THE EFFECTIVENESS OF GROUP COUNSELING WITH A REHABILITATION FACILITY POPULATION

By

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ABSTRACT

This study was an attempt to evaluate the effectiveness of a treatment program instituted in a rehabilitation facility, which provides vocational and residential services for mentally retarded adults. In order to satisfy the increasing need for community-based facilities to help their clients adjust emotionally to community living, Cottonwood, Incorporated in Lawrence, Kansas began conducting weekly group counseling sessions with several clients. In particular, the goal of these group counseling sessions was to develop a more positive self-concept and better personal/social adjustment.

This investigator examined the ability of the groups to achieve these goals, by conducting an experiment with fourteen clients from the semi-independent living program. These clients were randomly assigned to an experimental or control group. The control group received no treatment and experimental received sixteen group counseling sessions over an eight week period. Both prior to and after these sessions, all subjects were administered the Coopersmith Self-Esteem Inventory and were rated by two direct-line supervisors on a Behavior Rating Scale, developed by the investigator.

Analysis of the results was done using the *t*-test for independent samples. There were no significant differences between experimental and control group mean scores on any of the measures.

It was believed that positive behavior changes occurred after counseling, but these were not reflected in the measurement instruments. It was concluded that group counseling with mentally retarded adults can produce

positive behavior changes and better personal/social adjustment, but furtherinvestigation needs to be conducted to determine the specific areas that are affected. Also, better instruments that measure self-concept and adjustment need to be developed for use with this population.

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CHAPTER 1

Introduction

In the majority of psychological literature on mental retardation, the focus has been on how mentally retarded individuals learn and the nature of their overt behavior. As stated in the November, 1983 issue of the Psychiatric Aspects of Mental Retardation Newsletter, "Too little attention has been paid to the inner experiences of the mentally retarded" (Sovner & DeNoyers - Hurley, 1983, p. 41). Examination of the inner experiences of this group is extremely important, because of the effect it has on all aspects of their lives. Mentally retarded individuals are faced with more difficulties in adjustment to the community than the non-handicapped population. Difficulties are encountered when trying to learn new skills that are necessary to successfully adjust to everyday situations such as cooking, cleaning, budgeting, etc. These difficulties are compounded when the mentally retarded individual has difficulty with the emotional aspects of his/her life.

Perhaps the most important area to discuss when examining the inner experiences is the self-concept of the mentally retarded.

> People discover their self-concepts from the kinds of experiences they have had with life; not from telling, but from experience. People develop feelings that they are liked, wanted, acceptable and able from having been liked, wanted, accepted and from having

> been successful. One learns that he is these things, not from being told so, but only through the experience of being treated as though he were so. (Combs, 1962, p.30)

Since the self-concept is developed through experiences one has in his/her life and mentally retarded individuals, in general, are faced with more failures, less acceptance, and more ridicule by others, then it would seem that they would have a more negative self-concept. This has been supported in the literature by several authors (Curtis, 1965; Meyerowitz, 1962; Morena & Litrownik, 1974; Piers & Harris, 1964; Snyder, 1966).

The self-concept is reflected in the behavior of an individual. "Studies have indicated that individuals who view themselves as incompetent tend to lack the confidence to cope effectively with the tasks of daily life. Often this low self-esteem results in the client's lowering the goals that they still have difficulty meeting" (Nooe, 1977, p. 320).

Because mentally retarded individuals in general have a lower self-concept and the low self-concept can lead to a lowering of goals, the ability of the mentally retarded to adjust to the community will be negatively affected. This population will encounter many barriers to their integration into community life and will have to work that much harder to be successful.

Besides the problems associated with having a negative self-concept, the mentally retarded population is vulnerable to a wide range of emotional and personality disturbances. Their low intelligence may increase the risk of emotional disturbance and yet, decrease the opportunity for adequate

treatment (Reiss, Levitan & McNally, 1982). This "dual-diagnosed" population is just recently being recognized as a prevalent, yet vastly underserved population. In a review of the literature on this subject, Mary Fowler found that emotional disturbances may afflict from 17% to 100% of the mentally retarded population. The mean percentage of the estimates was 47.25% (Fowler, 1982). Eisenberg (1958) states a reason why the mentally retarded may be susceptible to emotional disturbances. Any emotion involves cognitive activity and intelligent behavior is stimulated by, and in turn generates, emotional forces as motivation factors. He believes that it is inevitable that emotional dysfunction will be accompanied by retardation in intelligence to some extent and that defective intelligence must have a profound influence on emotional development.

Treatment of emotional disturbances in mentally retarded persons has generally been overlooked by the field of psychology and psychiatry. The reason may be that graduate programs in these fields do not prepare their students to deal with the mentally retarded population. The feeling in this field has been that mentally retarded individuals cannot benefit from treatment because they lack the intelligence for insight and do not have the verbal skills necessary for therapy. Treatment of emotional problems in mentally retarded individuals takes on added importance because of the impact their behavior has on the success of their adjustment to society.

In the early 1970's, deinstitutionalization, mainstreaming and normalization movements were the guiding principles for the field of mental retardation. Community-based facilities were growing with an increased

emphasis on maximizing the independence and attaining the fullest potential of the clients whom they served. These facilities were prepared to train these individuals to live and work independently through teaching vocational skills, banking skills, cooking, etc., but few put an emphasis on preparing mentally retarded individuals for the social and emotional aspects that are so important in adjustment. Developing a more positive self-concept and helping mentally retarded individuals with social and emotional problems needs to be addressed by the community-based facility to help integrate this population successfully in the community.

A program has been developed at Cottonwood, Incorporated in Lawrence, Kansas, a rehabilitation facility for mentally retarded adults, to deal with these areas. For the past two years, group counseling sessions have been conducted by the Support Services staff with several of the clients. The sessions are generally held once a week with five to eight clients and are conducted by the clients' case manager.

The purpose of this study is to evaluate the effectiveness of the group counseling sessions with a rehabilitation facility population. The specific areas to be examined are changes in self-concept and changes in personal/social adjustment. The following hypotheses are generated:

Hypothesis I: Counseled group members, in contrast to non-counseled group members, reveal a more positive self-concept as measured by a self-rating inventory.

Hypothesis II: Counseled group members, in contrast to non-counseled group members, exhibit significantly better adjustment, as seen in supervisor

ratings on a behavior scale.

CHAPTER II

Review of the Literature

It is assumed by this investigator that a positive self-concept and adjustment in personal/social areas will increase the chances that mentally retarded adults will adjust successfully to the community. Group counseling was the method chosen, in order to modify the above and increase success. A review of the literature was done in the areas of self-concept of, and group counseling with mentally retarded individuals. The following review can be divided into three sections: general studies on self-concept of the mentally retarded, correlates of self-concept and group counseling with mentally retarded and the effects on self-concept.

General Studies on Self-Concept with Mentally Retarded

Generally, those who have studied the self-concept of the mentally retarded are aware of the limitations of such research. Knight (1970) states that there is a lack of suitable measuring instruments and techniques to be used with this population. Several problems with self-concept research emerged from his review of the literature: (a) validity of the inventories, (b) level of defensive behavior of subjects, and (c) truthfulness of self reports. Despite these problems, there is still an interest in this important subject and

several studies have examined the self-concept of mentally retarded individuals.

Studying the self-concept of mentally retarded is a relatively new concern. As recently as 1965 McAfee and Cleland (1965) found only three studies using mentally retarded subjects. Since then, however, there has been an increased number of studies on this subject.

The early classic study was reported by Guthrie, Butler, and Gorlow (1961) in which the authors used female subjects to establish patterns of self attitudes in retardates. They concluded that self-concept is not unidimensional and that it is reflected in behavior. According to Guthrie et al, there are several different sets of self-attitudes around which self concept is organized. The authors cite three positive sets of attitudes and four negative ones.

Other early studies suggest that mentally retarded individuals have unrealistic self-concepts. Ringness (1961) studied 120 boys and girls of low, average, and high intelligence to determine if there was a difference in self-concept, as determined by self-report. It was found that low IQ children rated themselves higher than average children. It was stated that this may have been a reflection of the secure atmosphere of the special classroom in which they were placed. It was concluded that mentally retarded children generally tend to overestimate success and have less realistic self-concepts. Curtis (1965) used the Bills, Vance and McLean Index of Adjustment and Values and adapted it for use with mildly retarded adjusted and maladjusted males to determine the discrepancy between self-concept and ideal-self. It

was concluded that the males use normal peers as ideal self-models and society tends to do the same. It also revealed that the higher IQ mentally retarded males are more aware of the discrepency between their capacities and other capacities.

All studies have not concluded that the mentally retarded's self-concept is higher or similar to other groups. Meyerowitz (1962) tested 120 retarded and 60 non-retarded first graders on the Illinois Index of Self-Derogation. The retarded children demonstrated a significantly larger number of self-derogations.

Piers and Harris (1964) compared the responses of 88 institutionalized female retardates, ages sixteen to sixty-nine to those of public school children in grades 3, 6, and 10 and found that retardates had lower self-concepts than any other group. Snyder (1966) studied the difference between self-concept, personality adjustment and achievement level of retarded adolescents. He used the Laurelton Self-attitude Scale and the California Test of Personality and found the self-concept of retarded subjects to be lower. Of particular interest in this study is the finding that even the high achieving retarded subjects only scored at the 30th percentile on the California Test of Personality when compared to the non-retarded population of comparable chronological or mental age.

The Tennessee Self-Concept Scale (TSCS) was used by Collins and Burger (1970) to compare educable mentally retarded adolescents' self-concept to their normal peers. The subjects were 61 adolescents from the middle

socioeconomic level who attended Catholic schools in St. Louis. It was concluded that mentally retarded subjects were significantly more defensive and less able to take criticism. The most important score in the TSCS is the Total Positive Score and no significant differences were found in this area. The Educable Mentally Retarded scored at the 15th percentile and the normal group at the 20th percentile, both considered to be low self-concepts. In a follow-up study by Collins, Burger and Doherty (1970) the results were supported, suggesting that the effects of mental retardation are not global, but specific to various aspects of self-concept.

Morena and Litrownik (1974) compared 48 educable mentally retarded and emotionally handicapped children on the Coopersmith Self-Esteem Inventory, the Nowicki-Strickland Locus of Control Scale for Children and three behavioral measures: (a) risk-taking, (b) a chance/skill task, and (c) delay of gratification. Both of these group's self-esteem scores fell approximately one standard deviation below the mean scores obtained in Coopersmith's standardization sample. The EMR's were also more defensive, more external, and less likely to delay gratification than the emotionally disturbed subjects. The authors concluded that retarded individuals "may have little regard for themselves because they see that what they do has little effect on their environment" (p. 290). They suggested that exposure to a self-confident role model and increasing opportunities for successful performance could change the behavior of EMR individuals.

The theory that mentally retarded individuals come to view themselves

negatively because of the label was challenged by Susan Stager, Laurie Chassin and Richard David Young (1983). They studied 50 educable mentally retarded adolescents who were enrolled in both special education and regular classrooms. The control group consisted of 330 non-retarded students. All subjects completed a questionaire which asked students to rate the following concepts: (a) Me in this Class, (b) A Popular Teenager, (c) A Juvenile Delinquent, (d) A Special Education Student, (e) a Football Player, and (f) An Honor Student. Subjects also completed the Rosenberg-Simmons Self-Esteem Scale. Lastly, they rated the importance of seven different aspects of self; for example, school achievement, physical attractiveness, etc. The results showed no significant difference between retarded and non-retarded on the self-esteem scale, but if the individual believes that the societal view of his or her label is similar to the self and the individual has a negative view of the label, then it is associated with low self-esteem. Therefore, the personal relevance of the label to the individual is seen as an important determinant of self-esteem.

Correlates of Self-Concept

Intelligence

Lawrence and Winschell (1973) in an extensive review of the literature on self-concept of the mentally retarded cite studies which seem to indicate that mentally retarded subjects with higher IQ's have more positive self-esteem. These studies are limited by the paucity of research on severely

and profoundly retarded individuals. McGarvie (1970) studied only educable mentally retarded students and found that the higher the IQ in this range, the higher the self-concept. Gorlow, Butler and Guthrie (1963), Curtis (1965), and LoBianco (1966) also obtained similar results. These findings are contrary to the belief that the more severely retarded are oblivious to their retardation and therefore have better self-esteem and that the higher functioning mentally retarded are more aware of their shortcomings and therefore have lower self-esteem. This is supported by McAfee and Cleland (1965), whose results showed that higher IQ mentally retarded individuals are more aware of the descrepancy between their capacities and thosa of their non-retarded peers.

Age

The effect of age on the self-concept has received very little attention. There were no studies found by this author, which compared age and self-concept. Most studies that have studied age as a correlate in the development of self-concept have used adolescent and young adult subjects, because of the verbal skills and insight that is felt to be important in measuring self-concept. Assessment of self-concept has been accomplished with children in some studies. Meyerowitz (1962) and LoBianco (1966) have tested six and seven year-old children successfully with the Illinois Index of Self-Derogation and the California Test of Personality, respectively. Their findings indicate increased personal adjustment with increase chronological age.

Summary

Research on the self-concept of mentally retarded subjects has provided inconsistent results. Subjects have generally been in the mildly retarded range and are usually adolescents or young adults.

Of the eight studies which were examined in detail which compare retarded to non-retarded subjects, four concluded that mentally retarded individuals have a lower self-concept, three showed no significant difference and one concluded that self-concept is higher in the educable mentally retarded. The lack of consistent results may be attributed to lack of valid measures, as noted by Knight (1970). All the studies which were reviewed used different methods of measurement and most had a different definition of self-concept. Some considered self-concept to be a unidimensional concept, while others feel there are many aspects to the self-concept. Therefore, no conclusions can be made about the self-concept of the mentally retarded.

Studies which investigate the correlates are scarce. It is generally concluded that the higher the IQ within the mentally retarded the more positive the self-concept. It is generally accepted that mentally retarded individuals are more defensive than their non-retarded peers. Since this is so, it could be that the higher self-concept scores are a reflection of this defensiveness.

Group Counseling with the Mentally Retarded

As early as 1936, psychoanalysis with mentally retarded individuals was applied by Leona Chidester and Karl Menninger. They attempted to treat the emotional disturbances of a mentally retarded boy in hopes of curing his inability to learn. They obtained positive results, although they were not able to "cure" him. Since this first attempt, psychotherapy has been supported by many in the field of mental retardation, but has decreased as an area of emphasis in the field of mental health.

Studies of the 1940's

Despite Chidester and Menningers' support of treatment of emotional disturbance in mentally retarded, the 1940's saw few studies attempting to further their positive findings. Lillian Glassman (1943) of the Smith College School of Social Work studied dull normal individuals and those with IQ's of 110 or above and concluded that the borderline defectives could benefit from service in child guidance clinics. Slavson, Wiener and Scheidlinger (1945) used activity group therapy with a dull boy. It was felt that this therapy was beneficial. Another study by Cotzin (1948), determined that mentally defective problem boys can correct and improve personality and social adjustment in psychotherapy.

> This can be effected either through release (a freedom to express aggression or hostility or an opportunity to act out feelings and impulses), through possible insight (the opportunity to relate one's self to others in a concrete situation) or through a more adequate diagnosis and insight on the part of the therapist.(p. 281)

Frederick Thorne (1948), in the first systematic attempt at individual psychotherapy, concluded that counseling mental defectives was both possible and profitable in an institutional setting.

Even with these positive results by these authors, psychotherapy and counseling with the mentally retarded was still seen by many during this period as a waste of time. (Lurie, Levy and Rosenthal, 1944; Hutton, 1945; Paster, 1944).

Studies of the 1950's

The 1950's saw a period of increased concern in the area of therapy with mentally retarded. This was obviously a reflection of society's changing attitude about mental retardation. There was an increased concern with providing treatment for this population, instead of custodial care. The majority of studies supported therapy as a form of treatment (Astrachan, 1955; Burton, 1954; Heiser, 1954; Michal-Smith et al., 1955; Neham, 1953; Ringelheim and Polatsek, 1955; Thorne and Dolan, 1953; Yepsen, 1952).Many articles supporting psychotherapy with mentally retarded can be found in an

excellent book by Stacey and DeMartino (1957) entitled, Counseling and Psychotherapy with the Mentally Retarded.

In a well-researched study conducted by O'Connor and Yonge (1955) the results of psychotherapy were evaluated with unstable defective delinquents. Three groups of boys, ages sixteen to twenty-four, were studied. The groups consisted of: (a) basic control group, who continued normal hospital life; (b) a group which received psychotherapy in addition to workshop training; and (c) a group, which received workshop training with no other special treatment. Time sampling of workshop behavior, check lists during therapy, and hospital records of punishment were the methods of evaluation. The results showed that the group who received psychotherapy changed in terms of positive attitudes and behaviors.

Wilcox and Guthrie (1957) also conducted a study to determine if any changes in adjustment occurred after group psychotherapy. They studied 150 institutionalized females, ages fifteen to forty-three, with IQ's ranging from 53 to 90. There were twelve experimental and three control groups. All the females were rated by three supervisors on a rating form which measured Care and Social Responsibility, Interpersonal Relations, Self-Control and Work and Recreation. The experimental groups then attended twenty-five group sessions whose goals were to: (a) reduce the suspiciousness the girls felt toward others, (b) release aggressions, (c) encourage feelings of self-confidence and self-worth, and (d) to develop a feeling of responsibility for their actions. The results showed that fifty-two girls showed an increase

in positive ratings overall in the experimental group versus four in the control, which was a significant difference.

Snyder and Sechrest (1959) conducted a study into the effects of directive group therapy with sixteen defective delinquents, whose average age was nineteen. They hypothesized that the experimental group would show significant improvement over "placebo" and no-treatment groups in adjustment to the institution, as shown by reduction in the number of negative comments on housing reports, an increase in the number of positive comments on these reports, and by fewer reports for serious conduct violations. The placebo group received nondirective therapy, while the experimental group was directive and goal-directed. The results showed that the number of negative comments decreased significantly in the experimental group. The experimental group also had only two members disciplined, the placebo six, and the control group had eight. This seems to show that group therapy does improve the immediate adjustment of the inmates and that directive therapy appears to be the most useful type of therapy.

Studies of the 1960's

Support for counseling of the mentally retarded continued during this decade. Sternlicht (1965) examined psychotherapeutic techniques that he felt would be useful with the mentally retarded. He included in this list projective tests, fingerpainting, music therapy, dance therapy, relationship therapy, ego-supportive therapy, directive counseling, social casework, play therapy,

psychodrama, and group therapy. He suggested that the first step in the program of psychotherapy would be to counsel those whom the mentally retarded is dependent upon for care. Fine and Caldwell (1964) and Rotman and Golburgh (1967) believed that group counseling was an effective method to be used with mentally retarded individuals.

The number of research studies investigating the effects of group therapy increased during the 1960's. Gorlow, Butler, Einig and Smith (1963) investigated changes in self-attitudes and behavior in seventy-nine young adult female mentally retarded individuals in institutions after group psychotherapy. They hypothesized that greater self-acceptance and more positive behaviors would occur in the areas of self-care, responsibility and interpersonal relations after therapy. Wilcox's Behavior Rating Scale and the Laurelton Self-Attitude Scale were used to measure the above. They concluded that, "group therapy was not observed to alter self-attitudes in the direction of greater self-acceptance nor did it materially influence the institutional behavior of the subjects".(p. 896)

Humes, Adamczyk and Myco (1969) investigated the effects group counseling had on the adjustment, personality, self-concept and choices on a sociometric test of twenty-eight EMR males and females. There were two counseled groups that received twelve hours of problem-oriented counseling and two control groups that received twelve hours of occupational and vocational information-giving classroom instruction. Results showed a significant change in the adjustment of the counseled groups, as seen in

teacher ratings, increased scores on a personality inventory and a change in choices on sociometric test, but failed to show any change in self-concept. Because of the positive changes that they did obtain, they recommended counseling with this population.

Mann Beaber and Jacobsen (1969) attempted to effect a change in the self-concept of EMR boys through the use of group counseling. Thirty-six EMR boys attending public schools were divided into experimental and control groups. The experimental group received group counseling over a twelve week period. The control group received twelve library sessions, with reading and study. The subjects were pretested on the Index of Status Characteristics, The Children's Self-Concept Scale, The Way I Feel About Myself Scale, The Children's Form of the Manifest Anxiety Scale, and the Pupil Behavior Rating Scale. The results showed that self-concept improved when measured by the Children's Self-Concept Scale, but not the other measures. There was also a reduction in anxiety and improvement in deportment, reading and arithmetic. They concluded that "self-concept can be modified through group counseling within the school setting".(p. 365)

Studies of the 1970's

Group counseling with mentally retarded persons was the issue addressed by Vance, McGee and Finkle in 1977. In this excellent article, the authors gave a summary of the research and some suggestions on group process with the mentally retarded population. They believed that the lack of interest in

counseling with this population could be attributed to several reasons. In the first place, graduate programs in psychology do not prepare students to deal with the mentally retarded. This could be because mentally retarded persons are infrequent self-referrals for help with emotional problems and many are unable to pay for psychological services. But, the main reason according to the authors seems to be that:

> Many counselors simply regard retarded individuals as unsuitable for counseling. It is assumed that:
>
> (a) retarded people experience less psychic distress and emotional pain than "normal" individuals and thus do not need counseling;
>
> (b) counseling requires verbal skills that most retarded individuals lack;
>
> (c) work with retarded individuals is too time-consuming and slow, with little to show as a result;
>
> (d) retarded persons are unable to engage in abstract thinking and seldom gain insight into their problems; and
>
> (e) an interesting and challenging client is one who has high intelligence".(p. 148)

After review of the literature, they concluded that "group counseling can assist retarded individuals to gain a clearer understanding of themselves and acceptance of themselves, to improve social relationships and to cope with problems of everyday adjustment confronting them at home, school, work and in the community" (p. 150).

Davis and Shapiro (1979), in the only article dealing with mentally retarded adults in a work-activity center, concluded that group process was beneficial for their expressiveness, socialization skills and self-image. Although this was not an experimental study, the authors strongly believed that group process was a powerful tool for treatment of this group.

Experimental studies into the effect of group counseling on self-concept increased during the 1970's especially in doctoral dissertations. McDaniel (1971) and Poole (1972) evaluated the effectiveness of group counseling on EMR students self-concept and both yielded positive results. McDaniel used the Children's Self-Concept Scale and Poole used the Tennessee Self-Concept Scale.

No significant difference in self-concept was found by Eldridge (1974), Amore (1979) or Blohm (1979), who used a group counseling approach with children.

Studies of the 1980's

Counseling of the mentally retarded in public schools has been studied by Janus and Podolec (1982), who believe that the success of the group is dependent on the social-emotional make-up of the members, not whether or not they are retarded. The advantages of group counseling with mentally retarded, according to these authors, include:

(a) economy in terms of time and money;

(b) opportunity for the development of social skills and interpersonal

relationships within a controlled context;

(c) provision of an environment where the feelings of isolation and differentness of the retardate may be lessened;

(d) opportunity for giving and receiving peer support;

(e) provision of a controlled environment for the release of anxiety, frustration and tension;

(f) peer influence in terms of problem-solving and learning to cope with the social situations they are likely to encounter once outside the group; and

(g) the opportunity for the therapist to gain insight into the behaviors of the group members which may be used in making appropriate recommendations to direct care and teaching staff who are involved with them.

Stanley Slivkin (Seligman, 1982) discussed group process in the mentally retarded population. He described three broad phases of the group as being rejection, conditional acceptance and sharing. He recommended structuring group activity, reinforcement of reality, limit setting and active teaching as most appropriate with these groups. He does believe that increased self-esteem and social competence are attainable goal for retarded persons who participate in group counseling.

Summary

Counseling and psychotherapy with mentally retarded individuals and groups has been supported by the field of mental retardation for almost fifty

years. It is interesting to note the lack of interest in this area by the field of mental health. In the review of the literature on this subject, no articles were found on mentally retarded persons in the International Journal of Group Psychotherapy and very few in the Journal of Clinical Psychology. This is an area that appears to have been virtually ignored by the majority in the field of mental health.

The vast majority of articles, both research and non-research that investigate the effects of group counseling with mentally retarded support it. Most articles show some change in personal adjustment, behavior or scores on achievement tests. The articles which look more specifically at the effects or group counseling on self-concept seem to run into the same problems as the studies that deal with the self-concept of the mentally retarded. The results are inconsistent. Generally, those which are not research studies conclude that self-concept has improved, and those which are research studies generally show no change after therapy.

CHAPTER III

Description of the Investigation

The purpose of this investigation was to evaluate the effectiveness of group counseling sessions with a rehabilitation facility population. Specifically, the areas to be examined were self-concept, as measured by a self-rating inventory and adjustment, as determined by supervisory ratings.

Description of the Setting

The setting of this study was Cottonwood, Incorporated in Lawrence, Kansas, a rehabilitation facility which provides vocational and residential services for mentally retarded adults. There were ninety-two clients in the vocational program and fifty-nine in the residential program at the time of the study. The clients attended the workshop daily for six hours, during which time they were involved in various contract jobs or work training. Ten clients were also competitively employed. The diagnosis of the population at Cottonwood was varied, from profound retardation to schizophrenia, with no retardation. The age range was also varied, from age eighteen to eighty. There were fifty-one males and forty-one females. The majority of the clients previously attended schools in which they were enrolled in Special Education, although some had been institutionalized until the time they were accepted into the Cottonwood program.

The specific setting in which the group counseling sessions took place was a conference room. The room had no windows, so there was very little distraction.

Description of the Population

The fourteen subjects who participated in this study were chosen based on two criteria. They all had to be involved in the Semi-Independent Living Program and they could not be involved in any other group counseling sessions at the time of the study. The subjects were then randomly assigned to control or experimental groups.

The experimental group had an average IQ of 71.71, with a range of 57 to 108. The average age was 35 years, with a range of 24 to 55. Control group mean IQ was 69.71, with a range of 57 to 85 and average age of 39 years, with a range of 25 to 55. Five of the experimental group and five of the control group had previously attended Special Education programs. One of both the control and experimental groups had been institutionalized during their school years and had no formal education. One subject of both groups had attended regular classes in school and had not been diagnosed as mentally retarded.

The population of the group was, for the most part, an accurate reflection of the total population of Cottonwood, in that there was a wide age range and range in functioning level. They all had in common their living arrangement. They all lived in apartments, either alone or with one roommate, and therefore, lived in what may be considered a more normalized environment. They had more contact with the community than other Cottonwood clients. This population may have particular problems in

adjustment to the community, because of the increased contact and the degree of independence.

The following is a brief description of each subject, who participated in the experimental group:

Subject A

Subject A was a thirty-year old woman, who had been diagnosed as mildly mentally retarded, obtaining a Full Scale IQ on the WAIS of 59. She also had been diagnosed as schizophrenic. She had been at Cottonwood for nine years, having previously spent six years in an institution. She also had attended school in Special Education prior to being placed at the institution. In a psychological evaluation, she was said to be dependent and immature. It was also stated that she regards herself as much more inadequate than she really is.

Subject B

This subject was a twenty-four old woman, who was diagnosed as mildly retarded, with a WAIS Full Scale IQ of 66. She had attended Special Education, until her graduation. She had poor family relationships and was accepted on an emergency basis, due to abuse at the home. She was a very withdrawn and insecure individual, who often expressed frustration with her association with Cottonwood and retardation.

Subject C

Subject C was a male, who was forty years old at the time of the study. He had a Full Scale IQ of 78, which placed him at the borderline range of

functioning. He had just recently been accepted into the program, after losing a job in which he had been successfully employed for thirteen years. The restaurant in which he worked was forced out of business and the restaurant which replaced it demanded a higher quality of work than this subject was apparently able to provide. At the time of the study, he was employed part-time as a dishwasher at Pizza Hut and was doing high quality work. Subject C attended Special Education and appeared to be fascinated with the English language. He talked at length with clients and staff about reading and writing.

Subject D

This was a twenty-five year old female, who had been diagnosed as mildly retarded, with an IQ of 63. She also had epilepsy. Subject D had been married and divorced twice, had a child, who was in the custody of her brother-in-law at the time of the study, had been in jail for writing bad checks, had been addicted to drugs and had attempted suicide. She had been referred to Cottonwood by her parole officer. She had stated a desire to get her life back in order and obtain vocational skills, so she could get custody of her daughter.

Subject E

Subject E had been institutionalized since he was an infant and had no family. He was forty-five years old and obtained Full Scale IQ of 57 on the WAIS, indicating mild mental retardation. He was competitively employed at two jobs at the time of the study and only received residential and support

services from Cottonwood. He had to provide his own transportation to the group sessions, since he did not work at the facility. This subject exhibited extreme difficulty in relating with others. He had been diagnosed in a psychological evaluation as paranoid and exhibited defensive behaviors in most interactions.

Subject F

Subject F was a twenty-eight year old, borderline mentally retarded male. He was the only married member of the group. He had received a Full Scale IQ of 71 on the WAIS. He was also diagnosed as having multiple sclerosis, which is progressively getting worse. At the time of the study, he was employed at a bakery, but lost this job during the sessions, due to his deteriorating condition. Subject F was very concerned with the disease and the effects it was having on his ability to work and participate in sports. He constantly wanted to discuss this subject with staff and clients.

Subject G

This was a fifty-five year old male client, who had been diagnosed as schizophrenic. He had received a Full Scale IQ of 108 on the WAIS. He lived wit his mother in a nursing home, until she died. He was also institutionalized for three years after a "nervous breakdown". He had no relatives with whom he kept in contact with during the time of the study. He was a very withdrawn and quiet individual, but was extremely capable of performing all jobs that were given to him. He seemed to have adjusted to the environment of Cottonwood and did not appear to have any desire to achieve a greater

amount of independence.

Description of the Instruments

The Adult Form of the Self-Esteem Inventory (Coopersmith, 1975) was chosen to measure self-concept of the subjects (see Appendix A). The Self-Esteem Inventory consists of three forms. Form A is the original form, which was developed for use with children. It consists of 58 questions and five subscales. Form B is briefer and faster to administer, and is also to be used with children. Form C was developed for those over fifteen years of age, because they were not comfortable with the wording of the other forms of the inventory. It consists of 25 questions that are more meaningful to persons whose life is not as closely bound to parents and school. The administration time for the form is approximately fifteen minutes, half of the time of Form A. Test-retest reliability with adults was .88 over a five month period. This short adult form also correlates .86 with the total scores of the long form. The mean score for groups over 15 years is 76.1, with a standard deviation of 11.1.

The test is administered by marking the statements as "Like Me" or "Unlike Me". In this study, the inventory was administered orally to deal with reading difficulties of some of the subjects. It is scored by counting the number of responses that indicate high self-esteem and multiplying this number by four.

A Behavior Rating Scale was developed by this investigator in an attempt

to assess those areas that the group would possibly modify. There are ten questions that are ranked from best adjusted behavior to least adjusted behaviors (Appendix B). In order to determine reliability of this instrument, two of the subjects' close supervisors completed the form. The results are discussed in Chapter IV.

A score was derived for each Behavior Rating Scale done on each subject, by ranking each item from four to one, based on the level of adjustment of the behavior. Each response was then added to get an overall score.

Procedure

All subjects who participated in the study attended an initial meeting for the purpose of receiving the subjects' consent to participate, to administer the Coopersmith Self-Esteem Inventory and to identify the control and experimental groups. The consent form can be seen in Appendix C. Immediately prior to this initial meeting, the Behavior Rating Scale was distributed to two of each subject's direct-line supervisors. The supervisors were chosen based on the amount of contact with the client, in order to ensure the most accurate results on the scale. These were completed and returned to the investigator the next day.

Group counseling sessions began with the experimental group two days after the initial meeting. These sessions were conducted twice a week for eight weeks. They lasted from one half-hour to forty-five minutes. These sessions were held in a conference room every time except twice, when

circumstances demanded that they be held in the client break room. During the eight weeks in which the experimental group attended group sessions, the control group received no treatment and continued with the normal workshop routine.

The sessions were conducted by the Support Services Coordinator and this investigator. The Support Services Coordinator had taken graduate coursework in counseling and had extensive experience with counseling with mentally retarded adults at a mental health center in Johnson County, Kansas. The investigator's experience was limited to a bachelor's degree in psychology and there hours of graduate coursework in counseling.

Each session was focused around a predetermined topic, unless a problem was brought up by a client. The group leaders attempted to provide a supportive environment in order to facilitate the interactions between the clients and the development of insights into their own behavior. No specific therapeutic approach was followed in the groups. The reasons for this were the lack of professional training in group psychotherapy that the group facilitators had received and the belief by this investigator that groups are all different and no therapy can be done consistently in any group of mentally retarded adults. In some aspects, the sessions could be considered to be directive in that a topic was focused on during the sessions and the facilitators would help the clients examine the topic and encourage their thinking about it through questions.

The topics to be discussed in the sessions were determined in several

ways. The investigator first examined areas in which the majority of the subjects showed a weakness on the Behavior Rating Scale and low self-esteem on the Self-Esteem Inventory. On the Self-Esteem Inventory, twelve of the fourteen subjects indicated that they felt they were not as nice-looking as mos people and twelve felt they gave in too easily. Six of the seven experimental group subjects also indicated that there were a lot of things about themselves they would change if they could. The Behavior Rating Scale indicated that most of the subjects had difficulties with personal problem-solving. These areas were determined to be important to discuss in the group.

A second method of determining topics was by asking the clients what they wanted to accomplish in the group. The first meeting was spent with the clients generating topics for discussion. They decided they would like to discuss getting along with others, dealing with shyness, assertiveness, and learning how to solve problems independently. It was noted that several of the concerns that were indicated on the Self-Esteem Inventory and the Behavior Rating Scale were brought up by the clients in the first meeting.

Other topics were generated through discussions between the group facilitators, before and after the group counseling sessions. For example, the facilitators felt that in order for the clients to learn to accept their disability they would need to understand what mental retardation was and how they received the label. It was also felt that the clients would need to focus on what things they could do and not what they were unable to do.

With the initial topics determined, the group counseling sessions began. After eight weeks with the experimental group in counseling, all subjects were again administered the Coopersmith Self-Esteem Inventory and two supervisors completed the Behavior Rating Scale.

Analysis of Results

The *t*-test for independent samples was used to compare the mean difference scores of the two groups. This procedure is recommended for comparisons of samples this size by Spatz and Johnston (1976). A .05 level of significance was set. Correlations of the pre and posttest scores on the Behavior Rating Scale were computed using Spearman's *rho* in order to assess the reliability of this measure (Spatz and Johnston, 1976).

Hypotheses

The following hypotheses were formulated in order to evaluate the effectiveness of the group counseling sessions:

Hypothesis I: Counseled group members, in contrast to non-counseled group members, reveal a more positive self-concept, as measured by a self-rating inventory.

Hypothesis II: Counseled group members, in contrast to non-counseled group members, exhibit significantly better adjustment, as seen in supervisor ratings on a behavior scale.

Summary

The purpose of this study was to evaluate the effectiveness of group counseling with a rehabilitation facility population. Fourteen clients were randomly assigned to either a control group with no treatment, or an experimental group. The experimental group attended sixteen group counseling sessions. Both groups were pre and posttested on a Self-Esteem Inventory and a Behavior Rating Scale. Analysis of the data collected from these measures is presented in Chapter IV.

CHAPTER IV

Results

Development of a positive self-concept and appropriate personal and social behaviors was assumed by this investigator to be a major determinant of success for mentally retarded adults in the community. Based on this assumption, group counseling sessions were being conducted at Cottonwood, Incorporated, a rehabilitation facility for mentally retarded adults in Lawrence, Kansas. The purpose of the group sessions was to provide a supportive environment in order to facilitate interactions between the clients and the development of insights into their own behavior. The ultimate goal, and basis on which topics were chosen, was the development of a positive self-concept and appropriate personal/social behaviors.

The purpose of this study was to evaluate the effectiveness of the group counseling sessions, focusing specifically on the effects on self-concept and personal/social behaviors. This was accomplished by the selection of fourteen clients, who were in the semi-independent living program, and the random assignment of these clients into experimental or control groups. The control group received no treatment and continued with normal work shop routine, while the experimental group attended sixteen group counseling sessions.

Measurement of self-concept was done through the use of Coopersmith's Self-Esteem Inventory. Personal/social behaviors were measured by a Behavior Rating Scale, developed by this investigator. All subjects were administered

the self-esteem inventory and supervisory ratings were obtained on the behavior scale, both prior to treatment and after treatment.

In order to analyze the data, the *t*-test for independent samples was used. The level of significance was set to .05. Reliability of the Behavior Rating Scale was examined using the Spearman's *rho*.

Reliability

Two supervisors completed the Behavior Rating Scale in order to establish reliability of the instrument, which was developed by this investigator. The raters completed both a pre and posttest measure. The supervisors were chosen based on their familiarity and the amount of contact with the client. The percent of absolute agreement was computed for the scale, as one measure of reliability. The range was from 20% agreement to 80% agreement, with a mean of 47%

Spearman's *rho* was also computed as another indication of the reliability of the instrument. This was done separately for pretest and posttest scores.

Correlation of the pretest scores revealed a r_{rho} of .396. When tested for significance, it was converted to a *t* value of 1.49. This fails to reach the critical value of 1.78, when applying 12 degrees of freedom at the .05 level of significance. Therefore, the correlation was not significant.

The posttest correlation revealed r_{rho} to be -.03. When tested for significance, this score was converted to a *t* value of -.104. This fails to reach the critical value of 1.78. This correlation also was not significant. In

general, the Behavior Rating Scale was not a reliable measure of the client's behavior.

Analysis of the Hypotheses

The first hypothesis stated that counseled group members, in contrast to non-counseled group members, would reveal a more positive self-concept, as measured by the Coopersmith Self-Esteem Inventory. The fourteen clients who participated in the study completed the inventory twice, separated by an eight week interval. The scores of the experimental group and control group on both the pre and posttests are shown in Table 1.

Table 1

Scores on the Self-Esteem Inventory

Counseled Group Members			Non-counseled Group Members		
	Pretest	Posttest		Pretest	Posttest
A.	44	60	H.	64	56
B.	32	28	I.	48	64
C.	60	80	J.	68	76
D.	16	48	K.	68	88
E.	48	40	L.	48	68
F.	52	68	M.	64	84
G.	100	100.	N.	64	64

A t-test for independent samples was used to compare the mean difference scores of the two groups. The test revealed a t value of -.082, indicating no significant difference between the two groups. This is summarized in Table 2.

Table 2

Comparison of the Mean Difference Scores on the Self-Esteem Inventory

Difference in Scores				
Counseled Group			Non-counseled Group	
A. 16		H.	-8	
B. -4		I.	16	
C. 20	$\Sigma X_1 = 72$	J.	8	$\Sigma X_2 = 76$
D. 32	$\Sigma X_1^2 = 2016$	K.	20	$\Sigma X_2^2 = 1584$
E. -8	N = 7	L.	20	N = 7
F. 16	$\bar{X}_1 = 10.286$	M.	20	$\bar{X}_2 = 10.86$
G. 0		N.	0	

t = -.082; df = 7+7-2 = 12

The t value of -.082 fails to reach the critical value of 1.78 for a test between two independent samples (with df = 12 and alpha = .05). Therefore, any difference that occured in the scores between the groups is attributable

to chance.

The second hypothesis stated that counseled group members, in contrast to non-counseled group members, would exhibit significantly better personal/social adjustment, as seen in supervisory ratings on a behavior scale. Two supervisors independently completed this scale for each client in the study. In all cases but one, the clients were rated by the same supervisor on the pre to posttest measures. There was an eight week interval between the completion of the Behavior Rating Scale. Scores on one of the Behavior Rating Scales which was completed by a supervisor are given in Table 3.

Table 3

Scores on Behavior Rating Scale I

Counseled Group Members			Non-counseled Group Members		
	Pretest	Posttest		Pretest	Posttest
A.	29	30	H.	35	27
B.	33	31	I.	35	30
C.	33	32	J.	29	31
D.	31	30	K.	22	31
E.	28	31	L.	33	35
F.	31	25	M.	34	36
G.	34	34	N.	38	37

A $\underline{t}$-test for independent samples was used to compare the mean difference scores of the two groups. The test revealed a $\underline{t}$ value of -.428, indicating no significant difference between the two groups. This is summarized in Table 4.

Table 4

Comparison of the Mean Difference Scores on Behavior Rating Scale I

Difference In Scores					
Counseled Group			Non-Counseled Group		
A.	1		H.	-8	
B.	-2		I.	-5	$\Sigma X_2 = 3$
C.	-1	$\Sigma X_1 = -6$	J.	2	$\Sigma X_2^2 = 183$
D.	-1	$\Sigma X_1^2 = 52$	K.	9	$N = 7$
E.	3	$N = 7$	L.	2	$\bar{X}_2 = .143$
F.	-6	$\bar{X}_1 = -.857$	M.	2	
F.	0		N.	1	

$\underline{t} = -.43$; $\underline{df} = 7+7-2 = 12$

The $\underline{t}$ value of -.43 fails to reach the critical value of 1.78 for a test

between two independent samples (with *df* = 12 and alpha = .05). Therefore any difference that occurred in the scores between the groups is attributable to chance.

The scores that were obtained from the second Behavior Rating Scale are shown in Table 5.

Table 5

Scores on Behavior Rating Scale II

Counseled Group Members			Non-Counseled Group Members		
	Pretest	Posttest		Pretest	Posttest
A.	25	26	H.	37	39
B.	27	26	I.	29	33
C.	27	31	J.	34	33
D.	34	36	K.	27	24
E.	27	23	L.	36	36
F.	32	35	M.	31	36
G.	36	36	N.	30	33

A *t*-test for independent samples was use to compare the mean difference scores of the two groups. The test revealed a *t* value of -.48, indicating no

significant difference between the two groups. This is summarized in Table 6.

Table 6

Comparison of the Mean Difference Scores on Behavior Rating Scale II

Differences in Scores

Counseled Group			Non-counseled Group		
A.	1		H.	2	
B.	-1		I.	4	
C.	4	$\Sigma X_1 = 5$	J.	-1	$\Sigma X_2 = 10$
D.	2	$\Sigma X_1^2 = 47$	K.	-3	$\Sigma X_2^2 = 64$
E.	-4	$N = 7$	L.	0	$N = 7$
F.	3	$\bar{X}_1 = .71$	M.	5	$\bar{X}_2 = 1.42$
G.	0		N.	3	

$\underline{T} = -.48$; $\underline{df} = 7+7-2 = 12$

The $\underline{t}$ value of -.48 fails to reach the critical value of 1.78 for a test between two independent samples (with $\underline{df}$ = 12 and alpha = .05). Therefore, any difference that occurred in the scored between the groups is attributable to chance.

Summary

Two hypotheses were formulated to evaluate the effectiveness of group counseling with a rehabilitation facility population. The hypotheses were analyzed using the *t*-test for independent samples. Hypothesis I stated that the counseled group members would reveal a more positive self-concept than the non-counseled members. This had to be rejected. The difference in scores of the two groups were analyzed using the *t*-test and no significant differences were found.

The second hypothesis stated that counseled group members would exhibit better personal/social adjustment, when compared to non-counseled group members. Before the *t* test was administered to these results, reliability of the Behavior Rating Scale was examined through Spearman's *rho* and by computing the percentage of absolute agreement between the two supervisors. The correlation of pre and posttest scores was .39 and -.10, respectively. Percent agreement ranged from 20% to 80% with a mean of 47%. This indicates that the Behavior Rating Scale had low reliability.

Hypothesis II was analyzed using the *t*-test for independent samples. The hypothesis was rejected at the .05 level of significance. There was no significant difference between the two groups in personal/social adjustment, as measured by the Behavior Rating Scale.

CHAPTER 5

Discussion

This study was an attempt to evaluate the effectiveness of a treatment program instituted by a rehabilitation facility, which provides vocational and residential services for mentally retarded adults. In order to satisfy the increasing need for community-based facilities to help their clients adjust emotionaly to community living, Cottonwood, Incorporated in Lawrence, Kansas began conducting group counseling sessions weekly with several clients. In particular, the goal of group counseling was to develop a more positive self-concept and better personal/social adjustment.

This investigator examined the ability of the groups to achieve these goals by conducting an experiment with a control and experimental group. Fourteen subjects were chosen from the Semi- Independent Living program. These clients were randomly assigned to an experimental or control group. The control group received no treatment and the experimental group received sixteen group counseling sessions over an eight week period. All subjects were administered the Coopersmith Self-Esteem Inventory and were rated by two supervisors on a Behavior Rating Scale, developed by the investigator.

Analysis of the results was done using the *t*-test for independent samples. There were no significant results shown on any of the measures. No observable changes were found in self-concept or personal/social adjustment of the counseled group members.

Discussion of Results

Statistical analysis showed that there were no significant differences between the counseled group and the control group on self-concept. When looking at each individual subject who participated in group counseling, the results do reflect some changes that do not appear in the analysis.

Subject A increased by sixteen points on the self-esteem inventory. The areas that changed to be more positive were the answers to the questions "Things usually don't bother me", "There are lots of things about myself I'd change if I could", "I'm a lot of fun to be with", and "Things are all mixed up in my life". After group counseling, answers to these questions indicated higher self-esteem.

Subject B decreased by four points. One question on the self-esteem inventory is equal to four points, so this does not seem to reflect a significant loss of self-esteem.

Subjects C and D each gained several points on self-esteem. Subject D answered eight questions more positively than the previous time she completed the inventory. This seems to be a substantial increase.

Subject E decreased by eight points or two questions. One of the questions stated, "I find it very hard to talk in front of a group". This may reflect insight on the part of this subject, who had never had the opportunity to speak in front of a group.

Subject F had no change, although no changes could be expected. He obtained a 100 out of 100 on his pretest score. This subject was the only

subject in the group who was not retarded. It is possible that this client was able to pick out the "right" or positive answers and therefore chose these.

Overall, it can be concluded that the group counseling sessions did not decrease the self-concept of any subject significantly and may have increased the insight of some of the participants.

When the Self-Esteem Inventories were examined by the investigator, some interesting points developed. The mean of non-handicapped persons over fifteen years old is 76.1. No pre or posttest score mean of either group was at or above the mean of non-handicapped persons. The means were five to sixteen points below that of the non-handicapped population. This indicated that mildly retarded adults generally have a lower self-concept than that of the non-handicapped comparable age population. Several articles would support these findings (Meyerowitz, 1962; Piers & Harris, 1964; and Snyder, 1966).

It is also interesting to note the areas of concern that were similar to the majority of subjects completing the inventory. Thirteen of the fourteen clients felt that most people were better liked than they were. Twelve agreed that they were not as nice looking as most people and that they give in easily. On the positive side, more subjects tended to agree with each other. All fourteen felt that if they have something to say, they will usually say it. Thirteen felt that they could make up their mind without too much trouble. Thirteen also felt they were a lot of fun to be with, which is interesting considering twelve felt that most people were better liked than they were.

Analysis of the Behavior Rating Scale showed no significant differences between the two groups, when completed by either supervisor. The mean of the control group was actually slightly higher after eight weeks. No explanation can be given for this.

When the Behavior Rating Scale was examined for similarities over all subjects, only two behaviors were rated consistently across the majority. These were personal problem-solving and self-confidence. These were rated low on the majority of subjects.

The agreements of the supervisors were also examined in order to see if two people agreed on a change in a specific behavior. Agreements were found in three of the experimental group subjects' rating scales. Subject C showed an increase in social conversation and interactions with others. Subject D increased on personal responsibility and Subject F decreased in the area of reaction to correction. These are the only areas that both supervisors agreed on changes in behavior. The control group also had one person increase in responsibility.

In summary, although the statistical analysis yielded no significant results, there were some positive effects with the counseled group. For those who showed a decrease in self-esteem, difference was slight, only one or two questions. The Behavior Rating Scale was unreliable and may not have given an accurate reflection of personal/social behavior changes with the counseled group members.

Observations of the Group

Group process with mentally retarded subjects has been described by Stanley Slivkin (Seligman, 1982). He said that groups progress through three distinct phases. These include rejection, conditional acceptance, and sharing. The experimental group in this study did not follow Slivkin's phases as he describes them.

One of the first meetings with the group was filled with emotion. The topic discussed dealt with mental retardation and how they received the label. Several clients expressed sadness at being labeled retarded and one girl said with tears in her eyes, that people stop being your friend when they find out you are retarded. Importance was placed on what the word actually meant and how it felt to have the label. There was much sharing of feelings about this topic. Other questions generated during sessions on this topic were why the felt the label was viewed negatively, what did they like best about themselves, what did they want to change, could it be changed and the strengths that need to be emphasized, not weaknesses.

Group sessions also covered the following topics: (a) assertiveness, (b) personal problem-solving, (c) getting along with co-workers, supervisors and friends, (d) independence, (e) client rights and responsibilities, and (f) Individual Program Plans.

Following the initial meetings, which involved participation by all group members, because of the emotional subject, the following sessions seemed to lead to acceptance, questioning of the role of the group and finally, rejection

by two clients. When approximately six weeks had passed with good attendance by all members, two or three members began to express a desire to go back to work and not attend the sessions. They questioned the role of the group and felt they were not getting anywhere. The facilitators stated that the group was voluntary and if they chose, they could quit, but emphasized that their input was helpful for the other group members. None of the members quit the group during the time of the study. The sessions continue to be held and one month after termination of the study, five of the seven subjects were still attending. One of the subjects who has quit is Subject F, who has been competitively employed on the day the group takes place. The other subject is Subject A, who showed an increase after the group in self-esteem and both rating scales, but was very uncomfortable speaking in front of the group.

It is believed by this investigator that more positive results occurred in the group than were reflected in the measures. Behavior changes were noted by both facilitators over the course of the eight weeks. Subject E, especially, appeared to change in the level of defensiveness he exhibited towards others in the group. During one group session, he was confronted by the group members about his getting mad at everything they said and he apologized and seemed surprised his behavior had been viewed that way.

More helping behaviors were also observed as the group progressed. Instead of relying on the facilitators to interact with the group members, they began to interact more within themselves as peers. Suggestions were made for

more appropriate behavior by other group members, both in the group and outside of it.

Many of the advantages of group counseling which Janus and Podolec (1982) noted were evident in this group. These included the opportunity to give and receive peer support, provision of a controlled environment for the release of tension, frustration and anxiety, and peer influence on problem-solving and learning to cope.

Limitations

The investigator believes there are three limitations that affected the results of the study. The first is the size of the population used in the study. Only fourteen subjects were used due to restrictions imposed by the facility and the investigator. The pool of subjects was limited to those in semi-independent living and those who were currently receiving no other group therapy. It was also felt that no more than seven clients should participate in the group at a time. This investigator believes that less than seven may be more beneficial in terms of increased interaction and participation.

The second limitation was the short length of the intervention. A longer study may reveal a change in the counseled group members self-concept and personal/social adjustment. Especially with self-concept, it may be unrealistic to assume that in eight weeks, changes will occur when it has developed over

several years.

The biggest limitation in this study was the measurement instruments used. The Behavior Rating Scale had poor inter-rater reliablility. It did not focus on the specific behaviors that were felt by the facilitator to have changed in the subjects during group sessions. There may also not have been enough items on the scale, affecting reliability. Better results might have been obtained if a behavior checklist had been developed to focus on specific behaviors that occurred in and outside the group. Each goal during the group session and the occurrence of that behavior could be measured during the session, for example, dealing with confrontations nondefensively. This could be checked with a supervisor, who would also keep data on the behavior.

This investigator also believes that an accurate measurement of self-esteem in mentally retarded adults has not been developed. A self-concept scale, which measures self-concept as a multidimensional construct in adults was not found by this author. The length of the self-concept scale is also a problem with mentally retarded adults, because of the tendency to lose concentration on the scales which take up to one hour to administer.

The Adult form of the Coopersmith Self-Esteem Inventory was administered in order to shorten the administration time of the test, as well as to gear the test more to the lives of the adults. By doing this, the instrument may have lost some validity, because of the difficulty in comprehension of some of the questions. The self-report measurement with

mentally retarded individuals has been found to be unreliable in many cases, because of the defensiveness on the part of the reporter.

Future Research

The results of this study suggest implications for future research. Positive results were observed by the group facilitators and these were not always reflected in the measurement instruments. It may be that this investigator did not focus on the behaviors that were modified by the group. A study needs to be done that answers the question "What behaviors can be changed through group counseling?" Future studies may need to focus on specific behaviors in individuals and attempts to modify this behavior during the group counseling sessions. This would require a more directive and structured counseling approach. Perhaps measurement of achievement or locus of control of the group members would have yielded more positive results.

Better measurement instruments also need to be developed for use the mentally retarded adults. In the review of self-concept measures by this investigator, no instruments were found that were developed specifically for this population. Those inventories that were at the reading level of the subjects were geared towards children and their lives in school and at home with their family. The Adult form of the Self-Esteem Inventory was chosen because it better reflected the lives of the subjects, but comprehension of some questions might have been affected.

It is suggested that a reliable measurement of personal/social adjustment

be developed in the future. Perhaps this should not be measured as a global concept, but as individual components of behavior. Future studies that investigate the effectiveness of group counseling may focus more closely on specific behavior changes that occur. This could be done using an observational checklist of behavior during the group and outside of the group.

Future studies should also be conducted over a longer period of time. It is suggested that the study last no less than six months in order to obtain valid results. Self-concept and the personal/social adjustment of mentally retarded adults has developed over many years and major changes are not likely to occur in two months.

One area that has not been investigated in the literature on self-concept of the mentally retarded population is the effect that age has on the self-concept. It would be interesting to examine the development of the self-concept in this population as compared to the non-handicapped population.

Finally future studies investigating the effectiveness of group counseling with mentally retarded adults should develop a measure of the ability of the population to generalize what they learn in the group to the community in which they live. The major assumption of this study was that developing o more positive self-concept and better personal/social adjustment would lead to increased ability to adjust to the community. In particular, this are needs to be examined to see if generalization is taking place.

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APPENDICES

APPENDIX A

The Coopersmith Self-Esteem Inventory - Adult Form

Like Me	Unlike Me	
☐	☐	1. Things usually don't bother me.
☐	☐	2. I find it very hard to talk in front of a group.
☐	☐	3. There are lots of things about myself I'd change if I could.
☐	☐	4. I can make up my mind without too much trouble.
☐	☐	5. I'm a lot of fun to be with.
☐	☐	6. I get upset easily at home.
☐	☐	7. It takes me a long time to get used to anything new.
☐	☐	8. I'm popular with persons my own age.
☐	☐	9. My family usually considers my feelings.
☐	☐	10. I give in very easily.
☐	☐	11. My family expects too much of me.
☐	☐	12. It's pretty tough to be me.
☐	☐	13. Things are all mixed up in my life.
☐	☐	14. People usually follow my ideas.
☐	☐	15. I have a low opinion of myself.
☐	☐	16. There are many times when I would like to leave home.
☐	☐	17. I often feel upset with my work.
☐	☐	18. I'm not as nice looking as most people.
☐	☐	19. If I have something to say, I usually say it.
☐	☐	20. My family understands me.
☐	☐	21. Most people are better liked than I am.
☐	☐	22. I usually feel as if my family is pushing me.
☐	☐	23. I often get discouraged with what I am doing.
☐	☐	24. I often wish I were someone else.
☐	☐	25. I can't be depended on.

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APPENDIX B

The Behavior Rating Scale

Name ______________________________

Date ______________________________

BEHAVIOR RATING SCALE

1. SOCIAL CONVERSATION

_____ Nearly always uses socially correct manners in conversation (doesn't interrupt, says please and thank you, etc.)

_____ Frequently uses socially correct manners in conversation

_____ Occasionally uses socially correct manners in conversation

_____ Rarely uses socially correct manners in conversation

2. SELF-CONFIDENCE

_____ Exhibits self-confidence, initiates and completes task on own

_____ Tries to complete activity with some prompting

_____ Appears worried, but generally willing to try activity with sufficient prompting or support

_____ Is easily discouraged, gives up

3. REACTION TO CORRECTION

_____ Reacts reasonable and tries to improve

_____ Becomes anxious

_____ Is annoyed and shows it

_____ Becomes very upset by correction

4. SPECIFYING WHAT IS UNCLEAR

_____ Indicates specifically what is unclear before attempting task

_____ Indicates in general terms what is unclear before attempting the task

_____ Indicates before attempting the task that he/she does not understand, but gives no specifics

_____ Indicates that he/she does not understand only after attempting to perform the task

5. INTERACTION WITH OTHERS

_____ Nearly always responds appropriately in interactions

_____ Frequently responds appropriately in interactions

_____ Occasionally responds appropriately in interactions

Rarely responds appropriately in interactions

6. PERSONAL RESPONSIBILITY

_____ Sets realistic goals for self, accepts own limitations and abilities

_____ Is satisfied with level of performance, experiments with own goals

_____ Has unrealistic expectations for self, attempts the improbable

_____ Has no expectations for self

7. INITIATING TASK

When he/she arrives in the morning, proceeds with daily routine without delay:

_____ Nearly always

_____ Frequently

_____ Occasionally

_____ Hardly ever

8. ALTRUISM

_____ Nearly always shows unselfish concern for the welfare of others

_____ Frequently shows unselfish concern for the welfare of others

_____ Occasionally shows unselfish concern for the welfare of others

_____ Rarely shows unselfish concern for the welfare of others

9. PERSONAL PROBLEM-SOLVING

_____ Solves personal problems independently

_____ Able to solve most problems without assistance

_____ Able to solve some problems without assistance

_____ Cannot solve personal problems alone, needs assistance with all problems

10. ATTITUDE

_____ Nearly always maintains a positive, optimistic outlook on life

_____ Frequently maintains a positive, optimistic outlook on life

_____ Occasionally maintains a positive, optimistic outlook on life

_____ Rarely maintains a positive, optimistic outlook on life

APPENDIX C

Consent Form

Dear ,

Mary Fowler and I are interested in finding out better ways to help you cope with living in the community. One of the ways we think we can help is to have meetings with some of you twice a week for group sessions. The groups will meet to discuss your concerns, problems and frustrations with living in the community. Before we start the meetings, though, I would like to ask all of you several questions about the way you feel about yourself. Then, in two months, I will again ask you the same questions. I will be the only one to see the answers to these questions and if the answers are used in any way, I will use a letter instead of your name. For those of you who will be coming to the meetings, you should use the time to speak up and talk about what problems you have in your life. At times, thinking about these things may make you feel confused, sad or even angry, but I hope that the group will help you to work out these feelings.

Even if you agree now to take part in the meetings and answer the questionnaire, you are free to quit at any time. If you have any questions, please feel free to call me or come by my office at work.

Sincerely,

Karen DeGasperi

Signature ______________________________