GROUP HOMES FOR THE MENTALLY RETARDED: A STUDY OF COMMUNITY AND FREEDOM

by

Robert J. Wendt

Thesis submitted to the Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

Master of Science

in

Sociology

APPROVED:

Dr. George A. Hillery, Jr.
Chairperson

Dr. Bradley R. Hertel

Dr. Charles J. Dudley

May 1988

Blacksburg, Virginia

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ABSTRACT

Through a case study, this study examines the organizational structure of group homes for the mentally retarded. The case study is found to represent a new form of communal organization according to Hillery's theory of communal organization (1968; 1978). As a communal organization, the structural measures utilized to maximize freedom in this group home are examined. A discussion of the implications of this study towards community theory and the management of group homes follows.

Acknowledgements

My initial desire to undertake this study began innocently enough as an effort to describe the eighteen months I spent living among the mentally retarded as a live-in counselor in a group home. My "roommates" were all retarded adults, ranging in age from 18 to 55. Their functioning levels ranged from the profoundly retarded to what was at the time considered borderline retardation. Several of the residents came to the group home from institutions while others had lived with family members. All in all, there was a great deal of variety in the social and psychological backgrounds of the residents of this group home. And yet for all of the differences that existed in both the psychological characteristics and the differential social experiences of the group, we all shared in common membership in this group home (herein referred to by the pseudonym "Oakton"). This membership enabled each of us to abandon our past histories and work towards the development of self and others.

The Oakton Group Home represents an organization in which all members (both staff and "residents") are free to express themselves and determine the direction their lives should take. At the same time, all members of this home willingly share a concern for the well-being of other residents and their development. In short, the Oakton Group Home represents a type of communal organization whose overriding goal is the welfare of its members.

In the two years that have passed since I left this home, I have taken many directions in my approach to describing this unique social experience. The end result only begins to express the total experience associated with my "participant" observations. By participating in the lives of these people, I have come to appreciate the joys of life so often neglected by "normal" people, and have developed a deeper knowledge of human nature. It is to my fifteen roommates over those eighteen months that this thesis is dedicated. They shall always remain in the foreground of my thoughts.

I wish to acknowledge with gratitude the support and direction received from my committee chair, George Hillery. His genuine excitement over the nature of this thesis has served as my inspiration throughout its development. In addition, Dr. Hillery's expertise in the field of community theory, and his never-ending desire to share that knowledge lead to my initial formulation of group homes for the mentally retarded as representing potentially new forms of communal organization. Thank-you.

I also wish to acknowledge the contributions of Bradley Hertel and Jack Dudley. Dr. Hertel's continual support of this effort and direction served to focus the objectives of this final draft. Dr. Dudley's support in developing an understanding of freedom, and his suggestion that I include my own personal experiences as a qualitative index, have

proven invaluable to the final product.

Finally, I wish to acknowledge the support I have received from my former employer and manager of "Oakton", . Without his acceptance of this research endeavor and permission to re-enter the home, this thesis would not have been possible.

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INTRODUCTION

Occasionally, there may exist a concept so well accepted that further investigation may be considered moot by the scientific community. This acceptance level however, does not prove the validity of our understanding of the phenomenon. There always exists the possibility that our understandings, regardless of the degree of acceptance, may be based on inadequate and/or outdated knowledge, and are thus flawed. I believe that the current understanding of the living conditions of the mentally retarded is one such phenomenon.

This thesis addresses the nature of freedom that has been associated with the mentally retarded population. It is based in part on research conducted during the two years I have spent as a graduate student, and also from my own experiences over 18 months as a counselor for the mentally retarded. The fundamental issue addressed is the nature of freedom that has historically been experienced by the mentally retarded population and how this freedom has changed over time.

The first chapter, entitled "The Mentally Retarded Community," addresses the nature of freedom that has historically been experienced by the mentally retarded population. This freedom, or more accurately, lack of freedom is reflected in the social attitudes that have confronted these people and their living arrangements as determined by their society.

Prior to the 1970s, individuals in the United States diagnosed to be retarded were routinely removed from society and placed into large state-run institutions. These custodial or "total" institutions (c.f. Goffman, 1961) afforded the mentally retarded little freedom. The belief was that the institution could serve the best interests of the mentally retarded **and** society by permanently removing these people from society. In effect, institutionalization simply provided a means for assuring that the mentally retarded would receive minimal requirements for their custody: food, shelter, and clothing.

The deinstitutionalization program of the 1970s involved the relocation of thousands of mentally retarded people from state-run institutions into localized community residential facilities. Behind the court rulings which led to this development was a belief that these people were legally entitled to more therapeutic and humane living conditions. By virtue of being both ineffective in the habilitation of the retarded, and financially unable to correct this problem, institutions were considered to be illegally detaining the retarded and thus preventing them from developing into potentially contributing members of society. This change in society's approach toward mental retardation marked a transition from a goal of custodial care to a goal of therapeutic care. This shift is also marks the beginning of a transition from habilitation systems which were formal in nature to poten-

tially communal organizations. As evidence of this shift from formal to communal organization, Chapter One presents a structural/functional model of the Oakton Group Home based on a content analysis of its management. This analysis demonstrates that there are conditions in place in group homes for the potential establishment of a communal form of social organization.

In the second chapter, this thesis addresses the current level of freedom as experienced by the mentally retarded population. One manifestation of communal organization is the ability of these organizations to maximize freedom among their members (Hillery, 1978). If we are to view group homes for the mentally retarded as having the potential to become communal organizations, then it is imperative that there exist evidence of attempts to maximize the freedom of the residents of these group homes. My own experiences and observations of the living conditions at Oakton are used to demonstrate the methods by which this one home does in fact attempt to maximize the freedom of its residents. In addition, interviews with the residents of Oakton are presented in order to assess the current level of freedom experienced by the residents.

Finally, the third chapter presents my own observations of the social processes and daily activities found in this group home. Whereas the first two chapters present a structural analysis of group homes and the subsequent functional

consequences of this form of social organization, the third chapter is concerned solely with the essence of group home life. Although subjective in nature, these observations, in conjunction with the analysis of the group home's management plan and the findings of the interviews, support the conclusion that the establishment of group homes for the mentally retarded does in fact represent a potential shift from formal to communal organizations, and thus a potential for the maximization of freedom among these people.

Chapter I

THE MENTALLY RETARDED COMMUNITY

There has always been (and always will be) a retarded segment of society. And, while today a great deal is known about this condition, defining this segment of our population has remained a constant problem throughout the history of mankind. Some definitions have referred to the mentally handicapped as "being punished by god" (as presented in Kanner, 1964), or "incapable of fulfilling obligations to society" (Goddard, 1914; as cited in Krishef, 1983). It is only recently that the definition of mental retardation has begun to approach an understanding which precludes any notion of religious determinants and/or an inability to perform moral obligations in society.

I believe that an understanding of the freedom experienced by the mentally retarded is nonetheless reflected in the attitudes held toward those so afflicted by the normal members of their societies over time. We can therefore approach an understanding of the nature of freedom as experienced by these people through a consideration of the historical evidence. In addition, the residential patterns of the mentally retarded throughout history provides evidence as to the freedom experienced by this social unit. The ability to move through society must be seen as one manifestation of freedom. Restrictions placed on that movement represent restrictions placed on the freedom of individuals.

1.1 HISTORICAL APPROACHES TOWARD MENTAL RETARDATION

The existing literature on the early attitudes toward the handicapped (physically and/or mentally) is rather limited. There are however a few early references. The earliest references are found in religious books (such as the Koran and Bible) and suggest a moral treatment of the handicapped. These sources however provide no evidence of any systematic efforts toward these ends.

The first references of organized treatment models for the "sick" can be traced to the early Egyptians (Krishef, 1983). This civilization is the first documented to have provided "healing temples" where the sick could retreat from society. It is thought that the retarded were likewise sent to these temples for the sick, although there is no direct evidence for this assertion. The next references come from the Roman and Spartan civilizations. It is a well established fact that these civilizations were known to eliminate the severely defective by leaving them to die on high mountain tops or in the woods (Kanner, 1964; Wolfensberger, 1975; Krishef, 1983). It has been suggested that this response was based on the belief that diseases and abnormal behavior were associated with evil spirits and that if the person was removed from the community the evil spirit could not infect any more members. Kanner (1964) has argued that although a few mentally retarded were known to have been kept around for entertainment during the Roman Era, the vast

majority were exposed to the elements due to a concurrent belief that physical and mental fitness were vital to the "Glory of the State".

It is noteworthy to point out that the attitudes and treatments described thus far occurred either prior to or during the development of the idea of freedom. Furthermore, at this point in the history of mankind, freedom referred to the ability of the city-state to realize its potential, not individuals (Muller, 1963: Laski, 1933). It should come as no surprise then that the severely defective were probably abandoned at birth or killed outright. Those individuals who were unable for any reason to pursue endeavors deemed beneficial to the state were more than likely viewed as preventing the city-state from attaining its full potential. In this sense, the mentally retarded must have been seen as burdens upon city-state, and thus unworthy of living in that society. Freedom as the right of individuals toward self-realization did not occur until the rise of Stoicism and the Christian Era.

During the early Christian Era (approximately 400 AD) we find the first references of a protector of the "feeble-minded", Saint Nicholas Thaumaturgos, the Bishop of Myra (Kanner, 1964). This is the same Saint Nicholas who would become better known as the patron saint of all children, sailors, and pawn brokers; a.k.a., Santa Claus. Continuing into the Middle Ages, the first asylums were built in Europe,

serving as refuges for the otherwise less fortunate members of society (Kanner, 1964). These were nearly always run by churches and allowed for the freedom to go in and out. Presumably, some retarded may have used these services. Also, there are numerous accounts of "fools" being kept in the courts and palaces of European kings during the Middle Ages.

It thus appears that there was a major shift in the attitudes of normal members of society toward the handicapped occurring around the beginning of the Christian Era, and continuing into the Middle Ages. Whereas before, these people were repulsive and to be feared (as evidenced by their abandonment and exposure to the elements), this new attitude seems to represent tolerance and to a lesser degree acceptance. As such, the retarded were allowed to roam freely and were provided with some amount of care in the forms of food, shelter, and clothing. During the years between 1100 and 1600 AD, we know a "Feast of Fools" was observed in many of the countries of Europe. During these celebrations, citizens were allowed to act out their most basic desires. Presumably, ranting and gluttony (also a trait largely attributed to the fools) were among these basic desires. However, this acceptance of mental and physical handicaps was not without limitations. The retarded were considered a primary source of amusement for the rest of their community (as implied by the term fool), not as equal members of that community. But

even this limited acceptance would disappear during the Reformation and Renaissance.

During the Reformation in Europe we find the development of the worst attitudes and treatment toward the retarded. Those who could not be responsible for their own actions were pressured by the community and were often subjected to harsh and cruel treatment (Krishef, 1983). All mental defectives were now labelled madmen with madness being considered the manifestation of God's wrath. These madmen were sent to dungeons where they often perished. Others were killed outright. The attitude toward these people is best represented in a remark made by Martin Luther in one of his Table Talks (as cited in Kanner, 1964). While visiting the Prince of Anhalt, Luther was confronted by a retarded boy being kept in the court. Appalled by the behaviors of the boy he asked the prince why he was not taken to the river and drowned. He referred to the retarded boy as being a "mass of flesh with no soul", and possessed of the devil.

Toward the end of the Reformation and the beginning of the Renaissance, we find reports of "Ships of Fools" sailing from port to port, bearing cargoes of mental defectives (Foucault, 1973). These individuals were often rounded up in the cities of Europe and (if not imprisoned) were turned over to sailors for their removal to other regions. During the high times of the Renaissance another transformation of public attitudes is reported by Foucault (1973). Madness was

now seen as a possible attribute of every man; one of the many moral dualities. Religion still played a large part in the diagnosis in that mental deficiency was nonetheless considered a result of sins. However, it was at this time believed that madness was the result of sins committed against oneself, such as vanity, and the other deadly sins. Before, the causes were unknown except to God and in any case, unquestioned.

Madness, which during the Reformation represented all that was evil (including death), became during the Renaissance sickness once again. During the 17th century, a period referred to by Foucault (1973) as "the Great Confinement", many "hospitals" were established to house madmen. Upon entering these hospitals however there was no therapy (except for extremely cruel punishment), and little if any opportunity to leave. Most of those confined died during their imprisonment.

During the Middle Ages we thus see many variations in the attitudes held toward, and the freedoms experienced by the mentally handicapped. At various points in time, mental deficiencies were deemed just causes for removal from society, either by imprisonment, or export, or death. At other times, these people were free to "roam the streets and countrysides" or seek shelter from society in asylums. There were also some consistencies. The causes of foolishness, madness, or idiocy were consistently believed to the result

of divine intervention. The insane and the retarded were considered the same (morally deficient) and treated alike. Mental handicaps were for the most part considered incurable and intolerable disorders which limited a persons ability to survive in or outside of society.

One might ask why there was no apparent differentiation between those people born with mental and physical disorders, and others who became insane later in life. The evidence presented here would suggest that historically anyone born with such afflictions was more that likely killed. The defects were most likely believed to render a person incapable of surviving in the mode of living for the day. Families before the industrial revolution were to a large extent economically self-reliant units and depended on children to provide additional labor. There was no concept of childhood as we know today. Any defective child allowed to live would be a complete economic burden on the parents who attempted to raise such a child. As a result most probably were either abandoned or killed at birth if the defect had manifested itself at that time. Mental deficiencies occurring later in life were similarly thought the result of divine intervention. These people were likewise considered economic burdens and abandoned by their communities. While we know that a few people with mental and physical handicaps did survive (as evidenced by the reports of fools in the courts of emperors and kings), the attitudes

toward these survivors involved ridicule and contempt and never involved a true notion of acceptance at the societal level. There was no practical distinction between the mentally retarded and the mentally ill prior to the 18th century. Medicine at the time was not concerned with such issues. It was not until the middle of the 18th century that a scientific interest in the condition later to be known as mental retardation spread through Europe.

With the abandonment of religious determinants of mental handicaps we find the first evidence of a rational system of study of mental retardation and the development of systems of habilitation for the handicapped. Jacob Pereire (1715-1780), one of the first to work with the handicapped, proved that it was possible to teach retarded deaf mutes to communicate and developed a sign language for the ones with which he was working. His neighbor, Jean-Jacques Rousseau, would later refer to Pereire as the "only person in his time who could make the mute talk" (as cited in Kanner, 1964). During this era known as the Enlightenment, Rousseau and other social scholars became concerned with the causes of oppression and the neglect of slaves, prisoners, the insane, the blind, and the deaf.

It is also during this time that a new philosophy of treatment for the mentally handicapped arose. In 1793, Philippe Pinel (1745-1826) was appointed director of the insane asylum of Bicetre (France) and instituted a new

therapy called "moral treatment". Pinel argued that the insane would improve if treated with kindness and sympathy (Cockerham, 1981). As the new director, he immediately ordered the patients released from their cells and the beatings and other punishments be suspended. Many mentally ill patients subsequently did improve sufficiently to be released from the asylum.

The first figure to work solely with the mentally retarded was Jean Marc Gaspard Itard. At the turn of the 19th century, Itard began what is perhaps the most famous case involving a retarded person. Itard began his study of the "wild boy of Aveyron". Many scholars of the day were wondering whether this feral boy was in fact an example of Rousseau's natural man (Kanner, 1964). Itard proposed the boy was retarded as a result of social isolation and educational neglect, and that with proper treatment, it might be possible to cure him. This model of retardation is one of the first to consider educational and social factors of causation, and paved the way for later formal definitions of mental retardation. While Itard never succeeded in curing him, he did teach "Victor" to recognize objects, letters of the alphabet, and a few words. Itard had taught Victor to bathe and dress, and in five years of working with him had taught Victor to prefer civilized/social life (Kanner, 1964). The work of Itard is important for several reasons. Of chief importance is that he showed that the retarded could be

educated, learn life skills, and function properly in society, even when severely retarded. He likewise demonstrated that it was possible to improve the lives of the mentally retarded.

The first residential facility built specifically for educating the retarded was established by Johann Guggenbuhl in Switzerland, in 1840. Within a few years, based on reports of dramatic successes by Guggenbuhl, institutions began springing up throughout Europe and the United States. Wolfensberger (1975) describes the attitude of this era as involving the desire to make the deviant less deviant. However, in the 1870s, facilities began focusing on teaching vocational and living skills, instead of the educational focus of the earlier treatment. The earlier reports of successes in educating the retarded had proven to be less than adequate. These facilities soon dropped the label of "school" and adopted the label "asylum". These years also mark a new attitude toward the mentally handicapped. Wolfensberger (1975) describes the period between 1870 and 1900 as one in which a major goal of residential programs was to protect the deviants from the non-deviant. Developmental models of treatment soon evolved into models of pity and charity.

Wolfensberger (1975), who has spent much time analyzing the conditions of the mentally retarded, suggests that the custodial function of these residential programs came about

as early as 1880. Prior to this time, the author writes that the institutions were established first in an attempt to educate or train these individuals, and later to protect them from a hostile society. Around the turn of the 20th century, Wolfensberger points to the development of an attitude which treated the retarded as social menaces, and states that the purpose of the mental hospital became "protecting non-deviant individuals from the deviant people" (1975:33). This sentiment is supported by Khulmann (1940), who states that during this period the public began to view the retarded as menaces and bearers of poverty and crime. The public sentiment was that the retarded should be isolated from the normal population in order to "cleanse" society. Retarded men were viewed as intensive economic burdens upon the larger society, and retarded women were feared even more because of their ability to reproduce. Wolfensberger states that this institutional orientation continued to exist at the time of his publication.

Organized efforts to prevent retardation through sterilization began around the beginning of the 20th century (Wolfensberger, 1975). A lack of sound knowledge of statistical procedures led the researchers of the day to conclude that mental retardation was purely hereditary.[1] This

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[1] Until recently, it was held that if individuals were born retarded, all of their offspring would be born retarded. It is know known that there are many causes of retardation which do not occur as a result of inheritance. Likewise, we now know that those so afflicted are not certain to produce

resulted in the belief that through forced sterilization of the retarded, along with a system of informing the public of high risk conditions, we could one day be rid of this incurable condition. The policy of indiscriminate sterilization continued through the 1970s. Today, sterilizations are still being performed in most countries (including the United States) but usually require the prior consent of parents or court appointed guardians.

1.2 THE DEINSTITUTIONALIZATION MOVEMENT

Many classic studies of organizational structure include mental institutions within their typologies (Katz and Kahn, 1966: Etzioni, 1960; 1961: Blau and Scott, 1962: Perrow, 1967: etc.).[2] Their inclusion indicates that mental institutions were considered stable enough phenomena to serve as models to which other organizational forms may be compared. Perrow (1967) categorizes the mental hospital as a "routine" organization with well understood, uniform and stable materials (the clients). This he states is accomplished through a process of deindividualization.[3] And yet, these early studies agree more on the instability of these organ-

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retarded offspring.

[2] This thesis is concerned primarily with the residential facilities of mentally retarded adults. Prior to the deinstitutionalization movement however, the retarded and the mentally ill were usually housed together in large public institutions.

[3] For further elaboration of this process, see Goffman, 1961.

izational forms than on their stability. Typically, it is pointed out that while the stated goals of these organizations are therapeutic, they are in fact organized toward custodial functions. Etzioni (1960) suggests that most mental hospitals cannot be effective at serving therapeutic goals for several reasons, including: (1) internal factors, such as the low ratio of professionals to inmates, and our limited knowledge of effective therapies; and, (2) external factors, such as environmental resistance to community placement. For these and other reasons, the author concludes that mental hospitals are nearly always forced into a custodial capacity. Etzioni points out that even systematic attempts to remedy this condition have historically failed. These custodial goals are designed to: (1) maintain the inmate population; and (2) maintain the organization. This notion is best illustrated by Greenblatt, York, and Brown:

> "In the very act of trying to operate these institutions their **raison d'etre** has often been neglected or forgotten." (Greenblatt, York and Brown, 1955; as cited in Etzioni, 1960).

In his book Asylums (1961), Goffman asserts that there are similarities between prisons, mental institutions, military barracks, etc.. These similarities revolve around the potential for each of these structures to completely regulate the lives of those who enter these organizations. In defining his ideal type, Goffman proposes that:

> "A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society

> for an appreciable period of time, together lead an enclosed, formally administered round of life." (1961: xiii).

Goffman goes on to distinguish among five categories of total institutions, based on the functions they serve. For our purposes, he proposes that mental institutions function to:

> "... care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one...." (1961:4).

The deinstitutionalization movement arose from the development of a series of new attitudes toward the mentally handicapped. During the 1950s, the pharmacological revolution introduced many new drugs which were able to suppress the outward manifestations of many forms of mental illness. As a result, many of the mentally ill residents of institutions were able to improve significantly and returned to the community. Once in the community, these mentally patients were provided with community-based clinics which served to monitor the patient's progress and provide prescriptions for any appropriate medications.

Soon afterwards, during the 1960s and 1970s, it became apparent that the mentally retarded should no longer be considered hopeless individuals, but had the potential to become productive members of society. The physical and social environment of the retarded was found to be a crucial factor in their potential development. Beginning in the 1970s, we see the development of a national movement directed towards establishing new facilities specifically for the

mentally retarded. There was a growing awareness that the retarded were capable of learning skills necessary for living independently in society, provided they be given the proper environment for developing those skills.[4] Yet there is little documentation in the sociological literature reflecting this new understanding of the social variables associated with mental retardation, and there is no description of the social processes occurring in modern residential facilities.

These first efforts at deinstitutionalization resulted in the creation of "training centers". These training centers, like their predecessors, were however ineffective in the therapeutic training of many of the residents. Group homes for the mentally retarded evolved from the recognition that the large public institutions were too expensive to maintain,[5] ineffective at habilitating the retarded, and in violation of certain legal rights of the residents (Baker, Seltzer, and Seltzer, 1977). Tracy and Sturgeon, have defined deinstitutionalization as "a process of reorganizing the delivery of services system" (1981: 1.1.1). This reorganizing process has been aimed at establishing a more

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[4] This orientation represents a new trend in the way we perceive the retarded and their relationship to the larger society.

[5] The costs associated with housing the mentally retarded in group homes is roughly half that required for their custodial care in institutions. This may be due in part to the fact that the ratio of residents to direct-care staff in institutions is approximately 0.9. In the average group home this ratio approaches 2.0

effective system for providing therapeutic services to the mentally retarded. Concurrent with this national movement was the establishment of group homes. Resulting from the increasingly widespread belief that the needs of the retarded could best be served in smaller, more therapeutic surroundings, there has been a massive exodus from the mental institutions over the past 15 years.

1.3 GROUP HOMES FOR THE MENTALLY RETARDED

Recent years have witnessed many changes in society's approaches toward the mentally retarded. It is hard to realize that only twenty-five years ago, doctors routinely recommended that children be sent to state institutions for their own good (when diagnosed to be retarded at birth). Many current residents of mental hospitals remain there as a result of such medical advice. However, the majority of the mentally retarded today have left these institutions and taken up residence in other forms of residential facilities. The deinstitutionalization movement in America was directly responsible for the granting of certain legal rights to the mentally retarded, and thus may be seen as a turning point in the nature of the freedom experienced by these people. One manifestation of this movement was the creation of group homes for housing mentally retarded adults.

Group homes for the mentally retarded are becoming commonplace phenomena in our communities. While the older institutions often housed around 1,000 mental patients and

were located away from the urban areas, these residences typically house from 5 to 15 clients and are generally located in existing residential areas (Baker, Seltzer, and Seltzer, 1977). These organizations are highly institutionalized,[4] with a vast array of procedures for managing the home. The general goal of these facilities is to train mentally retarded individuals in the skills necessary for independent living. There are generally no time limits for completing training, nor are there placement quotas. Group homes often refer to themselves as short-term facilities, and initially set goals of roughly two years for the completion of training.

The teaching of skills in the group home may be seen as a socialization process. A closely associated principle governing the management of most group homes is the "developmental model" which argues that all individuals are capable of learning any skill, the difference being in the time frame required for that learning. The retarded are seen as being slow learners (i.e., the definition of retarded), not hopeless individuals. Some skills, such as reading, math etc., are taught in a classroom format. Other skills, such as cooking, cleaning, shopping, community awareness, etc.,

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[4] The structure referred to as the **institution** and the notion of being highly **institutionalized** should not be confused as referring to the same phenomenon. The former refers to a specific type of residential structure. The concept of being highly institutionalized as used in this thesis refers to a more general principle of social organization.

are taught in a manner similar to those used by parents to teach their children the same skills (i.e., direct participation). While the skills to be taught are structured in format, counselors are expected to tailor the programs to the abilities of each resident so that progress is assured. This assurance is thought to foster the self-esteem of the residents and to encourage their continual commitment to the program. These skills typically include the areas of self help, money and home management, social and interpersonal development, hygiene, knowledge of community resources and mobility through the community, simple math, survival reading[7], recreation and leisure skills, and behavioral adjustment.

What best distinguishes these residential facilities from prior facilities has been the adoption of the goal of "normalization". Normalization has been defined as:

> "the principle of helping individuals who are developmentally disabled to obtain an existence as close to normal as possible, by making available to them patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream society." (ACMRDD, as cited in McCarthy, 1980: 33).

In many ways, the group home resembles a normal community residence. In all of the group homes I have visited, great measures are taken to avoid giving the image of a "rehab" facility. All areas of the home are accessible to the

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[7] Survival reading involves teaching individuals to recognize important words, such as hot, cold, danger, warning, poison, stop, etc..

residents, although permission is often required to enter the office. Residents are at the same time given the privacy of having their own rooms, and most doors can be locked from the inside (for example, bathrooms, and bedrooms). Normal decorations are found throughout the facility. Control switches to televisions, stoves, lights, outlets and other appliances are rarely covered by "protective" or preventative devises. The above practices are seldom found in institutions, since the institution by definition cannot be viewed as a normal environment. Some exceptions to this normal perception are those required of any multifamily facility, such as fire extinguishers, and the required posting of evacuation plans. All in all though, one is generally impressed by the air of normalcy upon entering most group homes.

1.4 THE GROUP HOME MODEL

The Oakton Group Home attempts to complete the transition to independent or semi-independent living in two years (although the projected time frame is highly dependent on the assessed needs of each client).[8] However, this goal does not play a part in determining the successfulness of the home, nor in the fates of the residents. There are in fact several

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[8] Semi-independent living arrangements differ from independent in that the resident receives periodic follow-up, usually on a weekly basis. These follow-up visits may involve additional training in non-vital areas, such as baking, or may involve assuring that bills are paid on time, and appointments are kept.

residents who are not expected to complete the training sequence, but are nonetheless allowed to remain as residents of the home. The only stipulation along these lines is that the residents participate in the training.

Reviewing the management plan of Oakton, the goal or "mission" is stated as providing

> "retarded adults with a community alternative to institutionalization, and providing training toward independent community living" (Riley and DeBusk, 1987).

Two things are apparent from this goal. First, there is a perceived superiority of community living arrangements to institutionalization. Second, it becomes apparent from this mission that the retarded are perceived as being capable of eventually living in an unsupervised situation. As such the program is oriented to developing within the residents skills that will eventually allow them to leave the program. The goal is not to retain members (residents), but to move these residents through the program. This goal differs from a specific goal in that the sole concern is the welfare of the residents. The lack of measurable goals (i.e., making a profit, successful placement of a specific percentage of all residents who enter the program, etc.) allows the group home management the freedom to concentrate on the welfare of the members. The mission or goal of Oakton gives primacy to the welfare of the members of the organization (specifically, the development of skills necessary for a normative life style), not specific goals.

This absence of specific goals is consistent with Hillery's definition of communal organizations (1985). Communal organizations are defined by Hillery as "highly institutionalized systems that do **not** give primacy to specific goals" (1985: 35). Hillery defines specificity as something measurable; one can know whether one has been successful in attaining the goal. Specificity gives things such as goals and products more importance than people. A clear illustration of this notion of specificity is found in production organizations, where the product, and the means for producing that product, are generally more important to the organization than the members of that organization. This is not meant to imply that communal organizations have no goals: All human organizations have goals. What distinguishes communal organizations is that their primary goal is the general welfare of the members of the group, not the attainment of specific goals. Thus the Oakton Group Home may be seen as meeting the initial criteria of communal organizations, as defined by Hillery. It is a highly institutionalized system, which does not give primacy to specific goals.

In Hillery's earlier studies of communities (1959; 1961; 1963; 1968), he constructs an empirical model (the vill) based on the features commonly reported in the existing descriptions of accepted communities. Hillery proposes 19 characteristics, or components, which are found to exist in each of the case studies (10 villages, and 5 cities). Of

these components, Hillery concludes that all variations in the systems studied stem from the functional consequences of changes in three independent components, or foci: locality (the spacial component), cooperation, and the family (Hillery, 1963; 1968). These foci are seen as the important components of all communities, representing continua, which vary in degree, or **quantitatively**, from system to system.

Some of the spacial components of group homes have already been discussed above. At Oakton, as well as the other group homes I have observed, space was organically and mechanically determined.[9] In the first sense, the home has a set of rules which address the allocation of space (see Appendix A). Unlike the rules governing space in the mental institution, these "practices of the house" are designed to create a sense of normalcy in the home. Specifically, they give residents complete control of their own bedrooms, and permission is required (even by staff) in order to enter someone else's room. Locks are on every bedroom door, on bathroom doors, and on the office doors. The office is not the restricted domain of staff. Residents, with permission, frequently use the office (for phone calls, training programs, etc.). Staff on the other hand, are expected to spend as little time as possible (by contract) in the office, under the premise that they are role models for the residents (not

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[9] The terms mechanical and organic solidarity are used here in the Durkheimian sense (cf. Durkheim, 1933).

caretakers). At the same time, these rules attempt to create a sense of mechanical solidarity (See specifically, Appendix A--rule 2). With the exceptions of bedrooms and the office, all areas of the home are accessible to the residents and staff alike.

Discussing the spacial focus, Hillery further describes the vill as a base of operations, from which all activities (economic, political, recreational, etc.) are organized and directed (1963; 1968). The boundaries of vills are vaguely defined, implying that members may readily pass through these boundaries. In contrast, his study of space in total institutions leads Hillery to write that:

> "Space was integrated according to the custodial or treatment goals of staff in reference to inmates.... Boundaries were 'pathologically' sharp and were part of and symbolic of staff's control over inmates." (1963: 783).

Through the utilization of the normalization principle, all of the group homes I have observed have established spacial arrangements similar to those reported by Hillery in his works. The boundaries of the group home are somewhat vague, as in the vill model. Residents are free to leave the grounds unsupervised, and they travel freely throughout the local community (although they are expected to inform staff). The group home also serves as a base of operations from which the residents plan their social, recreational, and economic activities. In addition, all residents are expected to have daytime activities away from the home (currently, all

residents at Oakton participate in sheltered work). Thus, the spacial component of group homes seems to vary from the vill model by degree, or quantitatively, not as in the mental institution, qualitatively.

The second focus of communal organization, cooperation, is viewed by Hillery as a continuum, ranging from a pure form of mutual aid, to a pure emphasis on contracts. This cooperation, whatever form it takes, must likewise exist between all members of the communal organization. In group homes, cooperation is institutionalized in a contractual nature between the two groups. Residents "choose" to live in these facilities through the application process, and as such agree by contract to live by the rules of the group home. The application process in part results from a need to assure certain minimal criteria have been met (typically, the ability to dress and bathe independently, as well as certain social skills), and also results from the fact that there are at present far fewer rooms available in group homes than there are people seeking residency. The staff are expected (by contract) to show compassion in all of their interactions with residents. Residential counselors are expected by contract to be teachers, advocates, counselors, and role models.

While many of these functions are contractual (implying organic solidarity), counselors often develop true friendships with their "clients", implying a sense of mutual aid in

the interaction of residents and staff. Residents, on the other hand, tend to rely on staff to solve most of their problems, supporting the notion of mutual aid. The cooperation in group homes occurs between staff and residents (not within groups), and there is little evidence to suggest a split between the ongoings of staff and residents, as reported by Hillery (1963; 1968) to exist in institutional models. And, while cooperation is largely contractualized in the group home, my observations lead me to conclude that there also exists a mechanical solidarity in the group home. At Oakton, residents often refer to staff as their friends and sometimes refer to them as "mom" or "dad". In nearly all cases, the relationships of staff to residents were of a mechanical nature.

By my observations, there is rarely hostility between the staff and residents (as reported to exist in institutions by Hillery, 1963; 1968). Conflict, while existing in the group home, is not institutionalized as in the mental institution. When it arises, the conflict is nearly always resolved through normative means. I rarely recall staff resolving conflict by asserting their "power" over residents. In fact, conflict is anticipated in the group home. The management plan for Oakton prescribes the following steps be taken in order to seek compliance: (1) an analysis of the task to assure its feasibility; (2) behavior modification (positive reinforcement); (3) individual and group counsel-

ling; (4) peer pressure through a residents' council; and last (5) the removal of privileges thought to resemble natural consequences for failure to complete the specific task or skill (Riley, and DeBusk, 1987).[10]

The removal of privileges is reported by Etzioni (1961) as a common form of coercive control utilized in therapeutic mental hospitals. I would argue that while this is true, this form of coercion (as found in the group home) is not unique to these residential structures, but is in fact basic to many social institutions in our society (including the family). The situation is very similar to what might occur in the normal household if a child refused to bathe or do his/her chores. To the degree that conflict is institutionalized in the group home, I suggest that this is done to control the potential power of staff, not the actions of residents.

All things considered, cooperation in the group home seems to exist on the continuum described by Hillery in the vill model. It is mostly of a contractual nature, although mutual aid occurs in the interactions of staff and residents. More importantly, this form of cooperation occurs between staff and residents and does not lead to an antagonistic

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[10] In reality, most of these natural consequences result in the resident relinquishing his or her town privileges until completing the task or program. As an example, if a resident refused to bathe for a few days, he or she would not be allowed to go into town under the premise that the resident is poorly representing the home.

split between the two groups. The purpose of cooperation is to facilitate the general welfare of the residents and involves their input in decisions that affect them.[11]

Of the three foci common to communal organizations in Hillery's theory of communal organization, the family is conspicuously absent from the group home.[12] This phenomenon (the absence of one of these foci) has been the subject of Hillery's more recent works (1984; 1985). These studies have lead Hillery to conclude that there are in fact accepted communal organizations in which one of the foci (i.e., family, space, and cooperation) is missing. As an example, the bio-social family is missing in the monastery. A similar situation is reported in the gypsy band in which the spacial focus in missing in as much as there are no boundaries (vague, or otherwise). These findings lead Hillery to propose what is referred to as the compensatory hypothesis:

> "If a communal organization does not contain one of the foci of the vill, it will compensate by emphasizing **something else**" (1984: 309).

Thus, Hillery argues, in the monastery we find the absence of a bio-social family is compensated for by a strong emphasis on religious ideology; the gypsy band's lack of a definitive territory they can call their own is compensated by a strong emphasis on familial solidarity (1984).

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[11] See Appendix A--rule 18.

[12] In Hillery's theory of communal organization, the family component is based on the purely bio-social family unit.

In addition, Hillery's compensatory hypothesis suggests that a communal organization can survive while lacking one focus of the vill model, as long as it compensates by emphasizing something else. Hillery (1985:35) states that:

> "other communal organizations may accordingly be classified in terms of completeness according to the extent to which they lack the foci of the vill."

If the group home is to be considered as a viable communal organization, then there should exist evidence that the organization compensates for the absence of the bio-social family by emphasizing **something else.**

Our first indication that the absence of the family is being compensated for, as stated above, comes from the fact that some residents refer to staff as mom or dad. This would tend to indicate as least the perceived presence of family by some members of the home. As I began my experience as a counselor, it quickly became apparent that some of the residents I worked with tended to establish familial role relationships with staff. I believe this occurs due to the importance placed upon the normalization concept of management in group homes. In attempting to establish a structure "as close as possible" to a normal household, it seems that many of the roles associated with that structure are assumed by the members.

The roles of all staff in some ways resemble the roles of parents in a normal household. As stated above, the governing principle in group homes is normalization.

Residential staff serve the functions of advocate, teacher, counselor and role model for residents. At the same time, there are additional duties for counselors which are not typical of the parent/child relationship (such as the highly bureaucratized procedures for teaching skills, the documentation of all interactions with clients, etc.). Nonetheless, due to the similarity between the roles of counselor and the parental role, the two roles often become combined. This perception occurs for some residents, but not all. Some residents maintain the client/counselor relationship all too well, while in one case, a client treated me not as a parental figure, but as an older sibling.

1.5 DISCUSSION

Historically, then the mentally retarded have enjoyed little freedom. The evidence presented here suggests that initially, individuals possessing known mental handicaps in early societies were killed outright. Upon diagnosis these individuals had literally no freedom, relinquishing the very right to life. It should be pointed out however, that the notion of freedom did not apply to individuals at this point in history. Freedom inferred the right of the state to realize its maximum potential above and beyond the desires of it's "citizens." The masses (which certainly included the mentally handicapped) were merely subjects of the social system.

The evolution from a city-state form of society to the

empires brought about the recognition of the rights of certain individuals toward self-realization. This point in history is also significant for the mentally handicapped. For it is at this time where we find the first recorded instances of these people systematically receiving protection from the hostile elements of their societies. Although the handicapped did not share equally in the rights of citizenship (for that matter, neither did most people) they were in some respects tolerated. In addition, they had gained the right to life, and the freedom to move through society.

During the Reformation, these few freedoms were taken away. The mentally defective were imprisoned until death or killed outright. However, Foucault reports that eventually these people were simply removed to other regions. And, by the Renaissance, there are reports of hospitals being developed for the mentally handicapped (although the therapy of the day was rather ineffective). All in all this era does represent the attainment of several freedoms for the mentally handicapped. They were entitled to life and shelter. In addition, by the end of the Renaissance these people were entitled to primitive treatment models. However, the mentally handicapped did lose their freedom of mobility through society at this point in time, not to be regained until the 1970s.

With the Enlightenment period we find the mentally handicapped living in asylums designed to isolate these

people from society. We also find the first research which differentiated between the mentally ill and the mentally retarded. Furthermore, it is during this historic period when we find evidence to demonstrate that the retarded are capable of reasoning and performing certain life skills, given the proper social environment. These revelations paved the way for humane treatment models.

By the 1900s, a new attitude had developed in the United States. Asylums became custodial institutions and were designed to protect society from the mentally retarded. In essence these institutions became prisons. By being diagnosed mentally retarded, people were systematically removed from society. Within these institutions, the mentally retarded were largely ignored and received little to no therapy. In addition, the mentally retarded were sterilized in an effort to prevent this condition.

The nature of the freedom experienced by the mentally retarded historically is thus difficult to describe. There seems to be a few brief instances in which these people were in fact able to "choose and carry out their own purposes." For the most part however, this social unit has been subjected to the desires of society as to their disposition. Any freedom that existed must have been highly conditional in nature. While permitted to live, the alternatives for action have been historically few and highly conditioned by the directives of others. To the extent that the retarded

experienced freedom it can only be likened to the degree of freedom experienced by prisoners and slaves.

In this light, the deinstitutionalization movement takes on a new significance. It represents the first time in the history of civilization when the mentally retarded have been allowed to "legally" participate in society. This goal of re-entering society is often referred to as mainstreaming. Concurrent with this movement was the granting of previously unknown freedoms in the form of legal rights. In addition to the right to participate freely in society came the rights to humane treatment and therapeutic habilitation programs for those in need of such services.

Over the past 15 years, residential facilities for the mentally retarded have evolved greatly.[13] Initially, this system was one in which these people simply shared residences designed to house all mental patients (thereby removing these people from society). Today there is an array of residential facilities designed to effectively meet the needs of mentally handicapped citizens, based on their perceived needs for eventual independence from the residential system. The different residential patterns include living in boarding

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[13] The year 1972 is chosen as a reference point because of the significant court case, Wyatt v. Stickney, 1972. In this case, the Alabama courts ruled that institutions were negligent in the habilitation of the mentally handicapped (both the mentally ill and the mentally retarded) and ordered revisions in 49 standards involving the care of retarded citizens. The impact of this and many similar cases that followed lead directly to the development of community alternatives for this population.

homes, small, medium, and large group homes, adult homes, sheltered workshop residential facilities, and what Baker, Seltzer, and Seltzer (1977) refer to as "mini-institutions" or residential facilities which provide for the housing of as many as 100 mentally retarded citizens. Each facility differs in the degree and type of training provided for the residents. This thesis has considered only the group home model[14] due to its prevalence as the most common residential alternative for the mentally retarded.

The description of the Oakton Group Home presented here is consistent with Hillery's definition of communal organizations. This conclusion has been reached through the development of a structural/functional model of the group home and its typical management plan, and a comparison of this model to the model of communal organization developed by Hillery (1968; 1985). The group home is a highly institutionalized organization which gives primacy to the welfare of its members, not specific or measurable goals. In addition, the spacial and cooperation foci of the group home model are very similar to those described as existing in bona fide communal organizations, differing only in degree from the vill model (see Hillery, 1963; 1968). Based on my observations as a live-in counselor of a group home, I am led to conclude that the absence of the third focus of communal organization, the

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[14] More specifically, medium sized group homes of between 5 and 15 residents.

bio-social family, is compensated for in the role of the staff at Oakton. For the staff of this group home, there is a strong emphasis on developing within the residents the abilities necessary to live independently in society. These functions of the staff are very similar to the roles performed by parents in the normal household.

The concept of normalization, as practiced within the Oakton Group Home, fosters the establishment of a social environment in many ways similar to that found in a normal family household. Furthermore, this principle of management develops within this group home an organizational pattern consistent with that reported to exist in communal organizations by Hillery. The application of the normalization principle is thus central to the potential development of residential facilities for the mentally retarded which are communal in nature. Group homes that are organized in such a manner thus have the potential to provide the residents with two social experiences associated with the functions of communal organizations; love, and freedom.[15]

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[15] Love, as presented by Hillery, represents that condition in which people "attempt to work for the best interests of the beloved" (1978: 28). In the Oakton Group Home, this principle is a "prerequisite" for the employment of residential staff. Within the earlier institutional model, staff certainly were less concerned with the best interests of the clients than with maintaining the custodial goals of these organizational forms.

Chapter II

FREEDOM AND THE MENTALLY RETARDED

Freedom is not a natural law: it is a product of the social relationships that people enter into. Depending on the nature of these relationships people may be said to experience a variety of social conditions, ranging from freedom to oppression, from democracy to fascism. While differing societies have attempted to maximize these conditions over the course of history, none of these conditions can exist in a pure state. The concept of a purely free society is an ideal type, not a reality. Social arrangements precluded the notion of absolute freedom or oppression. In that individuals seek the company of others, they are occasionally bound to yield their own desires in favor of the desires of others. In the same light, by virtue of belonging to a social order, individuals relinquish some degree of their freedom. Freedom is thus a social variable. The "amount" of freedom existing in any social setting, as well as the type of freedom, is dependent upon the structure of the groups to which individuals belong (Hillery, Dudley and Morrow, 1977).

2.1 PHILOSOPHICAL APPROACHES TOWARD FREEDOM

Freedom is often discussed by philosophers and other scholars as possessing either positive or negative connotations. This conception of freedom can be more simply stated

as the debate between defining this term as the freedom "to" do something, or the freedom "from" coercion. In the first sense, freedom is represented as self-directed action based on rationalized decisions. This conception is presented by Muller, who defines freedom as "the condition of being able to choose and carry out purposes" (1963; in Dewey and Gould, 1970:14). Those proponents of freedom as representing negative connotations often point out that the freedom to act is predicated by the concept of freedom from coercion. To these writers, coercion can exist in several forms. Primarily, there is that form of coercion in which an individual is prevented from acting out his desires by other more powerful individuals. Coercion is also said to exist to the degree that regulatory laws discourage behaviors that the individual might otherwise seek to perform. Finally, some have argued that coercion may exist in unrecognized forms. This point is well-illustrated by Partridge:

> "Let us imagine an authoritarian society in which rulers have for years been so successful in controlling and manipulating what members of the community read and what views they encounter, and in which the educators have been able so subtly and skillfully to mold the minds and dispositions of the very young, that almost all citizens naturally desire what their rulers desire them to desire, without its ever occurring to them that there are alternatives to what they are accustomed to or that their freedom to choose has been in any way circumscribed. ... We would scarcely concede that the members of such a society enjoyed any or much freedom" (1967; in Dewey and Gould, 1970).

To the extent that all peoples' ideals and desires are shaped by their social environment, it may be argued that

their freedom is limited by what they perceive as realistic alternatives for action. In support of this notion, it has been further argued that all acts are in fact causally related to pre-existing conditions, and therefore can never be considered truly free acts. This argument has been developed to its fullest by Baron Holbach. Writing in the 18th century, Holbach concludes that:

> "the actions of men are never free; they are always the necessary consequence of his temperament, of received ideas, and of the notions, either true or false, which he has formed to himself of happiness; of his opinions, strengthened by example, by education, and by daily experience" (as cited in Dewey and Gould, 1970:113).

Taking these two seemingly antithetical positions into consideration, it should become apparent that the "freedom to" v. "freedom from" approaches to defining freedom do not in and of themselves fully capture the essence of this condition. A more accurate approach is to view freedom as representing a duality. There are both positive and negative aspects behind the concept of freedom. In the positive sense, freedom does imply that ability to carry out ones' desires. Regardless of the nature or number of alternatives, people do choose among them according to their desires, and the perceived outcomes of their actions. In the negative sense of the term, this ability is diminished to the degree that the choices available to individuals are restricted by other individuals, or by social laws concerning behavior, or are in some manner limited by social manipulation. As a

condition of our social nature, humans are bound to limit their choices while participating in the social arena. These conditions placed on our actions do not negate the fact that individuals do choose courses of action, nor should they serve as evidence against the presence of freedom. It is perfectly reasonable to accept the notion that all actions are causally related to pre-existing conditions, and at the same time accept the idea of individual preference as leading to the choosing of alternative courses of action.

Another area of concern is describing the various forms freedom may take. At the generic level, scholars have distinguished several freedoms associated with social life. The freedoms of religion and speech, as well as social, political and economic freedoms are but a few of the many types of freedom addressed by social scientists. At a more general level some researchers have attempted to determine the nature of various types of freedom according to their origins. These discussions of freedom are social psychological in nature and attempt to demonstrate the relationship between individuals, their social environment, and the resulting manifestation of freedom.

In his attempts to differentiate the various types of freedom at a more general level, Mortimer Adler (1958) distinguishes five forms freedom may take. The first of these, the circumstantial freedom of self-realization, refers to the ability under favorable circumstances to act upon

ones' desires. This freedom is conditioned by social relationships in that by definition circumstances must be favorable for such acts including the absence of coercion. The next form freedom may take according to this scheme is labelled the acquired freedom of self-perfection. This form of freedom recognizes the restrictions imposed on individuals by "moral laws" in their attempts to live as they wish. Inherent in this form of freedom are the conditions placed on the actions of people by a "higher" moral order. The third type of freedom discussed by Adler is the natural freedom of self-determination. This form of freedom involves the ability of all people to shape their character (or self-image) according to what they wish to do or become. For this type of freedom the choices of action available are not conditioned by social relationships in that there exists (by definition) several choices available, all of which are within the ability of the individual to select. The chosen alternative thus represents a manifestation of the self. The two remaining forms of freedom discussed by Adler, namely political and collective freedom, represent social freedoms that may or may not be conferred upon individuals, as determined by the nature of their social arena. Political freedom represents the ability to participate in the determination of moral laws and political bodies. Collective freedom is described as a futuristic state of affairs, in which humankind, through an understanding of the relationship

between the natural and social necessities, will ultimately arrive at a harmonious social arrangement which precludes the necessity of moral laws.

A more recent approach to describing the forms freedom may take according to the social relationships people enter into is presented by Hillery, Dudley and Morrow (1977). Through a series of surveys with people belonging to groups of varying organizational structure, Hillery, Dudley, and Morrow describe different types of freedom perceived to exist by the members of these groups, as determined by group structure. Their findings lead them to propose three forms of freedom:

> "...**ego freedom** may be interpreted as placing importance on having (or acquiring) the rights and means to do what one desires. **Conditional freedom** refers to the notion that other people or things are important in determining the manner in which an individual lives. Finally, **freedom as discipline** is associated with the beliefs that freedom requires sharing and sometimes sacrifice" (1977: 694).

These three forms are more or less consistent with the first three forms of freedom proposed by Adler. In addition, the authors state that it is possible for all three forms to exist at the same time in a given organizational structure, although one form should predominate.

This discussion of freedom is admittedly brief. However, it does provide a beginning point in the search for an acceptable definition of freedom which can be utilized in the evaluation of freedom among the mentally retarded population. The idea of freedom is a very large concept, encompassing

many facets of human life. It is a social psychological phenomenon, in that while freedom is experienced at the individual level, it is manifested in the social relationships individuals enter into with others. In addition, as our social arrangements have evolved and expanded through history, so has the notion of freedom. Freedom has grown from an idea involving the ability of a social system to maximize it's potential, into the ability of individuals to act according to their desires in society (Laski, 1933; Muller, 1963). Also, it is now understood that there now exists many different forms of freedom, each related to the different social institutions of our society. Thus, it is possible for an individual to feel free in one facet of his life (for example he may be free to express his religious beliefs), while at the same time not feel free in other areas (for example, he may not experience political freedom).

How then are we to define this complex phenomenon? There are some consistencies to the literature provided above. First, it should be clear that nearly all conceptions of this term incorporate the idea of individuals being able to choose courses of action according to their own desires. Muller's definition provides a simple and adequate expression of this concept: "the condition of being able to choose and carry out purposes" (1963; in Dewey and Gould, 1970:14). Even those who argue that there is no such thing as a truly free act essentially define freedom or "free will" in this

way. Second, most authors recognize the importance of taking into account the social environment of the actors. The social relationships people enter into in some way makes an impact on their abilities to perform as they desire and is often referred to as coercion. Furthermore, coercion can exist in several forms, each of which represents an intrusion into the alternatives available to individuals. Finally, it should be recognized that the form freedom takes is related in some way to the structure of the groups that individuals belong to.

Considering these issues it would seem that freedom represents an ideal type. In this sense, one can never be completely free. By virtue of belonging to and participating in groups, individuals relinquish some degree of their freedom to participate in other activities, at least during the time spent in those groups. Likewise, the condition opposite freedom, which I shall call oppression, is an ideal type. In this sense, I suggest that people can never be truly oppressed. The social reality of freedom thus represents a continuum, ranging from freedom to oppression. To simply ask whether or not a person is free in this sense accomplishes little. The expression of freedom by individuals is actually an expression of the degree to which people are able to perform as they desire, within specific social environments. A more beneficial approach is to determine the degree to which an individual feels free in certain aspects

of their social life as defined by specific group memberships. This approach may lead to a better understanding of the relationships between actors and groups, the nature of freedom as related to those group memberships, and the conditions by which freedom is maximized.

2.2 GROUP HOMES AND FREEDOM

Hillery suggests that "communal organizations are groups which can maximize freedom and to which love is essential" (1978:30). If group homes are to be viewed as communal organizations, then it follows that freedom, whatever form it may take, is a functional consequence of these organizational structures and should be experienced by the members of the group home.

The works of Goffman (1961), Wolfensberger (1975), and others who have investigated the social processes occurring in mental institutions demonstrate that historically, freedom has not been associated with the experiences of living in these facilities. Indeed, the labels custodial institution (as applied to these organizational forms by many organizational theorists) and total institution would suggest little freedom should be present in these organizational forms. It may be argued that the residents of mental institutions have freedoms within the structure as defined by the rules and regulations. This argument at face value seems to be consistent with the definition of conditional freedom presented above. Certainly, the choices available to resi-

dents are subject to (or conditioned by) the decisions of staff. It may be further argued that the structure of the mental institution lends itself to the development of freedom as discipline, in that the residents are required to sacrifice freedoms within the structure in hope of one day having both the skills and discipline required to live independent of these structures. However, it must be pointed out that mentally retarded residents in state-run training centers rarely choose to come to and live in these facilities. Furthermore, failure to abide by the rules is nearly always met with coercive methods of assuring compliance and punishments (not expulsion from the group). Considering that the residents have no direct role in determining these rules, nor in "choosing" to become members of these social organizations, I suggest (as does Goffman, 1961) they are merely inmates of the system, and subject to needs of that system, not active participants (thus implying the absence of disciplined freedom.)[16]

In the cases of those committed to training center wards at birth (or soon thereafter) there is a stepped sequence to the residential system for the mentally retarded beginning with the residential wards in training centers, and running through independent living. There is likewise a direct relationship between the type of residential facility in

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[16] This position is consistent with the argument put forth by Partridge (see p. 40).

which the retarded live, and the degree of personal freedoms experienced. The training center ward may be seen as representing the bottom rung of the residential and habilitation ladder. The mentally retarded living on these wards are rarely there by choice.[17] A large number of the residents of state run training centers are involuntarily committed, many of whom have been in the training center since birth. One has reason to expect little actual freedom associated with this level of the habilitation continuum. As I have suggested above, these mentally retarded individuals do not participate in the development of rules governing their actions within this organizational form. In addition, their mobility into other parts of the residential system is nearly always at the discretion of the staff.

When a resident has demonstrated "minimal" competence in certain independent living skills, he or she is eligible to apply for release from the training center, provided there is available room in another residential facility. Most often, these residents apply to live in group homes located within a relatively short distance from the training center. The group home represents the midway point in the residential

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[17] There are certain exceptions, however. A few of the residents I worked with in the group home, who had been reared at home, passed through the training center in order to be evaluated in areas of social development considered to be minimal qualifications for admission to the group home. These minimal skills typically include bathing independently, dressing independently, self-feeding, and (as would be expected at the institutional level) following the directives of staff.

continuum, ranging from total custody to total independence. It is significant in that placement in the group home represents a clean break from the institutional model, and its associated control over the daily routines of institutionalized people. It is perhaps more significant in that placement in group homes in some cases represents a transition from a formal organization to a communal organization. Upon entering the group home and completing the mandatory probationary/evaluation period, the mentally retarded begin to actually experience more freedom. They are at this point more free to participate in the determination of their lives, and more free to move through the barriers of their residential facility and thereby participate in the larger society.

In the group home, there is much evidence to demonstrate the presence of freedom. Furthermore this freedom would seem to be predominantly conditional in nature. Looking at the management plan of the Oakton Group Home, there are several indications that freedom is institutionalized at the group home level.[18] Rule 4 allows residents their right to privacy, which I consider an important indicator of freedom. Rule 5 states that the residents are "free to see staff at any time" (Riley and DeBusk, 1987). Rule 18 gives the residents the right to participate in the development of their own treatment plan, something unheard of most mental institutions. Other rules of the house specifically imply

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[18] See Appendix A.

conditional freedoms. For example, residents are free to leave the home, as long as they tell staff where they are going. Residents are free to use the phones, as long as staff are asked (for accountability). Ultimately, residents are free to quit the group home of their own volition (as long as staff are told this is their intention!). In fact, most of the residents' daily routines are generally governed by what appear to be conditional freedoms.

These freedoms found in the group home are important privileges to the residents, especially those who came from mental institutions. Residents typically have the rights (institutionalized freedoms) to do as they please, as long as staff are aware of their intentions and grant permission. This form of freedom differs from freedom as discipline, in that the residents are not required to "share or sacrifice" as an aspect of membership to the home, and their admission to the home is "conditional" on their agreement to abide by the rules of the home. Conditional freedoms would thus appear to be institutionalized in the group home. From the perspective of the staff, these freedoms are intended to develop among the residents a sense of equality within the group. They are likewise intended to encourage the residents to think for themselves and more importantly to eventually make rational decisions for themselves. Should the residents of group homes complete the independent living training regime, and demonstrate sufficient social maturity in the

area of decision-making, they may eventually move into new living arrangements and hopefully one day be able to experience the freedoms associated with normal social existence.[19]

2.3 MEASURING FREEDOM IN GROUP HOMES

This brief analysis of the content of the Oakton management plan demonstrates that the mechanisms are in place at least in the Oakton Group Home to accomplish this maximization of freedom for its mentally retarded residents. Furthermore, it was suggested earlier that the movement from an institutional setting to residence in a group home would imply a directly related increase in freedom for these residents. However, freedom is an experiential truth. While I have provided indicators which imply that this group home attempts to maximize the condition of freedom for the residents, this phenomenon can only be demonstrated to exist by the reports of those believed to be experiencing it. Therefore, it remains before this thesis to consider whether or not the residents of the Oakton Group Home perceive the existence of freedom in their group home, and if so, whether or not its presence represents an increase in the freedom experienced, compared with the freedom experienced in their former residences.

The best method for measuring the perceived presence of

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[19] Usually, the next progression along the residential continuum is supervised apartment living, hopefully followed by independent living arrangements.

freedom in the group home must be through direct interviews with those predicted to be experiencing this phenomenon. While measures are being taken to provide new found freedoms to the residents, the only way to know if the goal is being accomplished is to ask the residents. Similarly, the only way we can know for sure whether or not the degree of freedom has changed as a result of the transition from training center to group home, and what form the existing freedom takes, is to ask those who have made such a transition to relate any differences they perceive between the two environments. It was with these objectives in mind that I conducted interviews with the residents of the Oakton Group Home.

The questions asked in these interviews are open ended in order to allow the respondents to more fully relate their social experiences. These questions have been modified from an earlier survey developed by Hillery, Dudley and Morrow (1977) in an effort to measure the forms freedom may take in relation to the differing structures of communal organizations.[20] For the purposes of this thesis, I have made a few changes. The first modification has been to convert the indices as presented by the authors from a Likert Scale format to simple yes/no questions. This change is based on the premise that the Likert Scale format is founded on the ability of the respondent to perform abstractions. Having worked with the mentally retarded for two years, I believe

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[20] See Appendix B.

that the process of abstraction in many cases proves too difficult for the respondents and prevent them from providing accurate information concerning their experiences. By utilizing a method designed to provide nominal data (i.e., the yes/no format), all respondents are believed able to relate their experiences honestly and openly. Prompts were provided as needed to induce further elaboration. A second variation from the survey developed by Hillery, Dudley and Morrow is that some indices have been eliminated. In attempting to convert the survey questions into a nominal scale, some questions either seemed to duplicate others or proved to be what I perceived as presenting abstract concepts. The questions asked in the interview do however tap each of the dimensions measured by the authors[21].

During the course of the interviews I recorded the proceedings on audio tape. This was done in order to expedite note-taking. However, the tapes are and shall remain absolutely confidential, and no names of respondents or other residents, staff, friends, etc. are included in the written discussion of findings. In addition, permission was obtained from both the residential staff and the individual respondents prior to conducting the interview.

By presenting the self reports of the mentally retarded, this thesis provides further evidence as to the communal

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[21] For example, measures of ego freedom, conditional freedom, disciplined freedom and deprivation of freedom are included in the questionnaire.

nature of group homes. As stated above, while we know measures are being taken to provide as much freedom as possible for the residents of these homes, the successfulness of these endeavors to maximize the experience of freedom can only be determined through the reports of residents. And, although there have been several studies which describe the social environment of the retarded, as perceived by social investigators, little is currently known about how the mentally retarded perceive their social situations. The data presented here begins to provide just such information.

2.4 DESCRIPTION OF THE OAKTON GROUP HOME

Oakton is typical of most middle-sized (5 to 15 residents) group homes for the mentally retarded. This home is located in a small town in Southwestern Virginia. The 10 year old home is a modern facility, financed through state and federal funding programs. Oakton is situated on roughly 2 acres, located two blocks from the center of town, within an established residential neighborhood. The home has a wing with 12 single rooms on two floors for residents. In addition, the common areas of the home include: a kitchen, a living room with an adjacent dining room, a recreation room, 3 bathrooms, a laundry room, and a patio/sundeck. The office is offset from the common areas of the home in order to give the home a more "normal" appearance. There is attached to the home an apartment for the live-in counselor, and an overnight room for both guests and staff.

There are currently 11 residents at Oakton, 7 of whom have lived there more-or-less since the home was opened. In order to live there, residents must be between 18 and 65 years of age. There are 4 male and 7 female residents. All have been primarily diagnosed as being mentally retarded. In addition, there are several residents with adjunctive disorders (secondary handicaps), including epilepsy, cerebral palsy, polio-related disabilities. Four residents have Down's syndrome. One resident is non-ambulatory. The residents' functioning levels (as determined by IQ scores) range from mildly retarded to profoundly retarded. Of the current residents, 8 came to Oakton from the regional training center for the mentally retarded. The other 3 had lived with relatives before coming to Oakton. All residents currently have daytime employment outside the home at the two affiliated workshops.

What primarily distinguishes Oakton from the other group homes I have visited in the past is that Oakton is directly managed by a private corporation. The others are managed by regional Mental Retardation Services, under the supervision of their respective Community Services Boards. However, like all group homes receiving federal, state and local funding, Oakton is required to meet regional and state guidelines concerning the operation of the home and the rights of residents. Oakton is one of two residential facilities operated by this private corporation, which also includes two

sheltered workshop facilities. The second residential facility is a set of supervised apartments for handicapped individuals more fully capable of independent or semi-independent living arrangements.

2.5 FREEDOM IN THE OAKTON GROUP HOME[22]

These interviews were conducted during two sessions.[23] With the exception of one interview, all were conducted in privacy.[24] Each interview lasted approximately 30 minutes. Of the 11 current residents of Oakton, eight were interviewed. Of the three not interviewed, one elected not to participate. The other two residents were non-verbal. While this condition should not in and of itself preclude them from being interviewed[25], I elected not to interview them based on my familiarity with their mental capacities. I did not feel the residents were fully capable of understanding the questions to be asked, nor capable of recalling their living conditions prior to their arrival at Oakton. One was profoundly retarded (IQ less than 20-25) and the other severely retarded (IQ between 20-25 and 35-40). Although

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[22] Although the questions from the interview guide were randomized, they shall be grouped at this point according to the four concepts being measured.

[23] For a tabulation of these results, see Appendix C.

[24] One resident did not want to move to another room. Another resident was present at the time, but did not overtly interfere.

[25] The current survey does include one respondent who is non-verbal.

interviews were not conducted with these two residents, I did take them aside in order that they might receive the individualized attention the other residents were given.

Before presenting the results, a few explanations are in order. Although the questions were developed based on my perceptions of the abilities of the residents to comprehend and thereby answer reliably, there were 20 missing responses (out of a possible 112 responses). These responses have been recorded under the category of "Don't Know" (DK). More accurately, this label represents the fact that I was uncertain as to the response given. In only five cases did the respondent answer in this fashion. In most instances, the residents did not respond to the question at all. In these cases, either the residents did not comprehend the questions adequately, or specifically chose not to answer. In addition, there were a few instances in which I was uncertain as to the answers given by the residents. The 20 "DK" responses were given by six of the eight respondents. There was no discernable pattern to these responses. Similarly, no respondent consistently answered "yes" or "no". Of the remaining 92 responses given, I believe they represent an understanding of the questions by the respondents, and their honest opinions. Finally, the percentages given should be recognized as approximations to the concepts being measured, given the small number of respondents. The results are presented as percentages, followed by the actual number

of responses given.

The concept of ego freedom receives moderate support in this group home. Taken as percentages, 37% (12) of the responses given support the presence of this form of freedom, 47% (15) refute this presence, and 16% (5) fall into the category of "Don't Know". In the questionnaire, I approached ego freedom from two directions, and the responses may be divided along these lines. From the psychological sense of "feeling" egotistically free (questions 1 and 4), the responses indicate that the residents do have this perception (75%). From the stand point of the absence of socially imposed constraints on this form of freedom, 81% of the possible responses indicate an awareness of a daily routine and rules in opposition to the concept of ego freedom. I interpret this difference as suggesting that for most of the residents of this home, the house rules and daily routine have to some degree been internalized.[26] This would explain the existence of a psychological sense of ego freedom in the presence of what should normally constitute social barriers to ego freedom.

Conditional Freedom receives the greatest support from the interviews. The responses given to the four questions indicate a 59% (19) support rate for the notion of the residents' freedom in some way being conditioned by the

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[26] It will be recalled that 7 of the 11 residents have lived at Oakton since its origins.

presence of others. Only 16% (5) of the responses oppose this notion. Twenty-five percent (8) of the responses given fall into the category of "Don't Know". In this category, there is one question which presents considerable difficulty for the residents. Half of the responses to question 9 fell into the DK category (representing 50% of the total DK responses). While questions 8, 12, and 14 approach conditional freedom from the perspective of the residents' actions being conditioned by considerations of the welfare of other residents, question 9 would seem to have represented an abstract concept to these residents. If we neglect this question for the moment, there is even greater support for the presence of conditional freedom in this home (75% for; 8% against; 17% missing). However, even with the difficulties provided by this question, the overall results imply that the primary form of freedom at Oakton is conditional freedom.

The concept of disciplined freedom receives little support by the respondents. This conception of freedom was measured by only two questions and involved the idea of giving up or sharing possessions for the benefit of the group. Although this line of questioning only represents one aspect of disciplined freedom, it is nonetheless a significant aspect (if not the central manifestation of this form of freedom). Of the responses given, only 6% (1) suggest the presence of this form of freedom, while 88% (14) of the responses refute this notion. Six percent (1) of the

responses fell into the DK category.

The data indicates that the residents perceive themselves as being deprived of some freedom. The concept of derivation of freedom is supported in 50% (16) of the responses. Thirty-one percent (10) of the responses negate the presence of this condition, and 19% (6) are considered missing data. It is noteworthy that when measuring this concept by asking whether or not the residents wanted to leave the home someday, all responded affirmatively and specifically indicated a desire to eventually live in the supervised apartments affiliated with Oakton. Although asked as a part of the question, I could not accurately determine whether or not this desire to move into the apartments was due to a perceived greater amount of freedom. The only responses to my additional prompts indicate that the residents liked the proximity of the apartments to the workshop.[27] In addition, half of the respondents (4) indicated that the staff could do more to help them, while only two indicated that the staff was providing them with adequate assistance. However when asked to compare their former residences with residence at Oakton, eight responded that they had more freedom currently, while four indicated the

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[27] However, my knowledge of the residents leads me to believe they also prefer the lesser degree of supervision associated with the apartments, as well as the privacy found in single apartments.

perception of more freedom in the former residential setting.[28]

To summarize, of the three forms of freedom being measured, there exists a considerable degree of conditional freedom (59% support) in this group home. To a lesser extent, the presence of ego freedom in the home receives modest support (37%). Finally, there is very little evidence (6%) that the residents' freedom at Oakton is of a disciplined nature. Looking at the deprivation of freedom measures, the interviews provide ample evidence that freedom is perceived to exist by the residents of Oakton. Furthermore, the residents on the whole perceive a relative increase in their freedom as a result of moving to Oakton.[29] At the same time, all residents indicate a desire to someday leave Oakton, in favor of the lifestyle (and degree of freedom) associated with residence in the supervised apartments.

2.6 DISCUSSION

In the first chapter it was established that the Oakton Group Home is a communal organization. Recalling Hillery's definition of communal organization, this home is a highly

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[28] Interestingly, all of the responses given suggesting greater freedom in the prior place of residence, indicated that the resident had more opportunity to simply relax, or "rest".

[29] Although the numbers are to small to draw any truly meaningful conclusions, there is no apparent difference in this sample when the residents are divided according to whether they came to Oakton from the training center, or from the homes of relatives.

institutionalized organization. Nearly every facet of life at Oakton occurs within written guidelines and is documented either in the records of the residents or the records of the home. There are procedural guidelines ranging from step by step instructions on how to brush one's teeth, to procuring and utilizing federal food stamps. The second aspect of this definition, that communal organizations do not give primacy to specific goals, is likewise consistent with the purposes of Oakton. By providing a permanent place of residence for those who cannot master the skills necessary to function independent of some form of supervision, and at the same time allowing those who choose to leave regardless of their completion of the training program, the Oakton Group Home does demonstrate a concern for the welfare of the residents. The very goal of training the residents for their eventual placement into "independent" living arrangements demonstrates this concern for the welfare of the residents. Thus, the Oakton Group Home seems to have developed the proper conditions for the establishment of a successful, communal organization for the mentally retarded.

As a communal organization, there are several implications. Of primary concern is the conclusion by Hillery that communal organizations are those which can maximize freedom. This is most evident in the "mission" or goal of developing within the residents the abilities necessary to function independently in society. If freedom is to be defined as the

ability to choose and carry out one's own purposes, then the condition by which freedom is maximized for the mentally retarded is through the attainment of an "independent living" status. For only under this condition are the mentally retarded able to direct their modes of living and determine the groups to which they choose to belong. Through independent living, the mentally retarded have the potential to achieve the same status of normal citizens. This goal of the Oakton group home is thus an attempt to maximize the freedom of its residents.

For the time spent in the Oakton Group Home, again the evidence shows that efforts are being made to maximize the freedom of residents. The "practices of the house" point to many such efforts (see Appendix A). The issue as to whether or not the residents in this home perceive an increase in freedom relative to the freedom experienced in the institution, receives moderate support from the self-reports of the residents of Oakton. When asked if they had more freedom at their former residence or at Oakton (question 10), a clear majority indicated the perception of more freedom in the group home. Of those who perceived a decrease in actual freedom, both specifically indicated a decrease in their ability to "rest". The second attempt to measure the relative difference in freedom between the two residential facilities (question 3) was less decisive, but does suggest that residents are able in the group home to do all the

things they were permitted in the institution. In addition, there is ample evidence to describe the freedom in the Oakton Group Home as being conditional in nature. This has been demonstrated through an analysis of the rules of the home, and through a summation of the interview results. Conditional freedom seems to be the predominant form of freedom in the home.

To summarize then, the Oakton Group Home represents a newly found form of communal organization.[30] It is a highly institutionalized structure which gives primacy to the welfare of its members. In addition, the three foci of communal organi-zation, space, cooperation, and family have been demonstrated to exist (or be compensated for) in the structural arrangement of this home. The spacial arrangements and the form that cooperation takes at Oakton vary only by degree or quantitatively from the continua described by Hillery to exist in all communal organizations. Furthermore, the absence of a bio-social family structure is compensated for in the relationships of staff and residents. The staff performs the socialization roles inherent in the parental roles of the bio-social household. Finally, the Oakton Group Home deliberately (and apparently successfully) attempts to maximize the freedom of the residents of this home. This finding supports the view of the Oakton Group Home as

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[30] New in the sense that this research project is the first to consider group homes for the mentally retarded as potentially representing a form of communal organization.

representing a new form of communal organization.

Obviously, with a limited sample of one home and 8 residents, I cannot interpret the findings of this study as being applicable to all residents in all group homes. To date, there is far too much variation by state, region, and actual managerial staffs to imply any study can provide this information. However, this case study approach and the information gathered through the interviews can begin to provide a better understanding of the relationship between some group homes and communal organizations, and the conditions by which freedom may be maximized in each.

A discussion of process of analytic induction can provide insight into the applicability of this study (c.f. Robinson, 1951). Robinson described this procedure as involving the formulation of a hypothesis, and then testing that hypothesis with a single study. After reviewing the results of that study, the hypothesis and definition of the phenomenon being investigated are reformulated to produce a more accurate presentation of the two. Through further analyses and reformulations of the hypothesis, the investigator should thus be able to reach an understanding of the causal conditions which are necessary (but not sufficient) to produce the phenomenon under investigation.

This thesis began with the observation that the group homw with which I was familiar seemed to represent communal forms of residential alternatives for the mentally retarded.

A case study was then scrutinized in order to determine whether or not the structure of that home was consistent with the structural definition of communal organizations. The finding that in fact this one home is consistent with the definition, led to a further investigation of the conditions which were necessary for the establishment of this communal form of residential facility for the mentally retarded. It was concluded that the primary causal agent for this phenomenon was the implementation of the principle of normalization as a managing principle. Stated another way, in order for group homes to function as communal organizations, it would thus seem a necessary condition that the facility implement the concept of normalization. There appears to be a causal link between this management principle, and the establishment of residential facilities which are communal in nature. In addition, the principle of normalization has been demonstrated to lead to the maximization of freedom for the mentally retarded residents of group homes. These finding leads me to propose the following hypothesis:

> **Through the implementation of the practice of normalization, group homes for the mentally retarded have the potential to develop into communal organizations, and thereby maximize freedom among the residents.**

Chapter III

GROUP HOME LIVING

This chapter addresses the reality of group home living. In the preceding chapters I have presented for the most part a structural/functional analysis of the group home and the freedom that results in the cases of those homes which are organized communally. This information, while important in establishing the group home as a bona fide communal organization, says little of the day to day reality of living in group homes. In short, this thesis has to this point only sketched an outline of the group home. What remains before this thesis is to provide color to this picture; to present the Bund or essence of group home life.

This task is approached in this chapter in three sections. The first section addresses the daily activities of the group home, with an emphasis on the impact the "daily routine" places upon the freedom of the residents. Next, the social processes found in the home are discussed (in particular, the manner in which these processes serve to develop the home as a primary group for its residents). Finally, my own experiences as a resident of the Oakton Group Home are presented. This information is included to provide additional insight into the experience of freedom found in this home.

3.1 DAILY ACTIVITIES OF GROUP HOMES

For the residents of Oakton as in most group homes, there are responsibilities which must be met on a daily basis. This begins at 6:00 a.m. with the "morning routine". The residents are expected to wake and get dressed for work. One resident helps prepare breakfast (or if capable, prepares it independently), which is served around 6:30. After eating, the residents are expected to complete their daily chores. With the supervision of the counselor on duty, certain residents self-administer any medications which may be needed after breakfast. Around 7:45, the residents are then driven to the workshop (or in some cases to other places of employment).[33]

During the morning routine, there is one counselor on duty. As the live-in counselor, I assumed this responsibility five days a week. One "duty" associated with the morning routine is to assess the moods of the residents. As with all people, some days are better than others. If I perceived any resident to be having a bad day, I was responsible for attempting to help them overcome the problem before going to work. More often than not this was not necessary. The typical morning ran rather smoothly, and often involved a lot of good hearted humor. Sitting around the table was a

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[33] During the first nine months I worked at this home, one resident attended the local high school where she completed the special education program and graduated. After this, she worked briefly at the workshop until gaining employment at local nursing home. Another resident likewise attended school while a resident of Oakton.

time for teasing and singing along with the radio. All were equal at the table and counselors were not immune to the teasing. After breakfast and chores were completed, there was usually 30 to 45 minutes of free time. During this time, some residents watched television: others continued listening to the radio. I sometimes spent this time reading the sports page to a few residents who wanted to know who won a particular game. When the time came, the residents gathered their lunches and were driven to the workshop. Upon my return, I entered into the daily log an analysis of the morning routine. The typical entry read like this:

> "When I got up, the cat was in the laundry room again. "So-and-so" woke up fussy, but calmed down by him/herself without any problems. All-in-all, a good morning."

Most residents attend the workshop from 8:00 a.m. until 4:30 p.m.. When they get home, the "cook" immediately begins dinner with one of the three counselors on duty. If another resident is working on a cooking program, they may help. However, for most residents the cooking chore seems to be highly regarded, and there is a great deal of pride associated with having prepared a nice dinner for 12 to 18 people. Whoever is responsible usually chases all others out of the kitchen during their "moment of glory". As for the other residents, the time between returning from work and eating dinner is free time. There are a few who can think of nothing better to do than to plop down on the couch in front of the television at every available moment. Most residents

however, choose to go into town and get a soft drink. Although upon giving notice the residents are allowed to go by themselves, they usually ask a counselor if he or she would like to join them. For those who can't, the residents going never fail to offer to buy drinks or snacks.

Dinner is usually served at 5:30 or 6:00 (depending on whether or not there are group activities planned for that evening, such as swimming classes or aerobics). After dinner, each resident again performs his or her chore. Upon completion, most residents are again free to do as they wish, although at this time, some are obligated to work on independent living programs. The actual teaching of skills involves two sessions per week, per program, per resident.[34] These sessions typically last 15 to 30 minutes. Typically, for the resident this means spending from one to two hours during the week in training. Other evening responsibilities include preparing lunches for the next day and taking a bath if needed. Other evening activities might included a trip to the grocery store if necessary. The residents participate in the planning of menus and are allowed to suggest any snacks to be bought for lunches or to be kept around the home. If enough residents are interested, a trip to the local depart-

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[34] Typically, each resident will be working on three separate independent living skills at any given time. During some sessions, the residents may in fact work on two or even all three of these programs, depending on their ability to handle the amount of information being taught. Upon completing a program, the residents often are allowed to choose the next one.

ment store is arranged. Otherwise, the residents usually do what they seem to enjoy most before the 10:00 p.m. bedtime: watching television or listening to the radio. At 10:00, all are expected to go to their rooms. Most go to bed at this time; however, a few stay up in their rooms and watch their personal television before falling asleep. One of the last responsibilities of the late night staff is to secure the house, record the evening's events in the log, and turn off the left on televisions and radios.

On the weekends, the daily routine is generally relaxed. Residents usually fix their own breakfasts and perform their chores when convenient. Weekends often involve a planned group activity. This may involve a picnic, camping trip, attending a concert or football game, trips to larger shopping malls or other recreational activities. Inevitably, one resident always chooses not to participate. This requires hiring a substitute counselor to remain behind with that resident. Residents are not made to participate in these extra activities. On Sundays, several residents attend different churches. Members of these churches pick up the residents and return them after the services. In addition, several of the church members provide Christmas and birthday gifts for the residents, as well as organize holiday parties for the residents.

As can be seen, the residents of the Oakton Group Home do have to perform some daily responsibilities. During the

course of interviewing, several residents commented on these obligations. To quote one:

> "I like to do my chores.... I got used to doing it (chores) when I was a kid so why not...? I like to stay active. If a man don't stay active, he ain't doing nothing."

Obviously, there are one or two residents who wait until asked, not enjoying the chores. But for the most part, residents do their chores without being asked, and even "police" themselves to make sure everyone does as needed. Especially when it comes to the bathrooms. It proves very difficult indeed for a resident to get away with skipping this chore. While the residents are obliged to perform the chores, the majority actually desire a clean home, and thus at least for most residents, the chores would seem to represent self-imposed obligations. For that matter, the entire daily routine is to some degree internalized by most residents, and not thought of as burdens placed upon them by staff.

There is an abundance of free time associated with living at Oakton. One goal for the staff is to in fact "create" as much free time as possible, by limiting the time involved with programs to 30 minutes or less, and seeing that residents who need help with chores are provided with this assistance. My own observations are that the residents are nearly always allowed to spend this time as they see fit. This is supported through the interviews. One resident states:

> "I can do most everything I want to. I can go to the store by myself...and everything. ...I can do what I please. Now you know how it is, everybody do what they want long as they don't hurt nobody else."

3.2 SOCIAL PROCESSES OF GROUP HOMES

For the staff and residents alike, there is a bonding process that develops, supporting the definition of the group home as a communal organization. For myself, this occurred during the first week of living at the home. I quickly felt responsible for the welfare of all residents and concerned for their social development. This bonding at the counselor level is apparent in the labels given to residents. The boastful term "**My** clients" is heard frequently in the home. One counselor often jokingly suggested that she intended to adopt two of her clients and constantly referred to them both as her children.

The bonding of residents to each other is vividly evident. Several residents said they got along with everybody in the home. Others, when asked if they were free to help other residents, directly expressed concern for the welfare of one resident who is wheelchair bound. As one put it:

> "I help 'em best I can; like "So-and-so" back there. She can't do nothing for herself, somebody has to help her."

This bonding is apparent also in the fact that the residents often argue among themselves. The freedom to disagree openly with the actions of others is often witnessed at Oakton. One

resident described the following situation:

> "Sometimes I grit my teeth.... I want to bark back. You know me. I want to bark back, I just grit my teeth so tight. 'So-and-so' made me mad one day. Them old cat."
>
> (The other resident keeps a cat, and all too frequently allows the cat the roam of the house.)
>
> "It got on the table when I was eating and I knocked him off. He in my space, where I eat, and I knock him off. Now I went to church and thought that would help. I didn't want to say nothing. I keep holding back, holding back. Just as tight. My little temper'll have to blow this coming Sunday night."

The arguments that crop up from time to time involve residents and staff alike. Each member of the home has expectations of how everyone should behave. When these expectations fall short, the disappointment is allowed to manifest itself and often does. By venting these frustrations informally and working them through, the emotional bonds of the house are made stronger.

Perhaps the bonds of belonging to this home are best demonstrated when a member leaves. When I left, there was a personal feeling of sadness. I had grown to love these roommates over the months of sharing their home. Several residents cried on my last day. All insisted I come back to visit (except one who was mad at me). During the interviews, one resident described her feelings when her most recent counselor left:

> "...See, I got a new staff now. His name is ____. When ____ quit, I didn't have nobody to take over. Now...you know, its hard to learn after somebody ain't had me so long. You know what I mean? ... It hurt me when he left. He's working in another

place where he can be home with his family. See--like it was here--night--be after dark getting home. He loves to be home with his two little boys. I don't blame him."

3.3 OBSERVATIONS OF A GROUP HOME COUNSELOR

The feeling of belonging to the group is an important aspect of communal organizations. By virtue of having lived inside Oakton for many months as a live-in counselor, I came to know this Bund or essence of community that exists in the home. The following discussion involves a few of my own experiences as a participating member of this home.

My first day as a counselor was a memorable one. One of the first questions I asked the program supervisor was "how do I talk to the residents." "Like anyone else" was her reply. After spending the first 6 hours studying the training manual, it was time to meet the residents. I and another counselor drove to the workshop where we picked up the then 12 residents of Oakton. They looked strange. One kept asking me something but I didn't understand. A female resident flirted with me for the entire 35 minute return trip. Most just stared at the new counselor. When we arrived back at Oakton, another counselor and a resident began preparing dinner for 15. Later, sitting around the table with 12 retarded people I knew this would be my last day.

By the end of the first week, I had finished training and moved into the live-in counselor's apartment. I was

assigned three male residents as clients. Before coming to Oakton, all three had lived in institutions for nearly all of their lives. One was committed around the age of 10 when he could not pass in grammar school. He was 43. Of the other two, one was approximately 54 (his actual birthday was not known, so he had been assigned the date May 1, 1932 for official purposes), and the other 28. I, 27, was expected (among other things) to teach these older men how to live independently. I honestly believed that I could succeed at training these clients and see them move from the Oakton into the affiliated supervised apartments before I moved on. I thought the measure of a counselor the degree of success he or she has with training and subsequently placing clients into the community. I remember being shocked when the program supervisor said that I shouldn't get my hopes up; that these three men would be at Oakton for a very long time to come.[35]

The home seems to have been well received by this community, as evidenced by the support the residents receive when shopping or simply walking through town. Sometime during my first few weeks at Oakton, I remember walking into

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[35] Three and a half years later, two are still living at Oakton. The third decided to leave prior to completing the training sequence after two years of residency. He now lives in a different home which has fewer requirements as far as daily responsibilities are concerned. In addition, this other home does not require it's residents have a daily activity (i.e., sheltered employment) away for the home. He seems to be doing well there.

town with some of the residents. As we got to the neighborhood convenience store, a local person smiled and asked me if it would be okay to buy me a soft drink. Apparently, I had been mistaken for a "new" resident at Oakton. I smiled back and said yes. I remember not being embarrassed or ashamed for the mistaken identity. Afterall, I did in fact live at the group home and the person was genuinely attempting to be friendly. What was significant was that I had identified myself with the home and did not attempt to assert myself as a counselor, not a client.

Many times as a counselor I found it "difficult" to persuade my clients to do their programs. Usually, the program was postponed until another time. One program however never failed to be performed as scheduled. The oldest of my clients had been at Oakton since its opening. He had worked on many, many programs over the years but had not been able to accomplish the level necessary to move out of the home. During the first March that I worked at the home, the supervisor and I decided to develop a new program for him--gardening. Certainly this program had little to do with independent living skills but this resident had spent the previous summer or two digging up the backyard and growing a few vegetables. We created this program with two objectives in mind: (1) to provide this resident with any training he might need for improving his technique; and (2) the program allowed the resident to "receive credit" for

doing what he truly loved to do after returning from the workshop and would have done anyway. There were many such instances at Oakton where programs were created for the residents without the expected concern for the need to "program" them.

Fussing and fighting were frequent events at Oakton. In fact, there was one resident who unless she was fussing, we knew something was dreadfully wrong. Her spells were nearly always resolved by completely ignoring the fussing. We rarely felt a need to stop the behavior since it occurred regardless of our efforts and always ended of its own accord. I remember another time during the morning routine when a resident told another that he was not afraid of me and I could kiss him "somewhere". This made the second resident furious that the first would speak of me this way. I resolved the situation by assuring both of the residents I had no intention of performing the "request", and went back to eating breakfast. At Oakton the official procedure for these types of disturbances was to fill out "incident reports". However, I often found that legitimating this behavior in the eyes of "staff" only served to alienate myself from the residents caught performing inappropriately. Many times I found it easier to resolve the matter off the record than on it.

Just as fussing and fighting were considered normal and often acceptable at Oakton, so was hugging. While protocol

would suggest that a counselor remain objective with his or her clients, most of the staff at Oakton was never above the practice of letting the residents know that they were loved. Although frowned upon in some of the homes I have visited, hugging was a natural consequence at Oakton for the residents' accomplishments, or when they simply asked. In addition, it was not at all uncommon for the staff to be found at the home during their off hours. Often, counselors would come by and pick up a resident or two when going shopping, or out to eat, or on family outings. For most of the counselors I worked with, their clients were thought of and treated as family members, even by the true family members.

The experience of having lived with these people for 18 months was deeply rewarding. I shared with them the joys of their accomplishments and the disappointments of their shortcomings. Sometimes we fought with one another over any and everything, and other times we got along famously. In every instance I felt a part of the home, and have benefitted from participating in the experiences of the home. I believe it is the same for all who pass through the Oakton Group Home.

CONCLUSIONS

Writing in 1960, Etzioni suggested that mental hospitals could not provide therapeutic services due to several reasons. Of primary importance was the custodial nature imposed on these organizations by the society-at-large. This finding is partially supported in the works of Wolfensberger, who accurately described the philosophy of the day as "protecting the non-deviant from the deviant" (1975). The end result was that the residential facilities for the mentally retarded of that era were forced into a custodial orientation which only served to "maintain the inmate population", and thus "maintain the organization" (Etzioni, 1960). The deinstitutionalization movement of the 1970s brought about the realization of therapeutic services for some (not all) mentally retarded individuals, as well as many new forms of residential facilities. In some cases, (for example, training centers) these facilities probably still retain the custodial nature of the older institutions. This orientation, the desire to retain members, involves the conversion of real people into statistical numbers, which give meaning to these formal organizations.

The establishment of group homes in localized community settings brought with it the potential for providing the mentally retarded with sufficient training for their eventual freedom from supervised custody. This thesis has demonstrated that one necessary condition for that potential is

the establishment of an environment that is "as close as possible" to the structure of the normal family environment. The creation of such an environment, based on the principle of normalization, may in some cases lead to the creation of an organization which is communal in nature. Furthermore, the development of such an environment would seem critical to the maximization of freedom among the mentally retarded, and the maximization of their potential.

This thesis has not demonstrated both the necessary and sufficient conditions for the transition of residential facilities for the mentally retarded from formal to communal forms of social organization. It is quite likely that there exists group homes which are not communal in nature. The thesis has however provided evidence that residence in a communally organized residential facility may be associated with an increase in freedom.

This study has implications for another form of group living arrangement, the "halfway house" rehabilitation model. The success at Oakton as well as other homes for the retarded is directly related to the concept of normalization. In order to learn and/or improve oneself, people must first be free to do so. By employing the concept of normalization, the residents at Oakton develop a sense of belonging to the group and a commitment to the objectives of the home. This was demonstrated previously by the fact that the residents feel a sense of ego freedom in the presence of social

barriers to this freedom (i.e., daily routines, house rules, etc.). Furthermore, in the attempt to maximize freedom for the residents of Oakton, the residents are able to maximize their potentials for independent living. This phenomenon of increased functioning and intelligence levels as a result of group home living has long been established in the field of mental retardation. In fact at the Oakton Group Home, one resident was evaluated to have improved her IQ by over 20 points upon disposition into the supervised apartments. I would suggest that the principle of normalization when applied in the management of halfway houses can lead to a higher rate of success in the rehabilitation of the residents.

The significance of this study in the area of community theory has already been in part discussed. This thesis has demonstrated through a series of qualitative methods that the case study, the "Oakton" Group Home, represents a new form of communal organization. Utilizing content analysis and direct observation it was determined that the case study is a "highly institutionalized organization which does **not** give primacy to specific goals". In addition, through interviews and direct observation, it was determined that the primary goal of this organization is to maximize freedom among its members. Another significant aspect of this thesis is that it demonstrates a means for gathering survey or interview data from the mentally retarded. As stated in chapter two,

the process of abstraction is often too difficult for some of the retarded. Nonetheless, it is possible to gain insight into the lives of the mentally retarded. The key to gathering reliable responses is in recognizing the difficulty abstraction presents for some of the mentally retarded. Often it is not the subject matter of the questions that presents difficulty for the retarded. It is the nature of the responses we seek. I was able to gather the information I wanted with a yes/no format. Although this information is not highly amenable to statistical manipulation, I feel it does represent the open and honest opinions of the residents and thus approaches reliability.

Finally, a discussion of prejudices toward the retarded community is in order. Upon entering the group home in 1984, I quickly became aware of my own prejudices. As stated above, I had to ask whether I should talk to the residents as children or adults. This approach to mental retardation is very common. Society today still approaches the mentally retarded as "eternal children". Even is academia, there may be certain questions raised when presenting the self-reports of these people. "How do we know that the retarded know what they are saying?" "Are the answers to our questions valid and reliable?" These questions are more based in prejudice than in truth. Who knows better the conditions of having been reared from birth in the institution than the retarded? Also, who better to report the reality of group home life

that the residents of these homes? The average staff member only briefly passes through these residential alternatives. For the mentally retarded, these living arrangements are a fact life.

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APPENDIXES

Appendix A

"Oakton"
Practices of the House

1. Each resident is responsible for washing and repairing their own clothing, the purchasing of personal items, the cleaning of their bedroom and to maintain good personal hygiene which includes body and hair care.

2. Residents should regard the house on "Oakton" Street as their home and help with keeping it clean and neat as they would in any family. This means helping with the cooking, cleaning, washing (dishes and clothes), lawn and garden care, and other such responsibilities.

3. Each resident will be assigned a weekly chore to perform at "Oakton". It is the responsibility of the resident to see that this chore is performed. If unable to meet this responsibility, the resident must find someone to perform the chore in his/her place.

4. Residents shall not enter another resident's room or borrow their property for any reason, unless permission is granted by the staff or other resident. In addition, residents are expected to knock on any closed door before entering. This includes the resident counselor's apartment, the bathrooms, and other resident's rooms.

5. Residents are free to see staff members at any time.

6. Smoking is only permitted in the living room, and recreation room. Residents shall not smoke in the bedrooms.

7. Alcoholic beverages and illicit drugs are not permitted anywhere on the premises.

8. Residents will be expected to go to work, training or other daytime activity unless excused by the staff.

9. When leaving "Oakton" grounds, residents must check out and in with the counselor on duty. This is a courtesy to the staff to eliminate unnecessary worry and a convenience to the residents in case family or friends should want to contact them.

10. All telephone calls must have staff permission. Local calls are free to residents. Long distance calls will be billed to resident(s). Due to the fact that "Oakton" staff and residents are sharing one phone line, calls should be limited to ten (10) minutes.

11. All resident's mail, sent or received, is guaranteed complete privacy.

12. Residents may not have guests for meals unless arrangements are made in advance with the residential staff.

13. On work nights, residents are requested to be in their bedrooms by 10:00 p.m.

14. On weekends and nights prior to holidays, residents are requested to be in the house by 11:00 p.m. and in (their) room(s) by 11:30 p.m..

15. Residents may have visitors from 7:00 p.m. to 9:00 p.m. on week nights, and 1:30 p.m. to 10:00 p.m. on weekends, except during times designated for instructional classes or activity periods.

16. Food and drinks are not allowed in the bedroom area.

17. Residents shall not enter the office unless invited by a staff member.

18. Residents will participate in determining their goals and objectives as well as the individual treatment plan to carry them out.

19. Residents must obey staff in order to maintain an organized program.

"Oakton's" house rules have been read and explained to me by

_____ on _____.
Counselor Signature Date

_____
Resident Signature

_____
Witness

Copied with permission from:

Appendix B

Interview Guide

EF--Ego Freedom
CF--Conditional Freedom
DF--Disciplined Freedom
DOF--Deprivation of Freedom

(1) Is this the best (freest) place you can live?
(E.F.-2)

(2) Do you want to leave here someday, so you will have more freedom to do as you please?
(D.O.F.-5)

(3) Are there things you used to be able to do that you cannot do now that you are here?
(D.O.F.-4)

(4) Can you do everything you want to do here?
(E.F.-4)

(5) Is there more the staff could do to help you?
(D.O.F.-2)

(6) Do you have to give up things to help other residents?
(D.F.-3)

(7) Is there a daily routine (schedule) here?
(E.F.-6)

(8) At this home, can you do anything you want as long as you don't hurt anyone, or yourself?
(C.F.-4)

(9) Do you have to choose between things to do here?
(C.F.-2)

(10) Did you have more freedom to do the things you want before coming here?
(D.O.F.-1)

(11) Are there rules here you must follow?
(E.F.-3)

(12) Are the rules made to help everyone?
(C.F.-3)

(13) Do you have to share your things with the other residents?
(D.F.-1)

(14) Are you free to help other residents?
(C.F.-1)

Freedom Scale (Likert)
--From Hillery, Dudley and Morrow (1977)

SD--Strongly Disagree
D--Disagree
DK--Don't Know
A--Agree
SA--Strongly Agree

EGO FREEDOM

(1) I enjoy living here because there is complete freedom from restrictions.

SD D DK A SA

(2) My freedom is greatest here because I can spend all the time I want doing the things that I want.

SD D DK A SA

(3) We have little or no rules or regulations to live by.

SD D DK A SA

(4) This place allows people to do what they want.

SD D DK A SA

(5) The only real restriction here is not to do anything that would in any way do harm to the community.

SD D DK A SA

(6) Here I am on my own unless I really bother others.

SD D DK A SA

CONDITIONAL FREEDOM

(1) I am free to help the people that I live with.

SD D DK A SA

(2) Self-discipline is important because there are so many things to do here.

SD D DK A SA

(3) The only rules here are made for the good of the group.

SD D DK A SA

(4) In this group, you have the right to do whatever you want as long as you don't hurt anyone else or yourself.

SD D DK A SA

FREEDOM AS DISCIPLINE

(1) Freedom here is closely linked with the idea of sharing and sacrificing.

SD D DK A SA

(2) Freedom here is disciplined, and each makes concessions to help the others.

SD D DK A SA

(3) There is freedom here, but to have it, each person must give up something to help the others.

SD D DK A SA

DEPRIVATION OF FREEDOM

(1) I used to have more freedom before I came here than I do now.

SD D DK A SA

(2) The people in charge here should be more considerate of the members.

SD D DK A SA

(3) I feel that I do not have the kind of freedom that I should.

SD D DK A SA

(4) I feel as if some of my freedom has been taken away.

SD D DK A SA

(5) I wish that I could leave here so that I could find a place that would let me do more of the things that I want.

SD D DK A SA

Appendix C

Results of Interviews (Oakton)

Ego Freedom	yes	no	dk
(1) Is this the best (most free) place you can live?	5	2	1
(4) Can you do everything you want to do here?	7	0	1
(7) Is there a daily routine (schedule) here?	6	0	2
(11) Are there rules here you must follow?	7	0	1

** Questions 7 and 11 as written represent negative connotations of Ego Freedom. The responses must therefore be inverted before tabulating the results.

	For EF:12	Against EF:15	Missing:5
Totals (N):			
Percentages:	37%	47%	16%

Conditional Freedom	yes	no	dk
(8) At this home, can you do anything you want as long as you don't hurt anyone, or yourself?	6	1	1
(9) Do you have to choose between things to do here?	1	3	4
(12) Are the rules made to help everyone?	7	0	1
(14) Are you free to help other residents?	5	1	2

	For CF:19	Against CF:5	Missing:8
Totals (N):			
Percentages:	59%	16%	25%

Disciplined Freedom	yes	no	dk
(6) Do you have to give up things to help other residents?	0	7	1
(13) Do you have to share your things with the other residents?	1	7	0

	For DF:1	Against DF:14	Missing:1
Totals (N):			
Percentages:	6%	88%	6%

Deprivation of Freedom

(2)	Do you want to leave here someday, so you will have more freedom to do as you please?	8	0	0
(3)	Are there things you used to be able to do that you cannot do now that you are here?	2	3	3
(5)	Are there more things the staff could do to help you?	4	2	2
(10)	Did you have more freedom to do the things you want before coming here?	2	5	1

Totals (N):	For DOF:16	Against DOF:10	Missing:6
Percentages:	50%	31%	19%

Appendix D

March 16, 1988

Residential/Rehabilitation Manager

Dear :

I am a graduate student in the Sociology Department of Virginia Polytechnic Institute and State University. For the past two years, I have been studying the condition known as mental retardation, the social situations that have historically surrounded this unique group of people, and the way in which our understanding of this condition has changed in recent years. I am currently writing a thesis entitled: "Social Experiences of Mental Retardation". In this thesis, I am examining the relationship between the management of group homes, and the degree of freedom experienced by residents of these facilities.

As you are well aware, there have been many changes in the treatment of the mentally retarded over the past fifteen years as a result of the deinstitutionalization movement in America. It is difficult to imagine that only a few years ago, children born with this condition were considered hopeless, and were routinely placed in mental institutions for the duration of their lives. These "colonies" more often than not have been described as presenting inhumane living conditions, and rarely provided therapeutic training programs. It was these very conditions which led to several court cases during the late 1960s and early 1970s, resulting in the abandonment of the institutional model for the habilitation of the mentally retarded. Today we now know that the mentally retarded are in many cases capable of learning the skills necessary for living independently, and thus have the potential to participate actively in our modern society. Based on the knowledge that residential environments play a crucial role in the development of these skills, we have witnessed rapid growth in the establishment of group homes for the mentally retarded. Group homes have been able to achieve dramatic successes in the preparation of the mentally retarded for independent or semi-independent living. This is in part due to a reliance on the normalization principle of management. However, the strong commitment of the residential staff in most group homes toward providing the residents with "whatever it takes" to ensure their progress and development must be seen as a major factor in the ability of group homes to succeed where other residential models have historically failed.

A major concern in most group homes is providing the residents with as much freedom as possible within the framework of the group home model. This goal stands in stark contrast to the objectives of most mental institutions and training centers. Indeed, many measures are taken in group homes to assure the rights of residents to enjoy the freedoms common to all citizens. And yet, freedom is an experiential truth, not a scientific one. Freedom is not a finite entity which can be manipulated and measured at will. The only method we have for demonstrating the presence of freedom is through the reports of those believed to be experiencing this condition. Accordingly, the effectiveness of group homes in conveying this condition can only be determined from the reports of residents. It is with this goal in mind that I would like to conduct interviews with several residents of the "Oaktom" Group Home. For your review, I have enclosed a copy of the interview questions I would like to ask the residents of "Oakton". My experiences as a counselor in this exceptional group home lead me to conclude that the residents of "Oakton" should be experiencing a high degree of personal freedom. This being the case, I would like to interview those residents who have come to "Oakton" from other residential facilities. The information gained from such interviews will provide a better understanding of the relationship between the organizational structure of group homes, their effectiveness at conveying freedoms to the residents, and the role freedom plays in motivating the mentally retarded to acheive the goal of independently living in our society.

I have found that the total time required to conduct these interviews is between 3 to 6 hours, depending on the number of residents currently living in the group home who have lived in both the institutional setting and the group home. Each interview should take approximately 30 minutes. In order not to interupt the routine of the home, I would like to conduct the interviews during the evening and hopefully complete these interviews within 1 week. The proceedings shall be tape recorded, so as to expidite note taking and maintain the integrety of the responses given. The tapes shall remain absolutely confidential, and no names of respondents or other residents, staff, friends, etc. will be included in the written discussion of findings. In addition, permission shall be gained from both the residential staff and the individual respondents prior to conducting the interview.

It is hoped that by presenting the self reports of the mentally retarded, this project can provide fresh insight in the social experience of being retarded in modern American Society. Although there have been several studies conducted which describe the social environment of the retarded, as

perceived by social investigators, little is currently known about how the mentally retarded perceive their social situations. The data to be gathered in these proposed interviews can begin to provide just such information. Hopefully, this study will begin to answer the question: "what is it like to be retarded?".

Respectfully,

Robert J. Wendt

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