INTERACTION OF STAFF AND RESIDENTS IN ADOLESCENT GROUP HOMES

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INTRODUCTION. There has been a trend toward shifting rehabilitation efforts for acting out adolescents from large institutional settings to small group homes, and at the same time such group homes employ paraprofessionals as front-line staff (Handler, 1975). Munson (1977) has identified the major functions of the consultant in these settings in relation to untrained staff. This paper focuses on one aspect of that role in which the staff and residents are viewed as a small group, and the dynamics of staff interaction are reflected in resident behavior. The staff and resident group process is analyzed through exploring: (1) achieving honest and clear communication; (2) acceptance and use of authority; (3) dealing with staff anxiety in threatening situations, and (4) development of appropriate levels of genuineness and self-awareness.

The discussion that follows is based on a specific model of group homes which includes: (1) the director of the group home functions both as an administrator and as a front-line staff member; (2) all staff are paraprofessionals who have little formal training in therapeutic relationships; (3) the consultant is a professional who works with the staff on a part-time basis; (4) there are regularly scheduled "house" meetings in which staff, residents, and the consultant participate; (5) there are regularly scheduled staff meetings in which the consultant participates, but no residents are present; (6) the program is based upon a therapeutic model in which the staff is engaged in change efforts; and (7) a cohesive, unified staff built on the above model can be effective regardless of the philosophic or theoretical basis upon which the group home operates.

ACHIEVING HONEST AND CLEAR COMMUNICATION. Before any change efforts can be effectively attempted, conditions must be created for honest and clear communication. This is basic in situations where residents are accustomed to dealing with the world through manipulation, and a paraprofessional staff is expected to accomplish a great deal with very little training. Decision making is the basis of much interaction between staff and residents. The staff exists as a group, and the residents exist as a group. Individual behavior on the part of a member of either group is often interpreted in a group context rather than on an individual basis. Behavior in this context is based on what Redl and Wineman (1952, 20) identified in one of the earliest group home experiments as " 'social reality.' " Often the two groups get polarized around issues and problems resulting in no resolution and continuing frustration. Where staff use group manipulation to deal with perceived resident manipulation, communication breaks down. This is epitomized in one resident's comment in a house meeting, "We ain't going to play the staff's games, so we don't expect you to play ours." This comment occurred after an incident in which the staff attempted to decrease "horseplay" in the house through increasing fines for such activity and notifying residents after the fact. Staff felt a need to make some on-the-spot decision to maintain order in the house, while residents viewed this as a change in the rules without their input. The staff could have more effectively contained the "horseplay" through assessing repeated violations at the agreed upon "rates" rather than increasing the amount for the sake of expediency. We have found that rules are effectively applied only when they are carried out according to previously agreed upon decisions that involved both the staff and resident groups.

Given the opportunity, residents as a group can develop self-regulation that takes the pressure off staff and allows them to intervene only when self-regulation fails. This allows the staff to avoid the "game playing" stance. This is very difficult to achieve when staff live with the constant fear that interpersonal conflict will escalate out of hand. This fear is very real in an unstructured situation where the staff group is smaller in number and is often physically weaker than the resident group that has limited self-control un-

der stress. Staff must come to recognize that less control is not being recommended here, only that the controls be exercised as agreed upon. Residents will not adhere to rules where the staff is perceived as not playing by the rules. We take this position fully recognizing that unique situations develop which require immediate decision making. In situations of this type, it is important that the staff group subsequently communicate to the resident group why such decisions were made. When feedback is not provided, such staff decisions will be viewed by the resident group as arbitrary and merely punitive.

Individual residents use the group to negate individual deviance as one resident's comment illustrates: "I was drinking in the house. So what? Everybody drinks in the house." The resident group will also focus on individual behavior to avoid group issues. This is illustrated when a group of residents dislike a particular resident and report him for various infractions to which the disliked resident responds, "You just want to see me kicked out of the house." The staff must be trained to recognize this variable use of the individual and the group to avoid communication of the real issues. Both of the examples that have been given demonstrate dysfunctional behavior that must be exploited for clinical purposes through use of what has been identified as "influence and interference techniques" (Redl and Wineman, 41-46).

USE OF AUTHORITY Use of authority does not come easy in any circumstance, and appropriate use of authority is even more difficult to attain. Young, untrained staff recognize the need for authority, but at the same time question its use since no exercise of authority goes unchallenged by the resident group. First, there are variations of authority within the staff group that must be identified. The individual staff member's authority varies when on-duty and off-duty. In a small, informal group home with a milieu orientation in which staff are frequently in the house when off-duty residents often attempt to negate the authority of staff at such times. This can be handled by making clear that staff are invested with their authority at all times. Staff are more likely to use authority when angry so that residents see them exercise authority inconsistently. Staff often knowingly in full view of residents overlook infractions of the rules when activity in the house is calm and on a positive note, but the same infractions can get the entire house put on restriction when matters are going badly. The consultant must help the staff to develop skill at exercising authority when not angry and to not use their authority excessively when angry. This balancing of power use can help the staff avoid the staff/resident standoffs that are so common in group homes. As one resident commented after the staff placed the entire house on warning in an angry exercise of authority, "You staff are idiots; with everybody on warning there are just going to be more fights in the house." What the resident was saying epitomizes the "standoff" situation -- when staff put residents on warning in anger, the residents respond by putting staff on warning through their behavior. There is only space here to make the two generalizations that authority must always be available for use but must be applied consistently based on rational rather than emotional response. There are many other authority issues, and the consultant will find that the resolution of specific authority problems is endemic and must be dealt with regularly in staff meetings and "house" meetings.

Second, the director exercises authority at another level, and this can become problematic, conflictive, and confusing when the director also carries the role of front-line staff member, because when in this role, he can use more sweeping authority in a resident encounter than a regular staff member. The director must be helped to recognize this difference and encouraged to use the directorial authority sparingly when functioning as a staff member. It has been our experience that when the director does not make this distinction, he will become isolated from residents, their feelings, and their behavior. The director is by nature in a difficult position and "is always the last one to know" about

deviant behavior in the house. The power of the director is inherently recognized by the residents and other staff, and through making the distinction we have described, the difficulties of the position can be minimized but certainly not overcome completely.

Third, the consultant has the most dubious authority. The consultant can exercise much authority if he allows the staff to view him as "the expert" and become dependent upon him for decisions, or he can function solely as a facilitator allowing the staff to work out all problems within the staff group. The most appropriate role for the consultant varies between these two extremes. As the staff should rely on resident self-regulation as much as possible, the consultant should rely on staff self-regulation to an even greater extent. To achieve this, the consultant needs to meet regularly with the staff, and the focus of these meetings should be improved staff intervention through discussion of problem-solving efforts in the house. The consultant is often the only source of support for individual staff members and the staff group. Staff undergo many conflicts and confrontations with residents that can be the focus of these sessions, but staff also have conflicts, disagreements, and occasional confrontations that must be dealt with. Staff are more willing to discuss their conflicts with residents than they are conflicts with one another. Staff conflict must be explored to promote more unified and healthy staff functioning. This is important because residents are keen observers of weaknesses in staff relationships, and they will manipulate staff conflict. Frequently, the consultant will learn about staff conflict from the residents before it is even identified by the staff.

Fourth, residents have authority that is often not recognized as such by the staff. Often residents are assigned duties related to operation of the house that requires supervision of other residents. Daily "clean-up details" and meal preparation are examples. Staff must be careful that assignment of such authority does not put the resident in a difficult position in relation to other residents or give the resident the opportunity to take advantage of a position of power. For example, it is appropriate to put a resident in charge of a cleanup detail, but the evaluation of the cleanup should be done by a staff member. Any authority granted residents requires supervision by a staff member to avoid abuse as well as preventing the resident in authority from being subjected to what Redl and Wineman have defined as "social death" within the resident group as a result of being perceived as allied with the staff (1952, 20).

STAFF ANXIETY IN THREATENING SITUATIONS The group home situation is sufficient to create anxiety in the most skilled practitioner. From the moment the resident enters the home, they overwhelm the staff with symptomatic behavior with intensity and great velocity (1951, 46). Untrained staff in the face of such behavior impose external controls rather than exploiting the behavior for therapeutic purposes. This is only natural given the coping mechanisms that have been supplied staff to deal with the situation. Unfortunately, external controls do not necessarily result in therapeutic change. Anxiety emerges from insufficient techniques for dealing with behavior, and when the few techniques available to the staff do not work, anxiety becomes more intense. The main strategy for the consultant to use in decreasing staff anxiety is to help them develop nonthreatening interventive skills. The emphasis should be on using external controls only as a last resort. Staff need to be exposed to interventive techniques that encourage residents to develop internal control mechanisms. Anxiety can be lowered by removing some interaction from the resident group. Staff should be supported and trained in doing individual counseling with residents. Issues such as drug use, sexual activity, school performance, etc., can be much less anxiety producing for a staff member and a resident when discussed in an individual relationship. The opposite is also true. There are times when sensitive issues cannot be articulated on an individual basis, and a group approach where no individual is singled out allows exploration without provoking se-

vere anxiety among residents or staff.

No amount of training or support will relieve all anxiety. Staff get anxious for the same reasons residents do -- lack of coping mechanisms (see Pearlin et al, 1978). The more coping mechanisms the staff develop, the more coping mechanisms they can pass along to the residents. This is the essence of the therapeutic process in a group home. An anxiety-ridden staff will only increase anxiety among residents. It is in this area that the consultant can contribute the most to the therapeutic program of the group home.

GENUINENESS AND SELF-AWARENESS The helping professions have long been concerned with the importance of self-awareness in therapeutic relationships without much study of how much self-awareness and what kind of self-awareness is enough. The concepts of genuineness and self-awareness are important for the paraprofessional staff working in a highly unstructured environment where roles are not highly differentiated. For us genuineness refers to sharing how one feels while self-awareness refers to knowing what one feels. Staff often engage in work activities, recreational activities, and leisure time directly with the residents as well as "living in" the house while on duty. Genuineness is more appropriately discussed in conjunction with staff/resident relationships and self-awareness in connection with staff relationships. So that genuineness involves sharing with a resident how it makes you feel whan a staff member is the object of a barrage of profanity, and self-awareness relates to discussing in a staff meeting why one responds personally to such an attack of profanity. In a threatening and anxiety-producing encounter with a resident, it is not always good to share fear and anxiety, but in a staff meeting this can be discussed to develop self-awareness about what in the situation was threatening and anxiety producing, and how new and alternative coping mechanisms can be developed.

Self-awareness can be used in encounters with residents just as genuineness can be discussed in staff meetings. For example, during a house meeting after genuinely sharing some of his feelings about how he deals with anger, some residents and staff helped the director develop self-awareness that often when angry, he would respond by inappropriately placing restrictions on the entire resident group. Second, in a staff meeting, the staff share that they felt a house meeting was "lousy." With help from the consultant, they were able to be more genuine and share that what they really felt was discomfort because the meeting involved some intense, negative exchanges between staff and residents. They went on to discover how they rated meetings on the basis of control, and that they associated comfort and good meetings with controlled sessions where little genuine feeling was shared. Staff have a propensity to be more genuine when angry or frustrated which can result in inappropriate sharing of feelings. The consultant must work to help staff be genuine through control rather than being genuine only when they are out of control.

As long as genuineness and self-awareness are discussed in the context of the work settings, paraprofessional staff can develop a great deal of cohesiveness resulting in a positive, supportive work group. The consultant has a responsibility to prevent such sharing from becoming therapeutically oriented and focused on the personalities of the individual staff. Where this type sharing is the focus of the consultation, the staff can become disillusioned, frustrated, and immobilized. Instead of concentrating on the motives of the staff for their behavior, the consultant should function as a role model for positive therapeutic intervention with residents. This can be achieved primarily through the "house" meeting conducted by the consultant in which both staff and residents participate. In order to do this, the consultant must have a well-articulated repertoire of interventive strategies and coping mechanisms, including appropriate levels of genuineness and self-awareness, specifically related to working with aggressive, manipulative, and poorly socialized adolescents. The timid and insecure consultant will quickly lose the respect of residents and staff and increase anxiety, especially in the staff group.

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