2 | 10.5 | 17 | 89.5 | 19 |
| Boys | 2 | 16.7 | 10 | 8.3 | 12 |
| Girls | 0 | - | 7 | 100.0 | 7 |
| Setting 2 | 8 | 50.0 | 8 | 50.0 | 16 |
| Boys | 5 | 55.6 | 4 | 44.4 | 9 |
| Girls | 3 | 42.9 | 4 | 57.1 | 7 |

[a]number of residents

[b]based on group totals

reliability, but also familiarized staff and residents with the observation procedures.

Interobserver reliability was obtained for the time sampling technique. Overall interobserver agreement among three trained observers was 95.2% (on the following measures: recognition of each client, activity of client, level of interaction with other people, number and kinds of people with whom client was either interacting or who were present in the room, and room location). Interobserver agreement on activity was 94.2% and on type of activity was 90.4%.

Data collection. Actual data collection took place from the last week of March, 1977 to the first week of June, 1977. Beginning in one setting, observations and collection of log data relevant to observations were begun on a Tuesday and continued through Thursday of that week. On Friday and the following Monday, the five residents who were observed were interviewed and were administered the self-esteem scale. Beginning on the next Tuesday, the same procedure was followed in the second setting. Settings were alternated each week until, at the end of eight weeks, the data were collected for each resident in each of the two settings. Concurrent with collection of these data, census data and medication schedules were obtained and kept up to date.

Following collection of data, the principal investigator returned to each of the two facilities and examined log notes of a two-week period that was not among the weeks observed. At that time, staff completed individual client scales.

Methods of Analyses. The present investigation predicts that the residents' setting and bedroom occupancy will be related to residents' reported privacy concepts (Hypotheses I through VI). These hypotheses were examined by a content analysis of interview questions, where residents

were grouped by setting and bedroom occupancy. The content analysis of interview responses provides information about residents' experiences within an institutional setting in relation to privacy as chosen aloneness as well as to other aspects of privacy (e.g., privacy as control over information).

A second set of predictions studies the relationships among residents' actual experiences of privacy as chosen aloneness, residents' reported privacy concepts, residents' behaviors in social situations, and measured levels of self-esteem, regardless of setting or bedroom occupancy (Hypotheses VII, VIII, IX).

In order to examine this latter set of hypotheses, the research design yielded several dependent measures, including: 1) an index on the experience of privacy as chosen alonenss; 2) scores reflecting residents' behaviors when in social situations; and, 3) measured levels of self-esteem.

These measures were derived as follows:

1) An index of the experience of privacy as chosen aloneness was obtained for each resident. This index was based on the frequency of chosen aloneness situations (obtained from both the time sampling and event sampling techniques). Initially, it was hoped that the index would be a composite of frequency of, duration of, and number of interruptions by other people during the time a client chose to be alone. These latter two pieces of information were to have been obtained from the event sampling technique. However, to obtain this information would have in itself been an intrusion on the client's aloneness; therefore, they were omitted from the index.

Since some analyses were to be performed in relation to nonchosen aloneness, a nonchosen aloneness score was also obtained for each resident.

This score was based on the frequency of times residents were alone, based seemingly on something other than the resident choosing to be alone on his/her own volition (usually these were times the resident was instructed by staff to go to his/her room).

2) Each resident was given four social interaction scores, based on the proportion of instances the resident was observed in each of positive social interactions, isolated active behaviors, isolated passive behaviors, and aggression compared to the total instances of observed behavior when in social situations. Thus, the scores were as follows:

$$\text{positive social interactions} = \frac{\#\text{ of positive social interactions}}{\text{total }\#\text{ of behaviors in social situations}};$$

$$\text{isolated active behaviors score} = \frac{\#\text{ of isolated active behaviors}}{\text{total }\#\text{ of behaviors in social situations}};$$

and,

$$\text{isolated passive behavior score} = \frac{\#\text{ of isolated passive behaviors}}{\text{total }\#\text{ of behaviors in social situations}}.$$

The aggression scores for clients when in social situations was derived differently. The aggression score when in social situations logically should have been: $\frac{\#\text{ of aggressive behaviors}}{\text{total }\#\text{ of behaviors in social situations}}$. However, so few incidents of aggression were observed, making an aggression score derived in this way meaningless. Thus, aggression scores (when in social situations) were taken from log notes of a two week period close to the time of observations. An Aggression score for each resident was the frequency of times a resident was recorded in log notes as having been involved in an acting out situation (based on a total of 28 entries for each client).

3) Residents' levels of self-esteem were derived following Rosenberg (1965).

The effects of setting differences and bedroom occupancy on these dependent measures were examined by use of univariate and multivariate analysis of variance techniques. Also, in order to explore the potential relationships among the different dependent measures, correlations were obtained between pairs of dependent measure scores.

The content analysis of interview responses was also compared to these behavioral scores, discounting setting of residence and bedroom occupancy. For example, it was expected that residents who displayed a score high on the "experience of privacy as chosen aloneness" index would use "choice of aloneness" as part of their reported definition of privacy.

Correlational analyses (two-tailed) and analyses of variance were performed with IBM Computer 370, using basic statistical programs from the Statistical Package for the Social Sciences (1975).

Statistical tests of content analyses of interviews were generally performed by use of the Fisher exact test of probability, with occasional use of z scores, where possible.

Most often, results will be taken to be statistically significant at the .05 level of significance. In the cases of correlational analyses, a correlation coefficient will be treated as significant if its value is .40 or higher, despite level of statistical significance. At times, results which merely approach statistical significance will be noted because of observed trends among findings in this study or in related studies.

In summary, both qualitative and quantitative methods of analysis were used. Where possible statistical analyses were performed. However, the nature of the present investigation often defied statistical analyses. This was an in-depth study involving a small sample size; it took place in a natural setting where many variables can have an impact on results. In keeping with the holistic approach, it was more meaningful to explore both converging qualitative and quantitative data, rather than to rely solely on statistical interpretations.

# Chapter VII

# RESULTS

The data obtained from the current investigation will be organized around the hypotheses proposed in the last section of Chapter V. Hypotheses will be presented one at a time, along with related analyses. However, since the bases of these hypotheses rest on the setting configurations described early in Chapter V, the presentation of hypotheses will be prefaced by a brief summary of general results which confirm setting and person similarities and differences across settings. This section appears immediately below, to be followed by a step-by-step analysis of hypotheses.

## The Settings for Study: Descriptive Results

Chapter III described the contextual nature of privacy; privacy was presented as a situationally-based concept. In succeeding chapters, the goals of the present investigation were outlined: in part, the present investigation seeks to consider how the contextual nature of settings contributes to privacy experiences and behaviors. A comparison study of two settings seemed to be a logical approach to this issue. In order for a comparison study of two settings to be meaningful, it is important that there be certain parallels and contrasts across the two settings. Chapter V summarized the similarities and differences between Settings 1 and 2. Informal observations and interviews prior to the actual investigation suggested that the two settings were similar with respect to client population, program and general staff attitudes, but were different in aspects which could conceivably be related to privacy as chosen aloneness. Formal results obtained from the procedures and methodology described in Chapter VI confirm these similarities and differences, thus strengthening

an argument in favor of the design of the present study. These results relate specifically to: 1. the client populations; 2. general staff perceptions of clients; and, 3. client patterns of space use, particularly with respect to freedom of movement throughout the setting.

1. Client population. As shown in Chapter VI, client populations across settings were similar with respect to age, racial background, length of present hospitalization, diagnostic categorization, and designated severity of illness. As importantly, measured levels of self-esteem were similar for clients across settings; in a one-way analysis of variance, setting effects were measured in relation to obtained individual scores of self-esteem and were found to be insignificant ($N=32$, $F=1.44$, $df=1$, $p=.239$).

2. Staff perceptions of clients. Clients were scored on each of the six items of the Staff Perception of Client Scale. These items dealt with staff perceptions of each client's: source and severity of illness, behaviors, and prognosis. The score on each item was simply the mean score of all staff responses to a particular item for a given client. Again, a one-way analysis of variance showed there were no differences across settings on scores for each item (see Table 4, p. 78).

3. Client patterns of space use. Results of formal observations indicated that there were some differences across settings in clients' use of space. Actual space use patterns concur with the description of settings presented in Chapter V. Most importantly, these results support the premise that residents in Setting 2 have more opportunity for privacy as chosen aloneness in terms of the range of spaces they can and do use.

Table 5 (p. 79) shows the client use of particular hospital spaces across settings. For purposes of analysis, spaces were categorized into

Table 4 . Client Mean Scores Across Settings on 'Staff Perceptions of Client' Scale

| Item | Setting 1 | Setting 2 | F (df=1) | p |
|---|---|---|---|---|
| Item 1: Cause of hospitalization (1=Internal; 7=Environment) | 2.95 | 3.08 | .25 | .62 |
| Item 2: Severity of illness (1=Not disturbed; 7=Most disturbed) | 4.08 | 3.71 | .61 | .44 |
| Item 3: Aggressive acting out (1=Almost never; 5=Almost always) | 2.59 | 3.00 | 1.88 | .18 |
| Item 4: Participation in social activities (1=Almost never; 7=Almost always) | 3.12 | 3.21 | .11 | .74 |
| Item 5: Withdrawal kinds of behavior (1=Almost never; 7=Almost always) | 2.67 | 2.31 | 1.37 | .25 |
| Item 6: Chances of return to community (1=Excellent; 5=Very poor) | 3.19 | 2.88 | .87 | .36 |
| | N=19 | N=16 | | |

Table 5. Client Use of Physical Spaces Across Settings
(Mean per cent)

| Physical Space | Setting 1 | Setting 2 | F (df=1) | p |
|---|---|---|---|---|
| Area 1: Indoor Community | 2.75 | 3.43 | .40 | .53 |
| Area 2: Outdoors | 0.00 | 12.98 | 57.2 | <.001 |
| Area 3: Dining Room | 17.56 | 8.90 | 72.3 | <.001 |
| Area 4: Dayroom, Benches | 55.71 | 34.12 | 29.3 | <.001 |
| Area 5: Living Room, Den | 6.34 | 28.81 | 26.9 | .12 |
| Area 6: Bathroom, Showers | 2.65 | 1.40 | 1.3 | .27 |
| Area 7: Bedrooms | 14.99 | 10.38 | 2.6 | .12 |
| Area 7A: Single Bedrooms | 2.15 | 5.91 | 1.6 | .31 |
| Area 7B: Multiple Bedrooms | 12.87 | 4.46 | 12.28 | .01 |
| | N=19 | N=16 | | |

one of seven categories. Indoor community areas included all indoor recreation and administration areas, as well as non-cottage/non-house indoor corridors. Outdoor spaces included outdoor areas surrounding the cottages/houses and the dining room is self-explanatory.

The cottage/house spaces were categorized into four areas, according to accepted function and potential degree of aloneness or being able to be away from the view or physical presence of other people. Area 4 included primarily the dayroom, in addition to the public corridors within each house or cottage, the nurse's stations, and the bench area of Setting 1. Area 5 was made up of the foyers, corridors, and living rooms within the "apartments" of each house or cottage, the laundry rooms, the client den/lounge in the adolescent boys' house of Setting 1, the seclusion rooms, and the outdoors courts of each apartment of Setting 2. Area 6 covered the bathroom and shower room within each apartment (the client bathrooms in Setting 2 located near the dayrooms of Cottage 3 and Cottage 4 were not used at all during observations). And finally, Area 7 included the bedrooms. The bedrooms were also broken down by single-person bedrooms (Area 7A) and by multiple-person bedrooms (Area 7B).

A number of the spaces categorized were used so infrequently that they will be omitted as part of the discussion here. These areas, listed with per cent of use relative to total hospital use of the two settings combined were: the nurse's stations (1.7%); the laundry room (0.2%); the community closet (0.2%); and, the seclusion rooms (0.1%).

Frequency of use of indoor community areas and bathrooms/showers, did not differ across settings. And, as expected, the outdoors was not used at all in Setting 1, while it was used moderately by clients in Setting 2. Most interesting, although not surprising, were the differences in bedroom use, dayroom use and living room use across settings (including

related areas).

The bedrooms were used slightly more in Setting 1 than they were in Setting 2. The higher use of multiple-person bedrooms in Setting 1 over Setting 2 reflects the fact that all but two of the residents in Setting 1 occupied multiple-person bedrooms, compared to the more even distribution in Setting 2 of residents occupying single-person and multiple-person bedrooms. It may have been that the bedrooms were one of the few places clients in Setting 1 could go to be away from staff; clients in Setting 2 may have used the outdoors to achieve this.

There were times, however, where bedroom use was prohibited in both settings, as revealed in log notes taken during observation days. Staff directives given at these times help to explain the greater use of the dayroom in Setting 1 over Setting 2 and the greater use of the living room in Setting 2 over Setting 1. In Setting 1 when residents were restricted from the bedrooms, they were most often specifically directed to the dayroom. On the other hand, when residents in Setting 2 were restricted from the bedrooms, they were seldom directed to another specific area. Thus, despite residents from both settings being forbidden to use the bedrooms at times, residents in Setting 2 seemed to have greater choice in the selection of alternative spaces and may have chosen to use the next most private and least surveilled space, namely, the living room.

Greater use of the dining room in Setting 1 over Setting 2 may reflect a slight variation in the location of the dining rooms across settings. Since the dining room was within the cottages in Setting 2, residents were free to leave the dining room and go to other cottage areas once they completed a meal. In addition, staff may have felt the dining room was close enough to other cottage areas so they could at least indirectly supervise residents in those areas. In Setting 1, on the other

hand, residents remained in the dining room until everyone had completed their meal, and then traveled back to the house as one group, always accompanied by a staff member (the dining room in Setting 1 was somewhat away from the houses).

Finally, client behavior across settings paralleled the similarities and differences of space distribution presented above. Table 6 (p. 83) shows the mean per cent of client behavior in each of the five behavioral categories: privacy as chosen aloneness, positive social interaction, isolated active behaviors, isolated passive behaviors, and aggression (the latter four when in social situations). Because of the infrequency of recorded instances of observed aggression, the aggression score of aggressive behaviors in social situations compared to all other behaviors in social situations was dropped. Instead, aggression scores were obtained from log note entries; this scoring procedure for aggression is to remain in effect throughout.

There were no significant differences across settings in the mean per cent of times residents were observed in experiences with privacy as chosen aloneness, nor in isolated active behaviors when in social situations. However, residents in Setting 2 were more often involved in positive social interactions than were residents in Setting 1; residents in Setting 1 engaged more in isolated passive behaviors and logged aggressive behaviors. These differences may be connected to residents in Setting 2 being able to choose a broader range of spaces within which to interact (away from staff surveillance, perhaps) than residents of Setting 1. In fact, fully one-fifth of all positive social interactions in Setting 2 occurred outdoors.

There was a possibility that bedroom occupancy, rather than setting of residence, was related to these behavioral differences across settings

Table 6 . Client Activity Across Settings
(Mean per cent)

| Behavior | Setting 1 | Setting 2 | F (df=1) | p |
|---|---|---|---|---|
| Privacy as Chosen Aloneness | 3.1 | 4.1 | .31 | .58 |
| Positive Social Interactions | 31.6 | 44.2 | 8.90 | .01 |
| Isolated Active Behaviors | 43.4 | 39.5 | 0.96 | .33 |
| Isolated Passive Behaviors | 23.5 | 14.7 | 6.51 | .02 |
| Aggression | 3.9 | 2.1 [a] | 4.01 | .05 |
| | N=19 | N=16 | | |

[a]This mean reflects log note entries for 10 of the 16 residents of Setting 2; log note entries were not available for the remaining six residents.

(since many more residents in Setting 2 occupied single-person bedrooms than did residents in Setting 1). In order to clarify these relationships, behavioral patterns related to bedroom occupancy will be presented briefly.

First, there were differences in clients' measured levels of self-esteem depending on bedroom occupancy: clients who occupied single-person bedrooms scored higher on self-esteem than did clients occupying multiple-person bedrooms ($N=32$, $F=3.64$, $df=1$, $p=.065$).

There were no differences in staff ratings of clients grouped by bedroom occupancy, as shown in Table 7 (p. 85). The similarities of staff ratings by bedroom occupancy is fortunate, in light of the observed differences by bedroom occupancy in clients' behavior of privacy as chosen aloneness and measured levels of self-esteem.

Table 8 (p. 86) shows the mean percent of client behavior in each of the five behavioral categories, categorized by bedroom occupancy. In contrast to differences across settings, the only behavioral difference by bedroom occupancy was in the amount of time spent in chosen aloneness: residents occupying single-person bedrooms were observed in chosen aloneness somewhat more often than residents occupying multiple-person bedrooms.

Table 9 (p. 87) presents differences in client use of physical spaces by bedroom occupancy. While there were no differences in the use of bedrooms by clients who occupied single-person bedrooms compared with clients who occupied multiple-person bedrooms, an additional analysis of bedroom use revealed that the use of multiple-person bedrooms by occupants of single-person bedrooms was significantly higher than the use of single-person bedrooms by occupants of multiple-person bedrooms ($N=35$, $F=9.28$, $df=1$, $p<.01$). This finding suggests that a multiple-person bedroom may have been perceived by clients to be a more public space than were single-person bedrooms. The argument that this situation is the result of there being more multiple-

Table 7. Client Mean Scores by Bedroom Occupancy on 'Staff Perceptions of Client' Scale

| Item | Single Bedroom | Multiple Bedroom | F (df=1) | p |
|---|---|---|---|---|
| Item 1: Cause of hospitalization (1=Internal; 7=Environment) | 3.08 | 2.98 | .12 | .74 |
| Item 2: Severity of illness (1=Not disturbed; 7=Most disturbed) | 3.96 | 3.89 | .02 | .90 |
| Item 3: Aggressive acting out (1=Almost never; 5=Almost always) | 3.08 | 2.66 | 1.65 | .21 |
| Item 4: Participation in social activities (1=Almost never; 7=Almost always) | 3.22 | 3.13 | .07 | .80 |
| Item 5: Withdrawal kinds of behavior (1=Almost never; 7=Almost always) | 2.49 | 2.52 | .01 | .94 |
| Item 6: Chances of return to community (1=Excellent; 5=Very poor) | 3.13 | 3.01 | .10 | .76 |
| | N=10 | N=25 | | |

Table 8 . Client Activity by Bedroom Occupancy
(Mean per cent)

| Behavior | Single Bedroom | Multiple Bedroom | F (df=1) | p |
|---|---|---|---|---|
| Privacy as Chosen Aloneness | 5.9 | 2.64 | 2.89 | .10 |
| Positive Social Interactions | 41.43 | 35.68 | 1.24 | .27 |
| Isolated Active Behaviors | 41.09 | 41.83 | 0.03 | .87 |
| Isolated Passive Behaviors | 16.33 | 20.71 | 1.13 | .30 |
| Aggression | 2.87 | 3.17 | 0.09 | .77 |
| | N=10 | N=25 | | |

Table 9 . Client Use of Physical Spaces by Bedroom Occupancy (Mean per cent)

| Physical Space | Single Bedroom | Multiple Bedroom | F (df=1) | p |
|---|---|---|---|---|
| Area 1: Indoor Community | 0.98 | 3.90 | 7.41 | .01 |
| Area 2: Outdoors | 9.00 | 4.71 | 2.00 | .17 |
| Area 3: Dining Room | 10.84 | 14.71 | 4.20 | .05 |
| Area 4: Dayroom, Benches | 38.54 | 48.73 | 3.13 | .09 |
| Area 5: Living Room, Den | 24.47 | 13.48 | 3.20 | .08 |
| Area 6: Bathroom, Showers | 2.24 | 2.02 | 0.03 | .86 |
| Area 7: Bedrooms | 13.95 | 12.46 | 0.21 | .65 |
| | N=10 | N=25 | | |

person bedrooms than single-person bedrooms is not supported, particularly when one recalls that overall use of single-person bedrooms was no greater than use of single-person bedrooms.

There were observed differences in client use of physical spaces according to bedroom occupancy, specifically in the use of the indoor community area, the dayroom, the living room, and the dining room. Three of those four areas--the dayroom, the living room, and the dining room--were not only used differently by clients grouped by bedroom occupancy, but also by clients grouped by setting of residence.

Ordinarily, in order to see the effects of bedroom occupancy and setting of residence on individual client use of these, one would perform a two-way analysis of variance. However, since there was such a discrepancy in Setting 1 between the number of occupants in single-person bedrooms and the number occupying multiple-person bedrooms, results of this statistic would be difficult to interpret. Thus, a one-way analysis of variance considering the effects of bedroom occupancy on the use of those spaces was performed for residents of Setting 2 only.

Results indicated that in Setting 2 bedroom occupancy was neither related to dayroom use ($N=16$, $F=.021$, $df=1$, $p=.89$), living room use ($N=16$, $F=.11$, $df=1$, $p=.74$), nor dining room use ($N=16$, $F=.38$, $df=1$, $p=.55$). Thus, one can conclude that the indoor community area was the only area whose use was connected to bedroom occupancy. (An analysis of variance of the effects of bedroom occupancy on indoor community use in Setting 2 only was significant: $N=16$, $F=7.93$, $df=1$, $p=.01$; residents occupying multiple-person bedrooms used the indoor community areas more than residents occupying single-person bedrooms).

The similarities and differences of client variables (self-esteem, staff ratings, use of physical spaces, behaviors) are summarized in Table 10 (p. 89) and will be considered in the analysis of the findings related each hypothesis, to be presented now.

Table 10. Summary Comparison of Client Variables by Setting of Residence and by Bedroom Occupancy

| Variable | By Setting | By Bedroom Occupancy |
|---|---|---|
| Self-esteem | = | Single > Multiple |
| Staff Ratings (all items) | = | = |
| Use of Physical Spaces | | |
| Indoor Community | = | Multiple > Single |
| Outdoors | Setting 2 > Setting 1 | = |
| Dining Room | Setting 1 > Setting 2 | Multiple > Single[a] |
| Dayroom | Setting 1 > Setting 2 | Multiple > Single[a] |
| Living Room | Setting 2 > Setting 1 | Single > Multiple |
| Bathroom/Showers | = | = |
| Bedrooms | Setting 1 > Setting 2 | = |
| Behaviors | | |
| Privacy as Chosen Aloneness | = | Single > Multiple |
| Positive Social Interactions | Setting 2 > Setting 1 | = |
| Isolated Active Behaviors | = | = |
| Isolated Passive Behaviors | Setting 1 > Setting 2 | = |
| Aggressive Behaviors | Setting 1 > Setting 2 | = |

[a]The effects of bedroom occupancy are negated when use of these rooms is examined in Setting 2 only. (Setting 1 does not provide the variability of bedroom occupancy necessary for a meaningful analysis).

Hypotheses

Hypotheses were presented in Chapter V. Hypotheses I through VI suggested that residents' reported concepts of privacy would reflect present environmental experiences, particularly with regard to setting of residence and/or bedroom occupancy. Hypothesis VII indicated a potential relationship between frequency of privacy as chosen aloneness and behaviors when in social situations across setting of residence and bedroom occupancy. Hypothesis VIII predicted that frequency of privacy as chosen aloneness would be positively related to measured self-esteem. And Hypothesis IX predicted a relationship between client behavior and reported privacy concepts. For purposes of analysis, each resident and his/her individual data will be grouped in a variety of ways, depending on hypothesis: sometimes residents will be grouped by setting of residence and/or bedroom occupancy; at other times, residents will be combined across setting and bedroom occupancy.

Reported Experiences with Privacy: Hypothesis I through Hypothesis VI

Interview questions were content analyzed, by phrases and categories children and adolescents typically use to describe privacy. Most of the interview questions as well as the categories used in the content analysis were taken from an interview study, whose sample was 1,000 children and adolescents, living in urban and rural/suburban areas of the United States, in a broad range of housing conditions (Wolfe & Laufer, 1974; Wolfe, Schearer & Laufer, 1976). In that study, categories and phrases used were derived from the actual responses of the sample, rather than having been predetermined a priori by the researchers.

The present investigation used these categories as a guideline. However, other categories and phrases were used in the content analyses as well, based on the nature and variety of responses given by the population

sample of the present investigation.

Content analyses of interview questions were performed in two ways. First, each question was analyzed separately according to the different elements respondents attached to each question (e.g., aloneness, choice, emotional upset). A second analysis looked at responses across privacy questions (Questions 1-3) for each individual. In this latter analysis, a respondent was included in analysis if, for any of those questions, she/he mentioned a particular element being focused on. If, for example, a respondent mentioned aloneness in the definitional question of privacy, and a second respondent mentioned aloneness in a description of a private time, each of these respondents was counted for having mentioned aloneness. (If either of these respondents mentioned aloneness in more than one question, she/he was only counted just once.).

Unless otherwise indicated, percents and other statistics are based on the number of people giving relevant responses to each question.

Hypothesis I. As compared to residents of Setting 1, residents of Setting 2 will more often cite outdoor spaces as a private place.

In response to the question "Can you describe what a private place is like for you?', few respondents in either setting mentioned the outdoors. The only response difference across setting to this question was mention of "a room"; residents in Setting 2 gave this response somewhat more often than did residents in Setting 1 (23.5% vs. 53.3%; $z=1.37$, $p=.15$). (There were no differences across bedroom occupancy in responses to this question.). Interestingly, residents in Setting 1 gave somewhat of a broader range of responses to the question (see Table 11, p. 92 ).

While the outdoors was not cited as a "private place" in either setting, it was viewed as a place to be alone for residents in Setting 2.

Table 11. Responses Across Settings to "Can you describe what a private place is like for you?"

| Type of Place Named | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| A room (my room, my own room) | 4 | 23.5 | 8 | 53.3 | z=1.37; p=.15 |
| Bathroom | - | - | 1 | 6.7 | |
| Den (Setting 1) | 2 | 11.8 | - | - | |
| On unit (Setting house or cottage) | 1 | 5.9 | - | - | |
| A place (unspecified) | 3 | 17.6 | - | - | |
| Home, apartment | 2 | 11.8 | 1 | 6.7 | |
| School | 2 | 11.8 | - | - | |
| Other indoor places | 1 | 5.9 | 2 | 13.3 | |
| Descriptor only (Alone, to relax, to keep valuables) | 2 | 11.8 | 3 | 20.0 | |
| N= | 17 | | 15 | | |

[a] number of respondents

This was evidenced in the question "Where do you go when you want to be alone (in this hospital)?"; 27.8% of the respondents in Setting 2 cited the outdoors, while none of the respondents in Setting 1 named the outdoors ($p=.05$, Fisher exact test of probability; see Table 12, p. 94). These results suggest that clients are, indeed, aware of the possibilities available within the setting, with this sensitivity reflected in response to this last question.

Hypothesis II. Residents of Setting 2 will more often include choice in their concepts of privacy than will residents in Setting 1.

The choice component of privacy was reflected in phrases suggesting volition on the part of respondents; these phrases were used in content analysis of previous studies (Wolfe & Laufer, 1974; Wolfe & Golan, 1976). Phrases which reflect choice include: being alone when you want to, doing what you want, being able to do what you want, being able to be alone, and doing and thinking what you want.

Analysis of the definitional question ("Would you tell me all the things the word privacy means to you?") showed no differences across settings in residents' use of phrases connected to choice ($p > .30$, Fisher exact test of probability; see Table 13, p. 95). There were no differences across settings for other individual questions. And there were no differences by setting in an analysis across all questions in the number of respondents who connected choice with privacy ($p=.54$, Fisher exact test of probability; see Table 14, p. 96).

At best, the choice component is hinted at by residents of Setting 2 in their citing outdoor spaces as a place to be alone, indicating that these residents did perceive themselves as having at least some freedom of movement (see Hypothesis I above).

Table 12. Responses Across Settings to "Where do you go when you want to be alone (in this hospital)?"

| Places Named | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| My room | 4 | 23.5 | 7 | 46.7 | |
| My bed | 3 | 17.6 | - | - | |
| My area | 2 | 11.6 | - | - | |
| Total: Room/Bed/Area | 9 | 52.9 | 7 | 46.7 | |
| Seclusion Room | 3 | 17.6 | 1 | 6.7 | |
| Bathroom | 1 | 5.9 | 3 | 20.0 | |
| Den (Setting 1) | 2 | 11.6 | - | - | |
| Outside | - | - | 5 | 33.3 | p=.05 (Fisher exact test of probability |
| Place with few people | 2 | 11.6 | - | - | |
| Other | 4 | 23.5 | 2 | 13.3 | |
| N= | 17 | | 15 | | |

[a]number of respondents

Table 13. Responses Across Settings to Definitional Question ("Would you tell me all the things the word privacy means to you?")

| Categories of Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone (includes away from others, doing things by myself) | 7 | 41.1 | 5 | 33.3 | |
| With somebody else (includes talk) | 6 | 35.2 | 4 | 26.7 | |
| Choice (includes "being able to", to do "what you want," "when you want") | 3 | 17.7 | 1 | 6.7 | No significant differences within any category |
| No one knows (includes a secret) | 3 | 17.7 | 4 | 26.7 | |
| Unbothered, undisturbed | 1 | 5.9 | 2 | 13.3 | |
| Bathroom/dress-undress | 3 | 17.7 | 1 | 6.7 | |
| Sexual | 1 | 5.9 | - | - | |
| Control access to things/objects | 1 | 5.9 | 2 | 13.3 | |
| Control access to spaces/rooms | - | - | 2 | 13.3 | |
| Emotional upset | 1 | 5.9 | 1 | 6.7 | |
| N= | 17 | | 15 | | |

[a]number of respondents (a respondent may be counted in more than one category)

Table 14. Respondents' Use of Particular Elements Across Questions in Relation to Privacy

(By Setting)

| Element | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone | 10 | 58.8 | 7 | 46.7 | |
| With somebody else; talk | 9 | 52.9 | 5 | 33.3 | |
| Choice | 3 | 17.6 | 4 | 26.7 | |
| No one knows | 3 | 17.6 | 4 | 26.7 | |
| Unbothered, undisturbed | 4 | 23.5 | 5 | 33.3 | |
| Bathroom/dress-undress | 4 | 23.5 | 2 | 13.3 | |
| Sexual | 1 | 5.9 | 4 | 26.6 | $p < .001$ (Fisher exact test of probability) |
| Control access to things/objects | 1 | 5.9 | 2 | 13.3 | |
| Control access to spaces/rooms | 1 | 5.9 | 2 | 13.3 | |
| Emotional upset | 5 | 29.4 | 2 | 13.3 | |
| N= | 17 | | 15 | | |

[a]number of respondents (a respondent may appear in more than one category)

Hypothesis III. Residents of Setting 1 will more often describe privacy in terms of intimate situations as compared to residents of Setting 2.

Since the 1:1 interpersonal situation between client and social worker seemed to be stressed more in Setting 1 than in Setting 2 and since the lounge/den in Setting 1 was often used by a small group of people, it was expected that residents in Setting 1 would cite privacy experiences as interpersonal situations more than would residents in Setting 2.

Analysis of the definitional question showed there to be no differences between settings in the number of clients who mentioned talking or being with somebody else as part of the definition of privacy ($p=.44$, Fisher test of probability). Nor were there differences across settings in the number of residents who mentioned aloneness in definitions ($z=.09$, $p=.93$). Nor were there setting differences to responses in an analysis across all question ($z=.34$, $p=.73$; see Tables 13 and 14, p. 95 and 96).

However, there was some indication that residents in Setting 1 perceived privacy to be an intimate situation (with two or more people), more so than did residents of Setting 2. In response to the question "Tell me the way other people on your unit let you know they want to be private," 42.9% of residents in Setting 1 who described other people's privacy activity said that these people were with others, compared to only 14.3% of those in Setting 2; the reverse pattern held in mention of aloneness as the nature of others' activity ($p=.07$, Fisher exact test of probability; see Table 15, p. 98).

Again, there seems to be an understanding by clients about the nature of privacy situations when they do occur. In Setting 1, where conditions may encourage privacy as intimacy (e.g., the client-social worker relationship), intimacy is, in fact, viewed as a privacy situation. In

Table 15. Responses Across Settings to "Tell me the way other people on your unit let you know they want to be private."

| Categories of Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Nature of Others' Activity: | | | | | |
| With scmebody else (includes talk) | 6 | 42.9 | 2 | 14.3 | p=.07 (Fisher exact test of probability) |
| Alone | 2 | 14.3 | 6 | 42.9 | p=.07 (Fisher exact test of probability) |
| Upset | 1 | 7.1 | - | - | |
| Unspecified | 5 | 35.7 | 6 | 42.9 | |
| N= | 14 | | 14 | | |
| Actions Taken by Others | | | | | |
| Verbal | 10 | 71.4 | 11 | 78.6 | |
| Other actions | 4 | 28.6 | 3 | 21.4 | |
| N= | 14 | | 14 | | |

[a]based on number of respondents giving relevant responses

Setting 2, where there seems to be a number of options for aloneness, clients described a privacy situation as an alone time.

Hypothesis IV. Residents of Setting 1 will more often describe privacy in relation to emotional upset than will residents of Setting 2.

Analysis of the definitional question indicates there were no differences across settings in the use of emotional upset as a definer of privacy (see Table 13). In addition, there were no differences in an analysis by setting across all questions ($p=.26$, Fisher exact test of probability; see Table 14). Nor was emotional upset used to describe the nature of any particular privacy situation. The absence of emotional upset as a general descriptor of privacy may be connected to the fact that the seclusion room (a room where aloneness is potentially synonymous to emotional upset) was seldom used in either setting at the time of the present investigation.

The only time emotional upset appeared significantly in any context was in response to the question "Tell me about a time when something or some person disturbed your feeling of being private." A total of 38.5% of the clients in Setting 1 responding to the question said they were angry or upset after having been disturbed, compared to only 9.1% of clients in Setting 2 responding to the question ($p=.12$, Fisher exact test of probability; see Table 16, p.100).

The somewhat greater use of emotional upset in any context by clients in Setting 1 over those in Setting 2 may reflect the fact that logged aggressive behaviors were somewhat higher for clients in Setting 1 than for clients in Setting 2. Here, one can begin to see the connection between client behaviors and client reported experiences.

Table 16. Responses Across Settings to "Tell me about a time someone or something disturbed your feeling of being private."

| Categories of Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Nature of Situation | | | | | |
| With others | 5 | 38.5 | 3 | 27.3 | |
| Alone | 2 | 15.4 | 3 | 27.3 | |
| Bathroom/dress-undress | 1 | 7.7 | 1 | 9.1 | |
| Sexual | - | - | 1 | 9.1 | |
| When upset | 2 | 15.4 | - | - | |
| Unspecified | 2 | 15.4 | - | - | |
| Other | 1 | 7.7 | 3 | 27.3 | |
| N= | 13 | | 11 | | |
| Who Disturbed Her/Him | | | | | |
| Other residents | 5 | 38.5 | 4 | 36.4 | |
| Staff | 4 | 30.8 | 2 | 18.2 | |
| Family members | - | - | 2 | 18.2 | |
| Unspecified | 4 | 30.8 | 3 | 27.3 | |
| N= | 13 | | 11 | | |
| Reaction to Disturbance | | | | | |
| Anger | 5 | 38.5 | 1 | 9.1 | p=.12 (Fisher exact test of probabili |
| Person left situation | 1 | 7.7 | 1 | 9.1 | |
| N= | 13 | | 11 | | |

[a]based on number of respondents giving relevant responses

Hypothesis V. Compared with residents of Setting 1, residents of Setting 2 will more frequently cite heterosexual experiences in relation to privacy.

This hypothesis was based on the different living arrangements of girls and boys in the two settings. In Setting 1 girls and boys occupied different houses, seeing one another only during program time when community areas were used. By contrast, in Setting 2 girls and boys shared the same cottages and often were in contact with one another.

In fact, residents of Setting 2 mentioned experiences related to sexuality more frequently than did residents of Setting 1, particularly in response to the question "Can you describe what a private thing to do is like for you?" Of all clients who responded to the question, 33.3% of residents in Setting 2 made sexual referents (e.g., sleep with my boy/girlfriend) compared to none of the residents in Setting 1 ($p < .001$, Fisher exact test of probability). These same patterns applied for an analysis across all questions (see Table 17, p. 102).

In Setting 1, the relative absence of mixed-sex situations--which is usually a part of ordinary living environments--was reflected in the absence of sexual referents in connection to privacy. It will be argued that references to sexuality in association with privacy is an age-appropriate response for adolescents, with the implication that in order to foster appropriate development (reflected in reported concepts, at the very least), one must provide the appropriate environment.

Hypothesis VI. Reported privacy concepts of residents occupying single-person bedrooms will reflect aloneness more often than will reported privacy concepts of residents occupying multiple-person bedrooms.

In contrast to what was predicted in this hypothesis, residents occupying multiple-person bedrooms mentioned aloneness more than did

Table 17. Responses Across Settings to "Can you describe what a private thing to do is like for you?"

| Categories of Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone (includes doing something by myself) | 6 | 50.0 | 3 | 25.0 | |
| With somebody else | 1 | 8.3 | 1 | 8.3 | |
| Doing a particular activity | 4 | 33.3 | 2 | 16.7 | |
| Don't want others to know | 1 | 8.3 | 2 | 16.7 | |
| Sexual | - | - | 4 | 33.0 | $p < .001$ (Fisher exact test of probability) |
| N= | 12 | | 12 | | |

[a]based on number of respondents giving relevant responses

residents occupying single-person bedrooms. This relationship surfaced first in the definitional question, where aloneness was mentioned by 50% of respondents occupying multiple-person bedrooms, compared to its mention by just 20% of respondents occupying single-person bedrooms ($p=.11$, Fisher exact test of probability; see Table 18, p. 104).

In response to the question "Can you describe what a private time is like for you?", several residents occupying multiple-person bedrooms described alone situations (42.9%) compared to the absence of that reference by residents occupying single-person bedrooms ($p=.11$, Fisher exact test of probability; see Table 19, p. 105).

And finally, an analysis by bedroom occupancy across all questions showed that more residents occupying multiple-person bedrooms mentioned aloneness compared to residents occupying single-person bedrooms ($p=.08$, Fisher exact test of probability; see Table 20, p. 106).

It is conceivable that residents who occupied multiple-person bedrooms described the kind of privacy experience they <u>wanted</u> and thought could be achieved by having their own bedroom (i.e., privacy as aloneness). Residents who occupied single-person bedrooms may have been more aware that the commodity of having-one's-own-bedroom, in fact, did not <u>insure</u> privacy as <u>chosen</u> aloneness. In the institutional structure, the ownership and use of a single-person bedroom does not necessarily allow the client to keep other people from coming in the bedroom. Nor does the client necessarily have the option to use his/her own bedroom freely.

There were no differences by setting of residence in client use of aloneness in the two questions described above or across all questions.

Table 18. Responses by Bedroom Occupancy to Definitional Question ("Would you tell me all the things the word privacy means to you?")

| Categories of Responses | Single Bedroom | | Multiple Bedroom | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone | 2 | 20.0 | 11 | 50.0 | p=.11 (Fisher exact test of probability) |
| With somebody else; talk | 3 | 30.0 | 7 | 31.8 | |
| Choice | - | - | 4 | 18.2 | |
| No one knows | 2 | 20.0 | 5 | 22.7 | |
| Unbothered, undisturbed | - | | 3 | 13.6 | |
| Bathroom/dress-undress | - | | 4 | 18.2 | |
| Control access to things/objects | 2 | 20.0 | 1 | 4.5 | |
| Control access to spaces/rooms | 1 | 10.0 | 1 | 4.5 | |
| N= | 10 | | 22 | | |

[a]based on number of respondents giving relevant responses

Table 19 . Responses by Bedroom Occupancy to "Can you describe what a private time is like for you?"

| Categories of Responses | Single Bedroom | | Multiple Bedroom | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone | - | - | 6 | 42.9 | p=.11 (Fisher exact test of probability) |
| With somebody | 2 | 40.0 | 2 | 14.3 | |
| When upset | - | | 2 | 14.3 | |
| Other (e.g., to do something) | 3 | 60.0 | 4 | 28.6 | |
| N= | 5 | | 14 | | |

[a]based on number of respondents giving relevant responses

Table 20. Respondents' Use of Particular Elements Across Questions in Relation to Privacy

(By Bedroom Occupancy)

| Element | Single Bedroom | | Multiple Bedroom | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Alone | 3 | 30.0 | 14 | 63.6 | p=.08 (Fisher exact test of probability) |
| With somebody else; talk | 4 | 40.0 | 10 | 45.5 | |
| Choice | 2 | 20.0 | 5 | 22.7 | |
| No one knows | 2 | 20.0 | 5 | 22.7 | |
| Unbothered, undisturbed | 3 | 30.0 | 6 | 27.3 | |
| Bathroom/dress-undress | - | - | 6 | 27.3 | p=.08 (Fisher exact test of probability) |
| Sexual | 2 | 20.0 | 2 | 9.1 | |
| Control access to things/objects | 2 | 20.0 | 1 | 4.5 | |
| Control access to spaces/rooms | 1 | 10.0 | 2 | 9.1 | |
| Emotional upset | 2 | 20.0 | 5 | 22.7 | |
| N= | 10 | | 22 | | |

[a] number of respondents

Additional results related to bedroom occupancy and aloneness. Other questions, which focused directly on aloneness, might help to support the reversal in findings related to this hypothesis. In response to the question "In this hospital, do you usually prefer to be by yourself or do you usually prefer to be with other people?", residents occupying single-person bedrooms were somewhat more likely to mention "with other people" (66.7% compared to 38.1% of residents occupying multiple-person bedrooms; $p=.15$, Fisher exact test of probability). There were no differences across setting in the number of clients who mentioned with others ($z=.67$, $p=.50$).

When asked the question "Do you have a private place for yourself in the hospital?", 40.9% of all residents who shared a bedroom said "No", compared to only 20.0% of all residents who had their own bedrooms ($p < .001$, Fisher exact test of probability). (There was no difference across settings in the number of respondents who said no to this question; $z=.32$, $p=.75$). Of those respondents who said they did have a private place, 87.5% of all residents occupying single-person bedrooms said "my room" compared to 15.4% of residents occupying multiple-person bedrooms giving that response ($p=.002$, Fisher exact test of probability).

However, since more residents in Setting 2 compared to Setting 1 said "my room" in response to this question ($p=.06$, Fisher exact test of probability), it is important to examine which of the two--setting of resident or bedroom occupancy--contributed more to differences. Again, client responses by bedroom occupancy in Setting 2 only were examined. Results indicated that in this case, bedroom occupancy seemed to account for differences in client responses: residents in Setting 2 who occupied single-person bedrooms mentioned "my room" more often than

did residents occupying multiple-person bedrooms (p=.015, Fisher exact test of probability).See Tables 21, p. 109 and 22, p. 110 for analyses by bedroom occupancy and by setting of residence on whether or not a client saw her/himself as having a private place.

Taken together, these results suggest that clients who occupied single-person bedrooms saw their bedrooms as providing them with opportunities for privacy, compared with residents who occupied multiple-person bedrooms who did not. This was true despite the fact that bedrooms were used equally often by residents who occupied multiple-person bedrooms as they were by residents who occupied single-person bedrooms. Recall, however, that residents who occupied single-person bedrooms were somewhat more involved in privacy as chosen aloneness than were residents who occupied multiple-person bedrooms. It may be that the experience of having one's own bedroom encourages one to seek and maintain privacy as chosen aloneness in other places. This will be treated more fully in the next chapter in a discussion of bedroom occupancy.

Responses to the question about perceived frequency of interruption when alone initially revealed that residents occupying single-person bedrooms felt interrupted more often than did residents occupying multiple-person bedrooms (N=32, F=3.77, df=1, p=.06). However, an inspection of the effects of setting of residence on perceived interruption indicates that setting of residence rather than bedroom occupancy accounted for client differences on this question. Specifically, residents in Setting 2 indicated they often felt interrupted, compared to residents of Setting 1 who indicated seldom feeling interrupted (N=32, F=3.5, df=1, p=.07). Coupled with this, a look at the effects of bedroom occupancy on perceived interruption in Setting 2 only (where variability of bedroom occupancy existed) revealed that bedroom occupancy

Table 21. Responses by Bedroom Occupancy to "Do you have a private place for yourself in this hospital?"

| Responses | Single Bedroom | | Multiple Bedroom | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Yes | 8 | 80.0 | 13 | 59.1 | p < .001 (Fisher exact test of probability) |
| No | 2 | 20.0 | 9 | 40.9 | |
| N= | 10 | | 22 | | |
| Place Named (Of respondents who said yes): | | | | | |
| Bedroom | 7 | 87.5 | 2 | 15.4 | p=.002 (Fisher exact test of probability) |
| Living room | 1 | 12.5 | 1 | 7.7 | |
| Bathroom/showers | - | - | 3 | 23.1 | |
| Seclusion room | - | - | 2 | 15.4 | |
| Den (Setting 1) | - | - | 2 | 15.4 | |
| Social worker's office | - | - | 1 | 7.7 | |
| Unspecified | - | - | 2 | 15.4 | |
| Total nonbedroom | 1 | 12.5 | 11 | 84.7 | |
| N= | 8 | | 13 | | |

[a]number of respondents

Table 22. Responses Across Settings to "Do you have a private place for yourself in this hospital?"

| Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Yes | 10 | 58.8 | 11 | 73.3 | |
| No | 7 | 41.2 | 4 | 26.7 | |
| N= | 17 | | 15 | | |
| Place Named (Of respondents who said yes): | | | | | |
| Bedroom | 2 | 20.0 | 7 | 63.6 | p=.06 (Fisher exact test of probability) |
| Living room | 2 | 20.0 | - | - | |
| Bathroom/showers | 1 | 10.0 | 2 | 18.2 | |
| Seclusion room | 1 | 10.0 | 1 | 9.1 | |
| Den (Setting 1) | 2 | 20.0 | - | - | |
| Social worker's office | 1 | 10.0 | - | - | |
| Unspecified | 1 | 10.0 | 1 | 9.1 | |
| Total nonbedroom | 8 | 80.0 | 3 | 27.3 | |
| N= | 10 | | 11 | | |

[a]number of respondents

was not related to perceived interruption (N=16, F=1.1, df=1, p=.31). Taken together, these statistics suggest that, indeed, setting of residence, rather than bedroom occupancy contributes to clients' perceived interruption. Table 23, p. 112 presents complete figures.

Additional results related to interview responses. Interview responses directly connected to Hypotheses I through VI were presented in the preceding pages. Content analysis of other interview questions provided additional information (not directly associated with the findings). This information will be presented briefly.

Clients were asked the question "Can you tell me what a private talk is like for you?" While there were no differences by hospital or bedroom occupancy in either persons engaged in talk with or place referents, there were differences in how a private talk was described. Respondents usually referred to a private talk in one of two ways: (1) by the contents of the talk (e.g., a talk about something or someone) or (2) by the conditions necessary to insure that such a talk be private (e.g., don't want others to hear, nobody else around).

There were no significant differences across settings in the number of respondents who used content vs. conditions as a descriptor of a private talk (z=.3823, p=.70). However, there were differences by bedroom occupancy: single-person bedroom occupants often used contents as a descriptor of a private talk, while multiple-person bedroom occupants more often used conditions necessary to insure a private talk (p=.05, Fisher exact test of probability; see Table 24, p.113).

Another difference in responses by bedroom occupancy may have implications about the meanings of privacy as a reflection of environment. An analysis of elements cited by residents across questions indicated that a substantial number of residents occupying multiple-person bedrooms

Table 23. Responses to Perceived Interruptions when Alone (By Setting; by Bedroom Occupancy)

By Setting

| Frequency of Perceived Interruption when Alone | Setting 1 | | Setting 2 | |
|---|---|---|---|---|
| | n[a] | % | n[a] | % |
| Most of the time | 4 | 26.7 | 7 | 46.7 |
| Sometimes | 5 | 33.3 | 5 | 33.3 |
| Hardly ever | 6 | 40.0 | 3 | 20.0 |
| N= | 15 | | 15 | |

[a]number of respondents giving relevant responses

By Bedroom Occupancy

| Frequency of Perceived Interruption when Alone | Single Bedroom | | Multiple Bedroom | |
|---|---|---|---|---|
| | n[a] | % | n[a] | % |
| Most of the time | 5 | 50.0 | 6 | 30.0 |
| Sometimes | 3 | 30.0 | 7 | 35.0 |
| Hardly ever | 2 | 20.0 | 7 | 35.0 |
| N= | 10 | | 20 | |

[a]number of respondents giving relevant responses

Table 24. Responses to "Can you describe what a private talk is like for you?"

(By Setting; by Bedroom Occupancy)

By Setting

| Categories of Responses | Setting 1 | | Setting 2 | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Contents (talk about something) | 3 | 21.4 | 6 | 42.9 | |
| Conditions (don't want others to hear; by ourselves) | 9 | 64.3 | 7 | 50.0 | |
| Other (unspecified; to myself) | 2 | 14.3 | 1 | 7.1 | |
| N= | 14 | | 14 | | |

[a]number of respondents

By Bedroom Occupancy

| Categories of Responses | Single Bedroom | | Multiple Bedroom | | Differences |
|---|---|---|---|---|---|
| | n[a] | % | n[a] | % | |
| Contents | 6 | 60.0 | 4 | 22.2 | p=.05 (Fisher exact test of probability) |
| Conditions | 3 | 30.0 | 12 | 66.7 | |
| Other | 1 | 10.0 | 2 | 11.1 | |
| N= | 10 | | 18 | | |

[a]number of respondents

(27.3%) connected privacy to bathroom activity/dressing-undressing, while no residents occupying single-person bedrooms made this association (p=.08, Fisher exact test of probability; see Table 14, p. 96 ). This finding is interesting in light of research which has shown that non-hospitalized groups of adolescents have seldom made the same connection (Wolfe & Laufer, 1974; Wolfe & Golan, 1975). There were no significant differences across settings in use of this element across all questions.

Following the questions related to privacy, residents were asked about bedroom preferences and about the benefits and disadvantages of both sharing and having one's own room. Of the residents who shared bedrooms, 72.2% said they would prefer to have their own bedroom. Of the residents who had their own bedroom, just 22.2% of those asked said they would rather share a bedroom compared to 77.8% who said they preferred their own room. To summarize, residents who had their own bedrooms were more satisfied with the present situation than were residents who shared a bedroom (p=.0098, Fisher exact test of probability).

Stated advantages about sharing a bedroom included: having a friend, someone to talk to, and not being scared. Some disadvantages mentioned were: fighting, interruptions by others, and stealing. The benefits about having one's own room included: being alone, hanging up personal objects, peace and quiet. Disadvantages included: being scared, and feeling lonesome.

## Relationships Among Client Behaviors: Hypothesis VII

Hypothesis VII. Residents who involve themselves in privacy as chosen aloneness will, when in social situations, more often be involved in positive social interactions than in aggressive or isolated behaviors; residents who less often have experiences

with privacy as chosen aloneness will, when in social situations, more often be involved in aggressive or isolated behaviors than in positive social interactions.

Client behavioral scores of frequency of privacy as chosen aloneness were compared to each of the four behavioral social interaction scores when in social situations, including: positive social; isolated active, isolated passive; and aggressive behaviors.

Clients were grouped by setting of residence and bedroom occupancy and Pearson product-moment correlation coefficients were obtained. A description of each part of Hypothesis VI appears below in sections (a) through (d), accompanied by the results in Table 25 (p. 116).

(a) Residents who involve themselves in privacy as chosen aloneness will engage in positive social interactions when in social situations.

An inspection of these results reveal a general reversal for this part of the hypothesis. That is, residents who were frequently observed in privacy as chosen aloneness were seldom observed in positive social interactions when in social situations. This relationship was statistically significant for residents in Setting 2 and for residents occupying multiple-person bedrooms. The correlation coefficient approached statistical significance for residents in Setting 1.

(b) Residents who involve themselves in privacy as chosen aloneness will not engage in isolated active behaviors when in social situations.

There was a relationship across groups between behavioral experience with privacy as chosen aloneness and isolated active behaviors when in social situations. However, it was different in direction from what was expected. That is, residents who were frequently observed in privacy

Table 25. Correlations Between Privacy as Chosen Aloneness and Behaviors when in Social Situations.

| Source | N[a] | Behaviors when in Social Situations: Positive Social r | p[b] | Isolated Active r | p[b] | Isolated Passive r | p[b] | Aggression r | p[b] |
|---|---|---|---|---|---|---|---|---|---|
| Setting 1 | 19 | -.38 | | .56 | .01 | -.11 | | -.33 | |
| Setting 2 | 16 | -.57 | .02 | .51 | .04 | .18 | | -.30 | |
| Total Settings | 35 | -.37 | | .51 | .002 | -.06 | | -.33 | .06 |
| Single Bedroom Occupants | 10 | -.49 | .15 | .50 | .14 | .09 | | -.46 | .18 |
| Multiple Bedroom Occupants | 25 | -.43 | .03 | .57 | .003 | -.03 | | -.22 | |

[a]number of clients

[b]listed only if $p < .12$ or if $r > .40$

as chosen aloneness were also frequently observed in isolated active behaviors when in social situations. This relationship applied for clients grouped by setting of residence and for multiple-bedroom occupants.

(c) Residents who involve themselves in privacy as chosen aloneness will not engage in isolated passive behaviors when in social situations.

There was no significant relationship between privacy as chosen aloneness and isolated passive behaviors when in social situations. Nor could one detect any consistent trend for this part of the hypothesis.

(d) Residents who involve themselves in privacy as chosen aloneness will not engage in aggressive behaviors when in social situations.

This relationship was confirmed for settings combined. While the correlation coefficients of other subgroups did not achieve statistical significance, all relationships were in the predicted direction.

The overall findings related to this hypothesis are quite complex, when one recalls behavioral differences between clients across settings and by bedroom occupancy, presented at the beginning of this chapter.

The implication was that level of environmental choice had an effect on behaviors, i.e., the investigator earlier postulated that setting of residence and bedroom occupancy, independently and together, created environments with differential levels of choice.

Specifically, residents of Setting 2 were seen as having more choice than residents of Setting 1. And residents occupying single-person bedrooms were seen as having more choice than residents occupying multiple-person bedrooms. Combining these two independent variables, one would

expect that residents in Setting 2 occupying single-person bedrooms would have the greatest degree of choice, while residents in Setting 1 occupying multiple-person bedrooms would have the least amount of choice. Residents in Setting 2 occupying multiple-person bedrooms and residents in Setting 1 occupying single-person bedrooms would fall somewhere in between.

Additionally, in an attempt to decipher a pattern among the different correlation coefficients just presented, it can be argued that the different subgroups of the total sample groups had varying degrees of choice (e.g., girls in Setting 1--all occupying dormitory-style bedrooms--had little choice by virtue of setting of residence and the bedroom set-up; many residents in Setting 2 had a lot of choice, given both setting of residence and the fact that many of them occupied single-person bedrooms).

To these ends, an additional set of analyses was performed which has substantial bearing on results connected to the hypothesis. First, each resident was rated according to degree of choice on two variables, namely setting of residence and bedroom occupancy. A resident received one point if she/he lived in Setting 2. And a resident received one point if she/he occupied a single-person bedroom. (Each of these two values represented more choice over the extreme alternative: living in Setting 1; occupying a multiple-person bedroom.).

Residents living in Setting 2 and occupying a single-person bedroom were scored two points; residents living in Setting 1 occupying multiple-person bedrooms received no points; and one point was given to residents in Setting 2 occupying multiple-person bedrooms and residents in Setting 1 occupying single-person bedrooms. In a sense, then, a new independent variable was created, called level of choice and residents were scored

a zero, one or two on this variable.

The effects of level of choice on client behavior is quite revealing, according to a series of one-way analyses of variance. In particular, the three different levels of choice are associated with significant differences in positive social interaction, isolated passive behaviors when in social situations, and frequency of experiences with privacy as chosen aloneness. These relationships are presented in Table 26 (p. 120).

A look at positive social interaction shows that residents with moderate or high choice were involved in positive social interactions somewhat more than residents with low choice. (The columns labelled low, moderate, or high choice, show the mean percentage points for each group's participation in the particular behavior, above (+) or below (-) the mean for the total sample combined.). Residents more frequently involved in isolated passive behaviors were also those with the least choice. And finally, it can be seen that residents with the most choice were more often involved in experiences with privacy as chosen aloneness than were residents with either moderate or little choice.

Taking these configurations together, there is, in fact, a relationship in the direction initially predicted between the experience of privacy as chosen aloneness and each of positive social interactions and isolated passive behaviors when in social situations, for residents with very specific levels of choice. That is, residents who were more frequently involved in positive social interactions were the same residents who more frequently had experiences with privacy as chosen aloneness (the group with the highest choice level). The residents who more infrequently engaged in positive social interactions were the same residents who had fewer experiences with privacy as chosen aloneness (the

Table 26. Client Level of Choice in Relationship to Mean Per Cent of Client Behaviors

| Behavior | Mean % of Total Sample[a] | Deviation from Total Sample Mean[b] | | | Differences | |
|---|---|---|---|---|---|---|
| | | Low choice | Moderate choice | High choice | F | p |
| Positive social interactions | 37.33 | -5.94 | 5.13 | 6.20 | 3.5 | .04 |
| Isolated active (when in social situations) | 41.62 | 1.92 | -2.62 | -0.82 | 0.5 | nsd |
| Isolated passive (when in social situations) | 19.45 | 4.30 | -3.81 | -4.37 | 2.8 | .08 |
| Aggression (when in social situations) | 3.09 | 0.50 | 0.04 | -1.11 | 1.0 | nsd |
| Privacy as chosen aloneness | 3.57 | -0.45 | -1.67 | 3.05 | 2.0 | .15 |

[a] N=35

[b] Figures represent percentage point deviations from mean of total sample

group with the lowest choice level).

To summarize, Hypothesis VII (parts [a] and [c]) are confirmed if one takes into account environmental effects, in this case, setting of residence and bedroom occupancy. The effects of these environmental variables were first translated into levels of choice. Findings then indicated a relationship in the predicted experiences of privacy as chosen aloneness and each of positive social interactions and isolated passive behaviors when in social situations.

Nonchosen Aloneness and Client Behaviors. In order to appreciate the impact of chosen aloneness on client behaviors, it is important to consider the potential relationship between nonchosen aloneness and each of the client behaviors. In the present investigation, nonchosen aloneness is operationally defined as a situation in which a resident is alone because of having been instructed to be alone by a staff person (usually for punitive reasons).

Contrary to the expectation that there would be no relationship between nonchosen aloneness and each of the client behaviors, findings indicated that nonchosen aloneness was related to isolated active and isolated passive behaviors for some subgroups. Table 27 (p. 122) shows these relationships for the different subgroups with Pearson product-moment correlation coefficients.

There was a negative relationship between nonchosen aloneness and isolated active behaviors for residents of Setting 1. There was also a moderately high correlation coefficient for multiple-bedroom occupants.

This pattern is interesting in light of the relationship between nonchosen aloneness and isolated passive behaviors when in social situations. There was a moderately strong positive relationship between these two behaviors for multiple-bedroom occupants. Thus, those residents who were

Table 27. Correlations Between Nonchosen Aloneness and Behaviors when in Social Situations.

| Source | N[a] | Behaviors when in Social Situations: Positive Social r | p[b] | Isolated Active r | p[b] | Isolated Passive r | p[b] | Aggression r | p[b] |
|---|---|---|---|---|---|---|---|---|---|
| Setting 1 | 19 | .07 | | -.47 | .04 | .32 | | .24 | |
| Setting 2 | 16 | -.08 | | -.03 | | .32 | | .25 | |
| Total Settings | 35 | .02 | | -.13 | | .13 | | .16 | |
| Single Bedroom Occupants | 10 | .005 | | -.08 | | .27 | | .20 | |
| Multiple Bedroom Occupants | 25 | -.10 | | -.35 | .08 | .40 | .05 | .25 | |

[a]number of clients

[b]listed only if $p < .12$ or if $r > .40$

often observed in isolated passive behaviors when in social situations were also observed in alone situations because of having been instructed by staff (nonchosen aloneness). These residents were often alone but choice was absent from this form of aloneness.

It follows from this that the ablity to choose aloneness is a critical element. These last results, considered with the results on chosen aloneness, indicate that the degree of choice in aloneness will contribute to the kinds of behaviors one will engage in when in social situations. Residents who frequently engaged in chosen aloneness were also frequently observed in isolated active behaviors when in social situations. Residents who were frequently observed in nonchosen aloneness seldom engaged in isolated active behaviors when in social situations, but instead engaged frequently in isolated passive behaviors in these social situations.

Looking at each of the isolated active behaviors and isolated passive behaviors when in social situations, one can argue that isolated active behaviors are more positively sanctioned than are isolated passive behaviors. It will be shown in the next chapter that isolated active behaviors represent an appropriate behavioral response to the constraints of an institutional structure (despite the institutional goal being to encourage positive social interaction). In addition, it will be argued that isolated active behaviors reflect a client's level of functioning, compared to the withdrawn quality of isolated passive behaviors.

It should be added here that the notion of isolated active behaviors representing a higher level of functioning than isolated passive behaviors is not merely a judgement by this investigator or by other researchers, but rather was confirmed by staff responses on the 'staff perception of client' scale on the item dealing with client's severity of illness. Responses to that item were compared with actual client behaviors. Cor-

relation coefficients indicated that: (1) the more ill a client was considered, the less she/he engaged in isolated active behaviors (N=35, r=-.27, p=.11) and (2) the more ill a client was considered, the more she/he engaged in isolated passive behaviors (N=35, r=-.50, p $<$.01). (Responses to that item were not related to client behaviors of positive social interaction or aggression when in social situations.). These results will serve as further information in evaluating what constitutes appropriate behavior in the institutional structure as it presently exists.

Relationship Between Privacy as Chosen Aloneness and Self-Esteem: Hypothesis VIII

Hypothesis VIII. Residents who involve themselves in privacy as chosen aloneness will exhibit higher levels of self-esteem than residents who have fewer such experiences.

Individual client behavioral scores on privacy as chosen aloneness were compared to each client's measured levels of self-esteem. Again, clients were grouped in several ways and Pearson product-moment correlation coefficients were obtained. Results are presented in Table 28 (p. 125).

Results show there to be no significant relationship between privacy as chosen aloneness and measured level of self-esteem for any population group. Nor could one detect any consistent trend. Thus, in the strictest sense, Hypothesis VIII would be rejected.

However, the relationship between privacy as chosen aloneness and self-esteem cannot be considered apart from bedroom occupancy, particularly when one remembers that: (1) single-bedroom occupants were observed in chosen aloneness situations somewhat more often than were multiple-bedroom occupants (5.9% vs. 2.6%; F=2.89, N=35, df=1, p=.10), and (2) single-bedroom occupants had somewhat higher measured levels of self-

Table 28. Correlations Between Privacy as Chosen Aloneness and Self-esteem

| Source | N[a] | r |
|---|---|---|
| Setting 1 | 17 | .21 |
| Setting 2 | 15 | -.005 |
| Total Settings | 32 | .13 |
| Single Bedroom Occupants | 10 | -.30 |
| Multiple Bedroom Occupants | 22 | .17 |

[a]number of clients

esteem than did multiple bedroom occupants (F=3.64; N=35, df=1, p=.07). These results will be considered in a discussion of bedroom occupancy.

Nonchosen Aloneness and self-esteem. Self-esteem was examined in relationship to nonchosen aloneness. An inspection of the correlation coefficients for all groups indicate there was no significant relationship between self-esteem and nonchosen aloneness (see Table 29, p. 127).

## Relationship Between Privacy Concepts and Behaviors: Hypothesis IX

> Hypothesis IX. Residents who involve themselves in privacy as chosen aloneness will more often report aloneness in their concepts of privacy than will residents who have such experiences less frequently.

This hypothesis explored the relationship between privacy as reported experience and privacy as behavior for individual clients. Client responses to the definitional question were compared to client behaviors of privacy as chosen aloneness. It was expected that clients who mentioned "aloneness" in the definitional question would also be frequently observed in experiences with privacy as chosen aloneness.

The relationships between reported experiences and behavior was undertaken statistically by performing point biserial correlations. A resident was given a value of 2 if she/he mentioned "aloneness" in response to the definitional question on the interview and was given a value of 1 if she/he did not mention aloneness in response to that question. These values were correlated with observed frequency of privacy as chosen aloneness for the total sample combined and for the different subgroups. Thus, a positive correlation would indicate that those who mentioned aloneness were also frequently observed in privacy as chosen aloneness; a negative correlation would indicate that that who did not mention aloneness were frequently observed in privacy as

Table 29. Correlations between Nonchosen Aloneness and Self-esteem

| Source | N[a] | r | p[b] |
|---|---|---|---|
| Setting 1 | 17 | .05 | |
| Setting 2 | 15 | .23 | |
| Total Settings | 32 | .13 | |
| Single Bedroom Occupants | 10 | .07 | |
| Multiple Bedroom Occupants | 22 | .03 | |

[a]number of clients

[b]listed only if $p < .12$ or if $r > .40$

chosen aloneness.

Results show that there was no relationship between client behaviors of privacy as chosen aloneness and the mention of "aloneness" in the definitional question. These results are presented in Table 30 (p. 129).

Nonchosen aloneness and reported privacy experiences. In order to fully appreciate the choice component in aloneness behaviors and reported privacy experiences, analyses of client behaviors of nonchosen aloneness and client definitions of privacy were performed. Point biserial correlations were performed; a positive correlation would indicate that those who mentioned aloneness were also frequently observed in nonchosen aloneness, while a negative correlation would indicate that those who mentioned aloneness were seldom observed in nonchosen aloneness (see Table 31, p. 130).

Results for residents of Setting 1 and for multiple-bedroom occupants indicate that those residents who mentioned aloneness in their privacy definition were seldom observed in behaviors of nonchosen aloneness.

In summary, the use of "aloneness" was negatively related to behaviors of nonchosen aloneness, but was not related to privacy as chosen aloneness. This set of results suggests that clear choice may not be as relevant to the institutional experience as are restrictions on choice. It is likely that in the institutional setting aloneness is often associated with punishment, rather than something that is positively viewed.

Additional results in support of Hypothesis IX. Hypothesis IX dealt with the relationship between client behaviors and reported experiences with or concepts of privacy. There was some evidence which confirmed the relationship between privacy as an experience and as a behavior.

The general relationship between experience and behavior is further

Table 30. Correlations between Privacy as Chosen Aloneness and Responses to Definitional Question.

| Source | N[a] | r | p |
|---|---|---|---|
| Setting 1 | 17 | -.22 | |
| Setting 2 | 15 | .01 | No significant differences |
| Total Settings | 32 | -.11 | |
| Single Bedroom Occupants | 10 | .01 | |
| Multiple Bedroom Occupants | 22 | -.15 | |

[a]number of clients

Table 31. Correlations between Nonchosen Aloneness and use of "Aloneness" in Definitional Question.

| Source | N[a] | r | p[b] |
|---|---|---|---|
| Setting 1 | 17 | -.46 | .05 |
| Setting 2 | 15 | .06 | |
| Total Settings | 32 | -.24 | |
| Single Bedroom Occupants | 10 | .31 | |
| Multiple Bedroom Occupants | 22 | -.42 | .04 |

[a]number of clients

[b]listed only if $p < .12$ or if $r > .40$

supported in an inspection of clients' perceived degree of interruption (when wanting to be alone) measured against client behaviors. Each client was assigned a value of 1, 2 or 3 depending on her/his response to the question about perceived interruption: 1 = hardly ever feels interrupted; 2 = sometimes feels interrupted; 3 = almost always feels interrupted). Pearson product-moment correlations were performed, comparing degree of perceived interruption to engagement in particular behaviors (see Table 32, p. 132).

Results suggested that the more often a person was involved in aggression when in social situations, the less often she/he felt interrupted. This applied most to residents in Setting 2. It may easily be that those who are the aggressors in social situations are the very clients involved in interrupting others, rather than being the one being interrupted. Aggression often involves the disruption of activities of other people.

Results also indicated somewhat of a relationship between perceived interruption and isolated passive behaviors for residents in settings combined. For this group, the more a person felt interrupted, the less frequently she/he engaged in isolated passive behaviors.

This last result may be interpreted by understanding the relationships among perceived interruption, isolated passive behaviors when in social situations, and self-esteem. First, for total settings combined, there was a negative relationship between isolated passive behaviors when in social situations and self-esteem ($N = 35$, $r = -.28$, $p = .09$). That is, clients who engaged frequently in isolated passive behaviors in

Table 32. Correlations between Client Responses to Perceived Interruptions (when wanting to be alone) and Client Behaviors.

| Source | N[a] | Privacy as Chosen Aloneness | | Behaviors when in Social Situations: Positive Social | | Isolated Active | | Isolated Passive | | Aggression | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | r | p[b] | r | p[b] | r | p[b] | r | p[b] | r | p[b] |
| Setting 1 | 17 | -.14 | | .21 | | .13 | | -.36 | | .03 | |
| Setting 2 | 15 | .26 | | -.24 | | .16 | | .08 | | -.54 | .03 |
| Total Settings | 32 | .08 | | .16 | | .08 | | -.33 | .05 | -.31 | .07 |
| Single Bedroom Occupants | 10 | .16 | | -.03 | | .06 | | .07 | | -.45 | .19 |
| Multiple Bedroom Occupants | 22 | -.09 | | .16 | | .11 | | -.33 | .11 | -.27 | |

[a]number of clients

[b]listed only if $p < .12$ or if $r > .40$

social situations measured low in self-esteem. In addition, for total settings combined, there was a positive relationship between self-esteem and perceived interruption (N=35, r=-.31, p=.07): clients with high self-esteem perceived themselves to be interrupted frequently, while clients with low self-esteem saw themselves as hardly ever being interrupted. It may be that the person with a high self-esteem was "together" enough so that: 1) when in social situations, she/he did not frequently engage in isolated passive behaviors--a behavior seen as negative by staff members and, 2) she/he was able to see the reality of the present environment, i.e., in an institutional setting, one would be frequently interrupted when she/he wanted to be alone. Recall that clients who were involved in isolated active behaviors were also involved in privacy as chosen aloneness.

Summary of Findings Related to the Hypotheses

A brief review of the major findings will be presented, to be followed by a chapter which will deal with an interpretation of the findings and implications of the research.

Some findings are as follows:

1. Reported experiences with privacy: Client descriptions of privacy supported the idea that clients' privacy responses often reflected the social and physical environments. This was revealed in response differences across settings. In particular, residents of Setting 2--who often used the outdoors during the day--cited the outdoors as a place to be alone, compared to residents of Setting 1 who did not mention the outdoors.

Residents of Setting 2 also cited heterosexual experiences in relation to privacy more frequently than did residents in Setting 1, based

perhaps on the mixed-sex living situation in Setting 2 compared with the sex-segregated living units of Setting 1.

Finally, residents of Setting 1 described other people's privacy experiences as an intimate situation (two or more people) more frequently than did clients in Setting 2. This may reflect a particular feature of Setting 1, that is, the emphasis of the 1:1 client/social worker experience.

Some patterns of client descriptions of privacy seemed to have reflected a client desire or need that was not being met by the environment. Most specifically, clients who occupied multiple-person bedrooms defined privacy in terms of dressing/undressing more frequently than did clients who occupied single-person bedrooms. In addition, clients who occupied multiple-person bedrooms frequently described privacy in terms of aloneness, while clients who occupied single-person bedrooms described privacy more in terms of being with others. Finally, clients who occupied multiple-person bedrooms frequently described a private talk in terms of the conditions necessary to insure such a talk, while clients who occupied a single-person bedrooms frequently described the contents of a private talk.

Some groups of client responses to the interview questions neither supported the stated hypotheses nor confirmed patterns in the reverse direction. Most notably, residents in Setting 2 did not use "choice" or describe privacy situations any more than did residents in Setting 1.

2. Relationships among client behaviors: It was expected that privacy as chosen aloneness would be positively realted to positive social interactions, and negatively related to each of isolated active, isolated passive, and aggression when in social situations. Findings indicated a reversal in the predicted direction for the relationship

between privacy as chosen aloneness with positive social interactions and with isolated active behaviors for some sample groups. That is, those residents who were frequently involved in privacy as chosen aloneness were seldom involved in positive social interactions, but were frequently involved in isolated active behaviors.

The negative relationship between privacy as chosen aloneness and aggression when in social situations was confirmed for the total sample. There was no relationship between privacy as chosen aloneness and isolated passive behaviors when in social situations.

When clients of the total sample were grouped according to choice levels (based on both setting of residence and bedroom occupancy), there was somewhat of a positive relationship between privacy as chosen aloneness and positive social interactions.

Nonchosen aloneness was also related to client behaviors for some groups. In particular, nonchosen aloneness was negatively related to isolated active behaviors for residents in Setting 1 and was positively related to isolated passive behaviors for multiple-bedroom occupants.

3. Relationship between privacy as chosen aloneness and self-esteem: There was no relationship between privacy as chosen aloneness and self-esteem. Nor was self-esteem related to behaviors of nonchosen aloneness.

4. Relationship between clients' reported privacy concepts and client behaviors: There was no relationship between clients' involvement in privacy as chosen aloneness and use of "aloneness" in the definitional question. However, there was a relationship between client behaviors of nonchosen aloneness and use of "aloneness" in the definitional question for residents in Setting 1. That is, those residents who were frequently involved in nonchosen aloneness seldom used "aloneness" in their definitions of privacy.

Finally, there was a relationship between perceived interruption and isolated passive behaviors when in social situations. Those clients who frequently felt interrupted (when they wanted to be alone) seldom engaged in isolated passive behaviors. This, coupled with the negative relationship between isolated passive behaviors and self-esteem and the positive relationship between perceived interruption and self-esteem, may support the idea that the response to perceived interruption is an indicator of the awareness of the realities of the institutional setting.

# Chapter VIII

# DISCUSSION

A brief discussion of the findings of the present investigation will highlight the nature of the psychiatric treatment setting and provide some additional information about privacy-related experiences and behaviors. Implications for policy of the existing institutional structure will also be presented.

## Privacy as Chosen Aloneness and Behaviors when in Social Situations

A major goal of the institutional structure is to encourage positive, social interactions among clients and to reduce aggressive and isolated kinds of behaviors among clients. A major question posed by the investigation was: in what ways can the institutional structure support these goals?

Based on the literature, it was hypothesized that one way to encourage positive social interactions would be to provide clients with privacy as chosen aloneness. The hypothesis which predicted a direct relationship between privacy as chosen aloneness and positive social interactions was rejected. In fact, the inverse relationship held: residents who were involved more often in privacy as chosen aloneness tended to have fewer positive social interactions than residents who were less involved in privacy as chosen aloneness. These same people tended to involve themselves in isolated active behaviors when in social situations, yet were infrequently involved in aggression when in social situations.

In a way, isolated active behavior--which is an active engagement with the physical environment if not with people--may represent an <u>appropriate</u> response to the institutional structure. Privacy as chosen

aloneness represented only a small percentage of behavior in either setting. Daily log notes revealed that residents often were directed by staff to be with other people rather than to be physically alone. It may be that residents who attempted to be alone and who were drawn into social situations by staff were displaying the "healthiest" possible response to the institutional structure. That is, these clients might not have wanted to be forced into interaction; they might have known that positive interaction could potentially lead to usual adolescent horseplay, which could be seen by staff as aggressive behavior, and could result in punishment of clients by the staff. Isolated active behavior when in social situations was probably reinforced by the staff, as evidenced by the positive correlation between that set of client behaviors and staff ratings of client mental health. There was no such relationship between staff ratings of mental health and client behaviors of positive social interactions. Taken together, these results suggest that isolated active behaviors when in social situations are rewarded in the institutional setting, while positive social interactions are not (see also Wolfe & Golan, in progress, for additional support of these results).

This is a striking irony. The stated goal of the institutional structure is to support social interactive behaviors among clients. Yet, staff ratings indicated that positive social interaction is not a basis for judging the mental health of clients. Rather, clients are judged on the basis of isolated active behaviors when in social situations. Isolated active behaviors when in social situations may be positively rewarded by staff simply because it makes supervision easier, yet is not considered a form of extreme withdrawal, as isolated passive behaviors might be.

Environmental Choice

In what ways can the institutional structure encourage positive social interactions? Results of the present investigation suggest that choice--or absence of choice--is important to the experiences and behaviors of clients.

In this study, the degree of environmental choice was conceptually related to two sociophysical elements: 1. setting of residence (two psychiatric institutions, similar in many respects, but different in the opportunities each provided for privacy as chosen physical aloneness, were studied); 2. bedroom occupancy (there was a within setting variation, which created differences in clients' potential ability to be alone and regulate social interactions according to whether they were in a single-person bedroom or a multiple-person bedroom).

Setting of residence. In terms of setting of residence, Setting 2 was seen as providing more environmental choice to residents than was Setting 1. This was primarily the result of the "open setting" physical design and related policy, which characterized Setting 2. While several staff members in Setting 2 complained about the "open setting", administrative policy dictated that program be based in accordance with the open setting, rather than in opposition to it.

Client behaviors of positive social interactions occurred significantly more often in Setting 2 than in Setting 1, while isolated passive behaviors in social situations occurred more in Setting 1 than in Setting 2. These differences are probably not attributable to population differences, since client levels of self-esteem and staff ratings of clients did not vary across setting. It is more likely that the "open setting" policy in Setting 2 contributed to the greater frequency of positive social interactions in Setting over Setting 1. Most notably, clients in

Setting 2 were able to use the outdoors with some degree of choice, while clients in Setting 1 could not. The outdoors is one place where clients could be away from staff surveillance. Recall that one-fifth of all client behaviors of positive social interactions occurred outdoors. In addition, staff members in Setting 2 saw the use of the outdoors as inhibiting the ease of surveillance. It is conceivable that staff absense facilitates positive social interaction among clients, and that successful staff supervision--a major concern of staff and administration alike--actually inhibits positive and social interaction from taking place.

Bedroom occupancy. Bedroom occupancy has also been described as a major component of choice; in particular, the advantages of a single-person bedroom over a multiple-person bedroom have been discussed (Ittelson, Proshansky & Rivlin, 1970; Wolfe & Golan, 1976).

In the present investigation, client involvement in positive social interactions did not differ for residents grouped by bedroom occupancy. However, it seems that single-bedroom occupants did experience the institutional structure somewhat differently from multiple-bedroom occupants and, perhaps in a more positive way. These differences were revealed primarily in client responses to interview questions.

First, it appears that clients who occupied single-person bedrooms had a greater sense of ownership of their bedroom compared to clients who occupied multiple-person bedrooms. This was revealed in client descriptions of a private place: residents who occupied single-person bedrooms cited their bedrooms as a private place significantly more often than did residents who occupied multiple-person bedrooms.

In addition, clients who had their own bedrooms scored higher on self-esteem than did those who shared a bedroom. While one cannot argue

that single-bedroom occupancy leads to increased self-esteem, it is not implausible that having one's own bedroom might single out a client from other clients in some sense. In the institutional structure, clients have little control over their lives. For example, record-keeping--which includes a detailed account of almost all client behavior--is an important means of staff control. In addition, all clients are programmed to be in group situations at most times. Thus, having a single-person bedroom may be the one status factor that makes a client different from other clients, in a positive way.

The most consistent finding across a number of questions was that clients who shared a bedroom described privacy in terms of aloneness more often than did clients who had their own bedroom (for example, see responses by bedroom occupancy for definitional question and descriptors of "a private time"). In addition, residents who shared a bedroom said they preferred to be alone (in the hospital), while residents who had their own room said they preferred to be with other people. Observational data indicate than single-bedroom occupants were observed in privacy as chosen aloneness somewhat more frequently than multiple-bedroom occupants. Thus, the use of "aloneness" as a descriptor of a privacy experience by multiple-bedroom occupants highlights the notion that these clients are not expressing behavioral experiences, but rather something to which they aspire. Related to this, a number of clients who shared a bedroom connected privacy to bathroom activity/dressing-undressing, while clients who had their own bedroom never made this connection.

Several factors may account for this last set of results. It is possible that residents occupying multiple-person bedrooms used "aloneness" as a definition to signal a violation of drastic limitations on

some basic forms of privacy in Western culture, i.e., privacy as chosen physical aloneness and privacy for bathroom activity/dressing-undressing. In Western culture, these forms of privacy as social rules are learned at very young ages (Lee, 1959; Kira, 1966). Following the pattern of tacit social rules suggested by Garfinkel (1960), it stands to reason that when there is a marked deviation from the expected rule, a person will vocalize the violation of that rule. For multiple-bedroom occupants, chosen aloneness, which is a basic necessity for dressing and undressing (at the very least), was unavailable.

There may be other explanations, however, as to why multiple-bedrooms occupants cited "aloneness" more frequently than did single-bedroom occupants. Perhaps multiple-bedroom occupants believed that having one's own bedroom might mitigate the effects of the institutional structure, by allowing a greater opportunity for privacy as chosen aloneness. Single-bedroom occupants, on the other hand, might have known--based on their experience--that having one's own bedroom does <u>not</u> insure substantial opportunities for privacy as chosen aloneness. For while single-bedroom occupants were able to be alone for dressing and undressing, the institutional policy allowing staff access to bedrooms was the same for single-bedrooms and multiple-bedrooms.

To summarize, bedroom occupancy was related to reported experiences of the institutional structure, to self-esteem, and somewhat to frequency of client involvement in chosen aloneness. However, it was not related to other client behaviors, including positive social interactions. Setting of residence, on the other hand, was connected to positive social behaviors, with the higher choice setting (Setting 2) encouraging positive social interactions and the lower choice setting (Setting 1) encouraging isolated passive behaviors when in social situations.

One must not be misled and assume that there is a great deal of choice available to any adolescent studied in the present investigation. While there did seem to be somewhat more choice provided to clients in Setting 2 over those in Setting 1 (by virtue of policies and single-person bedrooms in Setting 2), the choice provided in either setting was minimal, compared to the degree of choice available to adolescents living in ordinary home environments. Recall that few clients in either Setting 1 or Setting 2 used "choice" in their privacy definitions, compared to the somewhat greater use of "choice" by adolescents living in ordinary environments (Wolfe & Laufer, 1974).

In addition, it seems that nonchosen aloneness is more relevant to the (reported) experiences of clients than is privacy as chosen aloneness. This idea is supported by two findings: 1. there was no relationship between privacy as chosen aloneness and use of "aloneness" in privacy definitions and 2. there was a negative relationship between behaviors of nonchosen aloneness and use of "aloneness" in privacy definitions.

By far, the greatest discrepancy between institutional life and ordinary living is the limitation on any real choice in the institutional setting. The limitations on choice in the institutional setting compared to ordinary environments is well-documented (Goffman, 1961; Osmond, 1970; Wolfe & Golan, 1976). According to Osmond (1970):

> Ironically, the organizational and architectural structure of mental hospitals has managed, in the matter of exercising choice, to meet the patients' needs almost exactly in reverse (from ordinary day-to-day life) . . . People incarcerated in these places have their everyday choices--food, clothing, recreation--limited, whereas they have to choose intimate companions from a mob of equally sick strangers--a choice we are seldom faced with in normal living.

Related to choice limitations are restrictions on opportunities on privacy as chosen aloneness. In the institutional setting, aloneness is

more often connected with punishment or nonchoice than it is with choice. More striking is the notion that aloneness may be connected with emotional upset: clients can be placed alone in their bedrooms or seclusion room as a result of expressing emotional upset. Thus, aloneness which is often a positive and sought experience in ordinary environments may be seen as negative by clients living in a psychiatric institution.

Even when volitional aloneness is achieved in the institution, it is frequently accompanied by qualities uncommon to sought aloneness experiences in ordinary settings. For example, a resident is seldom in control over how long she/he can remain alone without being interrupted or instructed to join other people. Occasionally a client will feign emotional upset in order to be alone. Finally, clients may develop subtle strategies in order to be alone, for example, creating a tacit rule in which only one person at a time uses a multiple-occupancy bedroom (Wolfe, 1975).

Thus, in the institutional setting, aloneness may be seen as negative or when actually sought may be achieved in ways not typical to ordinary environments. These associations with aloneness may inhibit the client to cope with ordinary forms of aloneness when she/he returns to ordinary community living. In addition, chosen aloneness--an acceptable form of privacy in our culture--may not be seen as a means to privacy by the former client. If this is the case, the former client may resort to privacy strategies that were acceptable in the institution, but are not necessarily acceptable in ordinary environments, for example, psychological reserve or more extreme forms of tuning out when among other people.

## Implications for Policy of the Institutional Setting

Findings of the present investigation suggest that client experiences and behaviors are related to the opportunities and limitations of the environment. For the most part, the institutional setting supports experiences and behaviors which are inappropriate to noninstitutional settings or, at the very least, are not in line with the long-range goals sought by hospital clinicians and administrators.

This issue is particularly hard-hitting when one considers that the child or adolescent in residential treatment is at a crucial stage of individual and social development. Unlike the institutionalized adult who might have experienced an ordinary environment while growing up, institutionalized children and adolescents experience the treatment facility as their primary socialization environment.

Can the institutional structure as it presently exists support culturally inappropriate individual and social development of children and adolescents? Assuming that the children and adolescents will eventually return to an ordinary setting, what are the long-term effects of institutional experiences on them?

Considering the evidence of the present investigation and other studies of psychiatric facilities, it seems that the institutional structure and the experiences it supports are at odds with ordinary environments (see, for example, Goffman, 1961; Osmond, 1970; Tars & Appleby, 1973; Wolfe & Golan, 1976). How might the administrators of treatment settings begin to mitigate the effects of institutional structure? Several basic issues must be considered by administrators in order to deal with this difficult issue. These issues are relevant not only to traditional residential treatment centers, but to the newer alternatives to psychiatric child care, for example, the smaller group home.

A major obstacle in the success of psychiatric treatment environments is the disparity between the expressed administrative goals and the working goals actually followed in day-to-day treatment.

For example, increased positive social interaction among clients is a stated goal in almost any treatment plan. Studies have shown that placing clients together in the same room does not necessarily facilitate positive social interaction, and that giving clients some choice--including being away from staff--may encourage positive social interactions among clients. Yet, in many institutions, the staff concerns for supervision and surveillance takes priority over client choice in where the client wants to be and with whom. As a result, clients are frequently herded into the dayroom, where social interaction can be minimal, but where staff supervision is made easier.

In fact, the client behavior which is most frequently valued by staff is not positive social interaction, but isolated active behaviors when in social situations. In a sense, isolated active behaviors are easiest for staff to deal with. Positive social behaviors can often lead to teasing or horseplay among clients, which can potentially lead to aggressive behaviors. This would make staff supervision difficult.

Interestingly, these working goals are in opposition to the "normalization principle" espoused by administrators. In ordinary environments, adolescents are given some choice about the nature and extent of their social interactions; this is generally not the case for adolescents living in institutional settings. Additionally, adolescents in ordinary environments are given the opportunity to test new behaviors. These behaviors may include increased chosen aloneness or the teasing or roughhousing which can be a positive part of social interactions. In the institutional setting, such roughhousing is not only discouraged,

but is often punished. And the aloneness that residents can experience is not chosen aloneness, but nonchosen aloneness.

It appears that the inappropriate behaviors of clients in the institutional setting are not so much the result of individual pathologies as they are of the limitations within the setting. The connection of aloneness with emotional upset, staff complaints of inappropriate sexual behavior among clients, client psychological withdrawal when in social situations are all the outcome of a structure which is not necessarily normalizing, but which often functions as a separate system with rules and criteria which do not correspond to those in ordinary environments.

An administration must reevaluate its goals and its assumptions related to the clients serviced. In particular, the following steps must be considered:

1. The working goals of the treatment setting must be identified. Often, there exists not only an expressed set of goals, but a hidden agenda as well. This "hidden agenda" may be contradictory to official policy, but may have a substantial bearing on treatment.

2. An administration must begin to understand the behavioral parameters of their client population, rather than assume a set of client behaviors which may or may not be taking place. For example, all too often, policy decisions are based on the belief that aggression (towards self or others) is a dominant client behavior. Results of the present investigation and other studies indicate that this behavior represents an insignificant fraction of total client behaviors. Administrators should be more attuned to the broad range of nonaggressive behaviors which take place, notably the kinds of isolated behaviors of clients when in social situations.

3. The role of environmental choice in the institutional setting

should be explored. If the setting is to prepare the client for an ordinary living environment, the client must be provided with opportunities similar to those she/he would experience in an ordinary setting, including opportunities for privacy as chosen aloneness. This choice could facilitate both culturally appropriate alone behaviors and social interactive behaviors.

4. Likewise, the restrictiveness of the institutional setting must be considered, since it seems to foster experiences and behaviors inappropriate to ordinary noninstitutional environments.

5. An administration should be aware of the potential impact of any environmental decision. In particular, it should be recognized that in a low choice environment, any one policy decision can have a profound effect on client experience and behavior.

It is unlikely that the present institutional structure can provide clients with the full range of ordinary living experiences. At best, it seems that the present set-up can better approximate ordinary environments, but only with an honest willingness on the part of administration to encourage continual reevaluation and change.

It would be helpful to develop a process-oriented approach where design, evaluation, and change is done in conjunction with staff and clients. In this way, an administration can be aware of where they are satisfying or not meeting treatment goals. (See Architecture Research Construction, 1975 for an example of this approach.). The approach itself needs to be evaluated to see if it contributes to a less restrictive environment.

# APPENDIX A

Checklist: Children's Psychiatric Facilities Visits

## Residents

Age
Sex
Socioeconomic background
Diagnosis
Length of present hospitalization
Length and type of previous institutionalization
Day care/full care
Criteria for selection
Where do residents go upon discharge?
Could residents be elsewhere?

## Treatment Philosophy

What is it explicitly? (Other?)
Medication
Degree of interaction with community
Privleges, restrictions, how expressed
Short term vs. long terms care
How philosophy disseminated

## Physical Design

Bedrooms--type; is assignment random; access to
Use of doors, locks; general accessibility by kids to areas
Community areas, quality of and proximity to
School
How spread out are community areas, other areas (1 floor, one or more buildings)
Cafeteria
Dayroom
Quiet room, purpose of and use
Other alone areas
Personalization of space
Exterior of building: hospital-like? grounds?
How old is building?

## Programming

Time programming and quality of
Nature of free time (how "free"; what can do and where can go
Spaces used in programmed time and free time (e.g., of bedrooms)
School
Home visits
Weekends
Time spent with social worker/psychiatrist: intimate situations

Checklist (2)

Staff

Resident-staff ration
Direct staff/ indirect staff
Who sets policy? Who carries it out?
Tunover
Daily shifts

Community

Geographic location
Quality of community (e.g., business district, etc.)
Relationship to community

Other

Do children have own clothing? Own objects?
Is facility a model for others?
Is research carried out there?
Affiliation to other organizations

Aspects listed may apply to more than one category.

# APPENDIX B

## Staff Administrative Interview

1. Briefly, what do you see your job as being? (Probe: What are some of the responsibilities of your job?)

2. In general, why do you think children are here?

3. What do you think should happen to a child while s/he is here? (Probe: What should s/he get to know while here?)

4. I've heard people here mention the term "open setting". What is meant by that?

5. How is the open setting supposed to work here?

6. Is the open setting working that way? If no: Why not? How is it presently working?

7. Was there a change in the definition of an open setting since you've been here? If yes: What accounts for the change? (Probe if necessary: Changes in rules, use of space, etc.)

8. How do you think most of the staff feel about the open setting in terms of their job?

9. What about for the children -- do you think an open setting affects them at all? How? (Probe: How is the open setting good for the children? How is the open setting bad for the children?)

10. Is there a specific philosophy of treatment here? What is it?

11. How is the philosophy of treatment disseminated to staff? How easy or difficult is that to do?

12. Has the philosophy of treatment changed at all since you've been here? How?

13. What factors do you think may have contributed to changes in the philosophy of treatment? (Probe if necessary: physical design, budget cuts, kind of staff)

14. Is there anything you particularly value in the physical design of the cottages that is helpful to staff in their work or is good for the children? What? Why?

15. Is there anything about the physical design of the cottages that makes the staff's work more difficult or might not be good for the children? What? Why?

Appendix B/2

I know there are single-person bedrooms, double bedrooms and four-person bedrooms.

16. Do you think one of these sizes is better for the children than the others? Which? Why? (Probe: which do you like least for the children? Why?)

17. Do any of the children themselves seem to have a preference for one size over any of the others? What is it? Why do you think it is?

18. Do you like the fact that the cottages are separate from the other buildings or would you prefer that the cottage and recreation areas be in one building? Why?

19. Do children have a choice in what they do during a day? Do you think that this is the best arrangement? Why?

20. If a child doesn't want to go to program, what is done?

21. Are there any alternatives to going to program? If yes: What are they?

22. Is a child ever alone during a day, that is, without other children and without staff?

23. From you experience, would you think that there are times that a child would want to be alone during the day? If yes: Why would you think a child in this hospital would want to be alone?

24. What does a child do when s/he wants to be alone?

25. Where does a child go in order to be alone? (Ask is not answered in last question.)

26. How does a child's being alone aid or hinder the therapeutic process here?

27. How does a child's being in a group aid or hinder the therapeutic process here

28. Related to this -- do you think a child should be encouraged to spend most of the day in structured activity? Why or why not?

29. What about supervision -- would you say that children here are supervised by staff most of the time, some of the time, or hardly ever?

30. In general, do you think a child should be supervised here most of the time, some of the time, or hardly ever? Why?

31. Does the need for supervision aid or hinder in the therapeutic process? How? (Probe if necessary: Do you see any problems between the need for supervision and therapeutic goals for the children or are the two consistent?)

Appendix B/3

32. Has your thinking about supervision changed from your ideas about it in the past? How was it before? How is it now? What do you think accounts for this change?

I've questioned you on some of the areas that I feel are important to understanding this setting. While the focus of my work here will be on the physical design, it's important that I be aware of other aspects of the total setting.

33. Can you think of any topics or concerns that we haven't discussed that might assist me in my work here?

# APPENDIX C

Staff Interview

1. Briefly, what do you see your job as being? (Probe: what are some of the responsibilities of your job?)

2. I've heard people here mention the term "open setting". What is meant by that?

3. Do you think an open setting makes your work easier or more difficult? Why?

4. What about for the children -- do you think an open setting affects them at all? How? (Probe: How is the open setting good for the children? How is the open setting bad for the children?)

5. In general, why do you think children are here?

6. What do you think should happen to a child while s/he is here? (Probe: What should s/he get to know while here?)

I'd like to ask you some questions about the cottages.

7. Do you use the cottages in your work with the children? (If yes: continue with next questions. If no or little, go to Outside questions, q. 28)

8. Is there anything you particularly value in the physical design of the cottages that makes your job easier or is helpful to the children? What? Why?

9. Is there anything about the physical design of the cottages that makes your job more difficult or might not be good for the children? What? Why?

10. What do you think about the set-up of the nurse's station? (Probe if not volunteered: Do you think it's in a good location? Why or why not?)

11. What do you think about the set-up of the bayroom?

I've noticed that there are single-person bedrooms, double bedrooms and four-person bedrooms.

12. Do you think one of these sizes is better for the children than the others? Which? Why? (Probe: Which do you like the least for the children? Why?)

13. Do the children themselves seem to have a preference for one size over any of the others? What is it? Why do you think this is?

14. How is it decided which children will have their own rooms, which children are in a double room, and which children are in a four-person room?

15. How are the bedrooms used?

16. Are there rules about the use of the bedrooms? What are they? (Probe if not volunteered: Do children ask staff for permission to use the bedrooms?)

Appendix C/2

17. How are the bedroom doors used?

18. Are there rules about the use of the bedroom doors when the children are in the bedrooms? What are they?

19. What about the room outside of each set of bedrooms -- what is it known as and how is it used?

20. Do children ask for staff permission to use that room?

21. Is it important that children be supervised when they are in their bedrooms or in the area outside the bedrooms? Why?

22. How do you manage to supervise children when they are in the bedrooms or in the area outside the bedrooms?

23. I've noticed that some of the children's bedrooms are decorated. Are children encouraged or discouraged from decorating their rooms? Why?

24. I've also noticed locks on the outer doors of the cottages. When and how are they used?

25. How is the seclusion room in the cottage used?

26. Are there any rules about its use? What? (Probe if not volunteered: Can a child go in there whenever s/he wants? Also: If emotional upset is one reason for its use, ask: Must a child be acting out/upset, etc, in order to use the room or can s/he use it under any conditions?)

27. Do you think a seclusion room is important to have in the cottage? Why?

Now I'd like to ask you about the outdoor spaces.

28. Would you say that children use the outdoor areas often, sometimes or very little?

29. Does children's use of the outdoors create problems for you in your work? How?

30. Do children ask for staff permission to go outside?

31. Do you like the fact that the cottages are separate from the other buildings or would you prefer that cottage and recreation areas be in one building? Why?

Now I'd like to find out about what a day is like here.

32. If a child doesn't want to go to program, what is done?

33. Are there any alternatives to going to program? If yes: What are they?

34. Do children have free time during the day or evening? When is it? How is this time used?

Appendix C/3

35. Is a child ever alone during the day, that is, without other children and without staff? If yes: When might this occur?

36. From your experience, why would you think a child in this hospital would want to be alone?

37. What does a child do when s/he wants to be alone?

38. Where does a child go in order to be alone? (Ask is not answered in last question.)

39. How do you feel about a child being able to spend time alone? (Probe: Do you thihk it's good or bad for a child to be able to spend time alone? Why?)

40. In general, would you say that children in this hospital are supervised by staff most of the time, sometimes or hardly ever?

41. In general, do you think a child here <u>should</u> be supervised most of the time, sometimes or hardly ever? Why?

42. We're at the end of the interview. Is there anything else you'd like to add to what we've talked about?

# APPENDIX D

## BEHAVIOR CODES

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AGG-OBJ | 01 | GAMES ACT | 17 | PACING(UNSPEC) | 82 | SPACE INTO SPACE | 84 |
| AGG-PPL-PHYS | 74 | GAMES SIT | 18 | PER HYG(ISOL) | 29 | SWIM | 71 |
| AGG-PPL-VERB | 75 | GRP. MTG. | 19 | PER HYG(SOC) | 97 | SWINGS | 43 |
| AGG-SELF | 03 | HIDING (ISOL) | 68 | PHONO RADIO | 30 | TALK | 74 |
| AGG-UNID-PHYS | 76 | HOSP. ROUT. | 20 | PLAY | 31 | TEACHING | 67 |
| AGG-UNID-VERB | 77 | HOPPING | 21 | PLAY INSTRU | 32 | TENSE(MUSIC) | 35 |
| ANIMAL | 69 | IDIO. HAN(UNSPEC) | 90 | POOP ACT | 57 | TEASE(PROVOK) | 92 |
| ARGUING | 56 | IDIO. HEH(ROCKING) | 92 | PT SEP CONF | 61 | TELEPHONE | 45 |
| BARKING | 65 | IDIO. HEH(PACING) | 93 | READ(ISOL) | 33 | TRAVEL | 16 |
| BEADS & CRAFTS | 05 | JUMP OFF | 23 | RESTR CHILD | 59 | TRAYS OBJ | 47 |
| BIRD WATCH | 70 | KNAVING | 64 | RGH HOUSE | 78 | TV | 46 |
| CHASING | 06 | LIE AWAKE(ISOL) | 24 | ROLLER SKATE | 55 | WAITING | 60 |
| CLIMBING | 07 | LIFTING UP | 80 | RUNNING | 35 | WALK(ISOL) | 49 |
| CRY GRP | 08 | LOOK UNLOOK | 72 | SAND | 36 | WATCH ACT(ISOL) | 50 |
| CRY ALONE(ISOL) | 09 | LOOK AROUND ROOM | 76 | SEESAW | 37 | WATCH ACT SEQUEN | 91 |
| CUDD/HOLD CHILD | 66 | LOOK FOR PERS | 25 | SINGING | 38 | WHISPERING | 94 |
| DIG/MUD/SAND | 10 | LOOK FOR PLACE | 26 | SIT (ISOL) | 39 | WRITING(ISOL) | 51 |
| DISTURB ACT | 11 | LOOK THRU THINGS | 79 | SLEEP(ISOL) | 39 | YAWN | 52 |
| EAT/DRINK | 12 | LOOK WDW(ISOL) | 27 | SLIDE | 40 | | |
| EAVESDROPPING | 58 | LOOK WDW ACT(ISOL) | 28 | SMOKING(ISOL) | 88 | | |
| EMBRACE OBJ | 13 | MAINTENANCE | 73 | SMOKING (SOC) | 89 | | |
| EXPLORE PLACE | 14 | MEDICATION | 83 | SPORTS | 41 | | |
| FANTASY PLAY | 15 | MINISTERING | 96 | STAND(ISOL) | 42 | | |
| FEELING/AWKWARDNESS | 81 | | | | | | |
| FOOD PREP | 16 | | | | | | |

IDENT _____ 1-2

TIME _____ 3-4 5-6

DATE _____ 7-8 9-10 11-12

ACTIV _____ 13-15

INTERACT

| Alone in Room | | Others in Room | |
|---|---|---|---|
| Totally alone | In view of others | Resident interacting | Resident not interacting |
| ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

16

PPLWITH (people with whom resident is interacting)

| M | F | St | Vi |
|---|---|---|---|
| 17-18 | 19-20 | 21-22 | 23-24 |

PPLNOT (people not interacting with resident)

| M | F | St | Vi |
|---|---|---|---|
| 25-26 | 27-28 | 29-30 | 31-32 |

DOORPOS

| Open | Ajar | Closed | DNA |
|---|---|---|---|
| ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

33

ROOM _____ 34-36

Name of Room _____

House or Cott.# _____

Living Unit or Wing _____

Outdoors _____

HOSP _____ 37

OBS _____ 38

EVENT SAMPLING OBSERVATIONS APPENDIX F

ID Res #_____ Date_____ Hosp #_____ Obs_____

1. Time first seen alone:

2. Room/space:

3. Activ.:

4. Door pos (open, closed, ajar):

5. Initiation of time alone: (Circle one):
(1) Entered space seemingly by choice (2) Directed to space by other
(3) Others left space leaving resident alone

Comments:

6. Interruptions

| By whom (M,F,Staff) (If there is more than one interruption and ther person is the same, indicate by arrows) | Approximate duration | Nature (e.g., person trafficking through space; looking for things) Also, did person interact w. res.? How? Who initiated interaction? Did res. react to other at all? (annoyed, sighed, turned away, facial gest., body posture, etc.) |
|---|---|---|

7. Time alone period ended:

8. Termination of alone period: (Circle one):
(1) Res. left space seemingly by choice (2) Res. directed by other to leave space
(3) Others entered space & res. remained (4) Others entered space & res. left
Comments:

9. Duration of time alone:

10. Does time alone reflect excessive medication, punishmt., or sickness? If yes, elab.

11. Staff assistance: If yes, which aspect?

# APPENDIX G

## Residents' Privacy Interview

1. Would you tell me all the things the word "privacy" means to you? You can take your time and think about it.

2. Tell be about a time when something or some person disturbed your feeling of being private.

   Probe: Who disturbed you?
   What did they do?
   Why did they disturb you?
   Were you alone or were you with someone when _____ disturbed you?
   If with someone: Who were you with?

3. There are lots of ways people talk about privacy. I'm going to mention some and I'd like you to tell me what you think they would be like. For example, can you describe what:

   a) a private place is like for you?

      Then probe: How would you describe it?
      What does the place look like?
      Would you be there with other people or would you be there alone? If with others: With whom?

   b) a private time is like for you?

      Then probe: What makes it private?
      Would you be alone or would you be with other people during a private time? If with others: With whom?

   c) a private thing to do?

      Then probe: What makes it private?

   d) a private talk?

      Then probe: What makes it private?

4. Would you tell me about the ways other people on your unit let you know when they were private or wanted to be private?

   If necessary, probe: Do they say something to you or do something or go somewhere? What? Or where?

5. Do you have a private place for yourself in this hospital?
   What is it?
   Where is it?
   What makes it private?

Appendix G/2

6. Changing the topic a little- Some people mostly like to be alone by themselves and some people mostly like to be with other people. What about you- in this hospital, do you usually prefer to be by yourself or do you usually prefer to be with other people?

   Would you say you:
   -Almost always prefer to be alone
   -Usually prefer to be alone
   -Sometimes want to be alone and sometimes want to be with other people
   -Usually prefer to be with other people
   -Almost always prefer to be with other people

7. Do you ever want to be alone here? (to be asked if respondent answers "with others" to question # 6).
   (To be asked of all respondents):
   What do you do when you want to be alone?
   Where do you go?

8. When you want to be alone, are you usually interrupted by other people or don't they usually interrupt you?
   When you want to be alone, would you say you're interrupted by other people:
   -All of the time
   - Most of the time
   -Sometimes
   -Hardly ever, or
   -Never

9. About the outdoors- I know there are grassy areas (and a court at Setting 1) surrounding this hospital. Can kids go outside whenever they want or are there certain rules about going out?
   Do kids ask for staff permission to go outside or do they go on their own?
   Do you go outside? For what reasons?
   Do you go outside usually to be alone or to be with somebody else?
   Where are you interrupted more often- outside or in inside?

10. Now I'd like to talk about the bedrooms here. I've noticed that some kids have their own bedrooms and some kids share a bedroom.
    Do you share a bedroom or do you have your own bedroom?
    (If share): Do you like sharing a bedroom or would you prefer your own room?
    What are the good things about sharing a bedroom?
    What are the bad things about sharing a bedroom?
    What are the good things about having your own room?
    What are the bad things about having your own room?
    (If has own room): Do you like having your own bedroom or would you prefer to share a bedroom?
    What are the good things about having your own room?
    What are the bad things about having your own room?
    What are the good things about sharing a room?
    What are the bad things about sharing a room?

11. I've also noticed there is a (are) seclusion room(s)/quiet room(s) on this unit.
    How is that room(s) used by the kids?
    What do they do in there?
    How do you use that room?
    If a kid wanted to use that room now- say just to go in there- what would they do? Would they ask for staff permission or would they go in there on their own?

12. (In Setting 1 only, ask):
What about that room with the couch and the carpet (new room)-
How do kids use that room?
Do you use that room?
(If yes): What do you use it for?
Are you usually in there alone or with other people?

# APPENDIX H

## Client Self-esteem Scale

1. I can do things as well as most people.
2. At times, I think I'm no good.
3. Usually I'm happy about myself.
4. I wish I could have more respect for myself.
5. I take a positive attitude about myself.
6. Usually I think that I'm a failure.
7. I feel there are many good things about me.
8. I'm not too proud about too many things about myself.
9. I feel I'm as good as other people.
10. I feel useless at times.

# APPENDIX I

## Staff Perception of Client Scale

1. What do you see as the cause of this child's hospitalization?

| Related mostly to internal | | | | Related mostly to environment (e.g., family) |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

2. In general, how disturbed would you say this child is?

1 Normal, not disturbed at all
2 Borderline disturbed
3 Mildly disturbed
4 Moderately disturbed
5 Markedly disturbed
6 Severely disturbed
7 Among the most disturbed

3. To what extent does this child exhibit aggressive acting out behaviors?

1 Almost never
2 Occasionally
3 Moderately
4 Very much
5 Almost always

4. To what extent does this child participated in social, recreational, and other planned activities?

1 Almost never
2 Occasionally
3 Moderately
4 Very much
5 Almost always

5. To what extent does this child withdraw from other children, avoid conversation, and tend to stay by himself or herself?

1 Almost never
2 Occasionally
3 Moderately
4 Very much
5 Almost always

6. In your estimation, what are the chances for this child's eventual return to normal community life?

1 Excellent
2 Good
3 Fair
4 Poor
5 Very poor

# APPENDIX J

## LOG NOTES
(Observation Days)

Date_____ Hosp#_____ Observer_____

ID Res#_____

Nature of entry as recorded in log notes (verbatim, where possible):

Restriction:
Indicate if: to bedroom
to seclusion room
other (e.g., restriction on activities as no smoking, limited recreation, etc.)

Describe incident(s) leading to, time, termination, others involved, resident's reactions, etc.

Note any unusual behavior of resident:

# APPENDIX K

## RESIDENTS' MEDICATION SCHEDULES

| Name of Resident & ID # | Date | Time taken (if known) | Type of Med. (+oral or injection) | Dosage (if known) | Routine or Special (If special, indicate likely cause for administering) |
|---|---|---|---|---|---|
| | | | | | |

# APPENDIX L

## CENSUS
(Observation Days)

Date_____ Hosp#_____ Observer_____

Time of day_____

Residents off unit and whereabouts:

Total full care males on unit:

Total full care females on unit:

Total day care males on unit:

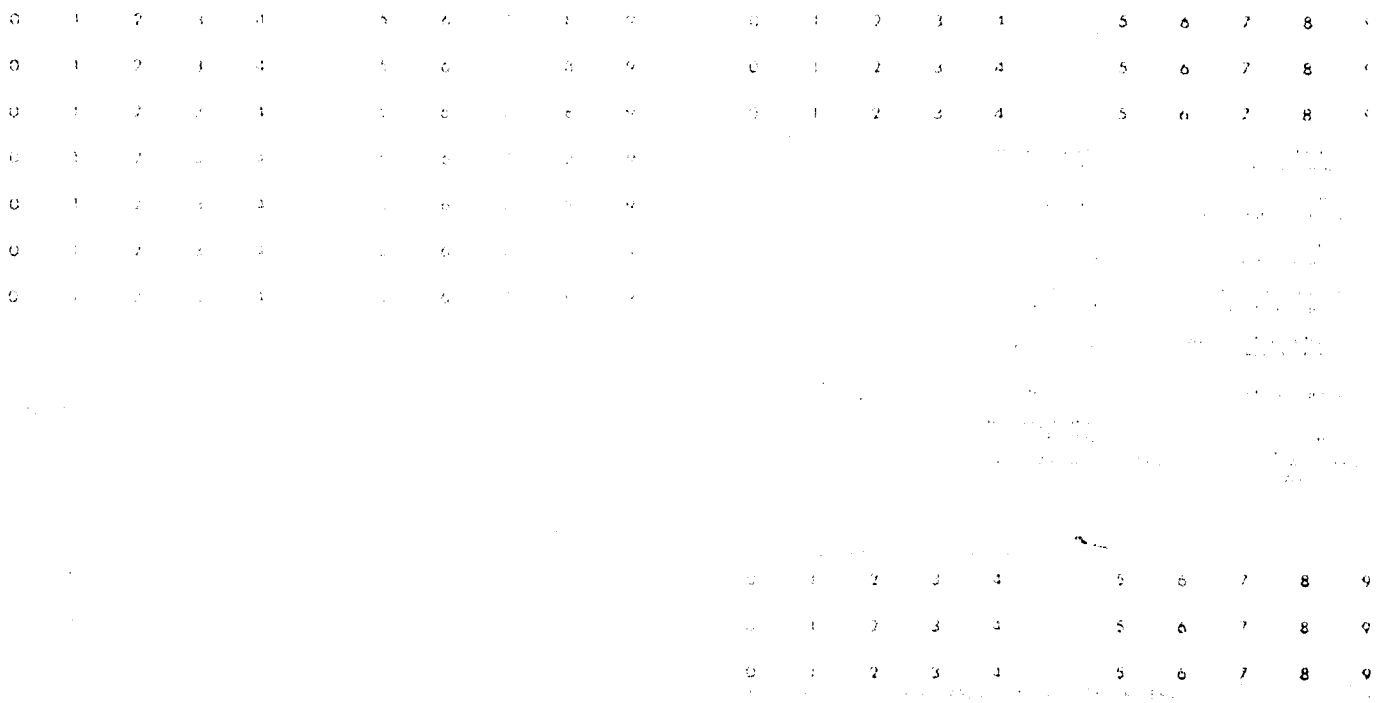
Total day care females on unit:

New Admissions:

| Name | Date of Birth | Date of Admission | Bedroom |
|---|---|---|---|

Discharges:

| Name | Date of Discharge |
|---|---|



FORM 15 MED. (3/70)

# PSYCHIATRIC DIAGNOSIS RECORD

FACILITY CODE | FACILITY: APPENDIX N | CONSECUTIVE NO. | BIRTH DATE (M, D, Y) / /

NAME (LAST, FIRST, MIDDLE INITIAL)

TRANSACTION: [ ] PROVISIONAL [ ] ADMISSION [ ] REEVALUATION [ ] FINAL OFFICIAL [ ] CORRECTION [ ] DELETION

PRIMARY | SECONDARY | TERTIARY

## I MENTAL RETARDATION

310. Borderline
311. Mild
312. Moderate
313. Severe
314. Profound
315. Unspecified

With each: Following or associated with
- .0 Infection or intoxication
- .1 Trauma or physical agent
- .2 Disorders of metabolism, growth or nutrition
- .3 Gross brain disease (postnatal)
- .4 Unknown prenatal influence
- .5 Chromosomal abnormality
- .6 Prematurity
- .7 Major psychiatric disorder
- .8 Psycho-social (environmental) deprivation
- .9 Other condition

## II ORGANIC BRAIN SYNDROMES (OBS)

### A PSYCHOSES

**Senile and pre-senile dementia**
- 290.0 Senile dementia
- 290.1 Pre-senile dementia

**Alcoholic psychosis**
- 291.0 Delirium tremens
- 291.1 Korsakov's psychosis
- 291.2 Other alcoholic hallucinosis
- 291.3 Alcohol paranoid state
- 291.4* Acute alcohol intoxication*
- 291.5* Alcoholic deterioration*
- 291.6* Pathological intoxication*
- 291.9 Other alcoholic psychosis

**Psychosis associated with intracranial infection**
- 292.0 General paralysis
- 292.1 Syphilis of central nervous system
- 292.2 Epidemic encephalitis
- 292.3 Other and unspecified encephalitis
- 292.9 Other intracranial infection

**Psychosis associated with other cerebral condition**
- 293.0 Cerebral arteriosclerosis
- 293.1 Other cerebrovascular disturbance
- 293.2 Epilepsy
- 293.3 Intracranial neoplasm
- 293.4 Degenerative disease of the CNS
- 293.5 Brain trauma
- 293.9 Other cerebral condition

**Psychosis associated with other physical condition**
- 294.0 Endocrine disorder
- 294.1 **Metabolic or nutritional disorder**
- 294.2 Systemic infection
- 294.3 Drug or poison intoxication (other than alcohol)
- 294.4 Childbirth
- 294.8 Other and unspecified physical condition

### B NON-PSYCHOTIC OBS

- 309.0 Intracranial infection
- 309.13* Alcohol* (simple intoxication)
- 309.14* Other drug, poison or systemic intoxication*
- 309.2 Brain trauma
- 309.3 Circulatory disturbance
- 309.4 Epilepsy
- 309.5 Disturbance of metabolism, growth, or nutrition
- 309.6 Senile or presenile brain disease
- 309.7 Intracranial neoplasm
- 309.8 Degenerative disease of the CNS
- 309.9 Other physical condition

* Categories added by ICD for use in U.S. only.

## III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

**Schizophrenia**
- 295.0 Simple
- 295.1 Hebephrenic
- 295.2 Catatonic
- 295.23* Catatonic type, excited*
- 295.24* Catatonic type, withdrawn*
- 295.3 Paranoid
- 295.4 Acute schizophrenic episode
- 295.5 Latent
- 295.6 Residual
- 295.7 Schizo-affective
- 295.73* Schizo-affective, excited*
- 295.74* Schizo-affective, depressed*
- 295.8* Childhood*
- 295.90* Chronic undifferentiated*
- 295.99* Other schizophrenia*

**Major affective disorders**
- 296.0 Involutional melancholia
- 296.1 Manic-depressive illness, manic
- 296.2 Manic-depressive illness, depressed
- 296.3 Manic-depressive illness, circular
- 296.33* Manic-depressive, circular, manic*
- 296.34* Manic-depressive, circular, depressed*
- 296.8 Other major affective disorder

**Paranoid states**
- 297.0 Paranoia
- 297.1 Involutional **paranoid state**
- 297.9 Other paranoid state

**Other psychoses**
- 298.0 Psychotic depressive reaction

## IV NEUROSES

- 300.0 Anxiety
- 300.1 Hysterical
- 300.13* Hysterical, conversion type*
- 300.14* Hysterical, dissociative type*
- 300.2 Phobic
- 300.3 Obsessive compulsive
- 300.4 Depressive
- 300.5 Neurasthenic
- 300.6 Depersonalization
- 300.7 Hypochondriacal
- 300.8 Other neurosis

## V PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS

**Personality disorders**
- 301.0 Paranoid
- 301.1 Cyclothymic
- 301.2 Schizoid
- 301.3 Explosive
- 301.4 Obsessive compulsive
- 301.5 Hysterical
- 301.6 Asthenic
- 301.7 Antisocial
- 301.81* Passive-aggressive*
- 301.82* Inadequate*
- 301.89* Other specified types*

**Sexual deviation**
- 302.0 Homosexuality
- 302.1 Bestiality
- 302.2 Pedophilia
- 302.3 Transvestism
- 302.4 Exhibitionism
- 302.5* Sexual masochism*
- 302.6* Sadism*
- 302.7* Masochism*
- 302.9 Other sexual deviation

**Alcoholism**
- 303.0 Episodic excessive drinking
- 303.1 Habitual excessive drinking
- 303.2 Alcohol addiction
- 303.9 Other alcoholism

**Drug dependence**
- 304.0 Opium, opium alkaloids and their derivatives
- 304.1 Synthetic analgesics with morphine-like effects
- 304.2 Barbiturates
- 304.3 Other hypnotics and sedatives or "tranquilizers"
- 304.4 Cocaine
- 304.5 Cannabis sativa (hashish, marihuana)
- 304.6 Other psychostimulants
- 304.7 Hallucinogens
- 304.8 Other drug dependence

## VI PSYCHOPHYSIOLOGIC DISORDERS

- 305.0 Skin
- 305.1 Musculoskeletal
- 305.2 Respiratory
- 305.3 Cardiovascular
- 305.4 Hemic and lymphatic
- 305.5 Gastrointestinal
- 305.6 Genitourinary
- 305.7 Endocrine
- 305.8 Organ of special sense
- 305.9 Other

## VII SPECIAL SYMPTOMS

- 306.0 Speech disturbance
- 306.1 Sleep disturbance
- 306.2 Tic
- 306.3 Other psychomotor disorder
- 306.4 Sensory disturbance
- 306.5 Psychosexual disturbance
- 306.6 Eneuresis
- 306.7 Encopresis
- 306.8 Psychalgia
- 306.9 Other special symptoms

## VIII TRANSIENT SITUATIONAL DISTURBANCES

- 307.0* Adjustment reaction of infancy*
- 307.1* Adjustment reaction of childhood*
- 307.2* Adjustment reaction of adolescence*
- 307.3* Adjustment reaction of adult life*
- 307.4* Adjustment reaction of late life*

## IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

- 308.0* Hyperkinetic reaction*
- 308.1* Withdrawing reaction*
- 308.2* Overanxious reaction*
- 308.3* Runaway reaction*
- 308.4* Unsocialized aggressive reaction*
- 308.5* Group delinquent reaction*
- 308.9* Other reaction*

## X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS

**Social maladjustment without manifest psychiatric disorder**
- 316.0* Marital maladjustment*
- 316.1* Social maladjustment*
- 316.2* Occupational maladjustment*
- 316.3* Dyssocial behavior*
- 316.9* Other social maladjustment*

**Non-specific conditions**
- 317* Non-specific conditions*

**No Mental Disorder**
- 318* No mental disorder*

## XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

- 319.0* Diagnosis deferred*
- 319.1* Boarder*
- 319.2* Experiment only*
- 319.9* Other*

## FIFTH DIGIT QUALIFYING PHRASES

**Section II**
- .X1 Acute
- .X2 Chronic

**Section III**
- .X6 Not psychotic now

**Sections IV through IX**
- .X6 Mild
- .X7 Moderate
- .X8 Severe

**All disorders**
- .X5 In remission

RATER NAME

DATE

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