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Management Style and Institutional Dependency in Sheltered Care*

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Summary. Two styles of management utilized by operators of California's alternative to the mental hospital – the community-based sheltered-care facility – have been identified. One style of management is characterized by a low-structure, laissez-faire approach that places the responsibility for decision making with the patient. The other style stresses structure and rule following, and leaves decision making to the operators of the facility. The authors examine patterns of client dependency in each type of facility. Residents in the highly structured environments manifest a distinct pattern of dependency while those in the environment emphasizing responsibility for one's own decision making do not.

The elimination of institutional dependency has been and continues to be a primary aim of the community care movement. To hasten the demise of institutional dependency, mental hospital patients have been relocated in community-based sheltered-care facilities such as halfway houses, board and care homes and family care homes. It is the general intent that these facilities prepare people for life 'on the outside'; or at the very least, foster a more independent relationship between the individual and his surrounding environment. It has been noted in other contexts that particular organizational characteristics (Schwartz, 1951; Caudill, 1958; Jones, 1953; Linn, 1970; Knight, 1971; Ullmann, 1967) and management styles (Goffman, 1961; Street et al., 1966) influence patient behavior and attitudes in treatment settings. Within the context of the community-based sheltered-care facility various organizational styles have developed. The purpose of this paper is to consider how two contrasting styles of organizational operation, 'Client-Centered' vs. 'Management-Centered', relate to the development of institutional dependency.

Street et al. (1966), in a study of six juvenile correctional institutions, distinguish a 'custody/treatment' continuum based on the organizations' dominant goals. At the custodial end, institutions put great energy into promulgating and enforcing rules, while 'treatment institutions' emphasize an individualizing, flexible and particularistic approach to resident care. Similarly, Bettelheim and Sylvester (1948), King et al. (1975), Moline (1977) and Zigler and Balla (1977), all distinguished institutional management styles in terms of emphasis placed on rigidity of routine, regimentation, and social distance of staff from patients on one hand and a resident-focused, individualized orientation emphasizing patient responsibility for themselves and others on the other hand. They described the unintended treatment result in the former environment as a syndrome of apathy and passive compliance referred to as institutional dependency (Martin, 1955; Wing, 1962). Martin (1955) characterized the institutionally dependent person as one who ceases to rebel or question his position in the institution and surrenders to institutional life.

Studies of individuals placed in environments emphasizing individual responsibility and individual choice report significant improvement in individual alertness, active participation and a general sense of well-being (Langner and Rodin, 1976; Phares and Lamiell, 1977).

Given these findings and the observations of considerable variance in the management style in com-

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munity-based sheltered-care facilities, the placement of former mental patients in sheltered care may, in certain instances shift an old problem into a new context.

Study Framework

This research specifically examines the effects of two extremes of management style on the development of a syndrome of institutional dependency in California's alternative to the state mental hospital – the sheltered-care facility. One extreme as the literature indicates has enhanced coping skills in other contexts and professes to stress an open, unstructured, come-and-go-as-you-please approach and claimed to be responsive to resident input; the other extreme stresses structure, rule-following, schedules and planning. The first style of management focuses on the resident as the locus of responsibility for his own actions and we have labeled it *Client-Centered.* The second focuses on the facility as the locus of responsibility for the actions of the resident and we have labeled it *Management-Centered.*

In the context of a larger study of sheltered care by Segal and Aviram (1978), three pertinent variables were available for an analysis of dependency. The three variables were:

1. Evidence in a variety of situations of a felt obligation to the operator of the sheltered-care facility.
2. An expressed wish to remain in the facility.
3. A number of perceived obstacles to leaving the facility.

The first indicator of institutional dependency – felt obligation to the facility operator – was taken as an index of Martin's (1955) observation that the institutionalized person surrenders to institutionalized life. This index measures whether residents felt it was necessary to obtain approval for daily routine actions, such as leaving the house, and whether they needed to be of service to the operator – e. g., run errands for them. The second index of institutional dependency was that used by Wing (1962). He observed a syndrome of apathy and dependence associated with the wish of a mental hospital patient to stay on indefinitely in an institution. The third index of dependency, increased perception of obstacles to leaving, despite the stated facility goal of promoting resident independence, would serve as a rationale to justify an increasing commitment to institutional life. It was hypothesized that, taken together, these three variables when causally interrelated, could be considered to be a *Triad of Dependency.* It was thought that no one behavioral measure would be of sufficient generality to identify the developing syndrome of institutional dependency.

Unfortunately, these items even taken individually, are not unidimensional. While high scores on these indexes can indicate dependency for some residents, for others they may simply result from a rational assessment for one's facility environment. The resident rationally assessing his environment as the best available to him is likely to feel obligated to the operator who provides the benevolent environment, is likely to wish to remain in this environment, and may be more aware of obstacles to leaving.

Given our literature review, we would expect to find in the Management-Centered facility environment, which in the past has produced institutionally dependent residents in other contexts, three indexes causally interrelated in a triad of dependency. We would, on the other hand, expect the interrelationships between our three indexes to be explained by a 'Consumer Assessment Measure', i. e., to have no causal interrelationships, in the Client-Centered environment – an environment which in the past has been productive of positive coping skills.

Given these theoretical perspectives, our model has four endogenous factors – the three dependency indicators and the resident's 'Consumer Assessment' of the facility.

As we have noted, however, other individual and organizational characteristics besides management style have been associated with the development of institutional dependency. These factors may be conceived of as independent and external influences, on the three dependency indicators and the resident's 'Consumer Assessment'. Such organizational characteristics include facility size, staffing pattern, and goal orientation (family vs. non-family oriented) (Linn, 1970; Knight, 1971; Ullmann, 1967). Individual characteristics, considered as exogenous factors, are: age, sex, education, severity of psychopathology and time spent in a mental hospital and in a sheltered-care facility (Gruenberg, 1967; Wing 1962).

Methods

Data collection within this study consisted of structured interviews with 499 non-retarded, formerly hospitalized, mental patients between the ages of 18 and 65 who were residing in California sheltered-care facilities at the time of the study (1973). Also included were the 234 operators of these facilities.

Survey Sample

The sample is a self-weighting, representative sample of all individuals with the aforementioned characteristics and sheltered-care facilities serving these individuals in California (Kish, 1965).

In order to obtain the sample, the state was divided into three population clusters: [1] Los Angeles County; [2] the San Francisco Bay Area – that is, Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma Counties; and [3] all other counties in the state.

In the Los Angeles and the Bay Area clusters, the sample was drawn from the total population. In each of these areas a two-stage cluster sample was designed with sheltered-care facilities as the primary sampling units, and individuals within facilities as the second sampling stage.

Facilities were stratified by size in both Los Angeles and the Bay Area, and a sample was drawn of paired primaries taken probability proportionate to size. Individuals within facilities were sampled using systematic random sampling from specially prepared field listings.

In the third area comprising 'all other counties', a three-stage cluster sample was designed using counties as primary selection units, facilities as the second stage, and individuals within facilities as the third stage.

The facility and individual samples in this area were taken within each of the selected primaries using systematic random sampling in the latter and selections probability proportionate to size in the former. (Further details of the sampling procedures are available in Segal and Aviram, 1977).

Of the 499 resident interviews attempted, there was a loss (due to refusal and inaccessibility) of 12%. Of the 234 operators contacted, 10% refused to participate in the study.

Measures

As part of the larger study of the social integration of sheltered-care residents, all residents and operators responded to an extensive interview and assessment schedule (Segal and Aviram, 1978). In addition to variables descriptive of the subjects, the assessment also included variables descriptive of the socio-psychological climate of the facility, its physical and organizational structure, and variables relating to characteristics of the surrounding environment.

The Client/Management Scale. All subjects, including the operators of the facilities, responded to the Community Oriented Programs Environment Scale (COPES) (Moos, 1974a). The COPES consists of 102 forced-choice items designed to describe these aspects of the social environment of community-based programs – relationships between residents and staff, treatment efforts, and system maintenance efforts (Moos 1974b). In the research reported here, COPES items were utilized to construct a measure of the management style – Client-Centered vs. Management-Centered – of a facility.

Response of operators to these items were used to construct the scale and items were chosen for initial examination if their content was judged to be descriptive of either extreme of management style, that is on the basis of the item's face validity. The next step was to examine the intercorrelation among face valid items and create a pool of statistically related items from which to choose a final set. The criterion for final inclusion was the extent to which each item contributed to the internal consistency – item to total score correlation – of the final set. Using this three-stage process, 8 items were selected from the COPES and one additional item was gleaned from the overall interview schedule to which operators had responded. The internal consistency (coefficient alpha) of the final scale was .74 based on an N of 206 operators. Operator's responses to the 9 dichotomously scored items were symmetrically distributed with a Mean of 4.24 and a Standard Deviation of 2.2. Using this distribution, facilities were thus identified as either resident-oriented or management-oriented. In order to further sharpen the distinction between the two facility types only the extremes of the distribution were retained. Facilities with operators scoring less than 4 were classified as Client-Oriented and those with operators scoring greater than 5 were classified as Management-Oriented. This classification resulted in 36% of the facilities being classified as Client-Oriented and 29% classified as Management-Oriented.

The Client/Management Scale consisted of the following nine items that required a simple response of agreement or disagreement:

1. Residents follow a regular schedule every day,
2. Once a schedule is arranged for a resident, the resident has to follow it,
3. Residents can generally do whatever they feel like,
4. Residents must make detailed plans before leaving the house,
5. Resident's activities are carefully planned,
6. It is important to carefully follow house rules,
7. Staff make and enforce all the rules,
8. Residents who break the rules are punished for it,
9. Do all of your residents have a curfew? (A non-COPES item.)

Measures of potential dependency. Three indicators were available for examination whose causal interrelationships could be taken as an indicator of the acceptance of a dependent role. The first is a score derived from a nine-item scale that assessed the resident's sense of obligation to the facility operator (Obligation to Operator). Residents were asked to

respond on a five-point scale (absolutely should, preferably should, may or may not, preferably should not, absolutely should not) to the following:
1. Consult with – (Operator's Name) – before making a job decision.
2. Talk over problems with ____.
3. After having an argument with another resident, ask, ____ to settle the argument.
4. Participate in activities organized by ____.
5. Spend time during the day in programs organized by ____.
6. When leaving the house tell ____.
7. Accept ____ suggestions.
8. Try to please ____.
9. Go on an errand for ____.

The second measure questions whether the resident wishes to reside in the facility for a long period of time (Wants to Stay).

The third and final measure referred to the resident's belief that there are significant obstacles to his leaving sheltered care (Obstacles to Leaving). Seven items made up the Obstacles to Leaving Scale and were responded to on a five-point scale that assessed the importance of barriers in determining whether or not the resident would consider moving away and into unsupervised housing. The items were:
1. The loneliness of living alone.
2. Lack of adequate funds.
3. Fear that past problems might recur.
4. Fear that once you become independent your Supplemental Security Income (SSI) will be stopped and it will be difficult to get support again should you need it[1].
5. This is a physically nicer place to live than you could get if you were on your own.
6. This is a socially nicer place to live than you could get on your own.
7. This is more of a family than any you have had.

Residents' evaluation. In order to assess the residents' overall evaluation of their facility, they were asked to respond a three-point scale (essentially positive, neutral, negative) to 20 items that described all essential aspects of their living arrangements (e. g., food, cost, location, care, friendliness, etc.). Scores on this 'Consumer Assessment Measure' could thus vary from 0 to 60. In analyzing the predictors of residents' evaluation, Segal and Aviram (1978) found residents' assessments to be based primarily on facility environment characteristics.

Organization characteristics and resident background variables. Three organizational characteristics were considered in addition to management style: [1] facility size; [2] facility staffing pattern; and [3] facility goal orientation (family vs. non-family).

Six resident background variables were also included in the analysis:
1. The amount of time the resident had previously spent in a mental hospital.
2. The time the resident had spent in sheltered care.
3. The extent of the resident's psychopathology as rated using the Overall and Gorham Brief Psychiatric Rating Scale (Overall and Gorham, 1962).
4. The resident's age.
5. The resident's sex.
6. The resident's years of education.

Results

To some extent the distinction between Management and Client-Centered facilities is validated by the significant differences in these two environments we found on organizational characteristics, i. e., facility size, staffing pattern, and goal orientation. The average size of Management-Centered facilities ($\bar{X} = 55$) is significantly greater than Client-Centered environment ($\bar{X} = 20$) ($p < 0.05$); 86% of the former facilities employed staff compared to 66% of the latter ($\chi^2 = 15.6$, $p < 0.05$); and 34% vs. 45% respectively, were family oriented ($\chi^2 = 3.69$, $p < 0.10$). These organizational characteristics vary consistently with those found in other environments having similar management orientations (Knight, 1971; Ullmann, 1967).

When the differences were examined between Client and Management-Centered resident groups on each of the three potential dependency measures taken singly and on the consumer evaluation index, only one difference was significant. Those residing in Client-Centered facilities exhibited a greater desire to stay on in the facility than did those residing in Management-Centered facilities. On the five-point response scale, where 3 is neutral and 4 is 'It would be all right', the Client-Centered mean was 3.55 and the Management-Centered, 3.12 ($t = 2.26$, $p < 0.05$).

Table 1 first gives the partial standardized regression coefficients for predictors of the three potential dependency measures and the consumer evaluation index. These variables are considered endogenous predictors with a specified causal relationship inter se. Table 1 next gives the exogenous predictors, both individual and organizational characteristics, with no specified causal relationships among themselves. In a

1 SSI is an economic aid program for the "totally" disabled under the U.S. Social Security System.

Table 1. Partial standardized regression coefficients for predictors of three measures of potential dependency in Client- and Management-Centered groups*

	Measures of potential dependency by Client- and Management-Centered groups							
	Obstacles to leaving		Want to stay		Obligation to operator			
	Client	Mgmnt	Client	Mgmnt	Client	Mgmnt		
Endogenous V's								
Want to stay	n.s.	0.47	–	–	–	–		
Obligation to operator	n.s.	0.33	n.s.	0.26	–	–		
Resident evaluation	0.32	0.15	0.52	0.33	0.44	0.37	Resident evaluation	
	Client	Mgmnt	Client	Mgmnt	Client	Mgmnt	Client	Mgmnt
Exogenous V's								
Time in mental hospital	−0.21	−0.22	0.23	0.24	n.s.	−0.22	n.s.	n.s.
Time in sheltered care	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	0.16	n.s.
Psychopathology	n.s.	0.20	0.16	n.s.	−0.15	n.s.	0.33	0.23
Age	n.s.	n.s.	n.s.	n.s.	n.s.	0.15	0.19	n.s.
Sex	n.s.	n.s.	n.s.	0.13	n.s.	n.s.	n.s.	n.s.
Education	n.s.	n.s.	n.s.	n.s.	−0.22	−0.14	n.s.	n.s.
Staff	0.14	0.14	n.s.	−0.15	n.s.	−0.22	−0.17	−0.33
Size	n.s.	n.s.	−0.16	n.s.	n.s.	n.s.	n.s.	n.s.
Family orientation	n.s.	n.s.	n.s.	0.17	n.s.	−0.11	n.s.	−0.19
% of variance acc't for by all predictors	19%	35%	57%	43%	35%	36%	34%	12%

* All tabled coefficients significant at the 5% level or less. The N in the Client-Centered model was 96; in the Management-Centered model, 95

Table 2. Comparison of correlations between resident evaluation and each measure of potential dependency across Client- and Management-Centered groups

Predictor	Measures of potential dependency by Client- and Management-Centered groups					
	Obstacles to leaving		Want to stay		Obligation to operator	
	Client	Mngmt.	Client	Mngmt.	Client	(Mngmt.
Resident evaluation	0.35	0.15	0.69	0.51	0.52	0.44
N	119	127	118	123	119	127
Significance of difference between correlations	$p < 0.10$		$p < 0.05$		n.s.	

sense these can be considered control variables as well as individual predictors of the potential dependency measures and consumer evaluation.

Our original prediction that obstacles to leaving would be predicted by both obligation to operator and want to stay and that want to stay would be predicted by obligation, *and in addition,* that these relationships would obtain only in the Management-Centered group was upheld. All three regression coefficients were significant in the Management-Centered sample; none were significant in the Client-Centered sample.

The second prediction, that resident evaluation would explain the relationship between the potential dependency indicators and be a stronger predictor of them in Client-Centered settings was in general upheld. Referring to Table 1, resident evaluation as a predictor of the potential dependency measures produced coefficients in the Client-Centered groups that were greater (and all in a positive direction) than those in the Management-Centered group. These findings indicate that in the Client-Centered environment the potential dependency measures are not true indicators of dependency. They reflect resident evaluation and thus a positive coping style.

Table 2 compares, across Client and Management-Centered groups, the correlations between resident evaluation and each potential dependency measure. The correlation between resident evaluation and want to stay is significantly greater in the

Client-Centered group when compared with the same correlation in the Management-Centered group ($p < 0.05$). The comparison of the correlation between resident evaluation and obligation to operator was also significantly greater in the Client-Centered group, but at the $p < 0.10$ level. The difference between the correlation of resident evaluation and obstacles to leaving for the two groups was not significant, although in the predicted direction.

Discussion of Results

The results indicate that a strongly interrelated pattern of dependency is produced in settings that emphasize a controlling Management-Centered environment. It is significant that when potential dependency measures are analyzed singly, only one out of three differentiate the two groups, and in that one case the difference is opposite to an interpretation of dependency – residents in Client-Centered facilities show a greater desire to stay.

It would seem that, as hypothesized above, the potential dependency measures are in fact, multidimensional. Given their multi-dimensional character, it is possible for different groups to have the same average scores on each measure taken alone and for each measure taken above to have different meaning. The crucial research question, however, in such a situation is not whether the average scores differ across groups, but what is the pattern of interrelationship among the criteria and what is the explanation of this pattern. We believe that the observed pattern of internal causation between the potential dependency measures in the Management-Centered facility indicates that these indexes 'feed on themselves' and as such can be understood as dependency. On the contrary, the relationships between these measures in the Client-Centered facility are dependent on a resident evaluation criterion, they do not perpetuate themselves. This distinction is the distinction between institutional dependency and successful coping.

As far as the six other predictors are concerned, no clear and consistent patterns of major proportion emerged when the two groups were compared.

Conclusions

To hasten the demise of institutional dependency, mental hospital patients have been relocated to community-based, sheltered-care facilities. The results of this study question whether these new living arrangements are necessarily a guarantee that institutional dependency will be minimized. Is the dependency syndrome found in hospitals merely being perpetuated in a new context? While we do not have comparative data on absolute levels of institutional dependency of residents in mental hospitals, we have determined that the management style of a significant proportion of sheltered-care facilities is dependency producing. The question must now be asked as to what safeguards must be taken to prevent the development of institutional dependency. Although these facilities have several benefits, it is evident that community care cannot always be considered a synonym for deinstitutionalization.

We know that any organization involving human beings either explicitly or implicitly makes decisions concerning the autonomy of those participating in it. We know also, that it is more difficult to maintain an environment where individuals (perhaps adapted to a more restrictive one) can be given every opportunity to develop a self-respecting, self-governing role. But, we concur with Pritlove (1976) when he states that a major goal of group homes is the promotion of the client's independence and that perhaps one of the most important means of achieving it is thru the regime of the home.

The good news of this study is that we have observed that a significant portion of community-based sheltered-care facilities indicated a positive, client-oriented procedural structure which does not seem to produce institutional dependency among residents in community care. Thus, while some residents may be reinstitutionalized, many are being deinstitutionalized.

References

Bettelheim, B., Sylvester, E.: A therapeutic Mileau. Am. J. Orthopsychiatry **18**, 191–206 (1948)

Caudill, W.: The psychiatric hospital as a small society. Cambridge, Massachusetts: Harvard University Press 1958

Goffman, E.: Asylums: essays on the social situation of mental patients and other inmates. New York: Doubleday 1961

Gruenberg, E. M.: The social breakdown syndrome – some origins. Am. J. Psychiatry **123**, 1481–1489 (1967)

Jones, M.: The therapeutic community: a new treatment in psychiatry. New York: Basic Books 1953

King, R. D., Raynes, N. V., Tizard, J.: Patterns of residential care: Sociological studies in institutions for handicapped children. London: Routledge and Kagan 1975

Kish, L.: Survey sampling. New York: John Wiley 1965

Knight, D.: The impact of living unit size in youth training schools. Sacramento, California: California Youth Authority 1971

Langner, E. J., Rodin, J.: The effects of choice and enhanced personal responsibility for the aged: a field experiment in an institutional setting. J. Pers. Soc. Psychol. **34**, 191–198 (1976)

Linn, L.: State hospital environments and rates of patient discharge. Arch. Gen. Psychiatry **23**, 345–351 (1970)

Martin, D. V.: Institutionalism. Lancet **1955** 1188–1190

Moline, R. A.: The therapeutic community and Mileau therapy: a review and current assessment. Community Mental Health Review **2**, 1–13 (1977)

Moos, R. H.: Community-oriented programs environment manual. Palo Alto, California: Community Psychologists Press 1974a

Moos, R. H.: Evaluating treatment environments: a social ecological approach. New York: Wiley-Interscience 1974b

Overall, J., Gorham, D.: The brief psychiatric rating scale. Psychol. Rep. **10**, 779–812 (1962)

Phares, E. J., Lamiell, J. T.: Personality. Ann. Rev. Psychol. **28**, 113–140 (1977)

Pritlove, J. H.: Evaluating a group home: problems and results. Br. J. Soc. Work **6**, 353–376 (1976)

Schwartz, M.: Social interaction on a disturbed ward of a mental hospital. Unpublished Doctoral Dissertation, University of Chicago (1951)

Segal, S., Aviram, U.: The mentally ill in community-based sheltered care. New York: Wiley-Interscience 1978

Segal, S., Aviram, U.: The mentally ill in community-based sheltered care: a technical supplement on study methodology 1972–1977. Unpublished memo, University of California, Berkeley (1977)

Street, D., Vinter, R., Perrow, C.: Organization for treatment. New York: The Free Press 1966

Ullmann, L.: Institutions and outcome: A comparative study of psychiatric hospitals. Oxford, England: Pergamon Press 1966

Wing, J.: Institutionalism in mental hospitals. Br. J. Soc. Clin. Psychol. **1**, 38–51 (1962)

Zigler, E., Balla, D. A.: Impact of institutional experience on the behavior and development of retarded persons. Am. J. Ment. Def. **82**, 1–11 (1977)

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