THE REALITIES OF ADOLESCENT GIRLS IN GROUP CARE: IMPLICATIONS FOR CURRICULUM THOUGHT

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TABLE OF CONTENTS

Chapter		Page
I.	INTRODUCTION	1
	Significance of this Study	4
	Background of this Study	6
	Summary	18
	Guiding Questions of this Study	19
	Basic Assumptions	21
	Organization of this Study	22
	Summary	22
II.	REVIEW OF THE LITERATURE	24
	Introduction	24
	Historical Overview of the Origination of Group Care for Children	24
	Causations of Out-of-Home Placements and the Rationale for Effective Communication	37
III.	DESCRIPTION OF THE STUDY	50
	Introduction	51
	Research Site	52
	Participants	57
	Caretakers	57
	Residents	58
	Research Procedure	62
	Participant-Observation	63
	Interviews	65
	Document Collection	67
	Data Interpretation	67
	Reciprocity	68
	Summary	69
IV.	RESULTS OF THE STUDY	71
	Introduction	71
	Description of Research Activity	71
	Description of the Research Field	74
	Presentation of the Data	78
	Caretaker-Resident Communication	79
	Communication Climate	79
	Communication Channels	81
	Group Care Programs	82
	The Life Skills Program	82

Chapter Page

Education/Tutorial Program 84
Counseling/Psychiatric Program 87
Communication Style 90
Communication Effectiveness 91
Summary 91
Distrust of Caretakers 91
Collective and Individual Experiences 92
Caretaker Concern 94
Resident Discipline 96
Summary 101
Individual Identity 101
Culture 102
Values 103
Summary 105
Dependence 105
Governmental Influences 106
Caretaker Influences 107
Psychological Influences 107
Summary 108
Control 109
Runaway Behavior 109
Inappropriate Sexual Acts 110
Gameplaying 111
Summary 113
Duplicity: A Theory of Communication Quandary 113
Discussion 114
Summary 118

V. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 119

Introduction 119
Summary of the Study 119
Purpose 119
Research Participants 120
Data Collection 120
Data Analysis 121
Summary of the Results 121
Distrust of Caretakers 122
Individual Identity 122
Dependence 122
Control 123
Duplicity: A Theory of Communication Quandary 123
Conclusions 124
Recommendations 126
Curriculum Leaders and Administrators . . . 127
Teachers 128
Researchers 129

REFERENCES 131

Chapter Page

APPENDIXES 139

APPENDIX A - CONSENT FORMS 140

APPENDIX B - INSTITUTIONAL REVIEW BOARD APPROVAL . 145

APPENDIX C - GROUP HOME DOCUMENTS 147

APPENDIX D - EXCERPTS FROM INTERVIEWS 157

LIST OF FIGURES

Figure Page

1. First Floor of Group Care Home 54

2. Second Floor of Group Care Home 55

3. Basement of Group Care Home 56

4. Directions to Group Care Home 76

CHAPTER I

INTRODUCTION

> Today's children are growing up in an unstable and threatening environment in which earlier sources of support have eroded. They live in a permissive culture that exposes them from an early age to drugs, sex, alcohol, and violence. The increasing divorce rate, the entry of many mothers into the full time work force, high rates of mobility, and the declining importance of the extended family all contribute to a decline in support and guidance (Feigelman, 1990, p. 174).

According to the Child Welfare League of America (1982), an increasing number of children are recognized to be in need of treatment because of emotional and behavioral difficulties disruptive to life in a family or community. Their behaviors prevent them from remaining at home and custody is being assumed by the child welfare system (pp. 9-10). Some of these children pose problems for social service agencies. It is now common to hear and read about "violent," "hardcore," "repetitive" "vicious" youthful offenders in the public media and among professionals in the juvenile justice system (Eisikovits and Kashti, 1987, pp. 2-3). Special skills are required to work with acting-out older children, and special facilities may be needed to provide appropriate care and treatment for them.

The Florida Group Child Care Association (1977) states there may be many reasons why children have to leave the care and protection of their own parents and live outside of

their homes. Parents may become separated or divorced. The parent left with the care of the children may find that the job is too difficult to handle along with earning a living and caring for themselves. Fathers or mothers may abandon their children, may be alcoholics, or have other personal habits of behavior which interfere with child rearing. Sometimes parents are temporarily overwhelmed with personal problems which keep them too busy to give their children what they need. Parents are often improperly prepared for parenthood and in many instances the state will interfere and remove the children because of abuse (p. 5).

The arrangement of residential out-of-home placements for over one-half million American youth per year represent a major commitment to provide constructive alternatives for troubled children. An estimate by the U.S. Bureau of the Census indicates the annual cost of the placements to be in excess of $800 million. While foster care represents the majority of these arrangements, over 29,000 children live in group care homes (Gilliland and Judd, 1986, p. 21).

Children who enter group care are coming from unstable environments and they are usually looking for solutions to their problems. Kagan (1989) states that children need to know that the treatment program will help them and their families resolve critical dilemmas (p. 112). The literature written on children in group care deals with treatment orientation. Whether its primary purpose is to gain insight into the causes of structure of children's problems or to evaluate the effectiveness of treatment strategies, it is

dedicated to the improvement of treatment (Buckholdt and Gubrium, 1985, p. 55). In determining treatment effectiveness, focus is placed on the social processes of the children and how the social workers, childcare workers, special education teachers, speech therapists, psychologists, and psychiatrists come to understand and to determine them more or less disturbed (Buckholdt and Gubrium, p. 11). Such thinking views these processes independent of parental involvement.

According to David Fanshel (1978), "Persons working with group care children have a long history in the United States of neglecting parents of these children and treating most parents as if they are not potentially valuable resources for their offspring. They are likely to be treated as discardable" (p. 197). Maluccio (1991) states that in most cases the central issue is not that the children are "without parents", it is that the child welfare system has "succeeded" in losing the parents, in abandoning them, in provoking or encouraging them to abandon or neglect their children (p. 23).

The purpose of this study is to determine if group care homes meet the emotional, physical, and social needs of the children who reside in them. If children are removed from their parental homes because of deficits in these areas, it is necessary for group homes to provide an environment that can be helpful in remediating these concerns. The sole informant who is actually able to state if help received is beneficial would be the recipient of that care, namely the

group care resident. This study will attempt to describe children's perceptions of the dynamics of living in group care homes, residential establishments for children from dysfunctional parental homes.

Significance of this Study

Children are facing many issues today that in previous years were not considered to be childhood experiences. They are exposed to fatal diseases and in many cases found to be parentless. Orphans have become a tragic legacy of AIDS in many countries around the world which do not yet have the necessary social structure to cope with children who have no families. World Health Organization estimates that over half a million children have already been infected with the AIDS virus and by the end of 1992 this figure is expected to have doubled. During this same period, it is estimated that over three million uninfected children will have been born to mothers infected with HIV and that by the year 2000, there will be over ten million uninfected orphans whose parent have died of AIDS who have no one to care for them (Haymann, 1990, pp. 13-14). Additionally, Simon (1991) states that many children are forced to run away from their homes because of abuse. Over half a million adolescents leave home annually. While many return home within a few days, a substantial proportion become recurrent, or chronic runaways for whom homelessness is a way of life. Chronic runaways do not leave home simply because of wanderlust, difficulties at school, or peer pressure. Rather, they are

running from very negative family environments. Usually, they have been subjected to pronounced parental rejection and to physical or sexual abuse (p. 225). Rafferty and Shinn (1991) examined the effects of homelessness on children. They state that children face serious disadvantages, including health problems, malnutrition, developmental delays, anxiety, depression, behavior problems, and educational underdevelopment (p. 1170).

Abuse and neglect have caused many youths to develop emotional problems and many resort to abusive, aggressive, and disordered conduct. Youngsters who display aggressive or disordered conduct comprise about one-third of all referrals made by parents and teachers. Many of these young people will undergo a diagnostic process in which the attending mental health personnel will often assume that a trait such as "personality disorder" is at the core of the individual's behavior problems (Polyson, 1990 p. 33). The aggressive and self-destructive behaviors of "acting-out" children and adolescents are typically experienced as dangers by "helping adults" in governmental or private agencies. They feel an obligation to impose stringent controls on the child or adolescent in order to protect everyone from further injury or harm. Such children often will be given a diagnostic label and placed in a treatment center. When this occurs, responsibility for the child is transferred from the parents to an agency monitored by a governmental authority (Kagan, 1989, p. 112). James, Smith, and Mann (1991) acknowledges the need for coordination of

health, social and education services in order to help children cope with existing circumstances (p. 305).

An extensive search of the literature indicated that few studies have examined the problem of communication between group home residents and their caretakers, from the resident's perspective. Studies have addressed the breakdown in family communication; however, they have focused on the consequences faced by the child as a result of the breakdown. They also attempt to provide information that is helpful to the caretaker in correcting unfavorable behavior that is exemplified by the child. To look at children's needs only through the eyes of the caretakers may generate mistakes in planning appropriate programs. These errors may affect society for many generations to come. For example, emotional needs that are diagnosed and felt to be addressed may be actually incorrectly diagnosed and treated. The "real" problem may continue to be untreated. It is crucial that children are heard in order to confirm the accuracy of the given treatments. When children age and they develop the ability to voice their opinions, opportunities should be provided for them to plan their lives.

Background of Study

Two hundred years ago the Swiss educator, Johann Heinrich Pestalozzi said, "Teaching is by no means the essence of education. It is love that is its essence. Without love, neither the physical nor the intellectual

powers of the child will develop naturally" (Green, 1912, p. 151). He went on to establish a series of schools for children in castles and convents and country estates. This was considered the beginning of the residential group care experience.

The establishment of poorhouses and asylums for indigent, disabled, and disreputable persons more than 150 years ago inaugurated the residential care movement into the United States. In the past fifteen years, significant changes have occurred in the nature and location of this care. The implementation of both state and federal regulations has established a mandate for community-based care to provide the least restrictive alternative. The trend in recent years has been toward small residential facilities located in or near residential communities (Smith, 1985, p. 155).

The growth of residential treatment is due largely to the work of persons attempting to apply psychoanalytic concepts to work with children and youth. This early work accompanied a rapid growth of treatment institutions for children. The institutions combined care specialization, an emphasis on treatment rather than custody. In the earlier treatments, there was more effort in involving the whole community and parents. Emphasis is now on controlling the child through isolation from the community and all contacts that are seen as destructive (Buckholdt and Gubrium, 1985).

Katz (1986) gave a brief synopsis of the group care that was prevalent in New York City in the 1800's:

> **In 1874**, The Society for the Prevention of Cruelty to Children (founded in 1874) had chapters in many cities. They concentrated its efforts on breaking up poor families and encouraged neighbors to spy on and accuse one another.
>
> **In 1875**, the New York State Legislature ordered the removal of all children between two and sixteen from poorhouses.
>
> **In 1881**, New York's county superintendent of Queens County passed a resolution that proposed "whenever families of children are likely to become pauperized by the dissipated habits of their parents, they will use their endeavors to have the children removed from those pernicious influences and placed in good respectable homes.
>
> **In 1890**, New York had forty-nine homes and The New York Protectory housed more than three thousand children (pp. 21-22).

McCarthy (1990) told of Pia McKay, a former orphan, who stated, "My own experience teaches me that by design, a foster home is a truck-stop existence. The alternative to the foster home if adoption is not feasible, is a return to the orphanage" (pp. 38-39). Everyone does not agree with McKay, Stallings (1988), in his dissertation stated, "The raising of children to adulthood in a residential institution is seen as too fragmented in terms of continuity of key parenting figures due to contractual relations and limitations of affective fictive kinship ties" (p. 477).

Shane (1989) interviewed Dr. Franklyn G. Jenifer, Chancellor, Board of Regents of Higher Education at Commonwealth University. Dr. Jenifer stated, "if we are going to help this population of students and give them an equal opportunity for success, we are either going to have to change the environment in which they live or temporarily remove them from it" (p. 24).

The Bush Administration's anti-drug chief, William Bennett, predicted in his "war on drugs" campaign an increase in orphanages. He proposed a removal of children from their parents by the government because of the parents' addictions to illegal drugs. He stated that there are communities where children are not being raised at all (Katz, 1986, pp. 21-22).

Family researchers and therapists who take a family system perspective often have focused on two dimensions of the intrafamilial environment, family cohesion and family adaptability. Family cohesion refers to relationship ties among family members. These ties are thought to exist along a continuum which ranges from over involvement among family members (an enmeshed family system) to no relationship ties (a disengaged family system). These extreme types of family cohesions are believed to be dysfunctional for the personality development of the offspring, while a balance between the two is thought to be functional. Functional family cohesion is characterized by an optimal connectedness or "sense of family" in which family members seem to sense

and maintain a balance between autonomy and the bonds of their family (Novy, 1992, p. 27).

Strom (1990) defines a strong family as one that includes mutually satisfying parent-child relationships and the capacity of members to meet each other's needs. In severely dysfunctional families these needs are not met, rather the families appear disorganized and chaotic. Family members cling together without clear personal identities. Exchanges with the surrounding world are reduced and, with the exception of the parents' families of origin, there is little openness to others or tolerance for differences (p. 611). Many children in chaotic families cannot develop a cohesive sense of self and they retreat from challenges that demand that they be autonomous (Lewis, 1990, p. 35).

Family breakups that are deliberately set in motion include the absence of the mother for the greater part of the day. This leaves the child alone to shift for itself. Also families experience splits when there is a rigid, but loveless discipline with a high emphasis on obedience. Children who are physically or sexually abused by family members impress on them that they are unwanted and unworthy individuals. This can also create a breakdown within the family structure (Janus, McCormack, Burgess, and Hartman, 1987, p. 35).

Abuse continues to exist although the Child Welfare Act S.O. 1978 c.85 (as amended in 1979), s. 49(1) now requires "every person who has information of the infliction of abuse upon a child to forthwith report that information to law

enforcement officials. Section 49(2) requires professionals or officials to even report suspicions of abuse (Basharov, 1985, p. 4).

Emotionally abused children will attempt to solve their own problems in certain instances. They may kill themselves by committing suicide. This act is a form of communication which has a variety of overlapping meanings and intentions. It may represent self-hatred, depression, hopelessness, indirect and displaced aggression and also is usually a cry for help. This cry for help suggests that no other way of requesting help seems open to the individual. The attempt implies that the family's rules of communication preclude the use of effectiveness of any less drastic means of communication (Molin, 1986, p. 177).

Attempts have been made to maintain children in foster homes when they are unable to remain with their biological families. It is felt that the best place to raise a child is with a family. The choice between a foster home and a residential treatment facility has been based not only on treatment considerations but also on economics. Depending upon agency resources, economic considerations have prevailed until the behavior of the child became so extreme that no other option was possible except residential treatment. In certain instances, the child was returned to the parent(s) when the system could no longer provide services (Woolf, 1990).

Kagan (1989) states that working with children, or adolescents, in group care is extremely difficult because

intense issues of abandonment, loss, grief, violence, and attachment must be addressed (p. 112). It is likely that group care youths will have difficulty in adapting to the structured surroundings of youth shelters and group homes and will be unprepared to take part in their own treatment plan. They will associate this new experience of planned treatment and structured living with the inconsistent, rigid rules of the families that they left behind. They may displace the anger and aggression they feel toward family members and direct those feelings toward crisis intervenors (Janus, et al, 1987, p. 35).

In group care homes, professional staff (cottage counselors, houseparents, child-care workers, or whatever they are called) are often employed after one interview, perhaps with only one person and many are assigned full duty the following day. Inservice training often exists only in name or not at all and with little knowledgeable back-up from a supervisor (Powers, 1980, p. 6).

Group care staff displayed varying conceptions of what should constitute an active treatment plan for the children. Clinical staff placed a high value on cognitively outlining a treatment plan for each child, but often this was largely a front-office exercise with minimal attention paid to continuous execution of the plan (Powers, p. 16).

The following categories depict positions that may be held by the helping professions in relation to non-compliant young people:

"Boot Camp" Menta
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current circumsta
productive indivi
"Get Even" Mental
people who behave
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"Lost Cause" Ment
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Feeling rejected

significant others, and in some cases, by helping professionals in numerous preceding placements, these young people rarely comply with behavioral expectations or follow through on conventional residential treatment service plans.

According to Kagan and Schlosberg (1989), the child may be initially identified as a victim with the public or private agency operating as a rescuer. Blame for problems is usually placed on the parents or secondarily on any of the individuals or agencies involved, the police, school officials, or the child. At the same time, the "victim" is perceived as relatively helpless to resolve problems without the assistance of professionals (p. 112).

To achieve an optimal acquisition of improved child management skills, parents must receive didactic and experiential structured learning opportunities. This training will allow parents to acquire appropriate parenting skills which is expected to bring about more confidence. This will create a willingness to resume full-time childrearing responsibilities during the anticipation of a

child expected to be discharged and returned home (Laufer, 1990, pp. 49-50).

Weekend visits to the home of the biological parent once every two or three weeks are made by ninety-eight percent of the children. Residential treatment personnel are not involved in home visits. Only on rare occasions is there an exchange of information between the residential personnel and the community welfare service caring for the family about what took place during the visit or the state of the family in general. The residential treatment personnel draw their conclusions about the nature of their home visits from the descriptions by the children and from their behavior on their return (Carlo, 1988, pp. 195-206).

A team consisting of teachers, the residential psychiatrist and other members of the hospital staff decides whether a child is able to attend a public school. If a child's emotional problems are independent of school and do not interfere with it, arrangements are made for him to attend (Murphy, p. 155).

Wells (1991) states that it is most clear that we are endangering the educational attainment and vocational training of children by constantly moving them. It is felt that we are undermining their relationships with children and workers in each facility and individuals in the community in which each is located. We are punishing children for the inevitably regressive behavior that they bring to us by moving them on. They are not proceeding along "the continuum of care" to a better place in some

instances, but rather they are discharged to homes or facilities where they have previously been abused (p. 13).

Group care children find it difficult to trust adults or to believe that the world is capable of providing happy and wholesome experiences for them. They are often fearful of trying something new and different and are more interested in meeting sheer survival needs (food, clothing, shelter) than they are in school work. These children often blame themselves for the breakup of their home. They tend to feel that they are bad and unworthy and they give up trying to achieve. They lack feelings of self-worth and confidence. It is not unusual for a child to have attended three or four schools during one school year. They find school an unpleasant place to be and do not look forward to attending (Florida Group Child Care Association, 1977, pp. 5-6).

Institutional children attending school outside might easily feel stigmatized if their appearance, dress, or participation in activities differentiates them in any way from the other children (Mayer, 1958, p. 100). Children from group care environments may not have clothing similar to children residing with natural parents. The clothing that is worn may be accepted in the group home environment, but not in school settings. Therefore, other children may ridicule them for their dress or appearance. This ridicule may create an emotional problem that may inhibit participation in school activities.

Stern (1946) stated, "just as children vary in personality, so it would be found that they would vary in intelligence. A few children would be exceptionally bright, while others would be feebleminded". She feels that such children ought to be in special institutions for mental defectives, but if there is not careful psychological testing before admission, some may "slip" into group homes. Stern further stated, "Some children are likely to be dull and slow learning, not so much because they lack innate mental capacity, but because unhappy experiences have so confused and disturbed them emotionally that they have been unable to make the most of themselves". She continues by further stating, "The slowest learner may have an ability to do something well, if not with his head, with his hands. Some apparently stupid children may be struggling with language difficulties because their parents are foreign born" (p. 9).

Even the most successful teachers, those with the highest expectations and standards for their students, tend to resist placement of a child with obvious behavioral or learning problems, social skill deficits, or other atypical characteristics. Such children are perceived as difficult to teach, as demanding of teacher time and resources, low potential achievement levels (Gersten, Walker, 1988, pp. 433-434).

Variations are normal for all children, but are more pronounced in emotionally disturbed and neurologically damaged children. Among the school population of the

Children's Hospital, a child may be working at second grade level math while he does well in fifth-grade reading, or the reverse. A child may have an eighth-grade vocabulary, but only a first grade level of comprehension (Murphy, 1974, p. 157).

Buckholdt and Gubrium (1985) believe the practice of doing schooling is complicated by what learning and teaching mean. Numerous related matters assume significance, the relevance of lessons, coming and going and lining up, the make-up of a class, teachers' threats, busy work, children's sense of fairness, information on children's backgrounds, testing, theories of behavior, or theories of learning or teaching. In practice, the business of schooling includes whatever children, their teachers, and others take into account in doing schooling (p. 55).

Group care children are often labeled as slow learners. Labeling is actually detrimental. It leads to the establishment of artificial barriers to communication and cooperation among educators. It also leads to inequality in viewing those students and programs labeled special and an equal basis with those labeled regular. Equality suffers when the education of some students is viewed as different, special and charity-like while the education of other students is viewed as regular, normal, and expected (Stainback and Stainback, 1990, p. 167).

Rather than to be considered different at school, some children are so anxious and eager about their homework that they start it immediately on their return from school and

often avoid any fun in order to finish their studying. These children have to be encouraged to relax. Their anxiety about homework has to be reduced rather than increased. Most children in group care need encouragement and perhaps slight pressure in order to complete their homework (Mayer, 1991, p. 100).

Summary

The American system of residential care has failed to provide an environment in which group care children thrive. Further, it has failed to recognize the child as a person who is able to make decisions. These failures are demonstrated in the ways the government and social institutions perceive them. Children have faced great hardship through involuntary removals from their families by the government due to economical reasons. These removals may be destructive to children because they alienate them from what is familiar.

Children also have suffered emotional and physical abuse in dysfunctional relationships. When placed in group care homes that are meant to provide them with safety through a structured and nurturing environment, they are met by caretakers who are unprepared for the task. In many instances, the caretakers do not care about children. When group care children attend educational institutions, those placed in charge of them are unable to determine the differences regarding the types of poverty, financial versus mental. In assessing children's total situation in group

care living, it appears that everyone else decides what is best for them without consulting them. These children are concerned about their lives and they should be allowed to be an active participant in them.

Guiding Questions of the Study

The intent of this study was to explore the experiences of children living in group care settings as a means of understanding the beliefs (values) which constitute their respective realities. Although it is felt that childhood behavior and thoughts can be studied psychologically, the accuracy of these findings cannot be determined without consulting the child. Smith (1991) in The Forms of Curriculum Inquiry indicates that the most important consideration to be taken up in education today is the meaning and place of children in our lives. This concern transcends every field where children's lives are at stake. Although children have had very few opportunities to provide input regarding their welfare, what few that they have had seems to be lost. Smith further states that the voice of the young has been translated out of any meaningful involvement with the powers that be. Their voices must be heard because the question of the young, their conception, care, and nurturance devolves precisely on so many of the defining issues of our time, such as the meaning of power, gender relations, and the matter of how we might learn to live more responsibly (p. 188). This responsibility would require that whatever is done in the name of the child is

seen as beneficial to the child. In other words, the child is perceived to be human with feelings.

Comments concerning group care living were gathered by interviewing children in a conversational mode of research. The guiding questions of this investigation were as follows:

1. Is group housing a beneficial option for children who are unable to remain home with parents?

2. What does the group home resident perceive and feel about being placed in a group home?

3. What metaphoric language do children use to describe perceptions of group home reality?

4. What factors in group living improve or inhibit educational achievements in group residents?

To answer these four questions, this study was both interpretive and critical. According to Schleiermacher (1979), one of the requirements of hermeneutical exploration of the human world is a deepening of one's sense of the basic interpretability of life itself. This according to him is a matter of taking up the interpretive task for oneself rather than simply receiving the delivered goods as bearing the final word. Once this interpretation is made, it may be necessary to be critical in challenging directly those underlying human interests and ideologies (p. 10). Concern must be with the improvement of the lives of children and they must be seen as functioning as a whole person within a whole world, not just within the group care home. An ongoing evaluation is required in order to determine that the procedures used in all phases of care are

the best care available. This evaluation is done individually and regardless to what others perceive. The final conclusion is drawn by that individual. If the interpretation of a policy is not seen to be beneficial to the group care residents, the policy is discontinued by the individual interpreting the situation.

Basic Assumptions

Six basic assumptions undergird this study. They are:

1. The significant perceptions that the individual child builds and maintains about people, experiences, events, and ideas all work together in a reciprocal fashion to help build "reality" for the child.
2. An awareness of the child's reality and the manner in which group care workers respond to this reality contribute to the child's feelings about his/her total self, ultimately creating a positive or negative group living experience.
3. Insight can be gained by deliberating a child's reality.
4. Research is important to the improvement of group home living. Group care environments are complex and subtle; research methods must include approaches that will bring an understanding of the phenomenon being studied.
5. An effective way to study a given phenomenon is through direct on-site contact and interactions with the individuals within the culture being studied. This type of observation may provide added meanings which may not be apparent through scientific measurement, test scores, or questionnaires.

6. Reciprocity, in the research, the act of involving the subjects themselves makes the research more significant.

Organization of this Study

This study will be organized into five chapters. Chapter I will provide an introduction, the study background, guiding questions, assumptions, and the organization. Chapter II contains a historical review of the origination of group care living for children. It also include causations for out-of-home placement and the rationale for effective communication. Chapter III includes a description of the research procedure to be followed in this study. Chapter IV provides the data gathered during this study and the children's version of that data. Finally, Chapter V presents the interpretations, implications, and recommendations which evolved from this study.

Summary

The American system has failed to provide an environment in which group care children thrive. Further, it has failed to recognize the child as a contributing force within his/her own life. His/her opinions do not seem to be of value to those who are in the decision-making position. This failure is demonstrated in the way that children are placed in environments in which they have no say about the appropriateness. The continued conditions of placing children in this manner are evidenced in the increased

number of runaway children living on the streets and in those who demonstrate abusive behavior. Effective communication between caretakers and group care children is mandatory if the welfare of children is to be improved. The purpose of this study was to examine the process of communication between caretakers and group care residents.

This chapter presented the significance of the study, background of study, guiding questions, basic assumptions, and the organization of study.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Chapter II contains a synopsis of selected literature related to residential group care for children. A historical overview examines the origination of various types of care for children residing in groups. It illuminates the past and contemporary problems that children face in attempting to exist in adverse situations. Further studies reveal the different causations in society that lead to out-of-home placement. A view is given of the contemporary issues involving communication between children and those who are attempting to understand them. The rationale is provided for the need of communication and the roles that are ascribed to persons involved in this process.

Historical Overview of the Origination of Group Care for Children

The first humane views and legal enactments on record in behalf of dependent children are those to be found in the Pentateuch (especially Deuteronomy 14:28, 29; 24:21; 26:12, 13). The first champion of the cause of a dependent child should have been the infant who was "placed out" hazardously

among the bulrushes along the Nile and eventually in the luxurious home of Pharaoh's daughter, and who was deprived of being brought up in his natural home (Wolins, 1974, p. 44).

According to Holloran (1989) the code of Hammurabi protected Babylonian orphans two thousand years before Christ. Charity toward the young was preached by Buddha, the ancient Greeks, and the Talmud teaches the duty of giving. The Talmud also teaches the right of the poor to receive alms (p. 16).

Before the Judeo-Christian era, history was filled with descriptions of sexual abuse of children. Anal intercourse by adult males, often within the family, and by teachers was imposed on young boys and routinely accepted in both Greece and Rome. Early castration of male children helped preserve a more feminine appearance for enhancement of their beauty as male prostitutes. Well into Christian times, castration of young boys before adolescence to preserve their soprano voices for church choirs was accepted by a series of popes and members of the highest level of the church hierarchy (Kempe and Kempe, 1984, p. 4).

Quinn (1989) tells in her book, Better Than the Sons of Kings, of the oblates who were initially received in the Benedictine institutions between the sixth and eleventh centuries. She stated boys between the ages of five and seven were prepared for the monastic life until they reached the age of profession, usually at fifteen. The boys were donated by their parents and trained under the constant

supervision of specially designated caretakers, the masters. These children lived together in quarters separated from those of the adult brothers, yet their schedule and round of activities throughout the day paralleled those of the monks in many ways (p. xv).

According to Lawrence (1984) the Cistercians refused to accept children; however, the Benedictine Monasteries accepted children who were not studying to become monks. These children were child orphans and servants, but they were also educated in these environments (p. 33).

According to Kazmierczak (1989), two of the first known orphanages were Christ Hospital and one that was established in Amsterdam. In her dissertation she told of Christ Hospital, founded in 1552 as an orphanage and school by Edward VI in England (p. 1777). The little known orphanage of the Spanish and Portuguese Jews was established by August Hermann Francke in Germany in 1695 (Wolins, 1974, p. 44). A replica of this orphanage was erected in colonial Georgia in 1696. It was called the Ebenezer settlement (Wilson, 1988, p. 471).

Green (1905) states that in the eighteenth century, it was the practice of the farmers of Bouhal to take orphan apprentices from the parish authorities. If sufficiently overworked and underfed, these poor children proved profitable to their masters, but the ultimate effect on the children themselves was disastrous in the extreme. Ignorant and entirely dependent upon others, they developed into hopelessly degraded men and women (p. 46). Pestalozzi, an

educator, hoped to improve these children's lives. It was not the poverty of the Poor that Pestalozzi pitied, but that they had no intellectual interest. "He longed to be able teach the people how to live self-respecting lives". Pestalozzi converted his farm, Neuhof, into a school for the children of the very poor. He began with twenty children and the curriculum was industrial (p. 47). In the summer the children worked in the fields; in the winter they would spin and weave. Pestalozzi made a noble effort to bring the children of the lowest classes out of their surroundings and to solve their Problems of education (p. 69).

Green further states that in the late eighteenth century, there was unrest and it was felt strongest in Nidwald Canton (p. 70). A little town called Stanz was invaded by French troops and the town was completely destroyed. Many children became destitute and an orphanage was erected. Pestalozzi was asked to take responsibility for these children (p. 71).

The first modern placing-out work done on a large scale was under the Napoleonic Decree of 1811. Children in France were boarded out at national expense when they were found to be destitute due to the death of parents and demolition of their communities (Wolins, p. 44). Massachusetts initiated the first efforts in the United States to place children in private families at public expense. The provisions could not be made in the state's institutions, that were existing in 1868, for all children needing care (Holloran, p. 46).

The rights of children proved to be nonexistent from the earliest times. Parents were given authority, often of a harsh nature, over their offsprings. The Roman concept of Potestas covered the absolute power of the father over his children to the extent of leasing or selling them and putting them into slavery or even to death (Rothman, 1991, p. 12).

Childhood was a vague status in Europe and America until the nineteenth century according to Holloran (p. 20). Puritans considered children to be merely undersized adults of unripe intelligence. Strict disciplines by parents was expected to break innately "sinful" natures (p. 157). This grim attitude prevailed until Horace Bushnell, a liberal Congregational Boston minister, wrote Christian Nurturer in 1847. However, social problems for children continued. Jews and other ethnic minorities were denied opportunities that were considered available for only children of white parentage. Although the Puritans considered themselves "God's chosen people building a new Zion in the wildernesses of America", they refused to admit Hebrews into their colony (Holloran, p. 157).

Elizabeth Poor Law of 1601 was brought with the Puritans from Europe when the city of Boston was founded in 1630. English poor law practices were accepted as a community obligation. These laws made parents, insofar as they had the means, legally responsible for supporting their children, and grown children liable for the support of their parents and grandparents. "Vagrants" refusing to work were

liable to be whipped, pilloried, branded, imprisoned, or executed. The helpless and needy child had a legal right to assistance from the state. Such children without homes or suitable parents were to be apprenticed in decent households as indentured servants (Bruno, 1957, p. 127). Billingsley and Giovannoni (1972) defines indenture as a system in which one person could buy or contract the labor of another for a specified period of time, usually five to ten years. After that time, the indentured individual was, theoretically, a free agent. There were some free Black children as well as English in the indenture system. There is evidence that some Colonial communities saw fit to make the indenture of Black paupers more harsh (pp. 25-26). The indentured servant or apprentice family was to receive food, clothing, lodging, training in his master's craft and instruction in religion, reading and writing. Sometimes the indentured contract provided for a gift of money, clothing, or tools at age twenty-one for a boy and eighteen for a girl (Holloran, p. 19).

Youngsters who had lost their way, their families, and their homes were called many names in the Victorian era. There were names uses to describe the children, their residences, and the people who cared for them. Some names for these children were "waifs, little wanderers, guttersnipes, ragamuffins, street arabs, and half-orphans". Most of these children were merely poor urban working-class children without intact families. The children of families who did not meet middle-class standards were deemed

"wayward". These children differed from "juvenile delinquents", another Victorian term, because they were accused of no crime. Later these unfortunates were called "dependent children", "status offenders", or "children in need of supervision". The private charitable organizations for "wayward children" were called "orphanages", "asylums", "temporary homes", "schools", "houses or homes", "child-placing societies", and "protectories". The staff were called "charity workers", "matrons", "agents", "child-savers", and "visitors" (Holloran, p. 14).

Public administrators were appointed for political reasons to run public institutions, or so-called homes for the poor. For the most part these administrators were lacking in the qualifications necessary for adequate services to the poor charges. Their principal claim for a continuance in office was based upon a record of economical management (Wolins, p. 46). One group of officials, called masters, were subject to particular scrutiny. They were in charge of public wards and their performance was often officially deplored. "Orphans", "bastards", and children of poor or incompetent parents were sent to masters by the overseers of the poor (Holloran, p. 19). The evil conditions that prevailed within these institutions caused citizens to establish private orphanages and homes.

Holloran stated that Boston was first in establishing free primary schools in 1818, but they excluded illiterate children over age seven. The City Missionary Society estimated four hundred children roamed the streets daily in

search of play, work, or mischief. They were "too old", "dirty", "wild", or illiterate to be admitted to school. Congregational charity opened schools and orphanages to fill the need and prepare all children for the public schools (p. 21).

Since so many children were found to be homeless, Judge Josiah Quincy suggested an answer to the problem. He was responsible for the first House of Reformation, a congregate municipal institution. It was part prison and part school. The inmates were 150 boys, aged seven to seventeen, apprehended by the constable and convicted by the Boston Police or Probate Court of petty crimes, vagrancy, and "waywardness". These children had been turned over to the police by distraught parents and they were felt to be willfully disobedient and "stubborn". The admission policy was flexible. School teachers, clergymen, overseers of the poor, or other responsible gentlemen who took the trouble to make official complaints about a child could be certain of swift action by the courts (Holloran, p. 16).

Holloran further told of the first Catholic orphanage, St. Vincent Asylum. In 1832, Bishop Benedict Fenwick brought three Daughters of Charity to Boston from the convent in Emitsburg, Maryland. These sisters educated ten thousand orphans or half-orphans (one parent deceased) and sheltered them. St. Vincent admitted only "pure virginal, innocent girls" aged four to sixteen from poor but respectable Catholic families of the diocese, not the petty

criminal, "fallen women", or well-bred young ladies other Catholic institutions attracted (pp. 66-67).

In 1852, Charles Loring Brace devoted his life to rescuing abandoned children from the streets of New York. He sent them to homes in the western states in groups of about a hundred each and distributed them to families of farmers who had gathered at designated places to receive them. By 1875, 35,000 had been taken off the streets of New York in this way (Bruno, p. 57).

In the name of anti-institutionalism and romantic reform, as well as an irresistible conviction that farm and rural life "purified" children (Holloran, p. 70), protestant charities sent thousands of urban lower-class youngsters to a wide variety of foster homes in the country. These protestants against poverty found the task of ridding Boston of street "arabs" and "guttersnipes" to be a huge undertaking. The "orphan train" provided a solution, but was still found to be inadequate.

The form of care for paupers after the Revolutionary War was the almshouse. These were deplorable places, but housed all who could not care for themselves. This included the orphans who were too young to be useful and children whose parents were unable to support them. In this situation, the parents were also housed. Some free Black children were found in the almshouses. While Black children had been included in the almshouses, they were excluded from most of the orphanages established before the Civil War (Billingsley and Giovannoni, 1972, p. 26).

The Quakers established the first Black orphanages. They were based on the premise that "children could be saved from a life of sin by learning to conform to the right standard". In 1838, white mobs burned the shelter for Colored Orphans in Philadelphia and the Colored Orphan Asylum in New York was broken into and set afire by 500 white men and women during the Draft Riot of 1863 (Billingsley and Giovannoni, p. 26).

Racial prejudice did not abate in the first decades of the century and the application of psychological and psychiatric techniques only provided new methods by which the inferiority of Blacks could be "proven scientifically" (Holloran, p. 156). For this reason, clubwomen devoted much of their time to educating Blacks in the areas of health, home and child care. They also built orphanages (Grossfeld, 1989, p. 16). Black women in Illinois adhered to the Victorian ideal of the era and bore a moral responsibility for reforming society. They maintained orphanages and shelters for "wayward" girls (Hendricks, 1990, p. 190).

According to Creighton (1990) the collapse of the United States Child-Protection system led to a growing need for orphanages (p. 37). The greatest growth of institutional care in the United States was during 1890-1903. This period coincides with the beginning of the greatest influx of immigrants. During these years over 400 orphanages were established (Wolins, p. 47).

At the White House Conference held January 25-26, 1909,

attention was directed to the child's own home and the need of preventing its breakup. It announced as its first findings, "Home life is the highest and finest product of civilization. . . . Children should not be deprived of the natural home except for urgent and compelling reasons" (Wolins, p. 256). Another conference was held in Washington in 1930 with 3,000 men and women assembled. Leaders in the fields of medicine, education, and sociology attended. The purpose of this conference was to set forth an understanding of the safeguards which would assure children health in mind and body. At the time of this conference, there were 5,000 child-rearing institutions in the United States standing in place of the parent for 1,200,000 incarcerated youth. The goal of the institutions were to adjust the individual child to "fit into" the world with happiness to himself and usefulness to the world (White House Conference 1930: Addresses and Abstracts of Committee Reports, 1931, p. 271).

At the 1915 Baltimore Conference of the National Conference of Charities and Correction, the findings were that each type of child care was to take stock of its own work in unsparing terms. The shortcomings of both types of care, residential and foster, were cited and the need for honesty on the quality of care was emphasized.

Dr. Hastings H. Hart believed:

> It is probably fair to say that of about 1500 institutions and agencies in the United States which place children in family homes, not 25 are doing such case work as would be recognized as adequate by any well-trained worker. There are many agencies, institutional and individual, who dispose of children body and soul, with little

> more thought or conscious than they would give to the disposal of surplus kittens or puppies.

This criticism resulted in the formulation of minimum standards for institutional care. It was drafted by Drs. Reeder and Bernstein and Mr. Doherty. The guidelines adopted with few modifications by most State departments of child welfare all over the United States and Europe. The "Minimum Standards for Child Welfare" were adopted at the Second Washington Conference by Woodrow Wilson held on May 5-8, 1919 (Wolins, p. 52).

Most states had their own standards, including Texas. Their standards of a sound institutional program relating to health mandated that all institutions give a full examination and insisted upon isolation of the child for a designated period of time upon admission. Texas required that each child would have a thorough (stripped) examination by a physician. This examination would be supplemented by laboratory test, throat culture, urine analysis for hookworm, test for gonorrheal, vaginitis, syphilis, and tuberculosis (University of Texas Publication N. 3837, 1938, p. 289).

In the 1960s, about half of the population at Audy Home for children, located in Chicago, Illinois, consisted of neglected children. They were between the ages of nine and twelve and minors in need of supervision. These youths were being held in custody because the social workers thought the families were insufficient or abusive. Audy home was a shifting one, admitting children for the first time while

others were between placements. It acted as a catchment between "dumps" (Murphy, 1974, p. 112).

Murphy further states that it was the policy of the State of Illinois to Place hundreds of children each year in Texas institutions. By 1973, over 500 Department of Children and Family Services children were in Texas. Abuses occurred at the Texas homes. While routinely investigating the files of DCFS youngsters at Chicago-Reed Mental Health Center, a worker discovered that one young girl had been sterilized in an institution near Austin. Documents stated the girl had originally undergone exploratory surgery, but the doctor had at the same time performed the hysterectomy, cutting out the uterus and both ovaries (p. 133).

In 1986, over 100,000 young people between the ages of 10 and 19 were admitted to psychiatric hospitals and countless others were placed in other out-of-home treatment centers for emotionally disturbed or socially maladjusted youth. The three types of residential mental health treatment facilities that existed for children and adolescents today are group homes, short term psychiatric hospitals, and public or private mental institutions:

> Group homes are residential treatment centers. They provide treatment for anywhere from 6 to 12 youths and are intended for youngsters who do not require the intensive services of larger, full-service institutions, such as the short term psychiatric hospitals and public or private mental institutions. Some larger institutions have developed multiple group homes within the confines of a single residential campus. The youths remain in group homes for several months or even years. Many of the youths placed in group care are status-offenders or youth who have been diagnosed as emotionally disturbed or socially

maladjusted, rather than mentally ill (Smollar, 1990, p. 4).

Causations of Out-Of-Home Placements And the Rationale for Effective Communication

The habits of communication are taken for granted. Verbal communication can be considered as nurturing support between the childcare worker and the child. Workers sharing with children that they thought of them during a separation can be beneficial to the child. The worker can also express feelings toward the child which communicates caring of being with the child. Children like human beings anywhere need to experience that someone cares and is fully with them even when they are alone (Ainsworth and Fulcher, 1981, p. 32).

According to White and DeBlassie (1992) family communication not only transmits sexual knowledge, opinions, and beliefs, but also attitudes. Parental communication with teenage children is often recommended as a means of discouraging early sexual activity. Parents should teach responsible behavior in general, which in turn will have a more positive effect than simply teaching about birth control or providing sex education.

Children who are placed in group care usually fall into two categories. The status offenders are categorized as either juvenile delinquents (JD) or persons in need of supervision (PINS). PINS are described as being incorrigible as a result of their rebelliousness at home.

They may exhibit runaway behavior or violate curfews. They may be children who are truant or possess any behavior that is not classified as criminal (Krueger and Hansen, 1985, p. 386).

According to Dinnage and Pringle (1967) residential care in particular has been depreciated in two ways:

1) It has been considered the poorer alternative to foster care.

2) It has become the accepted placement for difficult children who cannot be fostered (p. 26).

Those who work with adolescents are concerned that a positive sense of identity is fostered within the child. Stage theorist, Erikson, posited the existence of an "identity crisis" and indicated specific tasks to be completed as part of normal development. A failure on the child's part to successfully complete these tasks can result in the individual remaining alienated or becoming developmentally "stuck". When this occurs, it can increase the likelihood of regressive and acting-out behaviors (Hutchinson, Tess, Gleckman, and Spence, 1992, p. 340).

Dinnage and Pringle further states the potentially most damaging aspect of residential care are that a psychological, culturally, and educationally restricted impoverished substitute environment may unintentionally be provided. Unless special steps are taken, children may grow up without a personal sense of identity, lacking a coherent picture of both their past and their future (p. 35).

Children are presumed by law to be incomplete beings during the whole period of their development due to their

inability to provide for their own basic needs or even to maintain life without extraneous help. This justifies their being automatically assigned by birth certificates to their biological parents. (Goldstein, Freud, and Solnit, 1973, p. 9).

When children are not in possession of a positive self-identity and are not considered and treated to be complete whole beings, they react in certain ways. Some youngsters escape their parent and make themselves prematurely independent. Sterlin states there are four different types of runaways:

1) **The abortive runaway** - runs away precipitously, but never succeed. They are pulled back quickly by parents, neighbors, police or others.

2) **The lonely schizoid** - usually they have no peers to run to. They may loiter around and prefer lonely parks and churchyards.

3) **The casual runaway or driftaway** - connects with others casually and engage in transient, shallow, and exploitive behavior. They appear ruthless and tough.

4) **The crisis runaway** - the boy or girl who runs away for a few days or even weeks before he or she returns home, or is forced to return home. While away from home, they often seem deeply conflicted about running away, about living in the runaway culture, about hurting others while pursuing their own ends. The act of running away reflects as a crisis in their and their parents' lives (Sterlin, 1972, p. 3-21).

According to Palenski and Launer (1985) running away behavior is not systematically distinct from other adolescent behavior since it includes the act of exploring, testing, and defining one's limits. It is only when the running away behavior becomes a "career" that it

distinguishes from "normal" behavior (p. 349). There are cases when the runaway is attempting to communicate. Blum and Smith states some "kids" run away to say something important and immediate to parents. Children attempt to say that "being misunderstood and mistreated at home, miserable and ignored at school doesn't matter when you can leave it all behind for a community of your equals, your friends, no parents allowed, just kids". They also communicate that knowledge is not contained in books, but in hallucinogens. They feel that it is easier to swallow drugs than to read books, no rules, no limits. They are attempting to say nonverbally that the world seems to belong to those who go out on the streets and seize it (p. 19).

Sex roles and the status of females on the street are not radically dissimilar from the traditional patterns of the larger society. Young women who came to The Sanctuary, a short term home in Boston, did not always seem to be in control of their sexual situations. Just as they would have trouble telling their parents about their encounters, so they had considerable hesitancy about confiding in women counselors, even when they seem to want to discuss sex. Males were no better and, in some ways they were worse at their attempts in communicating. Many boys considered their girls in general as objects and sometimes coveted possessions (Blum and Smith, 1972, p. 15).

Dating itself, according to Samet and Kelly (1985) is shifting away from courtship as the main purpose as it used to be in past years. It is now considered that the date,

besides its other components, has become an end in itself. This is seen as providing the adolescent with a pleasant social experience and a socially approved outlet (p. 232).

A study of friendship and romantic involvements was conducted and the results indicated that adolescents are not as concerned about sexual issues as they are about other concerns within their lives. The data was gathered by interviewing 145 adolescents (82 girls and 63 boys). These children were asked about their communication exchanges with their best friend and with their romantic partner. Twenty-five percent of the respondents discussed leisure distractions, such as songs and dances. These children did not talk much about political and social problems or the future and unemployment. Ten percent discussed personal problems and fifty percent of the responses were concerned with disclosures of personal issues. Fifty-seven percent centered on sentimental problems. Mixed-dyads discussed love or sex in different proportions (Werebe, 1986, pp. 140-141).

According to Fisher, Marsh, and Phillips (1986) the difficulties over the care of parents' children which brought families into contact with social services were extremely long standing. Parents would describe their current difficulties as having started many years ago when the child was much younger (p. 33). Usually the discussion of the origin of care has focused on the parents' views and attitudes, while the part the children played has been less apparent. Children were noticeably less forthcoming about

problems in family life than were their parents. It seemed that children felt that they had most to lose and least to gain from going over the difficulties which led to admission into group care and their replies tended towards the monosyllabic and non-committal (p. 40).

Children can easily be deceived. Rosenwall (1987) provides insight into the ways that children think. In imagining the thoughts of others, adolescents can fail to differentiate between what is of importance to others and what is of concern to themselves. Adolescents may inaccurately perceive that others are as preoccupied with their concerns as they are themselves (p. 794). Some attendants who work in group care homes are aware of this deficiency. These attendants lose a real sense of the residents' individuality or humanity. They develop a stereotypic way of thinking about residents, their characteristics, and their nature as a category of people set apart from all others (Eisikovits and Kashti, p. 112). When this occurs, residents are in many instances exploited.

The abused child has no advocate, no one to take his side against his parents or other people. He is handicapped by his physical and mental immaturity and by what has been the classical legal position of a child with respect to his parents and society. He is too weak to defend himself against assault. He cannot speak on his behalf because he has not yet learned how to speak at all. He communicates that if others listened, they would not believe. If they believed, they would tend to say that the matter was not

their business. And if they decided to make it their business, they would find the legal support for their position questionable (Henry, and Sanford, 1971, p. 6).

According to Elmer (1967) child abuse occurs most frequently in the home, where no outsiders witness the event and young children cannot seek out the authorities to protest about their caretakers. In the absence of witnesses or complainants, the mistreatment of children must usually be inferred from circumstantial evidence (p. 2). Since there are no witnesses, thousands of children each year suffer the trauma of abuse or re-abuse either from reunification with their families or during the course of their stay in foster care (McDonald, 1989, p. 11).

The problem may be a lack of communication between parents. When a mother or father withdraws from his or her family, the deprived parent may turn to the children as a means of comfort and support. Porter (1984) feels that this lays the foundation for an incestuous relationship. The parent that is denied his conjugal rights may turn to the nearest available source of gratification, the dependent child (p. 9).

In the family sexual abuse may take many forms. There are four categories:

1) **Incest** - a physical sexual activity between family members.

2) **Pedophilia** - the preference of an adult for pre-pubertal children as a means of achieving sexual excitement.

3) **Exhibitionism** - involves the exposure of the genitals by an adult male to girls, boys, and women.

4) **Molestation** - a vague term which usually includes other vague terms, such as "indecent liberties". It includes behaviors such as touching, fondling, or kissing the child, especially in the breast or genital areas (Kempe and Kempe, p. 10-11).

In many instances the child is not abused at home, but rather within the group care home. Bloom (1992) states it has been his experience that allegations of sexual abuse of residents by staff members are true whatever the initial impression of the allegation may be. The clinically and ethically appropriate response is to listen to the child carefully, courteously, and nondefensively. The incident should be explored openly, candidly, and in an empathic and supportive manner (p. 134).

According to the United States Department of Commerce, "Statistical Abstract over 2.25 million children were reported to have been abused in 1987. One hundred and forty-three died as a result of child abuse. There are approximately 300 children reported to have died of AIDS under the age of twelve. Approximately eleven thousand children between the ages of 10 and 19 committed suicide in 1988.

The suicide rate for American Indians was nearly twice that for white youth, 26 compared with 14 per 100,000. The suicide rate for Hispanics, Blacks, and Asian youth were about 30-60 percent lower than the rate for white youth. Although the suicide rate was higher for the American Indians, death by homicide was the leading cause for Black

youth. The Black homicide rate of 59 per 100,000 was more than seven times the homicide rate for white youth, 8 per 100,000. The homicide rates for American Indian and Hispanic youth were about three to four times the rate for white youth. The homicide rate for Asian youth (7 per 100,000) was similar to the rate for white youth (National Center for Health Statistics, 1991, p. 14).

Some professionals in their attempt to help parents advocate the tough love approach. They tell parents whose adolescents take drugs, skip school, steal, and talk back to present the teen with strict unconditional rules for acceptable behavior. If the teen does not adhere to these demands, parents are to mete out stern responses that range with withholding privileges to actually changing the locks to bar the difficult teen from the house (Pieper and Pieper, 1992, pp. 369-371).

The tough love approach tends to alienate the child from the parents and many of the children resort to crime as a means of survival. According to Samenow (1989) the reason that children turn to crime is that a communication gap exists between themselves and their parents. Parents who do not know how to talk to them and do not care about their activities withdraw (p. 93).

In all instances the parent is not to blame. Sometimes a communication gap does exist, but it is one created by a very secretive child. If the parent attempted to communicate with the child, he would probably lie about whom he was with or what he was doing. Such a child rebuffs most

attempts by his parent to communicate and the gap becomes a chasm as the child grows older and even more secretive (Samenow, p. 93).

An exploratory study examined the characteristics and interpersonal relations of a relatively small group of adolescents who identified themselves as members of a revived "mod movement". In response to being asked to explain being a mod, the most typical responses were that it was a "state of mind", an orientation which demanded an acceptance of others and "doing your own thing". The notion of individuality was of critical importance (Stevenson, Roscoe, Brooks, and Kelsey, 1986, p. 393).

In working with group care residents, it is necessary to recognize the unattached child. This child's interest is severely limited by low verbal ability, not necessarily related to low intelligence. Rather, there is an inability or unwillingness to think straight. This often prevents the young person from being able to state to himself or to others what he feels his needs to be or what his problems are. This inability "to define himself to himself " prevents him from "protesting" in terms that can be recognized or discussed and severely limits his ability to do anything about what disturbs him (Goetschius and Tash, 1967, p. 121).

Communication in some instances is nonverbal. More Black children are placed in detention facilities, training schools, marginal foster home placements than in residential treatment centers, boarding schools, group care facilities,

and quality foster homes. This is a by-product of the same manifestation of racism that is evident in working with families of these children (Sinanogu and Maluccio, 1981, p. 135).

A Black person who feels at risk, may use language to stay hidden, using code words, half complete sentences, saying as little as possible. Black American culture is built on oral rather than written tradition. The strong verbal emphasis in the Black-American culture, and the very personal and intensely emotional interactive style, are altered by many Black people when they are commnunicating with Whites (Carmen and Small, 1988, p. 160).

Carmen and Small further believes that Black children learn to cope with interpersonal racism through verbal play. Verbal abuse, teasing, joshing and swearing are behaviors of the oppressed. Playing the dozen, humiliating, dehumanizing one another is an exercise undertaken because they are looking for a way to say that they are better than someone. This helps to establish a sense of an adequate self. Learning to stand up to such verbal abuse in play without backing down, losing control, or letting anyone see the hurt is a skill often used (p. 163).

According to Witmer and Kotinsky (1952) children who live in close proximity to the majority group are likely to find their initiative curbed by many external circumstances. Negroes probably suffer especially in this respect. Negro mothers must early warn their children to avoid offending White people (p.137).

Carmen and Small states that agencies must acknowledge that entry into group care may be experienced by Black children from Black communities as culture shock. A setting controlled by a White staff and reflecting a majority orientation may be perceived by many children as an alien environment. Food, music, discipline, and language may be different (p. 163).

The institution staff needs to keep in mind that the adolescent can speak for himself. The youngster should feel that he has some say about the selection and purchase of his clothing. He should decide the size of the portion of food he is served. He should have some input into how he is going to spend his allowance. He should determine what he wants for Christmas or his birthday. He is capable of determining who his friends will be (Burmeister, 1960, p. xxiii).

Burmeister further states that the child with problems, the one who feels different, whom no one has wanted, and who feels that he has been kicked around here, there, and everywhere, should feel, when he comes into the institution and into group care that "this is a place where they try to help you". Something in the atmosphere, in the surroundings, "speaks" to him (p. 11).

Summary

Historically, adults have found ways to exploit children and use them to their advantage. Children have been subjected to the inhumane treatment of physical,

sexual, and emotional abuse. This abuse has been inflicted on them by adults. Because of childhood neglect and abuse the group care home came into being. The original purpose for group living was to teach children how to lead self-respecting lives. It began as a charitable venture. However, it has evolved into a system in which children are not recognized for their unique qualities and they continue to be exploited.

Although group care was established as a means of assisting children in meeting their daily needs and providing a safe environment, it has failed in this accomplishment. Rather, children continue to be abused in facilities that are meant to provide the safety and security that the children's biological parents cannot provide. For this reason, an additional need is created, the need for a caring and stable environment.

CHAPTER III

DESCRIPTION OF THE STUDY

Introduction

Children's perceptions of institutional care are essential to a full understanding of group care living. Throughout history adults have spoken for children and they have chosen what they felt was best for them. The decisions that have been made by these adults have been wrong in many instances. If children had been allowed to voice their opinions, most of the decisions would have been based on information taken from all possible sources available. This could have prevented speculations regarding the needs of children. Adults have ignored children's views and focused more on treatment from a professional standpoint. This has produced a system which is based on the caretaker meeting the physical needs of children, at the neglect of emotional needs which are those that bring about a sense of well-being. The primary purpose of this study was to look at group care living through the eyes of children. Viewing group care living through the lenses of children and their realities called for research methodology that departed from traditional research approaches. An ethnographic approach

permitted the researcher to get an "insider" view of group care living from this perspective.

Ethnography is the study of a culture which encourages the researcher to become a part of the group being studied. Aceves (1974) states, "the researcher gains a better knowledge of people when he lives with them for an extended period of time and lives like them insofar as possible and prudent".

The word ethnography, the Greek ethnos means race and grapehein means to write. Literally, ethnography means to write about a race. Its contemporary usage means a descriptive account of the customs of a group of people. Adding the suffixology **ology** to **ethno**, the word ethnology is derived. Ethnology is used to explain the behavior of a human or social group. Analysis follows from the ethnographic data procured (p. 76).

Ethnography makes use of direct observation and extended field research to produce a thick, naturalistic description of a people and their culture (Gephart, 1988). The data, which are derived from real life situations, are analyzed. Therefore, an ethnography is basically a function of the ethnographer who brings to the work his values and past background (Agar, 1986). In this chapter the researcher presents a description of this research approach.

Research Site

The research site in which this study was conducted was a group care home located seven miles south of the downtown

area of a large metropolitan city. The home was established in 1975 because of a federal mandate to the state. Originally, it was a residence for adolescent girls who were status offenders, those who had committed a felony. Services include a twenty-four hours a day, seven days a week residential program. The average length of stay for a resident is 6-8 months. Most referrals are made through the Department of Human Services which are given priority treatment. Residents are teen-age girls, ages 13-18 in the Department of Human Services custody and live within a 25-county catchment area known as District V. In recent years, this guideline has relaxed and girls are accepted from throughout the state. Since 1980, the referral pattern has changed from status offenders to abused and neglected girls. More than 92% of the residents admitted have experienced some form of sexual abuse. In order for a resident to be admitted, there must be evidence of abuse or neglect. The home is funded by the United Way, private contributions, Social Service Block Grants, and the Department of Human Services. The home has received the highest evaluation possible from the review board of the Department of Human Services. It is considered a model program by the Department of Human Services and there has been an expressed interest in duplicating the program. It is recognized throughout the state for quality service delivery and for its strong volunteer program.

The group care home is a brown brick Tudor-style home. It has fifteen rooms with many open areas that are not

considered to be rooms. It is located on a residential street in a middle class neighborhood. It has also been approved by the Department of Public Health to house a maximum of eleven girls. Originally, the home was considered to be a single family dwelling. The home has three floors, the first and second with a basement. There are seven rooms on the first floor. It includes a living-waiting room, two primary counselor offices, a staff lounge, a large bedroom that accommodates three residents, a dining room, and a modern kitchen (Figure 1).

There are five rooms with a bath on the second floor. An office accommodates two administrators. In a large opening in the center of this floor is a single bed used by the night staff. There are three bedrooms, one accommodates two residents and the other two accommodates three residents each (Figure 2).

There are stairs leading to the basement. At the bottom of the stairs is a large room used for group sessions. There is a television, a video recorder, a piano, an organ, and a stereo. In this room is a long sectional sofa with two oversized chairs. Near this room, is a laundry room housing two washing machines and dryers (Figure 3).

The entire house is tastefully decorated with many wicker baskets and dried flowers on bookcases. There are various framed pictures throughout the home. At some windows are textured curtains. Also, there are potted plants in various rooms.

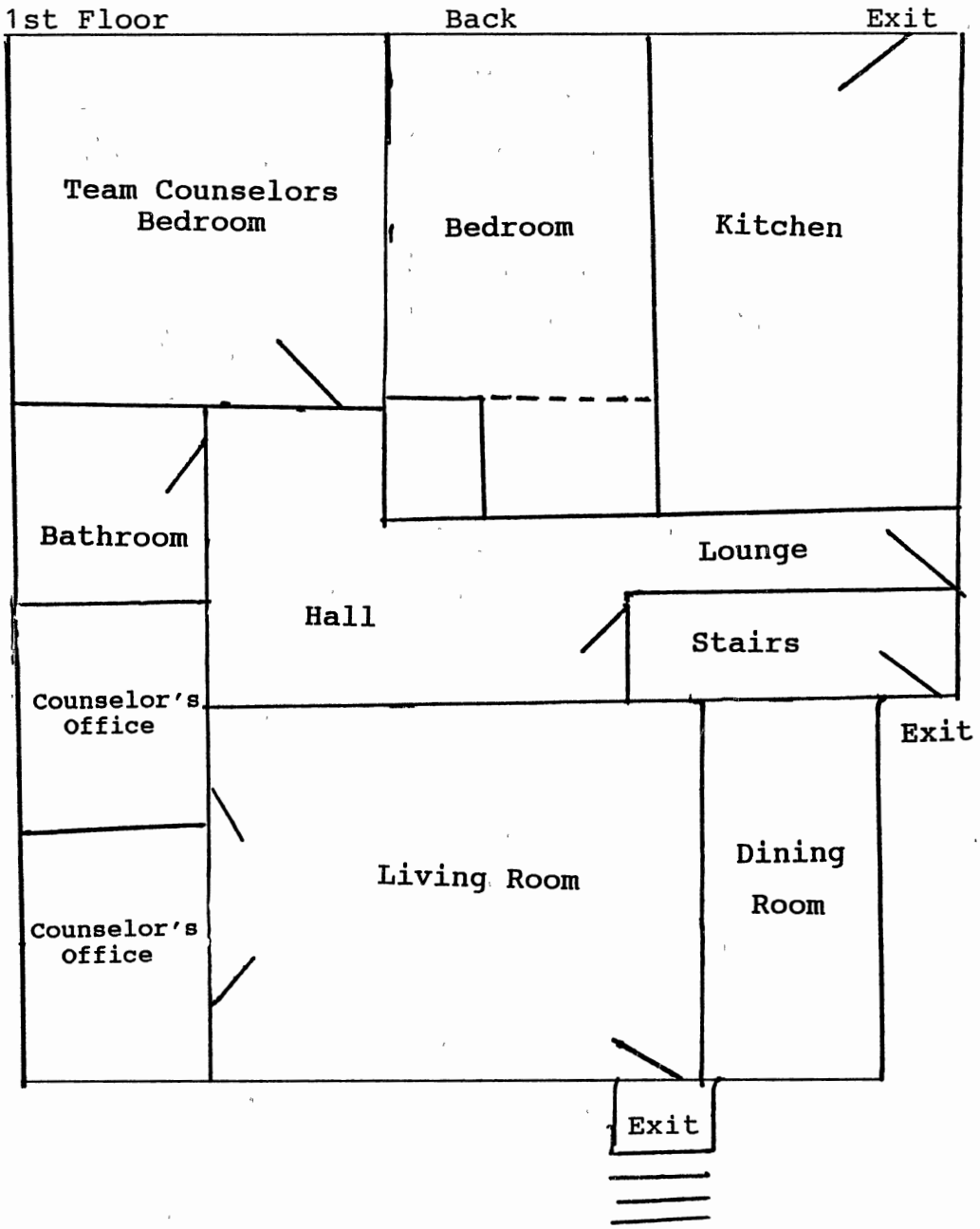
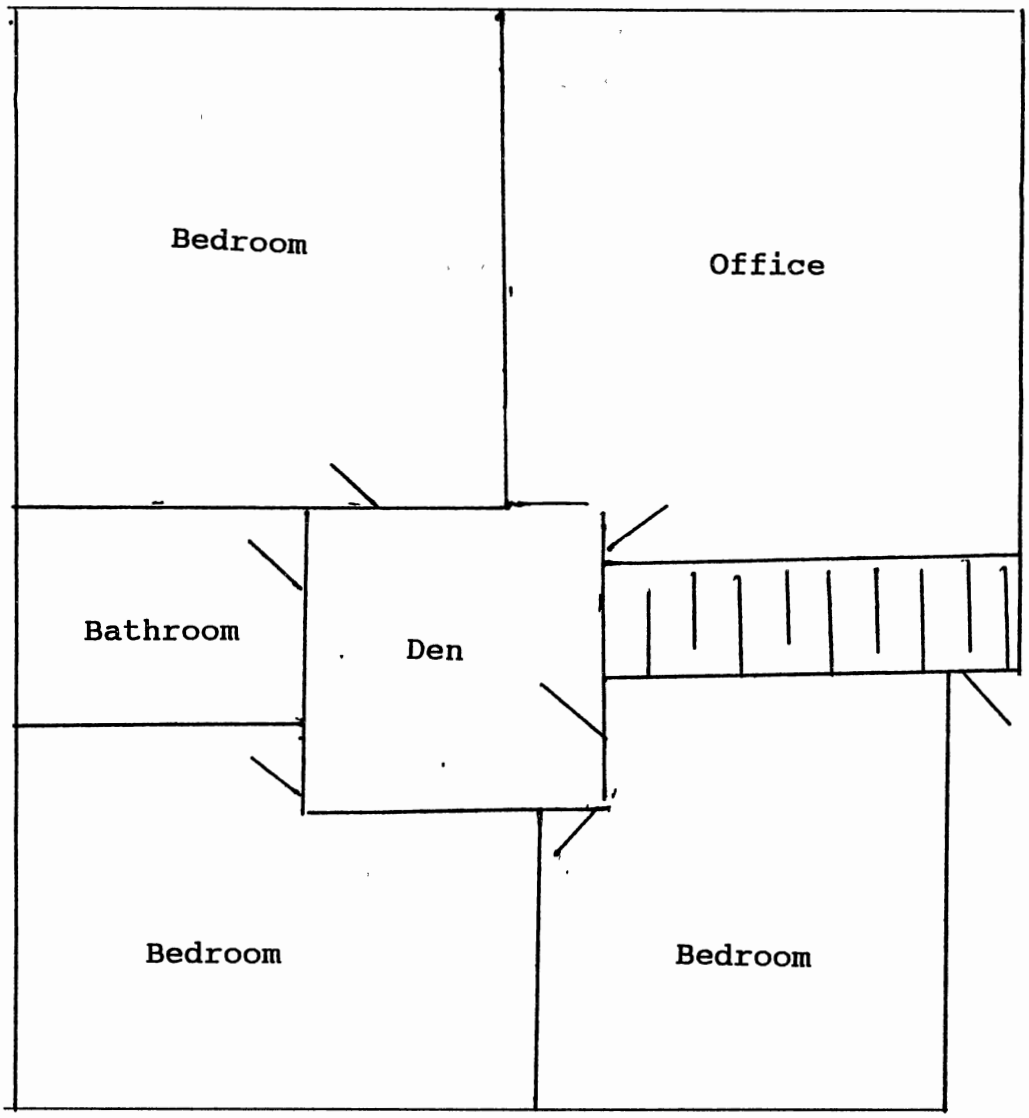


Figure 1. First Floor of Group Care Home

Outside Back



Outside Front

Figure 2. Second Floor of Group Care Home

Basement

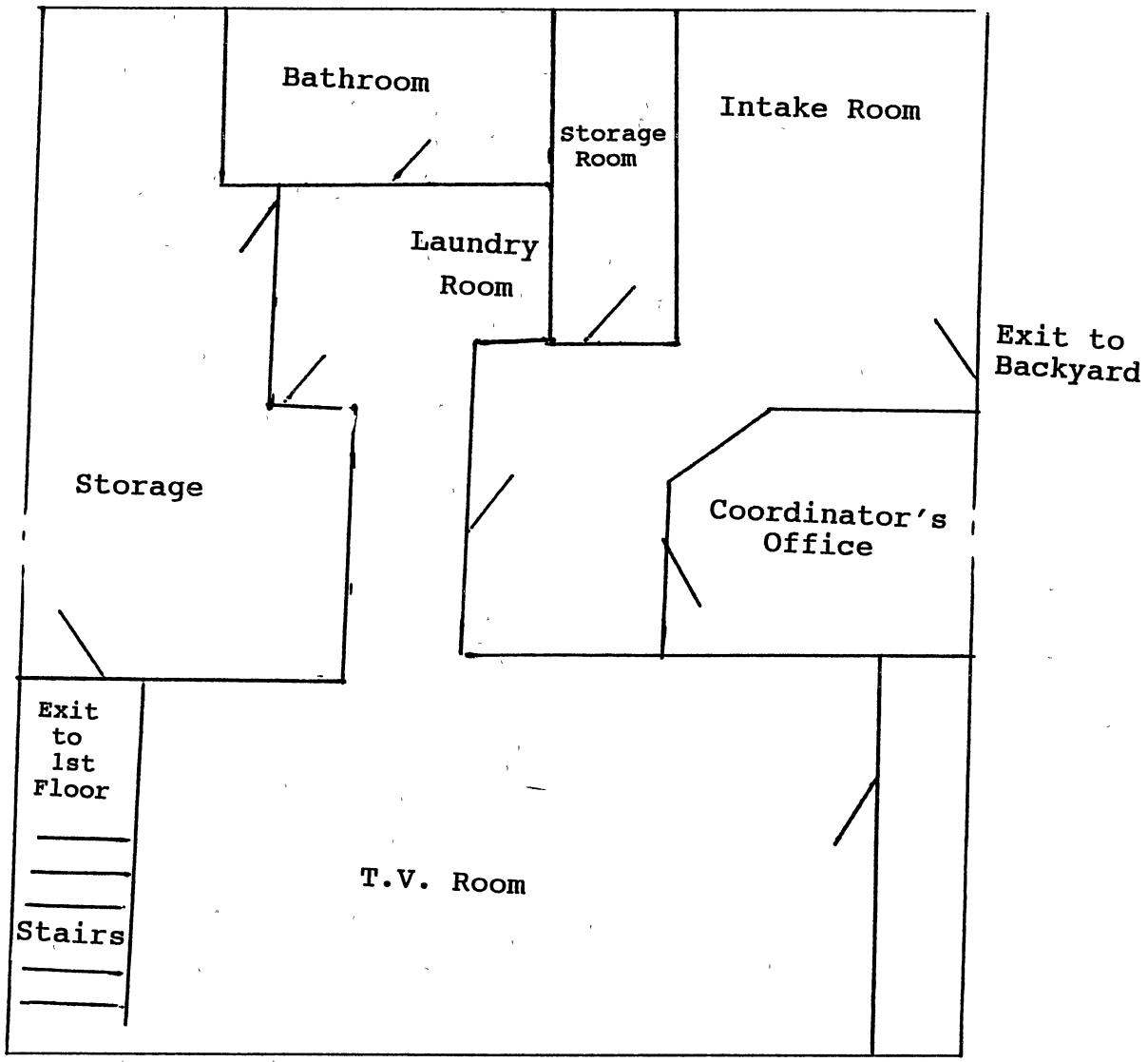


Figure 3. Basement of Group Care Home

Participants

There were five caretakers and nine adolescent girls who participated in this study. In order to provide a profile of the people who contributed to this study, brief biographical sketches will be given. The names that are used are fictional. Residents have been placed in the group home because of a multitude of problems that prevent them from remaining at home with their biological parents. All residents are in the custody of the Department of Human Services (DHS).

Caretakers

Betty is the coordinator of the home. She was promoted within the group home after being a primary counselor. Her responsibilities include the direction, coordination, and supervision of the home in accordance with the program goals and policies adopted by the sponsor. She recruits, trains, and supervises staff and volunteers for program activities. Betty has a Master's degree in Social Work.

Joan is the supervisor of the clinical staff. She also worked as a primary counselor before becoming a supervisor. She works directly with the primary counselors and direct care staff in providing daily care to the residents. She answers directly to the group home coordinator. Joan has a Master's degree in Social Services.

Pat is the supervisor of the Life Skills Program. She supervises the Life Skill and the Tutorial instructors. She

reports directly to the coordinator. She works with the volunteer staff that assists in the implementation of the above programs. Pat has a Master's degree in Social Services.

Brenda is a primary counselor. She has direct influence over the residents. She counsels and advises residents. She plans social and group meetings, as well as treatments plans for individual residents. She also monitors the activities of the residents on a daily basis. Brenda has a Bachelor's degree in Psychology.

Pamela is also a primary counselor. She has the same responsibilities as Brenda. Pamela or Brenda must be available to the residents at all times. When Pamela is not at the home, she must be on-call, able to report immediately in cases of emergency. Pamela has a Bachelor's degree in Psychology.

Residents

Jean is a 15 year old white female. She is out-going and very friendly. She attends high school and is in the tenth grade. Before coming to the group care home, Jean was living with a foster care family. Jean experienced difficulty in remaining home with her mother because of a disagreement over Jean's boyfriend. There was confusion about where she was when she was with him. As a result of this, there was a confrontation with her mother. Jean refused to return home and ran away. A petition was filed for placement and she

was placed in foster care and later transferred to the group care home.

Susan is a 16 year old Black female. She is attractive with a large black eyes and flowing black hair. She attends high school and is in the tenth grade. Susan is in group care because of the family's inability to control her behavior. Her mother states that she resents authority, has a bad attitude, has run away from home and has been associating with older men that are or have been involved in illegal behavior such as selling drugs.

Arlene was brought to the group care home because of allegations of abuse and neglect. She is thirteen years of age. The family is extremely dysfunctional. The father has had little contact with Arlene, yet he is trying to gain custody over her. The adoptive mother, who is also the grandmother, is going through a divorce and blames Arlene for the divorce. The mother is living with a man who has been in trouble for possession of illegal drugs.

Helen was admitted into the group home because of a Detention/Release Order. She was missing school and her custodians would not allow her to return home. She has been in care twice before, once because she pulled a knife on a boy at school and because of her behavior and attitude. Helen is working on her GED. Helen is eighteen years of age.

Mary entered foster care with her brother due to allegations of physical abuse. Her father confessed that he had hit both children about the head with an object. It also came out that he had attempted to run Mary down with a car. Mary's mothers whereabouts are unknown. The Department of Human Services had received sexual complaints in the past; however, the department was not able to conduct an investigation because the father left the county before anyone could interview the children. Mary disclosed the sexual abuse after being caught at school with a boy on the playground. She related that she had grown up with sex with her dad. Mary is fifteen years of age.

Gwen is a 15 year old white female. Allegations of sexual abuse were received by the Department of Human Services. The perpetrator was an 82 year old neighbor. Gwen was neglected by her mother when she left her with friends and family. Most of the time Gwen stayed with her grandmother who did not supervise her. She roamed the neighborhood. Her grandmother was more concerned with her own life and felt that Gwen would be better off in foster care. Gwen was placed in another group home prior to coming to this one.

Patricia was placed in Department of Human Services custody because of an unruly petition filed by her parents. Patricia was reported to have charged over $900 on her parent's credit card. She reportedly hit her mother. The social worker related an incident of sex abuse within the

neighborhood, a group of adolescent males held her down and fondled her. Patricia is seventeen years of age.

Francis is a sixteen year old white female who has a reported history of intellectual limitations in school. She also received treatment for sexual abuse by her biological father. She was place in a previous home for about a year. She was discharged to foster care after the year of group care. She was returned to her biological father after the two placements. A pregnancy was disclosed, reportedly fathered by a 28 year old man. When he "dumped" her, she filed charges for statutory rape. During the fifth month of the pregnancy, the result was a stillborn birth of twins. It was also disclosed that during the time of this pregnancy her father continued to molest her.

Cynthia is a sixteen year old Black female. She is admitted because of an unruly petition. Cynthia is quoted as "difficult to control". She and her mother has difficulty communicating. Her mother questioned Cynthia's choice of male friends. Cynthia resented this and ran away often and her mother did not know her whereabouts. She was placed in group care by the Department of Human Services. Cynthia has a child that is residing with her mother and she resents this also.

Research Procedure

An administrator of a women's shelter assisted in the selection of the group care home for children. She acted in the role of gatekeeper in assisting the researcher by arranging contact with the group care home primary counselor supervisor. A meeting was scheduled between the supervisor and the researcher on August 6, 1992 in order to discuss the benefits of this study to the home and the group care residents.

The study initiated on August 10, 1992 and data collection continued through October 31, 1992. The researcher visited the group home two/three times each week, for between five and seven hours per day, for a total of 156 hours. Visits took place during the morning, afternoon, and evening hours. By scheduling staggered visitations, access to the children was enhanced since they were in school or at work during the day. The staggered visits also permitted the researcher to observe the daily cycle of events performed by the residents throughout the day. Opportunities were provided to attend group meetings, visit during meal times, take occasional walks, visit on patio and in bedrooms, attend parties and celebrations, accompany residents to doctor appointments, and go on drives to nearby stores.

Participant-Observation

Participant-observation was the research strategy used to study the atmosphere that prevailed within the group home setting. LeMaster (1975) states that using this approach the researcher will attempt to penetrate a social system that he is not a native of, with the hope that he will be able to view the social world of his subjects from the inside rather than looking at it from the outside (pp. 3-4). Participant-observation is a research method that permits the fieldworker to see life as it is being lived, and to understand it by actually living it as much as possible (Adler, 1987).

Participant-observation allowed the residents of the home to gradually get to know this researcher. Fielding (1986) states that it is necessary for the researcher to employ verstehen, a Greek term used to imply empathetic behavior, in situations where participant-observation is to be used (p. 48).

Not all field work situations permit participant observation. In certain instances, the technique may have to be supplemented by other methods of qualitative research. Special incidents may require systematic interviewing or various frequencies may call for systematic observation.

According to Edgerton (1974), techniques of participant-observation can be divided into two types:

1. The techniques that are used with a limited number of persons include:

Key informant interview - the researcher relies on certain persons for much of their detailed or specialized information.
Indepth interview - a confiding informant talks at length on a subject allowing the investigator to probe deeply into difficult psychological information.
Ethnoscience - a formal research procedure that is designed to discover the different ways people perceive their world.
Life history - a key informant is asked to tell in detail his life story.

2. The techniques that are designed to gather a more representative kind of data from a large number of persons are:
Genealogical - through interviews the researcher reveals a basic kinship relation that defines expected rights and duties attached to each kinship status.
Census taking - interviews permit measurement of variation among individuals as well as comparison between individuals or groups.
Questionnaires - The questions are written, then mailed or delivered to the persons in the sample. The answers are written, then mailed back or picked up.

As a researcher observes and participates, awareness of the complexities and contradictions in what people say and in what they do are revealed. Edgerton also states that the researcher will discover that many people do not behave as they are expected to behave (p. 31). Veit and Clifford (1985) state interviewees will sometimes say what they think the interviewer wants to hear or else what they think will make them look impressive (p. 197). In interviews the researcher discovers people's current thoughts, ideas, and attitudes (Johnson, 1987, p. 99). A mini-tape recorder was used to record the data in this study. This freed the researcher to interact with the interviewees without having to be concerned with recording the data during the process of communication. Data derived from the interviews was

transcribed later (usually within the hour after the interview) on cards or paper. This data was categorized according to topics indicating the various responses given by the residents.

Aceves (1974) expressed reservations about the notion of participant-observation. He believed that a participant may double as a participant, one may only observe or may become so involved in participating that observation is forgotten. Then, the observer may be unable to record what has been observed. There is also the problem of being such a "detached" or "objective" observer that one never really gets the "feel" or intuitive knowledge of a people that is essential not only for survival, but for understanding (p. 76). Veit and Clifford (1985) state objectivity does not mean detachment, it means respect. It means the ability not to distort and falsify things, persons, and oneself. Another problem that may exist for the researcher is to become so identified with the people that are being studied. The assumption of their values and practices will in turn prevent a reasonable objective account of their way of life.

Interviews

Interviews were conducted with caretakers in order to secure pertinent documents and information that was necessary in helping to understand the group resident's environment. However, key informant and indepth interviews were conducted mainly with group care residents. The researcher learned the group care resident's language and

its patterns. Where possible the precise language of participants was recorded, identifying who said what. This provided a more accurate description that was true to the world views of the participants (Patton, 1987). The evaluation of residents' precise language was an important step in understanding how the children perceived their own experiences. The basic responsibility of the researcher was to be descriptive, to provide the richest, fullest, most comprehensive account that was possible. Such "thick" description enabled the researcher to perceive subtleties in human behavior that are vital to full understanding. Such description suggests a basic interest in process rather than product or output (Rogers, 1991).

According to Hans George Gadamer (1987), when interviewing, there is no method to generate good questions in a mechanical way. They arise naturally out of the process of communication. The process of communication inspires sequences of questions and answers that emerge dialectically until the breakdown is resolved (Agar, p. 22). Drawing from the work of Gadamer, Carson (1986) proposes conversation as a mode of curriculum research and a hermeneutical activity. Conversation is considered a "moral discourse." Interviews were in the form of discussions through conversations rather than as formalized researcher participant roles.

Document Collection

Archives are the ongoing records kept by society for purposes other than scholarly. Archival data are potentially standardized, reliable and valid. The job of the researcher is to discover the error have crept into the record system (Dooley, 1984, p. 196). The researcher visited the group care home in order to evaluate all archival records kept on the group care children in this study. Observational records, The Staff Handbook, academic files, and other documents were evaluated for any written conversations between caretakers and residents. School records were also kept in a file at the group care home. These were also evaluated. Records kept at the group care home were evaluated for the communication aspects between the residents and caretakers. These records included important data that was helpful in understanding the child's existence inside, as well as outside, of the group home setting.

Data Interpretation

The grounded theory approach was utilized to interpret the data. This methodology of analysis was integrated within the entire research process.

> A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship to each other (Strauss and Corbin, 1990). A grounded theory permits the

> researcher to study "unchartered waters" or human phenomena including feelings, emotions, perceptions and values which are idiosyncratic (Haggerson, 1988).

Patton (1987) states a grounded theory approach to evaluation research is inductive, pragmatic, and highly concrete. The researcher generated program theory from holistic data gathered through naturalistic inquiry. The purpose for using grounded theory in this study was to provide an explanation of the process of group living and how the programs and interactions promote the theory. Grounded theory provided possible conclusions regarding the ways in which the impact, consequences or outcomes flow from program activities. Program staff and other program decision makers can use grounded theory to "reality" test their own theories of programmatic action, effects, and the relationship between action and effects. Grounded theory can be useful in consideration of whether a program should be replicated (p. 39-40).

Domains were established using the data derived from the conversations with the participants. A domain is defined as an organized set of words, concepts, or sentences. Written responses were compiled and categorized under conceptual headings.

Reciprocity

The process of reciprocity was used to determine if the realities of the residents had been accurately interpreted. This type of requital was used because children play an important and reciprocal role in the research process. They

were able to provide their feelings regarding the various interactions and programs in effect in the group home environment. Patton states, "The giving of feedback can be a major part of the verification process in fieldwork" (p. 102). The researcher provided the participants with descriptions and analyses, verbally and informally, and include their reactions as part of the data. Mutual trust, respect, and cooperation are dependent on the emergence of an exchange relationship in which the observer obtains data and the people being observed find something that makes their cooperation worthwhile, whether that something is feelings of importance from being observed or feedback that helps them understand their world better (Patton, p. 172).

Summary

The purpose of this study was to explore the experiences of children living in group care settings as a means of understanding the beliefs (values) which constitutes their respective realities. Qualitative research methods were utilized in this investigation to determine the conditions which mediated the communication process and the effects of those mediating conditions on the process. Data were gathered through participant-observation, ethnographic interviews, and collection of pertinent documents. The grounded theory method was applied to data analysis. The data were conceptually labeled and categorized into domains. During the process of establishing domains, the central category was identified

and the remaining categories related to it. Reciprocity was instrumental in determining if the realities of the group care residents had been accurately interpreted.

This chapter has presented a description of the research site, the participants in the study, the research procedures and methods, and the research design.

CHAPTER IV

RESULTS OF THE STUDY

Introduction

Chapter IV presents the data accumulated for this study. This chapter includes a description of the research activity, a description of the research field, and a presentation of the collected data. It provides the group care resident's version of the data accumulated. A purpose of this study was to describe group care resident perceptions of the conditions which mediate the ways in which caretakers communicate with them and how these perceived mediating conditions impact the communication process. A further purpose was to generate theoretical explanations of the communication process grounded in the reality presented by the group care residents.

Description of Research Activity

Data were collected through ethnographic field work methods. The multi-modal data collection methods included participant-observation, interviews, and an analysis of pertinent documents.

The method of participant observation was utilized in the initial stages of research and continued throughout the

course of this study. The purpose of the research and the role of the researcher were explained to the coordinator of the group care home. After field visits commenced, the researcher conversed with group care residents about the problems and rewards of group living. Discussions also centered on their feelings regarding the programs implemented at the home. Rapport and trust was established as each resident learned that the researcher was not a paid member of the "staff". Some manipulation by the residents was felt as they found ways to avoid previous consequences of misconduct by being with the researcher. For instance, those required to remain inside could go for brief walks to discuss feelings about living in the home.

Field observations were recorded in notation form immediately upon leaving the field or they were audio taped. The collected observations were written on index cards in a timely manner.

Five caretakers provided information and opinions regarding programs and procedures implemented in the group home. Of the eleven adolescent girls admitted to the group home, nine individuals participated in open-ended interviews. The caseworker of one resident refused to sign the consent form and the other resident was expected to be discharged in the near future. The interviews were conducted from August, 1992 through October, 1992. The length of the interviews ranged from one hour to two and one-half hours. In order to capture the nuances of the responses, the interviews were audio-taped. Although formal

written permission was granted for the interviews to be taped when necessary, the residents were asked to consent at the time of taping as a courtesy. The audio tapes were later transcribed by the researcher.

The process of data categorization was initiated with the field notes. The notes were read and near each passage, a notation was made in the margin indicating the concept represented. The context of each concept was determined and this information was written in notation form on a three by five card. The same information was repeated with the interview data. The conceptual labels were grouped into categories and domains established. During the process of establishing domains, the central category was identified and the domains related to it. The central category was defined as "duplicity". A determination was made that residents are caught in the middle of a bureaucracy that is not understood by them. Their attempts at functioning in this environment jeopardizes their safety and minimizes open communication. The core category which emerged from the data is labeled "duplicity". Four additional categories emerged which are integrated into the core category. These categories include:

1. Resident distrust of caretakers.
2. Resident fear of loss of identity.
3. Group care resident dependence on caretakers and on governmental institutions.
4. Group care resident resistance to control.

Description of the Research Field

The group care home offers a residential treatment program for abused and neglected teenage girls, ages 14-18, who are in the Department of Human Services custody and live within a 25-county catchment known as DHS District V. Recently, two regulations appear to have relaxed. The home has admitted a girl of a younger age and the area boundary now includes a statewide catchment. The home provides a structured therapeutic environment as well as family-type atmosphere which guides the residents to live positive, productive lives in their community. It is a placement where girls can develop mature ways of handling personal issues, coping with emotional conflicts and learn basic life skills. They also learn basic ways of communicating and receive help with educational skills. Many residents are referred to the home on completion of an inpatient treatment program. The group care home is a United Way Priority I Program.

The group care home networks with other agencies and individuals in the community to provide additional group and/or individual therapy as needed. A 12-step program through Alcoholics Anonymous. Residents may attend 12-step meetings as part of their individual treatment plan.

The clients at the home generally come from homes with more or less severe dysfunction. They have experienced personal traumas and disruptions ranging from divorce or death of a parent to physical, sexual and/or emotional

abuse. They may have experienced or witnessed violence, alcohol and drug addiction. Additionally, they may have lived in situations where caregivers were unable to provide for them adequately.

During pre-admission, the referring agency or department is required to provide the home with a written summary of the child's needs and situation. This should include a social history and recent psychological testing, if available. A formal interview is required and the resident must present herself and agree to participate in the programs in effect at the home. An evaluation can be determined as to whether resident's needs can be met at the group care home by the clinical staff.

Upon admission, the resident is requested to submit a birth certificate, social security card, Medicaid or other medical insurance card or policy. Copies of recent medical information, including immunization or psychiatric records, are also requested. A copy of the most recent foster care plan is required, if applicable. Also, copies of the most recent school grades are needed.

The group care home is accessible via a major interstate highway. It is approximately nine blocks away from the exit. The home is near a high traffic street leading to the downtown area of a major metropolitan city (Figure 4). People travel to this area for jobs, shopping, services, educational institutions, and entertainment. This street accommodates many restaurants, service stations,

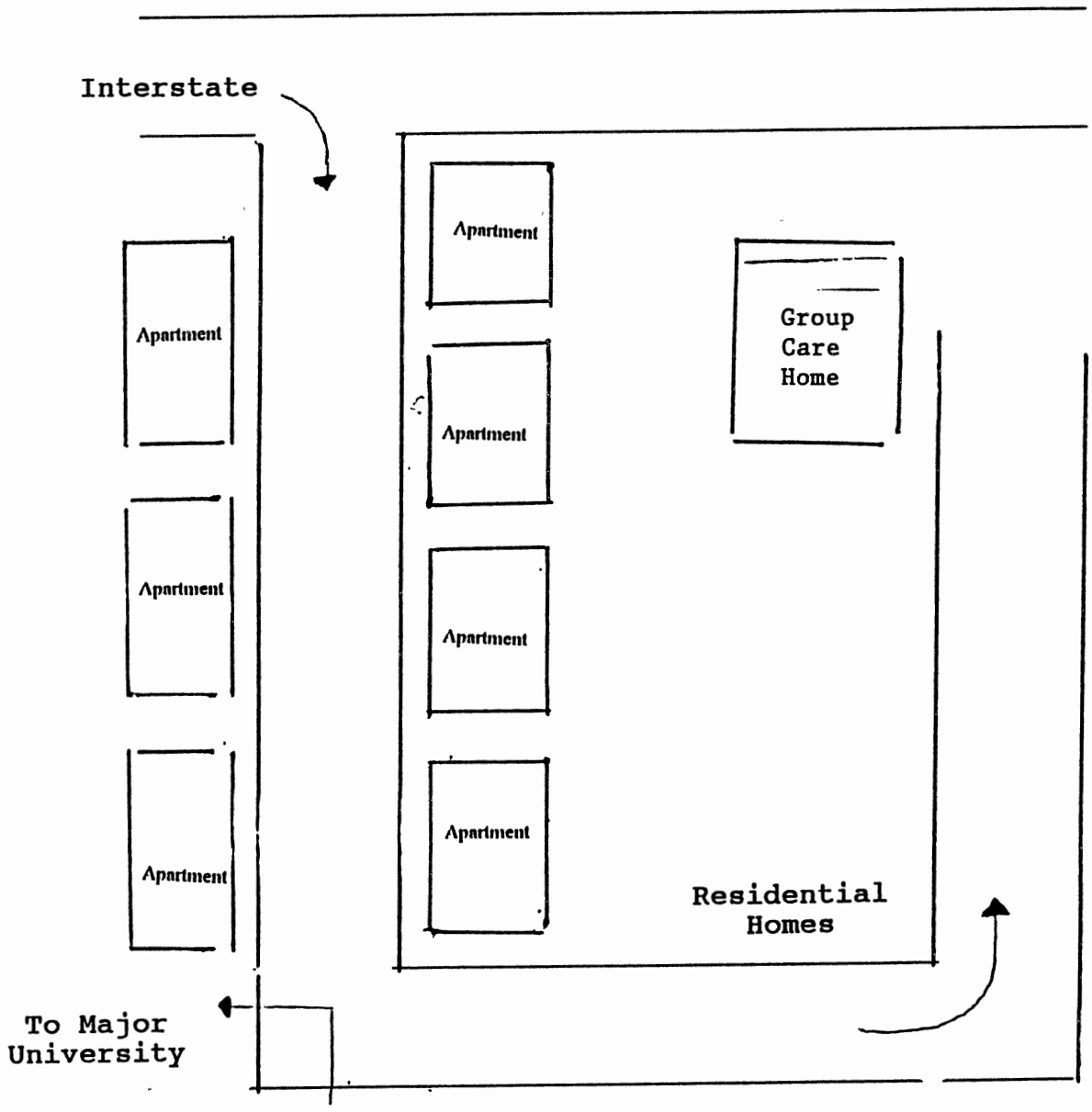


Figure 4. Directions to Group Care Home

stores, and deluxe apartment complexes. A caretaker commented:

> In this area, the residents are provided with jobs and outside activities. The only problems are when derelicts wander near the home and perform deviant acts or when there are break-in attempts.

Nearby are two major universities of higher learning. One of these universities provide medical care for the residents through their clinic. It also provides volunteer support for the residents in learning life skills through the Rainbow Status System which is implemented at the home. In 1990, it was reported that over 120 volunteers assisted at the home, donating over 3,198 hours of service. Many of these volunteers provided the residents with piano lessons, planned social activities, and assisted with the general operations of the home on a daily basis.

The group care home is located on a quiet residential street. The atmosphere of the neighborhood appears to be relatively slow, only changing during rush hour traffic periods. The home sits amidst other houses of comparable styles, tudor, brownstone, or cape cod. These homes are brick and they were built in the early nineteen hundreds. The predominance of houses built during this era gives the neighborhood an appearance of being older and well established. The houses are adjacent to each other on plots of land with each having a front and back yard. The front yard is two small plots of grass on each side of a continuous sidewalk which leads from the street sidewalk. There are oblong strips of grass leading to the back of the

house along each side of the house. The home's back yard is secluded by trees and the rear side is blocked off from the alley by a six foot fence. There is a handicapped ramp on the right side of the home which leads to the entrances.

The group care home is operated by an all female staff, seventeen white and one black. There are eleven female residents, nine white and two black. There are two administrators, the coordinator of the home and the coordinator of the Life Skills Program. The clinical staff consists of a clinical supervisor and two primary counselors. The Direct Care Staff includes nine team counselors and four relief staff members.

Presentation of the Data

Presentation of the data includes a description of the communication environment, descriptions of the mediating factors and their impact on the communication process.

An assurance of anonymity was made to those individuals who were interviewed. One resident stated:

> . . . even though the responses are anonymous, we will be punished by the staff for negative responses regarding the home if they find out about them.

In order to protect the individual identities of the girls and the caretakers who responded, they are not identified by "real" names. The names used are fictional. To further insure anonymity, neither the name of the group care home, the community, city, or state have been identified.

Caretaker-Resident Communication

Caretakers perceive the communication linkages with group care residents to be much better than that experienced between group care resident and the biological parents. A caretaker commented:

> . . . At the group care home expectations are clearer. Parents are caught up into a power struggle. At the group care home, no personal goals are expected to be achieved within the child. We see ourselves as being teachers.

Communication between caretaker and resident can be initiated by the caretaker or the resident. Although communication takes place in impromptu situations between caretaker and resident, the caretaker initiates communication most frequently during scheduled group or individual meetings. The resident initiates communication by requesting an informal meeting or through written charts kept at the home. A caretaker stated:

. . . Communication is effective with the resident because a lot of staff is available to assist them at all times.

Communication Climate. An almost tangible aura of tension exists between the group care resident and caretakers. The residents perceive the group home generally as a "lock up". They believe that the group care home will never take the place of their home with parents, although they are encouraged to view it as home. While most group care residents are concerned about their safety and welfare, not one of them believes that the group home satisfies these concerns.

Group care residents perceive the communication linkage with caretakers to be almost nonexistent. Communication between caretaker and resident is usually initiated by caretakers and is most frequently related to disciplinary actions and health related issues. Most of what is stated in these instances is merely "talk". A resident commented:

> . . . I won't allow myself to tell anyone more than they need to know because they can verbally attack me with it. I feel that caretakers are "just doing their jobs."

"They are not listening", one resident stated:

> . . . When they don't listen to me, it makes me feel that they are treating me as my mother did. That makes me hurt and I lose self-esteem. I'll still care, but I won't let them know I care.

Direction. As perceived by some group care residents, communication with caretakers flow one way. Because most interactions occur as a result of scheduled meetings, disciplinary actions and health related issues, communication rarely occurs between caretaker and resident. It occurs between residents.

Caretakers are described as being more concerned with "controlling" and "referring to rules" than in listening or attempting to create shared meaning. One resident stated:

> . . . There are so many silly rules that are impossible to follow. Staff tries to suppress my behavior to fit these rules, but I won't allow it.

A resident believes that caretakers listen to her if it suits their purpose to do so. When they are attempting to find out about her or another resident, they will be extra nice or even attempt to threaten her if she does not tell them what they want to know.

Group care residents believe that messages flow one way in the communication process with caretakers: from caretaker to resident. Messages from caretakers are perceived by residents as being unheard, ignored, or discounted.

Communication Channels. Caretakers rely on seven methods to communicate verbally with the resident. They are:

1. House Council - This is a group meeting held once a month that permits voluntary attendance by the resident. Discussions center around what the resident deems important. Residents are also informed of the announcements for the scheduled activities at the home and allowances are given.

2. Growth Group - This is a meeting which requires mandatory attendance by the resident. It is held on each Wednesday in the month. Group rules and topics of interest are determined and discussed by the residents.

3. Planning Group - This meeting is held on Sunday evenings. Residents are allowed to decide where they want to go for entertainment every other week.

4. Life Skills - This is a meeting held on each Monday night. It is conducted by a Life Skill Instructor and the residents focus on attaining goals necessary for independent living.

5. Individual Session - This meeting is with a counselor at the group home. It is scheduled for one hour per week and focuses on the individual treatment plan for each resident.

6. Informal Meetings - These meetings can be requested by the caretaker or the resident. It is used to discuss personal issues involving the resident.

7. Tutorial Meetings - Meetings are held twice a week and they focus on improving academic skills.

Nonverbal communication is promoted through four methods:

1. A Staff Log - used to communicate between staff member regarding the day-to-day experiences of each resident.

2. Dining Room Charts - The resident are given a sufficient number of pages for the week at the Sunday night meetings and notations are made on a daily basis. The staff responds to these notations by providing a written reply to each statement.

3. Four Wall Boards - In the hallway near the front entrance, there are two cork and two erasable boards. The first cork board is used to indicate the schedule for the day. It also provides the fire and the floor plan for the home. The second cork board provides a notice of the Equal Employment Opportunity Job Safety and Health Protection. It indicates the proceedings of the last House Council meeting. It indicated the rules regarding the loss of privileges and ways to receive an "X". It stated that if a resident signs up to go to church and does not, she will receive an "X". It stated that residents are encouraged to respect house furniture and do chores, refusal to do so will result in an "X" Additionally, there was a reminder about academic tutoring. Each resident was required to attend until report cards were received. The erasable board indicated the schedule for monthly activities. The other erasable board indicated daily activities.

4. Posters - On various walls in locations throughout the home are posters with motivating messages on them. A large framed poster is entitled, I am Me . . . I am Okay. Another poster is placed near the stairs leading to the second floor. It reads, "It's Like Being Grounded for Eighteen Years . . . Having a Baby When You're a Teenager Can Do More than Take Away Your Freedom, It Can Take Away Your Dreams - The Defense Fund". In the staff lounge, a poster reads "The Group Care Home, Goals, Girls, Guidance - A Chance to Choose."

Group Care Programs

There are two programs funded through the Federal Chapter I Program. They are Life Skills and the Tutorial Program.

The Life Skills Program

The resident is encouraged to accept more responsibility for herself by developing increasingly complex skills required for personal independence. For this

purpose, The Rainbow Status System is the behavior modification program that is implemented at the home. The components for this program stresses improvement in responsibility, privileges, and life skills. The lowest level, purple, is where the resident is expected to establish trust and each resident must remain here for one month. The other levels, blue, green, yellow, orange, and red are earned as residents demonstrate the expected behavior for each level color. Increasing privileges are also earned as the resident ages. For example, older residents are able to have a later curfew, male visitors, and date. A caretaker stated:

> . . . this program is better than the four-step traditional program. In the traditional program, the resident is able to figure out right away what is expected and the residents are demoted when they fail to maintain a certain behavior. The Rainbow Status System requires almost a year for the residents to figure it out. Also, it is age related. As the residents age, they earn more privileges. There is no backward movement in the program. Once a resident reaches a level, she remains. Finally, this program does not initially lend itself to competition because of the colors.

Another caretaker stated:

> . . . The Rainbow Status System is pretty good. It is an effective mechanism in providing structure, guidance, and learning skills for the girls. The only problem is that it takes the staff and the girls time to understand how it works.

Keeping track of where each resident is can be quite time consuming. A caretaker stated:

> . . . Because the residents have so many needs, I know that I would like to spend more time with them, but whenever I spend the amount of time that they need, I fall behind in my other responsibilities.

A caretaker experienced difficulty in carrying out her job responsibilities. She stated:

> . . . I feel that there is a conflict in my job responsibilities when I have to take away privileges and expect the girls to be honest with me about their feelings.

The coordinator administers the program through the help of a part time instructor who comes into the home to teach life skills two times per week. Throughout the week each resident's progress is monitored by staff members on duty as they acquire the skill and responsibility needed to earn additional privileges. They move from one color to the next higher color after all skills are accomplished at each level.

Group care residents feel restricted by the Rainbow Status System. They believe that although they have accomplished all criteria for a specific level, they are restricted from moving to the next higher level because of staff refusal. They feel this to be judgmental and not based on their accomplishments, but rather on favoritism, or how well they are liked.

Education/ Tutorial Program

The group care home assist with the enrollment and attendance of group care residents in the public schools. Residents are provided an opportunity to attend alternative schools. There are three residents attending middle school, six are attending high school, and two are studying the prelessons for acquiring a General Educational Development (GED) certificate.

The home provides tutorial services twice per week. The tutor comes to the home and works three hours each day with the residents. Residents are required to participate in the tutorial program until after the first report card is received, usually after the first six weeks of school. According to one caretaker, the method used to determine the resident's initial participation in the program is:

> . . . We assume that everyone needs tutoring because residents have had limited success in school. Truancy or emotional difficulties has taken the focus off of school.

If the resident is found to be on the Honor Roll at the time of report card issuance, making all A's and B's, exemption from the tutorial programs is permitted.

The tutor provides individual and group instruction. Assessment is made of the academical problems experienced by each resident. Often the resident will state where the problems exist. At other times, the tutor will assign work that is deemed beneficial.

The school and the group home has a very limited communicative relationship. Often homework is assigned at the school and left at the school by the resident. Books needed to improve in areas of academics also remain at school. When the school communicates with the group home, it usually is because of a disciplinary action taken at the school. In cases of out-of-school suspensions, written notification is sent home with the resident. No call is received or conference requested by the school in order to discuss the stipulating conditions or consequences created

due to the student misbehavior. In-school suspensions are usually heard from the resident, at other times, the group home may never know. In extreme situations, when a resident is not performing well academically, a notice may be sent to the home. However, no solution to the academical failure is ever initiated by the school. One caretaker commented:

> . . . It is felt that teachers are prejudiced because of where the girl is living. They don't expect as much from them. Resident often experience personality problems with teachers.

Residents tend to agree with the caretaker by further stating that children at school refer to the group care home as a "whorehouse". Boys expect deviant sexual acts to be performed when they find out that a resident resides in the group care home. One resident stated:

> . . . When I leave here, I am not going to ever tell anyone that I lived here.

The caretaker told of a particular situation when:

> . . . Several girls were being harassed and attacked without school intervention. The group home representatives met with school personnel and discussed the issues. The solution enacted by the school was for the resident to go to the nearest teacher and report the complaint. The school trivialized the situation; however, they responded better in future instances.

A resident had a different opinion of the school's commitment to discipline, she stated:

> . . . when I was at school, a girl verbally attacked me. I retaliated through verbal abuse and threatened to attack the girl physically while a teacher looked on. We were preparing to fight, but the girl backed down and went her way. The teacher later told me that she didn't care if we fought or not.

Counseling/Psychiatric Program

The counseling program has a clinical supervisor and two primary counselors who work with the residents in helping them to deal effectively with their feelings. Counselors assume a surrogate parental role with the residents. They are available to them throughout the day and have major responsibility for the resident's whereabouts. This may include ensuring that they are at school daily, transported to medical and dental appointments, the monitoring of employment activities, and granting permission for a multitude of personal requests. Personal requests may be to go out on the back porch to smoke cigarettes, to go for walks, or to use the telephone. When requests are made, the primary counselor must consult the resident's level of achievement on the Rainbow Status System. If the resident has earned a privilege that is requested, permission can be granted. All caretakers, including primary counselors, possess the power to revoke privileges regardless as to whether the resident has achieved a specific level.

The counseling program offers two group meeting that help residents deal with personal issues. Residents attend Growth Group once per week. Group rules for the home are discussed. They also discuss various topics of interest with the primary counselors. The topics may include the benefits or disadvantages of smoking cigarettes, values held which are important, the dangers of drunk driving and the

consequences of drinking alcohol and taking drugs. The communication flow in one Growth Group meeting transpired as:

> Caretaker: What happens when you drink alcohol and take drugs?
>
> Resident: I feel that it makes you crazy!
>
> Second Resident: I don't feel that it makes you crazy.
>
> Caretaker: (speaking to second resident) You are always able to respond to someone else's response. What happens when you drink alcohol and take drugs?
>
> Resident: (second resident) I don't know. I don't drink and take drugs.
>
> Caretaker: I know you have drank and done drugs. It didn't have to be illegal drugs.

Another group meeting sponsored by the counseling program is House Council which is held once per month. The resident is informed of the activities that are scheduled for the month. The resident is also allowed time to voice anything that is personally deemed important.

Individual counseling sessions are scheduled with the primary counselors once per week for one hour. The personal problems that each individual are experiencing is discussed. Also, the resident's treatment plan is explained. The treatment plan is based on the resident's Foster Care Plan for Children in Court Order or Voluntary Agreement. This plan defines whether the goal is to return the resident eventually back to the parents or whether there is a possibility of placing the child with a relative. Adoption of the child may be an option or permanent foster care. For residents who are not to be returned to their

previous living arrangement, emancipation or independent living may be the alternative. The resident is able to live on her own at the age of eighteen. The foster care plan will indicate the problems preventing the child from remaining at home and the services required in order to reduce or eliminate the risk factor of these problems. The foster plan will define the visitation schedule, the relatives and friends permitted to see the resident. It will state the parent(s) and Department of Human Services responsibilities, and the source of financial support of the resident. The treatment plan will provide a means of determining the steps necessary to progress resident towards the ultimate goal, returning home or independent living. The treatment plan will state academic, behavioral, medical, ecological, or emotional objectives and goals that are set for the resident by the group care home caretakers.

A resident stated that even though everything is planned by the counselors, she stated that she couldn't be honest about her progress with caretakers because they are here for the money. She felt that some caretakers really did care about her, but most don't show emotions. They don't try to comfort her when she is hurting. She believed that they don't understand her even though they are trained to understand. Therefore, the resident states that the caretaker becomes the "enemy", just like all of the others who don't understand.

Communication Style. The communication style of staff members, specifically caretakers, and group care residents differ in several respects. Caretakers are perceived as "taking a superior attitude" and "talking down" to group care residents. They are further perceived, in face to face verbal communication to speak "in a low-pitched controlled voice. "A resident refers to this tone as having a "radio voice". During communication exchanges in which the caretakers do not wish to further participate, they become unapproachable by staring at the resident without using words or they appear to discontinue listening.

Typically, group care residents vocalize in the average range. However, on certain occasions there may be anger or frustration and the resident's pitch may be loud. At other times, their tone of voice is subdued and muffled. Group care residents may react to the caretaker communication style by using silence, avoidance body movements (such as avoiding eye contact) or by confronting the caretaker. At the time of confrontation, residents may use verbal threats or profanity.

The researcher accompanied one of the volunteers at the home to secure residents who had remained at the high school for extracurricular activities. When the residents entered the van, they wanted the music volume increased. The volunteer refused their request. Immediately, one resident retorted to profanity stating:

. . . f_ _k **both** of you!

When questioned as to the reason for the inclusion of the researcher in this attack, the resident stated it was because the researcher also was an adult.

Communication Effectiveness. From the perspective of the group care resident, communication with caretakers is limited and ineffective. None of the residents express satisfaction in their interactions with caretakers. One resident stated the reason that she was unable to effectively communicate with caretakers was;

> When I get angry, I feel that I can't express it because staff gets angry too and take it out on me.

Another resident stated:

> I can say what I want to happen, but I will lose privileges or I will have to leave.

Summary. Group care resident and caretaker communication occurs in a climate that is erratic and tense. Communication often is initiated by caretakers through meetings and written exchanges. Communication is perceived to be one-way, controlled, and ineffective.

Distrust of Caretakers

In the group care home two groups are formed creating a dichotomy referred to by the resident as "they", meaning the caretakers, and "we", meaning the residents. The causal conditions of this split in the data include collective and individual experiences of the residents being unable to trust adults. It is based on the feelings of residents and is determined by whether caretakers are perceived as being

concerned with their welfare. Since residents believe that caretakers are not concerned, they are placed in a separate group implying a specific difference in the focus of that concern.

Collective and Individual Experiences. The collective history and experience of group care residents is perceived as "disheartening". Initially, group care living was viewed as a means of placing children from unstable backgrounds into safe and nurturing environments. Most of the newly created environments proved to be worse than those from which the child was coming. In other words, the child was victimized more in the created environment even though this living arrangement was meant to provide a solution to his/her problems. The recounting of stories regarding children who were removed from their homes and placed in group care homes and the experiences they encountered invokes anger and sadness. Sadness that children have had to endure the mistreatment and anger that adults have repeatedly exploited children for their own personal or financial gain. Aspect of earlier attempts at group living for children included the refusal to acknowledge the child as a "real" person, as one with feelings about what was happening to him. Group care living was initially instituted as a humanitarian act. However, it has evolved as a means of merely satisfying the whims of adults to be in control. Historically, even the works of praised humanitarians whose goals were to get the children off of

the streets proved not to be done for the benefit of the children. Rather, removing the children was done to satisfy the adults who were disgruntled over having to see them there everyday. Children benefits from adult interventions has been minimal. They have been provided shelter and food, both usually of an inferior quality to what adults would select for themselves. Adults assume that children will accept, without question, the plans made for them. However, this has proven not to be the case. Children are rebellious and resentful of the way that they have been transported from place to place without being consulted. This mass "herding" has produced a society of children who are angry at adults for not listening nor understanding. This distancing has produced a generation of children who are afraid to trust adults. One resident stated:

> . . . I feel that I communicate anger because I feel that they don't care about me. They put me in any group home that they can find.

Caretakers don't consider the fact that residents may have feelings about what is happening to them. One resident explained her experiences in a group care settings:

> . . . I have been placed in four institutions. At the time of each discharge, I was never allowed time to say good-by to my friends. My caseworker refused to inform me of my next placement location or departure date in advance. She simply arrived and stated it was time to go. Each time it was like she said to me that I had no feelings. After each experience, I trusted her less.

Trust is a bonding between two people who feels that they can relax and not worry about what is being done or said according to one resident. This can never be possible

between the staff and her because if something is said, it will be later discussed or written for others to read.

Another resident stated that in order for her to trust caretakers they must believe her when she gives them a reason for her doing something. They won't believe that she is telling the truth. It is as though they have a preconceived idea about what the reason should be. The resident told of an instance when she met with her caretaker and told her that she would run away because she didn't like her caseworker and wouldn't go to the next planned placement. The caretaker refused to accept her reason. The caretakers said that there must be another reason.

Caretaker Concern. Group care residents appear to be dissatisfied with the relationships established with caretakers. The reason cited for this dissatisfaction is caretakers are more concerned with the implementation of programs and setting rules. They are more concerned with the group care resident's conformation to the rules, rather than whether the rules are meeting the needs of the resident. Residents reported that occasionally rules are not enforced equally among residents. The reason cited for this inconsistency is due to favoritism on the part of the caretaker regarding specific residents, the unwillingness of caretakers to conform to the needs of the residents, and the perceived irrelevance of some house rules.

A resident reported an experience in which two residents were involved in a fight. The standing house rule

stated: if residents are found to be involved in a fight, both residents would be discharged from the home and alternative placements would ensue. Neither resident involved in the fight was discharged, nor were alternative placements considered. Rather, both residents lost privileges for one week. However, one of the residents had a birthday occurring within the week of punishment. She was allowed to go home to celebrate her birthday and talk on the telephone to friends and relatives. The other resident served the entire week of punishment.

Another resident felt that when caretakers found out about a personal issue in her life, they reached back into her past to bring it up instead of thinking positive about her future. She stated that her privileges had been temporarily revoked and she knew that she shouldn't do what she later did. However, a caretaker was quick to remind her of the reason that she was admitted into the group home was due to the behavior currently exhibited being the same as that demonstrated in her parents home.

The group home rules, according to one resident, do not focus on resident needs. Rather, they focus on staff needs. In her view, staff regulates the temperature of the house and food for their convenience. She stated that if the group care home is meant to be "a home away from home", the kitchen should not be locked at any time. Also, a resident should not be denied food if she is hungry.

Additionally, residents believe if caretakers were concerned about their welfare, time would not be a factor.

When residents go to them with a problem, repeatedly, they have been reminded that they are no longer available. Caretakers have informed them that they are "off the clock".

Resident Discipline. Most residents of the group care home believe that disciplinary measures are applied unfairly. The specific measures which were discussed included the revocation of privileges and discharge from the home.

The Discipline Policy of the group care home states that its purpose is to promote a positive attitude towards the youth in the program. It urges the staff to view mistakes that are made by the resident as teaching/learning opportunities. Caretakers are admonished to ensure that the consequences for a specific misbehavior is appropriate and related to the misbehavior. Staff must be respectful to the youth and they are advised to involve the youth in deciding the logical consequences for the misbehavior. The policy also states that under no circumstances is staff to use cruel and unusual punishment, nor are they to assign excessive and inappropriate work. The denial of meals, daily needs and programs are not to be used as a form of discipline. The staff is cautioned against the use of verbal abuse or ridiculing or humiliating a resident. A resident is never to be punished by another youth, nor are chemical, mechanical, or physical restraints to be used. The denial of planned visits, telephone calls, or mail contact with family is prohibited as a form of discipline.

Finally, the use of corporal punishment is strictly prohibited.

The revocation of privilege policy is very controversial among group care residents. Threats are used by the staff to get the co-operation of residents. Staff threatens that the "Chore Check", a method used by staff to determine when residents have done their chores and used to earn privileges on the Rainbow Status System, will not be done. Residents are also threatened with the disallowance of telephone calls and planned home visits.

One resident ran away the previous night and the caretaker was interrogating another residents that was purported as knowing to where the resident had gone. The conversation proceeded as:

Caretaker: Where did the resident run to? You realize that she (the runaway youth) could be hurt or killed?

Resident: At least she would be free!

Caretaker: Did you give her (the runaway youth) money?

Resident: I'm not stupid!

Caretaker: I wouldn't be worried about you because you are smart, streetwise.

Resident: She's (the runaway youth) fine. She's got friends, so she's all right.

Caretaker: Do you want to go home this weekend?

Resident: (sigh)

Caretaker: Do you think I am going to approve your home visit if you don't tell me what you know?

The resident stated later that it angers her when she is forced to discussed something against her own free will. She further stated that her consent to talk should be voluntary and not forced by threatening her privileges.

Residents complained of rules being enforced that are not seen as rules in a "normal home" with a family. They stated that the "X" system is "ridiculous". The system works as: for one "X", no privileges are revoked. However, for each additional "X", a resident loses two days of privileges. The revocations can involve anything that a caretaker deems as insubordination of the home's policy or the caretaker's personal policy. One resident stated the rule of having to be in the bedroom by a specific time as an example of a rule that is not enforced at home. She stated that to be in the residence by a specific hour is understandable, but the residents should be able to be in the television room, living room, or anywhere within the house in order for the group home to feel like "a natural home".

Another resident told of an instance when a resident felt a cold coming on and left the bedroom, after the preset bedroom curfew, to secure Actifed. She did not receive an "X", but she was reminded of bedtime privileges and threatened.

Other reasons to receive an "X" can include anything from not being at the table for prayer at dinner time or for not eating a meal. One resident stated it didn't matter

about a resident's faith preference, all residents are expected to pray to God.

An "X" can be received due to a resident not meeting with the tutor. The tutor is believed to be ineffective by the residents. She is described as being "sarcastic", "a "smartass". A resident stated that she didn't see a reason to continue to go to a person who was not helping her. She stated that she failed a test on a subject for which she was tutored.

A resident commented that an "X" can be received for "standing up for yourself". She told of a situation when two residents were in bed and they were arguing. Staff came into the room and said "Shut up". One of the residents got out of bed and ran out of the room screaming. The resident returned to the room and got into a vacant bed. The staff returned and demanded that resident get out of the bed. The resident called the staff member a "whore" and threatened to cut her throat. The caretaker informed the resident that her privileges were to be revoked for one day. The staff member stated the revocation could be suspended if the resident wrote a letter of apology for the derogatory remarks. The resident refused.

The situations that all residents felt most controversial regarding the revocation policy were when residents were victimized away from the home and penalized when they returned. They felt that although residents had been punished due to their inappropriate behavior, the residents were again punished by the group care home. A

resident reported an instance when another resident was allowed a walk away from the home. She used inappropriate behavior and was raped in a nearby park. When she returned to the home and reported the occurrence, she was punished again by her privileges being revoked.

Discharge from the home occurs as a last resort. When resident's safety is threatened due to inappropriate behavior on the part of the resident, another type of setting is considered. Inappropriate behavior may include an inability of the group care home staff to control a resident's behavior and she is determined to be unsafe. Sexual victimization and runaway behavior can be defined as unsafe. After repeatedly running away, a resident who had been picked up and returned to the home, stated before she ran away the final time:

> . . . I would leave this group care home today if I could because I have nothing to hold me here.

According to other residents, the runaway resident was promised by the staff that she would not be locked up if she returned. After she returned, she later discovered that caretakers had an evaluation in process for "permanent lockup", institutional care that prevent residents from leaving without adult supervision, planned for her.

Discharge is also considered when the resident is believed not to be benefiting from the programs at the home. A resident who refused to attend school or participate in the programs was found alternative housing in a halfway house, a low income building that provides housing to

destitute people. When a resident is discharged, concern for her is quickly resolved by the resident and caretaker. A resident who continued to run away from the group care home had been gone for approximately two weeks. At a group meeting, her name was mentioned. A resident appeared angered and voiced:

> . . . I am tired of hearing about _____, we have been discussing her for over two weeks.

Residents believe that caretakers forget about residents in a short period of time after they are gone or discharged. One resident stated:

> . . . All they (caretakers) do is call the police and report that a girl has run away. After that, they forget about her even though they may know the girl's whereabouts since they are no longer being paid for her room and board.

Summary. There is a high level of distrust of caretakers among the residents in the group care home. The distrust is based upon historical and personal experiences as well as a belief that they will not be treated fairly by caretakers. Residents are dissatisfied with the relationship established with caretakers. They feel that caretakers are simply doing their jobs and they are not concerned with the resident, but in following and setting the rules.

Individual Identity

Issues of group care resident and caretaker interactions were addressed within the context of personal identity. The maintenance of the culture and values

prescribed by the biological family emerged as a definite concern of group care residents. The striving in the maintenance of these variables affected the method of responses in the communication process with caretakers.

Culture. Although the histories and cultures of the individual residents can be seen as different, similar values emerge and they are represented within each child. Family values include the usage of language, how kinship is viewed, and a need for privacy. The residents share the experiences of attempted deprogramming, forced assimilation, and subjugation to group living and governmental influences. With each placement experience, residents are further indoctrinated into a bureaucracy that threatens to eliminate their personal sense of identity. According to one resident,

> . . . I have been moved from here, to there, to anywhere and after each move my personality changed a little bit more. In each setting, I learned what it takes to survive and exist.

Another resident stated caretakers don't treat residents as individuals, but as a group. She further stated, "When they communicate, I don't think they are talking to me personally, but to everyone that is here".

A resident stated that she refused to allow caretakers to tell her how to act and what to say. According to her, staff attempts to control the way that a resident talks. The method of communication is determined by what the resident has to lose. If nothing is at stake, a resident

may use profanity with caretakers or another resident. At a group meeting, one resident became frustrated and spoke to another resident telling her to, " . . . Kiss my a-- white skinned girl! If a privilege is in jeopardy, the resident has a tendency to change her personality by becoming manipulative. Her voice will soften and even light touching will nonverbally communicate a sense of co-operation. One resident stated, " . . . I am not like this at home, but I act like this here because I will lose privileges or be forced to leave if I don't do what they want me to do. When I am home, I am different".

Language also is occasionally used by the staff as a form of retaliation. Statements that are considered serious or not to be humorous are utilized to twist the denotations of the statements. A resident told of a conversation with a caretaker involving her boyfriend. She stated that the caretaker was informed that her boyfriend was coming to the group care home. For some reason, he didn't come. This angered the resident and she was looking angry at everyone. The caretaker commented, " . . . Maybe the look on your face is why your boyfriend didn't come".

In another situation, a resident stated that she was eating chicken and she stated that she liked the dark meat of the chicken instead of the white. The caretaker stated, " . . . We know that you like black men".

Values. Group care residents appreciate the values that are being threatened by extinction. While these values

change from day to day, they are common to all families throughout generations. Group care residents value relationships. They have been frightened by their removal from their biological families. Therefore, they attempt to hold on to relationships that simulate the facsimile of a family regardless to its quality. This include biological relatives, boyfriends, and certain subgroups within the group care setting. One resident who avoids contact with caretakers, appears very comfortable with other residents. According to one resident, she describes her relationship with other residents as:

> . . . there is a closeness, a type of resident family-like atmosphere. In this atmosphere, we are best friends. We live off of each other's mistakes. We help each other and learn from each other.

Another resident stated that they consider themselves to be each other's mother. According to her:

> . . . The caretakers feel that they are in the role of housemothers, but really the residents are the ones who help each other look beautiful. We help each other with our hair.

Residents feel that there is a need for privacy. In the group care home there is no area which is completely private for resident usage. Residents feel that the home is organized in this manner so that caretakers can observe them at all times. The telephone is kept in an open area for this reason. All residents agree that they should have a right to privacy. A resident stated, ". . . Caretakers listen to your telephone conversations and write it in the log". Another resident stated that:

> . . . I don't appreciate caretakers knowing about my business. I have business that is not their business.

According to another resident:

> . . . the group care home values its privacy. In meetings, we are informed not to tell things that happen. When the house was broken into, we were told not to tell anyone. When things happen to residents, such as a rape, we are told not to tell.

Summary. The survival of group care residents is considered to be dependent upon the maintenance of individual identity. This identity is based on maintaining cultural and traditional values as a foundation for improvement of children's lives. The right to privacy is a value that is currently not a part of this improvement. The attempts at the removal or denial of these assets are indications of the ways that group care residents interact with caretakers and the community at large.

Dependence

Dependence is encouraged even when it is not beneficial to the resident. One resident stated, ". . . It is time for me to take responsibility for myself". When a resident is controlled indefinitely and all decisions are made for her, the resident eventually is unable to decide on appropriate solutions to problems. When this occurs, the resident is open to victimization. This victimization can occur repeatedly throughout a residents life. Caretakers and those employed by governmental agencies and outside psychological support groups help to foster a sense of dependency. These employees assume a "superior role" and

imply to the resident that she is a subordinate and does not fully understand the situation at hand.

Governmental Influences. The Department of Human Services (DHS) has historically interacted with group care residents in the paternal role. Traditionally, children were removed from their homes without parental consent and placed in the care of DHS caseworkers. These caseworkers assumed a surrogate Parental role and dictated to children what was best for them. Assuming the role has resulted in the establishment of an unequal relationship. This relationship is one in which DHS sets all of the rules and the resident is expected to follow them.

DHS has prevented residents from contact with family members or friends in specific instances. One resident stated, " I am restricted from seeing my boyfriend who is also in lock-up". Relatives who are seen as potential hindrances in controlling the resident's behavior or as a danger to them are also restricted from seeing the resident. One resident is restricted from seeing her mother until specific requirements are met. The requirements include the resolution of any problem that may prevent the resident from returning home. This may require family counseling or weapon removal from the household.

In some instances, children are admonished by DHS caseworkers to forget about their past involvement with the biological family. One resident stated, " . . . DHS almost turned me against my real family". She stated that DHS, in

an attempt to get her to forget about her past secured a "Sponsor Family" This family was to take the place of her "real family" during the Christmas holidays. She was encouraged to go with this family instead of home to her parents. Residents believe that although they have been victimized or rejected by family members, they continue to want to visit them.

Another resident stated that DHS attempted to manipulate her mind. The resident stated the caseworker informed her that:

> . . . "The only family that you now have is the DHS family".

She stated that residents who believe this feel a sense of isolation because she did. She also stated that she felt she had lost her family and she knew that she could not depend on DHS.

Caretaker Influence. Residents feel that the group care home works in agreement with DHS. A resident stated that staff at the group care home wants residents to depend on DHS as their "backbone". Caretakers discourage independence. She stated that residents are told that they are unsafe when they have to depend on themselves.

Psychological Influences. The therapist treating group care residents continue the encouragement of dependency through the use of language, or labeling. One resident in DHS custody stated, ". . . A therapist applied pressure on me and attempted to make me believe that I was crazy". She

told of an instance when she had been sleeping continuously. She was taken to a therapist by the caretaker because it was believed that she was depressed. After talking with the therapist for approximately fifteen minutes, the conclusion was drawn that the resident was suicidal. An antidepressant drug was prescribed. The resident refused the drug, stating:

> . . . If I wanted drugs, it would not be necessary to come here to get them. I could get them on the street.

Residents have placed themselves in position to be victimized repeatedly due to an inability to make appropriate decisions. In a situation where two residents were allowed to go on a walk away from the home, they decided that they would defy authority by going to a park that they were advised not to frequent. They met a male in the Park who asked one of the resident to commit a sexual act with him underneath some bushes. The resident got under the bushes while the other resident looked on. The resident followed through on everything that she was asked to do by the male. When questioned later as to why she didn't resist, she stated she didn't know.

Summary. Continued dependence on governmental agencies has created a generation of children who are unable to make appropriate decisions for themselves. Those working in professional support positions have encouraged this dependency through the use of drugs and as a means of controlling their behavior.

Control.

The caretaker is seen by the resident as the obstruction to freedom. They are resented for attempting to control what the resident nor their parents are able to control, the resident's inappropriate behavior. Residents are unable to outwardly defy the staff in charge of them and as a result of this they rebel in concealed ways. Defiance may be demonstrated by runaway behavior, inappropriate sexual acts, or gameplaying.

Runaway Behavior. Since group care residents are often considered to be "pushout" or "throwaway" children, running away has become second nature to them. Running away is discussed frequently among the residents as a means of getting away from the home. Occasionally, they run to seek fun and adventure; however, most often they run because their options seem severely restricted and running becomes their way of coping, of finding alternatives to an intolerable status quo. One resident stated:

> . . . when I am at the group care home, I feel like I am in a box. I can't do things that are done in a regular home.

The residents all feel that the reason most of them run away from the home is because the communication process has broken down between the caretakers and the resident. They feel that unreasonable or excessive demands are placed on them by caretakers. Sometimes the rules are so controlling that running is seen as unavoidable.

One resident was informed that her grandmother had been placed in the hospital. Although the grandmother had

physically abused the resident, the resident idealized her and continued to care about her. She requested to visit her in the hospital. The request was denied by the DHS worker. The resident confided in the researcher by stating that if her request was not approved by the weekend, she would run away.

Some residents plan their runaway. Sometimes, it may involve two girls who will run at the same time. In most instances, it is discussed by the girls with the other residents before the runaway occurs. Some residents feel this discussion is for attention because in most instances the runaway does not occur. One resident seemed to fit this pattern by stating:

> . . . It would take approximately two days for me to plan my runaway, but if I ever ran, I would never return".

Inappropriate Sexual Acts.

Group care residents use sexual acts as a means of defiance. In an attempt to break the holds that are placed on them by caretakers, residents do what they feel will place them in control. One way to succeed in doing this is through the selection of male friends. Most residents have Black boyfriends. According to a resident, ". . . Adults are racist . . . There is nothing wrong with dating Blacks". Most of the Black males selected are also in lock-ups for adolescent misconduct. The group care residents in the home attend schools with a predominantly Black male population.

One resident stated that another resident attempts to control herself by imitating her behavior with boys, but she goes too far. She stated that the girl lets boys at school violate her physically by touching her on parts where she shouldn't be touched. She stated that the girl thinks that she allows boys to do this to her also, but she does not.

In another situation, two girls sneaked out of the house after dark and got into a van with four unknown Black males. One of the girls was raped by all four of the males. After the rape, the girls were dropped off on the street near a telephone booth. The girls continued to stand near the telephone booth and the males later returned and picked them up again and took them to a nearby motel. One of the girls was raped again and the other one left with one of the guys to get alcohol. While the guys were in another room, the raped girl telephoned a friend who came and got her and took her back to the home. The other girl returned two days later.

Although residents are being subjected to deviant sexual acts, staff continues to attempt to control resident behavior through punishment. A resident told of seeing someone that was known at the fair. It was one of the resident's boyfriend. He walked up and hugged the resident. The resident was reprimanded about physical contact and her privileges were revoked for the day.

Gameplaying. In an attempt to outsmart the caretakers, residents participate in a form of gameplaying. Drawing on

various degrees of ritual, imitation, and inventiveness, they use games to serve two principal goals, manipulation and defense. Games to the resident implies both recreation and a form of contest with a set of rules. The rules are unlimited and may be devised at the time that the gameplaying is occurring. However, the objective is specific, to do what one wants to do without getting caught.

According to one resident, " . . . caretakers attempt to take over my mind and I am going to prove to them that I am my own person. I can do things without getting caught, without them knowing. I have had cocaine, "footballs", "eightballs", "White Crosses", "Blue Crosses", joints, and Jack Daniel in the house. Another resident stated, " . . . I have had male companions at night in my bed".

A resident told of an instance when the residents wanted to order a pizza at night. The staff would not allow them to do it. The resident ordered it anyway and met the pizza delivery man outside of the home, paid for it, and brought it into the house without staff discovering it.

Residents also tell of instances when they are out on the streets at night without caretakers knowing about it. Sometimes a pair of residents will walk approximately a mile to the nearest convenience store. They will stand outside of the store and ask adults to purchase alcohol for them. Most of the time homeless people will purchase it contingent upon them receiving the change.

Summary. Caretakers are resented for attempting to apply constraints on group care children. As a result of these constraints, residents rebel by becoming defiant. Defiance and rebellion against caretakers are exhibited in residents by runaway behavior, inappropriate sexual acts, and gameplaying. Although staff employs rules restricting resident movement, the residents continue to devise ways to continue doing what is desired by them.

Duplicity: A Theory of Communication Quandary

Historically, communication with adult caretakers has proved to be ineffective and complex. In most cases, this continues to be the case in the present. In the communication process between caretaker and resident, neither person is permitted to be honest. Caretakers show discrepancies between the words that are spoken and their behaviors. They send ambiguous messages that tend to confuse residents. These ambiguities lack consistency. There is a tendency for one part of the message to negate the other. Caretakers state that they care about the resident, while simultaneously they commit acts that disregard that concern.

Residents on the other hand, are in need of one thing and receive another. They communicate that they do not care about what is occurring; whereas in actuality, they do. The pretension of reacting in unexpected ways provide a means of protection. The complexities of confusing adults by

disobeying are used as a means of control. They have found this to be a way of coping.

Caretakers and residents tend to be suspicious of each other's underlying motivations. Caretakers often are afraid that the resident is hiding something, being manipulative, or is not telling the truth. Whereas, residents regard many of the questions that are asked by caretakers as an invasion of privacy or they view their messages as propaganda or commands. For these reasons, truth does not prevail.

The style in which caretakers and residents communicate creates problems. Residents resent being put down by caretakers when they are addressed in an accusatory or judgmental fashion. They do not enjoy being ordered around or being diagnosed or psychoanalyzed. The messages sent by caretakers at the group care home and persons in outside agencies are meant to promote the welfare of the resident; however, the use of deception, condescension and threatening remarks contradict the purposes.

Discussion

Considering themselves to be the victims of an uncaring environments, group care residents feel that they must remain in a group home that does not meet their needs. Under these conditions, communication between caretakers and resident is limited. It is perceived by group care residents to occur within an environment where rule setting takes precedence over concern for personal welfare.

All group care residents have a deep distrust of caretakers, including those away from the group care home. This condition is grounded in interpretations of personal experience and derived from observations and interactions with caretakers. Personal group care experiences were described as moderately negative to extremely negative. Group care residents feel that caretakers (including parents and other relatives) are responsible for the phenomena of their runaway and inappropriate sexual behavior. They feel that in too many instances the residents are seen as the problem rather than the caretaker.

Group care residents feel that they are not valued or respected by caretakers and that they will not be listened to. Furthermore, they feel that they are powerless to demand an equal voice in the communication process because they are children. Considering themselves to have no power or influence to affect decisions or change circumstances, group care residents exercise the control they do have. They control the occurrence or non-occurrence of communication experiences through their presence or absence, interaction or non-interaction, co-operation or non-cooperation. Interaction between caretakers and resident does occur. Yet, the barriers to an open and equal exchange of information and ideas are believed to be so overwhelming that they prevent communication from occurring. The years of bureaucracy that have intertwined the system of group care living would require all rules and regulations to become obsolete.

Group care residents are very well attuned to the group home environment and predicate their actions upon their perceptions of that environment. Factors that affect their actions are the degree of control that is placed on them by caretakers and the amount of tension present within the home setting. Control comes as a result of caretakers attempting to prevent what they perceive as misbehavior on the part of the resident. Tension is determined by the comfort level or the amount of hostility present within the home. When control is tightened and tension is high, interactions are unlikely to occur. If they do occur, group care residents are prepared for a confrontive situation. Interactions are more likely to occur if the resident perceives the environment to be less controlled and with a low tension level. While these interactions may not lead to a free flow of information, they do result in some level of exchange. Environments that are perceived to be less controlled and have low tension levels may not be confrontive, but result in limited exchange.

Regardless of the environment in which interactions occur, group care residents maintain a degree of communicative distance between themselves and caretakers. Distancing occurs as a result of the desire to avoid confrontations. They use distancing as a means of maintaining a sense of privacy. Confrontive interactions are used as a means of "saving face" even though they engender feelings of anger and rage within the resident. Future interactions are avoided if confrontations are

expected. Residents believe that attempting to communicate is a futile act because as one resident stated, ". . . No one listens to children in DHS custody. Some residents avoid interacting with caretakers because they believe they will suffer negative consequences if caretakers become angry with them. Negative consequences may include, revocation of privileges or even discharge from the home.

The strategies group care children employ to produce communicative distancing include: physical avoidance, non-responsiveness, silence, facial expressions and body movements. Many residents prevent interactions from occurring by deliberately avoiding being in the same room as caretakers. They seldom participate in the extracurricular activities planned at the home, preferring to stay in their rooms or sleep. Another way that residents avoid interaction is by refusing to respond to written messages, often they are ignored completely. Silence is also employed as a strategy to create distance. The lack of verbal engagement prevents interaction from occurring. Group care residents employ facial expression and body movement to maintain communicative distance. Lack of eye contact, facial non-expression, and turning the body away from the speaker serve to produce a sense of distance.

The introduction of a third party serves to intervene in the communication process. If requested by caretakers, the caseworker at the Department of Human Services act as an intermediary. Serving in a advocacy role for the Department

of Human Services, the caseworker explains policies from a governmental standpoint.

Summary

Communication between group care residents and caretakers is mediated by the conditions of group care resident distrust of caretakers. Residents share a sense of suspicion of caretakers based upon historical and personal experiences. A belief exists that group care residents will not be treated fairly within the group home setting. Residents also believe that caretakers are not concerned with their welfare, but are merely doing their jobs.

The attempts at control and the tension which dominate relationships between the caretaker and resident are reflective in the group home environment. Communication is often erratic and it occurs in a climate of hostility. It is perceived to be one way, controlled, and ineffective.

Dependency is encouraged by those employed by governmental agencies, as well as caretakers and support groups. Generations of group care residents have been forced to be dependent upon the Department of Human Services, a condition which persists today. Dependency is exacerbated by the need for support, food, clothing, and shelter.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The data collected in this study provided a view of caretaker-resident communication process from the perspective of the group care residents. Present in the perceptual realities provided by the residents is an emerging theory which has implications for curriculum practice.

This chapter presents a summary of the study which reflects the grounded theory generated by the research design, the data collection, and the data analysis. The summary and conclusions are followed by the recommendations.

Summary of the Study

This study was conducted in a group care home located in an urban metropolitan city in a southern state. The study focused on the realities of the residents within the group care home.

Purpose

The purpose of this study was to examine caretaker-resident communication from the perspectives of the group care resident. The research focused on the

perceived conditions which mediate the communication process and the interpretations of how these conditions impact the process.

Research Participants

Participants in this research included five caretakers employed at the group care home and nine residents who are admitted. The researcher, in the role of participant-observer, served as the data gatherer.

Data Collection

Multi-modal qualitative research methods were used to collect the data. These methods included participant-observation, open-ended interviews, and document collection.

Participant observation was the primary method used in the data collection process. In the initial stages of the research, the role was more of an observer than a participant. As the researcher became familiar to the residents, rapport and trust was developed with individual residents. The researcher was able to observe or participate in the activities planned for the children as they went about their daily routines. The purpose of the research, and the role of the researcher, were explained to the home administrators and residents. Through the use of open-ended interviews, the researcher collected the stories of group care residents in their own words. The interviews provided rich data through descriptions of personal experiences and the interpretations of those experiences.

The interviews were conducted from August, 1992 to October, 1992.

The collection of documents provided an additional dimension to the data base. They included forms and descriptions of guidelines and policies. Information from written communications was documented or photocopied. This information was secured from daily logs, journals, minutes of meetings, and individual resident's files.

Data Analysis

The data analysis occurred through grounded theory analytic procedures. Data were systematically organized into categories according to conceptual similarities. The identified concepts were linked to the categories as conditions which give rise to the group care residents' beliefs regarding a distrust of caretakers, a fear of the loss of self-identity, resident dependence on caretakers, and the attempts at behavior control. Explanatory description of the categories were identified. The categories were integrated into a central "core" category as the data were linked. A theoretical explanation of the phenomena of duplicity emerged from the data.

Summary of the Results

The results of this study include the perceived conditions which mediate communication between group care residents and caretakers. It also addresses the ways in

which those conditions impact the data which explicates the dilemma of "duplicity" of the communication process.

Distrust of Caretakers

A shared distrust of caretakers among group care residents is based upon historical and personal experiences of contemporary group care residents. They believe that caretakers will not treat them fairly. The climate in which communication interaction occur is partially shaped by the dissonance produced by distrust. The condition of distrust leads to the duplicity of communication interactions.

Individual Identity

Group care residents have struggled to maintain the beliefs and values which are defined by their biological families. The maintenance of a personal identity that is directly related to the family is necessary for the survival of these residents. The ways in which group care residents interact with others are indicative of the behaviors created by the traditional culture. The phenomenon of personal identity maintenance serves as a foundation on which other experiences take shape.

Dependence

The conditions for governmental dependency were created by the federal government during the late nineteenth and early twentieth centuries. During this era of forced removal of children from unsuitable parents and the creation of institutional group homes, children were totally

dependent upon the government and private citizens for survival. The creation of the Child-Protection system served to institutionalize the maternalistic relationship between the government and group care residents. Dependency behavior persists today and is exacerbated by conditions of family dysfunction and poverty. The communication process is impacted by the presence of caretakers, serving as surrogate parents for children removed from their parental homes. Therefore, governmental and group home caretakers serve as an intervening condition in the communication process.

Control

Caretakers are seen as an obstruction to the freedom of group care residents. The residents believe that caretakers are constraining them, even though, they are unable to control their own behaviors. When residents attempt to free themselves from what is seen as an overwhelming obstacle, caretakers tighten the control over them. Residents resist against this control and defy caretakers by creating improper solutions to their problems that bring about destructive behavior. Such behavior may include the resident's participation as a runaway child, involvements in inappropriate sexual acts, and through gameplaying.

Duplicity: A Theory of Communication Quandary

Communication between group care residents and caretakers occurs in an erratic and tense environment that does not acknowledge the resident as a "real" person. Group care residents perceive themselves to be powerless to

control the experiences that are encountered. Attempts at control in these processes produce duplicity, a contradictory means of communication loaded with ambiguities. Duplicity determines the method of responses within the communication processes. The degree of interaction in which group care residents interact is determined by the degree of control that is placed on them by caretakers and the amount of tension within the home setting. If control is tightened and tension is high, interaction is very unlikely to occur. If control and tension are perceived to be low, interaction is more likely to occur, but limited in nature. Group care residents create a communication distance between themselves and caretakers for the purposes of maintenance of privacy and the avoidance of confrontation. In the perception of group care residents, duplicity in the communication process and communication distance is necessary to maintain personal identity, "save face", and to protect themselves.

Conclusions

This study was conducted in a group care home which has residents from different economic levels. The physical decor of the home is attractive, spacious, and decorated in a tasteful manner. There is access to computers and other recreational equipment, such as a piano, an organ, video recorders, televisions, and a complete stereo system.

Residents participate in group activities and other forms of recreation. They are provided with a clothing

allowance which permits them to purchase clothing at nearby malls and shopping plazas. They select various places that they frequent for personal recreation, such as skating rink and restaurants.

Although residents are provided with the necessary amenities for a secure life, the conditions of estrangement from the family bond produces insecurities. Children are attempting to cope in the best ways that they know how, but their inability to make appropriate decisions continue to create a life of repeated abuse. A conclusion that is drawn is that abuse does not cease because of the removal of children from dysfunctional homes. Rather, the placement may provide further opportunities for its increase. Placing children in group care homes is not a perfect solution.

The conclusion that is drawn is that resident beliefs, attitudes, and actions are necessary in assuring that the group home is providing what is necessary for residents to benefit from this type of housing. Residents are more likely to thrive in an environment that takes into consideration the feelings regarding those who must reside there. Group care residents must be actively involved in the plans and the search for solutions of problems regarding group living.

In order for adolescents to mature into adulthood, it is necessary for them to accept responsibilities and learn appropriate strategies for decisionmaking. Children who fail to learn how to accomplish these behaviors, become perpetual adolescents throughout their lives. Adolescent

behavior is not confined to the ages from thirteen to nineteen. Adult behavior is a state of mind as well as a socially prescribed set of behaviors. Group care children must not be prevented from acquiring these behaviors. Constraints must be loosened in order to allowed residents the opportunity to practice in safe environments. Caretakers need to let go and allow the residents to become maturing adults, to be free. They need to listen to them and model authentic behavior so that children can develop a personal sense of authenticity. The releasing of control over adolescent children, will transfer the responsibility of control from the caretaker back to the resident.

Recommendations

The contemporary relationship between the group care resident and caretaker is embedded in historical circumstances and mediated by the refusal of caretakers to recognize each resident as a "real" person. The distrust, loss of identity, dependency, and lack of power are conditions which also contribute to this relationship. The results of this study can be applied by curriculum leaders and administrators, teachers, and researchers and improve these conditions which, ultimately, impact the educational experiences of these children. The results of this study have implication for curriculum thought.

Curriculum Leaders and Administrators

Curriculum leaders and administrators are instrumental in the preparation of the curriculum utilized with group care residents within the school setting. Realizing that residents are coming from environments that are complex, the curriculum can communicate the concerns that are deemed beneficial. Means of promoting those issues that are found lacking in residents' lives can be addressed through a specific curriculum. This curriculum may involve the use of methods that help to build trust, a necessary element of open communication. A curriculum that focuses on the specific concerns of group care residents has an added advantage over the use of one that is devised for the entire school system. Traditionally, a curriculum that was provided for a whole school system has proved not to contribute to the success of children who come from group living arrangements.

School is a social institution and its mission is to fulfill the needs of the community in which it exists. Therefore, better communication between the school leaders and group care home administrators can prove to provide a comprehensive knowledge of resident life in, as well as out of, the group home. School experiences can be based on curriculum thought which improves the quality of children's lives in both environments. However, before these thought are based on curriculum preparation, leaders and administrators must examine and own the ambiguities that they bring to the communication process.

Group care residents feel "different" within the school setting. Since the curriculum is geared around middle class standards, a curriculum which allows the inclusion of group living would promote for an understanding of the problems being faced by these children.

Developing a process in which group care residents would have input into the selection of subject matter and providing opportunities for shared communication could provide the sensitivity to the perplexities encountered. This process could also provide the opportunity to develop curricular matter that is uniquely geared to the group care resident. Currently, none exist that is meant for this purpose.

Teachers

Teachers are a daily communication link with the community. Occasionally this link becomes weak through a failure to contact members. Teachers serve as spokespersons for the school system, in advising parents of the successes or failures of children at school. Since very little success, or none in most situations, is reported, the group home administrators are not kept informed regarding the educational needs of residents. Through an increased awareness program, teachers and administrators can plan a comprehensive program that can be initiated at school and supported at the home.

Teachers also communicate expectations and nonverbal limitations to residents. Although teachers state that all

children can succeed, the group care resident is seen as limited in ability and expectations are set according to this interpretation. Teachers who are not cognizant of the issues being faced by residents often communicate "hopelessness" regarding success. An examination of the ambiguities in teacher/resident communication will assist in teacher understanding of personal prejudices.

A series of group discussions could be incorporated into the curricular activities to increase the sensitivity to resident difficulties in living in the now, as opposed to the future. Since the classroom is organized to provide a curriculum around objectives that are planned to prepare students in the future, its usefulness to students experiencing hardships in the now is limited. The ability to focus on "superficial" matters is nonproductive. Also, children who are experiencing adult problems are not focusing on childhood subject matter. Namely, these children are quoted as "being adults before they are adults".

Although school and teacher expectations are straight A's for all students, determining the resident's "real" potential would be more valuable. Curriculum preparation can be planned around that potential, rather than a prescribed objective for the masses. Consistency of achievement in curricular activities would also enhance the potential of the resident by providing motivation to succeed according to that potential.

Researchers

This study examined the conditions which mediate communication between group care resident and caretakers and the effects of those conditions on communication process. Further investigation of the questions examined in this study is needed for a more complete understanding of communication interactions between group care residents and caretakers. Studies are needed on residents who have passed through the adolescent stages and the impact regarding the methods of communication. This may determine the long term effects of caretaker/resident communication.

The group care residents in this study were members of a group care home in an urban area. Further studies should be conducted among group care residents at other group care homes to determine if replication of the perceived mediating conditions and their effects might occur. Also, further studies pertinent to communication between group care residents and caretakers should be undertaken to determine if their findings would support the grounded theory which emerged from this study.

This study was limited to one group care home. Further studies should be conducted in group homes of varying sizes with a larger and smaller population to determine replication of the results. These results derived from research conducted among group care resident in urban settings could be compared to residents in rural settings in order to determine if similar mediating conditions are perceived to occur.

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APPENDIXES

APPENDIX A

CONSENT FORMS

OKLAHOMA STATE UNIVERSITY

Individual Consent for Participation in a Research Project

I, _____, voluntarily agree
(parent or legal guardian)
for my child, _____, to participate
(name of minor)
in this study entitled: AN ETHNOGRAPHIC STUDY OF THE REALITIES OF CHILDREN IN GROUP CARE: IMPLICATIONS FOR CURRICULUM THOUGHT.

I understand:
1) that the study involves research.
2) that it is being conducted in order to understand how children feel about group care living.
3) that program improvements may result based on the findings of this study.

This study involves research that will be carried out under the supervision of Russell Dobson, Ed.D. The purpose of this study is to increase awareness of the realities of children in group care settings.

This study will be conducted in a group home for an approximate three month period. It will involve residents in their normal daily routines. Interviews will be conducted in a conversational mode.

An increased awareness of the opinions and feelings of group care residents can generate program evaluations, thus creating improvements.

Whereas no assurance can be made concerning results that may be obtained, (because results from investigational studies cannot be predicted with certainty), the principal investigator will take every precaution consistent with good research practice.

By signing this consent form, I acknowledge that my participation in this study is voluntary. I also acknowledge that I have not waived any of my legal rights or released this institution from liability for negligence.

I may revoke my consent and withdraw from this study at any time.

Records of this study will be kept confidential with respect to any written or verbal reports making it impossible to identify me individually.

If I have any questions or need to report an adverse effect about the research procedure, I will contact the principal investigator, Onetta Williams, by calling Oklahoma State

University, (405) 744-7125.

If I have any questions about my rights as a research subject, I may take them to the Office of University Research Services, Oklahoma State University, (405) 744-5700.

I give my consent for the researcher to examine school documents.

I give consent for the interviews to be taped as necessary.

I have read this informed consent document. I understand its contents and I freely consent to participate in this study under the conditions described in this document. I understand that I will receive a copy of this signed consent form.

Date	Signature of the Research Subject
Date	Parent/Guardian (identify the signatory)
Date	Signature of the Witness
Date	Signature of the Principal Investigator

OKLAHOMA STATE UNIVERSITY

Individual Consent for Participation in a Research Project

I, _____, agree to participate
(resident)
in this study about group care living. The title of the study

is: AN ETHNOGRAPHIC STUDY OF THE REALITIES OF CHILDREN IN GROUP CARE: IMPLICATIONS FOR CURRICULUM THOUGHT.

I understand that:
1) The study involves communication through questions and answers and that it is considered to be research.
2) I will only talk or answer the questions that I wish to answer.
3) The study will allow me to tell how I feel about group care living.
4) The results of the study may help others understand better about what group care living is all about.
5) Programs that include group care residents may improve or change as a result of this research.

The person conducting the research is Onetta Williams. She has a supervisor at Oklahoma State University named Dr. Russell Dobson. His telephone number is (405) 744-7125

The researcher, Onetta Williams, will be in the group home for approximately three months. She will discuss with you how you feel about being in group care.

When I sign this form, I am giving my permission to talk with her.

I may disagree to talk even though I have signed, if I change my mind.

My real name will not be used in the report and anything that is written other than the final report will be destroyed at the end of the three month period.

If I have a problem with the researcher or questions about the research, I can call Onetta Williams at _____ or (405) 744-5700 and discuss them with a person in the University Research Service.

I give my consent for the researcher to examine school documents.

I give consent for the interviews to be taped as necessary.

8. SIGNATURES:

I have read this informed consent document. I understand its contents and I freely consent to participate in this study under the conditions described in this document. I understand that I will receive a copy of this signed consent form.

Date	Signature of the Research Subject
Date	Parent/Guardian (identify the signatory)
Date	Signature of the Witness
Date	Signature of the Principal Investigator

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
FOR HUMAN SUBJECTS RESEARCH

Proposal Title: AN ETHNOGRPHIC STUDY OF THE REALITIES OF CHILDREN IN GROUP CARE: IMPLICATIONS FOR CURRICULUM THOUGHT

Principal Investigator: Dr. Russell Dobson/ Onetta Williams

Date: July 9.1992 IRB # ED-93-002

This application has been reviewed by the IRB and

Processed as: Exempt [ ] Expedite [ ] Full Board Review [XX]

Renewal or Continuation [ ]

Approval Status Recommended by Reviewer(s):

Approved [X] Deferred for Revision [ ]

Approved with Provision [ ] Disapproved [ ]

Approval status subject to review by full Institutional Review Board at next meeting, 2nd and 4th Thursday of each month.

Comments, Modifications/Conditions for Approval or Reason for Deferral or Disapproval:

Modifications Received

Signature: Marcia L. Tilley
Chair of Institutional Review Board

Date: July 24, 1992

APPENDIX C

GROUP HOME DOCUMENTS

RAINBOW STATUS SKILL DEVELOPMENT

Page 1 STATUS: 16 BLUE

Education

_____ Attends school regularly

_____ Uses study hour/quiet time appropriately

_____ Works cooperatively with tutor

_____ Has realistic view of her chances of completing high school

_____ Puts forth concerted effort to make passing grades in all subjects; makes passing grades in all subjects

Food Management

_____ Can fix breakfast for one

_____ Can fix lunch for one

_____ Can follow food label preparation instructions

_____ Can prepare dinner with assistance for other residents and staff

Health

_____ Follows orders of health care professionals

_____ Takes medications as prescribed

_____ Can recognize and describe symptoms of colds, flu and other common health problems

_____ Knows basic first aid

_____ Understands the health risks of drug, alcohol and tobacco use

Transportation

_____ Communicates through chart weekly transportation needs of TAH staff or uses TAH transportation appropriately

_____ Can use MTA for transportation needs (knows cost, can make transfers, secures student ID)

_____ Plans in advance with TAH staff for needed rides

Time Management

_____ Gets self up in the morning

_____ Is on time for appointments, school, meals, groups, etc.

_____ Follows through in meeting TAH weekly schedule

Page 2 STATUS: 16 BLUE

Personal Property Management

_____ Respects others' property

_____ Takes responsibility for care of borrowed property (borrowing/lending contract

_____ Takes responsibility for care of personal property by storing neatly in respective bedroom and/or other storage areas

Management of Personal Feelings

_____ Learns to identify personal feelings

_____ Doesn't "dump" bad/hurt feelings on others

_____ Uses staff to process feelings

_____ Participates in weekly individual session with Primary Counselor

_____ Learns appropriate ways of dealing and coping with negative feelings (counseling, writing, exercise, hobby, etc.)

_____ Participates in TAH weekly growth group

Human Sexuality

_____ Knows parts of the body and sexual functioning

_____ Knows how pregnancy occurs

_____ Understands the risks of pregnancy and sexually-transmitted diseases

_____ Knows methods of birth control and how to obtain birth control devices

_____ Knows how to prevent contracting sexually-transmitted diseases; how to be tested and treated

_____ Learns and develops appropriate sexual boundaries with others

_____ Begins to explore personal feelings related to sexuality

_____ Maintains appropriate sexual boundaries with others

_____ Exhibits responsible dating behavior

Personal Hygiene

_____ Showers or bathes regularly

_____ Brushes and flosses teeth regularly

_____ Keeps hair neat and clean

Page 3 STATUS: 16 BLUE

Clothing

_____ Can read clothing labels and determine which clothes are to be dry cleaned, machine washed or hand washed

_____ Can sort and wash clothes using appropriate temperatures and amounts of detergent and bleach

_____ Can dry clothes in dryer using appropriate settings

_____ Can iron clothes

_____ Dresses appropriately according to the weather

_____ Knows own clothing sizes - underwear, outerwear, shoes

Household Management

_____ Can make bed and change linens

_____ Keeps room clean and neat

_____ Can wash dishes sanitarily

_____ Knows how to sweep floor and stairs, wash wood and linoleum floors, wash windows, dust, polish furniture, clean toilet, clean bath tub and sink

_____ Knows appropriate cleaning products to use for different jobs

_____ Does household chore daily

_____ Can change a light bulb and vacuum cleaner bag

_____ Knows how to prevent sinks and toilets from clogging

Money Management/Consumer Awareness

_____ Can make a transaction at a store and count change

_____ Has an understanding of the difference between "luxuries" and "necessities" in food, transportation, clothing, etc. or knows the difference between a want and a need

_____ Knows how to clip and use coupons

_____ Understands difference between sale and regular price

Interpersonal Skills

_____ Is polite (says thank-you, please, uses appropriate greetings)

_____ Can respond to introductions and answer simple questions

_____ Looks others in the eye and shakes hands if other person offers

_____ Can answer phone and converse appropriately

Page 4 STATUS: 16 BLUE

Interpersonal Skills, cont'd.

_____ Uses staff assistance if unable to resolve interpersonal conflicts alone

_____ Respects privacy of others; maintains confidentiality among peers

_____ Knows when and how to send a written thank-you note

_____ Takes telephone messages accurately

_____ Learns/develops negotiating skills

_____ Refrains from physical violence to resolve personal conflicts

_____ Makes one positive self-statement weekly

_____ Learns assertive communication

_____ Has some ability to resolve conflicts with others

Job Seeking Skills

_____ Has reasonable idea of the types of jobs that will be available to her

_____ Knows what the minimum wage is

Knowledge of Community Resources

_____ Knows how to get information by telephone

_____ Knows where nearest park is located

_____ Knows where nearest supermarket or shopping district is located

_____ Knows where personal bank is located

_____ Can use the yellow pages to obtain information

_____ Knows who to contact if lost, frightened, depressed, anxious, sick, injured, out of food and money, utilities disconnected, or heat goes out.

Emergency and Safety Skills

_____ Knows functions of police, ambulance and fire department. Can reach each by calling the appropriate number

_____ Is trained to evacuate the residence in case of fire

_____ Knows proper way of disposing of smoking materials, if smokes

_____ Understands basic fire prevention (no smoking in bed, using gas stove to heat, excessive use of extension cords, frayed electrical cords, etc.)

_____ Knows that improperly used appliances can cause fire

Page 5 STATUS: 16 BLUE

Legal

_____ Would have the phone number of someone to call if arrested or victimized

_____ Understands generally what actions are against the law and what the consequences are

_____ Knows legal age for buying alcohol and tobacco products

Name _____ Status _____ Week of _____

MONDAY

	(Yes)	(No)
Awake time:	____	____
Breakfast:	____	____
Room Check:	____	____
School/Work:	____	____
Dinner:	____	____
Study:	____	____
Bedtime:	____	____
Phone:	____	____
Daily Medication.		
	____	____

Times a day:

____ ____ ____ ____

Daily Program·

Signouts/Visits/Walks

Where·

With·

Time: To:

Evening Program:

Signouts/Visits/Walks·

Where:

With:

Time: To:

Notes:

Name _____ Status _____ Week of _____

TUESDAY

	(Yes)	(No)
Awake time:	____	____
Breakfast:	____	____
Room Check:	____	____
School/Work:	____	____
Dinner:	____	____
Study:	____	____
Bedtime:	____	____
Phone:	____	____
Daily Medication:		
	____	____

Times a day:

____ ____ ____ ____

Daily Program:

Signouts/Visits/Walks:

Where:

With:

Time: To:

Evening Program:

Signouts/Visits/Walks:

Where:

With:

Time: To:

Notes:

Name _____ Status _____ Week of _____

WEDNESDAY

	(Yes)	(No)		
Awake time:	____	____	Daily Program:	Signouts/Visits/Walks
Breakfast.	____	____		Where
Room Check:	____	____		With
School/Work:	____	____		Time To
Dinner	____	____	Evening Program	Signouts/Visits/Walks
Study	____	____		Where
Bedtime:	____	____		With:
Phone:	____	____		Time. To
Daily Medication			Notes:	
	____	____		
Times a day:				
____ ____ ____ ____				

Name _____ Status _____ Week of _____

THURSDAY

	(Yes)	(No)		
Awake time:	____	____	Daily Program:	Signouts/Visits/Walks:
Breakfast:	____	____		Where:
Room Check:	____	____		With:
School/Work:	____	____		Time: To:
Dinner:	____	____	Evening Program.	Signouts/Visits/Walks:
Study:	____	____		Where:
Bedtime:	____	____		With:
Phone:	____	____		Time: To:
Daily Medication.			Notes:	
	____	____		
Times a day:				
____ ____ ____ ____				

Name _____ Status _____ Week of _____

FRIDAY

	(Yes)	(No)
Awake time:	____	____
Breakfast.	____	____
Room Check.	____	____
School/Work·	____	____
Dinner:	____	____
Study	____	____
Bedtime:	____	____
Phone	____	____
Daily Medication	____	____

Times a day·

____ ____ ____ ____

Daily Program: _____

Signouts/Visits/Walks.

Where _____

With· _____

Time: _____ To· _____

Evening Program· _____

Signouts/Visits/Walks.

Where· _____

With: _____

Time: _____ To: _____

Notes: _____

Name _____ Status _____ Week of _____

SATURDAY

	(Yes)	(No)
Awake time:	____	____
Breakfast:	____	____
Room Check:	____	____
School/Work·	____	____
Dinner:	____	____
Study	____	____
Bedtime:	____	____
Phone:	____	____
Daily Medication:	____	____

Times a day:

____ ____ ____ ____

Daily Program: _____

Signouts/Visits/Walks:

Where: _____

With: _____

Time: _____ To: _____

Evening Program. _____

Signouts/Visits/Walks:

Where: _____

With: _____

Time: _____ To: _____

Notes: _____

Name _____ Status _____ week of _____

SUNDAY

	(Yes)	(No)		
Awake time	____	____	Daily Program:	Signouts/Visits/Walks
Breakfast.	____	____		Where
Room Check	____	____		With
School/Work	____	____		Time: To
Dinner:	____	____	Evening Program:	Signouts/Visits/Walks
Study	____	____		Where
Bedtime:	____	____		With:
Phone	____	____		Time. To
Daily Medication.			Notes	
	____	____		
Times a day:				
____ ____ ____ ____				

GOALS:

1. _____

Action steps to help reach goal:

a. _____

b. _____

c. _____

2. _____

Action steps to help reach goal:

a. _____

b. _____

c. _____

3. _____

Action steps to help reach goal:

a. _____

b. _____

c. _____

4. _____

Action steps to help reach goal:

a. _____

b. _____

c. _____

5. _____

Action steps to help reach goal:

a. _____

6. _____

Action steps to help reach goal:

a. _____

APPENDIX D

EXCERPTS FROM INTERVIEWS

Excerpts from Interviews

Sample 1

Question: Why do you feel that you have no control?

Respondent: because. . . Before I came into State Custody I wasn't disciplined. Mom showed me that I had to have control and she did that with her behavior.

Question: Isn"t that what the Rainbow Status System is for. . . to teach you how to set goals and reach them by self-disciplining yourself?

Respondent: I don't pay any attention to the Rainbow Status Chart anymore because staff won't give it to you.

Question: What do you mean when you say staff won't give it to you?

Respondent: The persons involved with the Rainbow Status are not around us enough to say where we need to be on the chart. They only come long enough to say that we haven't earned the next color. I don't even try anymore.

Question: Have you tried to tell the staff how you feel?

Respondent: yes, but they won't listen and most of the time they come to work in a bad mood. They bring their personal problems to work. I feel that I have no input. . . no say about what happens to me.

Question: When you try to communicate your feelings, how do you feel afterwards?

Respondent: I am afraid! I know that they can tell me to leave. They have already told me that my next placement will be a Wilderness Program if I don't stay here. In that program, it will be like prison - a lock up. Although I know that this home will never be like my real home, I am afraid of a Wilderness Camp.

Question: Why do you feel that this home will never seem like home?

Respondent: I don't feel that this will ever be my home because of the fact that I am treated different than friends or family would treat me. At home, it was the only family that I knew,

but it wasn't like a family should be. I think a family should have close ties. At home I was existing. Mom never talked to me. She would tell me what to do. When I would come home from school, they would be gone, some days until very late at night. Here, it is not like a family. All employees are considered not to be even friends. They are just doing their jobs. Some people care and they are here for me, but others are here for the money.

Question: How do you feel about employees coming just for the money?

Respondent: Because I feel this way, I do what I want to do. I know that they don't care about me because when I get angry and show my feelings, the staff gets angry too. Because they get angry, they take it out on me.

Question: What do you mean when you say I do what I want to do?

Respondent: I feel so bad sometimes until I go out and just do things. They make me do things. They make me want to get back at them. For example, when it is time for me to finally go home, I am going to smoke four cigarettes in my room just because I know that there is a rule against doing this.

Question: What do you mean when you say they take it out on me?

Respondent: They revoke my privileges by not allowing me to go on home visits or telephone my relatives and friends.

Question: What else do you do to get back at them?

Respondent: Sometimes I get so angry at staff. _____ told me that my parents didn't want me back at home. I talked to my mother and she said that this wasn't true. I feel that if _____ cared about me she wouldn't have said that. _____ also keeps telling me that I have low self-esteem. I keep telling her that there are days when I don't feel up as good as other days, but I don't have low self-esteem. She keeps telling me that I do. I believe that she is really talking about herself.

Question: How do you feel when they won't believe what you are saying?

Respondent: It frustrates me and it makes me want to start walking away from this house and never look back. A lot of what happens here frustrates me.

Sample 2

Question: Do you feel that the group home is a good idea for children who can't stay home with their parents?

Respondent: No, I don't think that group living will ever be good for children. Foster care is better because it allows rules to be set in a family atmosphere. It is the next best thing to being home. In a foster home, you have more freedom. In group care, bad children are brought in. Some need to be in a "real lock up". There are thieves in the home. I will never feel safe because men break in and there is no one to defend me. I would feel safer if there was at least one male at the home, but there are only females. They can't do anything if there is a break-in. It is irritating and nerve racking when I feel unsafe. I can't get comfortable here. I want to be able to go home. I can't call my friends or see people who can't come to the home. My grandma is in a wheelchair and I want to see her. There are too many rules that are not in a real home. The rule of no phone calls when I am eating is one that is not at home. The only time that I feel like I am at home is when I go to my room. I fantasize that I am home in order to escape where I really am. I pretend that I am at a long slumber party.

Question: Have you explained how you feel about the home to caretakers?

Respondent: They pretend that they want me to provide my opinion, but if I give it nothing is ever done according to what I say or nothing is changed. They don't want to know.

Question: What would you change?

Respondent: The first thing that I change is that I would never have a rule that prevents a child from seeing her mother. My mother is not allowed to see me. I hear from her every day on the telephone, but I can only see her with supervised visits at the Department of Human Services office. I believe that caretakers stopped her visits to the home. They feel that she was speaking negatively about the group home. There are so many rules and steps to everything. She must meet requirements and go through the program as a visitor, a friend first. Then, she can sign me out on day visits. Next, I can have overnight visits. Finally, week visits of seven days can be approved. I hate all of these rules because mom lives in

_____ and she does not have a car to drive all the way here. I value my relationships and the group home is trying to take them from me.

Question: Why do you feel that the group home is trying to take them?

Respondent: . . . . . because the administrators are the ones who determines who sees who. They are the ones who stopped my mother from coming because they felt that she was a bad influence on me. My mother has done everything that they have asked her to do, but they still won't let me go on a home visit.

Question: If they would let you have home visits and see your mother, would group living be a good alternative for children who are unable to live at home with parents?

Respondent: No, because it's not like a real home. I can't see my friends like I do at home. There are too many things that I can't do here. I feel like I am in prison. I feel frustrated most of the time because I feel trapped. I never know when an attack is going to come from the staff or another resident. I wish that the staff would be more positive and think about the future instead of negatively dwelling on the past all of the time. The group care home has too many girls in it and too many personalities. There needs to be less people in order for it to feel like a real home.

VITA

Onetta Williams

Candidate for the Degree of

Doctor of Education

Thesis: THE REALITIES OF ADOLESCENT GIRLS IN GROUP CARE: IMPLICATIONS FOR CURRICULUM THOUGHT

Major Field: Curriculum and Instruction

Biographical:

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