CHANGES THAT OCCUR WITH MILD MENTAL DEFECTIVES
FOLLOWING TWO APPROACHES TO GROUP COUNSELING:
DIRECTIVE AND GROUP-CENTERED

DISSERTATION

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

by

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Denton, Texas
May, 1971

The problem with which this research study is concerned is that of appraising and evaluating the therapeutic effectiveness of two different group counseling approaches, group-centered and directive, with institutionalized mental defectives. More specifically, this investigation is designed to assess the changes, if any, in self concept, behavior, and anxiety level of mental defectives that result from two different group counseling approaches. The hypothetical assumption is made that there will be a significant positive change in self concept, anxiety, and overt behavior of students participating in group-centered group counseling compared to students in both the directive and control groups.

A total of thirty-six mentally retarded students is included in the study; all of whom function within the mild range of retardation (I.Q. 50-75), range between the chronological ages of fifteen years to twenty years and six months, and are diagnosed as cultural familial retardates.
The thirty-six subjects were randomly assigned to three major groups: Experimental I (group-centered), Experimental II (directive), and a control group. Each major group was randomly divided into two smaller sub-groups comprised of six members. The rationale for the sub-group arrangement was to create an atmosphere conducive to maximum group interaction and expression.

In order to quantitatively assess the magnitude of change of the three research study groups on the variables being investigated, three evaluation instruments were used in the study. Prior to the treatment procedure, subjects in each of the three major groups were administered the Children's Self Concept Scale and Children's Form of the Manifest Anxiety Scale. In addition, a behavior rating report was made on every individual participating in the study. The behavior rating device was specifically designed for the research investigation. Post-treatment evaluations were made with these same instruments and conducted in the same manner as was the pre-testing.

Subjects of both Experimental I and Experimental II sub-groups participated in twenty group counseling sessions during a thirteen week period. Sessions were scheduled twice weekly and each group session lasted approximately one and one-half hours. Experimental I sub-group members
received group-centered counseling while the Experimental II sub-group members participated in group counseling sessions that were highly directive and didactic. Control group subjects continued to participate in routine scheduled assignments.

Results of the study were based on a statistical treatment (analysis of co-variance) and subjective observations made by the experimenter during the investigation. Although none of the proposed research hypotheses reached the required level of significance (.05 level), statistical findings did reveal a trend in the direction of the hypothesis which stated that students receiving group-centered counseling would develop more positive self concepts than students in the directive and control groups. The subjective evaluation indicated that more positive therapeutic changes were experienced by the students who received group-centered group counseling.

This study concludes that there is no statistically significant difference in the therapeutic effectiveness of the two group counseling approaches employed. However, findings of the study do not indicate that group counseling be excluded in the educational and vocational programming of the mentally retarded. It is suggested that, in view of the discrepancy between the statistical findings and the
observational analysis, a similar study be conducted incorporating the proposed recommendations.
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CHAPTER I

INTRODUCTION

Generally, counseling with the mentally retarded has received minimal attention from therapists and psychologists. This has been due in part to the negative attitudes of these professionals concerning the effectiveness of counseling with the intellectually defective individual. Although a perusal of the current literature regarding counseling with the mentally retarded reflects a more positive and optimistic turn, there still remains residuals of the old feelings that the mentally retarded are unable to profit from a therapeutic relationship.

One well regarded theoretician, Carl R. Rogers (19), stated in a 1937 report that he discouraged any form of psychotherapy with the retarded. Rogers' arguments basically implied that there are certain social and intellectual abilities inherently absent in all mental retardates which precludes the effective application of psychotherapy with them. Sarason (20) postulated that some of the liabilities of the mentally defective person include his inability to control or delay emotional expression, to seek and to
accept socially appropriate substitute activities in the face of frustrations and restrictions, to view objectively the behavior of others, to adjust or want to adjust to the needs of others, and to realize the sources and the consequences of his behavior. The deficiency in the retardate's capacity to abstract and deal cognitively with acting-out impulses was felt by many researchers to be a factor that limited the benefits derived from a therapeutic process (6, 7, 13). Another problem viewed as contributing to the ineffectiveness of counseling was the retarded individual's lack of expressive language skills. This was indicated by Lurie and Levy (10) but was more directly stated in Allen's (1) comment that the defective person's inability to perceive or to verbalize the interpersonal nature of his problems results in his being unable to seek help, to create the therapeutic relationship, or to understand the purposes of an individual offering it.

Despite these arguments, some clinicians and research workers in the field recognize that mental retardates are subject to emotional trauma and difficulties incidental to their intellectual limitations and that they do respond, in varying degrees, to psychotherapeutic assistance (21, 27). Sarason (21) pointed out that many of the conclusions that were drawn concerning the unfeasability of therapy with
mental defectives have been based more on deductions from theoretical consideration than on systematic research in the area.

Thorne's (27) report of the results of systematic therapy with institutionalized retardates was one of the first documents that suggested that counseling and psychotherapy was not only possible but resulted in marked improvement in the behavior and individual welfare of the individuals involved. Thorne's findings, along with other experimentally designed research projects, provided impetus to a revised philosophical orientation on the part of many concerned professionals in the field. Several authors, among these Wiest (29), Yepsen (31), and Neham (14), began publishing supportive evidence to the rejuvenated attitude that counseling and psychotherapy was a potentially valuable procedure for assisting the retardate in adjusting and adapting to his environment.

This resurgence of interest in therapy with mental retardates led to the development of and the emphasis on varied therapeutic techniques and procedures particularly in the area of group therapy. The crucial need for experimentation with group procedures with the mentally retarded was pointed out by Humphrey in his statement:
How can one or a few men meet the personal needs of these thousands? Obviously, it is impossible. The answer lies in the development of intimate relationships among the psychiatric and other services of our institutions, namely, in the development of group techniques in psychotherapy (9, p. 41).

Other researchers (8, 24) recognized the importance of employing group procedures with the mentally defective and as a result, a concerted effort was initiated to explore the therapeutic advantages and/or disadvantages with this type of approach.

Group therapeutic approaches with mental retardates were initially of diversified forms and types. There was much confusion about methodology, objectives, etc., and many of the descriptive names used with these various techniques did not adequately reflect the actual procedures involved. Cotzin (4) was one of the first researchers who attempted, by experimental methods, to define his technique, describe the values of group therapy, indicate some types of cases dealt with by others, and show the results of his efforts with mentally defective problem boys. Cotzin's study is also significant in that it was the initial project concerned with non-directive treatment procedures. Although the results obtained by Cotzin were not conclusive, they did substantiate the assumption that group therapy, specifically non-directive, was advantageous with the mentally retarded.
As evidenced by later research, Cotzin's study provided encouragement to researchers (5, 12, 16) in the area of group therapy with the mentally retarded. However, even with this increased emphasis on research, there still was a negligible amount of investigation regarding the comparing of the relative effectiveness two different group techniques would have on a population of defectives with similar etiologies. With the exception of one study made by Polatsek and Ringleheim (15), previous efforts had dealt with only one therapeutic approach and no attempts were made to assess the effects of therapy with a study design involving a control or no treatment group. It is also interesting to note that in previous exploratory research studies (5, 12, 16) the efficacy and value of group counseling with mentally retarded persons was generally measured by some behavior rating scale. In reading these studies, it becomes apparent that the declaration of unsuccessful or questionable results was based on whether or not the students manifested an observable change in their behavior. The distinct possibility exists that retardates as well as "normal" individuals, experience a change in self concept or perceive themselves differently before there is any noticeable change in overt behavior.
As a result of their research, Mann, Baeber, and Jacobson (11) recommended that future studies deal with more than one group counseling technique.

Although researchers have not published any experimental studies that deal specifically with anxiety and retardation, unpublished data, observations made by professionals working in the field of mental retardation and counseling, as well as this writer's previous clinical experience, indicate that anxiety is an important and influential facet of the retardate's total psychological behavior. Considering the impact anxiety has upon the defective person's repertoire of behavior, it appears that an investigation to assess what effects various group counseling techniques have upon anxiety level as well as self concept is warranted.

Statement of Problem

The problem of this study was to appraise and evaluate the therapeutic effectiveness of two different group counseling approaches, group-centered and directive, with institutionalized mental defectives.

Purpose of Study

The purpose of this study was to determine the changes, if any, in self concept, behavior, and anxiety level of
mental defectives that result from two different group counseling approaches.

Statement of the Hypotheses

In order to determine the efficacy of the two treatment procedures prescribed, the following hypotheses were formulated:

1. Significant differences will be found among the mean self concept scores of the group-centered, directive, and the control group, with group-centered scores being the highest (indicating more positive self concepts) and control group scores being the lowest (indicating more self disparagement).

2. The subjects who receive treatment in the group-centered group will experience a significantly greater reduction of anxiety (mean scores will be lower), as measured by the anxiety scale, than those subjects in the directive and control groups.

3. Significant differences will be found between the magnitude of behavior adjustment of subjects in the group-centered, directive, and control group with the group-centered post-test mean score being lowest (suggesting better behavior adjustment) and control group score being the highest (indicating less improvement in behavior adjustment).
Background and Significance of Study

A survey of published research reveals that there have been few well-designed and effectively carried out experimental studies in the area of counseling with the mentally retarded. The fact that reported results are so ambiguous further complicates matters. The studies that have been conducted have been primarily concerned with the refutation or demonstration of change in the areas of behavioral adjustment and intellectual functioning. Unfortunately, the area of personality adjustment has been neglected in the previous investigations and this oversight has been justified by some rather erroneous assumptions.

The most predominant argument used by those schools of therapy that oppose psychotherapeutic treatment with retardates is the intellectually deficient individual's incapacity to gain insight into his maladaptive unconscious motivations. This inability would preclude the person from understanding the rationale of his behavior, recognizing the consequences of various behaviors, distinguishing between the reality and unreality of situations, and acting upon his psychological and social environment in an attempt to make it more conducive to better adjusted behavior. These same theorists state that insight is dependent upon the ability to employ language concepts. Another proposed factor that
has been used frequently as supportive evidence to the ineffectiveness of therapy is that the retardate cannot recognize reality. This is supposedly true because the retarded have, from the moment of birth, been neglected, refused, thwarted, exploited, and due to this unsatisfactory exposure, they automatically avoid reality. In that growth consists of testing reality, the retardate is unable to grow, psychologically, because of this continued effort to evade (17). An additional argument that has certainly had a negative influence upon the use of therapeutic procedures intended to modify the fundamental personality structure of the retardate is the attitude that these individuals have no image of self. This is based on the theoretical assumption that the mentally defective person cannot identify what the self does nor can he accurately interpret what is done to the self. Without the ability to understand this interaction with the environment and not possessing the capacity for integrating others' perception of them, the retardate cannot develop a self structure. These concepts were not conclusions drawn from experimentally designed research with proper controls and statistical analyses.

In an attempt to refute the idea that mental retardation negated any therapeutic value of counseling, Cooley (3) conducted the first experiment that dealt specifically with
the relative amenability of dull and bright children to psychotherapeutic treatment. His project was also the initial study that established diagnostic classifications of mental retardation and evaluative criteria. The youngsters involved were categorized into three groups: a bright group comprised of 25 children with I.Q.'s above 115, a dull group consisting of 16 children with I.Q.'s between 76 and 84, and a low dull group made up of 9 students with I.Q.'s between 61 and 74. All of the cases were matched for age, sex, and economic status. Over half of the students in the dull groups had from one to ten hours of therapy, while only four of the children in the bright group had so few sessions. Only five of the children of low intellectual level had more than twenty hours of therapy, in contrast to thirteen of the bright children.

The results of Cooley's study indicated that psychotherapy appeared to be equally successful with the two dull groups, and it appeared that the children of inferior intelligence required no more and in many instances less expenditure of time in treatment than the bright youngsters. These encouraging results were similar to those obtained by Wegman (28). Although these researchers indicated that children of deficient intellect are amenable to and benefit from a therapeutic experience, their findings were interpreted
as only being suggestive of the feasibility of such procedures with the mentally retarded and the need for further research was clearly pointed out.

Although the experiments by Cooley and Wegman had an affect on the professionals in the field, there still existed a deficit of research data concerning any systematic approach, specific methodology employed, objectives of treatment, and evaluation techniques. Inasmuch as it was impossible to correctly interpret the findings of earlier investigators and make any useful generalizations from their efforts, Thorne's report (27) of the results of systematic psychotherapy with institutionalized retardates was one of the most well received, informative, and comprehensive pieces of research of the times. In his report, Thorne provided detailed information concerning two areas that had been previously neglected. First, the author attacked the long established attitude that the retardate was "abnormal" in every respect and that therapeutic procedures used with the intellectually "normal" individual were entirely ineffective with the mental defective. Secondly, he emphasized the inescapable need for establishing objectives in counseling with the mentally retarded. Concerning the first issue, Thorne strongly supported the theory that the retarded individual experiences the same emotional and psychological
needs as does the "normal" person. His theoretical position was later experimentally supported by Yepsen (31), also a strong proponent of the use of therapy with retardates. According to Yepsen the retarded person rarely reasons at a high level of abstraction; therefore, his life and behavior are more frequently guided by the emotional elements in a situation than by the intellectual elements. This makes it more imperative that the retarded individual have some knowledge and awareness of his feelings, what they mean, and how he can effectively deal with them.

The mentally retarded person, as well as the intellectually average or superior individual must meet societal expectations and restrictions; consequently he needs some understanding of what motivates behavior, the ethical and moral implications of good and bad, and the consequences of his behavior. In essence, retardates must function by the same learning principles as does the rest of society: extensive periods of trial and error associated with positive or negative reinforcement. Although Thorne stated that counseling and therapy are directed toward shortening this learning period, he made it explicitly clear that this did not mean that the ultimate aim was to make the individual adjusted to certain situations in the hope that he would not encounter novel situations, but that it was to make the person adjustable.
A second major contribution resulting from Thorne's report was the establishment of therapeutic objectives. Previous experimentation did not adequately describe the methodology employed or document the therapy process. In most instances, no basic objectives were formulated. Consequently, there was much confusion regarding what was done and what were the ultimate aims of the therapist. The objectives developed by Thorne (27) involved the following: (a) accepting the retarded person as being a worthy individual in spite of his defects, (b) permitting expression and clarification of emotional reactions, (c) patiently assisting the retardate in developing methods for resisting frustration and achieving emotional control, (d) outlining standards for acceptable conduct within the ability of each individual, (e) building up self-confidence and respect by providing experiences of success, and (f) helping the person use counseling services when faced with insurmountable problems.

Realizing that therapeutic goals alone would not suffice, Thorne stressed that the therapist, in the process of counseling, make every attempt to establish a warm, accepting, and empathetic relationship with the retarded person. For the first time, the retarded child was to be treated as an equal rather than an inferior. It was particularly
important that the retardate be given as much freedom and responsibility for self control as he could manage, and the therapist was to continue showing tolerant accepting attitudes toward the individual when he was in the midst of an acute period of maladjustment.

Although Rogers (19) in his early writings was one of the opponents of therapeutic procedures with retardates, the non-directive approach which he developed became increasingly popular with researchers in the field (Rogers' approach is currently referred to as client-centered therapy). This approach, which emphasizes self perception and the client-therapist relationship, was brought to the attention of many investigators by a statement made in Stacy and DeMartino's (24) excellent book of writings on therapy with mental retardates:

In our experience, the non-directive methods developed by Rogers are very effective in certain stages of treatment when the objective is to assist the child to express and clarify his feelings and emotions. When dealing with the child who is emotionally upset, it is desirable to listen quietly to the initial outburst of feeling, reflecting and clarifying feelings non-directively (24, p. 466).

It appears that in many instances the retardate's adjustment difficulty is rooted in an inadequate self-concept. Without ego integration the intellectually deficient individual has no security and accordingly cannot be
expected to behave in a stable, well adjusted, and relevant manner. Consequently, the important impact that a "self concept" therapy can have upon the retardate's adjustment process is obvious.

The aim of client-centered therapy is to provide a situation whereby the client will be free from threat, free to examine and differentiate aspects of himself, his immediate environment, and his relationship to his environment. The client is given the opportunity to integrate the meanings of these examinations and thus, finally, a more adequate adjustment. This adjustment is considered to be largely a function of the sort of self perceptions the person has and of the manner in which they are organized. There are three aspects of client-centered therapy that make essential contributions to this goal (18). First, there is assumed to exist a drive toward psychological equilibrium or health, a drive that is not manifested under great threat. Strong threats function to rigidify the person's perceptions and meanings, and hence his behavior, and result in inadequate adjustment. Therapy acts to release the individual from threat. This strive toward maintenance and enhancement of self is assumed to exist in the retardate as well as the intellectually normal person.
Secondly, in client-centered therapy, the therapeutic process is viewed as primarily emotional rather than intellectual in nature. Affect, emotions, and feelings are dealt with; therefore, the intellectual prowess of the individual is minimized in importance. There is no direct attempt made to give the person insight, nor does the person necessarily concern himself directly with his problem. The assumption here is that the mentally deficient person, despite his intellectual limitations, can grow in therapy because progress does not depend on intellectual ability.

Third, and probably most important, client-centered therapy views the counselor-counselee relationship as crucial. The personality of the therapist is not denied or neglected, but rather is utilized. The relationship is marked by warmth, stability, acceptance, and permissiveness. The client is accepted as he is and the structure of the relationship is such as to facilitate acceptance of the client by himself. Techniques are subordinate to the relationship. In a client-centered relationship, the focus of the therapist is on the feeling being expressed, and one of the functions of the approach is to induce or create an atmosphere where there can be free expression of such feeling.

At the same time that the client-centered approach was receiving much attention by researchers, the need for group
approaches became a prominent issue. This interest was due in part, to some of the economical and practical advantages group therapy has over individual therapy and the increased number of mental retardates being admitted to institutions. The group provides a situation in which interpersonal relationships can be examined and tried out; it reveals many common problems which reduce tension and anxiety about an individual's own situation; and the group is conducive to mutual acceptance, respect and helpfulness which tends to develop improved self concepts. Some researchers (8, 24) felt that group techniques were particularly advantageous for the retardate. Hobbs (8) indicated that group counseling with the mentally retarded aids the participants in the development of interpersonal relationships and social ability and furthermore, diminishes the participant's feelings of isolation and insecurity. Considering that the defective individual is most affected by his inability to express feeling, and gain insight into his own behavior, the use of group techniques were felt to be of tremendous aid to the retardate in that he can gain a great deal from others with similar problems.

Group approaches with mental defectives thus far have been of diversified forms and the inconclusive findings concerning the efficacy of these varied approaches has
stirred up considerable debate. In the literature, one finds mention of directive and non-directive techniques, but the actual descriptions of the various investigations suggest that the differences are more of degree than of kind. In some of the studies reportedly using non-directive techniques the therapist was very active in establishing group structure and content interpretation (22). In fact, many of the researchers made no attempt to describe the particular technique being employed. Although several studies were conducted using a modified non-directive or an eclectic approach, only a few researchers (22, 30) attempted a true client-centered approach with retardates. Unfortunately, these studies were done without adequate controls and measures were not taken to determine the relative effects of two or more different treatment procedures.

Group Counseling Studies

Wolfson and Fisher's (30) study was conducted to evaluate the effectiveness of group counseling with twelve female institutionalized retardates. The students were selected by hospital personnel and were screened for similar etiological factors with the intelligence level restricted to the mildly and borderline retardate (I.Q.'s 50-80). Of the twelve students selected, two patterns of behavior
were present. In one type, an aggressive, uncooperative, hyperactive, and attention-demanding behavior predominated, whereas in the other type, tendencies of submissiveness and withdrawal were prominent. Because of a wide chronological range (ten years and three months to thirteen years and three months) two groups were formed, but each group met with the same therapist. The various behavior patterns were randomly assigned to the two groups.

The technique employed by the therapist was described as one in which the students were given the opportunity to discuss any matter they felt to be important. These open discussions were supplemented by activity sessions. The therapist was extremely permissive, always accepting the children at their own level. Limitations and restraints were made only when the therapist felt it was necessary for the physical safety of the individual.

A total of thirty-six sessions, each lasting one hour, was held with each group. At the termination of the study, the method of evaluating the progress of the two groups involved these variables: the amount of group unity attained, the expenditure of energy for constructive activity, and the degree of expression of positive feelings rather than negative ones. Improvement in overt behavior outside the group was also investigated. In addition,
intelligence tests were administered to see if the group experience had caused any significant psychometric changes. All members of the two groups were pre-tested and post-tested with either the Form L or Form M of the Stanford-Binet Intelligence Scale.

Eight of the twelve children showed improved behavior (aggressive children becoming more cooperative, quieter, much less prone to use attention-getting devices, and withdrawn children becoming more socially adept and less solitary in social and interpersonal relationships) and attitude as well as more positive feelings after the group experience, which the authors felt would not have been due to any other influences. Although the results were most encouraging, the most dramatic result of this study was the idea that the therapist should not respond to the retardate as being different and that the group will lead the therapist according to their needs, their mental level, their emotional level, etc. Fisher and Wolfson concluded that the insignificant change in psychometric ratings was due to the fact that such group treatment for the retardate may extend only to the more readily modifiable aspects of the personality structure—such as change in feelings and attitudes.

The value of group psychotherapy with mental retardates was also the focus of a study conducted by Astrachan (2) at
the Rosewood Training School in Tennessee. Her intent was to
duplicate the project directed by Wolfson and Fisher, but
to do so with a few modifications. The three major changes
included a larger experimental population, a voluntary open
group membership and the treatment procedure was totally
discussion oriented. There were no supplementary sessions
of activity therapy; the emphasis was on verbal communication.

The approach used was very similar to a client-oriented
approach with the therapist being as passive as was consistent
with group progress. Therapist intervention was applied in
instances when a new participant was introduced to the group,
to include a persistent non-participant, to relate a
particular student's difficulties to other members'
problems, to identify group and/or individual goals, and to
direct a student's attention to their interpersonal
reactions with other group members or with the therapist.
The therapist's primary role was to clarify prevailing
attitudes, emotions, and feelings to the group members.
At no time did the therapist attempt to interpret reactions
and the discussion topics were left entirely to the
discretion of the group participants. Confidentiality was
stressed as well as the students being guaranteed that
discussion materials would not be placed in ward files.
Thirty-one female residents, ranging in age from fifteen to forty-three with a mean age of nineteen, constituted the total number of participants in the study that ran for a period of two and one-half years. Therapy sessions were held for one hour twice weekly. Membership was voluntary but new students were admitted upon the approval of all group members and the therapist. The average verbal intelligence quotient on the Wechsler Bellevue was 64 while the average performance quotient was 71. Twenty-two of the patients were diagnosed as familial retardates, seven as undifferentiated types, one an epileptic, and one as microcephalic. In addition to the etiological categories, each patient was categorized into one of seven personality classifications: (a) depressive, (b) schizoid personality, (c) aggressive acting-out, (d) sexual acting-out, (e) mild paranoid trends, (f) excessive passivity, and (g) excessive immaturity.

As individual students were terminated, a committee made up of staff personnel determined the degree of improvement shown in overt behavior. Although statistical data was not available, resultant clinical changes were felt to be highly related to the personality problems presented and the etiological classifications of the patients involved in the group treatment. Eight of the nine patients with depressive
difficulties showed noticeable behavior improvement particularly in the areas of institutional participating and a greater sense of well being. Six of these patients made successful adjustments and were discharged from the institution. Two of the three patients considered to be mildly paranoid revealed marked behavior changes. They manifested better self control and increased positive interpersonal relationship. Both were furloughed and at the time of the article were making adequate adjustments to community living. There were three patients diagnosed as excessively passive and all were discharged as habilitated clients. The most conspicuous change was a reduction in the patients' feelings of isolation, shame, and defeat. Dependency needs were diminished with self direction becoming a more prominent factor in behavior. Astrachan, therefore, concluded that discussion group psychotherapy has a place among the treatment resources for institutionalized mental retardates diagnosed as cultural familial, and particularly for those who present problems associated with depression, passivity, and mild paranoid trends.

Previous failures to provide statistically significant data concerning experiments utilizing unmodified non-directive group approaches with mental defectives provided the impetus for a study made by Snyder and Sechrest (23).
The thesis of their study was that a part of the failure to produce significant therapeutic progress with retarded individuals had resulted from the application of group procedures inappropriate to the patients in question. Their study was the first endeavor to investigate the effectiveness of group therapy with the defective person by employing an approach that was directive in nature. This approach was intended to be verbal, highly structured, and didactic, thereby departing from a traditional, non-directive approach.

The research sample consisted of forty-five male subjects, Negro and Caucasian, who ranged in I.Q. from 50 to 79. The criteria used for selection included: diagnoses of organicity were excluded, patients could not have had prior individual or group therapy, each subject must have the potential for rehabilitation, and no subject could have spent less than one year or more than two years in the institution. From the total number of subjects selected, each individual was assigned to one of three homogeneous groups. Sixteen subjects were assigned to the therapy group which was divided into two groups of eight. The placebo group, which was instructed that it was selected to participate in a study and had discussion meetings at the same time as the therapy group, was made up of sixteen subjects divided into two smaller units of eight members.
A no-treatment or control group consisted of thirteen patients who were free to continue their normal routine activities. Both the therapy and placebo groups met once weekly for one hour sessions over a thirteen week period. The mean chronological age for the therapy group, placebo group, and the control group was nineteen, twenty-two, and twenty, respectively.

There were two methods by which results of the group therapy were measured. Both were dependent upon reportings made by supervisory staff. A written report of behavior violations was submitted upon occurrence. This report reflected negative, inappropriate behavior presented by the subject. A "housing" report filled out by the ward attendant was the other source of information. These reports were made on each subject every four months and were concerned with conduct and personal characteristics. Constructed in the form of a checklist, the housing report consisted of sixty-seven items that could be dichotomized as favorable or unfavorable. They were scored for positive or negative comments and these reports were administered to each subject prior to and following treatment. Assessment involved determining if the number of reported comments significantly decreased following group therapy. Both evaluative techniques were administered and filled out by the same staff personnel.
The therapist of the treatment group was a guiding manipulating leader who interacted minimally but did not hesitate to structure and organize when necessary. At times the therapist instructed in a classroom lecture fashion, but upon completion of his educationally aimed discussion, he stimulated discussion. Each of the sessions began with a topic that had been predetermined by the therapist. Discussion material could be introduced by group members as long as it was felt to be relevant by the group leader. All subjects were instructed in the mechanics of group therapy and informed that their goal was to improve their individual adjustment to the institution programs.

Statistical data revealed a significant difference at the .05 level between the experimental, placebo, and control groups in the number of positive housing reports made on the subjects included in the study. After thirteen weeks of therapy, the adjusted mean for the control group showed an addition of .78 favorable comments per individual. The adjusted mean for the placebo groups indicated an addition of 1.40 favorable comments per individual and the therapy group showed a gain of 3.38 favorable comments per individual. An evaluation of the differences among the groups in terms of conduct violation reports was not significant; however, the experimental group had only two reports, the placebo group
six, and the no-treatment group eight. Two and one-half months later, the treatment group continued to maintain its superior adjustment while the other groups were receiving an increasing number of negative housing reports. According to Snyder and Sechrest, the encouraging results of their project were due to the more structured, directive nature of therapy and the trend should be a departure from non-directive approaches.

In spite of the uncertainty of the findings of these and other research projects, researchers in the late 1950's seemed to agree on two facets of therapy as being vitally important to the success of group treatment. Providing a non-threatening atmosphere whereby the individual can verbally express repressed feelings, emotions, and attitudes appeared to be superior to techniques that were activity oriented and did not stimulate interpersonal communication. A second factor that gained the support of most researchers was the concept of increased participation on the part of the therapist. This did not mean that the therapist was to rigidly structure the therapy sessions or be active in directing behavior and interpreting reaction, but his role should be one in which he interacts spontaneously, gives verbal support, encourages patient participation, clarifies feelings, etc.
Slivkin and Bernstein (22) and Sternlicht (25), conducted experiments designed to investigate the relative importance of "expressive group" therapy and therapist involvement. Although not well controlled or statistically analyzed, the study by Slivkin and Bernstein provided some enlightenment in this area. Their research involved eight boys ranging in age from fifteen to nineteen years. All of the students possessed I.Q.'s within the 46 to 78 range and all were residents of a training school. Most of the students had histories of disruptive and anti-social behavior. Therapy sessions ran over a period of nine and one-half months with weekly one hour meetings. Therapist interaction with the group was frequent, usually in terms of response clarification, attention direction, and verbal support. Discussion topics were originated by group members with any material being allowed as long as it did not precipitate group acting out. The therapist attempted to promote group empathy by pointing out similar problems of the group members and always being aware of some very intense feelings that were not openly verbalized. As the sessions continued, the therapist set up a system of rotation of leadership among the group members. This was done to give each member the opportunity to accept a responsible role and experience a lessening of anxiety that is felt in an unaccustomed role of leadership.
On the basis of their preliminary experiences with discussion oriented group therapy with mental retardates, Slivkin and Bernstein reported considerable evidence of positive behavior change. Although their study did not develop concrete criteria for assessing improvement, the subjective reportings made by the therapist indicated that the group relationship and expression of feelings led to a significant change for the better in both school and job performance. Both authors implied that the strategy of group therapy is that the leader does not gratify the infantile needs of the members, but rather gives to them increased understanding through clarification and interpretation of their feelings toward each other and towards the leader. This therapeutic aim can only be accomplished in the context of a strong and positive alliance between the group members and the leader. Again, the therapist-client relationship was determined as being the essence of valuable, effective group therapy with the mentally retarded.

One major failure of the research regarding group counseling with mental retardates was that studies dealt with only directive or non-directive approaches and there were no attempts to investigate the therapeutic effectiveness of both approaches with a similar population of subjects.
In most research studies, the measurement criteria used for evaluating the therapeutic value of group procedures with the mentally retarded consisted of some behavior rating device or an intelligence test. In each case, some observable change in behavior was necessary before any positive or negative conclusions could be obtained. Recognizing that diagnostic procedures and rating techniques are not infallible, it follows that these particular measures should not be utilized exclusively for the purpose of judging the success or failure of therapy.

Some of the evaluation procedures employed in previous studies present considerable concern for those researchers who have a client-centered orientation. Traditional methods of assessing the effectiveness of group therapy may be failing to recognize some very dynamic cognitive and perceptual changes that occur within an individual following a group experience. According to Rogers' (18) self theory, adjustment is in part a function of self concept and self acceptance. The basic philosophy of the phenomenological theory is that an individual perceives himself in a certain manner and also is attentive to perceptions others have of him. As a result of this perceived "self" the individual behaves accordingly. When concept of self is altered, the person behaves in a fashion that corresponds with this
concept of self. Therefore, a change in the way one perceives himself and the realization of abilities and limitations will precede any overt behavior change. A re-orientation of one's self concept is necessary for any significant behavior modification to occur. By only concentrating on the intellectual and/or behavioral factors alone, sight is lost of the fact that the mentally handicapped individual is also a part of a dynamic environment which involves affective interaction.

The only reported study that has been made to date that has dealt with the factor of self concept and the resulting changes in self concepts of retardates following group counseling was conducted by Mann, Baeber, and Jacobson (11). The primary purpose of their research was to attempt through group counseling procedures to effect a change in the perceptions that educable mentally retarded boys have of themselves. Other variables were considered, e.g., anxiety, reading, attendance; however, in that this was the first exploratory effort with personality factors, the aspect of self concept was of major interest.

Thirty-six educable mentally retarded boys were selected and identified by teachers as behavior problems on a pupil behavior rating scale. The chronological age of the students was nine through thirteen and the I.Q. range was from 56 to 80. Twelve subjects were white and twenty-four were Negro.
All of the boys were administered the Wechsler Intelligence Scale for Children or the Stanford-Binet Intelligence Test previous to the study. In addition to the intelligence tests, all of the subjects were pre-tested with a self concept scale and an anxiety measurement. Teachers were asked to rate each student at the beginning of the study on the variables of conduct, reading, and arithmetic. Information was also taken to determine the socioeconomic status of each student.

The thirty-six subjects comprised two groups, the experimental (A) and control (B), each consisting of eighteen subjects who were matched on the basis of chronological age, I.Q., race, and socioeconomic status. Groups A and B were divided into three subgroups each. The six subgroups spent equal time with the therapist over a period of twelve weeks. The three subgroups in group A received counseling with the therapist one hour a week for twelve weeks. These sessions were held in the same place each time. Makeup sessions were held with those students who were absent from regular scheduled meetings. The three subgroups in group B received twelve library sessions with the same therapist and these meetings consisted of supervised reading and study. A minimum of personal interaction took place between the counselor and the control group subjects.
The therapist attempted to facilitate an improvement in self concept by establishing rapport with each individual in the experimental group and indicating to each student that he felt the individual was a worthwhile and important person. The sessions were structured but permissive in that the therapist began each session by asking a question or making a statement and then permitting the group members to develop the discussion topic from there. The therapist occasionally stimulated discussion and interaction with appropriate comments and questions. Although the therapist acted as a guide for the group, he at no time tried to exert any influence over the group. His major role was to unify and provide impetus to the group process. Opportunities for all types of expressions were provided through discussions, role playing, games, and sharing of experiences. The therapist was continually supportive and allowed for complete free expression. Each session ended with a recapitulation of the materials discussed by the therapist who attempted to close each meeting on a positive note.

The findings of Mann, Baeber, and Jacobson's study clearly indicated that self concept can be modified through group counseling. The hypothesis that stated the boys who received group counseling would tend to manifest a more positive self concept than those who did not receive this
service was supported at the .05 level of confidence. The hypothesis that those students receiving group counseling would experience greater reduction of anxiety than those in the no-treatment group was found to be statistically significant at the .05 level of confidence. The hypothesis that group counseling would result in significant improvement in deportment, reading, and arithmetic as rated by teachers was also supported at the .05 level. The investigators felt that a great deal depended upon the establishment of rapport between the counselor and the group.

Mann and his associates acknowledged that their study was of a pilot nature. It did, however, point out a need for further research in the area of self concept in relation to the mentally retarded. Two suggestions made for follow-up studies were the application of more than one counseling technique and the utilization of different therapists. Both suggestions were incorporated in the present research project.

If the mentally defective individual is viewed from the phenomenological position, his behavior is best understood from the individual's own internal frame of reference. As a result of his interaction with his environment and particularly with others' evaluation of him, the individual develops a dynamic sense of self, and he molds his behavior and perceptions accordingly. The individual who has built
up a self structure that includes stupidity, rejection, inadequacy, fear, failure, etc., certainly will manifest these self perceptions through intense anxiety. The mentally retarded appear to be especially vulnerable to this type of self perception.

By following the basic objectives of group counseling, e.g., establishing a therapeutic relationship, expression of emotions, developing ego, strength, improving self concept and awareness, it could be hypothesized that the level of anxiety of institutionalized retardates would diminish as a result of therapy.

In keeping with the theoretical approach that is suggested by previous postulations stated in this study, the aspect of overt behavior must be considered as an important factor in determining the success of group counseling with mental defectives.

The present research is a basic endeavor to determine the therapeutic effects that occur with mental retardates following the application of two different approaches to group counseling, a group-centered approach and a more structured, directive approach. If the hypotheses proposed are statistically supported, the present study could have a positive influence on programming for the mentally retarded, i.e., group-centered counseling being developed as an accepted therapeutic treatment program.
Definition of Terms

**Mild Mental Defective**—an individual who functions intellectually within the educable range of mental retardation (I.Q. range 50-75); possesses all basic self-help skills, has been exposed to basic academic curricula, and has the vocational potential for eventual return to the community.

**Group-Centered Counseling**—involves an approach that follows the phenomenological philosophy. This point of view characterizes man as having the capacity to experience in awareness the factors in his psychological maladjustment and possessing the capacity to guide, regulate, and control himself, providing that conditions exist that will liberate this potential. The client-counselor relationship is of utmost importance. The group process is one that provides for expression of feeling, group interaction, freedom for role playing, and opportunity for problem solving. In this approach, the members select the material to be discussed. The leader accepts this material as worthy of consideration and as a means for group development. The group leader facilitates the change of individual self concept by his acceptance, reflection, and clarification. The leader, through his respect for the ability of each group member, assists each member to understand, accept, and respect himself.
The leader is constantly aware of responses made from the client's frame of reference. The counselor accepts the individuals as people of worth and refrains from interpreting expressions and/or behavior. Group process is completely dictated by the group members.

**Directive Group Counseling**—follows a didactic approach. The counselor acts as a teacher and is very active in directing the group process and interpreting feelings and/or behaviors. The counselor initiates group discussions centered around problem solving situations. Group discussions are restricted to previously selected subjects and topics. The counselor points out consequences of behaviors and suggests more approved modes of behaving.

**Limitations of Study**

The subjects included in this study were institutionalized mild mental retardates who had been diagnosed as cultural familial retardates. Generalizations are, therefore, limited to individuals of similar etiology and retarded individuals residing outside the institution cannot be included in these generalizations. It should
also be noted that even though one group may show a significantly more positive self concept score, generalization cannot be made for each individual in the group.
CHAPTER BIBLIOGRAPHY


A review of the literature indicates that the effectiveness of counseling with mental retardates has certainly not been universally accepted. Much of the skepticism concerning the feasibility of counseling with the mentally retarded is based on information that has long since been outdated and misconceived ideas many people have regarding the concept of mental deficiency. In some instances, the misconceptions result from researchers not possessing sufficient knowledge of retardation and the dynamics of the mentally retarded individual.

The official definition of mental retardation developed by Heber states that, "mental retardation refers to subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior" (7, p. 499). This definition encompassed some meanings that were dramatic changes from previous ones. The greatest departure from the classical and historical concept of mental retardation was the fact that retardation was not viewed as a reversible condition. Heber and his
associates were suggesting that an individual may meet the
criteria of mental deficiency at one time and not at
another. A person may change status as a result of changes
in social standards, environmental conditions, or as a
result of changes in efficiency of intellectual functioning,
with level of efficiency always being determined in relation
to the behavioral standards and norms for the individual's
chronological age group. This new direction had a tremendous
impact upon the type of diagnostic and treatment programs
that were being used with the retardates.

Mental retardation is a constellation of syndromes
that affect approximately 3 per cent of the total population.
It is not a disease, although retardation may be the result
of a disease. The principal characteristics of mental
deficiency are retarded intellectual development and
inability to adapt to demands of society. Based on current
knowledge, more than one hundred causes of retardation have
been identified. Retardation may be caused by factors
which affect the embryo or fetus during development; affect
the infant during the birth process, shortly after birth,
or during the child's early years of growth and development.
With present techniques of diagnosis it is possible to make
a positive and precise identification of the cause of
retardation in only 15 to 25 per cent of all the cases.
Unfortunately, the present state of knowledge does not permit a definitive diagnosis of the remaining 75 to 85 per cent (16).

By far the largest group of the mentally retarded is composed of those individuals for whom there is no demonstrable pathology in the brain and who are non-identifiable. This segment of the population is usually classified as the mildly retarded. There is some evidence to suggest that this group may be the result of yet to be determined or understood genetic factors. A large number of individuals are born and reared in intellectually, socially, and emotionally deprived environments. There is ample evidence to indicate a positive correlation between the prevalence of mental deficiency and the socio-economic status of the family and the community. Such conditions foster a lack of opportunities for learning that somehow interferes with normal development during the early years.

For the most part, the mildly retarded individual approaches normalcy in physical characteristics. Motor development is relatively normal and eye-hand coordination is about average to that of individuals of the same chronological age range. Education skills may be developed in structured special classes and related academic programs; however, rarely is the retardate capable of profiting from
instruction beyond the elementary level. They are generally able to compete, with a moderate degree of success, in selected non-academic subjects at the secondary level, such as physical education, art and crafts, and manual arts.

Individual Counseling with the Mentally Retarded

Renewed efforts toward the resolution of the problems of the mentally retarded following World War II did much to develop and implement new treatment programs for the mildly retarded. The sheer economic costs to states providing adequate residential facilities for the ever increasing number of mild defectives reached a level whereby alternate measures were sought to help alleviate the problem. One such measure was that of providing concentrated training for the mildly retarded individual so as to make him capable of sustaining himself with only minimal assistance.

In order to reach this goal of preparing the mild retardate for an eventual self-supportive existence in society, innovative training programs were initiated. The concentration of programming was on educational and vocational training for the mild retardate; the assumption being that improvement in these areas would greatly facilitate the individual returning to this community. Although these efforts made significant contributions to the overall goal
of habilitating the retarded, it was discovered that many of their problems of learning and adjustment were further complicated by serious social and/or emotional problems. While great strides were being made in the vocational and educational training programs with the mentally retarded, it became evident that this approach alone would not suffice. Without therapy programs designed to aid the retardate in developing ego awareness, healthy interpersonal relationships, emotional stability, socially appropriate behavior, self control, etc., these other programs would be meaningless.

Even though a variety of programs had been implemented with the mentally retarded, only until a relatively few years ago was counseling and psychotherapy accepted as a treatment procedure. A large part of this change in the philosophy concerning counseling with the retarded was due to the fact that mental deficiency was being viewed in a different light. Principally, mental retardation was seen as having contributing emotional causes and counseling was reported to be effective as a modifier of emotional problems. The logical conclusion of this newly proposed concept was that when the primary cause of mental retardation was emotional, it then became a condition amenable to counseling and psychotherapy (19).
A vast majority of the conflicting reports of early studies in the area of counseling with the mentally retarded at first appeared to demonstrate the inconclusiveness of research in this area (18). In actuality, these reports were indicating the need to assess more accurately the varying needs of the mentally retarded and to keep in mind that a variety of circumstances generally determines how individuals may best be served. Most of the researchers agreed that mental retardation offers an obstacle to change in personality dynamics, but they were likewise convinced that counseling and psychotherapy could surmount these difficulties and provide a suitable outlet for the release of emotions, tensions, and anxieties which handicap behavioral functioning. Non-verbal adherents felt very strongly that intellectual retardation did not seriously deter the retardates' amenability to non-verbal techniques. However, the exponents of verbal procedures were also convinced that the intellectual limitations of the individual did not negate conceptual communications.

The question regarding the appropriateness and efficacy of psychotherapy with the mentally retarded left the realm of theoretical conjectures and entered that of experimental inquiry during the late 1940's and early 1950's. Heiser (8) reported on the progress of fourteen children enrolled in a
program of individual counseling at the Training School in Vineland, New Jersey. The students were selected on the basis of their need for therapy, their potential for improvement, and their etiology. Those children selected consisted of one familial, six organic, and seven psychogenic retardates. The results of one year of therapy showed improvement in eleven cases, four which showed I.Q. increments. A follow-up study showed that the one familial and one psychogenic case were returned home, two others went home slightly improved, and nine of the remaining ten continued to show significant improvement. Although there were no controls and the study lacked precise measurement devices, the author believed that counseling was of great benefit to the students involved.

Being knowledgable of the learning difficulties of the retardate, Kaliski (11) and Neham (14) dwelt upon the reeducation of the retardate to assist him in realizing his intellectual potential and to aid him in functioning more appropriately. Both authors proposed that the essence of therapy and counseling was setting a stage for learning and growth. Stress was placed upon properly motivating the individual by creating incentives and reducing undesirable stimuli. The role of the therapist was that of a model which the student could emulate. The therapist established
this type of relationship by being friendly, accepting, tolerant, supportive, yet directive enough to "teach" the student acceptable modes of behavior. Neither Kaliski nor Neham reported any conclusive findings.

A less education-oriented approach was reported by Munday (13) with twenty-three mentally and physically handicapped adolescents. Treatment, which consisted of individualized therapy and non-directive play activities, was continued for nine months. The underlying hypothesis of the experiment was that the most potent factors in psychotherapy with the retarded are emotional rather than intellectual comprehension and that the success of therapy depends more on the necessary emotional processes taking place than on the mental level of the individual. Of the twenty-three children who were involved in the treatment program, fifteen demonstrated considerable progress in language development, reduction of anxiety, and social behavior. The author concluded that sufficient comprehension existed down to the forty and above I.Q. level for individual therapy to effect change in emotional adjustment. In addition to these findings, it was noted that those students who were diagnosed as being organically impaired did not profit from therapy. Mundy concluded that therapy with mental retardates was justified and could have some
profound influence on their intellectual as well as social behavior.

Success with individual psychotherapy in an institution for the mentally retarded was also achieved by Friedman (5). The client was an adolescent retardate reported to have scored I.Q.'s from a low of 51 to a high of 72. The youngster had a previous history of acting-out and incorrigible behavior. A very permissive atmosphere created by the therapist for the first six months resulted in improved client behavior and courtesy toward the therapist. During the second 6 months, the student's behavior continued to improve, but the therapist became the object of extreme hostility and aggression. Later, the student became more friendly and expressive, therefore, quite amenable to counseling. Behavior outside counseling sessions likewise revealed improvement. A period of visits to the student's home followed, and he eventually adjusted to living with his family. Scores from I.Q. tests and projective devices confirmed the therapist's belief that progress was obtained. The concluding period of counseling showed continuing improvement, which resulted in the student being placed at home. The author concluded that "contrary to other reports in the literature, prognosis can be favorable" for defective individuals (5, p. 31). The implications were that
institutions should make use of counseling for borderline
and mild retardates.

Group Counseling with the Mentally Retarded

The techniques and methods of group counseling with
retardates were drawn from psychology, psychiatry,
recreation, group work and progressive education. The
bulk of the literature in psychotherapy with the mentally
retarded deals with group counseling and therapy, doubtless
because of many retardates' institutionalization; forced
group living, and the shortage of funds and personnel in
institutions. Varying degrees of success have been reported
with groups of mentally defective students.

A pioneer study in the field of group counseling with
the mentally retarded was conducted by Cotzin (2). He
hypothesized that regardless of the individual's intellec-
tual capacity, it was possible to facilitate progress in
personality and social adjustment through group interaction.
This exploratory project was conducted with nine mentally
defective males ranging in age from eleven years and six
months to fourteen years and eleven months. The I.Q.'s of
the group members ranged from 50 to 79. Only one student
had an I.Q. above 70 and the average I.Q. was approximately
62. Average length of institutionalization was five years.
The group met for a total of ten sessions, each one lasting for one hour and fifteen minutes.

Some of the observations resulting from this study were most interesting. The therapist found that it was necessary to change his role from a neutral, passive one to a more active but indirect one. He became more involved in stimulating collective and cooperative behavior. As the amount of his involvement increased, the behavior of the boys proceeded to be more purposeful and disciplined. The author indicated that the first five or six sessions were unruly, yet he felt they were important and productive in that these "warming up" sessions provided some baseline of decorum for the group, a setting for release of tension and hostility, and valuable diagnostic dynamics for the therapist. On the basis of observations and reports made by teachers who had these boys in class, all nine of the students showed remarkable improvement over their previous behavior. Considering that activities outside the counseling sessions were unchanged, the change in behavior and personality was assumed to be due to insight and release obtained in the sessions.

After an observation period of one year, six of the nine boys who participated in Cotzin's study were still showing improvement, three of them being judged as well
adjusted and three of them rated as fairly well adjusted. One boy was dropped from the study because of severe epileptic seizures and the remaining two students were rated as regressing back to their former behavior. Cotzin viewed his results as indications of success. However, he recommended that long-term group counseling might lead to good adjustments for longer periods of time. The value of group therapy with retardates appeared to be substantiated and the way toward further research was clearly indicated.

During the mid-nineteen fifties, several years after Cotzin's research, further exploratory studies were conducted (9, 15, 17, 25). Most of these experimenters reported results that concurred with the concept that group counseling could have positive effects on the total adjustment of the mentally retarded. A contrary view, however, was presented by Vail.

In Vail's (21) study, which revealed no dramatic changes, a non-directive counseling approach was used with four to ten mentally retarded subjects ranging in age from twelve to thirty-seven years. The I.Q. range of the students was from 35 to 72, with most of the students being unstable, aggressive, and disturbed. Counseling sessions were conducted twice weekly for seven and one-half months. The results obtained in the study indicated that students
receiving group counseling showed no marked changes; however, Vail did conclude that the effectiveness of group counseling largely depended on the particular counseling approach that was used.

Although Vail was investigating the efficacy of non-directive therapy with mental retardates, it is interesting to note that the therapist was inconsistent in the type of approach he intended and the approach he actually implemented. By definition, non-directive treatment utilizes verbal communication and stresses the imparting of emotionally significant information by the patient and minimal necessary rise of interpretation as well as dictation or direction by the therapist. However, the author repeatedly made mention of setting limits for the group, establishing rules, discouraging acting-out behavior, and didactic instruction. Vail admitted that the technique employed was clearly not non-directive. A follow-up after one year indicated that the students who attended the fewest number of sessions showed the greatest improvement. However, these findings are seriously questioned because of insufficient experimental control and evaluation data. One major contribution made by Vail's study was that it pointed out the inherent difficulties in categorizing therapy as either directive or non-directive.
A study conducted by D'Angelo (3) likewise found no measurable differences between experimental and control groups of mentally retarded girls who were involved in a program of group psychotherapy. Although he did not define the approach used in his study, D'Angelo used a technique that was similar to the one used in Vail's research project. The experimental groups were comprised of twenty-six students who were given therapy one hour a week for six months. All of the students were pre-tested and post-tested with a self-concept scale, Barron's Ego Strength Scale, Inventory of Affective Tolerance, an adjustment rating scale, and a specifically drafted symptom rating scale. The test results failed to reveal any changes in the students' adjustment, although it was noted that the experimental group evidenced greater realism, concern, and introspection. The small margin of difference between the students' pre- and post-treatment adjustment behavior made it impossible to ascertain to what degree the results were fortuitous or the consequence of therapy.

Of the other reported studies using a non-directive orientation with groups of retardates (15, 17, 25) the research of Yonge and O'Connor (25) reported the greatest success. The approach used by Yonge and O'Connor was that of a permissive, though not a passive therapist attitude.
Three groups of defective male delinquents, matched on intelligence, age, and behavior disorder, were selected. Each group consisted of eight students. The students ranged in age from sixteen years to twenty-one years and had earned I.Q.'s of 52-89 on the Wechsler Verbal Scale. One group was given workshop training plus two sessions of group psychotherapy a week for six months. The second group received only workshop training, and the third group continued to follow their everyday institutional routines.

As a method of evaluating the effectiveness of therapy, checklists of behavior and psychological re-evaluations were administered. Both measurements revealed positive behavior changes in the experimental group that received group psychotherapy. No significant changes were reported in the workshop or control group. The improved verbal intelligence scores of the experimental group who received group psychotherapy and the significant changes in workshop behavior matched the changes in attitude observed in the therapy sessions. Probably the most important feature of the reported therapy process was the development of an improved therapist-client relationship. The students seemed to accept the therapist and look to him for support.

For further clarity on the advantages and effectiveness of directive procedures, Appell and Martin (1), Fine and
Dawson (4) and Kaufman (12) each offered reports on group therapy where the focus was upon the leadership and guidance of the therapist. Although the long term effects of these projects were questionable, Kaufman (12) indicated significant progress on the part of the students involved in his study. Eight male students, aged eighteen to twenty-five, with Wechsler Adult Intelligence Scale I.Q. scores of 61 to 77, and with no gross neurological involvement or physical defects were involved in the study. The group met once a week for a period of one year. The therapist supplemented these sessions with field trips to the community twice a month. During these outings the students were acquainted with situations that they would encounter after they were discharged. The author reported that he was able to identify four aspects of the group process; namely, catharsis, transference, new impetus for learning, and social pressure of the group toward conformity. After one year, the changes of the students seemed to be mainly in the direction of increased socialization. Of the eight students, six had received permanent discharges from the institution and were living in the community.

Although the researchers with directive orientation were reporting changes in the behavior of students involved in their projects, there were no indications of increased
self-reflective insight, increased capacity to offer solutions or interpretations of a meaningful nature, or more positive self concept. Realizing that neither of the traditional approaches, non-directive and directive, were sufficiently serving the desired purposes, a large number of therapists began deviating from these therapeutic patterns. What ensued from these explorations was a new therapeutic design which combined non-verbal, directive, and non-directive techniques. The role of the therapist was one wherein he was accepting yet not totally permissive, interacting but not directing, providing clarification and not interpretation, and supportive.

Utilizing this modified group therapy technique, Kaldeck (10) reported on a program which involved 104 patients, in groups of ten to fourteen each, whose chronological ages were between 17 and 40 and whose I.Q.'s were close to 50. Therapy sessions lasted approximately one hour per week for a period of thirty months. The underlying hypothesis was that the institutionalized retardate could adjust to community living if they had appropriate and effective psychotherapy to remedy their emotional and social difficulties. Although the therapist adopted an accepting attitude, he made it clear to the students that certain kinds of behavior were unacceptable. The project attempted to decrease
anxiety, withdrawal, and hostility through group discussions. The reported results were encouraging in that the students' tensions were alleviated and their interpersonal relationships were improved.

In the study of Wilcox and Guthrie (23), the role of the therapist as well as group heterogeneity was emphasized. Thirty-seven female retardates were divided into three groups, one passive, one aggressive and one mixed group. Three therapists saw the students three times a week for one hour, for a total of twenty-five sessions. The objectives of therapy were to reduce the suspiciousness the girls felt towards others, to release hostility, to encourage feelings of self-worth and self confidence, and to develop in the girls a feeling of responsibility for their behavior. The students were encouraged to share and ventilate their feelings of insecurity, inferiority, and hostility. The therapist offered reassurance, clarification of feelings, and support. Throughout the sessions, the therapist attempted to help the students to develop more mature ways of meeting their personal needs and increase the girls' feelings of acceptance as worthwhile human beings.

During the first part of the therapy sessions, the students revealed very little understanding of their difficulties and an inability to deal with them.
The therapists found that when they became more active in the group process, the sessions became more productive. This activity included taking the lead in initiating topics for discussion, encouraging group participation and keeping the discussion focused on relevant information. It was thus concluded that a therapist who contemplates working with a group of retarded individuals should be prepared to take the responsibility of leadership of the group until some of the group members can assume this role. A rating form divided into categories of care of self and social responsibility, interpersonal relations, self control, and work and recreation indicated that the experimental group showed marked improvement and led the authors to conclude that primary verbal therapy is effective in producing change in groups of institutionalized mental retardates.

Stubblebine's study (20), which utilized a similar design and structure to that of Wilcox and Guthrie's study yielded similar results. He employed a modified non-directive approach with six mentally retarded students in an effort to see if this type of treatment could draw the students into a closer contact with their environment and counteract some of their feelings of resentment and depression. A total of forty-four sessions were held, each lasting one hour. Although some individual behavior changes
were encouraging, no universal or common improvement in all of the students was indicated.

Conflicting results have been reported in other studies utilizing a modified non-directive approach. Gorlow's study was designed to determine the changes in self-attitudes and behavior of retardates following participation in group therapy. Forty-two females, fifteen to twenty-three years of age, with I.Q.'s of 50-80, were divided into groups of seven each and given one hour of therapy three times a week for thirteen weeks. A control group of thirty-seven other retardates pursued normal institutional routines.

Ratings were made in terms of Wilcox's Behavior Rating Scale and the Laurelton Self-Attitude Scale. The therapy procedure consisted of allowing the participants to express themselves freely, while enabling them to experience the interest and warmth of a generally permissive, accepting, encouraging adult. The goal of helping the students to develop more natural ways of coping with their problems was not realized, as test results showed no differences in the ratings of the experimental and control groups.

Wanderer and Sternlicht (22) presented exploratory findings on a procedure designed to aid the retardate in achieving acceptable behavior patterns. A modified non-directive group psychotherapy approach was suggested to
avoid overdependency upon the therapist by the students. This technique consisted of a discussion of behavioral alternatives in the therapeutic relationship. Acting on the premise that the first few sessions were crucial in establishing a positive, working relationship between the student and the therapist, the therapist employed a novel technique to establish rapport.

With the four groups of institutionalized mentally retarded male adolescents, each group comprised of from eight to eighteen subjects, ages fourteen to eighteen, and I.Q.'s from 38 to 68, the author conducted a series of wrestling matches to determine the strongest member of the group. The victor then engaged in an Indian hand-wrestling match with the therapist who, by employing leverage, assured himself of victory and thereby demonstrating his physical superiority. The underlying rationale for this was that the wrestling matches permitted an "authority-dependency transference" to develop.

Following a two year period of therapy, the authors concluded that the negative aspects of directive counseling (fostering of dependency and destruction of self-image) could be eliminated by having the therapist offer the students a series of alternatives. By allowing the student to choose a solution, the therapist could facilitate
realistic attitudes and consequent adaptive behavior. They also felt that although the student might not choose the best solution, it was nevertheless valuable in that it was his own choice. There were no formal experimental reports of this procedure, yet the provocative nature of the study gave rise to further research.

The concluding investigation reported in this review of the literature, one conducted by Wilson (24), used a technique whereby the therapist was active in the therapy process; however, in a supportive, understanding manner. An innovative aspect of this study was that the author attempting to assess the effects of short-term group interaction sessions on the social adjustment of mentally retarded youngsters. There were six students in the treatment group who participated in interaction sessions of one hour each for five weeks. The control group of six students was not involved in such sessions. The mean age of the two groups was 20.25 years with the mean I.Q. being 68.1. Before and after the five week program, both groups were given the Social Adjustment section of the California Test of Personality.

The mean gain in social adjustment for the experimental group was 2.83 (p = .05). Consequently, the results of this study revealed that participation in group interaction
sessions did lead to significant change in social adjustment and that a short-term group approach is effective with the mentally retarded.

Summary

Thus far, the reported research on counseling and psychotherapy with the mentally retarded has been primarily of an exploratory and pioneering nature. The approaches and techniques used for the most part have been unrefined and unsystematic. Consequently, the results reported have been tentative and not conclusive. A majority of the reported studies indicate successful results in the use of individual and group counseling with mental retardates. Unfortunately, though, the degree of success is frequently ill defined and subjectively explained.

Two features of group counseling that research studies have consistently reported as being of utmost importance are the necessity of an approach which is group-centered and designed to fit the individual needs of the retarded, and the therapeutic advantages of working with the retarded in groups. Group-centered counseling is characterized by creation of a warm, permissive atmosphere, client-centered discussions, response to and clarification of feeling, setting some limits, giving support, praise, encouragement, and reassurance.
The most important implication drawn from the literature reviewed in this chapter is that counseling and psychotherapy can be effective in the total habilitation of the mentally retarded. Although a hasty observation may suggest that little has been accomplished by this research, it should be understood that problems of confusion and lack of clarity always exist in the earlier periods of research in the behavioral sciences. Moreover, because of the previous studies, it should be possible now to raise more pertinent questions, improve techniques, and attain more conclusive results. All of the research reported underscore the opportunity available to therapists to fully utilize their imaginative capacities in order to aid the mentally retarded in realizing their potential contribution to society.
CHAPTER BIBLIOGRAPHY


CHAPTER III

METHOD AND PROCEDURE

Research Setting

The setting for the present study, Denton State School, is a residential institution for mental retardates. Denton State School is one of ten residential facilities operated by the Texas Department of Mental Health and Mental Retardation. There are approximately 1,625 resident admissions, ranging in chronological age from one year to seventy-four years, at the school. The total population is comprised of some 280 mild retardates (I.Q. 50 to 75), 351 moderate retardates (I.Q. 35 to 50), 382 severe retardates (IQ 20 to 35), and 612 students who are functioning at the profound level (I.Q. 20 and less). Training programs vary with the specific levels, e.g., operant conditioning projects for the profound retardate, self-help training with the severe, and pre-vocational instruction for the moderately retarded. For the most part, the classification group from which the research sample was selected is involved in a habilitation program consisting of vocational and academic training. The vocational-education program generally
includes academic classroom instruction, which is supplemented with on-the-job evaluation and training.

Subjects

A total of thirty-six students residing at the Denton State School, eighteen males and eighteen females, was used as subjects for this study. Initially some fifty students were determined eligible for the research project. All of these students met the standards established by the research criteria. The thirty-six subjects involved in the study were randomly selected from the group of fifty eligible participants. Subject selection was based on intelligence quotients (I.Q.) obtained from the most recently administered Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence Scale. All of the individuals involved in the study functioned within the mild range of mental retardation (I.Q.'s 50-75). Chronological age (CA) for the subject population ranged from fifteen years to twenty years and six months. The etiology classification of all subjects was diagnosed as cultural familial retardation by the medical staff of Denton State School. Students manifesting significant sensory impairment and/or medication problems were excluded. Tables I and II give descriptions of the three major groups of students who participated in the research study.
TABLE I

DESCRIPTION OF RESEARCH SUBJECTS

<table>
<thead>
<tr>
<th>Student Number</th>
<th>Group</th>
<th>MA</th>
<th>I.Q.</th>
<th>CA in Months</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Exp. I</td>
<td>8-2</td>
<td>68</td>
<td>188</td>
</tr>
<tr>
<td>2</td>
<td>I</td>
<td>8-1</td>
<td>66</td>
<td>193</td>
</tr>
<tr>
<td>3</td>
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<td>4</td>
<td>I</td>
<td>10-3</td>
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</tr>
<tr>
<td>5</td>
<td>I</td>
<td>9-5</td>
<td>66</td>
<td>212</td>
</tr>
<tr>
<td>6</td>
<td>I</td>
<td>7-2</td>
<td>58</td>
<td>181</td>
</tr>
<tr>
<td>7</td>
<td>I</td>
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<td>8</td>
<td>I</td>
<td>8-2</td>
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<td>I</td>
<td>8-5</td>
<td>57</td>
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<tr>
<td>11</td>
<td>I</td>
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<td>I</td>
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<tr>
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<td>7-1</td>
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<td>7-5</td>
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TABLE II
MEANS OF GROUP CLASSIFICATIONS

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<th>Mean CA in Months</th>
<th>CA Range in Months</th>
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<td>12</td>
<td>63</td>
<td>50-75</td>
<td>204</td>
<td>183-236</td>
</tr>
</tbody>
</table>

Description of Instruments

The Children's Self Concept Scale.--This scale, developed by Lipsitt (2) is comprised of twenty-two trait descriptive adjectives, nineteen of which are rated positive and three negative. Each subject rates himself on a five point scale ranging from "not at all" to "all of the time." The subject is to place an "X" in the rating category that best describes how he perceives himself. A score of five is received on an item if the subject checks the first category, a score of one if the last category is checked, except in the case of the three negative adjectives where the scoring procedure is reversed. A score on the self concept scale is obtained for each subject by summing the ratings on each item. Higher scores reflect more positive self concept and lower scores indicate degree of self disparagement. The range of possible score is 22 to 110.
Norms for the Children's Self Concept Scale were obtained from a population of 298 fourth, fifth, and sixth grade students. This scale has been extensively tested for reliability with large numbers of children. The test-retest reliability correlations varied from .73 to .91. They were said to be significant at the .01 level of confidence.

The Children's Self Concept Scale was selected as an evaluation instrument for this study because of several reasons. After considerable investigation, it was determined that the Children's Self Concept Scale was the most professionally accepted self concept assessment instrument available. The population used for standardizing the Children's Self Concept Scale was comparable in mental age functioning to the subjects used in the research study. Another reason for utilizing this particular evaluation tool was the reasonably good test-retest reliability that had been established. In addition, the relatively elementary reading skills required in taking the Self Concept Scale made it more applicable for the mentally retarded individuals involved in the study (see Appendix B for reading levels of research subjects).

The Children's Form of the Manifest Anxiety Scale.--This scale, developed by McCandless, Castaneda, and Palermo (1),
is a modified extension of the adult manifest anxiety form devised by Taylor. The scale consists of forty-two anxiety items, each necessitating a "yes" or "no" response from the student. The student is instructed to place a circle around the word "yes" if he thinks the statement is true of him. He is to circle "no" if the statement is not true about him. An index of the level of anxiety is obtained by summing the number of items that are answered "yes." Larger scores indicate a higher index of anxiety level.

Normative data was obtained from a population of 361 fourth, fifth, and sixth graders drawn from four different school populations. The scale has been tested for reliability with a one week test-retest reliability correlation that averaged about .90. The correlation coefficients were significant at well beyond the .01 level for all three grades included in the population.

The primary rationale for using the Children's Form of the Manifest Anxiety Scale in the research study was the comparability of its normative population and the research sample. This comparability was based on mental age levels of the two populations. Also, in comparison to similar evaluation instruments measuring anxiety, the Children's Form of the Manifest Anxiety Scale has the most respectable test-retest reliability correlation (.90).
Behavior Rating Scale.--As a result of not finding an instrument that was especially designed for the institutionalized mentally retarded in an academic setting, a behavior rating form was developed that would better describe behavior characteristics observed in the classroom. This measuring instrument was developed by the investigator with the assistance of four special education classroom teachers employed at Denton State School. In order to construct this instrument, one teacher from each Level III, IV, V, and VI academic class was asked to record incidents of inappropriate behavior they observed in the classroom. Levels III, IV, V, and VI are specific grades in a special education program. These classes represented typical special education groups and were comprised of the research subjects as well as residents who were not involved in the study. Three students in Level III were not involved in the study. Teachers collected this information for three weeks. At the end of the third week, the experimenter and teachers selected sixty behavioral traits that occurred most frequently in a classroom setting. These descriptive traits were then used as evaluation statements on the rating scale (see Appendix A).

All of the behavior traits included in the scale were rated negative and reflected inappropriate behavior.
Each subject was rated by his teacher on a six point scale ranging from "always" to "never." The rater placed a check mark under the appropriate rating category that best described the student's current behavior. A score of six was received on an item if the "always" category was checked. The numerical value of an item decreased as the rating occurred in categories along the other end of the continuum, i.e., a rating in the "never" category would receive a value of one. A score was obtained by summing the ratings made on each item. Higher scores indicated more inappropriate behavior whereas lower scores reflected better behavioral adjustment. The range of possible scores was 360 to 60.

Inter-rater reliability of the Behavior Rating Form was established at .89. The inter-rater reliability was established by having the four teachers, who made the ratings in the research study, rate ten students on the Behavior Rating Scale. The same ten students were then rated by two other teachers at Denton State School who were not involved in the study. A statistical comparison was then made on these ratings, resulting in the reliability coefficient.

Design of Study

Subjects were randomly assigned to one of three major groups; group-centered (Experimental I), directive
(Experimental II), and control. Each of the three groups were comprised of twelve students.

After the pre-testing period was concluded, the two experimental groups (group-centered and directive) were divided, by random assignment, into two smaller sub-groups. The resulting experimental treatment arrangement is shown in Figure 1.

Experimental Group  
Sub-Groups

![Diagram of experimental arrangement](image-url)

Fig. 1--Experimental arrangement involved in grouping
The rationale for the division into sub-groups was to create an atmosphere conducive to optimal group interaction and emotional expression. The final statistical analysis was based on the change shown between the major groups and not the sub-groups.

Experimental group Ia met for two sessions a week; Tuesdays from 6:00 P.M. to 7:30 P.M. and Thursdays from 7:30 P.M. to 9:00 P.M. Experimental group Ib met twice weekly; however, their schedule was Tuesdays from 7:30 P.M. to 9:00 P.M. and Thursdays from 6:00 P.M. to 7:30 P.M.

Both experimental groups Ia and Ib met for a total of twenty sessions with the experimenter serving as the counselor for each group. As indicated previously, a group-centered counseling approach was used with the Experimental I groups. The distinctive characteristics in this particular counseling approach included focusing on interpersonal relationships, emphasizing counselor-client relationship, providing means for self concept development, and offering opportunities for acceptance, self direction, and problem solving. Discussion material and content of the sessions was dictated solely by the participants and the emotional tone of the group at the time. The only structure placed on the sessions was that everyone was to be on time for a session to begin and that sessions would run only for the specific time allotted.
Counseling sessions for Experimental groups IIa and IIb were conducted at the same time as were those for groups Ia and Ib. Both groups met for a total of twenty sessions and were led by a counselor who had a strong didactic orientation and training experience. Consequently, the counseling approach was highly directive and structured. In contrast to the group-centered sessions, discussion materials were prepared and introduced by the counselor. Much of the session time was spent with the counselor lecturing on problem areas and pointing out appropriate modes of behavior. Group interaction was not excluded; however, the counselor always attempted to direct the discussion and keep it focused on the problem situation. Interpretations of underlying feelings and behavior were frequently made by the counselor. In cases of indecisiveness on the part of a student, the counselor would offer advice as to the most acceptable way in confronting a problem. On three different occasions, films and other visual aids were used as instructional materials. At the end of each session the counselor summarized and evaluated the session with regard to group progress, emotional climate, and individual behavior. The intent of the counselor was to establish a therapeutic relationship with the students, yet
remain sufficiently detached from the group process so as not to destroy his leadership role.

All of the students in the Experimental I and Experimental II groups were enrolled in a vocational-education program at Denton State School. Each student received classroom academic instruction for half a day. The remaining half day included vocational training in assignment areas on the grounds of the institution.

The twelve subjects in the control group continued their respective regularly scheduled activities. Eleven of these students were enrolled in the vocational-education program. One of the control group subjects was a full-time academic school student. The involvement of these twelve subjects was limited to pre-testing and post-testing procedures.

Counselor Qualifications

The experimenter served as the facilitator for the two Experimental I sub-groups that received group-centered counseling. At the time of the research project, he was employed as the Director of Vocational-Education at Denton State School and had completed the required coursework for the doctoral degree in counseling at North Texas State University. In addition to classroom instruction, he had
completed a one-year graduate practicum in counseling in the North Texas State University Pupil Appraisal Center. Graduate level classroom requirements included a course in group counseling and group counseling experiences with college students. The experimenter had four years of experience as a psychologist at Denton State School and adhered to the group-centered counseling approach. While employed as a psychologist, the experimenter conducted several group counseling sessions with retarded students.

The counselor for the Experimental II sub-groups that received directive oriented group counseling was also a doctoral candidate in the counseling program at North Texas State University. During the study, he was enrolled in a graduate level course in group counseling. He was employed as a psychologist at Denton State School. He also had three years of experience as a school counselor in the Dallas Independent School District. The Experimental II group counselor adhered to a directive, didactic approach.

Procedure for Collecting Data

Subjects of all three major groups were administered the Children's Self Concept Scale and the Children's Form of the Manifest Anxiety Scale prior to the treatment procedure. Both of these instruments were orally administered and fully
monitored by the counselor in order to insure student understanding. Prior to the actual pre-testing, the evaluation forms were administered to several students at the Denton State School who were not involved in the study and it became apparent that most of the individuals did not comprehend the word "obedient." Therefore, in an effort to facilitate understanding, Item 17 on the Children's Self Concept Scale was modified to read, "I obey rules," instead of the original statement, "I am obedient." No other revisions appeared necessary.

In addition to the Children's Self Concept Scale and the Children's Form of the Manifest Anxiety Scale, a Behavior Rating Scale (Appendix A), specifically designed and developed for this study, was used in the pre-testing procedure. Each subject was rated on the Behavior Rating Scale by the teacher with whom he had regularly scheduled classes.

All of the twenty-four experimental subjects participated in twenty group counseling sessions spaced over a period of thirteen weeks. One week following the termination of the counseling sessions, both of the experimental groups were administered the Self Concept Scale and the Anxiety Scale by their respective counselors. The control group subjects were post-tested by the counselor of the group-centered group.
The post-testing was conducted in the same manner as was the pre-testing. Test questions were presented orally and the testing was closely monitored. Subjects of the control group were administered the above mentioned evaluation instruments by the same person who conducted their pre-testing.

The remaining evaluation instrument, the Behavior Rating Scale, was administered two days after the other post-testing procedures. Rating forms for each student involved in the study were sent to their respective curriculum classroom teachers. In each instance, the teacher making the post-test rating was the same person who made the initial rating. Teachers were instructed to rate the present classroom behavior of each student in accordance with the items listed on the rating scale. Teachers had no knowledge of particular group assignments of the students.

Procedure for Treating Data

The pre-test and post-test scores of the three measures, Children's Self Concept Scale, Children's Form of the Manifest Anxiety Scale, and the Behavior Rating Scale, were statistically analyzed by means of an analysis of co-variance design for the purpose of assessing the amount of change which occurred in these three areas as a result of different group counseling techniques.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

PRESENTATION AND DISCUSSION OF RESULTS

An analysis of co-variance design was applied to measure the magnitude of change in self concept, behavior, and anxiety level of mental retardates that resulted from two different group counseling approaches. The hypotheses formulated in the study were restated as research hypotheses for the purpose of statistical treatment and analysis. A .05 level of confidence was established as criterion for either accepting or rejecting the research hypotheses.

Subsequent to the post-testing period, all of the raw data was processed by the University Computer Center. The research data was computed and punched at the Center; consequently, information received from it was the basis of the statistical report included in this results summary.

Hypothesis I

In an effort to assess the relative degree of change in self concept, as measured by the Children's Self Concept Scale (1), following the different group counseling approaches, Hypothesis I was stated as follows: Significant differences will be found among the mean self concept scores of the
group-centered, directive, and the control groups, with group-centered scores being the highest (indicating more positive self concepts) and control group scores being the lowest (indicating more self-disparagement). Table III presents the pre- and post-test mean scores and standard deviations of the three research study groups on the variable of self concept. Table IV presents the statistical analysis of Hypothesis I.

**TABLE III**

PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS OF THE GROUP-CENTERED, DIRECTIVE, AND CONTROL GROUPS ON THE VARIABLE OF SELF CONCEPT

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Test Mean</th>
<th>Post-Test Mean</th>
<th>Pre-Test SD</th>
<th>Post-Test SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Centered (Exp. I)</td>
<td>78.666</td>
<td>83.500</td>
<td>12.658</td>
<td>10.202</td>
</tr>
<tr>
<td>Directive (Exp. II)</td>
<td>80.750</td>
<td>79.333</td>
<td>11.005</td>
<td>10.882</td>
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<tr>
<td>Control</td>
<td>84.083</td>
<td>83.750</td>
<td>15.441</td>
<td>13.705</td>
</tr>
</tbody>
</table>

The adjusted means obtained by the analysis of covariance design for Experimental I, II, and control groups for pre- and post-test scores were 85.3898, 79.6483, and 81.5452, respectively. With two and thirty degrees of freedom, an F value of 3.32 was required to reach significance.
The F value obtained from the analysis of co-variance, 2.6116, fell below the required level; therefore, the research hypothesis was rejected.

**TABLE IV**

**ANALYSIS OF CO-VARIANCE RESULTS OF HYPOTHESIS I**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Level of Significance</th>
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<tr>
<td>Within</td>
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<td>38.9569</td>
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<tr>
<td>Total</td>
<td>34</td>
<td>1450.0969</td>
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</table>

*Not significant at .05 level.

The data did not support the hypothesis that significant differences would be found among the mean self concept scores of groups Exp. I, Exp. II, and the control group. Although the results were not statistically significant, it should be noted that the obtained F value approached the .05 level (.08). This finding seems to indicate that the two different group counseling approaches did not bring about a significant difference in the way the students perceived themselves. However, results suggest that there was a trend in the direction of the proposed hypothesis, i.e., the students receiving group centered counseling seemed to
express more positive self concepts than students in the directive or control groups.

Hypothesis II

The intent of the research design was to reveal the effect two different group counseling approaches would have on the anxiety level of mental defectives. In order to determine this, Hypothesis II was formulated as follows: The subjects who receive treatment in the group centered group will experience a significantly greater reduction of anxiety (mean scores will be lower), as measured by the anxiety scale, than those subjects in the directive and control groups. Pre and post-test mean scores and standard deviations for the three research study groups on the variable of anxiety are presented in Table V. Results of the analysis of co-variance treatment of Hypothesis II are included in Table VI.

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Test Mean</th>
<th>Post-Test Mean</th>
<th>Pre-Test SD</th>
<th>Post-Test SD</th>
</tr>
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<tr>
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<td>29.0000</td>
<td>7.3045</td>
<td>8.6969</td>
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<tr>
<td>Directive (Exp. II)</td>
<td>26.2500</td>
<td>29.4167</td>
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<tr>
<td>Control</td>
<td>25.2500</td>
<td>23.6667</td>
<td>9.6307</td>
<td>8.5103</td>
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</table>
TABLE VI

ANALYSIS OF CO-VARIANCE RESULTS OF HYPOTHESIS II
N (36)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>Sum Squares</th>
<th>Mean Square</th>
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<th>Level of Significance</th>
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</table>

*Not significant at .05 level.

Adjusted means obtained by analysis of co-variance for Exp. I, Exp. II and control groups for pre- and post-test scores were 27.4162, 29.8522, and 24.8149, respectively. With two and thirty degrees of freedom, an F value of 3.32 was required to reach significance. The F value obtained from the analysis of co-variance, 2.405, fell below the required level; therefore, research Hypothesis II was rejected.

The data did not support the hypothesis concerning anxiety. In fact, the pre- and post-test mean scores of the two experimental groups and the control group reflect an infinitesimal amount of change in anxiety level subsequent to the counseling sessions. Although the research instrument did not measure an increase in anxiety, a change was detected through observations made by the two counselors involved in the research study, i.e., the general anxiety level of the
Exp. I and Exp. II groups was extremely cyclical and fluctuated greatly in accordance with session content. Considering this situation, it is tenable that short term group counseling does not provide sufficient time for anxiety level to stabilize and take on some consistency.

Hypothesis III

A third variable considered in the study was the changes in overt behavior that would occur following two varied group counseling approaches. To determine and statistically evaluate the effect two different group counseling approaches would have on behavior, Hypothesis III was stated as follows: Significant differences will be found between the magnitude of behavior adjustment of subjects in the group-centered, directive, and control groups, with the group-centered post-test mean score being the lowest (suggesting better behavior adjustment) and control group score being the highest (indicating less improvement in behavior adjustment). Table VII presents the pre- and post-test mean scores and standard deviations of the three research study groups on the variable of behavior. Statistical results of the analysis of co-variance treatment of Hypothesis III are presented in Table VIII.
TABLE VII
PRE- AND POST-TEST MEANS AND STANDARD DEVIATIONS OF THE GROUP-CENTERED, DIRECTIVE, AND CONTROL GROUPS ON THE VARIABLE OF BEHAVIOR

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Test Mean</th>
<th>Post-Test Mean</th>
<th>Pre-Test SD</th>
<th>Post-Test SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Centered (Exp. I)</td>
<td>147.4167</td>
<td>136.9167</td>
<td>43.1413</td>
<td>33.0852</td>
</tr>
<tr>
<td>Directive (Exp. II)</td>
<td>141.8333</td>
<td>142.5833</td>
<td>35.3009</td>
<td>41.5833</td>
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<tr>
<td>Control</td>
<td>141.0000</td>
<td>140.5833</td>
<td>36.0782</td>
<td>39.8371</td>
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</table>

TABLE VIII
ANALYSIS OF CO-VARIANCE RESULTS OF HYPOTHESIS III
N (36)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>2</td>
<td>757.1523</td>
<td>378.5762</td>
<td>0.8347</td>
<td>NS*</td>
</tr>
<tr>
<td>Within</td>
<td>32</td>
<td>14513.2344</td>
<td>453.5386</td>
<td></td>
<td>NS*</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>15270.3867</td>
<td>. . .</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Not significant at .05 level.

Adjusted means obtained by analysis of co-variance for Exp. I, Exp. II, and control groups for pre- and post-test scores were 133.5672, 143.9091, and 142.6069 respectively.
With two and thirty degrees of freedom, an F value of 3.32 was required to reach significance. The F value obtained from the analysis of co-variance, 0.8347, fell below the required level; therefore, research Hypothesis III was rejected.

Although the results of Hypothesis III indicate that there were no statistically significant changes in behavior, as determined by the measures used in this study, it is interesting to look at the raw data obtained. The pre- and post-test means scores of Exp. I group reflect a decrease of some ten points (147.4167 to 136.9167) which would seemingly indicate a considerable improvement in behavior adjustment. This would also concur with comments made by teachers who reported some dramatic positive changes in the behavior of students involved in treatment procedures of Exp. I group. However, in comparing the pre-test mean score of Exp. I group (147.4167) with the pre-test mean score of Exp. II group (141.8333) and the control group (141.0000), one finds an initial discrepancy of approximately six points.

Non-Statistical Information

The present study was designed to assess the efficacy of two different group counseling approaches, group-centered and directive, with mental retardates and to determine the subsequent effects these approaches would have on variables.
of self concept, anxiety, and behavior. A cursory observation of the statistical results implies that there were no significant differences between the two approaches in terms of therapeutic benefit. Nevertheless, a casual look at the quantitative results without further investigation could be somewhat misleading.

The concept of group counseling and the emotional nature of its therapeutic processes do not always lend themselves to a quantitative evaluation. Different aspects of group counseling, e.g., therapist-client relationship, insight, self concept modification, etc., are extremely difficult to use as criterion to determine therapeutive change. A problem of this nature regarding this study was the factor of insight and its relationship to anxiety.

There were no significant differences in anxiety levels of the members of the three groups following treatment procedures. Yet, there were indications that the anxiety level did increase, particularly in the directive group. Considering that insight is one of the primary aims of group counseling, an increase in anxiety may indicate a very important aspect of short-term group counseling. More specifically, increased insight may be synonymous with or may lead to greater awareness of one's personal problems and this possibly could precipitate a heightened state of
concern and anxiety. Consequently, a strictly objective evaluation may indicate negative therapeutic results when in actuality results may be positive in the sense that the individual has achieved some insight.

Involved too is the question of how sensitive are the measuring instruments. Many dramatic psychological changes take place without disappearance of overt symptoms. It might well be that objective measuring instruments used are not sensitive enough to pick up what might be subtle yet important changes at a deeper personality level. Even if there are no statistically significant findings regarding test data, this is not justification for concluding there were no positive therapeutic changes.

In an attempt to provide a more descriptive report on the research study, it is incumbent upon the investigator to reveal subjective observations made by the counselors and personal accounts of subjects who participated in the study. From this subjective evaluation, there are numerous indications that students did experience positive changes as a result of group counseling. These therapeutic changes are particularly evidenced by those students who received a group-centered counseling approach.
Throughout the twenty sessions of group counseling with Exp. I and Exp. II groups, the respective counselors recorded numerous, valuable observations. After each session, the counselors of both groups would meet and discuss some of the more significant group dynamics evidenced. It was interesting to make progress comparisons of the two groups.

Both Exp. I and Exp. II groups went through similar stages and transitional phases discussed in the study by Rosen (2). The first few sessions for both groups were relatively superficial and unproductive. Following three or four sessions, both groups entered into a stage of testing limits and frequent acts of open aggression against most everything. During the fifth or sixth sessions both counselors began detecting a difference in the rate of progress and emotional involvement between the two groups.

After the fifth session it became apparent the Exp. II group counselor was having extreme difficulty establishing consistent rapport with his students. There was almost a total absence of a therapeutic relationship between the counselor and students. This lack of rapport manifested itself in several ways. The students seemingly did not feel at ease enough to relate experiences of a personal nature. Therefore, when there were instances of student-counselor interaction, the discussion was very superficial.
Students appeared to be much more comfortable when sitting quietly and listening to the counselor impart information. Attempts to involve the students generally led to even longer periods of non-participation. The counselor commented on several occasions that students were becoming so dependent on his direction that he was finding that the only way to initiate responses from students was to ask questions.

The tremendous desire the retarded have for attention and interest would imply that they are vulnerable to developing strong identifications with anyone who shows them concern. Yet, in Exp. II group there was little evidence of counselor emulation. This fact was quite contrary to the behavior of the students involved in group-centered counseling. There were repeated instances of students overtly seeking a strong positive identification with the counselor. This need was shown in varied manners ranging from dressing like the counselor to asking the counselor how he would react to particular problem situations. In general, the group-centered counseling approach seemed to lend itself to more positive counselor-student relationships and unconditional acceptance of the counselor by the students.

Content and emotional depth of expression was another point of comparison between the two experimental groups. As mentioned previously, members of the directive group
were hesitant to talk freely, particularly about matters that were personal and emotionally loaded. Discussions were very sterile and dealt primarily with institutional rules and regulations. There was almost a total lack of discussion of feelings and emotions. It should also be noted that on occasions when there were brief exchanges among group members, no interest in each other's verbalizations was shown.

In contrast to the directive group, members of the group-centered group were far more verbally expressive. Students became so verbally hyperactive at times that it was necessary for the counselor to ask for brief periods of complete silence so as to regain group composure. Initial expressions were directed toward negative feeling the members had regarding particular dorm attendants and institutional regulations. As the group entered into the sixth or seventh sessions, criticisms lessened in frequency and students expanded the scope of content outside the institution. Focus of the group interaction seemed to center on anxieties experienced by group members when going off-campus and problems related to their vocational training in the community. It was at this point that there was a marked change in the emotional level of the group discussions. Expression became more personalized and there were frequent instances when
students shared mutual problems. Interestingly enough, as the emotional level of the group discussions heightened, group members became observably more empathetic and understanding of their problems.

During the remaining sessions members of the group-centered group evidenced a growing interest and concern for one another. Individual members began showing responses to the needs of other members of the group while previously they only appeared to be concerned with their own needs. Criticism for the sake of criticism seemed to decrease proportionately to the amount of interest they showed in each other's feelings and activities. Criticism levied in group discussions was largely of a constructive nature.

Along with this movement toward a more group-oriented feeling by each member, the students receiving counseling with the group-centered approach began expressing strong support for one another. An example of this supportive attitude was seen on one occasion when a student made repeated derogatory comments about another member. The member who was being verbally attacked was extremely effeminate and spoke in a high-pitched voice. In earlier sessions, he had been called many names by this one member, ranging from "sissy" to "drag." The effeminate student's response to this verbal harrassment was a total withdrawal
from any group interactions. On this particular evening, the feminine-acting student was very despondent; nevertheless, the other group member persisted in making caustic remarks. It was at this point that the remaining members of the group directed an extreme amount of hostility toward the individual making the remarks. This verbal barrage lasted for some fifteen minutes, at which time the student broke down crying and the counselor intervened. A remark made by one of the group members was a classic summation of the feelings being expressed, "Everybody has got their own way of being, but there aint none of them all right. We ought to look at our own bad ways before we talk about others."

Group cohesiveness and group control were two more dynamics of the therapeutic process that revealed marked differences in the two counseling procedures. Members of the directive group never expressed feelings of togetherness. Interaction that took place was high individualized and behavior was ego-centered. The group looked to the therapist for setting limits and establishing group control when necessary. The more the counselor accepted a role of disciplinarian, the more dependent the group became.

In contrast to the directive group, members of the group-centered group exerted a great deal of control. Only in a few instances was it necessary for the counselor to place
restrictions on behavior. Members exerted group control to a significant degree in situations where behavior could lead to ending the group sessions. Frequently, group control initiated by members was far more extreme than it would have been if left to the counselor. The group seemed to develop their own acceptable codes of behavior and mores. It was interesting to observe how similar this value system was to a "normal" society, even though these youngsters had resided in an institution for most of their lives. An illustration of this occurred in the case of one student who repeatedly came to sessions dressed in his dirty work clothes and an Army fatigue jacket. Several times in previous sessions, when group discussions centered around how one should act and dress when off campus working or participating in educational field trips, group members had stated that a person should dress according to the situation. The young man dressed in the fatigue jacket contended in opposition to the whole group that a person should dress the way he wanted. During this particular session, much of the group interaction regarded anxiety that was experienced by students when they were to begin their off-campus vocational training. In order to dramatize some of these feelings, it was suggested by the counselor that a role-playing job interview session be conducted with students acting as both the employer and
prospective employee. The other members were to observe the interview and make personal comments as to how they felt. Ironically, the first group member who volunteered to act the employee role was the sloppily dressed student. Following the mock interview, every remaining member stated that he would have not hired the young man, principally because of his carefree attitude and dress. It was not apparent at that time how much of an impact this incident had upon the young man. However, at the very next session, this student arrived exactly on time dressed in a neat suit of clothes, straight from the shower. There was also a noticeable change in attitude along with the change in physical appearance.

One brief statement should be made in relation to the role leadership played in the counseling process of both experimental groups. Emphasizing what has been reported previously, students participating in the directive groups were extremely dependent upon the counselor. On the contrary, members of the group-centered counseling groups progressively moved toward more independence and individual responsibility. At first, discussions were initiated by the counselor. The counselor found himself very much involved in making interpretations for the group, clarifying feelings and misconceptions, and setting up problem-solving and decision-making situations for the students. Oftentimes the counselor assumed a role of
"reality" arbitrator for the group. This role was expected of the counselor in that he represented society outside the institution grounds. As the group members felt more accepted and secure in the group atmosphere, demands for counselor intervention decreased. These feelings of acceptance and security reached a peak during the sixth and seventh sessions. Eventually, the group members became almost totally independent of counselor leadership; i.e., discussions were initiated by spontaneous group instruction, interpretations were offered by group members, limit-setting was controlled by the group, problem-solving situations came as group suggestions, and leadership roles were assumed by various group members. This is not to imply that the counselor reacted passively to the group situation. Quite the contrary, the counselor was very active in the group process; however in more of a supportive manner. This particular observation was strikingly similar to those made by Fisher and Wolfson (3). In their study they proposed that defective group members tend to lead the group leader according to their respective needs resulting from their intellectual and emotional levels.

To leave an impression that the group-centered counseling process was without problems would be misleading. One difficulty that was manifested in later sessions centered around a regression period that invariably followed sessions...
that were very emotional. It appeared that subsequent to a session in which the interaction was highly personalized, all of the group members would return with an attitude that they possibly had revealed too much of themselves. Intense emotional insight was extremely frightening. Usually, half of the next session time was gone before the group members were able to overcome this fear and not be protective of what they said. Nevertheless, these regression periods progressively got shorter as the study continued. It was as though they were becoming more adept in dealing with emotions and being perceptive as to their true meanings.

Personal comments made by the group-centered students following the study also supported the theoretical contention that a group-centered approach was of more therapeutic value than group counseling of a structured, directive nature. Although these personal accounts indicated a crude awareness of changes that had occurred, they nevertheless, revealed introspective learning and realistic self appraisals. This increased perception and control over behavior was illustrated by remarks such as, "Being retarded doesn't mean I will be in an institution all my life," "I don't feel mad as much as I used to." Things have sort of changed inside," "Maybe somebody does care about how I am." Considering the intellectual functioning level of the students making these
remarks, the very fact that they were capable of acknowledging changes that had occurred was of tremendous significance. These unsolicited expressions without question, indicated a strong self identity and understanding.

Although these subjective observations and reports are not reflected in the statistical results of the study, they nevertheless are of extreme value in describing the therapeutic process of the two treatment groups. All too often these seemingly insignificant changes are ignored without considering that learning is premised on assimilation and sequentialness. This learning process is particularly retarded in the mentally defective individual. Consequently, the relative impact these small learnings have upon the developmental processes of the intellectually limited student is of prime importance. Many group counseling dynamics do not lend themselves to a quantitative analysis, yet they can be significant benchmarks, indicating dramatic, positive changes in personality and behavior.
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CHAPTER V

SUMMARY, RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This research study was developed to experimentally investigate changes in self concept, anxiety level, and behavior of institutionalized mental retardates that resulted from two different group counseling approaches. Twelve resident mentally retarded students participated in group-centered counseling and another twelve comparable mental defectives participated in group counseling with a directive, didactic orientation. Following this treatment procedure, efforts were then made to determine the relative therapeutic effectiveness of the two group counseling methods.

Providing impetus to this research project was a prevailing attitude of many professionals that group counseling, particularly group-centered, was ineffective with the mentally retarded. This assumption was premised in large part, on poorly designed experiments and theoretical considerations. Much of the research dealt with only one group counseling approach and therapeutic success was generally measured by some modifications of overt behavior.
Unfortunately, the underlying psychological dynamics were given very little attention. Consequently, the problem then was to elucidate information pertaining to this situation by evaluating the efficacy of two different group counseling approaches and the relative effects each would have on some of the psychological processes that contribute to adjustive behavior.

The general nature of the research hypotheses was that there would be a significant positive change in self concept, anxiety, and overt behavior of students participating in group-centered group counseling compared to students in both the directive and control groups. However, in order to statistically analyze the obtained data, the following hypotheses were formulated:

1. Significant differences will be found among the mean self concept scores of the group-centered, directive, and the control group, with the group-centered scores being the highest (indicating more positive self concepts) and control group scores being the lowest (indicating more self-disparagement).

2. The subjects who receive treatment in the group-centered group will experience a significantly greater reduction of anxiety (mean scores will be lower), as measured by the anxiety scale, than those subjects in the directive and control groups.
3. Significant differences will be found between the magnitude of behavior adjustment of subjects in the group-centered, directive, and control group, with the group-centered post-test mean score being lowest (suggesting better behavior adjustment) and control group score being the highest (indicating less improvements in behavior adjustment).

A total of thirty-six students of Denton State School, a residential institution for the mentally retarded, were included in this study. All of the individuals participating in the research project functioned within the mild range of mental retardation (I.Q. 50-75), ranged between the chronological ages of fifteen years to twenty years and six months and were clinically diagnosed by the Denton State School medical staff as having the same etiology of cultural familial retardation. Intelligence quotient scores used as selection criteria were based on recent psychometric assessments with either the Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence Scale.

The thirty-six students were randomly assigned to three major groups: Experimental I, Experimental II, and a control group. Each major group was then divided into two smaller sub-groups consisting of six members each. The sub-group assignment was also made on a random basis. Prior to subject
assignment, Exp. I was designated as the group-centered group and Exp. II was designated as the directive group. The writer of this research study served as counselor for Exp. I sub-groups and Mr. Dick Naylor was the counselor for Exp. II sub-groups.

Two pre-test instruments, Children's Self Concept Scale (2) and the Children's Form of the Manifest Anxiety Scale (1) were administered to each student in the three groups. This testing was done by the experimenters. In addition, a behavior rating report was made on every individual participating in the study by their regular classroom teacher. Both the anxiety form and the self concept scale were administered orally to minimize misunderstanding due to insufficient reading skills.

Along with the self concept scale and anxiety form, a third pre-test measurement was made on each student. A behavior rating scale was designed specifically for the purpose of this study. This behavior rating scale, developed jointly by the experimenter and four academic school teachers, was comprised of sixty behavior traits that had been reported by teachers as inappropriate behavior students had manifested in a classroom situation. The four teachers involved in the test construction were also the regularly assigned instructors for the four academic level classrooms.
that included all of the research subjects. Consequently, the pre-treatment behavior rating of each student was made by his or her respective teacher. Inter-rater reliability of the behavior rating scale was established at .89.

Experimental I and Experimental II sub-groups participated in twenty group counseling sessions during a thirteen week period. Each session lasted approximately one and one-half hours. The control group, consisting of twelve students, continued to participate in routine scheduled assignments.

Subsequent to the treatment period, administration of the post-treatment evaluations was conducted in the same manner as was the pre-testing, i.e., questions were orally presented and testing was closely monitored.

To test the research hypotheses formulated in the study and statistically analyze the experimental data, an analysis of co-variance design was used. An .05 level of confidence was established by the investigator as criterion for either accepting or rejecting the research hypotheses.

Results

After submitting pre-test and post-test raw data to an analysis of co-variance, none of the proposed hypotheses reached a level of confidence required for statistical significance.
Quantitative results of Hypothesis I revealed a trend in the direction formulated.

Subjective Observations

In reviewing the results of the research study, there are several considerations that merit discussion. It is quite important in an exploratory study of this nature that any observation that may lead to more specific information and knowledge be documented. Realizing the inherent difficulties in attempting to quantitatively assess the counseling process and the extremely subtle personality dynamics that are manifested during this process, the investigator felt it was incumbent upon him to report some of the subjective observations and evaluations during the study.

Several observations made by the investigator during the study did point out some differences between the two experimental groups concerning the relative therapeutic effectiveness of the two group counseling approaches, utilized. The most noticeable difference between the group-centered group and directive group was the counselor-student relationship. Students receiving group-centered counseling more readily established and accepted a permissive, understanding counselor-counselee relationship and the group-centered approach seemed to lend itself to increased
interaction and emotional release. Members of the group-centered group exhibited a great deal more cohesiveness and control than did students in the directive group. It was also noted that the directive counseling seemed to promote tremendous counselor dependency whereas the students participating in group-centered counseling readily worked for their independency and group responsibility. In summary, the subjective evaluation indicated that more positive therapeutic benefits were derived by the students in the group-centered group counseling even though these benefits were not statistically confirmed.

Conclusions

The study was designed to determine if a group-centered counseling approach had more significant, positive, therapeutic, effects on the self concept, anxiety, and adjustive behavior of a selected population of mental retardates. In an attempt to statistically verify the research hypothesis which stated that there would be a significant positive change in self concept, anxiety level, and overt behavior, the group-centered approach was compared to a directive approach and a control group of students who did not receive group counseling. Quantitative treatment of the raw data did not confirm or support the proposed hypotheses. Consequently,
it was concluded that there was no significant difference between group-centered and directive group counseling in the therapeutic effect these approaches had on self concept, anxiety level, and adjustive behavior of mental retardates.

While acknowledging the statistical results obtained in the study, it is important that some possible causative factors for this lack of significant findings be discussed. Statistical non-significance of the present research study may be attributed to the following factors:

1. The relatively small number of subjects used in the study (thirty-six) certainly influenced the statistical results. With a population sample of this size, the magnitude of change in research variables must be greater in order to reach a statistically significant level. This was borne out in the present study by the fact that individual pre- and post-test scores of students receiving group-centered counseling revealed considerable positive change in both self concept and behavior. However, due to the small research sample, the changes indicated by the pre- and post-test mean scores were not sufficient for attaining a statistical level of significance.

2. Individual variability within the two experimental groups was such that group mean scores were tremendously effected by evaluative data on one subject in the groups.
This problem was compounded because of the small number of students in each group. One example of this occurring was in the group-centered group where a student's extremely low post-test self concept score negated eleven other students' post-test self concept scores that revealed some rather dramatic, positive changes in the way they perceived themselves.

3. It is possible that the design and content of the Children's Self Concept Scale and the Children's Form of the Manifest Anxiety Scale, which were both standardized on "normal" school age students, were not applicable to mental retardates of comparable mental age functioning. It might well be that these two instruments, used as assessment tools, lacked sensitivity to pick up what may have been subtle but important changes that resulted from the group counseling process.

4. Involved in this problem of therapeutic evaluation, too, is the question of when should post-testing procedures begin. If the evaluation criteria to determine therapeutic change is applied too soon after group counseling has been concluded, there may not be sufficient time for some of these underlying personality dynamics to stabilize. This might suggest that post-treatment evaluations be made a month following the conclusion of counseling and/or several evaluations be made over a period of three or four months subsequent to group counseling.
5. It is theoretically possible that the model we have regarding self concept development for "normals" cannot be applied to the mentally retarded. Therefore, treatment procedures that are based on the traditional assumption (if a person gains more insight, modifies his internal frame of reference, and realizes a more accepting understanding of himself, he will develop a more positive perception of self) may not be applicable to the mentally deficient individual.

The mentally retarded person is extremely hyper-sensitive to perceptions others have of him. It may well be that the primary self concept development process for the retardate is not an internal perception of "self," but is repeated assimilation and reactions to how others in his immediate environment perceive him. Consequently, any treatment program designed with the intent of changing self concept would necessitate a corresponding change in the total immediate environment.

6. In that the retarded individual has difficulty in transfer of learning and typically possesses a limited attention span, group counseling sessions should be conducted more often than twice a week and sessions should be limited to one hour. The frequency of sessions (two per week) and the total number of group counseling sessions
(twenty) possibly were not sufficient for the hypothesized changes to take place.

7. Another factor which could have adversely affected the statistical results of the study was the apparent frustration some students experienced while participating in the study. This frustration resulted from the fact that students were operating in the same physical environment, yet their behavior was reinforced by two different sets of standards. Students who received group-centered counseling were certainly exposed to this situation in that some of the very behavior and/or feelings reinforced, supported, and openly encouraged during counseling sessions by the counselor were not condoned outside the group counseling setting.

It can be concluded from the obtained statistical results that a group-centered approach to group counseling should not be used as a general treatment procedure for all retardates. However, one cannot conclude from these findings that group-centered counseling is not therapeutically beneficial for the higher level educable retardate. On the contrary, observational data collected throughout the research study indicated that some of the subjects did manifest marked improvements during the group-centered counseling process. It is the belief of the experimentor that if future researchers would consider the factors
mentioned previously and attempt to minimize their effect on the research study results, a similar study would provide significant findings.

Group-centered counseling offers many possibilities in the treatment and care of mentally retarded individuals. The retarded can no longer be denied the therapeutic atmosphere provided by group-centered counseling. The retardate experiences feelings and emotions and any treatment program that makes it possible for him to explore and better understand these feelings and emotions has a significant place among the program resources for the mentally retarded. Even if the results of the present study serve to accomplish nothing else, it is the experimentor's hope that this study will provoke others to attempt follow-up research.

Recommendations

On the basis of findings of this investigation and subjective observations, the following recommendations are offered:

1. Group counseling be made an important ancillary service to regular educational and vocational programs for the mild mentally retarded.

2. Counseling coursework at the graduate level include both individual and group counseling techniques with the mentally retarded.
3. Research study be conducted with a sample of at least sixty mild mentally retarded subjects, half of whom would be institutional residents and the remaining half being non-residents.

4. Three different group counseling approaches be used as treatment procedures, e.g., group-centered, directive, and milieu oriented group-centered with the resident and non-resident groups.

5. All evaluation instruments be designed for and standardized on a population sample comparable to the research sample.

6. Group counseling sessions be conducted one time daily for a period of not less than two months.

7. Each group session be limited to approximately one hour.

8. Post-treatment evaluations be made several times after the conclusion of the group counseling, i.e., the first post-testing be conducted one month following the termination of counseling, the second post-testing take place after another month, and a final post-testing be made three months subsequent to the group counseling.

9. In view of the discrepancy between the statistical findings and the observational analysis, a similar study be conducted incorporating the above recommendations.
10. Group-centered counseling study by conducted with follow-up, longitudinal evaluations being made.

11. Group counseling studies be attempted utilizing audio-video taping equipment for the purpose of recording the counseling process and using this media as a play-back device.
CHAPTER BIBLIOGRAPHY


APPENDIX A

Student ___________________________ Rater __________________ Date ______

Please rate this student on each of the behavioral traits listed below by placing a check mark under the most appropriate rating category (i.e., A-always; B-almost always; C-usually; D-sometimes; E-almost never; F-never).

Rating Guide

1. Base ratings on resident's observed and current behavior
2. Base ratings on your own observations with the resident
3. Consider each trait independently
4. Avoid rating near the middle of all scales
5. Rate each item quickly
6. Rate every item
   Legend: A-always; B-almost always; C-usually; D-sometimes; E-almost never; F-never

Behavioral Traits

1. acts before he thinks
2. is unable to wait for his turn
3. talks loudly or shouts to gain attention
4. resists help or suggestions
5. talks rapidly as if excited
6. shows no pride in his accomplishments
7. avoids looking directly at others
8. is timid or shy
9. is upset by changes in his surroundings

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<tr>
<td>Behaviorial Traits</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
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<td>10. has pessimistic, hopeless attitude</td>
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<td>11. bursts into tears or rage with little provocation</td>
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<td>12. does not give assistance to others</td>
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<td>13. uses unusual phrases or makes up new</td>
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<td>14. clothes are unbuttoned</td>
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<td>15. rarely finishes a task before starting another</td>
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<td>16. expresses contempt or scorn for others</td>
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<td>17. is sullen, pouts</td>
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<td>18. persists when told he cannot have something</td>
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<td>19. does not seem to care what goes on around him</td>
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<td>20. waits for things to be given to him</td>
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<tr>
<td>21. depends on others to initiate activities</td>
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<td>22. requests to see doctor or nurse</td>
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<td>23. is easily discouraged</td>
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<td>24. expresses anger, in poorly controlled tantrum fashion</td>
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<td>25. will not share with others</td>
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<td>26. seems unaware of feelings of others</td>
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<td>27. mechanically repeats certain words or phrases</td>
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<tr>
<td>28. must be reminded to change clothes</td>
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</table>
29. does not wait for instructions to be completed
30. complains he is picked on
31. does opposite of what is asked
32. paces or shifts restlessly
33. talks about emotional matters in a flat, detached fashion
34. is physically inactive and lethargic
35. refused to relinquish old and established habit patterns
36. is self-blaming
37. reacts with immediate anger when desires are thwarted
38. rarely returns borrowed property
39. speech is unclear
40. demands more than his share
41. takes no pride in his personal appearance
42. is distracted by others and events around him
43. procrastinates
44. stammers or stutters when under stress
45. facial expressions are fixed, immobile, and expressionless
46. plays or remains by himself
47. looks unhappy, sad, is unsmiling
### Behavioral Traits
(continued)

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<tr>
<td>48.</td>
<td>seeks unwarranted amount of help from others</td>
<td>A</td>
<td>B</td>
<td>C</td>
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<td>49.</td>
<td>does not cooperate with others</td>
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<td>50.</td>
<td>does not like to change his clothes</td>
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<td>51.</td>
<td>disrupts routines</td>
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<td>52.</td>
<td>bosses and dominates others</td>
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<td>53.</td>
<td>malinger; avoids work if he can</td>
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<td>54.</td>
<td>is tense-appearing</td>
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<td>55.</td>
<td>does not laugh, smile or react when kidded</td>
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<td>56.</td>
<td>expresses concern about his health</td>
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<td>57.</td>
<td>head usually bowed, shoulders droop</td>
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<td>58.</td>
<td>does not ask permission to use other's property</td>
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<td>59.</td>
<td>usually plays or works by self</td>
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<td>60.</td>
<td>hair not combed</td>
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### APPENDIX B

#### READING LEVELS OF RESEARCH SUBJECTS

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<th>Student Number</th>
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<td>1</td>
<td>Exp. I</td>
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<tr>
<td>2</td>
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<td>I</td>
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<td>8</td>
<td>I</td>
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<td>I</td>
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<td>12</td>
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<td>36</td>
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