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Changing the Social Milieus of Psychiatric Treatment Settings*

RUDOLF H. MOOS

The article presents a concrete paradigm which may be useful in the facilitation and evaluation of social change, particularly in relatively small groups with moderate to high amounts of interaction among their members. The methodology includes (1) the systematic assessment of the social environment, (2) individualized feedback to participating members, (3) concrete planning of specific methods by which change might occur, and (4) reassessment of the social environment in order to monitor the results of the change process. Preliminary applications of the method have been made on psychiatric wards, small correctional units or cottages for young juvenile offenders, university residence halls, and high school classrooms. Examples of the use of the methodology in studies of a psychiatric ward and an adolescent residential center are presented.

INTRODUCTION

There have been important recent advances in the development of systematic methods for assessing psychosocial environments in different types of organizations, e.g., insurance agencies (Schneider & Bartlett, 1968), colleges and universities (Pace, 1969; Stern, 1970), elementary schools (Halpin & Croft, 1963), and psychiatric wards and correctional institutions (Moos, 1968; Moos & Houts, 1968). These new assessment methods have been used in many different types of studies, but their use

* Portions of this paper were presented at a symposium entitled "Social Change and Adaptive Behavior" at the American Psychological Association Convention, Washington, D.C., September 1971. The research was supported in part by a Veterans Administration Research Grant and by NIMH Grant MH 16026, and by NIAAA Grant AA00198.

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in the facilitation and evaluation of change has been relatively unexplored. This paper describes a paradigm which utilizes information about perceived psychosocial environments in planning and directing change within those environments.

The development of methods for assessing social environments and for making these assessments useful to participants through feedback has been motivated in part by the desire to facilitate planned change in social settings. Attempts at changing group environments began on a large scale with the development of human relations training in industrial settings, where change has frequently been centered on improving employee morale or production procedures (e.g., Bavelas & Strauss, 1961).

Beckhard (1971) reports on his consulting technique in a case study of work done at the Vernon Company. He conducted a series of interviews to identify common problems of key personnel, gave feedback on his findings, lectured on and aided the use of problem-solving methods at a conference, and directed the administrators on how to continue such problem-solving sessions in the future. Four months after the conference, he again conducted interviews at the company to assess the progress made and he found that staff felt relationships and planning ability had improved. He also identified more problems, indicating that the process of change may be a continuous one, in that new problems always arise as old ones are solved. His feedback was used as the basis for planning change, with company personnel taking the leading role.

Mann (1971) reviews several studies on the use of feedback of questionnaire results as a stimulus for change in industrial settings and reports on the development of a survey instrument that provides information about (1) employee attitudes toward their work, promotions, supervision, and fellow employees; (2) first-line supervisor attitudes about their jobs and supervisory beliefs; and (3) top management attitudes about their philosophy, role in policy formation, and problems of organizational integration. In one project, this information was fed back to eight accounting departments, in four of which intensive discussions at all levels were begun. The other departments were designated as control groups. After a two-year period, a second administration of the survey was given with 17 "perceived change" items added to determine if change in expected directions had occurred. Mann found that a fourth of the items from the original survey showed mean positive changes at the .05 level in the experimental group, and a significantly higher percentage of the experimental group than the control group felt that change had occurred in

15 of the 17 additional areas. He believed that the change was facilitated by involving both employees and supervisors in the process and by working within the institution rather than removing people from the work environment, in contrast to human relations training practices.

Heller (1969) proposes a multidimensional approach to field research. He suggests that questionnaire results, while easily quantified, can be misleading because questionnaire items may be interpreted in a variety of ways by respondents, and their responses to items may be influenced by variables in the testing situation, e.g., noise level or interruptions. On the other hand, interpretation of "soft" data such as those collected in interviews, while allowing for more flexibility and depth in analysis, is difficult because of the broad range of responses possible. Heller has developed a method called "Group Feedback Analysis" in order to overcome these difficulties. The method is composed of three steps: administration of traditional questionnaires, which are subjected to standard statistical tests; feedback of questionnaire results; and "content analysis." Content analysis (as defined by Heller) invites respondents to review their thinking on the meaning of questionnaire items and expand their thoughts on the subject under study. Heller conceives his technique as primarily an information-gathering device, though the content analysis phase clearly lends itself to the facilitation of change.

Miles, Hornstein, Calder, Callahan, and Schiavo (1971) identify the basic processes resulting from feedback and discussion such as that described by Mann and Heller. Presentation of data leads to client inquiry as to why certain results were obtained, and can lead to discussion of problems that were not the primary focus of the data collection. Client involvement at this level promotes acceptance of the data as representing something they have taken part in creating, and develops a positive set toward using the data. Group meetings occurring in the feedback process increase client responsibility for making changes, which can lead to positive interactions among members of the problem-solving groups and clarification of issues. Increased discussion of issues can also establish potentially useful norms and agreement on problems and goals. As practical group problems are attacked and change effected, groups also learn how to interact and problem-solve more effectively, via process-analytic discussion. New change goals, change-supporting structures and norms, and new action decisions emerge. These authors emphasize the usefulness of objective data from surveys, rather than the subjective data usually available in human relations training groups, because surveys are role,

intergroup, or system focused and allow for a higher degree of involvement by clients in planning, collecting, analyzing, and interpreting data.

METHODOLOGY: SURVEY FEEDBACK

Although it was independently derived, the methodology reported in the present article includes four basic components, which are very similar to those used in industrial and educational survey feedback studies. First is the *systematic, dimensionalized assessment* of the social environment of the particular system under study. All individuals involved in the system have an opportunity to give their opinions about the current functioning of the system on relevant dimensions. For example, in our own work on psychiatric wards and in transitional community-oriented treatment programs, residents and staff are asked about three broad types of dimensions that characterize their program (Moos, 1972): *relationship* dimensions (e.g., Involvement, Support, Spontaneity); *personal development* or *treatment program* dimensions (e.g., Autonomy, Practical Orientation, Personal Problem Orientation); and *system maintenance* or *administrative structure* dimensions (e.g., Order and Organization, Program Clarity, Staff Control). All residents and staff are also given an opportunity to provide information about their concept of an ideal social system; thus the goals and general value orientations of participants can be systematically assessed.

Second, *individualized feedback* is given on the results of these assessments. Particular attention is paid to similarities and differences in the perceptions of various important groups, e.g., residents and staff. Agreements and disagreements among the goals and values of different groups are also outlined. In addition, the similarities and differences between the "real" and the "ideal" social environment are emphasized and the implications for change that are thereby suggested.

Third, *concrete planning* of specific methods by which change might occur along specified dimensions is then instituted. This planning is usually done with the aid of a social systems change "facilitator" experienced in ways different types of social systems can change. The specific methods by which decisions are made and implemented vary a good deal from one environment to another.

Fourth, one or more *reassessments* of the characteristics of the social environment are made in order to provide systematic information about the results of the change process, as perceived by all of the participants in the particular social system involved. Some of the rationale underlying this method is discussed in more detail by Moos (1973, in press).

A STUDY ON A PSYCHIATRIC WARD

In an initial study of a small in-patient psychiatric ward (Pierce, Trickett, & Moos, 1972) assessment was carried out by means of the Ward Atmosphere Scale (WAS), a 99-item true/false measure which assesses on 10 different dimensions both patient and staff perceptions of the ward treatment environment. The ward staff had decided to use the WAS to (1) describe the ward atmosphere in order to learn more about patient and staff perceptions of the treatment environment and (2) identify and design ways in which the WAS and the ideas generated from it could be employed in a continuing effort to create a maximally beneficial ward environment and treatment program. Thus the major aim was to apply the information obtained from the WAS to change the treatment environment in directions more consonant with staff goals.

Feedback and discussion of WAS results had a number of effects. The staff perceived the treatment environment of the ward as closer to their "ideal ward" after feedback, discussion, and the institution of ward changes. Much of the staff discussion in feedback sessions focused on the variables of Autonomy and Staff Control. Specific issues raised included how to handle acting-out behavior clearly beyond the rules of the ward and therefore requiring limit-setting by the staff. From these and other discussions, a committee was formed to review community meetings in order to generate suggestions and ideas for making the meetings more meaningful in terms of the total ward treatment program. Another committee was formed to review the ward activity program and suggest ways of increasing staff and patient participation in ward activities. As a result of reports of these committees, several changes were initiated: e.g., staff agreed that community meetings could be used to define, explain, and reiterate staff expectations of patients and to transmit ward norms and values. The staff also decided that it would more actively structure the meetings, to make them more manageable for patients.

On retest with the WAS, the staff felt that there had been significant increases in the amount of emphasis on Support, Practical Orientation, and Program Clarity; the patients felt that there had been significant increases in both Involvement and Support. The systematic feedback about the ward's social environment helped staff conceptualize and artic-

ulate some of their current concerns. The use of this information in discussion sessions was an important supplement to the staff's knowledge of the ward and, as such, a meaningful contribution to the change process as well as an evaluation of change. In addition, staff who had infrequently verbalized concerns about the ward were able to discuss ward issues in terms of the WAS information. Apparently this kind of feedback may have motivating properties, helping some individuals to become involved in the articulation of specific issues and goals.

It is important to note that the ward changes which took place did so within a generally consistent ideology that remained essentially stable throughout the study. Thus a social system like a psychiatric ward can institute a series of carefully thought-out and graduated changes in its program while still retaining a characteristic overall direction ideology.

A STUDY IN AN ADOLESCENT RESIDENTIAL CENTER

A methodologically similar study was carried out in an adolescent residential center. In this case, the Community-Oriented Program Environment Scale (COPES), which assesses the social environment of community-oriented psychiatric treatment programs on 102 true/false items, subdivided into 10 different dimensions, was used. Like the WAS, this scale has two forms. Form C asks residents and staff to describe their current program (*real* program); Form I asks them to describe their *ideal* program. The 10 subscales of COPES, brief definitions of each, and examples of items included in each are given in Table 1. The ordering of these subscales reflects a conceptualization of the relationships among them.

TABLE 1.

Community-Oriented Program Environment Scale (COPES)

DESCRIPTIONS OF SUBSCALES	
1. INVOLVEMENT:	*measures how active members are in the d. y-to-day functioning of their program.* Members put a lot of energy into what they do around here. The members are proud of this program.
2. SUPPORT:	*measures the extent to which members are encouraged and supported by staff and other members.* The healthier members here help take care of the less healthy ones. The staff know what the members want.

Community-Oriented Program Environment Scale (continued)

3. SPONTANEITY:	*measures the extent to which the program encourages members to act openly and express their feelings openly.* Members say anything they want to the staff. Members are strongly encouraged to express their feelings.
4. AUTONOMY:	*assesses how self-sufficient and independent members are encouraged to be in making their own decisions.* Members are expected to take leadership here. Members here are encouraged to be independent.
5. PRACTICAL ORIENTATION:	*assesses the extent to which the member's environment orients him toward preparing himself for release from the program.* This program emphasizes training for new kinds of jobs. Members must make detailed plans before leaving the program.
6. PERSONAL PROBLEM ORIENTATION:	*measures the extent to which members are encouraged to be concerned with their personal problems and feelings and to seek to understand them.* Members tell each other about their intimate personal problems. Staff are mainly interested in learning about members' feelings.
7. ANGER AND AGGRESSION:	*measures the extent to which a member is allowed and encouraged to argue with members and staff, to become openly angry and to display other aggressive behavior.* Staff here think it is a healthy thing to argue. Members often criticize or joke about the staff.
8. ORDER AND ORGANIZATION:	*measures how important activity planning and neatness are in the program.* Members' activities are carefully planned. The staff make sure that this place is always neat.
9. PROGRAM CLARITY:	*measures the clarity of goal expectations and rules.* If a member breaks a rule, he knows what the consequences will be. The program rules are clearly understood by the members.
10. STAFF CONTROL:	*assesses the extent to which the staff determine rules.* Once a schedule is arranged for a member, the member must follow it. The staff make and enforce all the rules here.

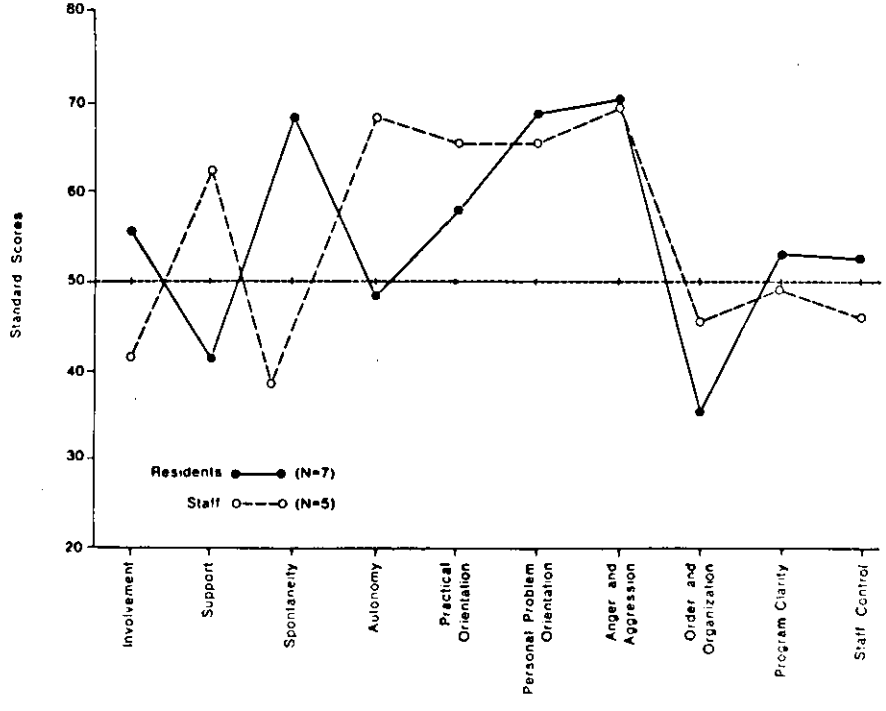
The Program Involvement, Support, and Spontaneity subscales are conceptualized as measuring *relationship* dimensions, i.e., the types and intensity of personal relationships among members, and between members and staff. The involvement of members in the program, the extent to which a member receives support from staff and other members, and the degree of openness (spontaneity) within all these relationships are assessed.

The next four subscales, i.e., Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression, are conceptualized as *treatment program* dimensions. Each assesses a dimension particularly relevant to the type of therapeutic program that has been initiated and developed. The extent to which members are encouraged to be self-sufficient and independent, to prepare for the future, and to have insight into their problems reflects the major types of psychotherapeutic treatment orientations in current psychiatric programs. The Anger and Aggression subscale is usually related to psychotherapeutic values of staff, e.g., whether or not open expression of anger is perceived as beneficial. These four subscales appear to assess the major treatment dimensions along which psychiatric programs vary.

The last three subscales of Order and Organization, Program Clarity, and Staff Control are conceptualized as assessing *system maintenance* dimensions. These subscales are system oriented, in that they assess dimensions related to the goal of keeping the program functioning in an orderly, organized, clear, and coherent manner. The items relate to clarity of rules, rule enforcement, emphasis on order and neatness, and authority of staff.

Figure 1 shows the COPES Form C (real program) profiles at the first testing for the residents and the staff as compared to the average score obtained by residents in the initial reference group sample of 21 community-oriented programs. This average is shown on the profile as a straight line down the center at a standard score of 50. Thus areas in which the residents and staff perceptions are above, at, or below average emphasis, as compared statistically to the 21 reference group programs, can be seen. For example, the residents feel that the program str ngly encourages them to act openly and to express their feelings freely (Spontaneity), to be concerned with their personal problems and feelings (Personal Problem Orientation), and to express openly their feelings of anger (Anger and Aggression). Residents feel that there is moderate emphasis on preparing themselves for release from the program (Practical Orientation); however, they feel that there is somewhat less emphasis on both Support and Order and Organization.

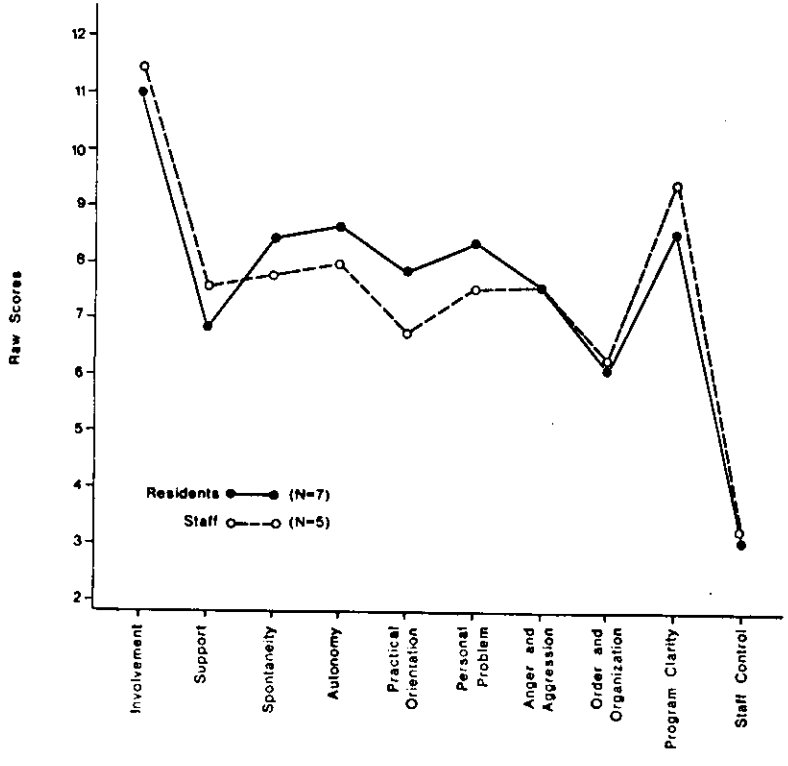
FIGURE 1.
Comparison of COPES Form C Scale Profiles for Residents and Staff on Unit PC104 (First Testing), Based on Resident Norms for 21 Units



In the initial testing, residents and staff showed some fairly large disagreements about the characteristics of the current program. For example, staff believed that the amount of emphasis on both Support and on Autonomy was high, whereas the amount of emphasis on Involvement and Spontaneity was moderately low. On the other hand, residents and staff did agree about the relative amounts of emphasis in several of the other dimensions, most notably Personal Problem Orientation and Anger and Aggression.

Figure 2 shows the comparison of the average raw scores of the residents and the staff on COPES Form I (ideal program). This figure compares the residents' ideal program with the staff ideal. It is clear that the residents and staff prefer a quite similar treatment environment. The

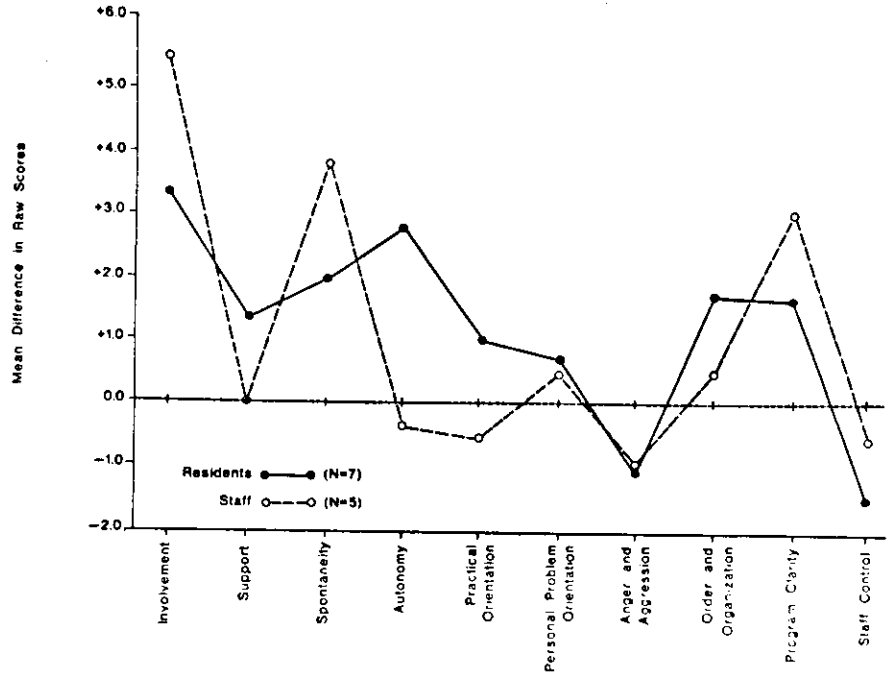
FIGURE 2.
Comparison of Ideal COPES (Form I) Scale Profiles for Resident and Staff on Unit PC104 (First Testing)



importance of this information lies in its indication that the residents and staff share similar goals, at least insofar as the program environment is concerned.

Figure 3 compares the degree of change the residents would like to see in the program with the degree of change desired by the staff. The amount of change desired was calculated by subtracting the score the residents gave the actual program (Form C subscale scores) from the score they gave an ideal program (Form I subscale scores). The sam was done for staff. The profile shows the amount of increase or decrease that would have to occur in each area in the actual program in order for it to become ideal, as the residents and the staff currently conceptualize it. The line marked zero in the center of the profile indicates no change desired in the program, i.e., no discrepancy between real and ideal subscale means. For example, neither the residents nor the staff desired change in

FIGURE 3.
Comparison of Real-Ideal Discrepancies on COPES Subscales for Residents and Staff on Unit PC104 (First Testing)



the amount of emphasis on Personal Problem Orientation.[1] Positive scores indicate a desire for increased emphasis in that area. For example, both residents and staff agreed that they would like to have fairly substantial increases in emphasis on the relationship dimensions of Involvement and Spontaneity and the system maintenance dimensions of Order and Organization and Program Clarity. Negative scores, on the other hand, indicate a desire for decreased emphasis. For example, both the residents and the staff agreed that they would like to have somewhat less emphasis on the expression of Anger and Aggression than currently existed in the program.

These three profiles were discussed in detail with the residents and

[1] Given the small *N*, it did not seem appropriate to compute tests of significance; thus the differences noted are judged in terms of practical significance.

staff. Jean Otto,[2] a change "facilitator" from our Laboratory, gave this detailed feedback and met with residents and staff on several occasions over about a four-month period. Both residents and staff showed an interest in attempting to change the program's social environment systematically.

Several specific change attempts were made, and careful notes about all discussions and plans for change were kept. In summary, four different areas were discussed in the greatest detail.

1. It became clear that there was a need to set up some types of exciting, involving, special activities, so that residents could really enjoy doing certain things with one another. It became evident that slightly too much of the house structure was centered around problem-solving activities, which apparently tended to have a dampening effect on both residents and staff, decreasing their involvement.

2. The issue of increasing support was also discussed in some detail. Some staff felt that the residents wanted support for some of their acting-out behavior, which the staff wanted to discourage. A specific procedure for obtaining peer support when residents were having a personal problem was instituted. Any resident could call a "game" when he or she wished. All the other residents would then come over and talk about the problem and help the person seek some solution, or at least feel better about the situation. For example, one girl called a "game" after she had had a particularly upsetting fight with her boyfriend. The staff did not enter these "games," which were usually held in the room of the person who was having the problem.

3. Issues revolving around Autonomy and Staff Control were also considered to be important, especially since the residents had perceived much less emphasis on Autonomy than had the staff. The residents had also indicated that they would like much more emphasis on Autonomy in the house than was currently present. The staff's main concern was that residents often turned to them to make minor decisions which they could really make for themselves; e.g., sick residents often asked the staff whether or not they should go to school. On the other hand, the staff felt that the residents had visions of having total freedom to do whatever they wanted, without concurrent responsibility.

A resident government system was instituted, but it initially functioned poorly because there was no agreement about the exact activities

[2] Jean Otto, Robert Shelton, and Penny Smail were instrumental in facilitating the detailed feedback and data analyses presented in the example.

for which the residents would be responsible. Staff agreed that if the residents were to take their responsibilities seriously, they must have real autonomy and decision-making power on some significant issues. The director, staff members, and residents then discussed specific activities for which the resident counselors and resident government could be responsible. A decision was made to try increasing autonomy by making the resident government a meaningful experience for the residents and an important line of communication and decision-making authority *vis-à-vis* the staff.

There were specific changes relative to autonomy. (a) A position of crew-job chairman was created. A resident was given the job of supervising work around the house as it was assigned and of checking the house daily to be sure that residents were doing their jobs adequately. There had been some confusion over specific responsibilities for each particular job, and the staff had been taking most of the responsibility for seeing that specific jobs were actually done. (b) A position of food manager was established. The food manager was responsible for checking menus and checking with other residents who were cooking dinner to be sure that they knew how to fix the meal and had all the supplies they needed. (c) The resident coordinator's position and sphere of responsibility were clarified. The coordinator was given the responsibility of supervising both the crew-job chairman and the food manager and the authority to call resident group meetings whenever residents needed to discuss house problems. In addition, he was placed on the screening committee for accepting new residents. As might be expected in an adolescent residential center, issues relevant to autonomy and staff control were particularly complex and were discussed in great detail.

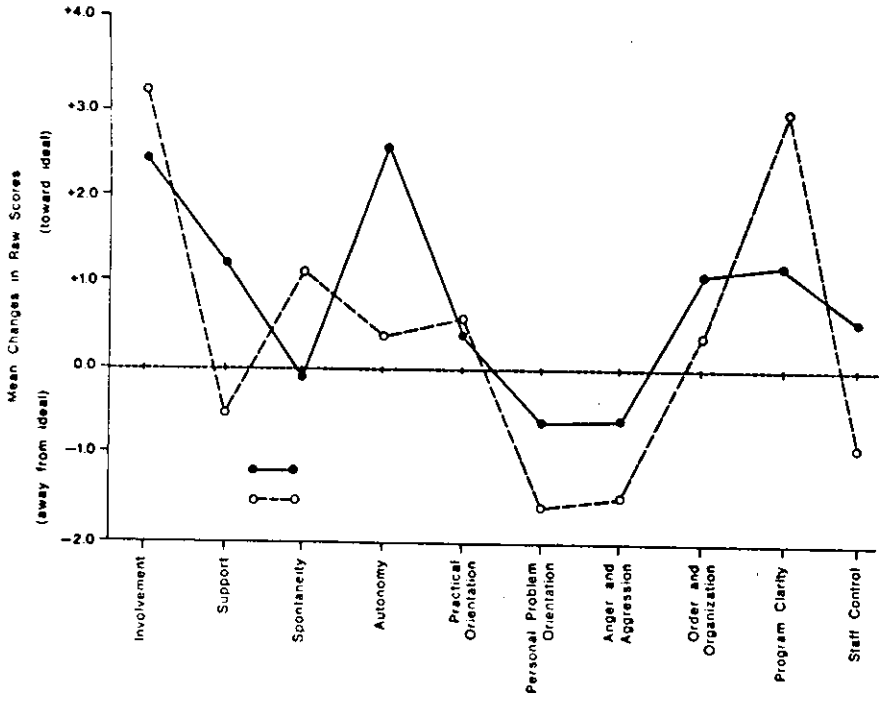
4. The changes made relating to these three major issues were also expected to increase Program Clarity. There was a great deal of discussion about this area in each of the resident staff meetings, and several specific attempts were made to increase the clarity of expectations, e.g., giving a resident the responsibility for teaching new residents their specific job obligations in the house, instituting a clearer process of individual goal setting, and establishing a new rating procedure by which each of the residents rated one another on specific characteristics.

New residents were required to keep a journal of their initial activities in and their reaction to the house. The journal was kept for two weeks and was used to help set personal goals. Originally, new residents were simply told that they should think of specific operational goals for them-

selves, but they were given no clear way of figuring out what areas of personal behavior they should try to improve nor how to do it. The journal was designed to help them focus on areas that others perceived to be problems for them. A procedure was also instituted for each new resident to meet with the director to go over his journal and set his goals.

Approximately six months after the initial testing, both COPES Form C and I were given to both residents and staff again. Figure 4 summarizes resident and staff mean changes in real-ideal program perceptions and discrepancies from the first to the second testing. Points above the zero line indicate that they perceived their program to be closer to their ideal program in the second testing; points below the zero line indicate that residents or staff perceived the program to be farther away from their ideal program in the second testing. On most dimensions (7 of 10), resi-

FIGURE 4.
Resident and Staff Mean Changes in Real-Ideal Program Discrepancies on Unit PC104 (from First to Second Testing)



dents felt that their treatment environment was closer to their ideal at the second than at the first testing. The largest changes occurred in the relationship dimensions of Involvement and Support, the treatment program dimension of Autonomy, and the system maintenance dimensions of Order and Organization and Program Clarity.

The staff felt (for 6 of 10 dimensions) that the program was closer to their ideal program at the second testing, particularly in the relationship dimensions of Involvement and Spontaneity and in the system maintenance dimension of Program Clarity. Thus, specific changes had occurred in each of the four major areas discussed in the house over the past several months.

In interpreting these results it should be noted that treatment environments, as assessed by the WAS and by the COPES, remain highly stable over relatively long periods of time (e.g., test-retest profile stabilities average above .80 over 6-12-month intervals as assessed by the intraclass correlation) when no change attempts are made. For example, the staff in the Pierce *et al.* (1972) study showed very high stability in their perceptions of their treatment environment on two assessments, made five months apart, before any changes were attempted. Thus it is extremely improbable that the above results are due to any simple test-retest phenomenon. A self-fulfilling prophecy may have influenced the results (e.g., staff perceive more support because they have tried to enhance support), but the evidence of specific behavioral and structural changes which were instituted, as detailed above, seems to militate against this explanation.[3] Independent outside observers should be used in future studies of this type, though there is the risk that they may themselves somehow become involved in the change process.

In this connection it is important to note that both residents and staff felt that the program was *further* from their ideal on the dimensions of Personal Problem Orientation and Anger and Aggression, mainly because during the program-change discussions residents and staff decided that they would *ideally* like less emphasis on these two areas. This finding illustrates the fact that concepts of an ideal environment also change as feedback and discussion sessions are instituted. Thus it is not possible to attempt to change a psychosocial environment toward a "static ideal."

[3] It is also possible that practice effects on the instrument or an interaction between the pretest and the "treatment" (discussion and action) may have occurred. Without a control group or the use of some non-fed-back change data, as in McElvaney & Miles (1971), it is not possible to assess this precisely. However, the differential changes noted in staff and residents' data are some indication that such effects did not occur.

Feedback of information must be considered as a dynamic, ongoing process that may result in changes in the concept of an ideal social environment, as well as changes in perceptions of the real environment. In addition, changes in concepts of an ideal environment may occur subsequent to change in the actual environment. Cooper (1970), in a follow-up of the Pierce *et al.* (1972) study, indicated that the ward staff's concept of an ideal treatment program, as assessed several months after the last testing, became more like the currently existing program.

DISCUSSION

The components of this methodology are founded on certain basic assumptions:

- The social environment must be systematically defined and assessed so that meaningful discussion and systematic evaluation of social change attempts can occur.
- All, or as many as possible, of the participants in a social system should be included in the various steps of both planning and instituting change.
- The individual motivations and goals of the participants need to be taken into account in formulating the directions and the methods for social change.
- The systematic utilization of research results can itself have an adaptive value in directing, facilitating, and evaluating change.

The feedback and discussion sessions function in a manner which makes practical applications of ongoing research. By initially tying research to current issues in a particular social system it is possible for individuals participating in the system to help design and cooperate in research that is both acceptable and relevant to their felt needs. This paradigm has been discussed by Miles *et al.* (1971), Menne (1967), and Heller (1969); Heller has pointed out that the increasing complexity and subtlety of problems investigated in field research have put a strain on standard research techniques. In any case, feedback and discussion sessions using perceived environment data may be an extremely important mechanism in the acceptance and use of research, as well as a critical source of information and ideas about future relevant research. In this

regard, easy-to-administer assessment instruments such as the WAS and the COPES may be reasonable short-term information-gathering techniques for overburdened staff lacking extensive facilities or personnel for evaluation. Techniques of this sort may shed light on the congruence of perceived environments from the perspectives of different groups, and they may help in articulating the relationship of the current environment to the goals of the social system.

Two important considerations may help to identify the conditions under which this methodology is most likely to be relevant. First, this methodology probably facilitates social change best when used with relatively small groups, most of whose members interact directly with one another. The method tends to utilize and maximize the involvement of each individual in the social setting and thus in the definition and facilitation of change. Second, the dimensions on which change is planned need to be under "local control." Thus, residents and staff in community-oriented psychiatric programs can profitably discuss attempts to change the degree of emphasis on Involvement, Support, Autonomy, and Clarity, because these variables are essentially under their control. Plans for effecting change in other important variables, such as the amount of money spent on each resident per day, the staffing ratio, and so on, may need to be handled in other ways.

The methodology is also directly linked with concepts of problem-solving, coping, and adaptive behavior. Many theorists have discussed each individual's active need for involvement, for efficacy, and for the prediction and control of his own environment (e.g., White, 1959). The active propensities of man-as-scientist, different aspects of stimulus and variety-seeking motivation, and cognition and information-seeking behavior must all be taken into account in planning effective social change methods. The methodology described here is consonant with these important needs, which include active molding of one's social environment in desired directions. Its use may help some individuals achieve a new competence; viz., being able to change and control their own environments.

The methodology is currently being used with a number of other newly derived perceived environment scales for other types of high-interaction groups, including small correctional cottages for young offenders, university residence halls (Gerst & Moos, 1973), and high school classrooms (Trickett & Moos, 1973). The hope is to broaden the method-

ology somewhat so that individualized dimensions particularly relevant to a specific social environment can be meaningfully assessed and utilized in change attempts.

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The need for consensus demands that individuals should be able to refuse agreement when they see no way of reaching it. . . . Shared action that rests on the voluntary or involuntary suppression of individual experience is a malignant sociological process.

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From "Group Forces in the Modification and Distortion of Judgments,"
Social Psychology