

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

#

**VIDEO FEEDBACK IN A SOCIAL SKILLS GROUP
WITH PSYCHIATRIC / MENTALLY RETARDED ADULTS**

by

JAMES P. NORMANDY

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

1997

UMI Number: 9720124

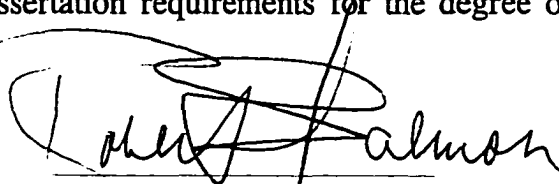
UMI Microform 9720124
Copyright 1997, by UMI Company. All rights reserved.

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

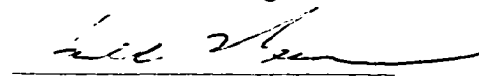
This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirements for the degree of Doctor of Social Welfare.

1/23/97
Date



Dr. Robert Salmon
Chair of Examining Committee

1/23/97
Date



Dr. Harold Weissman
Executive Officer

Dr. Roselle Kurland

Dr. Phil Hore

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

ABSTRACT

VIDEO FEEDBACK IN A SOCIAL SKILLS GROUP
WITH PSYCHIATRIC / MENTALLY RETARDED ADULTS

by

JAMES P. NORMANDY

Advisor: Professor Robert Salmon

Two Social Skills groups composed of psychiatric / mentally retarded adults were videotaped. The social skills training utilized modeling, behavioral rehearsal and feedback - social reinforcement. Planned group discussion topics were social skills areas and in several areas paralleled the stages of social work group development. Targeted behaviors were appropriate statements (one word, more than one word) and inappropriate statements. Both groups were videotaped. The experimental group observed clips of their videotape as feedback. The control group did not receive video feedback. Outcome measures were frequencies by type of response (appropriate and inappropriate statements) at selected intervals using the videotape record, Social Avoidance and Distress (SAD) scale, Fear of Negative Evaluation (FNE) scale and a group therapy evaluation questionnaire. Traditional social skills training proved to be statistically effective with the control group. Video feedback did not prove to be effective as an augmentation in the acquisition of social skills as measured in this project with the experimental group.

ACKNOWLEDGEMENTS

Special thanks to the Chairman of my committee, Dr. Robert Salmon, for his interest, expertise and encouragement. I am also indebted to the other members of my committee; Dr. Roselle Kurland, Dr. Harold Weissman, and Dr. Phil Hore.

Among those at the Association for Children with Retarded Mental Development, I am grateful to the Executive Director, Arthur Rosa Jr., the Assistant Executive Director, Dr. Mary Lucas, and SPAN staff Marguerite Harder and Gianna Acosta. My special thanks also to Dellre Patterson and Jay Kleinman.

Most especially I would like to recognize my family and friends for their encouragement, help, and support.

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION AND PROBLEM DEFINITION	1
II. LITERATURE REVIEW	
Epidemiology	13
Group Work	24
Group Work with the Mentally Retarded	53
Social Skills Training	60
Theoretical Basis for Video Feedback: Pre-Therapy and Observational Learning	71
Video Feedback	84
III. METHODOLOGY-RESEARCH DESIGN	
Need	95
Sample	96
Techniques of Measurement	96
Research Design	102
Intervention: Social Skills Training	105
Group Topics	107
IV. RESULTS	
S.A.D. and F.N.E. Scales	114
Group Therapy Evaluation Questionnaire	119
Analysis of Videotapes	124
V. IMPLICATIONS FOR PRACTICE	
Discussion	136
Summary	141
APPENDICES	
Appendix A: S.A.D. and F.N.E. scales	145
Appendix B: Group Therapy Evaluation Questionnaire	149
BIBLIOGRAPHY	150

LIST OF TABLES

Table		Page
1	Pre and Post Intervention S.A.D. and F.N.E. Mean Scores and Significance	115
2	Evaluation Questionnaire Statements' Ranking and Mean Scores	120
3	T-Test Comparing Week Two and Week Fifteen by Category	133
4	Mann-Whitney U-Wilcoxon Rank Sum W Test for the Means of the Experimental and Control Groups	134

LIST OF FIGURES

Figure		Page
1	Mean Control Group Data for Four Categories	128
2	Mean Experimental Group Data for Four Categories	129
3	Total Appropriate and Inappropriate Comments for Both Experimental and Control Groups	130
4	Difference Scores for Experimental and Control Groups	131
5	Total Appropriate and Inappropriate Comments for Both Experimental and Control Groups	132

CHAPTER ONE: INTRODUCTION AND PROBLEM DEFINITION

This project will study the use of video feedback in training mentally ill / mentally retarded groups in social skills. The project evaluates the effect of the provision of video feedback to a social skills group and tries to determine if video feedback enhances the acquisition of social skills with mentally ill / mentally retarded consumers. There is an assumption of need on the part of these individuals which leads to the purpose of the training. Issues of composition, structure, and content will be considered as well as agency context. Dr. Roselle Kurland's monograph, Group Formation: A Guide to the Development of Successful Groups, provides a useful framework for the areas needed to be considered in planning for the formation of a group.¹ These factors were considered in the video feedback social skills groups and are important in the formative evaluation of the work. In addition, Kurland's model is useful for the analysis of a group, its success and failure. James Garland, Hubert Jones and Ralph Kolodny's model of stages of development in groups is also used to examine the life of a group.² Their stage theory provides

¹ Kurland, Roselle (1982). Group Formation: A Guide to the Development of Successful Groups, Albany, New York: Continuing Education Program, School of Social Welfare, State University of New York at Albany and United Neighborhood Centers of America,

² Garland, James; Jones, Hubert and Kolodny, Ralph (1973). A Model for Stages of Development in Social Work Groups, Saul Bernstein, (Ed.), Explorations in Group Work, Boston: Milford House.

another theoretical basis for the review of this project. These two conceptual works on groups in conjunction with video feedback and social skills training techniques are the bases for this project.

The first step will be to define and / or discuss some important terms:

Mental Retardation:

The American Association on Mental Retardation's 1983 Definition states that "mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."³ The deficits in adaptive functioning generally refer to such areas as social skills and responsibility, communication, daily living skills, personal independence, and self-sufficiency. In 1992 the American Association on Mental Retardation published a new definition of mental retardation. The 1983 definition focused attention on the personal deficiencies of the individual in terms of intellectual behavior. The 1992 definition focuses attention to the possibility of supporting people in inclusive environments. It suggests:

"Mental retardation is an interaction between the person and the environment. The focus of mental retardation is no longer in the person; instead, limitations in personal capabilities are seen as only one of these factors producing mental retardation. The AAMR model holds that mental retardation results from an interaction among the following three factors:

- 1) Limitations in personal capabilities;
- 2) The environments in which the person spends time;

³ Grossman, H., (1983). Manual on Terminology and Classification in Mental Retardation. Washington, D.C: American Association on Mental Deficiency, page 1

3) The supports available to the person."⁴

The consumers in this study were moderately to mildly retarded with I.Q.'s between 50 and 80. Individuals with the same I.Q. can differ markedly in skills. Generally, the consumers have limitations in two or more adaptive skill areas: communication, self-care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, and work. A Piagetian analysis of mental retardation would align moderate mental retardation with the pre operational Intuitive stage categorized by pre-logical reasoning, perceptions dominate judgements, ability for simple classifications, able to converse, difficulty understanding abstract concepts, and problem solving by trial and error. A Piagetian analysis would align mild mental retardation with the operative stage categorized by concrete thinking, problem-solving based logic and the ability to predict concrete transformality.⁵ The consumers in the SPAN Continuing Day Treatment program are most reminiscent of third - fourth grade in elementary school regarding their basic adaptive skills and functioning.

Mental Illness:

The American Psychiatric Association states that "In DSM -III

⁴ Reiss, Steven (1994). Handbook of Challenging Behavior: Mental Health Aspects of Mental retardation. Worthington, OH: I.D.S. Publications. page 92

⁵ Fletcher, Robert and Menolascino, Frank: (1989). Mental Retardation and Mental Illness. Lexington: Lexington Books, D.C. Health and Company. pages 4-5

each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society."⁶ Beyond this definition, the consumers in this study met the criteria for New York State's Office of Mental Health's definition of Severe and Persistent Mentally Ill (S.P.M.I.) adults. The criteria is a DSM-III-R psychiatric diagnosis and extended impairment in functioning due to mental illness defined as:

"The individual has experienced two of the following four functional limitations due to a designated mental illness over the past twelve months on a continuous or intermittent basis:

- A) Marked difficulties in self-care (personal Hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- B) Marked restriction of activities of daily living (maintaining a residence; using transportation; day to day money management; accessing community services).
- C) Marked difficulties in maintaining social functioning (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
- D) Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school

⁶ American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders, (Third Ed.) Washington, D.C. page 6

settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or requires assistance in the completion of tasks)."⁷

Social Skills:

Robert Liberman, William DeRisi and Kim Mueser, in their book Social

Skills Training for Psychiatric Patients, defined social skills as:

"In a general sense, social skills are all the behaviors that help us to communicate our emotions and needs accurately and allow us to achieve our interpersonal goals. A variety of specific skills are involved in any successful social encounter. Social interaction can be broken down into a three stage process that requires a different set of skills at each stage."⁸

First Stage = Receiving Skills:

"Those skills that are necessary to attend to and perceive accurately the relevant social information contained in situations. Since the appropriateness of our interpersonal behavior is usually situationally specific, choosing the correct social behaviors depends heavily upon accurately recognizing the environmental and interpersonal cues that will guide us to effective responses."⁹

Second Stage = Processing Skills (problem solving):

"Those steps that are necessary for choosing the most effective skills for the situation. To succeed in an interpersonal encounter, we need to know what we want to achieve and how to best achieve it. Selecting the most effective skills for achieving the goals at hand requires the ability to problem solve in an organized systematic fashion. Problem solving involves generating a list of possible solutions (i.e. potentially effective behaviors), evaluating the relative merits of each solution in terms of their

⁷New York State Office of Mental Health (1991). Statewide Comprehensive Plan for Mental Health Services 1992 1996. Albany, New York: page 24

⁸ Liberman, Robert; DeRisi, William and Mueser, Kim (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, page 3

⁹ Ibid., page 3

anticipated consequences, selecting the best solution or combination of solutions, and deciding how to best put the plan into action. Thus, processing skills primarily allow us to identify the content of what we will say, as well as where and when the interaction will take place."¹⁰

Third Stage = Sending Skills:

"The actual behavior involved in the social transaction. Sending skills include both the verbal content or what is said, and how the message is communicated to others."¹¹

Robert Liberman, William DeRisi and Kim Mueser summarized:

"Good communication requires accurate social perceptions (receiving skills) and cognitive planning ability (processing skills) before implementing an effective behavioral response (sending skills). Problems in interpersonal communication among psychiatric patients may reflect deficits in any one or all of the three stages."¹²

Agency Context:

Kurland's guide for group formation lists agency context as one of the seven general areas considered in planning for a group. This research project was conducted at the Association for Children with Retarded Mental Development's SPAN program in the Continuing Day Treatment unit. SPAN is funded by Community Support Services (C.S.S.), which targets funds to serve deinstitutionalized and / or chronic psychiatric adults. SPAN specializes in a dually diagnosed, psychiatric / mentally retarded population. The consumers have a DSM-III-R, Axis I, psychiatric diagnosis (excluding substance abuse) and are Severe and Persistent Mentally Ill (S.P.M.I.) adults. The consumers also have a secondary diagnosis of Mental Retardation or Borderline Intellectual

¹⁰ Ibid., page 3

¹¹ Ibid., page 3

¹² Ibid., page 6

Functioning with I.Q.'s in the 50 to 80 range. The Continuing Day Treatment unit is certified by the New York State Office of Mental Health in the same category of services as a Psychiatric Day Hospital. The consumers attend Monday through Friday nine a.m. to three p.m. SPAN is located in Hollis, Queens, near Jamaica. The consumers live in Brooklyn and Queens with the vast majority being bused to the facility by a leased van service. The Continuing Day Treatment unit is a group activity day program serving approximately fifty psychiatric / retarded consumers.

The philosophy of treatment is based on group activities with an emphasis on generating a mutually supportive and cohesive therapeutic community. The consumers generally attend four groups per day, two in the morning, two in the afternoon, with an hour for lunch in between. The groups are very diverse and include socialization, dance therapy, art therapy, remediation, pre-vocational, daily living skills, and several other types.

Problem Definition:

Several authors have discussed the deficits of psychiatric / retarded consumers in the area of social skills (Eaton & Menolascino 1982, Borthwick-Duffy & Eyman 1990, Lansdell 1990). The psychiatric / retarded consumer finds it difficult to establish and maintain close family and significant social relationships.

"These lacks may be related to the complexity of the dual disability : The combination of the clinical dimensions of both mental illness and mental retardation makes it intellectually and emotionally difficult for dually diagnosed individuals to develop meaningful relationships. Their poor social skills, in particular, and their peculiar - even bizarre - behavior results in their social rejection and

isolation."¹³

Social skills have many components and facets. Receptive and expressive skills influenced by the consumer's perceptions and expectations are very pivotal. It is not difficult to accept that this dual disability (mental illness and mental retardation) would have a tremendously negative effect on a person's receptive and expressive abilities and that this in turn would effect their basic perceptions and expectations. Often the mental illness has thought disorder as an aspect which further distorts perceptions of social interactions. Psychiatric / retarded consumers often exhibit deficits in various social skills such as engaging in appropriate conversations, expressing feelings, assertiveness, and social responsibility. In their interpersonal interactions they often interrupt each other, give tangential responses, and do not employ basic social skills such as requesting clarification. They can misinterpret statements other people make to them and lash out angrily towards them in response. The consumers have difficulty understanding how emotions operate in influencing behavior and subsequently have difficulty channeling their emotions into beneficial and constructive endeavors. This can lead to an interaction pattern of negative, violent interactions or withdrawal to isolation. They need to develop skills to relate adaptively to others by achieving increased emotional control. Communication and

¹³ Fletcher, Robert (1989). The Role of a Day Program in Increasing Support for Dually Diagnosed Persons. Fletcher, Robert and Menolascino, Frank (Ed.) Mental Retardation and Mental Illness. Lexington MA: Lexington Books, page 207

problem solving skills are fundamental to this endeavor. They need to be able to verbalize their feelings rather than act them out in negative behavior. An understanding of their communication patterns is crucial to the development of their social skills. The lack of social skills often deprives psychiatric / retarded consumers of the social supports they need to stabilize and maximize their functioning in the community.

Legal - Ethical Issues:

Robert Levine in his article, A Researcher's Concerns with Ethics in Human Research, outlined four major ethical considerations in human research: 1) Honesty, 2) Informed Consent 3) Safety, and 4) Patient Benefit.¹⁴

1) Honesty establishes an obligation for the researcher to inform all volunteers that "They are participating in an experiment. The purpose of the experiment is to gain information. This information will later be the basis upon which to publish a scientific paper."¹⁵ The consumers in this project were informed prior to volunteering of the basic parameters of the study (a social skills group that would be videotaped), that it was academic research for a staff member doing the project for school and that it was totally voluntary.

2) Informed Consent was addressed both with the consumers, and due to mental disabilities, with the parent or guardian. The basic

¹⁴ Levine, Robert, M.D., (1994). A Researcher's Concerns with Ethics in Human Research. Journal of the California Alliance for the Mentally Ill. Vol. 5, #1, pages 6,7,& 8.

¹⁵ Ibid., pages 6 & 7.

parameters to the project were explained prior to volunteering at a community group meeting of all consumers in the Continuing Day Treatment program, and the groups were composed of a random sample of volunteers. The parents or guardians of the volunteers were contacted and their consent obtained prior to participation in the project.

3) Safety is a major concern in any human research activity. The oldest ethical axiom of the helping professions is from Hippocrates in his Epidemics over 2300 years ago: "Primum non nocere:" First Do No Harm.¹⁶ The project has no aversive components and no withholding of services. The project uses social skills training methods and video feedback methods previously proven successful by prior studies. The work of Johnny Matson, Vincent Senatore as well as other studies in social skills training and the work of Lee Dunlap, Karen Esveldt as well as other studies in video feedback will be discussed further in the literature review chapter. The research area of this project is the combination of social skills training and video feedback with psychiatric / retarded consumers.

4) Patient Benefit relates to the goal of the project which is that all of the consumers would benefit from the social skills groups. The comparison between the two groups is to determine if those

¹⁶ Ghaemi, Nassir S., M.D. & Hundert, Edward M.D. (1994). The Ethics of Research in Mental Illness, Journal of the California Alliance for the Mentally Ill. Vol. 5, # 1, page 47.

consumers receiving video feedback would benefit more.

Confidentiality and use are issues for any photographic materials involving participants of a Mental Health program. Bernard Lo, in writing about the principle of autonomy, asserts that "the patient's rights as a human being, as a person in contrast to as a patient, need to be respected; he or she must be assured confidentiality."¹⁷ The consent form stipulated: "The videotape will only be used for educational purposes and will not be used commercially or for publicity." The videotapes are considered confidential and access / viewing is determined by academic purposes and requirements. Only professionals are involved with the access / viewing and they have an understanding of professional responsibility in dealing with confidential clinical materials / records.

Conclusion:

An organizing framework for the project is taken from Roselle Kurland and James Garland, Hubert Jones and Ralph Kolodny. The relevance of the work of additional group work theorists also will be included. This will include contributions from Helen Northen, Sondra Brandler and Camille Roman, Ruth Middleman and Gale Goldberg Wood. Studies of social skills training with psychiatric and mentally retarded populations in addition to video feedback research will be reviewed. Other sections of the literature review are: Epidemiology of mental illness / mental retardation and the theoretical basis for video feedback (Pre-Therapy and Observational

¹⁷ Ibid., pages 47 & 48

Learning) .

CHAPTER TWO: LITERATURE REVIEW

Preface

There are several themes in the literature relevant to this project. Since the mentally ill / mentally retarded population is not generally familiar to most professionals, the first section is on the epidemiology of mental illness / mental retardation. The second section is concerned with relevant social group work theory. The third section discusses group work with the retarded. The fourth section is on Social Skills Training. The fifth section provides the theoretical basis for video feedback: Pre-therapy and Observational Learning. The sixth and final section is about video feedback.

Epidemiology

"There is no doubt as to the tremendous human needs and challenges presented by persons with the diagnosis of both mental retardation and mental illness. Although there is some question as to the precise incidence rate of mental illness in the mentally retarded, it was unanimously agreed that the incidence rate is dramatically higher than in the non-retarded population and that there are psychiatric syndromes that are unique to the mentally retarded. A number of panelists cited studies of mental illness in the mentally retarded that encompassed the entire spectrum of psychiatric diagnoses."¹⁶ (President's Committee on Mental Retardation).

Betsy Galligan stated: "There is general consensus that people with mental retardation are vulnerable to a full range of psychiatric impairments. They may even be at greater risk of mental illness than the general population because of their

¹⁶ Stark, Jack, Menolascino, Frank, et.al. Mental Retardation & Mental Health. (1988) New York: Springer-Verlag. Ex. Sum. page XI

substantial biological and psychosocial challenges."¹⁹

Frank Menolascino maintains that the mentally retarded are nearly twice as likely to develop mental illness as the general populace due to: "The vulnerability that the various levels of mental retardation bring to a person in terms of his or her ability to master and control an otherwise unresponsive world."²⁰ H.M. Pollack "identified four reasons for the high incidence rate of mental illness among mentally retarded individuals: 1, reduced capacity to withstand stress; 2, poor ability to resolve mental and emotional conflicts; 3, lack of social competence and, consequently, a potential for being led into difficult situations by associates; and 4, emotional instability, which may lead to loss of self control."²¹

Christine Nezu, Arthur Nezu and Mary Jane Gill-Weiss proposed that psychopathology in mentally retarded individuals is probably multiply determined. They proposed several factors that contribute to a mentally retarded individual's vulnerability to psychiatric difficulties and susceptibility to psychopathology. "These factors include lowered socioeconomic level; increased presence of physical disabilities, especially epilepsy; heightened family stress and

¹⁹ Galligan, Betsy (1990). Serving People Who are Dually Diagnosed: A Program Evaluation. Mental Retardation, Vol. 28, Dec., #6, page 353

²⁰ Menolascino, Frank (1989). Overview: Promising Practices in Caring for the Mentally Retarded-Mentally Ill, Fletcher, Robert & Menolascino, Frank. Mental Retardation & Mental Illness, Lexington, MA: Lexington, page 4

²¹ Ibid, page 4

maternal stress; increased probability of central nervous system damage; increased presence of reading and language dysfunctions; decreased opportunities to learn adaptive coping styles; increased likelihood of chromosomal abnormalities, metabolic diseases and infections; increased likelihood of institutionalization; significant problems related to emotional and personality development; and decreased inhibition in responding to stressful events."²² Any combination of these factors increases the probability of a person's experiencing significant psychiatric symptomatology.

Nezu, Nezu and Gill-Weiss proposed that while "individuals with mental retardation may become psychiatrically impaired through the same pathogenic mechanisms that operate for persons without mental retardation, particular etiological variables may be more characteristic or salient for individuals with mental retardation."²³ They used the example of clinical depression. Recent studies suggest a causal relationship between certain psychological constructs and depression with nonretarded individuals. These psychological constructs include poor social skills, lack of social support and learned helplessness. Nezu, Nezu and Gill-Weiss stated: "By definition, persons with mental retardation are below average in adaptive functioning and exhibit poor coping ability, ineffective problem solving, and inadequate

²² Nezu, Christine, Nezu, Arthur & Gill-Weiss, Mary Jane (1992). Psychopathology in Persons with Mental Retardation. Champaign, Ill: Research Press, page 25

²³ Ibid, page 23

social skills. Further, research findings strongly suggest that mentally retarded persons are more likely to feel helpless than non-retarded individuals."²⁴ Although there is no definitive research to substantiate their conclusions, their model illustrates the probable relevance of certain psychopathology related variables in contributing to increased vulnerability to psychiatric difficulties in mentally retarded individuals.

Galligan believes that the increased awareness of psychiatric problems among the mentally retarded is due to at least three factors.

"First, the stresses of deinstitutionalization and community living may cause or exacerbate psychiatric problems. Second, researchers are recognizing a broader range of mental health issues because some of those problems are more apparent among people with mild mental retardation in the community than among institutionalized individuals. Finally, the prominent group for whom community living has not been successful are people with mental retardation who also exhibit problem behaviors. These individuals are more likely to enter an institution initially or to return to an institution after moving to the community. Because not all problem behaviors have a psychiatric basis, we cannot attribute this recidivism dilemma altogether to people with psychiatric problems. However, there is evidence that the scope of the issue is significant."²⁵

Andrew Russell agreed with Galligan and proposed additional factors.

"It is well known that mentally retarded individuals are at risk for the development of a wide variety of emotional and behavioral disorders. The magnitude and importance of this problem have been emphasized by two relatively recent trends. The first has been the deinstitutionalization and

²⁴ Ibid, page 24

²⁵ Galligan, Betsy, (1990). Serving People who are Dually Diagnosed: A Program Evaluation, Mental Retardation. Vol. 28, #6, Dec. page 353

mainstreaming of retarded persons. The second has been the development of separate service delivery systems for the developmentally disabled and mentally ill. These two trends in health care have contributed to the growing realization that a significant proportion of developmentally disabled individuals have coexisting psychiatric disorders."²⁶

Nezu, Nezu and Gill - Weiss elaborated on the trend towards separate service delivery systems for the mentally retarded and the mentally ill:

"Administratively, mental hygiene services in most states generally are divided into an office of mental health and a separate office or dept. of mental retardation. Each delivery system often develops policies and procedures independently of the other related system. The gateway to either system, but not to both, is the diagnosis: An individual found to have mental retardation would be referred to the mental retardation office - referral to the mental health system would then be unlikely. This system of dual but separate institutional tracks reinforces professionals' perceptions about the orthogonality of the two diagnostic constructs. Much worse, because of this policy of separateness, the mental health needs of persons with mental retardation are grossly underserved. Given the recent trend towards deinstitutionalization and main-streaming of persons with mental retardation, this deficiency is especially serious."²⁷

There appears to be a consensus between Galligan, Russell and Nezu et.al. regarding the importance of deinstitutionalization, mainstreaming, and dual service systems in developing an increased awareness of mental health problems among the mentally retarded.

The National Association for the Dually Diagnosed proposed several factors leading to a high prevalence of mental illness

²⁶ Russell, Andrew The Association Between Mental Retardation & Psychiatric Disorder. Stark, Jack, (Ed.) Mental Retardation & Mental Health page 41

²⁷ Nezu, Christine, Nezu, Arthur & Gill-Weiss, Mary Jane (1992). Psychopathology in Persons With Mental Retardation. Champaign, Ill: Research Press, Pages 6 & 7

among the mentally retarded:

"Negative social conditions throughout the life span of the mentally retarded place enormous stress, as does rejection by others, stigmatization, and the lack of acceptance in general. Additionally, limited coping skills associated with language difficulty, inadequate social supports, and a high frequency of central nervous system impairment, all contribute to the vulnerability of developing emotional problems."²⁸

A major problem of any review of prevalence of mental illness among the mentally retarded is that there is no national epidemiological study on that prevalence in the United States. There are several obstacles to such a study. Clyde Lansdell wrote: "By definition, persons with developmental disabilities seldom (if ever) are dealing with only one disability. The person may have communication deficits (receptive or expressive), perceptual problems (visual, verbal, etc.), motoric difficulties (visual motor co-ordination), general comprehension problems, abstract reasoning difficulties, etc."²⁹

Sharon Borthwick-Duffy and Richard Eyman acknowledged the difficulty in assessing whether a mentally retarded individual is exhibiting problems related to his mental retardation, generally referred to as behavioral, or related to a psychiatric disorder, generally referred to as psychopathology. They stated: "However, even if mentally retarded people are emotionally well adjusted, by definition they experience difficulty functioning in their environments and are likely to evince many of the same problem

²⁸From pamphlet; National Association for the Dually Diagnosed.

²⁹ Lansdell, Clyde (1990). Psychotherapy with Persons who have Developmental Disabilities. Nat. Assoc. Dually Diag. Newsletter. Vol. 7, #2, page 1

behaviors that are characteristic of those who also have a psychiatric disorder."³⁰ Galligan concurred in the difficulty of assessment:

"We do not have a clear picture of the expected psychiatric profile for persons with mental retardation. The main obstacle to studying their psychiatric problems is the difficulty in diagnosis. Diagnostic criteria developed for the general population are often inappropriately applied to people with mental retardation. Also, the same symptoms that lead to a psychiatric diagnosis in intellectually average people are often not seen as indicators of psychiatric problems in people who are mentally retarded."³¹

Nezu, Nezu and Gill-Weiss agreed and proposed that part of the problem may be attributable to stereotyping by professionals:

"Unfortunately, the distinction between mental illness and mental retardation led to the belief commonly held among professionals that mentally retarded persons somehow enjoyed immunity to mental illness as a specific function of the retardation. For example, with regard to affective disorders, mentally retarded individuals were viewed as too psychologically immature to develop a depressive illness (Gardner 1967)."³²

Robert Fletcher elaborated on this thought and noted: "The mildly retarded have been characterized as worry - free and thus mentally healthy. The severely retarded have been considered to express no

³⁰ Borthwick-Duffy, Sharon & Eyman, Richard (1990). Who Are the Dually Diagnosed?, American Journal on Mental Retardation. Vol. 94, #6, page 586

³¹ Galligan, Betsy (1990). Serving People Who Are Dually Diagnosed: A Program Evaluation, Mental Retardation. Vol. 28, #6, Dec., page 354

³² Nezu, Christine; Nezu, Arthur & Gill-Weiss, Mary Jane (1992) Psychopathology in Persons with Mental Retardation. Champaign, Ill.: Research Press, page 5

feelings and therefore do not experience emotional stress."³³ Nezu et.al. continue their assessment: "A second factor perpetuating the gap is the perception that any emotional problem observed in a mentally retarded person is actually a feature of the retardation itself. Moreover, the existence of intellectual deficits takes precedence over the presence of any psychiatric symptoms. In other words, mental retardation diagnostically overshadows any accompanying emotional disturbance."³⁴

Diagnostic overshadowing, the perceived preeminence of mental retardation over psychopathology, is a major obstacle to assessment. Sharon Borthwick-Duffy and Richard Eyman wrote:

"Reiss, Levitan and Szysko (1982) suggested that the variability of diagnosis that they termed diagnostic overshadowing is at least partially related to unsubstantiated attributions of abnormal behavior to an even more debilitating handicap such as mental retardation. These investigations provide impressive evidence supporting the existence of a phenomenon in which the presence of mental retardation decreases the diagnostic importance of abnormal behavior. Hence, the attribution of problem behaviors can affect both the screening and diagnosis of psychiatric disorders."³⁵

John Jacobson, who conducted a study of over forty thousand mentally retarded people in New York State, also commented on

³³ Fletcher, Robert (1988). A County Systems Model: Comprehensive Services for the Dually Diagnosed. Stark, Jack, Menolascino, Frank, et.al. (Eds.) Mental Retardation and Mental health: Classification, Diagnosis, Treatment, Services. New York: Springer, page 255

³⁴ Nezu, Christine; Nezu, Arthur & Gill-Weiss, Mary Jane (1992) Psychopathology in Persons with Mental retardation. Champaign, Ill., Research Press Co., page 5

³⁵ Borthwick-Duffy, Sharon & Eyman, Richard (1990). Who Are The Dually Diagnosed? American Journal on Mental Retardation. Vol. 94, #6, page 587

Diagnostic overshadowing: "Some diagnostic criteria in DSM-3 may require extensive modification to be suitably applied to persons with severe disabilities. Diagnostic overshadowing (Reiss, Levitan, & McNally, 1982) and other phenomena described by Sovner (1986) could also impact on relative prevalence patterns by affecting referral practices, exploration of potential diagnostic signs practitioners, or rendering a diagnosis."³⁶

One of the best research studies available on prevalence rates of mental illness among the mentally retarded is the Isle of Wight (England) studies conducted by M. Rutter and his colleagues more than twenty years ago. It is believed to be one of the more reliable studies because it studied an entire age cohort (9, 10, and 11 year olds) on the island. The Isle of Wight study found that the prevalence of psychiatric disorders in the age cohort was about 7%. Children with I.Q.s of less than 70 had psychiatric disorder prevalence rates of 30% based on parental reports and 42% based on teacher reports. Mentally retarded children had psychiatric disorders at a rate of over four times more frequently than children of normal intelligence.³⁷

Jacobson, in a recent study (1990) of more than forty thousand mentally retarded people in New York State, found that

³⁶ Jacobson, John (1990). Do Some Mental Disorders Occur Less Frequently Among Persons with Mental Retardation? American Journal of Mental Retardation. Vol. 94, #6, page 600

³⁷ Russell, Andrew: The Association Between Mental Retardation & Psychiatric Disorder. Stark, Jack, et.al. Mental Retardation & Mental Health. Ibid page 43

"rates of reported schizophrenic and psychotic disorders were generally higher than expected relative to rates of personality disorders, affective disorders, anxiety and phobic disorders, and behavior disorders."³⁸ The method of assessment was survey-based protocols completed by clinical staff. They found twenty percent of the sample classified as having psychiatric disorders.³⁹

Borthwick-Duffy and Eyman, in their 1990 study of almost eighty thousand mentally retarded people in California, found that given that all clients are properly diagnosed, only ten percent of their mentally retarded population also have psychiatric disorders. Their method of assessment was a client development evaluation report (multitrait - multimethod evaluation of all state clients).⁴⁰ They stated however: "For mildly retarded individuals, we have less confidence in the prevalence rates and other conclusions that are drawn from the database because we estimate that a significant number of mildly retarded individuals are not part of the system."⁴¹ Indeed, in states such as New York and California where the service system for mental retardation and the service system for mental health are separate and distinct, M.R. service system database studies (Jacobson 1990, Borthwick-Duffy & Eyman 1990) are flawed

³⁸ Jacobson, John (1990). Do Some Mental Disorders Occur less Frequently among Persons with Mental Retardation? American Journal of Mental Retardation. Vol. 94, #6, page 596

³⁹ Ibid pages 597, 8 & 9.

⁴⁰ Borthwick-Duffy, Sharon & Eyman, Richard (1990). Who are the Dually Diagnosed? American Journal of Mental Retardation. Vol. 94, #6, page 592

⁴¹ Ibid page 593

when they do not include Dually Diagnosed clients in the mental health system.

Louise Eaton and Frank Menolascino's study sample was a community based population of mentally retarded individuals in a five county region of Nebraska that included the city of Omaha. Their focus was the prevalence of psychiatric disorders seen in a community based population. Of the 798 clients receiving general services, 168 were referred for psychiatric assessment. Based on Clinical interviews, 114 or 14.3% were found to be Dually Diagnosed.⁴²

Nezu, Nezu, & Gill-Weiss proposed four reasons for variability among studies on prevalence rates of psychiatric disorders among the retarded: "(a) use of differential definitions of the construct on mental retardation, (b) failure to discriminate among levels of retardation, (c) diagnostic problems regarding the assessment of psychiatric disorders, and (d) various situational factors (i.e. residence of subject, subject selection procedures, source of data)."⁴³ After they reviewed the available research, Nezu, Nezu & Gill-Weiss summarized:

"Experts currently agree that the actual rate of incidence of mental illness among persons with mental retardation ranges from 20% to 35% In fact, many investigations show that people with mental retardation experience higher rates of

⁴² Eaton, Louise & Menolascino, Frank (1982). Psychiatric Disorders in the Mentally Retarded: Types, Problems, and Challenges. American Journal of Psychiatry. 139:10, Oct., page 1298

⁴³ Nezu, Christine; Nezu, Arthur & Gill-Weiss, Mary Jane (1992) Psychopathology in Persons with Mental Retardation. Champaign, Ill.: Research Press, page 26

psychopathology than do people without retardation. Indeed, according to the third and revised edition of the DSM-III-R, other mental disorders are at least three to four times more prevalent among people with mental retardation than among the general population."⁴⁴

SECTION TWO OF LITERATURE REVIEW: Group Work

Roselle Kurland's monograph; *Group Formation: A Guide to the development of Successful Groups*, provides a useful framework for the formation of a group.⁴⁵ In it, she outlined seven general areas to be considered in group formation: 1) Need, 2) Purpose, 3) Composition, 4) Structure, 5) Content, 6) Pre-Group Contact, 7) Agency Context. Kurland stated: "the seven areas outlined above need to be thought through concurrently. The relationship among them is not a linear one; rather, the seven areas are interdependent and overlapping."⁴⁶ This model is used as an organizing framework for this project and the specifics of six areas are discussed in chapter three of this paper, Methodology and Research Design. The seventh area, Agency Context, has been previously discussed in chapter one of this paper. Sondra Brandler and Camille Roman, in reviewing Kurland's model, noted that its use does not guarantee the development of a successful group, but rather "the model starts the worker off on a firm footing that acts as a predictor of group success. At each point in the early

⁴⁴ Ibid., page 17

⁴⁵ Kurland, Roselle (1982). Group Formation: A guide to the Development of Successful Groups. Continuing Education Program, School of Social Welfare, State University of New York at Albany and Untied Neighborhood Centers of America. Albany, New York.

⁴⁶ Ibid., page 4

planning, the worker struggles to maximize the proper blending of factors. She considers the needs of potential members and the best ways to implement a group which can serve those needs."⁴⁷ Helen Northen noted that failure to plan frequently results in "excessive drop outs, sporadic and irregular attendance, low cohesiveness, inadequate sanction for the practice, and lack of successful outcomes."⁴⁸ She also noted it negatively affected the workers' confidence and ability to use themselves effectively. Kurland, in an earlier article, quotes Dewey on the need for planning in progressive education:

"He must survey the capacities and needs of the particular set of individuals with whom he is dealing and must at the same time arrange the conditions which provide the subject matter or content for experiences that satisfy these needs and develop these capacities. The planning must be flexible enough to permit free play for individuality of experience and yet firm enough to give direction towards continuous development of power."⁴⁹

The relevancy of social work with groups is apparent.

Kurland postulates that insufficient pre-group planning may be based upon a perception of it as client manipulation and a negation of client self-determination. She proposes that pre-group planning enhances rather than detracts from client self-determination in that it increases clarity of purpose which maximizes the client's

⁴⁷ Brandler, Sondra & Roman, Camille (1991). Group Work: Skills and Strategies for Effective Interventions. New York: Harworth Press, page 114

⁴⁸ Northen, Helen (1988). Social Work with Groups 2nd Ed. New York: Columbia Univ. Press, page 98

⁴⁹ Kurland, Roselle (1978). "Planning: The Neglected Component of Group Development" Social Work with Groups 1. page 174

ability to make a clear and informed decision about group participation.⁵⁰ Kurland noted that Charles Garvin proposed that clarity of purpose contributes to goal achievement.⁵¹ She further stated:

"Clarity of purpose exists when four conditions prevail: when the purpose of the group can be stated clearly and concisely by both the worker and the group member; when that stated purpose is the same for both the worker and the group member; when that purpose is specific enough that both the worker and the group member will know when it has been or is being achieved; finally, when that purpose is specific enough to provide direction for group content."⁵²

This project meets those conditions. The purpose of the group, enhancing social skills, can be stated and is the same for both the workers and the group members. The purpose is specific, clear and concise in that it is structured in terms of target behaviors which are reviewed by either verbal feedback or video feedback. The group content is structured and given direction by a social skills training outline paralleling the stages of group development proposed by James Garland, Hubert Jones, and Ralph Kolodny.

James Garland, Hubert Jones and Ralph Kolodny

James Garland, Hubert Jones, and Ralph Kolodny, in their article, "A Model for Stages of Development in Social Work Groups", outlined five stages of growth for group process: 1) pre-affiliation, 2) power and control, 3) intimacy, 4) differentiation,

⁵⁰ Kurland - 1982 page 3

⁵¹ Kurland - 1982 page 2

⁵² Kurland - 1982 page 13

and 5) separation.⁵³

In this project the group discussion topics in several areas parallel the stages of group development outlined by Garland, Jones and Kolodny.

The pivotal concept of Garland, Jones and Kolodny's model is closeness. The consumer at each stage is determining the extent of their interpersonal involvement with others in the group. The first stage, pre-affiliation, in terms of closeness, focuses on approach and avoidance. James Garland, Hubie Jones and Ralph Kolodny elaborate:

"The tendency to approach and to involve himself in the situation because of the gratifications which it promises, and the tendency to avoid the situation because of the demands, the frustrations and even the pain which he may anticipate. The resolution of this dilemma appears to lie in the member's use of a set of behaviors which satisfies both of these tendencies simultaneously, i.e., which facilitates exploration of the situation and at the same time permits some distance and protection from close involvement."⁵⁴

They go on to discuss that it is "normal" or "healthy" for the ego to preserve its integrity and protect itself in new situations (i.e. the beginning of a group) by trying to maintain a degree of distance and control over the actions of the individual and over external factors (i.e. other group members, group leader).

The second stage, power and control, the initial approach / avoidance evolves into more formalized relationships and the

⁵³ Garland, James; Jones, Hubert and Kolodny, Ralph (1973).
A Model for Stages of Development in Social Work Groups.
Saul Bernstein, ed., Explorations in Group Work.
Boston: Milford House

⁵⁴ Ibid., page 26

creation of a status hierarchy. Often, a power struggle phenomena occurs with three basic issues coming to the front. Rebellion and autonomy concerns the establishing of the parameters of the relationships. Similarly, permission and the normative crisis concerns the establishing of an equilibrium. Finally, protection and support concerns the establishing of a safe environment.⁵⁵

The third stage, intimacy, very directly relates to closeness. This stage "is characterized by intensification of personal involvement, more willingness to bring into the open feelings regarding club members and worker, and striving for satisfaction of dependency needs."⁵⁶

The fourth stage, differentiation, is a natural progression from intimacy. Clarification and acknowledgement of intimacy and natural acceptance of personal needs facilitates the ability to differentiate. Group members can evaluate relationships and events in the group based upon the realities of their personal situation.⁵⁷

The final stage, separation, equates with the completion of the group and the members moving on to other experiences. There can be negative components of separation which can exhibit themselves as denial, regression, or feelings of still needing the group. These can be developed into a learning / growth experience through recapitulation and evaluation. If the group was a positive

⁵⁵ Ibid., pages 31 & 32

⁵⁶ Ibid., page 34

⁵⁷ Ibid., pages 37 & 38

experience it can become a frame of reference for approaching new situations. The interpersonal relationships or closeness is something they can take with them and incorporate into how they feel about themselves and how they relate to others.⁵⁸

Garland, Jones, and Kolodny's stage theory is used in this project. In other studies, such as Matson and Senatore's 1981 research, the topics of discussion in the social skills training groups were events in the day program. This project, however, significantly deviated from that practice and used group work stage theory as a structure for the group discussion topics. The social skills training involving modeling, behavior rehearsal and feedback were operationalized by the shaping and reinforcement of appropriate comments by the group leaders and fellow participants. On another level, social skills were developed by the use of group work stage theory as a framework for the group discussion topics. Going through the process of the stages, modified for their cognitive abilities, provided an additional method of developing social skills, communication skills and the ability to relate to others.

The group discussion topics in several areas parallels the stages of group development outlined by Garland, Jones, and Kolodny and follows their sequence and phases of group development.

Garland, Jones and Kolodny outlined that the worker's focus of the first stage; Pre-affiliation - approach and avoidance, should be: "To help members to explore and to work on their involvement at

⁵⁸ Ibid., pages 41 - 45

a safe pace, should allow distance, furnish information regarding the operation of the group, encourage exploration of the physical setting and gently invite trust."⁵⁹ The group outline for the project devoted group session weeks one and two to stage one activities. The group leader discussed the operation and parameters of the group, solicited consumer feedback and encouraged consumer participation.

Garland, Jones and Kolodny discussed the worker's focus of the second stage; power and control, in terms of: "It is through the clarification with the group of the existence and nature of this power - control issue and its successful resolution that the group members become able to trust their vulnerable intimate selves to one another and to the worker."⁶⁰ The group participants in this project are psychiatric / retarded adults and therefore require clarification on a fundamental level. Group session week three discusses negativity with other people and group session week four discusses fears in social interactions. These are power and control issues, negativity as a method of exercising it, fear as a reaction to it. On a fundamental level these groups attempt to clarify and discuss power and control issues in social interactions and relationships.

Garland, Jones and Kolodny stated that in the third stage,

⁵⁹ Garland, James; Jones, Hubie and Kolodny, Ralph (1973). "A Model for Stages of Development in Social Work Groups." Saul Bernstein, ed., Explorations in Group Work. Boston: Milford House, page 30

⁶⁰ Ibid., page 33

intimacy, the worker's focus is described in terms of: "We have noted that often the process of clarification during stage three takes place not only in relation to specific attitudes and emotions, but finds expression also in the general meaning of the group experience."⁶¹ Group session week six discusses assumptions (misunderstandings) in communication with other people. On a simplistic but practical level the group participants are asked to hold off jumping to conclusions or making assumptions in their social interactions with others. Assumptions are primarily based upon the person's own psychodynamics, self perspective, and belief system. The consumers instead, are encouraged to ask direct, clarifying questions to try to understand what the other person is trying to communicate. Group session week seven discusses empathy. Empathy is a fundamental concept needed to develop more intimate social relationships. The cognitive and emotional limitations of the participants restricts the discussion to a simplistic but practical level of putting yourself in the other person's position. This is a beginning for the participants to understand interpersonal dynamics beyond egocentric dynamics. Group session week ten discusses listening to the other person in a conversation. This is similar to the discussion concerning empathy in that it encourages taking a step back and evaluating if they are relating and interacting with others on a more intimate, human level. Actually listening to what the other person is saying in a conversation and asking questions is basic to establishing a

⁶¹ Ibid., page 37

relationship and bringing that relationship to a two dimensional level going significantly beyond the single dimension of two people each conducting a monologue. It also assists in differentiation in clarifying the parameters of "self" and "other". Group session week eleven discusses friendship and socializing with others. Friendship is presented as a reciprocal relationship where intimacy or friendship is reinforced by mutual consideration, caring and understanding. Garland, Jones and Kolodny referred to this as "mutual acceptance of personal needs."⁶² It also reinforces differentiation in clarifying the parameters and mechanics of friendship.

Garland, Jones and Kolodny stated that in the fourth stage, differentiation, the worker's focus is described in terms of: "The worker's activity during stage four most appropriately centers around clarification and facilitation of differentiative and cohesive processes."⁶³ Group session week eight discusses appropriate assertiveness. Appropriate assertiveness is the mechanism through which the group participants can express themselves as individuals and maintain good social relationships. This allows them to differentiate themselves from others but remain as participants in group and social interactions. Group session week twelve discusses disagreements and arguments with other people. This is similar to the discussion concerning appropriate

⁶² Ibid., page 37 & 38

⁶³ Ibid., page 40.

assertiveness in that it encourages differentiation from others but with the maintenance of good social relationships. Group session week fourteen discusses social skills in the community.

Psychiatric / retarded people often have difficulty in the community. They can look and act bizarre and often, unfortunately, are treated very negatively by people in the community. The focus of this group is how to survive and adapt to what can be a hostile environment. The emphasis is on decreasing behaviors that draw negative attention and not being submissive to strangers. The mentally disabled are easily victimized by others and need to be taught survival skills in the community. The group participants discuss integrating themselves into the community and expressing themselves as individuals in a way that minimizes their exposure to the negative features of the community.

The Fifth and final stage of the model is separation. "The worker's activity should be generally oriented once again to facilitating the completion of the major developmental task at hand - in this case, moving apart. To this end, the worker will make opportunities and resources available for individual and group mobility."⁶⁴ This can be facilitated through recapitulation and evaluation. Group session week fifteen discusses termination. The group participants discuss what they received from the group. The consumers discuss how they can apply what they learned in situations outside of the group and practice some of those applications in hypothetical situations.

⁶⁴ Ibid., page 46

Psychiatric / mentally retarded consumers need social interactions and relationships but have major problems because of their disabilities understanding boundaries. The group discussion topics, therefore, focus on the parameters of social relationships. Garland, Jones, and Kolodny's stages of group development provide a useful framework for group discussion topics for a social skills group.

James Garland, Hubert Jones, Ralph Kolodny, and Eric Erikson

Garland, Jones, and Kolodny noted the similarity between their stages of group development and Eric Erikson's stages of personality development, his eight stages of man.⁶⁵ Erikson's eight stages of man as outlined in his book, Childhood and Society,⁶⁶ propose eight stages of human development from infancy to the twilight of a person's life span.

A group has an existence similar to the life span of a human being. The stages of group development parallel in many ways stages of personality development. The connection is powerful and vivid in that it conveys that a group is a living entity unto itself. It has a life and dynamics where the whole is not equal to the sum of the parts. This is relevant to the groups in this project because they too have a life. The group discussion topics, discussed in the methodology chapter, parallel the stages of group development outlined by Garland, Jones and Kolodny and therefore

⁶⁵ Ibid., page 33. - footnote

⁶⁶ Erikson, Eric (1963). Childhood and Society. New York 1950: Norton and Co.

parallel or connect to Erikson's stages of personality development. A fundamental component of a group is being a group and not multiple isolated individuals. A social skills group, such as the groups in this project, specifically focuses on developing the tools to interact with others and transcend multiple isolated individuals to achieve a sense of the collective and of being a group. The discussion topics paralleling stages of group development and stages of personality development accentuates the concept of the life force and the life span of the group. This is particularly true in a social skills group such as in this project where the focus is on interacting with others.

Erikson's eight stages of man can be juxtaposed with Garland, Jones and Kolodny's stages of group development. The first two stages, 1) Basic Trust vs. Basic Mistrust, and 2) Autonomy vs. Shame and Doubt, can be related to the pre-affiliation stage of group development. Basic Trust vs. Basic Mistrust concerns an infant's trust in receiving sensitive care of his / her individual needs and a sense of identity. Erikson stated there are "few frustrations in either this or the following stages which the growing child cannot endure if the frustration leads to the ever-renewed experience of greater sameness and stronger continuity of development, towards a final integration of the individual life cycle with some meaningful wider belongingness."⁶⁷ This can be perceived as being related to the "approach" component of the approach / avoidance paradigm which is a pivotal aspect of the pre-

⁶⁷ Ibid., page 249

affiliation stage. Erikson's second stage, Autonomy vs. Shame and Doubt, concerns the baby's experimentation with holding on and letting go. Erikson stated that "firmness must protect him against the potential anarchy of his as yet untrained sense of discrimination, his inability to hold on and to let go with discretion. As his environment encourages him to stand on his own feet, it must protect him against meaningless and arbitrary experiences of shame and of early doubt."⁶⁸ This can be perceived as being related to the "avoidance" component of the approach / avoidance paradigm of the pre-affiliation stage.

Erikson's third, fourth, and fifth stages; 3) Initiative vs. Guilt, 4) Industry vs. Inferiority, and 5) Identity vs. Role Confusion, can be related to the power and control stage of group development. Initiative vs. Guilt concerns a child's need to undertake a task, to be active and on the move. Erikson stated "He is eager and able to make things cooperatively, to combine with other children for the purpose of constructing and planning, and he is willing to profit from teachers and to emulate ideal prototypes."⁶⁹ This can be perceived as being related to the establishment of the parameters of relationships in the power and control stage of group development. Industry vs. Inferiority concerns a child's need to become a part of a productive situation. Erikson wrote "this is socially a most decisive stage: since industry involves doing things beside and with others, a first

⁶⁸ Ibid., page 252

⁶⁹ Ibid., page 258

sense of division of labor and of differential opportunity, that is, a sense of the technological ethos of a culture, develops at this time."⁷⁰ This can be perceived as being related to the establishment of an equilibrium or of a productive process in the power and control stage. Identity vs. Role Confusion focuses on a youth's concern with what they appear to be to others as compared with what they feel they are, and with concerns about how to relate the roles and skills developed earlier with the current occupational prototypes. Erikson stated "The sense of ego identity, then is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as evidenced in the tangible promise of a career"⁷¹

For our purposes, substitute group membership for career. This can be perceived as being related to the establishment of a safe environment or accepted by the group for who they perceive themselves to be, as part of the power and control stage.

Erikson's sixth and seventh stages; 6) Intimacy vs. Isolation, and 7) Generativity vs. Stagnation, can be related to the intimacy stage of group development. Intimacy vs. Isolation concerns the person's readiness for intimacy "the capacity to commit himself to concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments, even

⁷⁰ Ibid., page 260

⁷¹ Ibid., pages 261 & 262

though they may call for significant sacrifices and compromises."⁷² This clearly relates to the intimacy stage of group development very directly. Erikson's seventh stage Generativity vs. Stagnation, in his system concerns the creating and guiding, educating of the next generation, either of their own or other's offspring. The parallel to group development does not concern procreation, but rather, once intimacy in a group is established the sharing creates a mutual learning (educating), mutually beneficial (nurturing) situation which is a fundamental core of the group work process.

Erikson's eighth and final stage, 8) Ego Integrity vs. Despair, can be related to the differentiation and separation stages of group development. Ego integrity "implies an emotional integration which permits participation by fellowship as well as acceptance of the responsibility of leadership"⁷³ (which is an optimum group situation). It is the person's acceptance of the realistic parameters of him / herself. Differentiation in group process concerns mutual acceptance of personal needs and the evaluation of relationships and events in the group based upon the realistic parameters of their personal situation and the group process. Separation in group process concerns the conclusion of the group. Erikson discussed ego integrity in terms of the conclusion of a person's life. Erikson finished his outline by proposing a circular relationship in the stages of man by linking

⁷² Ibid., page 263

⁷³ Ibid., page 269

trust, the first of his ego values, with integrity, the last of his values. He quoted Webster's definition of trust as "the assured reliance on another's integrity."⁷⁴ He went on to relate adult integrity and infantile trust by saying that "healthy children will not fear life if their elders have integrity enough not to fear death."⁷⁵ In group process, if the group was a positive experience, it can become a frame of reference for approaching new situations and new groups at least partly because group members have developed a basic trust in the integrity of others and themselves.

This juxtaposing of group development with personality development relates to the groups in this project in that the group discussion topics, discussed in the methodology chapter, in many ways parallel these two stage theories. The groups in this project are geared specifically towards psychiatric / mentally retarded consumers. The focus is developing social skills or acquiring skills in interacting with others. The connection is clear when you consider personality development implies interacting with your environment, primarily other people. Group development implies interacting with other group members and a social skills group for psychiatric / mentally retarded consumers implies acquiring skills in interacting with others. Maturation of an individual, maturation of a group, and maturation of a psychiatric / mentally retarded social skills group follows the same pattern or goes

⁷⁴ Ibid., page 269

⁷⁵ Ibid., page 269

through similar stages. The common denominator is the process. A group is composed of individuals who experience their own maturation or growth who come together to share part of themselves and through that participation develop the group, hopefully help others and hopefully help themselves. This interrelationship of the individual to the group and the group to the individual can be seen in the similarities of personality development, group development and the dynamics of a psychiatric / mentally retarded social skills group.

Helen Northen

Helen Northen developed a four stage model of Group Development consistent with the work of Garland, Jones and Kolodny in her book; Social Work with Groups (2nd Ed.)⁷⁶ Her four stages are: Stage One; Orientation - Inclusion, Stage Two; Dissatisfaction and Power Conflict, Stage Three; Mutuality - Work and Stage Four; Separation - Termination.

In the Orientation - Inclusion stage "the predominant socioemotional themes are inclusion and dependency. The typical patterns of behavior are those of approach - avoidance, reflecting ambivalence about becoming a part of or included in the group's membership."⁷⁷ Northen noted that at this stage the members had not developed trust, and discussions were generally scattered, self-centered, and superficial. Interpersonal and intragroup

⁷⁶ Northen, Helen (1988). Social Work with Groups 2nd Ed. New York: Columbia University Press

⁷⁷ Ibid., page 180

conflicts, however, were generally minimal. The members' task is to become oriented to the group. "The task is to become oriented to the new situation, including the group's purpose, role of workers and members, and natural expectations."⁷⁸

In the Second Stage: Dissatisfaction and power Conflict the predominant socioemotional theme is dissatisfaction with the perceived structure and expectations of the group. "The typical patterns of socioemotional behavior are expressions of frustration, competition for status, disappointments, anger, discouragement, and anxiety about natural acceptance and group identity. Exploration of the reality of the situation in respect to its hoped for benefits, testing of the worker's acceptance and authority, and challenges to the existing structure occur."⁷⁹ The members' task is the "development of realistic mutual expectations and interpersonal relationships based on mutual trust and acceptance."⁸⁰

In the third stage: Mutuality - Work the predominant socioemotional theme is interdependence. "The typical socioemotional patterns of behavior are intensification of personal involvement, seeking or avoiding intimacy, and enhancing personal identity along with group identity. Members tend to cooperate and participate actively in the group's work."⁸¹ The members' task is

⁷⁸ Ibid., page 180

⁷⁹ Ibid., page 181

⁸⁰ Ibid., page 181

⁸¹ Ibid., page 182

to work towards goal achievement. The members utilize appropriate problem resolution, develop their understanding of self and others, and enhance their social competence. They work towards the group's goals as well as individual goals.

In the fourth stage: Separation - Termination the predominant socioemotional theme is separation. "The predominant behavior patterns tend to be the mobilization of defenses against ending, feelings of loss of relationships, regression, reenactment of earlier experiences, and uncertainty about ability to function without the group."⁸² The members' task is to leave the group and make transitions to other activities. This is facilitated by a review and evaluation of the experience, stabilization of gains, and is hopefully transferred to situations in the community.

Northen's model is consistent with the model of Garland, Jones and Kolodny. Northen's first stage; Orientation - Inclusion, parallels their first stage, Pre-affiliation. Her second stage, Dissatisfaction and Power Conflict, parallels their second stage; Power and Control. Northen's third stage, Mutuality - Work, parallels a combination of their third and fourth stage; Intimacy and Differentiation. Northen wrote "This stage (stage three) would be divided by some writers into a stage in which issues concerning intimacy predominate, followed by a fourth stage of differentiation that precedes separation."⁸³ Her fourth stage, Separation - Termination, parallels their fifth stage; Separation. Garland,

⁸² Ibid., page 182

⁸³ Ibid., page 182

Jones and Kolodny propose the central theme of their model is closeness. Helen Northen phrases it slightly differently, referring to her model as a relationship and process -oriented approach with emphasis on socioemotional dynamics."⁶⁴ This project's group discussion topics, discussed in the methodology chapter, in many ways parallel the stages of group development outlined by Garland, Jones and Kolodny. As previously discussed, Northen's model is consistent with their model. Her work gives a slightly different perspective in that it is geared towards process. A social skills group for psychiatric / mentally retarded participants is also very process - oriented in that it focuses on the tools of interacting as well as the content.

Sondra Brandler and Camille Roman

Sondra Brandler and Camille Roman, in their book, Group Work - Skills and Strategies for Effective Intervention,⁶⁵ propose a model of group stages consisting of beginning, middle, and end stages, dividing the middle stage into three parts (early middle, middle middle, and end middle). In their beginning stage, group members experience approach - avoidance conflicts. These conflicts involve "wanting to share, explore, belong, and be close with others yet fearing vulnerability, hurt, and rejection."⁶⁶ The worker in the beginning stage focuses on contracting with the group, establishing

⁶⁴ Ibid., page 176

⁶⁵ Brandler, Sondra and Roman, Camille (1991). Group Work - Skills and Strategies for Effective Interactions. New York: Haworth Press

⁶⁶ Ibid., page 15

guidelines, structures, goals and purposes, and their own role as facilitator of goal achievement. "The group's beginning stage is characterized by the creation of norms and values, the development of structure and goals, and the establishment of patterns of communication."⁸⁷

In Brandler and Roman's Early - Middle stage "The members' issues in this stage include the beginning issues of trust, testing, approach and avoidance, and clarification of contract. Some sense of vulnerability, fear of exposure, and tentative exploration persist."⁸⁸ In the Middle - Middle stage "the group moves to a greater level of spontaneity, clarifying, focusing, talking about intimate and emotional issues, and sharing vulnerability as well as strength, risking exposure, and active problem solving."⁸⁹ The End - Middle stage focuses on preparation for separation and individuation phase of termination. "The work proceeds with the individual more clearly defining his independent goals and needs, but there is a fluidity between the meeting of group and individual needs."⁹⁰

The ending or termination stage is the final stage of group development. The ending may be for a member, the entire group, or the current worker. "In the ending phase, the importance of striking the right balance between preserving what has been gained

⁸⁷ Ibid., page 17

⁸⁸ Ibid., page 38

⁸⁹ Ibid., page 40

⁹⁰ Ibid., page 41

by the group experience and successfully breaking away from the past cannot be underestimated."⁹¹

Brandler and Roman compared group structure to an organism moving through several life stages to achieve growth:

"The group process parallels the life process in several ways. First, as in life, the group begins with tentative explorations of the environment, its demands, its rewards, and its expectations. Essentially, this is an orientation phase. Next, the group passes into the work phase in which norms are refined and struggled with and goals are established and some achieved. This is the adaptation phase. In the third and final stage, there is a more sophisticated and complete mastery of survival skills. This is the final acceptance of self in relation to norms. It prepares the way for separation with individuation, the termination phase."⁹²

The earlier comparison of Garland, Jones and Kolodny's model of group development and Erikson's model of personality development can easily be juxtaposed with Brandler and Roman's model and their analogy of group process to the life cycle. Brandler and Roman outline five stages that correlate to Garland, Jones, and Kolodny's five stages.

Gale Goldberg Wood and Ruth Middleman

Gale Goldberg Wood and Ruth Middleman, in their book, The Structural Approach to Direct Practice in Social Work,⁹³ refer to a linear model of group development with beginning, middle and end stages. They stated "the focus on the group elements of the process is future oriented, with goal attainment, development, and

⁹¹ Ibid., pages 75 & 76

⁹² Ibid., page 9

⁹³ Wood, Gale Goldberg and Middleman, Ruth (1989). The Structural Approach to Direct Practice in Social Work. New York: Columbia University Press

achievement ordering the worker's and groups' thinking."⁹⁴ They emphasize that groups have core processes resulting from the group dynamic. Wood and Middleman outlined eight core processes: 1) development of cohesion, 2) conformance with group norms, 3) expression of emotion, 4) use of the group to work on problematic ways of relating, 5) experience of power and influence, 6) experience of role taking and different group functional and dysfunctional acts, 7) development of increased intimacy, and 8) pursuit of group purpose.⁹⁵ The authors maintain the worker's goal is to recognize these processes and connect with these salient group forces.

Although Wood and Middleman's conceptual approach is different from Garland, Jones and Kolodny, there are many similarities between the two theories. Garland, Jones and Kolodny refer to a pre-affiliation stage, whereas Wood and Middleman discuss core processes of development of cohesion and conformance with group norms. Garland, Jones and Kolodny refer to power and control and Wood and Middleman discuss the experience of power and influence. Garland, Jones and Kolodny outline an intimacy stage and Wood and Middleman propose development of increased intimacy as a core process. Garland, Jones and Kolodny specify a separation stage which can be related to Wood and Middleman's pursuit of group purpose related to the accomplishment of the group's goal. The other core processes, expression of emotion, use of the group to

⁹⁴ Ibid., page 193

⁹⁵ Ibid., page 190 & 191

work on problematic ways of relating, and experience of role taking and different group functional and dysfunctional acts, can be said to occur in varying degrees throughout all of Garland Jones and Kolodny's stages. Wood and Middleman focus on group sessions related to where the group is in the overall process. This is consistent with Garland, Jones and Kolodny's focus on a progressive development with correlations to human maturation.

In this Group Work section Kurland's guide for group formation was reviewed with supporting references by Northen, Brandler and Roman. Garland, Jones and Kolodny's model was reviewed. Other stage theorists were discussed; Northen, and Brandler and Roman, who are generally consistent and supportive of the work of Garland, Jones and Kolodny. Correlations were made between the Structural Approach of Wood and Middleman and the Garland, Jones, and Kolodny model. Parallels were made between group development and human maturation with specific comparison of the Garland, Jones, Kolodny model and Erikson's stages of man as well as an analogy made by Brandler and Roman. The conceptual framework of this project, Kurland's group formation and Garland, Jones, and Kolodny's model, is well established in social work practice. Group work theorists discuss two key components of this project, social skills, and feed back information (video).

Brandler and Roman outlined the parameters of the remedial or rehabilitative model:

"The rehabilitative or remedial model suggests that the worker is in a somewhat superior position to group members whose social skills are impaired or not fully developed. This model might be used, for example, in a skills of daily living group

for retarded children or a group for schizophrenics. Using this model, the worker instructs, exercises considerable authority, models behavior for group members, and creates an atmosphere which motivates individual growth. The group participants are regarded as clients rather than members. Although there is an attempt to involve clients in decisions regarding goals, structure, and direction for the group, the expectation is that the professional will actively guide the group. The rehabilitative model, as its name suggests, is strongly allied with structured learning and can be viewed as an educational model."⁹⁶

Northen, in discussing procedures and skills, reviewed education as a component of group work. Specifically, she refers to communication or social skills:

"Ability to communicate with other people is basic to effective psychosocial functioning. Unless a person understands the intent of messages sent to him, he cannot respond in ways that meet the expectations of the sender of the message. Likewise, unless a person can convey his intents to others in such a way that they can be perceived with accuracy, he cannot make his desires known. When a person cannot understand others, he tends to become anxious. Many difficulties in interpersonal relationships and role performance derive from inability to make clear one's desires, feelings, and ideas. If members do not participate actively in the communicative network within a group, they miss an opportunity to give to others and to receive validation of their feelings and thoughts from others. There is a close interrelationship between facility in verbalization and exposure to and use of experiences in the physical and social environment. Stimulation from dealing with a variety of nonhuman objects, within supportive social relationships, seems essential to the development of adequate verbal skills."⁹⁷

This perspective on communication or social skills justifies and validates the need of social skills training for a population with emotional and cognitive impairments such as psychiatric / mentally

⁹⁶ Brandler, Sondra, and Roman, Camille (1991). Group Work - Skills and Strategies for Effective Interventions. Haworth Press, page 8

⁹⁷ Northen, Helen (1988). Social Work with Groups 2nd Ed. New York: Columbia University Press, page 65

retarded consumers.

Northen devoted an entire chapter to activity - oriented experiences (such as social skills training) in her book Social Work with Groups. She proposes that using activity - oriented experiences to enhance social competence, the worker is primarily using an educational process. The educational role of the social worker is different than a school teacher in that the social worker uses the learning process primarily directed towards the acquiring of knowledge that facilitates the completion of certain tasks or in the resolution of problems related to social living.⁹⁸ The worker achieves this by providing social experiences to test the application of knowledge and skills and uses "activities, demonstrations, and audiovisual aids as tools in teaching."⁹⁹ This project follows this approach and is fundamentally composed of social skills training using activities and demonstrations reinforced with the audiovisual aid of video feedback.

The Structural Approach of Wood and Middleman also refers to the educational role of social workers in running certain types of groups. An example would be groups that focus on learning new behaviors and / or giving up undesired behaviors. The group leader functions as an assessor / teacher and determines the members' current level of functioning, teach different behaviors, and determine whether or not the new behavior was learned. The worker's special knowledge / skill in the behavior - change group

⁹⁸ Ibid., page 86

⁹⁹ Ibid., page 76

resides in methods of teaching, reinforcement, amongst other techniques.¹⁰⁰ Wood and Middleman describe basic change processes and factors characteristic of all group types. They refer to Yalom's identification of therapeutic factors in psychotherapy groups. Three are relevant to this project; 1) imparting of information, 2) development of socializing techniques and 3) interpersonal learning. He also refers to change processes in self-help groups. Two are relevant to this project; 1) feedback on behavior inside and outside the group and 2) modeling.¹⁰¹ This project uses a structured social skills training approach. It tries to utilize the change processes of development of socializing techniques and interpersonal / learning augmented by video feedback. It utilizes the change processes of feedback on behavior, modeling (self - modeling), and provision of information. The project is a structured interaction using different activities to provide a constructed learning experience.

Wood and Middleman in another book, Skills for the Direct Practice in Social Work, discuss the pivotal role of information provision in social work practice. "A situation or event is knowable to the extent that information pertinent to that situation or event can be generated, collected, manipulated, and reconstructed. And to the extent that a situation or event is known, there can be greater accuracy in problem definition and

¹⁰⁰ Wood, Gale Goldberg and Middleman, Ruth (1989). The Structural Approach to Direct Practice in Social Work. New York: Columbia University Press, pages 195 & 197

¹⁰¹ Ibid., pages 199 & 200

determination of action to resolve the problem defined. It follows that generating and processing information is central to social work practice."¹⁰² Feedback is a major component of the provision of information. Feedback clarifies communication to accurately relay the meaning intended. It provides the participants with an opportunity to adjust their presentation to attain more accurate communication. Another component is confronting distortion. Again, the goal is increasing accuracy in communication. Confronting distortion focuses on receiving communication. The participants may have inaccurately understood communication either because the message sent was not clear or because the receptive abilities of the receiver is impaired or both. The use of Video Feedback in this project capitalizes on technology to provide practical information on consumers' social skills and social interactions. It has the capacity to provide feedback on communication sent and confront distortion on communication received. The consumers' emotional and cognitive impairments increase their need for such information. Wood and Middleman stated: "Information is a resource. Given the relationship between possession of resources and possession of power, when the worker gives the client information, she increases the client's power to exercise some measure of control over his experiences."¹⁰³

Northen stated that group was often the treatment modality of

¹⁰² Middleman, Ruth and Wood, Gale Goldberg (1990). Skills for Direct Practice in Social Work. New York: Columbia University Press, page 73

¹⁰³ Ibid., page 83

choice in working with mentally ill consumers. Many decompensate because of interpersonal stress. A majority have chronic interpersonal problems, such as isolation and loneliness, poor social skills and difficulties in dealing with anger, intimacy and dependency. Group addresses these concerns directly. Northen quotes Yalom: "The group is the therapeutic arena par excellence in which patients learn to explore and to correct maladaptive interpersonal patterns."¹⁰⁴ She goes on to specifically discuss psychiatric consumers in the community: "He is often clinically improved but socially disabled. The purpose of groups for such persons may be to help them to maintain and enhance their social relationships and to become more socially able."¹⁰⁵ This project works with psychiatric / mentally retarded consumers in a group modality to enhance their social skills. Northen related some features of group work with the mentally ill. The participants in this project are dually diagnosed and are both mentally ill and mentally retarded.

General group work theory specifically relates to groups in this project in its orientation towards very structured work. Group work with mentally retarded participants requires a more focused, more structured approach than work with the general population. The general population has a greater ability to function in a more open group with less constraints. The mentally

¹⁰⁴ Northen, Helen (1988). Social Work with Groups 2nd Ed.
New York: Columbia University Press, Page 109

¹⁰⁵ Ibid., page 110

retarded however, because of the cognitive challenges they face, do better with a more direct, focused, structured approach. The stage models, Garland, Jones and Kolodny's model, Northen's model, Brandler and Roman's model, and Wood and Middleman's model, all provide a structured framework upon which a practitioner can develop a group for cognitively impaired participants. Group work with mentally retarded participants contains the same basic components as with the general population but must be adapted to meet their special needs. Structure and process are more important because cognitively impaired participants need to be guided to stay focused. General group work theory, especially stage theory, is important to group work practitioners with the cognitively impaired because the worker must develop the interactional sensitivity and "systems knowledge" necessary to appreciate the group process. Since group work with the mentally retarded has some special considerations, a separate section is included in the literature review on group work with the mentally retarded.

SECTION THREE OF LITERATURE REVIEW

Group Work with the Mentally Retarded

A separate section of the literature review is devoted to group work with the mentally retarded because they are a unique population with their own special needs and characteristics. Group work theories need to be adapted to meet the special challenges of work with this population.

Daniel Tomasulo, in The Healing Crowd, proposed five erroneous

assumptions on the part of some practitioners regarding the mentally retarded and group therapy: 1) Since many mentally retarded consumers have difficulty verbalizing they are thought to be unable to make inferences regarding regulating their behavior. 2) The secondary disabilities often accompanying mental retardation, i.e. short attention span, auditory and visual handicaps, etc., are thought to be insurmountable obstacles to group therapy. 3) Mentally retarded consumers are thought to lack the cognitive ability to benefit from insight into the causes and consequences of their behavior. 4) Several practitioners believe the emotional disorders exhibited by mentally retarded consumers are a side effect of a biochemical brain dysfunction. As such there is little which group therapy can offer. 5) The emotional and behavioral problems of mentally retarded consumers are believed to be the result of mental illness or behavior disorders. With such elementary discriminations only psychopharmacological or behavioral interventions alone are sought. The use of group therapy to help ameliorate these problems is rarely considered.¹⁰⁶ Although in some instances these conditions might prove to be true, looking at the mentally retarded as a collective population these assumptions have proven not to be true.¹⁰⁷

John Mordock and William Van Ornum noted some specific

¹⁰⁶ Tomasulo, Daniel (1996). The Healing Crowd: The Intervention - Behavioral Model of Group Psychotherapy. Published under the aegis of the National Association for the Dually Diagnosed, pages 16, 17, 18

¹⁰⁷ Ibid., pages 16, 17, 18, 19. Also see Literature Social Skills Section.

characteristics of the psychiatric / mentally retarded consumer to be considered when providing therapeutic services to them: 1) They are egocentric. Psychiatric / mentally retarded consumers are egocentric, not in the sense of being selfish, self - serving or conceited but rather in being focused on themselves and not taking into account the viewpoint of others. This can be operationalized as attributing to others, simply because they are there, the same feelings and wishes that they have. A practitioner needs to help the consumer differentiate that although they are angry or sad, others (practitioners, fellow participants) are not angry or sad. 2) They take things literally. Idiomatic expressions, adult phrases such as "don't pull my leg" can be too abstract for them to be readily understood. Communication needs to be clear and direct. 3) They make unique connections. Psychiatric / mentally retarded consumers make their own connections between events, objects and people which may seem totally unrelated to the practitioner. Through experience and careful questioning their thinking can be more readily understood. 4) They are avoiders of issues. They have difficulty dealing with intense feelings. They can be fragile, vulnerable, and fearful that they will regress and decompensate. Communication in the context of an activity or project tends to relieve some of this anxiety. 5) They can be blind to inconsistencies. Sometimes they do not understand the communication and sometimes the practitioner does not realize that they do not understand. Communication needs to be clear, repeated

and rephrased.¹⁰⁸

Steven Reiss advises group therapists to use a concrete, direct, and structured approach with the active participation of the group leader when working with the mentally retarded.¹⁰⁹

Daniel Tomasulo agrees and maintains that group therapy for mentally retarded consumers has been most effective when a directive style with structured sessions is used. He also proposes that "the use of active / interactive techniques stimulates more sensory and affective modes of learning than the verbal modality alone".¹¹⁰

Michael Monfils, in his article on group psychotherapy with the retarded in Mental Retardation and Mental Illness (Fletcher & Menolascino, eds. 1989), outlined seven advantages, and four key variables of groups with this population.¹¹¹

He proposed seven dimensions of the advantages of group therapy: First: self disclosure. It offers an opportunity to share information about self which is a crucial aspect of the

¹⁰⁸ Mondock, John and Van Ornum (1989). "Evaluating the Dually Diagnosed Client". Fletcher, Robert and Menolascino, Frank; Eds., Mental Retardation and Mental Illness. Lexington, MA, Lexington Books, page 20

¹⁰⁹ Reiss, Steven (1994). Handbook of Challenging Behavior: Mental Health Aspects of Mental Retardation. Worthington, OH: I.D.S. Publications, page 144

¹¹⁰ Tomasulo, Daniel (1996). The Healing Crowd: The Interactive - Behavioral Model of Group Psychotherapy. Published under the aegis of the National Association for the Dually Diagnosed, pages 16 - 17

¹¹¹ Monfils, Michael (1989). Group Psychotherapy, Fletcher, Robert & Menolascino, Frank eds. Mental Retardation and Mental Illness. Lexington MA: Lexington Books

group process. Second: Peer and therapist modeling. The retarded have decreased cognitive functioning and often have difficulty processing new information. Group therapy, through the use of such techniques as role playing and behavior rehearsal, can give them an opportunity to see a demonstration of desired behavior and then imitate that behavior. The client tries to acquire adaptive skills through peer and therapist modeling by approximating the desired skills. Third: Confrontation or Catharsis. Clients have an opportunity to confront each other about attitudes, beliefs, and behaviors. Peer confrontation can have a more significant effect than the same stance taken by a professional. Catharsis, or the healthy release or expression of ideas and emotions, can be exceptionally therapeutic for the clients. Fourth: Group support and encouragement. Practically all of the retarded have experienced varying degrees of self-perceived "failure." Group offers them an opportunity to receive support and understanding from peers and therapist. Fifth: Problem solving. The clients often have a limited repertoire of problem solving skills. Their judgment is characteristically poor. Group gives them an opportunity to develop and extend their coping skills through group exploration and modelling. Sixth: Cohesion. The retarded are often, unfortunately, viewed by society and even themselves as "misfits". Group can give them an opportunity to develop a sense of 'belonging.' "Cohesiveness refers to the attractiveness a group has for its members, in that they value the group and wish to remain in it. As a cohesive group

develops, members feel a sense of belonging in the group and become more open in revealing personal thoughts and feelings."¹¹² The group members should develop and enhance their sense of self - esteem through the acceptance and understanding found within the group. Seventh: Efficient use of resources. The financial constraints placed on human services in the nineties dictate efficiency. Multiple clients can be seen within the group therapy session as opposed to one - to - one therapy.

Monfils outlined four key variables in group treatment for the retarded. First: Composition. Intelligence level or I.Q. cannot be the only criteria for group membership. Other major factors to be considered should be motivation for change, capacity for verbal expression, and extent of insight. The client should not be acutely psychotic and / or severely paranoid nor prone to physical aggression or threatening behaviors. These would prove to be too disruptive to the group. Second: Purpose. The purpose of the group must be well defined yet be flexible enough to adapt to the unfolding progress of the therapy. "In many groups, clients develop goals related to self - assessment and self - image, in terms of honestly looking at personal strengths and gaining an understanding of their handicaps. As clients begin to accept their personal or social deficits, they are able, in the group, to develop and rehearse coping strategies. These types of goals are generally appropriate for mildly retarded individuals who possess adequate verbal skills and comprehension. ... Many retarded

¹¹² Ibid., page 118

individuals exhibit deficits in various interpersonal skills, such as engaging in appropriate conversations, expressing feelings, and social responsibility. These deficits can be specifically addressed in the small group format."¹¹³ Third: Structure. The group should be structured to allow for the intellectual and verbal abilities of the group members. The therapist must make an effort to communicate with the group members on a level they can comprehend. Fourth: Rules and Procedures. The clients are in the process of learning appropriate social behavior in a group setting. Basic rules such as speaking one at a time, not wandering around the room, not shouting, accepting responsibility for one's self, etc. need to be reinforced.

Nezu, Nezu, and Gill - Weiss propose that group therapy can be very empowering for the mentally retarded. Beyond being a useful teaching forum, group therapy can assist in reducing the distance between helpers and consumers. Through group therapy the participants are empowered to help each other. This can "indirectly address some undesirable effects of prolonged involvement with professionals, such as dependency and low self-esteem".¹¹⁴ The group participants can feel more competent to deal with problems and assist others in similar situations with their own knowledge from experience.

¹¹³ Ibid., page 116

¹¹⁴ Nezu, Christine; Nezu, Arthur, and Gill - Weiss, Mary Jane (1992). Psychopathology in Persons with Mental Retardation: Clinical Guidelines for Assessment and Treatment, Illinois: Research Press Co., page 226

The section on group work with the mentally retarded is relevant to this project in that it takes the structure discussed in the general group work theory section and helps focus and adapt it to the special needs of the consumers in this project.

SECTION FOUR OF LITERATURE REVIEW

Social Skills Training

The social skills training literature is a pivotal component of this project. The groups in this project use social skills training techniques described in the literature. The articles propose a basically similar approach using modeling, behavioral rehearsal, and feedback - social reinforcement. These techniques are employed in this project. A large part of the design areas of the social skills training component of this project is taken from the research done by Johnny Matson and Vincent Senatore in their 1981 article.

Robert Liberman, William DeRisi and Kim Mueser in their book on social skills training, propose that the most effective method of teaching social skills is to utilize a three step procedure:

"(1) observing another person competently use the skill (modeling), (2) practicing the skill in a simulated situation (behavior rehearsal) and (3) obtaining feedback and suggestions for improvement from others (social reinforcement). Modeling, behavior rehearsal, and social reinforcement are the learning ingredients that form the backbone of social skills training."¹¹⁵

Douglas Strohmer and Thompson H. Prout, in their book on

¹¹⁵ Liberman, Robert; DeRisi, William and Mueser, Kim (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, page 2

counseling and psychotherapy with the retarded, defined modeling as:

"A process in which individuals learn by observation. In this process the behaviors of similar others serve as the stimulus for learning. Individuals learn by watching other individuals perform a behavior, seeing the consequences of the behavior, and then imitating it. Modeling is also called observational learning, vicarious learning, and imitation and generally is thought to be most effective when individuals first watch a model who is similar to themselves perform a task, then attempt the task themselves. Modeling can have two effects on the individual: (1) learning a new behavior or set of behaviors and (2) inhibiting or disinhibiting an already learned behavior."¹¹⁶

The authors also defined behavioral rehearsal:

"Behavioral rehearsal is a specific procedure used to teach new behaviors, typically interpersonal, social, or work skills, in which the client practices the new behavior under the direction of the counselor. This may involve the counselor assuming the role of significant others in the client's life and helping the client in developing and rehearsing more effective ways of interacting with these individuals. It may also involve the practice of work skills. A common variant on this technique is role reversal, in which the counselor acts the role of the client and the client takes the role of the significant other."¹¹⁷

The third component of social skills training, feedback, is the primary technique used in this project in the form of video feedback and is dealt with in a separate section of the Literature Review. The use of feedback in the form of video feedback is the main focus of the research in this project. It is a crucial component that is extremely important to the work of this project.

¹¹⁶ Strohmer, Douglas, and Prout, H. Thompson (1994). Counseling and Psychotherapy with Persons with Mental Retardation and Borderline Intelligence. Vermont: Clinical Psychology Publishing Co., page 155 & 156

¹¹⁷ Ibid., page 176

Martha Perry and Mary Cerreto (1977) used a structured learning approach which utilized videotaped models, role playing, and social reinforcement in a group modality, to teach social skills to moderately mentally retarded young adults. In this study the participants first observed a videotaped model which demonstrated the component parts to the social skill behavior to be learned (i.e. meeting and conversing with people). This was followed by a verbal summary of the behavior. The participants then engaged in rehearsal, feedback, and reinforcement. The group that received structured learning training did significantly better in both a real - time observation and in a structured situation test that measures social interactions than the study's control group.¹¹⁸

Matson, Alan Kazdin and Karen Esveldt - Dawson (1980) used a combination of instruction, modeling, behavior rehearsal, performance feedback and reinforcement to teach social skills to two moderately retarded boys who had conduct problems. The social skills were appropriate verbalizations, eye contact, appropriate facial expression, and appropriate motor behavior. In this study the special education teacher taught certain social skills to the participants using modeling and rehearsal. The teacher worked with each participant, individually presenting them with six social situations and asking the participants to try to respond to each. If the participant engaged in inappropriate behavior during the

¹¹⁸ Perry, Martha, and Cerreto, Mary (1977). Structured Learning Training of Social Skills for the Retarded. Mental Retardation, Vol. 15, pages 31 - 34

practice (rehearsal), the teacher would model the appropriate behavior and then have the participant rehearse the situation again. This was completed for up to three repetitions. The effects of the training in developing appropriate social performance were evaluated in separate multiple - baseline designs across behaviors for each participant. The training improved social skills and brought them up to or beyond the level of same - age and gender - normal subjects.¹¹⁹

Matson and Frank Andrasik (1982) worked with mentally re-
tarded adults, providing social skills training to enhance the
participants leisure time social interaction skills. The training
consisted of instruction, information feedback, social reinforce-
ment and modeling aimed at target behaviors of appropriate
social interactions (introducing oneself, requesting an item,
asking a question, etc.) and inappropriate social interactions
(complaining, insulting, responses not related to statements made
by others, etc.). The study involved self - reinforcement; tokens
for items, and self - monitoring; record / log occurrences of
target responses both in the training session and in the natural
environment of the leisure - time situation. The study showed that
the training increased the occurrence of appropriate social
interactions in the natural environment of the leisure time
situation. Self - monitoring and self - reinforcement in the

¹¹⁹ Matson, Johnny; Kazdin, Alan and Esveltd - Dawson , Karen
(1982) Training Interpersonal Skills Among Mentally
Retarded and Socially Dysfunctional Children. Behavior
Research and Therapy. Vol. 12, pages 369 - 382

natural environment proceed to be effective for facilitating generalization of the social skills.¹²⁰

Matson and Joyce Adkins (1980) used a self - instructional social skills training program with two mentally retarded institutionalized adults. In this study, the authors used audiotape to teach appropriate use of the target skills in a leisure situation. The target skills were appropriate social interactions (positive statements, compliments, requests etc.) and inappropriate social interactions (cursing, unreasonable requests, failure to respond appropriately, etc.). Following listening to the audiotaped social skills training program (scenarios of appropriate social skills), the participants reviewed material on appropriate social behavior covered on the audiotapes with a therapist, including behavioral rehearsal between the participant and therapist on appropriateness of responses. The participants were observed by raters during leisure time in the evening. The observers scored the occurrence of target behaviors in the participants' live environment. The training was found to be effective and the use of a self - instructional audiotape proved to be very time efficient for staff resources.¹²¹

Matson (1982) did a study on the treatment of behavioral

¹²⁰ Matson, Johnny and Andrasik, Frank (1982). Training Leisure - Time Social - Interaction Skills to Mentally Retarded Adults. American Journal of Mental Deficiency. Vol. 86, pages 533 - 542

¹²¹ Matson, Johnny, and Adkins, Joyce (1980). A Self - Instructional Social Skills Training Program for Mentally Retarded Persons. Mental Retardation. Vol. 18, pages 245 - 248

characteristics of depression with mentally retarded participants. He treated depressed consumers for abnormalities in number of words spoken, somatic complaints, irritability, grooming, aggression, negative self - statements, flat affect, eye contact, and speech latency. The treatment was done in individual therapy sessions and consisted of information, performance feedback, modeling by therapist, role play by participants, and token reinforcement of correct responses. Treatment varied from ten to thirty five sessions due to a multiple baseline design for the various targeted behaviors. All four participants improved significantly on the target behaviors and effects were maintained at follow - up (four to six months later) using social validation criteria. The intervention did not claim to be successful in the treatment of the total complex of depression. The author refers to other studies that suggested "clinical work in depression should move away from a unitary model, and that depression should be evaluated on its behavioral, cognitive, and physiological components."¹²² At a minimum, depressive behavior can have a negative effect on a retarded person's social interactions. The removal of depressive behavior can facilitate the retarded person's positive social interactions and enhance their social support.

Sam Turner, Michael Hersen, and Alan Bellack (1978) studied the use of social skills training to teach prosocial behaviors to an organically impaired and mentally retarded young adult. The

¹²² Matson, Johnny (1982). The Behavioral Treatment of Depression in the Mentally retarded. Behavior Therapy. Vol. 13, pages 204 - 218, refer page 217

prosocial targeted behaviors were; number of words spoken, eye contact, and smiles. The social skills training consisted of behavior rehearsal, modeling, instruction, feedback, and reinforcement. All behaviors significantly improved. After six months, booster sessions were used to bolster the initial training. Decrements in skill performance seen over the six months of no social skills training were reinstated in booster sessions. The authors thought the social skills training was particularly useful for this type of client for several reasons:

"(1) The emphasis is on teaching small component behaviors rather than global responses. Thus, the amount of stimuli to which the patient must attend to is reduced. Turner, Hersen and Bellack (1977) report this to be a crucial factor in the training of schizophrenic patients. (2) Modeling is an integral part of the treatment package, and this procedure is known to be particularly effective in individuals with severe behavioral deficits. (3) The patient receives an enormous amount of attention. (4) A socially reinforcing milieu is created where the patient receives support and encouragement for attempts to display prosocial behavior. (5) The patient is given many opportunities to practice new responses (behavior rehearsal)."¹²³

Beth Wildman, Hal Wildman and Jeff Kelly (1986) did a study on group conversational skills training and social validation with mentally retarded adults. A group multiple baseline design was utilized. The targeted conversational skills were: asking questions about the conversational partner, giving compliments, and appropriately disclosing information about oneself. The conversational skills training consisted of instructions,

¹²³ Turner, Sam; Hersen, Michael and Bellack, Alan (1978). Social Skills Training to Teach Prosocial Behaviors in an Organically Impaired and Retarded Patient. Journal of Behavior Therapy and Experimental Psychiatry. Vol. 9 (3), pages 253 - 258, refer page 258

modeling, and behavioral rehearsal. It used videotaped and live models, followed by behavioral rehearsal and feedback. Assessment was based on pairings of participants into conversational dyads for ten minute conversations which were audiotaped and scored for target behaviors. Generalization of the conversational skills training was assessed during baseline and intervention and at one month, three month and six month follow - up intervals by recording conversations between participants and novel, non-retarded persons. The participants showed substantial improvements in the targeted behaviors. Subjective social validity rating of pre intervention, and post intervention generalization tapes by community volunteers reflected improvements in their social perceptions of the participants as a function of the conversational skills training. The study suggests that retarded consumers living in the community can be taught to make changes in their conversational behaviors that are viewed positively by other non-retarded community residents.¹²⁴

Matson and Vincent Senatore's (1981) study is the model for many design areas of the social skills component of this project. The techniques they used in developing social skills in their study were used extensively in this project. It is reviewed in detail in the Methodology chapter of this paper. It is appropriate, however, to include a brief summary of the study here.

¹²⁴ Wildman, Beth; Wildman, Hal and Kelly, Jeff (1986) Group Conversational - Skills Training and Social Validation with Mentally Retarded Adults. Applied Research in Mental Retardation. vol. 17 pages 443-458

Their study compared the effectiveness of social skills training (instruction, modeling, and behavioral rehearsal) to traditional group psychotherapy (group cohesion and expressing feelings) in teaching more appropriate verbal skills. The social skills training was aimed at specific target behaviors, such as increasing positive statements about others and decreasing complaining statements about others and other inappropriate statements. Both groups discussed events in the workshop. Pre -, post - and follow - up assessments on participant performance of target behaviors were completed, as well as general measures of social competence and psychotic characteristics. Social skills training proved to be significantly more effective than group psychotherapy or no treatment (control group) in changing behavior with three of four dependent measures.¹²⁵

Summary

Reviewing the articles in the social skills training section; Perry and Cerreto (1977), Matson, Kazdin and Esveldt - Dawson (1980), Matson and Andrasik (1982), Matson and Adkins (1980), Matson (1982), Turner, Hersen and Bellack (1978), Wildman, Wildman and Kelly (1986) and Matson and Senatore (1981) all advocate a basically similar approach (modeling, behavioral rehearsal, feedback - social reinforcement) and support its effectiveness with

¹²⁵ Matson, Johnny and Senatore, Vincent (1981). A Comparison of Traditional Psychotherapy and Social Skills Training for Improving Interpersonal Functioning of Mentally Retarded Adults. Behavior Therapy. Vol. 12, pages 369 -382

their research. Matson is a major contributor to social skills training literature. He believes social skills refer to the ability of an individual to exhibit behaviors appropriate to a variety of settings such as work, home, and social situations. "Deficits in these skills result in lower adaptive functioning, and therefore, prevent a person with mental retardation from achieving normalization."¹²⁶

Liberman, DeRisi and Mueser stated that "social skills are the ability to give and obtain information and to express and exchange attitudes, opinions, and feelings in a wide variety of situations."¹²⁷ They also stated: "social skills training helps people to improve the way they communicate their feelings, emotions, needs, and desires to others. It also provides training for better ways of responding to other people by knowing how to tune in and be more sensitive and accurate in understanding what others are trying to say."¹²⁸ They said that the purpose of social skills training "is to teach patients to communicate their needs and feelings to others in a positive, productive manner, and the best way we know to be sure people learn is to have them practice the real situation again and again."¹²⁹ This is achieved through

¹²⁶ Matson, Johnny (1984). Social Skills Training. Psychiatric Aspects of Mental Retardation Reviews. Vol. 3, page 2

¹²⁷ Liberman, Robert, DeRisi, William and Mueser, Kin (1984). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, page 34

¹²⁸ Ibid., pages 203 & 204

¹²⁹ Ibid., page 74

modeling, behavior rehearsal, and feedback - social reinforcement. Social skills are crucial skills and training in social skills for psychiatric / mentally retarded consumers is a necessary component of developing their independence and integration into the community. In order to maximize their capacity for individualization the consumers must be able to relate to others and their environment.

The research discussed in the articles in this social skills section demonstrate that the training is effective in developing social skills with mentally retarded consumers. The techniques are the bases of the social skills training used in this project. This research provides the theoretical underpinnings of the social skills training component of this project. Modeling, behavior rehearsal and feedback - social reinforcement has been proven by the research in being effective in developing social skills and it from this work that this project hopes to expand.

Feedback is the primary technique used in this project in the form of video feedback. It is also a component of modeling (self - modeling) and facilitates behavioral rehearsal. Before specific video literature is reviewed, it would be beneficial to discuss some theoretical basis for video feedback with a psychiatric / retarded population; pre - therapy and observational learning.

SECTION FIVE OF LITERATURE REVIEW

Theoretical Basis for Video Feedback:

Pre-Therapy and Observational Learning.

Video feedback can be perceived as a mechanical augmentation of a relatively new treatment intervention: pre - therapy, designed for working with psychiatric / mentally retarded clients. "Pre - therapy, as a treatment for the dually / diagnosed, is an evolution in client - centered therapy and clinical method."¹³⁰ Carl Rogers believed that mentally retarded persons were not good candidates for client - centered therapy. In his book; Counseling and Psychotherapy (1942), Rogers wrote: "there is a tendency to select a group with essentially normal intellectual ability. It is probably rare that an individual of borderline level or below is selected for psychotherapy."¹³¹ He also listed normal intelligence as one of the eight conditions indicating counseling or psychotherapy: "He possesses adequate intelligence for coping with his life situation, with an intelligence rating of dull - normal or above."¹³²

Rogers stated that "psychological contact" was the first necessary condition of a therapeutic relationship: "The first condition specifies that a minimal relationship, a psychological

¹³⁰ Prouty, Garry (1991). Pre-Therapy: A Treatment for the Dual / Diagnosed - Schizophrenic / Retarded. National Association for the Dually Diagnosed Newsletter. Vol. 8, #6, page 1

¹³¹ Rogers, Carl; Houghten - Mifflin (1942). Counseling & Psychotherapy. New York: page 73

¹³² Ibid., page 77.

contact, must exist. I am hypothesizing that significant positive personality change does not occur except in a relationship. This is of course a hypothesis, and it may be disproved."¹³³ Garry Prouty, commenting on "psychological contact" and pre-therapy, work: "Unfortunately, Carl Rogers assumed 'psychological contact' exists between therapist and client; also he did not define 'psychological contact'. Finally, he did not describe any method to develop or restore 'psychological contact' when it was impaired in the client. Many dually / diagnosed clients, due to organic impairment, psychotic isolation and institutionalization lack the necessary 'psychological contact': for a genuine psychotherapeutic relationship. 'Pre -' therapy is a theory and method to develop or restore psychological contact for the dual diagnosed who are too impaired to form the contact necessary for therapeutics. This is the basis for the language 'Pre -'therapy."¹³⁴

Prouty notes that often schizophrenic and mentally ill/retarded consumers are not fully capable of maintaining therapeutic relationships. Prouty tries to deconstruct Rogers' definition of necessary conditions to form a therapeutic relationship into its necessary and sufficient components. The first meaning of "pre" is pre - relationship or what comes before the formation of a

¹³³ Rogers, Carl (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. Journal Of Consulting Psychology. Vol. 21, #2, page 96

¹³⁴ Prouty, Garry (1991). Pre-Therapy: A Treatment for the Dual / Diagnosed -Schizophrenic / Retarded. N.A.D.D. Newsletter. Vol. 8, #6, page 1

classical client - centered relationship.¹³⁵ In a similar manner, he evaluates the concept of experiencing. Often schizophrenic and mentally ill / retarded consumers cannot easily access their experiencing. Prouty states, "This is probably due to a lack of 'internal contact' resulting from a strong autistic component ... schizophrenic clients do not seem able to process their experiencing."¹³⁶ Prouty tries to conceptualize the necessary conditions of experiencing or what needs to be psychologically operative before experiencing can occur. The second meaning of "pre" is pre - experiential. Prouty states: "When we think clinically about pre - relationship and pre - experiential, we are exploring how to help clients who are relationship or experientially impaired and cannot use these functions for therapy. This is the genesis of pre - therapy; it describes the clinical search of a mode of treatment for those who cannot fully use relationship or experiencing processes."¹³⁷

Prouty and Kubiak thought that, "Pre - therapy represents an evolution in reflective psychotherapeutic method which has been especially designed for the treatment of mentallyretarded persons. The goal of pre - therapy is to help the clientcome into reality and be more accessible to further treatment and habilitation

¹³⁵ Prouty, Garry (1994). Theoretical Evolutions in Person - Centered / Experiential Therapy. Westport, Conn., Praeger Pub., page 36

¹³⁶ Ibid., page 36

¹³⁷ Ibid., pages 36 & 37

programming."¹³⁸

Prouty wrote that pre - therapy was especially useful for dually diagnosed clients who have deficits in "reality contact, affective contact, and communicative contact."¹³⁹ He believes that, "because the typical psychotic retardate has difficulty being the locus of his own experience; feeling his own experience, and coping with primary process, the therapeutic method must be designed to help him with these specific problem areas."¹⁴⁰

"Pre - therapy as a clinical method is an extraordinarily concrete level of 'reflection.' These reflections are designed to assist the client's contact with the world, self or other. These contact reflections aid reality contact, affective contact or communicative contact."¹⁴¹ There are five contact reflections:

"Situational Reflections are designed to help reality contact. These reflections are pointed at the client's situation, environment or milieu. The therapist may reflect: "You are looking out the window; You are holding the ball."

Facial Reflections are for helping affective contact. The therapist reflects implicit or explicit feeling in the client's face. "You look sad; Your lips are closed; Your eyes look angry."

Word for Word Reflections facilitate the restoration of communicative contact. Many of these clients, due to organic damage and/or psychosis, are incoherent. These reflections

¹³⁸ Prouty, Garry & Kubiak, Mary Ann (1988). Pre-Therapy with Mentally Retarded / Psychotic Clients. Psychiatric Aspects of Mental Retardation Reviews. Vol. 7, #10

¹³⁹ Ibid., page 62

¹⁴⁰ Prouty, Garry (Fall 1976). Pre-Therapy: A Method of Treating Pre - Expressive Psychotic and Retarded Patients. Psychotherapy: Theory, Research & Practice. Vol. 13, #3, page 290

¹⁴¹ Prouty, Garry (1991). Pre - Therapy: A Treatment for the Dual / Diagnosed -Schizophrenic / Retarded. N.A.D.D. Newsletter. Vol. 8, #6, page 2

capture the coherent language in the stream of confused language. The client may say "(incoherence) tree (incoherence), (incoherence), car (incoherence)" etc. The therapist reflects only the socially appropriate language "Word for Word" even though he may not understand the message. Occasionally, he/she may reflect sounds.

Body Reflections integrate the client's sense of his/her body. They may be done verbally, such as: "Your arm is in the air; Your body is stiff and straight" etc. Sometimes, the therapist may use his/her own body as a response and model. Reiterative Reflections, These responses constitute re - contact. If a particular reflection results in contact with the client, it may be fruitful to repeat it. Occasionally, material from earlier in the session may be useful."¹⁴²

There are parallels between pre - therapy and the use of video feedback. Pre - therapy was described by Prouty as "an extraordinary concrete level of reflection."¹⁴³ Video feedback used in a therapy situation is also an extraordinarily concrete level of reflection. Fredrick Stoller, commenting on video feedback with psychiatric patients, stated: "insofar as it is his own behavior, recently perpetuated, an individual seeing himself on videotape is receiving the clearest, least distorted, and most comprehensive feedback possible."¹⁴⁴

Prouty described reiterative reflections in an early article (1976), as the reiterative principle: "in treating the psychotic retarded, a further principle is indicated - the reiterative principle. It is defined as the slow, careful repetition of body, situational, facial, word for word reflections,

¹⁴² Ibid., page 2

¹⁴³ Ibid., page 2

¹⁴⁴ Stroller, Fredrick (1968). Focused Feedback with Videotape: Extending the Groups Function. from Self - Confrontation in Psychotherapy Reviewed; Danet, Burton American Journal of Psychotherapy. Vol. 22, #2, page 245

and primary process content. It is applied to reflections that previously produced felt responses. Its purpose is to maximize the interactive effect of reflecting and experiencing - that is to catalyze and develop the experiencing process. It restimulates feeling and assists the psychotic retardate in remembering and locating his affect."¹⁴⁵ Video feedback used in a therapy situation also employs the reiterative principle. It can be used to restimulate feelings and assist the client in remembering and locating his affect and becoming the locus of his own experience. Both pre -therapy and video feedback use reiterative reflection as a therapeutic method. Pre - therapy does so in a verbal / physical way, while video feedback does so in a mechanical way. Video feedback is a mechanical augmentation to a reiterative reflection process.

Prouty supports this in his most recent (1994) work by stating "reiterative reflections refer not to a specific technique, but to a principle. The principle is: If a specific reflection succeeds in making psychological contact, repeat it. Repeating the psychological contact maximizes the opportunity to develop a relationship or to facilitate experiencing."¹⁴⁶

Prouty commented that "pre - therapy has significance because it provides therapeutic access to dually / diagnosed

¹⁴⁵ Prouty, Garry (Fall 1976). Pre - Therapy: A Method of Treating Pre - Expressive Psychotic & Retarded Patients. Psychotherapy: Theory, Research & Practice. Vol. 13, #3, page 293

¹⁴⁶ Ibid., page 39

clients who are generally not accessible because of reality, affective and communicative disturbances. It is an Existential-Humanistic therapeutic alternative."¹⁴⁷ Video feedback has similarities to pre - therapy and can be seen as a mechanical augmentation to a reiterative reflection process.

Prouty discusses communicative contact, which is another aspect of pre - therapy relevant to this project. He defines communicative contact as "the symbolization of reality (world) and affect (self) to others."¹⁴⁸ This goes beyond the transmission of information. "It is the meaningful expression of our perceived world and self to others. It conveys denotative and connotative meanings from our experiential universe. It reveals to the other. It enables psychological contact with the other."¹⁴⁹ Prouty acknowledges that communicative contact refers primarily to social language. He states: "We concretely live in language. It is an infinite thematic of our being-in-the-world."¹⁵⁰ Communicative contact is very directly related to social skills. Social skills are a pragmatic operationalization of communicative contact. This project evaluates the use of video feedback (reiterative reflection) in developing a cognitive grasp of social skills (communicative contact).

Rogers' perception of reflection evolved in his later

¹⁴⁷ Prouty, Garry. Pre-Therapy: Treatment Dual / Diagnosed - Schizophrenic / MR, NADD Newsletter. Vol. 91, page 3

¹⁴⁸ Ibid., page 42

¹⁴⁹ Ibid., page 42

¹⁵⁰ Ibid., page 42

work into a feeling technique. "The client felt understood, achieving greater emotional clarity and a sense of self. Rogers described reflection as conveying unconditional positive regard, empathy, and non - directiveness."¹⁵¹ A later theorist of client - centered therapy, Gendlin, perceived reflection as an experiential response in that it facilitates the experiencing process. The two theorists have different concepts of the theoretical function of reflection; Rogers maintains it conveys therapist attitudes and Gendlin maintains it implements a carrying forward of concrete, bodily felt process (experiencing).¹⁵² Gendlin elaborated on his concept:

"In the reflecting and experiencing process, a felt sense that is bodily felt will differentiate and carry forward into a "felt meaning." The undifferentiated, vague experience will evolve into a sharper, clearer, fine - tuned experience. The felt meaning is now more than body vagueness. It has evolved to include a cognitive, perceptual and intellectual grasp, by the client, of her situation. A felt meaning is always more than feeling or emotion; it includes an explicit cognitive grasp."¹⁵³

Gendlin's concept of a "cognitive grasp" establishes a bridge to the other main theoretical basis for video feedback; observational learning. Video feedback enhances a consumer's cognitive grasp through observational learning.

Observational Learning:

Observational learning is "the ability to acquire new

¹⁵¹ Ibid., page 18

¹⁵² Ibid., page 18

¹⁵³ Ibid., page 19

responses as a result of observing the behavior of a model."¹⁵⁴ Albert Bandura summarized the modeling process as: "new modes of behavior are acquired and existing response patterns are extensively modified through observation of other people's behavior and its consequences for them. This is a multiprocess theory of observational learning, according to which modeled stimulus events are transformed and retained in imaginal and verbal memory codes. Later, reinstatement of these representational mediators, in conjunction with appropriate environmental cues, guide behavioral reproduction of matching responses. Performance of observationally learned responses is largely regulated by reinforcing outcomes that may be externally applied, self-administered, or vicariously experienced."¹⁵⁵

Diane Browder, Sharon Schoen, and Francis Lentz proposed that observational learning can be theoretically conceptualized in terms of a hierarchy of three distinct levels: "At the initial acquisition level, training is conducted with the sole purpose of developing a discrete imitative response. The utility of this level of observation lies in its contribution to acquire skills in other domains. Once imitative behavior emerges, instruction can proceed to include more novel and functional tasks. During the fluency level of training then, learning to imitate the

¹⁵⁴ Browder, Diane; Schoen, Sharon & Lentz, Francis (1987). Learning to Learn Through Observation. Journal of Special Education. Vol. 20, #4, page 447

¹⁵⁵ Bandura, Albert (1969). Principles of Behavior Modification. New York: Holt, Rinehart & Winston Pub., page 202

behavior of a visible model is initially instructed and faded over time. Gradually, behavior comes under control of the intended stimulus. Ultimately, the skill of learning through observation must demonstrate durability and flexibility to be functionally effective - durability in being maintained across time and flexibility in occurring across different settings, people and behaviors in the absence of an externally targeted model."¹⁵⁶

At the first level, that of acquisition / learning, the person is learning the skill of imitation, or how to match his / her response to a model. Browder, Schoen & Lentz commented that at this level there was "a basic pattern of instruction: (1) the selection of simple, discrete behaviors, (2) the utilization of model and verbal cues, and (3) the administration of direct reinforcement. The multiple stimuli of modeled behavior and teacher direction (e.g., "Do this") and the social or tangible reinforcement of a correct response combined to increase the likelihood of eliciting imitative responding."¹⁵⁷

At the second level, that of fluency / learning, the person is learning to imitate the behavior of a visible model while instruction is being decreased or faded over time. They wrote: "At this second level in the observational learning hierarchy,

¹⁵⁶ Browder, Diane; Schoen, Sharon & Lentz, Francis (1987). Learning to Learn Through Observation. The Journal of Special Education. Vol. 20, #4, pages 448 - 449

¹⁵⁷ Ibid., page 450

student performance should evolve from imitating a visible model with direct instruction to imitating a visible model without instruction."¹⁵⁸

At the third level, that of generalization / learning, the person is learning to imitate the behavior of a withdrawn model. Browder, Schoen and Lentz wrote: "The most rigorous test of any instruction is whether behavior gains established in training settings will generalize to environments in which they are not artificially cued and reinforced. Non - handicapped people acquire skills by observing a model and then imitating the behavior in the absence of the model. Handicapped students, likewise, must master this skill for greater independence in the natural environments. The ultimate goal for socialization is to function appropriately in novel situations by matching one's behavior to suitable models."¹⁵⁹

Robert Liberman, William DeRisi and Kim Mueser outlined the principles of learning that are used in the structuring and process of social skills training:

- "(1) Individualized specification and targeting problems and goals in behavioral and operational terms.
- (2) Measurement and monitoring of behavioral progress.
- (3) Functional analysis of environmental antecedents and consequences that may be maintaining behavioral problems and deficits.
- (4) Identifying reinforcers that can serve to motivate participation and progress.
- (5) Compensating for cognitive deficits by use of audiovisual and other media.
- (6) Optimal types and doses of psychotropic drugs that promote, not impede, learning.
- (7) Reinforcement of small increments of adaptive behavior

¹⁵⁸ Ibid., page 453

¹⁵⁹ Ibid., page 456

- (i.e. shaping).
- (8) Therapeutic instructions and expectancy.
 - (9) Social modeling - "live" and video.
 - (10) Repeated practice and overlearning.
 - (11) Active prompting and coaching.
 - (12) Positive feedback for progress.
 - (13) Generalization to real life setting."¹⁶⁰

They proposed that social skills training works best in groups:

"The group setting increases positive expectations, helps with generalization, allows for closer approximations of practice rehearsals to real life, and provides many more opportunities for modeling and learning by imitation."¹⁶¹ Liberman, DeRisi and Mueser emphasize that each situation practiced in a social skills group should include: "the basic principles of learning: positive feedback in the form of specific approval for effort and accomplishment, models to demonstrate different methods to imitate, shaping by progressing gradually, and extinction of inappropriate behavior by selective inattention. Along with the nonverbal elements of communication, social perception and problem - solving skills are targeted in sessions."¹⁶² Their approach to social skills training for psychiatric patients is theoretically based primarily on observational learning through modeling.

Summary

Pre - therapy was discussed as a theoretical basis for video feedback. Video feedback can be perceived as a mechanical

¹⁶⁰ Liberman, Robert; DeRisi, William & Mueser, Kim (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, page 70

¹⁶¹ Ibid., page 134

¹⁶² Ibid., page 135

augmentation of reflective psychotherapeutic methods used in pre - therapy. The reflections used in pre - therapy take the form in this project of video images. The video image is the reflection of the participant engaged in the social skills group. The same dynamics which are employed in the reflections used in pre - therapy are hoped to have therapeutic effects using video feedback as the reflections used in this project.

Observational learning was also discussed as a theoretical basis for video feedback. Video feedback can be perceived as a form of both modeling and feedback. In this project a main component of the modeling is the use of videotape showing modeling of appropriate social skills by other participants, the group leaders, and self - modeling by observing him / her self on the tape. In this project a main component of the feedback is the use of videotape showing the attempts at imitating the desired behavior.

Several research articles have referred to video feedback as "self - modeling" (Booth & Fairbanks, 1984, Dowrick & Hood, 1981, and Morgan & Salzberg, 1992). Video feedback has a theoretical basis in observational learning through modeling. Video feedback provides a videotaped model (self - model) that facilitates observational learning of targeted skills. Additionally, video feedback can be used in another aspect of the learning process: feedback. Observational learning requires feedback of the successive attempts at imitating the desired behavior. Feedback provides both an instruction and a shaping

(reinforcement of positive change) of the targeted behavior. Several research articles have focused on video feedback as objective feedback for self - monitoring, self - evaluation for instruction and shaping (Warrenfeltz et.al,1981; Walther & Beare, 1991; and Dunlap et.al, 1992).

Video feedback is the primary technique used in this project. The focus of the research is to determine if augmenting the modeling and feedback components of the social skills training techniques (modeling, behavioral rehearsal, and feedback - social reinforcement) through the use of video feedback enhances the acquisition of social skills. The literature on the use of video feedback in the therapeutic interventions will be elaborated on and expanded in the next section.

SECTION SIX OF LITERATURE REVIEW

Video Feedback

The use of video feedback in therapeutic interventions is a relatively recent development and the literature is not extensive. Included are eight relevant studies: six with children / young adults, one with severely retarded adults and one with an adult psychiatric group.

Sharon Booth and Doreen Fairbank (1984) worked with one nine - year - old emotionally disturbed boy of average intellectual functioning. Video feedback was used as a procedure for increasing on - task behavior. The student evaluated the frequency of his on - task behavior using videotape with teacher assistance. Baseline on - task behavior was very low. The intervention resulted in a

marked increase which decreased somewhat during the second baseline but the gains were recovered with the reinstatement of video feedback. The study provides evidence supporting the efficiency of a video feedback procedure in increasing the frequency of on task behavior in a nine - year - old emotionally disturbed male youth.¹⁶³

Walther and Beare (1991) worked with one - ten - year old boy diagnosed with attention deficit disorder with hyperactivity but of average intellectual functioning. Video feedback was used as an intervention to increase on - task behavior. The student evaluated the frequency of his on - task behavior using videotape with teacher assistance. The results showed an increase in on - task percentage during intervention, a drop during return to baseline, and an increase during reintervention. The data suggest a functional relationship between the videotape procedure and the student's on - task behavior rate.¹⁶⁴

Karen Esveldt, Patrick Dawson and Steve Forness worked with three ten - year - old boys from a neuropsychiatric inpatient class for children with behavior problems / disruptive behavior. Video feedback was used as an intervention to increase appropriate behaviors (task or teacher attention and / or positive verbal

¹⁶³ Booth, Sharon and Fairbank, Doreen (1984). Video Tape Feedback as a Behavior Management Technique. Behavioral Disorders. Vol. 9, pages 55 - 59

¹⁶⁴ Walther, Michael and Beare, Paul (1991). The Effect of Videotape Feedback on the On - Task Behavior of a Student with Emotional / Behavioral Disorders. Education and Treatment of Children. Vol. 14, #1, Feb., pages 53 - 60

interaction with others about academic work) and decrease inappropriate behaviors (hostile or disruptive behavior, non - attention). The results showed a marked increase in appropriate classroom behavior and a decrease in inappropriate behavior for both video feedback and video feedback with teacher conference. The control group, teacher conference alone, did not show the same changes.¹⁶⁵

Robert Morgan and Charles Salzberg (1992) worked with three severely retarded adults from an employment training program. Two studies were done on the effects of video assisted training on employment related social skills. In the first study, consumers were trained to request their supervisor's assistance when encountering work problems. In the second study, consumers were trained to fix and report work problems. The video - assisted training consisted of the participants discriminating a model's behavior on video and then receiving feedback from the trainer for responses to questions about the video scenes. In the first study, the participants discriminated the target behaviors on video but two of three were not able to incorporate the behavior at work until they had engaged in behavioral rehearsal. In the second study, participants were taught using video - assisted procedures how to fix and report four work problems. After the participants engaged in behavioral rehearsal on how to fix and report one or two

¹⁶⁵ Esveltdt, Karen, Dawson, Patrick and Steve Forness, Steve (1974). Effect of Videotape Feedback on children's Classroom Behavior. The Journal of Educational Research. Vol. 67, #10, pages 453 - 456

problems, they began to fix and report the remaining problems with video - assisted training alone.¹⁶⁶

Peter Dowick and Marie Hood (1981) worked with fifteen young adults with moderate or severe physical handicaps (excluding mental retardation, deafness or blindness). The self - modeling group observed daily videotapes of themselves showing them engaged in assembly tasks with mistakes and excessive hesitation edited out. Focus was on the effect of video feedback on workers' productivity. There were two other non - video groups; one that received rewards for productivity and one that received attention to discuss their general progress. The results showed that the hourly production rates increased significantly for the video group, increased slightly for the reward group, and decreased for the attention - control group. Four month follow - up indicated that most gains were maintained. The study showed that video feedback / self modeling can be effective in increasing productivity with physically handicapped young adults, even more effective than a simple operant type behavior modification system.¹⁶⁷

Joseph Rubin and Karen Locascio (1985) worked with inpatients from a twenty - three - bed long and short - term psychiatric ward.

¹⁶⁶ Morgan, Robert and Salzberg, Charles (1992). Effects of Video - Assisted Training on Employment - Related Social Skills of Adults with Severe Mental Retardation. Journal of Applied Behavior Analysis. Vol. 25, #2, pages 365 - 383

¹⁶⁷ Dowick, Peter and Hood, Marie (1981). Comparison of Self - Modeling and Small Cash Incentives in a Sheltered Workshop. Journal of Applied Psychology. Vol. 66, pages 394 - 397

Patient diagnoses included schizophrenia, borderline personality and affective disorders. They ran a group that focused on providing an opportunity for patients of a psychiatric ward to look at their interactive styles and to develop improved social skills. This was achieved through focused video feedback and videotaped exercises completed within a supportive group atmosphere. Qualitative evaluation based upon anecdotal reports from patients and staff were positive. Patients reported that video feedback helped them become more aware of how they appear to others. Although it was only a short term group, patients felt they became more aware of their self defeating interactional patterns, rigid defenses, and sources of identification. Patients reported the self - image experience evoked strong affective reactions which served as a catalyst in long term psychotherapy. Focused feedback and videotaped exercises can be a useful tool for psychiatric in - patients to look at their interactional styles and to develop improved social skills. Video feedback can assist in problem solving as a group and in practicing communication skills.¹⁶⁸

R. Warrenfeltz, et.al. (1981) worked with four emotionally disturbed adolescents in a short - term residential treatment center involved in a vocational training program. The study focused on the effects of role - play and self - monitoring on the generalization of vocationally relevant social skills.

¹⁶⁸ Rubin, Joseph and Locascio, Karen (1985). A Model for Communication Skills Group Using Structured Exercises and Audiovisual Equipment. International Journal of Group Psychotherapy. Vol. 135, #4, pages 569 - 584

Intervention included a two - step sequential process. The first step was didactic training followed immediately by role - play and self - monitoring instruction. Vignettes were role - played and videotaped. Videotapes were played back and students rated each employee's response as appropriate or inappropriate. Students were also observed at a generalized simulated work site and evaluated by work supervisor for target behaviors. The results showed that a combined role - play intervention and video feedback / self - monitoring procedure effectively produced generalized social behavior change in a simulated work setting for most students.¹⁶⁹

Lee Dunlap, et.al. worked with five boys ranging in age from eleven to thirteen. All were identified as having behavioral and emotional challenges and were in classes for students with severe emotional disturbance. The study's focus was on peer interactions. The goal was to increase "desirable" (positive or neutral / verbal or nonverbal) and decrease "undesirable" (negative or inappropriate verbal or nonverbal) interactions. This was achieved through the students' evaluation of his / her peer interactions using video feedback with staff assistance and staff feedback and reinforcement. The results showed that video feedback produced lower levels of undesirable peer interactions and higher ratios of desirable to undesirable interactions for all participants. Video feedback was shown to be an effective tool in improving the social

¹⁶⁹ Warrenfeltz, R., Kelly, W., Salzberg, C., Beegle, C., Levy, S., Adams, T. and Crouse, T., (1981). Social Skills Training of Behavior Disorder Adolescents with Self - Monitoring to Promote Generalization to a Vocational Setting. Behavioral Disorders. Vol. 7, pages 18 - 27

interactions of students with emotional difficulties.¹⁷⁰

Several of the articles were from the field of education. Liberman, DeRisi and Mueser wrote: "Most patients with serious mental illnesses have had little positive feedback for their learning efforts in the past and have considerable cognitive and attitudinal problems that add up to a 'learning disability.' To overcome these disabilities, social skills training resembles a special education classroom rather than a conventional, insight oriented therapy session."¹⁷¹ Making a connection between social skills training and the educational use of video feedback is appropriate in this context.

Several of the studies mentioned the effect video feedback has on the denial defense mechanism. Sharon Booth and Doreen Fairbanks noted: "The subjects were willing to accept responsibility for their own behavior. Prior to the intervention the subject routinely denied any responsibility for his disruptive classroom behavior. When the subject watched the videotape he recorded his own behavior and began to discuss alternatives to these disruptive behaviors that he could implement in order to

¹⁷⁰ Dunlap, Lee; Dunlap, Glen; Clarke, Shelley; Childs, Karen; White, Ronnie; and Stewart, Mary (1992). Effects of a Videotape Feedback package on the Peer Interactions of Children with Serious Behavioral and Emotional Challenges. Journal of Applied Behavior Analysis. Vol. 25, #2 pages 355 - 364

¹⁷¹ Liberman, Robert; DeRisi, William & Mueser, Kim (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, pages 69 - 71

develop self - control."¹⁷²

Karen Esveldt, Patrick Dawson and Steve Forness made a similar observation: "Viewing a videotape of one's own behavior may offer an opportunity for a clearer perception of one's actual behavior without a chance for denial mechanisms to cloud the issue."¹⁷³

Rubin and Locasio used the term "self perception" in a related concept: "The group confronts an individual with discrepancies in perceived self image. With video there is less identity confusion and a greater congruence of the different levels of self - image. The playback rapidly helps people confront the reality of their self perception."¹⁷⁴

Dunlap et.al. made a pragmatic statement concerning this area: "Videotapes also provide a permanent record of behavior; this tends to limit arguments about what transpired, and self assessment can occur out of the context of any conflicts that may have occurred during taping."¹⁷⁵

Video feedback provides more accurate feedback about his /

¹⁷² Booth, Sharon & Fairbanks, Doreen (1984). Videotape Feedback as a Behavior Management Technique. Behavioral Disorders. Vol. 9, page 58

¹⁷³ Esveldt, Karen; Dawson, Patrick & Forness, Steve (1974). Effects of Videotape feedback on Children's Classroom Behavior. The Journal of Educational Research. Vol. 67, #10, page 454

¹⁷⁴ Rubin, Joseph & Locasio, Karen (1985). A Model for Communication Skills Group Using Structured Exercises & Audiovisual Equip. International Journal of Group Psychotherapy. Vol. 35, #4, page 573

¹⁷⁵ Dunlap, Lee et.al., (1992). Effects of a Videotape Feedback Package on the Peer Inter - actions of Children with Serious Behavioral & Emotional Challenge. Journal of Applied Behavior Analysis. Vol. 25, page 362

her behavior. Walther and Beare noted: "Feedback can be an effective tool in increasing on - task behavior. It seems that the videotape images gave the students clearer feedback than other procedures and that they were either more meaningful or more reinforcing of appropriate behavior than the other extrinsic rewards and punishments that had been applied earlier."¹⁷⁶

Video feedback can provide a model for change. Esveldt, Dawson and Forness stated: "An increase in perception resulting in a behavior change towards more desirable behavior probably requires, as Soloman has suggested, that the subjects have within their value system a model or standard for appropriate and inappropriate behavior."¹⁷⁷ Dowrick and Hood expanded on the model / self - model concept: "A self - model provides the ultimate in similarity to the observer, and there are claims that model observer similarity strengthens observational learning. Also the self - image on a video monitor apparently commands attention, and attention factors account for major variations in the amount of observational learning that takes place."¹⁷⁸

Dowick and Hood noted that observing a self model video tape exhibiting superior competence may be interpreted by the

¹⁷⁶ Walther, Michael & Beare, Paul (1991). The Effect of Videotape Feedback on the On - task Behavior of a Student with Emotional / Behavioral Disorders. Education & Treatment of Children. Vol. 14, #1, Feb., page 58

¹⁷⁷ Esveldt, Karen et.al., (1974). Effects of Videotape Feedback on Children's Classroom Behavior. Journal of Educational Research. page 454

¹⁷⁸ Dowick, Peter & Hood, Marie (1981). Comparison of Self - Modeling & Small Cash Incentives in a Sheltered Workshop. Journal of Applied Psych. page 396

subjects as implied goals for future performance, even though these goals were not expressly verbalized.¹⁷⁹ Dowick and Hood elaborated on this concept:

"If viewing suitably edited video recordings promotes tacit goal setting, an interesting possibility arises because the videotapes illustrate not outcome (rate of production) as much as process (work activity). That is, the edited tapes provide the clearest possible description of the behavioral goals in improved efficiency, although the tapes but vaguely define productivity. A reverse emphasis is offered in the usual procedure of expressing goals in assemblies per day, which is explicit about outcome but only suggestive of process. The concept of goal setting by implication puts the video in a role of a "feedforward" rather than a feedback mechanism. Given this interpretation, observational learning and goal setting theories are complementary rather than competitive because both skills and motivation are necessary for performance."¹⁸⁰

Summary

Video feedback is the primary technique used in this project. The focus of the research in this project is on the effectiveness of video feedback upon the development of social skills with psychiatric / mentally retarded consumers. The articles on the therapeutic use of video described in this section provide the basis upon which the research in this project hopes to expand. The therapeutic use of video has proven effective as demonstrated by the research articles reviewed in this section. The success demonstrated by their research influenced and motivated me to use video feedback as the focus of the research in this project. This project plans to study the use of video feedback in the new context of a social skills training group for psychiatric / mentally

¹⁷⁹ Ibid., page 396

¹⁸⁰ Ibid., page 297

retarded consumers.

CHAPTER THREE: METHODOLOGY - RESEARCH DESIGN

The Methodology chapter is organized under six headings: 1) Need, 2) Sample, 3) Techniques of Measurement, 4) Research Design, 5) Intervention: Social Skills Training, and 6) Group Topics

Need

This project focuses on the psychiatric / retarded consumer's needs in the area of social skills. Liberman, DeRisi and Mueser discussed the pivotal nature of social skills training for psychiatric patients:

"Humans are social creatures who need to interact with others to meet their emotional, social, and biological needs. One of the most important reasons that psychiatric patients have so much difficulty obtaining their needs and coping with everyday life is their inability to express themselves effectively to others. Even when the most recognizable symptoms of mental illness are controlled by medication, patients' ability to communicate effectively remains impaired. In short, most people with a major mental disorder have poor social skills, and social skills are the ingredients of effective communications. ...

Helping patients improve their social skills is vital. Research of the past twenty years point to the importance of the stress - vulnerability - coping skills model of mental illness, which holds that certain people are biologically vulnerable to psychiatric illness, that stressors in life can make it much more likely that the person will develop symptoms, and that medication, coping skills, and social support can buffer the noxious effects of stress vulnerability. The major component of coping skills is social skills; therefore, proficiency in social skills protects against the symptoms and disabilities of mental disorder."¹⁸¹

There is an assumption of need on the part of these individuals due to their mental disability. Kurland listed "the important

¹⁸¹ Liberman, Robert; DeRisi, William and Mueser, Kim (1989). Social Skills Training for Psychiatric Patients. New York: Pergamon Press, page 25

developmental needs of potential group members"¹⁸² as an area of need to be considered. The group participants psychiatric and developmental disabilities establishes the need for social skills training.

Sample

The sample for this study originally consisted of sixteen adult men and women who were diagnosed as having an Axis I disorder as defined by DSM-III-R, and also were identified as moderately - mildly retarded or of borderline intellectual functioning. All had tested I.Q.'s between fifty and eighty. They also met New York State Office of Mental Health's criteria for Severe and Persistent Mental Illness (SPMI) which is a DSM-III-R psychiatric diagnosis and is an extended impairment in functioning due to mental illness. The sample is from the fifty consumers enrolled in the SPAN Continuing Day Treatment program. The sixteen participants were randomly assigned to treatment and control conditions. Each participant's name was placed on an index card. Cards were shuffled and names were alternately placed in treatment and control piles.

Techniques of Measurement

The social skills component of this project is modeled in many design areas after Matson and Senatore (1981). In their study, thirty-five mild to moderately retarded adults were randomly

¹⁸² Kurland, Roselle (1982). Group Formation: A Guide to the Development of Successful Groups. Albany, New York: Continuing Education Program, School of Social Welfare, State University of New York at Albany and United Neighborhood Centers of America. page 5

assigned to one of three experimental conditions: No treatment, traditional psychotherapy and social skills training.

"Training in the traditional psychotherapy groups was oriented towards establishing group cohesion and expressing feelings. Social skills training was aimed at specific 'target behaviors' such as decreasing complaining statements and increasing positive statements about others. In both groups the topic for discussion was events at the workshop. Performance of specific target behaviors was assessed and general measures of social competence and psychotic characteristics were obtained at pre -, post -, and follow-up assessments. Social skill training proved to be significantly more effective than traditional psychotherapy or no treatment in changing behavior with three of four dependent measures."¹⁸³

This project attempts to expand on the social skills component of Matson and Senatore's study by introducing video feedback to their basic social skills training design. Modeling (demonstration) and feedback was a component of their social skills training and this project studies the augmentation of that process through video feedback. This project tries to determine if video feedback enhances the acquisition of social skills with psychiatric/ retarded consumers.

Matson and Senatore derived their target behaviors from workshop staff who were asked to list in order of importance the five most necessary social skills for mentally retarded persons. This established a social validation criteria for the most important skills necessary for the training. The most frequently mentioned behaviors were chosen for treatment.

"The target behaviors were defined as (1) appropriate

¹⁸³ Matson, Johnny and Senatore, Vincent (1981). A Comparison of Traditional Psychotherapy and Social Skills Training for Improving Interpersonal Functioning of Mentally Retarded Adults. Behavior Therapy Vol. 12, page 369

statements of one word, (2) appropriate statements of more than one word, and (3) inappropriate statements. These behaviors were not only used to select clients (clients were selected from their workshop who most needed treatment on these interpersonal skills), but were used in training and evaluating outcome. An appropriate statement was defined as responding to a comment made to a client within 5 seconds. Additionally, the content of the verbal response had to indicate a relationship to the statement addressed to him/her. Also, the statement must be positive or neutral rather than negative in content. This response class was divided into two target behaviors: client statements of one word and those of more than one word. The division was made since a typical problem was that most verbal statements were limited to only one word. Staff and the authors agreed that teaching longer statements that might prove to be social reinforcers would be perceived as enhanced social skills and more adaptive behavior. Inappropriate statements: This behavior was defined as any statement that was of a socially unacceptable nature. Responses fell into three general categories: nonsense statements, insults, or complaining remarks."¹⁸⁴

The project conducted at ACRMD - SPAN used Matson & Senatore's operational categories and definitions with a minor modification. A subcategory was introduced within the category of appropriate statements of more than one word. This subcategory was a reflective statement defined as an evaluation of personal behavior acknowledging personal responsibility and not reallocating responsibility for personal actions onto other people or situations. This subcategory was introduced because of the video feedback focus of the project. This project, through video feedback, augments the modeling (demonstration) and feedback components of Matson & Senatore's original research design. Since the purpose of this component is an evaluation of self in the context of a social skills group, a reflective statement or self - evaluation sub category was introduced to determine differences

¹⁸⁴ Ibid., page 372

between the control and study group in this area.

SOCIAL SKILLS in the project focus on target behaviors **DEFINED** as: (1A) appropriate statements of one word, (1B) appropriate statements of more than one word, (1C) reflective statements, and (2) inappropriate statements. Appropriate statement is defined as responding to a comment made to a consumer within five seconds. The content of the verbal response must also indicate a relationship to the statement addressed to him/her. The statement must be positive or neutral rather than negative in content. Appropriate statements are divided into those of one word and those of more than one word. A subcategory of appropriate statements is a reflective statement. A reflective statement is defined as an evaluation of personal behavior acknowledging personal responsibility and not reallocating responsibility for personal actions to other people or situations. An inappropriate statement is defined as any statement that is of a socially unacceptable nature. Generally inappropriate responses are; nonsense statements, insults, or complaining remarks. Inappropriate statements would also include interrupting others (poor impulse control) or inappropriate physical activities (i.e. leaving the room without acknowledgment, walking around the room, etc.) On an operating level, the problem the project is addressing is the problem behavior of inappropriate statements. The project hopes to decrease inappropriate statements and increase appropriate statements in the context of the social skills groups. The video tapes are exact process recordings of the groups. The videotapes

from weeks two, seven, eleven, and fifteen are evaluated for frequency by type of response. The major technique of measurement is the statistical analysis of the frequency by type of response (appropriate or inappropriate) at selected intervals (weeks 2,7,11, & 15) over the course of intervention.

Two other evaluation methods were used in this project. The first was a pre- and post- group measure comparison using the Social Avoidance and Distress (SAD) scale and the Fear of Negative Evaluation (FNE) scale.¹⁸⁵ The second was a group therapy evaluation questionnaire completed at the termination of the groups. This questionnaire was used in a previous study with psychiatric adults.¹⁸⁶

The SAD scale is a 28 - item true and false answer scale with the answers evenly divided between true and false. The FNE scale is a 30 - item true and false answer scale with 17 true and 13 false items (see appendix A for SAD scale and FNE scale with scoring key given after each item). The scales' designers reported: "People high in SAD tended to avoid social interactions, preferred to work alone, reported that they talked less, were more worried and less confident about social relationships, but were more likely to appear for appointments. Those high in FNE tended

¹⁸⁵ Watson, David & Friend, Ronald (1969). Measurement of Social - Evaluative Anxiety. Journal of Consulting and Clinical Psychology. Vol. 33, #4, pages 448 - 457

¹⁸⁶ Kanas, Nick and Barr, Mary Ann (1982). Short - Term Homogeneous Group Therapy for Schizophrenic Inpatients: A Questionnaire Evaluation. Group. Vol. 6, #4, Winter, pages 32 - 38

to become nervous in evaluative situations, and worked hard either to avoid disapproval or gain approval."¹⁸⁷

The group therapy evaluation questionnaire consists of 13 statements concerning a group where the consumers rate their group as; very important (2 points), somewhat important (1 point), and not important at all (0 points). The total number of points for each statement for all group members could therefore be added together. In this way, the factors described by each statement could be ranked; most helpful to least helpful for all the group members. This allows for an overall rank ordering (see appendix B for 13 questions). The data from this questionnaire will be rank ordered to see which aspects of the group the consumers found most helpful.

The review of the videotapes and tabulations of frequency by category of response was completed by three mental health professionals employed at the facility but not involved with the study. They observed the tapes together and resolved any differences in coding as they occurred based upon majority opinion. Disagreements were very rare. The pre-group, post- group SAD and FNE scales as well as the group therapy evaluation questionnaire were completed with each participant individually by mental health professionals from the Continuing Day Treatment program but not involved with the study. The data was analyzed with a computer using the STATPAK statistical program.

¹⁸⁷ Watson, David & Friend, Ronald (1969). Measurement of Social - Evaluative Anxiety. Journal of Consulting and Clinical Psychology. Vol. 33, #4, page 448

Research Design

The project consists of two groups, each group meeting twice weekly for fifteen weeks. All group meetings are approximately fifty minutes in duration. Each group was originally composed of eight Continuing Day Treatment consumers. The meetings run consecutively. Both groups focus on social skills following the same predescribed outline. Both groups have the same group leader (CSW), and camcorder operator (researcher). The groups also have a paraprofessional as an assistant. Both groups are videotaped at each weekly session.

The first group is the control group. This group's first weekly meeting (Tuesday afternoons) focus on that week's scheduled social skills topic. Their second weekly meeting (Thursday afternoons) is a review of the meeting that occurred earlier that week and a continuation of the same topic. This procedure continues for the duration of the group: fifteen weeks. The second group begins following the termination of the first group at fifteen weeks. It is composed of eight different Continuing Day Treatment consumers. The second group is the study group. This group's first weekly meeting (Tuesday afternoons) focuses on that week's scheduled social skills topic following the same outline as the control group in the same sequence. In their second weekly meeting (Thursday afternoons) they see approximately twenty minutes of videotape from that week's first session chosen by the group leader and researcher. The tape is turned on and off by the group leader to allow for group discussion of certain segments. The

group watches the tapes on a TV monitor using a VCR while being videotaped on the camcorder. This procedure continues for the fifteen week duration of the group.

Two groups are used in the research design in order that one group (group one) would function as the control group. The second group (group two) serves as the study group. The groups are identical in structure, design and composition, but the study group observes in the second session of the week approximately twenty minutes of videotape from the first session of the week. In the second session of the week the control group reviews what transpired in the first session of the week without the use of the videotape from that first session. In this way, any differences between the control and study groups should be attributable to the review of the videotape. The focus of the project is to examine the effect the provision of video feedback has on the acquisition of social skills in a social skills training group with a psychiatric / retarded population. The social skills component of the project is modeled in several areas after Matson and Senatore's research from 1981. In their study, the social skills group meets twice weekly, at least two days apart, for one hour. This project also meets twice weekly, two days apart, for fifty minutes (to conform with the Continuing Day Treatment program's schedule of group sessions of fifty minutes duration). There are functional aspects of the project's design. The focus of the project is to examine the effect of video feedback in the context of a review. It is essential, therefore, that the control and study group meet

twice weekly in order that the first session of the week can serve as the introduction and discussion of that week's social skill topic and the second session of the week serve as a review and continuation of discussion of the first session. Having the review session during the same week (first session; Tuesday, second session; Thursday) would facilitate the consumers' recollection of the first session.

The participants for the project are taken from the fifty consumers enrolled in the SPAN Continuing Day Treatment program. The consumers were collectively told of the basic parameters of the social skills group and that it would be videotaped. No mention was made about the difference between the control and study group concerning the provision of video feedback so as not to affect the outcome of the study.

The focus of the project is verbal social skills and the study could be conducted using simple audio equipment. Pilot work in the facility, however, showed that listening to twenty minutes of audio tape does not hold their attention. The consumers require stimulation from other sensory modalities (i.e. visual) in order to maintain their attention. The consumers' mental disabilities negatively affect their receptive skills (Murdock & Van Ornum in Mental Retardation and Mental Illness, 1989) and a multi-sensory, audio-visual approach expands media of receptive information to facilitate comprehension (Danet 1968). Video feedback enhances the consumers' ability to be more cognizant of their interactional transactions than audio tape alone.

Intervention: Social Skills Training

The groups discuss social skills topics (i.e. negativity, fears, assumptions, empathy, assertiveness, listening, friendship, disagreements) and also directly focus on the target behaviors (acknowledging others, making positive statements about others, and acknowledging personal behavior). As part of the procedure followed for achievement of target behavior, the group leader will encourage consumers' appropriate comments during their interactions in the group. Appropriate responses are praised by the group leader and she will acknowledge that the consumers exhibited the appropriate target behavior. If a consumer makes an inappropriate comment, the group leader "models" an appropriate response or asks another group member to "model" an appropriate response. The consumer is then given an opportunity to try again. Following this response, the group leader provides verbal feedback and reinforcement for an appropriate comment. Throughout the group, the group leader gives prompts and identifies specific information about how to give a response (i.e. "When someone asks you a question, you should answer them rather than talk about something else"). Towards the end of each group session the group leader speaks to each individual, one at a time in the group, giving him/her positive feedback and constructive criticism on the target behaviors based on his/her performance in the treatment group.

The consumers were told at the first group session that beyond talking about social skills the group leader would be working with them in the group on practicing good social skills. The consumers

were told that to practice good social skills they should make only appropriate comments. Appropriate comments are; responding to a comment made to them right away, be about what the person said to them, be positive or average but definitely not negative, and it would be better if it was more than one word. They should especially think about their own behavior and not blame other people or things for their behavior. In order to help them practice good social skills the group leader would remind them when they make a wrong comment and maybe show them how to say it correctly or ask someone else in the group to show them. At the end of the group they would go over how they did.

Liberman, DeRisi and Mueser in their book; Social Skills Training for Psychiatric Patients (1989) wrote:

"Strategies that form the basic sequence of social skills training harness basic principles of human learning. Positive expectations are set by correcting false assumptions and negative self-talk. Behavior change is accomplished through a combination of didactic presentation of information, observational learning from role models, prompting specific behaviors, and positive reinforcement of success approximations towards desired behavioral goals. ... Inappropriate or maladaptive behaviors are extinguished or reduced by either ignoring them or teaching alternative skills that are incompatible with them. Once behavior changes have been effected, they are maintained by the naturally occurring social reinforcers present in the environment, providing that the person lives in a sufficiently rewarding milieu"¹⁸⁸

The ACRMD-SPAN project incorporates many of these basic principles of human learning. The target behaviors foster positive expectations, prompt specific behavior, give positive reinforcement

¹⁸⁸ Liberman, Robert; DeRisi, William and Mueser, Kim (1989). Social Skills Training For Psychiatric Patients. New York: Pergamon Press, page 12

of successive approximations towards desired behavioral goals, and try to extinguish inappropriate or maladaptive behaviors. The observational learning is specifically accentuated through video feedback where the consumer can observe not only other consumers in the group but his / her own interactions with others. The consumer can critique his / her own behavior and serve as a self - model.

Group Topics

The Topics for the group discussions must be well defined yet flexible enough to adapt to the unfolding progress of therapy. There were three scheduled review groups to obtain consumer feedback and inquire about their reactions, feelings and thoughts concerning the video, modeling, group topics or other topics the consumers mentioned or wanted to discuss. The review groups were scheduled for weeks five, nine, and thirteen to allow for flexibility over the course of the fifteen week to address consumer needs as they developed in the process of the group therapy. Twelve groups were planned with specific social skills topics with general outlines for the group discussions.

Group Discussion Topics Outlines

Group 1: Rules of the group and basic operation (one person speaks at a time, no wandering, no violence or shouting, food will be served, etc.). The consumers were asked the rules they would like. Discuss videotaping, its purpose, and how, they feel about being videotaped. Discuss target behaviors and how that will be operationalized. Discuss goals of group and agreement (contract) on focus of group, activities, relationships etc.. Review target

behaviors and provide positive feedback on performance regarding target behaviors.

Group 2: Discuss again target behaviors and how that is operationalized. Ask the consumers what are social skills and for them to give some examples. Review some of the topics scheduled and ask the consumers if there are any specific topics they would like to focus on. Ask each consumer individually the following five questions; 1) How do you get along with others? 2) How do you get along with other consumers? 3) How do you get along with SPAN staff? 4) How do you get along with people where you live? 5) What would you do when you meet a new consumer in the program? Discuss aspects of socialization the consumers mentioned. Review performance regarding target behaviors.

Group 3: Discuss negativity with other people (criticizing, condemning and judging other people). Ask consumers the following questions; 1) How do you feel when other people are negative or criticizing you? 2) How do you think other people feel when you criticize them? 3) What are some of your reactions when you are criticized? 4) How do people react to you when you are being negative with them? Discuss compliments with a similar format. Discuss constructive criticism and ways of phrasing things positively (i.e. This is very good tea, can I have some more sugar please - as opposed to - this tea stinks, it needs more sugar.) Review performance regarding target behaviors.

Group 4: Discuss fears in social interactions. Fear of: people, new situations, being judged negatively, failing to meet an

expectation, not talking well (i.e. mispronouncing a word, stuttering), being laughed at, not understanding someone and appearing stupid, not controlling emotions (all realistic fears of psychiatric / retarded people). Discuss how sometimes these fears are valid and sometimes they are not valid. Discuss to what extent our fears should affect our social interactions. Review performance regarding target behaviors.

Group 5: This is a review group and used to obtain consumer feedback. The consumers were told that for this discussion we would suspend the practice aspect of the social skills group (working on the target behaviors). The consumers were asked their reactions, feelings and general feedback on the video and modeling aspects of the group. Time allowing the modeling aspect of the group was resumed and previous topics and/or topics the consumers suggested were discussed. Review performance regarding target behaviors.

Group 6: Discuss assumptions (misunderstandings) in communication with other people; that you understand them and they understand you. Assumptions regarding actions (i.e. you go to talk to someone and they cannot talk to you - is it because they do not want to talk to you or because they have something else important to do?). Assumptions regarding words (someone says you are funny - is that funny they think you are fun or funny they think you are strange?). Discuss the importance of asking direct questions to clarify understanding and prevent misunderstanding. Review performance regarding target behaviors.

Group 7: This group focuses on empathy (putting yourself in the other person's position). This is a good opportunity for two of the three staff in the group to role - play a verbal fight between two consumers. Two of the consumers role - play staff. After the verbal fight the role play continues with one of the consumers (played by staff) not wanting to go to group. The consumers are asked individually the following five questions: 1) What do you think staff (played by consumer) felt or thought about in the role-play? (rephrased = how would you feel if you were the staff?). 2) How do you think you interact with staff from the staff's point of view? 3) How do you think you interact with other consumers from the other consumer's point of view? 4) How do you think you interact with the people you live with from their point of view? 5) How do you think you interact with people in the community (i.e. stores) from their point of view? Discuss empathy and its role in communication. Review performance on target behaviors.

Group 8: Discuss appropriate assertiveness. Ask consumers how they ask for what they want or need? Discuss taking "no" as an answer. Discuss strategies for obtaining what they want (i.e. negotiation and compromise). Discuss appropriate expression of feelings (recommend be specific: "You made me feel sad when you did X" instead of "I hate you!"). Review performance on target behaviors.

Group 9: Review group. This group is another opportunity for the consumers to discuss their thoughts and provide feedback. This group follows the same outline described in group five.

Group 10: Discuss the importance of listening to the other person in a conversation (i.e. do you think about what the person said to you and think of a question to ask him / her or do you always just talk about yourself?). Ask if their conversations are "back and forth". Ask if they show they care about the other person by listening to him / her. Discuss problems that arise from not listening to what the other person is saying (using program examples). Discuss the importance of asking questions to clarify what people are saying. Review performance on target behaviors.

Group 11: Discuss friendship and socializing with others. Ask consumers; what is a friend? Ask consumers individually these five questions: 1) What is it about you that other people like? (rephrased = what do you do that is good with your friends?) 2) What is it about you that other people do not like? (rephrased = what do you do that is bad with your friends?) 3) How do you show other people you like them - respect them? 4) How do you deal with people you do not like? 5) Should you be nice to people, especially people you do not like? Discuss what they receive from socializing and what do others receive from them (discuss possible opposites; loneliness, boredom). Review performance on target behaviors.

Group 12: Discuss disagreements and arguments with other people. Ask consumers: What causes fights? How do you fight with other people? What happens when other people hurt your feelings? How do you hurt other people's feelings? How do you make up after a fight? (can you say I am sorry?) Do you have more fights with

staff or other consumers? Why do you think this is? (authority figures as opposed to peers) Review performance on target behaviors.

Group 13: Review group. This group is another opportunity for the consumers to discuss their thoughts, feelings and provide feedback. This group will follow the same outline described in group five. Begin to mention termination.

Group 14: Discuss social skills in the community. Ask consumers: How do you get along in your neighborhood? Do you have problems in the neighborhood? Do people give you a hard time or make fun of you? If so, why do you think this is? Do people know you are in a program? Does this bother you? What can you do to change it? What behavior can you change in order to decrease their being negative? How should you act; in stores, McDonalds, other places? Discuss how consumers should not be too submissive to strangers. Mention termination. Review performance on target behaviors.

Group 15: Termination group. Group leader summarizes topics and activities of group. Ask consumers what did they receive from the group. Ask consumers individually the following five questions: 1) What would you say to a new consumer in the program? 2) What would you say to a fellow consumer who got mad at you for no reason? 3) What would you say to a person who jumped ahead of you on line? 4) What would you say to a cashier who did not give you enough change back? 5) What would you say to a family member who promised to take you out but had to cancel? Review consumer progress in the group. Ask if there would be anything they would

do differently in the group. Terminate with the group.

CHAPTER FOUR: RESULTS OF THE STUDY

Three evaluation methods were used in this project. The first was a pre - and post group measure comparison using the Social Avoidance and Distress (SAD) scale and the Fear of Negative Evaluation (FNE) scale. The second was a group therapy evaluation questionnaire completed at the termination of the groups. The third evaluation method is the statistical analysis of the frequency by type of response (appropriate or inappropriate), taken from the videotapes, at selected intervals (weeks 2,7,11,& 15) over the course of the intervention.

SAD and FNE scales:

The SAD and FNE scales were taken from Watson and Friend's article; " Measurement of Social-Evaluative Anxiety" in the Journal of Consulting and Clinical Psychology.¹⁸⁹ The SAD scale is a twenty - eight - item true and false answer scale with the answers evenly divided between true and false. The FNE scale is a thirty - item true and false answer scale with seventeen true and thirteen false items. Appendix A is the SAD and FNE scales with scoring key given after each item. Watson and Friend's purpose in developing the two scales was to attempt to measure social-evaluative anxiety. They wrote: "Social-evaluative anxiety was initially defined as the experience of distress, discomfort, fear, anxiety, etc., in social situations; as the deliberate avoidance of social situations; and finally as a fear of receiving negative

¹⁸⁹ Watson, David & Friend, Ronald (1969). Measurement of Social-Evaluative Anxiety. Journal of Consulting and Clinical Psychology. Vol. 33, #4, pages 448 - 457

evaluations from others."¹⁹⁰ Each scale's face validity was established in the following manner: "People high on SAD did avoid social situations, and were anxious in social interactions. Individuals high on FNE became nervous in evaluative conditions, and seemed to seek social approval."¹⁹¹

Watson and Friend wrote: "Studies of the social processes within groups such as the study of communication, might use the SAD as a moderator variable. In general, the FNE might be relevant in any potential evaluative situation, and the SAD could be useful in studies of social interaction."¹⁹² This is the context for the use of the SAD and FNE scales in this project.

TABLE ONE
PRE AND POST INTERVENTION S.A.D. AND F.N.E. MEAN SCORES AND SIGNIFICANCE

GROUP	N	PRE S.A.D.	POST S.A.D.	SIGNIFICANCE TWO-TAILED T-TEST *indicates significance
CONTROL	8	13.87	14.37	p < .05
EXPERIMENTAL	7	11.71	11.51	p < .05

GROUP	N	PRE F.N.E.	POST F.N.E.	SIGNIFICANCE TWO-TAILED T-TEST *indicates significance
CONTROL	8	12.37	17.25	*p < .05
EXPERIMENTAL	7	15.14	16.42	p < .05

¹⁹⁰ Ibid page 448.

¹⁹¹ Ibid page 456.

¹⁹² Ibid page 456.

The Control group had a pre-intervention SAD mean score of 13.87 and a post mean score 14.37. The pre- and post SAD scores for the control group were compared using a two - tailed T test. The scores were not significantly different at the .05 level of assurance. The control group had a pre - intervention FNE mean score of 12.37 and a post mean score of 17.25. The pre- and post FNE scores for the control group were compared using a two - tailed T test. The scores were significantly different at the .05 level of assurance. The experimental group had a pre-intervention SAD mean score of 11.71 and a post mean score of 11.51. The pre - and post SAD scores for the experimental group were compared using a two - tailed T test. The scores were not significantly different at the .05 level of assurance. The experimental group had a pre-intervention FNE mean score of 15.14 and a post mean score of 16.42. The pre- and post FNE scores for the experimental group were compared using a two tailed T test. The scores were not significantly different at the .05 level of assurance. Reviewing the results of the pre- and post SAD and FNE comparison, the differences between the mean pre- and post SAD scores of control and experimental groups were not significant. The differences between the mean pre- and post FNE scores of the experimental group were not significant but the control group differences did achieve significance at the .05 level of assurance.

It is important to note that low SAD scores does not

imply social approach or affiliation as the opposite instance of social avoidance but rather, simply a lack of avoidance. Low SAD scores indicates the absence of that trait, not the presence of some other trait. Similarly, low FNE scores does not imply a desire for positive evaluation but rather, a lack of anxiety about others' evaluations.¹⁹³ In this context the lack of statistical significance in the pre - and post intervention comparison on the SAD scale for both the control and experimental groups means that the effect of the intervention was not significant on their social-evaluative anxiety, according to the SAD scale. Neither group felt significantly more or less distress, discomfort, fear, anxiety in social situations nor avoided social situations, after the intervention as before it. It does not imply that either the control or the experimental groups were any more or less inclined to social approach or affiliation. The lack of statistical significance in the pre- and post intervention comparison on the FNE scale for the experimental group means that the effect of the intervention was not significant on their fear of receiving negative evaluations from others, according to the FNE scale. The experimental group was not any more or less anxious about others' evaluations after the intervention as before it. The control group did show statistical significance in the pre - and post intervention comparison on the FNE scale. It is important to note that high FNE does not imply a person evaluates himself

¹⁹³ Ibid page 449.

negatively, or that he / she is concerned about revealing his / her inferiority but it does imply a fear of loss of social approval.¹⁹⁴ FNE scale results suggest that the control group being videotaped but not being able to observe their own videotape made them more fearful of losing social approval.

The lack of a significant difference on the SAD scale for both groups and on the FNE scale for the experimental group could be due to several factors. One possible factor is the small size of the sample. It can be more difficult to show significant change in a small sample. Another possible factor is the lack of instrument sensitivity. The SAD and FNE scales may not be precise enough to adequately measure pre - and post group differences. A third possibility is the lack of treatment effect. The intervention may not yield a significant difference on the areas measured by the SAD and FNE scales. The differences between the control group's pre - and post scores were significant. This could be due to several different factors. It could be an arbitrary change not related to the intervention. Another possibility is that the process of the social skills group being videotaped but not being able to observe their own videotape made them more fearful of negative evaluation by people reviewing the videotapes. Not knowing how they appeared on the videotape might have heightened their concerns about negative evaluation by others. This is obviously not a desired effect of the intervention. If this is a result of the difference between

¹⁹⁴ Ibid page 449.

the control and experimental conditions (not viewing video feedback as opposed to viewing video feedback) greater emphasis needs to be placed on desensitizing the control group to being videotaped. This will be discussed in greater detail in the Implications for Practice chapter.

Group Therapy Evaluation Questionnaire:

The group therapy evaluation questionnaire was taken from Kanas and Barr's article; "Short-Term Homogeneous Group Therapy for Schizophrenic Inpatients: A Questionnaire Evaluation" in the periodical Group.¹⁹⁵ They originally developed the questionnaire for evaluation of an acute care psychiatric inpatient unit for schizophrenic patients. The purpose of their group was to ventilate emotions, improve coping skills, enhance reality testing, and encourage socialization. The group therapy questionnaire consists of 13 statements concerning a group where the consumers rate their group as; very important (2 points), somewhat important (1 point), and not important at all (0 points). The total number of points for each statement for all group members could therefore be added together. In this way, the factors described by each statement could be ranked most helpful to least helpful for all the group members. This allows for an overall rank ordering (see appendix B for 13 questions).

¹⁹⁵ Kanas, Nick & Barr, Mary Ann (1982). Short-Term Homogeneous Group Therapy for Schizophrenic Inpatients: A Questionnaire Evaluation. Group. Vol. 6, #4, Winter, pages 32 - 38

TABLE TWO
EVALUATION QUESTIONNAIRE STATEMENTS' RANKING AND MEAN SCORES

Control Group			Experimental Group		
STATEMENT	RANKING	MEAN SCORE	STATEMENT	RANKING	MEAN SCORE
FOUR	1-tied	2.	ONE	1-tied	2.
FIVE	1-tied	2.	TWELVE	1-tied	2.
TWELVE	3	1.87	FOUR	3-tied	1.85
NINE	4	1.75	FIVE	3-tied	1.85
ONE	5-tied	1.62	TWO	5	1.71
TWO	5-tied	1.62	THREE	6-tied	1.43
SIX	7-tied	1.5	EIGHT	6-tied	1.43
EIGHT	7-tied	1.5	NINE	6-tied	1.43
THREE	9	1.37	SIX	9	1.28
SEVEN	10	1.	TEN	10	.86
TEN	11-tied	.87	SEVEN	11-tied	.57
THIRTEEN	11-tied	.87	ELEVEN	11-tied	.57
ELEVEN	13	.75	THIRTEEN	13	.28

The control group gave statements four and five the highest rating both with a mean score of 2. Statement four is "the group showed me that I can help other people." Statement Five is "the group taught me how to relate better with people." Statement twelve placed third with a mean score of 1.87. Statement twelve is "the group helped me to control some of my emotions." Statement nine was fourth with a mean score of 1.75. Statement nine is "the group gave me insight into the causes of my problems." Statements one and two both placed fifth with a mean score of 1.62. Statement one is "the group allowed me a place to

express my emotions." Statement two is "the group showed me that I am not the only one with problems." Statements six and eight were both seventh with a mean score of 1.5. Statement six is "the group helped me decide the difference between reality and my imagination." Statement eight is "the group helped me feel hopeful about my future." Statement three was ninth with a mean score of 1.37. Statement three is "the group helped me become less suspicious of others." Statement seven placed tenth with a mean score of 1. Statement seven is "the group helped me cope better with my voices and / or visions." Statements ten and thirteen both placed eleventh with a mean score of .87. Statement ten is "the group gave me useful advice about the nature of my illness." Statement thirteen is "the group gave me useful advice about jobs, finances, or places to stay." Last place goes to statement eleven with a mean score of .75. Statement eleven is "the group gave me useful advice about medications."

The Experimental group gave statements one and twelve the highest rating both with a mean score of 2. Statement one concerns expressing emotions and statement twelve concerns learning to control emotions. Third place went to statements four and five with a mean score of 1.85. Statement four concerns helping others and statement five concerns relating better with people. Fifth place, mean score 1.71, went to statement two concerning not being the only one with problems. Sixth place went to statements three, eight and nine with a mean score of

1.43. Statement three concerns being less suspicious of others, statement eight concerns feeling hopeful about the future, and statement nine concerns insight into the causes of problems. Ninth place, mean score 1.28, went to statement six concerning deciding the difference between reality and imagination. Tenth place, mean score .86, went to statement ten concerning advice about the nature of illness. Eleventh place went to statements seven and eleven with a mean score of .57. Statement seven concerns coping with voices and statement eleven concerns medications. Last place, mean score .28, went to statement thirteen concerning advice about jobs, finances, and housing.

Comparing the ranking given to each statement by the control and experimental groups both groups gave very similar ordering. The rank ordering of one statement was equal, two statements differed by one place, eight statements differed by two places, one statement differed by three places, and one statement by four places. Statement three concerning becoming less suspicious of others was given ninth place by the control group and sixth by the experimental group. Sixth place in the experimental group, however, was a three - way tie and the control mean score of 1.37 did not differ markedly from the experimental mean score of 1.43. Statement one concerning a place to express emotions was given fifth place by the control group and first place by the experimental group. Here, the mean score of 1.62 given by the control group did vary from the experimental mean score of 2. According to the results of the questionnaire, the experimental

group felt more comfortable in the group as a place to express emotions than did the control group. Conversely, according to questionnaire evaluation results, the control group being videotaped but not being able to observe their own videotapes made them perceive the group as a place to express emotions less than did the experimental group. This could be due to several different factors. It could be an arbitrary difference not related to the intervention. Another possibility is that the process of the social skills group being videotaped but not being able to observe their own videotapes made them perceive the group as a place to express emotions less than if they were videotaped and did have an opportunity to observe their own videotapes. The slight variation on statement three; concerning becoming less suspicious of others, between the control group (ninth place) and the experimental group (sixth place) might be related to this as well. If this is a result of the difference between the control and experimental conditions (not viewing video feedback as opposed to viewing video feedback) greater emphasis needs to be placed on desensitizing the control group to being videotaped. This will be discussed in greater detail in the Implications for Practice chapter.

The rank ordering for both groups can be divided for the most part into three sections of most helpful, somewhat helpful, and least helpful. Both groups found the intervention most helpful in the areas of; A) helping other people, B) learning to control emotions, and C) relating better with people. Both

groups found the intervention somewhat helpful in the areas of; D) insight into causes of problems, E) not the only person with problems, F) feeling hopeful about the future, G) becoming less suspicious of others and H) discriminating between reality and imagination. Both groups found the intervention least helpful in the areas of; I) coping with voices, J) advice about the nature of illness, K) advice about jobs, finances, and housing, and L) advice about medications. This was a social skills group focused on developing skills in communication and social interactions. The consumers found those areas covered by statements related to social skills the most helpful.

Analysis of Videotapes:

The videotapes from selected intervals (weeks 2, 7, 11, and 15) were observed for frequency by type of response. The responses were classified into one of four categories. Category (1A): appropriate statements of one word. Category (1B) appropriate statements of more than one word. Category (1C) reflective statements, operationally defined as an evaluation of personal behavior and acknowledging personal responsibility. All appropriate statement (1A, 1B, and 1C) are defined as responding to a comment made to a consumer within five seconds, be related to the statement addressed to him / her, and be positive or neutral rather than negative in content. The fourth category, (2), is inappropriate statements. This category is defined as a statement that is of a socially unacceptable nature. Characteristically they are nonsense statements, insults,

complaining remarks, interrupting others and inappropriate physical activities.

The data is from eight group sessions. The selected intervals are weeks two, seven, eleven, and fifteen, each week having two group sessions. The data is presented in five graphs; figures one through five. The horizontal line on all graphs represents the group session; one being week two-first session, two being week two-second session, three being week seven-first session, four being week seven - second session, and so on. The vertical line on all graphs represents the number of statements made. Connecting lines of varying design have been inserted to enhance the graphic depiction.

The first graph, figure one, (see figure one, page 128) represents the control group's mean data for the four categories of responses. The first category, appropriate statements of one word, increases, then fluctuates and then becomes flat. The second category, appropriate statements of more than one word, has a steady positive slope (slope = 1.6). The third category, reflective statements, remains at a low level. The fourth category, inappropriate statements, is level at a slightly higher position than reflective statements but below appropriate statements of one word and dramatically below appropriate statements of more than one word after group session four.

The second graph, figure two, (see figure two, page 129) represents the experimental group's mean data for the four categories of responses. The first category, appropriate

statements of one word, increases and then stabilizes at a slightly higher level than the probable baseline. The second category, appropriate statements of more than one word, goes through a process of steep increase (increasing slope for three data points), fluctuates for the next five data points with a continued general slope increase at a slower rate (smaller positive slope). The third category, reflective statements, remains low through the series. The fourth category, inappropriate statements, has a slight general increase over time (slightly positive slope).

The third graph, figure three (see figure three, page 130) represents the collapsing of all appropriate statement categories, categories one, two, and three, into total appropriate statements, graphed with inappropriate statements for both experimental and control groups. The experimental group's appropriate statement line has a steep increase for three data points, then a sharp drop for one data point, then fluctuates on a generally positive slope. The control group's appropriate statement line is less volatile than the experimental group's line, with a more consistent, less dramatic, steady positive slope. The experimental group's inappropriate statement line has a slightly positive slope over time. The control group's inappropriate statement line begins at a lower level than the Experimental group's line and remains level.

The fourth graph, figure four, (see figure four, page 131) represents the difference scores for the experimental and control

groups. This is the difference between the total appropriate statements and inappropriate statements. This attempts to take into account the difference between groups in their levels of inappropriate statements. The experimental group has a steep increase for three data points, then a sharp drop for one data point, then fluctuates on a generally positive slope. The control group has a steady positive slope.

The last graph, figure five, (see figure five, page 132) represents the total appropriate and inappropriate statements for both the experimental and control groups with a trend line for the total appropriate statements. This graph is the same as attachment five but with a trend line for both groups to illustrate the degree of the slope. The control group has a steeper, more pronounced, increasing slope than does the experimental group. Both groups show progress and positive results from the intervention.

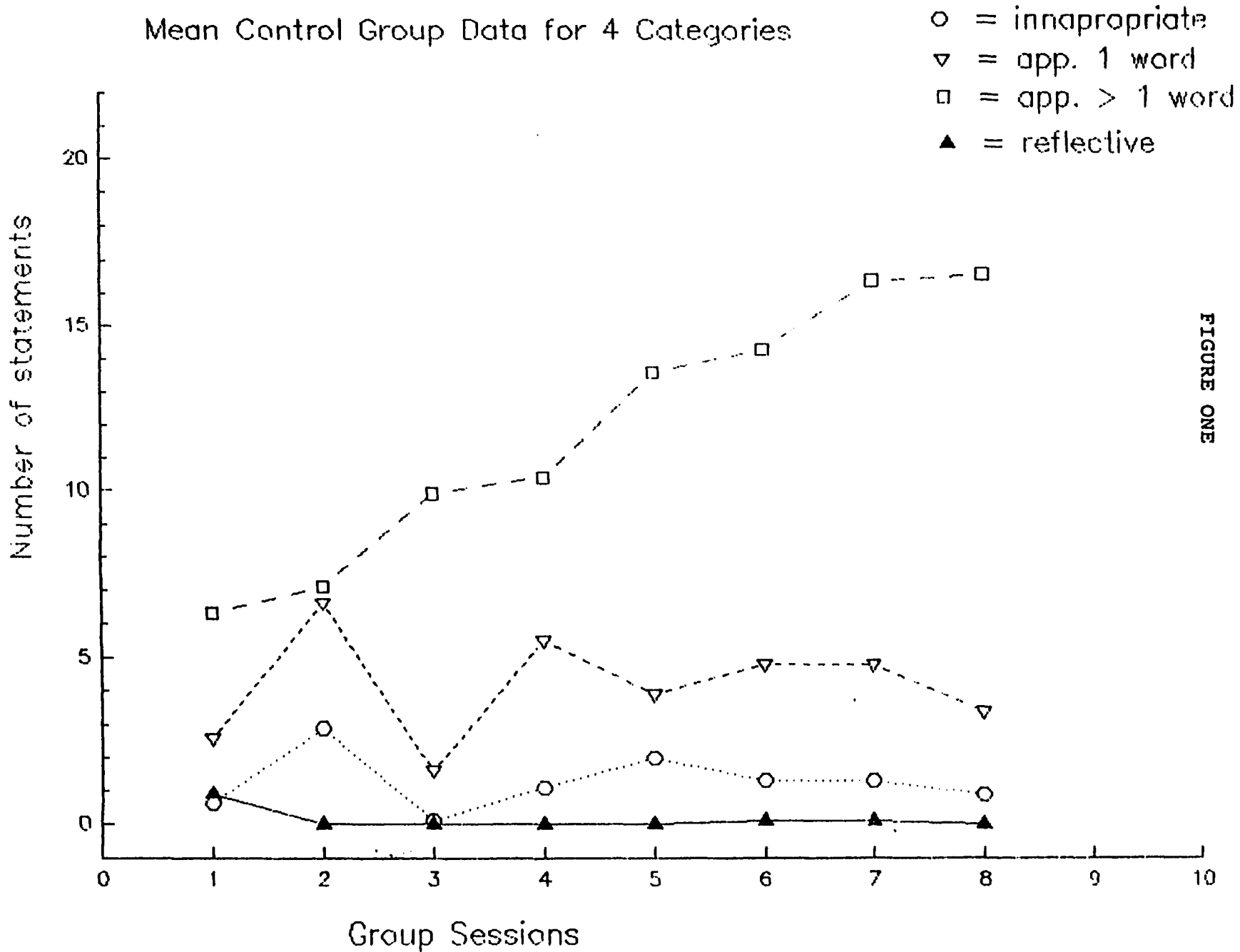


FIGURE ONE

FIGURE TWO

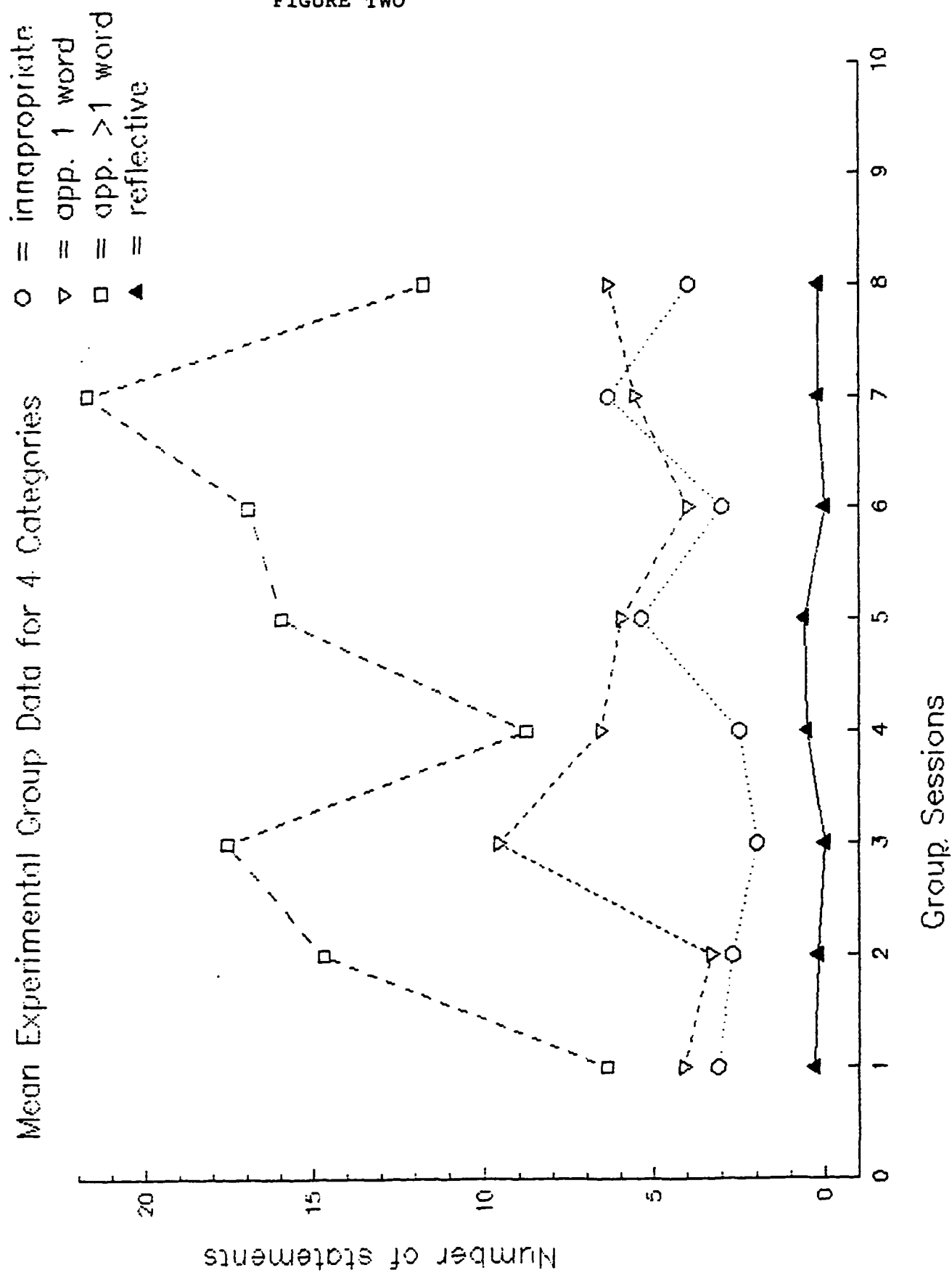
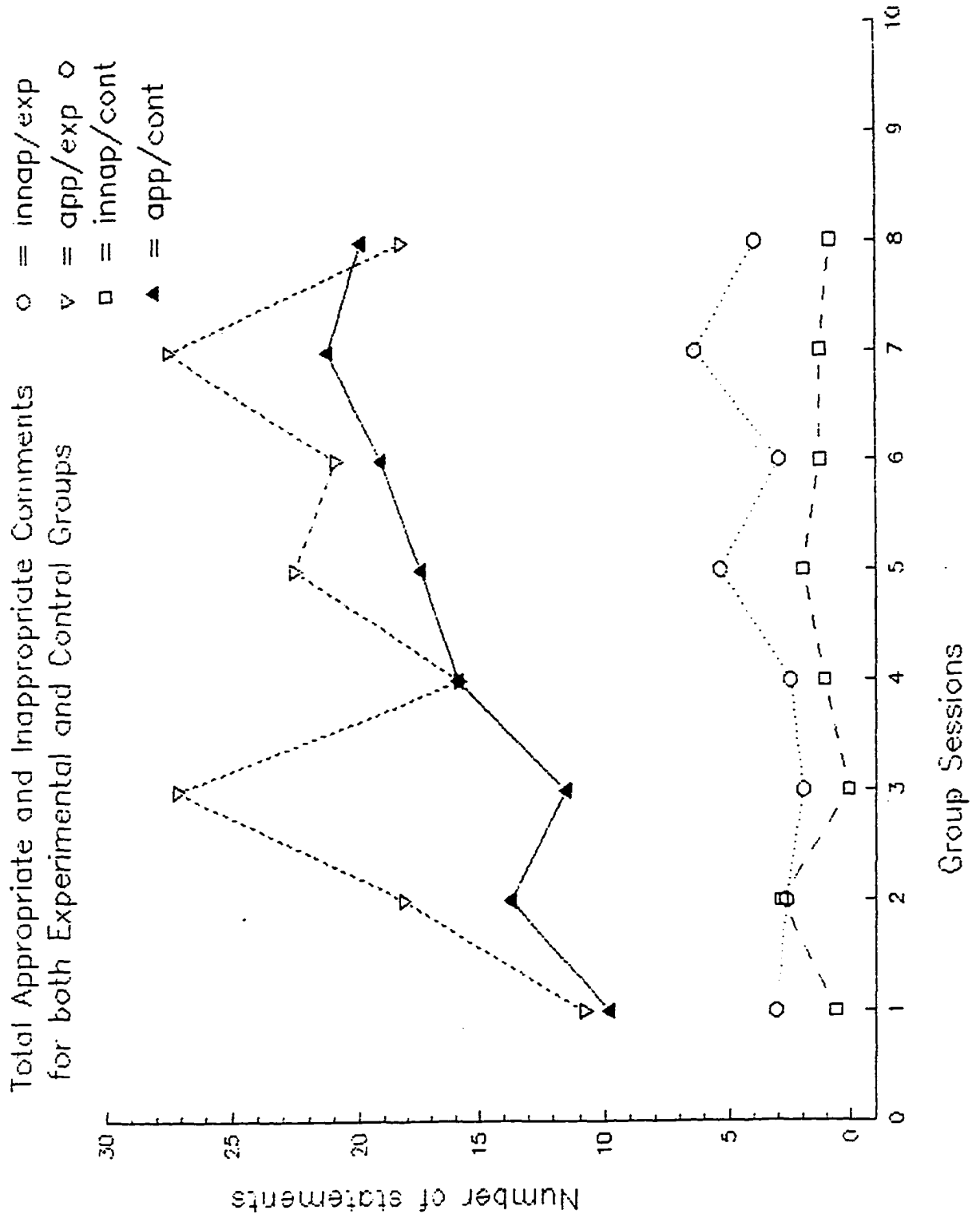


FIGURE THREE



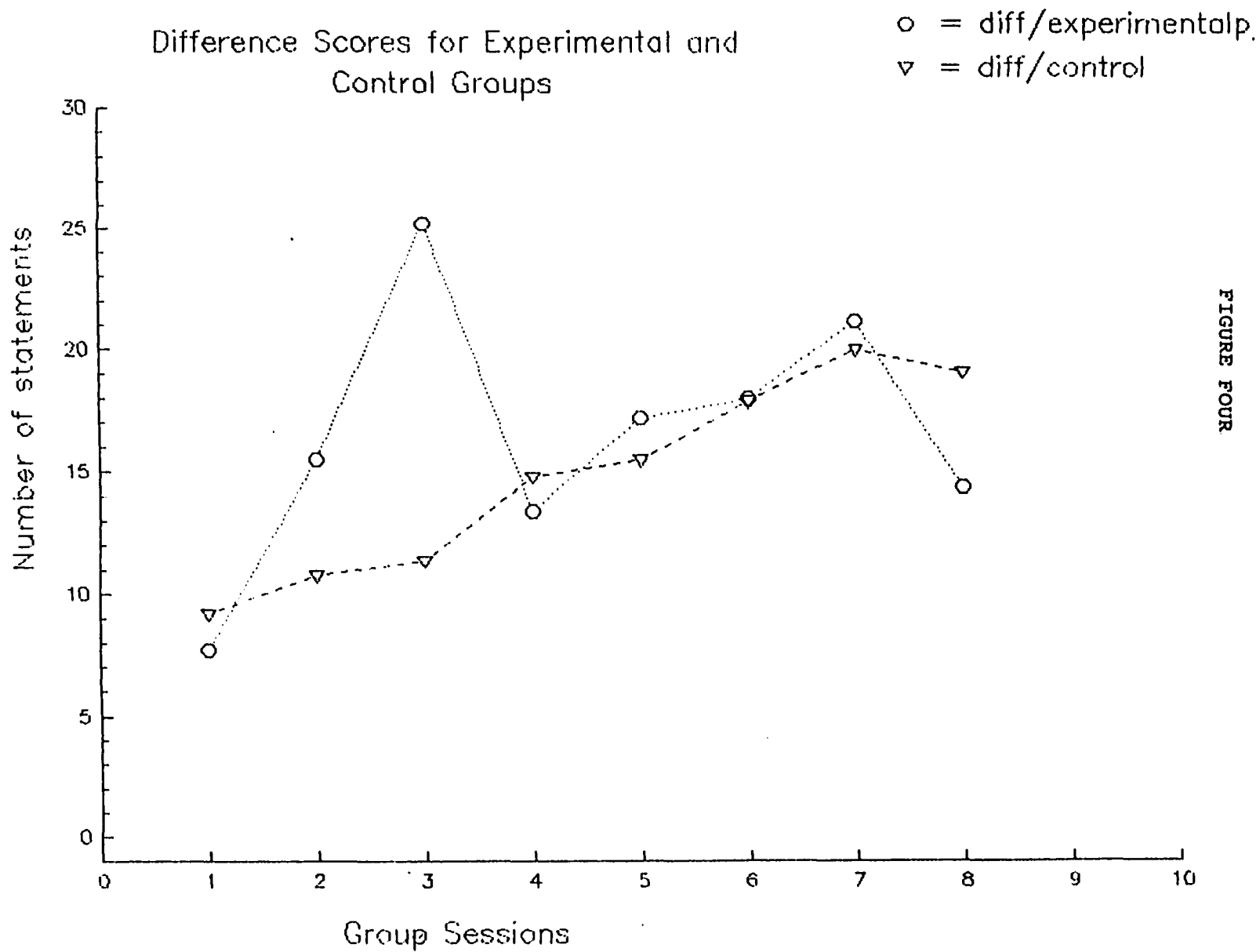


FIGURE FOUR

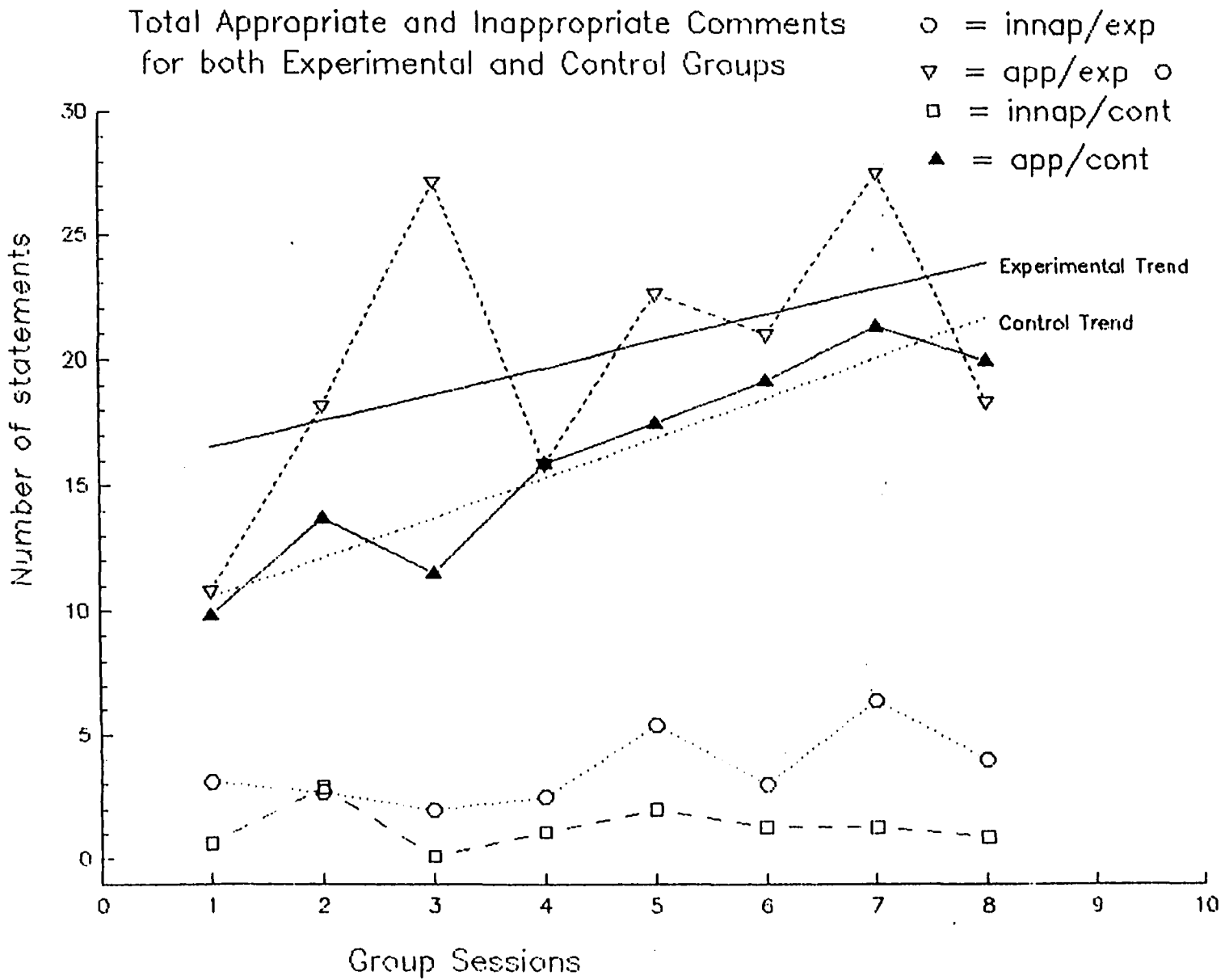


FIGURE FIVE

TABLE THREE

T-TEST COMPARING WEEK TWO AND WEEK FIFTEEN BY CATEGORY

Experimental Group

CATEGORY	T-TEST	SIGNIFCANCE * indicates significance
(1A) Appropriate statement of one word	.178	$p < .05$
(1B) Appropriate statement of more than one word	.346	$p < .05$
(1C) Reflective appropriate statement	.678	$p < .05$
(2) Inappropriate statement	.085	$p < .05$

Control Group

CATEGORY	T-TEST	SIGNIFICANCE *indicates significance
(1A) Appropriate statement of one word	.851	$p < .05$
(1B) Appropriate statement of more than one word	.000	* $p < .05$
(1C) Reflective appropriate statement	.054	$p < .05$
(2) Inappropriate statement	.544	$p < .05$

T-Tests for paired samples were conducted on pooled week two (sessions one and two) compared with week fifteen (sessions one and two) for both the experimental and control groups. The two-tail T-Test for the experimental group's categories were: (1A) -

appropriate statement of one word = .178, (1B) - appropriate statement of more than one word = .346, (1C) - reflective appropriate statement = .678, and (2) - inappropriate statement = .085. Two tail T-Test levels of less than .05 are significant. None of the experimental group data is significant. The two tail T-Test for the control group's categories were: (1A) -appropriate statement of one word = .851, (1B) - appropriate statement of more than one word = .000, (1C) - reflective statement = .054, (2) - inappropriate statement = .544. Two tail T-Test levels of less than .05 are significant. The control group in category (1B), appropriate statements of more than one word, proved to be statistically significant with a T value of .000. Comparing the T-tests for the experimental and control groups, more improvement was shown by the control group than the experimental group in increasing appropriate statements of more than one word.

TABLE FOUR
MANN-WHITNEY U - WILCOXON RANK SUM W TEST FOR THE MEANS OF THE
EXPERIMENTAL AND CONTROL GROUPS

TWO-TAILED P VALUE	SIGNIFICANCE *indicates significance
.1411	$p < .05$

A Mann - Whitney U - Wilcoxon Rank Sum W test was conducted to determine if the means of the experimental and control groups were significantly different across all responses. A non - parametric test was used due to the need to have data come from normally distributed variables. This cannot be demonstrated satisfactorily in a small sample such as the sample of this

project. A non - parametric test was used which is less powerful but does not require this assumption.¹⁹⁶ The Mann - Whitney U - Wilcoxon Rank Sum W test for the means of the experimental and control groups across all responses had a two tailed P of .1411. This is not significantly different at the .05 level. The provision of video feedback to a social skills group did not enhance the acquisition of social skills with mentally ill / mentally retarded consumers. This could be due to several factors. The small sample size could have been a factor. The experimental group had one participant barely attend due to psychiatric hospitalization, another moved out of state after the ninth week, and in general had more problems with attendance than the control group. Another possible factor is the lack of instrument sensitivity. An analysis of the frequency by type of response might not be adequately reflective of the acquisition of social skills or be able to measure the progress made by the participants. A third possible factor might be the lack of treatment effect. Video feedback might not enhance the acquisition of social skills as designed and implemented in this project. Both the experimental and control groups had treatment effects from the intervention. Both groups showed improvements. The main hypothesis, that video feedback would enhance the acquisition of social skills for mentally ill / mentally retarded consumers, was not supported by the results of the project.

¹⁹⁶ Weinberg, S. and Goldberg, K. (1994). Statistics for the Behavioral Sciences. Cambridge MA., Cambridge University Press, page 465.

CHAPTER FIVE : IMPLICATIONS FOR PRACTICE

The social skills component of this project proved to be effective in developing social skills as defined by the target behaviors. The control group's T-Test comparing week two and week fifteen for appropriate statements of more than one word was statistically significant. Social skills training for psychiatric/mentally retarded consumers was supported by the results of this project. The basic social skills training approach used with psychiatric and / or mentally retarded consumers of modeling, behavioral rehearsal, and feedback - social reinforcement, parallels the learning cycle model developed by Kolb and Fry. Their cycle consists of four stages:

"In the first stage, the learner is involved in a concrete, here - and - now experience. In the second stage, through reflective observation, relevant phenomena are selected from the experience. In the third stage, such phenomena are analyzed, conceptualized, and generalized in relation to theoretical knowledge. Finally, the concepts and principles formulated in the third stage are tested and applied in new situations, which may constitute the beginning of a new cycle."¹⁹⁷

Social skills training for psychiatric and / or mentally retarded consumers fits into the framework of theories of group process through this applied theory of experiential learning. The learning cycle model is supported by the results of this project and with its application with psychiatric / mentally retarded consumers.

¹⁹⁷ Behroozi, Cyrus (1995). The Dual - Purpose Group : It's Use and Misuse in Group Work Education. Kurland, Roselle and Salmon, Robert, Eds. Group Work Practice in a Troubled Society. New York: Haworth Press, pages 54 - 55

As will be discussed later in this chapter, the results did not show video feedback as an effective tool in developing social skills. The results, however, did find much support for traditional social skills training with mentally retarded consumers. We did learn the relevance of traditional social skills training. In addition, the use of general group work stage theory as a guide for the group topics proved to be useful. The groups were working on two levels. On one level, social skills training involving modeling, behavioral rehearsal, and feedback helped developed social skills. The shaping and reinforcement of appropriate comments by the group leaders and fellow participants had positive results. On the other level, the content of the group discussion topics helped communicate information and develop social skills. General group work stage theory provided a useful structure and framework for the social skills groups. Whereas previous groups such as Matson and Senatore's research used events in the day program as the group discussions topics, in this project the groups used general group work stage theory as a guide for the group discussion topics. In this way, the consumers benefitted not only from traditional social skills training but from what they learned from the discussion topics themselves. Going through the process of the stages, modified for their cognitive abilities, taught them something about social skills, communication, and relating to other people.

Both the control and experimental groups showed improvement

in their social skills through the intervention and neither group showed any regression. The intervention was beneficial to both groups. The participants felt the group was helpful to them as indicated by the high ratings (2 being the highest rating equaling very important) given on the questionnaire. Both groups found the intervention most helpful in the areas of: A) helping other people (Control = 2, Experimental = 1.85), B) learning to control emotions (Control = 1.87, Experimental = 2), and C) relating better with people (Control = 2, Experimental = 1.85). The consumers believed they benefitted from the group and found it most helpful in those areas.

The control group showed statistical significance in the pre and post intervention comparison on the Fear of Negative Evaluation (FNE) scale. This could be due to several different factors. It could be an arbitrary change not related to the intervention. Another possibility is the participants did not like the modeling aspect of the social skills training where they were encouraged not to make inappropriate (negative) comments. The control group's graph of inappropriate comments was low and flat. The experimental group's graph of inappropriate comments started at a higher level and over time had a slightly positive slope. The control group could have been more inhibited about making inappropriate comments due to a fear of loss of social approval (higher FNE score). This could also be related to the questionnaire results where the control group gave statement three; concerning the group as a place to express emotions, a

much lower score (1.62) than did the experimental group (2). A third possibility is that the control group being videotaped but not being able to observe their own videotape made them more fearful of negative evaluation by people reviewing the videotapes. This also could be related to the questionnaire results in the discrepancy between groups concerning the group as a place to express emotions. It would also relate to the slight discrepancy on the statement concerning being less suspicious of others where the experimental group gave it sixth place and the control group gave it ninth place. If this is the main factor then greater emphasis needs to be placed on desensitizing the control groups to being videotaped. Although videotaping was discussed and explored in weeks one and five perhaps more attention needs to be placed on desensitizing consumers who are videotaped but do not observe their tapes.

The main hypothesis, that video feedback would enhance the acquisition of social skills for mentally ill / mentally retarded consumers, was not supported by the results of the project. This could be due to several factors. It could be due to the fact that specific targeted behaviors rather than global concepts were measured. What was measured might not be reflective of social skills learned. Another possible factor could be that modeling, in conjunction with group observation of video feedback, might have been overly coercive and controlling and not conducive to natural social interactions and the development of social skills. A third possibility is the small sample size. Group dynamics

differ with each group. Although participants were assigned to groups randomly, in a small sample of two groups one group could still be arbitrarily more of a challenge than the other group. The experimental group started at a higher level of inappropriate comments and this could be indicative of their being more of a challenge.

Video could not enhance the acquisition of social skills for mentally ill / mentally retarded consumers. Video might be an unnecessary distraction that detracts from the process and primary purpose of developing social skills. This option is supported by the control group showing more improvement and achieving significance on the T-Test comparison of week two and week fifteen in the category of appropriate statements of more than one word. The control group that did not have video feedback showed more improvement in the main targeted behavior than did the experimental group with video feedback. Video feedback could detract or have no positive effect on the development of social skills with this population.

The final proposed option concerns how video feedback was operationalized in this project. The video feedback was provided in a group setting. Rubin and Locascio's (1985) study, mentioned in the literature review, provided video feedback in a group context and found it to have positive results. This was a qualitative evaluation however, based upon anecdotal reports. Group observation of video feedback is not self - monitoring but group monitoring. Group has proven to be an ideal context for

social skills training with this population but group might not be the best forum for video feedback. Group observation of video feedback might not be focused enough to be beneficial, therefore, becoming a distraction. It might possibly be too threatening for this population. Dunlap et.al.'s (1992) study, as noted in the literature review, provided individual video feedback with staff supervision. They operationalized video feedback as a self - monitoring, self - evaluation intervention. The participants during individual video feedback completed a self - monitoring record sheet and were given reinforcers (rewards) for exhibiting the desired peer interactions and accurately evaluating their own behavior. Video feedback is the optimal mechanism for self - monitoring in that it does not disturb the course of social interactions. Social Skills training for psychiatric and / or mentally retarded consumers is proven to be best conducted in a group context. Video feedback, however, might be much more beneficial provided in a supervised individual context for this population. Future studies could attempt a similar social skills training program as conducted in this project but with the provision of supervised individual video feedback with self - monitoring, self - evaluation, and reinforcement.

Summary

Social skills training was shown by the results of the project as a useful technique with psychiatric / mentally retarded adults. Social skills training involving modeling, behavior rehearsal and feedback - social reinforcement helped the

consumers develop social skills. The use of target behaviors, shaping behavior by prompting specific behavior (appropriate comments), modeling appropriate behavior, and extinguishing inappropriate behavior (inappropriate comments) by showing alternative skills and giving social reinforcers for appropriate behavior, all proved to be beneficial techniques.

Traditional group work stage theory was shown to be a useful framework for the group discussion topics of a social skills group. Going through the process of stages, modified for their cognitive abilities, taught them something about social skills, communication, and relating to other people. The groups operated on two levels; the social skills training techniques and the group discussion topics using a stage theory framework. This use of a two level approach had beneficial effects.

The control group was statistically significant with the target behavior appropriate statements of more than one word. They showed marked improvement in increasing appropriate statements of more than one word. The control group progressed and developed their skills through social skills training techniques in the context of a group using stage theory as a framework for group discussion topics.

The control was statistically significant with the pre - and post scores on the Fear of Negative Evaluation (FNE) scale. This implies they were more fearful of losing social approval after the intervention. Although other factors may have affected this change in the FNE scale, the primary assumption is that the

control group being videotaped but not observing their own tape made them more fearful of losing social approval (presumably by the people who did watch the videotape). If this is the situation, this would indicate that more emphasis needs to be placed on desensitizing the groups being videotaped but not observing the playback.

The use of video feedback in the context employed in this project did not prove to be beneficial according to the project results. The experimental group did not show any statistical significance on the target behaviors. This could be due to research design flaws; sample size, instrument sensitivity, etc. or it could be due to lack of treatment effect. Video feedback might be an unnecessary distraction for a social skills group with this population. The participants might have benefitted more from an individual viewing of the playback as opposed to the group viewing as done in this project.

The graphs of the target behaviors for both groups did show improvement. Both groups benefitted from the intervention. The results of the consumer questionnaire shows that both groups felt that intervention was useful and helpful. They found it most helpful in the areas of helping others, learning to control emotions and relating better with other people.

In Through The Looking Glass, Humpty Dumpty in a rather scornful tone tells Alice: "When I use a word, it means just

what I choose it to mean - neither more nor less."¹⁹⁸ Previously, some of the group participants might have believed that of their own speech. Hopefully, the group participants through the project have become more aware, sensitive, and cognizant of their social interactions. They have a lot to offer as caring friends and humane, supportive, compassionate people. Hopefully, the project in at least some small way helped develop their ability to communicate that to others.

¹⁹⁸ Carroll, Lewis (1988 printing). Alice in Wonderland and Through the Looking Glass. New York: Grosset and Dunlap, Pub., page 229

SOCIAL AVOIDANCE AND DISTRESS (SAD) SCALE

CLIENT NAME _____	DATE _____
	T F A
1. I feel relaxed even in unfamiliar social situations.	() () (F)
2. I try to avoid situations which force me to be very sociable.	() () (T)
3. It is easy for me to relax when I am with strangers.	() () (F)
4. I have no particular desire to avoid people.	() () (F)
5. I often find social occasions upsetting.	() () (T)
6. I usually feel calm and comfortable at social occasions.	() () (F)
7. I am usually at ease when talking to someone of the opposite sex.	() () (F)
8. I try to avoid talking to people unless I know them well.	() () (T)
9. If the chance comes to meet new people, I often take it.	() () (F)
10. I often feel nervous or tense in casual get-togethers in which both sexes are present.	() () (T)
11. I am usually nervous with people unless I know them well	() () (T)
12. I usually feel relaxed when I am with a group of people.	() () (F)
13. I often want to get away from people.	() () (T)
14. I usually feel uncomfortable when I am in a group of people I don't know.	() () (T)
15. I usually feel relaxed when I meet someone for the first time.	() () (F)
16. Being introduced to people makes me tense and nervous.	() () (T)
17. Even though a room is full of strangers, I may enter it anyway.	() () (F)

- | | T | F | A |
|---|-----|-----|-----|
| 18. I would avoid walking up and joining a large group of people. | () | () | (T) |
| 19. When my superiors want to talk with me, I talk willingly. | () | () | (T) |
| 20. I often feel on edge when I am with a group of people. | () | () | (T) |
| 21. I tend to withdraw from people. | () | () | (T) |
| 22. I don't mind talking to people at parties or social gatherings. | () | () | (F) |
| 23. I am seldom at ease in a large group of people. | () | () | (T) |
| 24. I often think up excuses in order to avoid social engagements. | () | () | (T) |
| 25. I sometimes take the responsibility for introducing people to each other. | () | () | (F) |
| 26. I try to avoid formal social occasions. | () | () | (T) |
| 27. I usually go to whatever social engagements I have. | () | () | (F) |
| 28. I find it easy to relax with other people. | () | () | (F) |

FEAR OF NEGATIVE EVALUATION (FNE)

- | | T | F | A |
|--|-----|-----|-----|
| 1. I rarely worry about seeming foolish to others. | () | () | (F) |
| 2. I worry about what people will think of me even when I know it doesn't make any difference. | () | () | (T) |
| 3. I become tense and jittery if I know someone is sizing me up. | () | () | (T) |
| 4. I am unconcerned even if I know people are forming an unfavorable impression of me. | () | () | (F) |
| 5. I feel very upset when I commit some social error. | () | () | (T) |

- | | T | F | A |
|---|-----|-----|-----|
| 6. The opinions that important people have of me cause me little concern. | () | () | (F) |
| 7. I am often afraid that I may look ridiculous or make a fool of myself. | () | () | (T) |
| 8. I react very little when other people disapprove of me. | () | () | (F) |
| 9. I am frequently afraid of other people noticing my shortcomings. | () | () | (T) |
| 10. The disapproval of others would have little effect on me. | () | () | (F) |
| 11. If someone is evaluating me I tend to expect the worst. | () | () | (T) |
| 12. I rarely worry about what kind of impression I am making on someone. | () | () | (F) |
| 13. I am afraid that others will not approve of me. | () | () | (T) |
| 14. I am afraid that people will find fault with me. | () | () | (T) |
| 15. Other people's opinions of me do not bother me. | () | () | (F) |
| 16. I am not necessarily upset if I do not please someone. | () | () | (F) |
| 17. When I am talking to someone, I worry about what they may be thinking about me. | () | () | (T) |
| 18. I feel that you can't help making social errors sometimes, so why worry about it. | () | () | (F) |
| 19. I am usually worried about what kind of impression I make. | () | () | (T) |
| 20. I worry a lot about what my superiors think me. | () | () | (T) |
| 21. If I know someone is judging me it has little effect on me. | () | () | (F) |
| 22. I worry that others will think I am not worthwhile. | () | () | (T) |

23. I worry very little about what others may think of me. () () (F)
24. Sometimes I think I am too concerned with what other people think of me. () () (T)
25. I often worry that I will say or do the wrong things. () () (T)
26. I am often indifferent to the opinions others have of me. () () (F)
27. I am usually confident that others will have a favorable impression of me. () () (F)
28. I often worry that people who are important to me won't think very much of me. () () (T)
29. I brood about the opinions my friends have about me. () () (T)
30. I become tense and jittery if I know I am being judged by my superiors. () () (T)

QUESTIONNAIRE EVALUATION

 CLIENT NAME

 DATE

RATING SCALE

VERY IMPORTANT (2 POINTS) - SOMEWHAT IMPORTANT (1 POINT)

NOT IMPORTANT AT ALL (0 POINTS)

- | | | |
|------|---|---------------|
| 1). | The group allowed me a place to express my emotions. | (Points ____) |
| 2) | The group showed me that I am not the only one with problems. | (Points ____) |
| 3). | The group helped me become less suspicious of others. | (Points ____) |
| 4). | The group showed me that I can help other people. | (Points ____) |
| 5). | The group taught me how to relate better with people. | (Points ____) |
| 6). | The group helped me decide the difference between reality and my imagination. | (Points ____) |
| 7). | The group helped me cope better with my voices and/or visions. | (Points ____) |
| 8). | The group helped me feel hopeful about my future. | (Points ____) |
| 9). | The group gave me insight into the causes of my problems. | (Points ____) |
| 10). | The group gave me useful advice about the nature of my illness. | (Points ____) |
| 11). | The group gave useful advice about medications. | (Points ____) |
| 12). | The group helped me learn to control some of my emotions. | (Points ____) |
| 13). | The group gave me useful advice about jobs, finances, or places to stay. | (Points ____) |

BIBLIOGRAPHY

- American Psychiatric Association (1980). Diagnostic and statistical manual of mental disorders (3rd ed.) Washington, DC: Author.
- Bandura, A. (1969). Principles of behavior modification. New York: Holt, Rinehart & Winston Publishing.
- Behroozi, C. (1995). The dual - purpose group: Its use and misuse in group work education. In R. Kurland & R. Salmon, (Eds.). Group work practice in a troubled society (pp. 53-62). New York: Haworth Press.
- Booth, S., & Fairbanks, D. (1984). Videotape feedback as a behavior management technique. Behavioral Disorders, 9, 55-59.
- Borthwick-Duffy, S., & Eyman, R. (1990). Who are the dually diagnosed? American Journal of Mental Retardation, 94 (6), 586-595.
- Brandler, S., & Roman, C. (1991). Group work - skills and strategies for effective interventions. New York: Haworth Press.
- Browder, D., Schoen, S., & Lentz, F. (1987). Learning to learn through observation. Journal of Special Education, 20 (4), 447-461.
- Carroll, L. (1988 printing). Alice in wonderland and through the looking glass. New York: Grosset and Dunlap Publishing.
- Dowick, P., & Hood, M. (1981). Comparison of self - modeling and small cash incentives in a sheltered workshop. Journal of Applied Psychology, 66, 394-397.
- Dunlap, L., Dunlap, G., Clarke, S., Childs, K, White, R., & Stewart, M. (1992). Effects of a videotape feedback package on the peer interactions of children with serious behavioral and emotional challenges. Journal of Applied Behavior Analysis, 25 (2), 355-364.
- Eaton, L., & Menolascino, F. (1982). Psychiatric disorders in the mentally retarded: types, problems, and challenges. American Journal of Psychiatry, 139 (10), 1297-1303.
- Erickson, E. (1963). Childhood and society. New York: Norton and Co.

- Esveldt, K., Dawson, P., & Forness, S. (1974). Effect of videotape feedback on children's classroom behavior. The Journal of Educational Research, 67 (10), 453-456.
- Fletcher, R. (1988). A county systems model: Comprehensive services for the dually diagnosed persons. In J. Stark & F. Menolascino (Eds.), Mental retardation and mental health: Classification, diagnosis, treatment, services (pp. 254-264). New York: Springer.
- Fletcher, R., & Menolascino, F. (1989). Introduction. In R. Fletcher & F. Menolascino (Eds.), Mental retardation and mental illness (pp. 4-5). Lexington, MA: Lexington Books.
- Fletcher, R. (1989). The role of a day program in increasing support for dually diagnosed persons. In R. Fletcher & F. Menolascino (Eds.), Mental retardation and mental illness (pp. 203-215). Lexington, MA: Lexington Books.
- Galligan, B. (1990). Serving people who are dually diagnosed: A program evaluation. Mental Retardation, 28 (6), 353-358.
- Garland, J., Jones, H., & Kolodny, R. (1973). A model for stages of development in social work groups. In S. Bernstein (Ed.), Explorations in group work (pp. 12-53). Boston: Milford House.
- Ghaemi, N. S., & Hundert, E. (1994). The ethics of research in mental illness. Journal of the California Alliance for the Mentally Ill, 5 (1), 47-49.
- Grossman, H., (1983). Manual on terminology and classification in mental retardation. Washington, DC: American Association on Mental Deficiency.
- Jacobson, J. (1990). Do some mental disorders occur less frequently among persons with mental retardation? American Journal of Mental Retardation, 94 (6), 596-602.
- Kanas, N., & Barr, M. (1982). Short-term homogeneous group therapy for schizophrenic inpatients: A questionnaire evaluation. Group, 6 (4), 437-439.
- Kurland, R. (1978). "Planning: The neglected component of group development." Social Work with Groups, 1, 173-178.
- Kurland, R. (1982). Group formation: A guide to the development of successful groups. Albany, New York: Continuing Education Program, School of Social Welfare, State University of New York at Albany and United Neighborhood Centers of America.

- Lansdell, C. (1990). Psychotherapy with persons who have developmental disabilities. National Association of the Dually Diagnosed Newsletter, 7 (2), 1-5.
- Levine, R. (1994). A researcher's concerns with ethics in human research. Journal of the California Alliance for the Mentally Ill, 5 (1), 6-8.
- Liberman, R., DeRisi, W., & Mueser, K. (1989). Social skills training for psychiatric patients. New York: Pergamon Press.
- Matson, J. (1982). The behavioral treatment of depression in the mentally retarded. Behavior Therapy, 13, 209-218.
- Matson, J. (1984). Social skills training. Psychiatric Aspects of Mental Retardation Reviews, 3, 1-4.
- Matson, J., & Adkins, J. (1980). A self-instructional social skills training program for mentally retarded persons. Mental Retardation, 18, 245-248.
- Matson, J., & Andrasik, F. (1982). Training leisure - time social - interaction skills to mentally retarded adults. American Journal of Mental Deficiency, 86, 533-542.
- Matson, J., Kazdin, A., & Esveldt-Dawson, K. (1982). Training interpersonal skills among mentally retarded and socially dysfunctional children. Behavior Research and Therapy, 12, 369-382.
- Matson, J., & Senatore, V. (1981). A comparison of traditional psychotherapy and social skills training for improving interpersonal functioning of mentally retarded adults. Behavior Therapy, 12, 369-382.
- Menolascino, Frank (1989). Overview: Promising practices in caring for the mentally retarded-Mentally Ill. In R. Fletcher & F. Menolascino (Eds.), Mental retardation & mental illness (pp. 3-13). Lexington, MA: Lexington Books.
- Middleman, R., & Wood, G. G. (1990). Skills for direct practice in social work. New York: Columbia University Press.
- Mondock, J. and Van, O. (1989). "Evaluating the dually diagnosed client". In R. Fletcher & Menolascino, F. (Eds.), Mental retardation and mental illness (pp. 15-33). Lexington, MA: Lexington Books.

- Monfils, M. (1989). Group psychotherapy. In R. Fletcher & F. Menolascino, (Eds.), Mental retardation and mental illness (pp. 111-125). Lexington, MA: Lexington Books.
- Morgan, R., & Salzberg, C. (1992). Effects of video - assisted training on employment - related social skills of adults with severe mental retardation. Journal of Applied Behavior Analysis, 25 (2), 365-383.
- New York State Office of Mental Health (1991). Statewide comprehensive plan for mental health services 1992-1996. Albany, New York.
- Nezu, C., Nezu, A., & Gill-Weiss, M. J. (1992). Psychopathology in persons with mental retardation. Champaign, Ill: Research Press.
- Northen, H. (1988). Social work with groups (2nd ed.). New York: Columbia University Press.
- Perry, M., & Cerreto, M. (1977). Structured learning training of social skills for the retarded. Mental Retardation, 15, 31-34.
- Prouty, G. (1976). Pre-therapy: A method of treating pre - expressive psychotic and retarded patients. Psychotherapy: Theory, Research & Practice, 13 (3), 290-294.
- Prouty, G. (1991). Pre-therapy: A treatment for the dual / diagnosed - schizophrenic / retarded. National Association for the Dually Diagnosed Newsletter, 8 (6), 1-3.
- Prouty, G. (1994). Theoretical evolutions in person - centered / experiential therapy. Westport, CT: Praeger Publishing.
- Prouty, G., & Kubiak, M. A. (1988). Pre-therapy with mentally retarded / psychotic clients. Psychiatric Aspects of Mental Retardation Reviews, 7 (10), 62-66.
- Reiss, S. (1994). Handbook of challenging behavior: Mental health aspects of mental retardation. Worthington, OH: I.D.S. Publications.
- Rogers, C. (1942). Counseling & psychotherapy. New York: Houghten - Mifflin.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21 (2), 95-103.
- Rubin, J., & Locascio, K. (1985). A model for communication skills group using structured exercises and audiovisual equipment. International Journal of Group Psychotherapy, 135 (4), 569-584.

- Russell, A. (1988). The association between mental retardation & psychiatric disorder. In J. Stark & F. Menolascino (Eds.), Mental retardation & mental health (pp. 41-49). New York: Springer-Verlag.
- Stark, J., & Menolascino, F. (1988). Executive summary. In J. Stark & F. Menolascino (Eds.), Mental retardation & mental health. New York: Springer-Verlag.
- Stroller, F. (1968). Focused feedback with videotape: Extending the groups function. American Journal of Psychotherapy, 22 (2), 240-248.
- Tomasulo, D. (1966). The healing crowd: The interactive - behavioral model of group psychotherapy. New York: National Association for the Dually Diagnosed.
- Turner, S., Hersen, M., & Bellack, A. (1978). Social skills training to teach pro-social behaviors in an organically impaired and retarded patient. Journal of Behavior Therapy and Experimental Psychiatry, 9, (3), 253-258.
- Walther, M., & Beare, P. (1991). The effect of videotape feedback on the on-task behavior of a student with emotional / behavioral disorders. Education and Treatment of Children, 14 (1), 53-60.
- Warrenfeltz, R., Kelly, W., Salzberg, C., Beegle, C., Levy, S., Adams, T., & Crouse, T. (1981). Social skills training of behavior disorder adolescents with self-monitoring to promote generalization to a vocational setting. Behavioral Disorders, 7, 18-27.
- Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. Journal of Consulting and Clinical Psychology, 33 (4), 448-457.
- Weinberg, S., & Goldberg, K. (1994). Statistics for the behavioral sciences. Cambridge, MA: Cambridge University Press.
- Wildman, B., Wildman, H., & Kelly, J. (1986). Group conversational - skills training and social validation with mentally retarded adults. Applied Research in Mental Retardation, 17, 443-458.
- Wood, G. G., & Middleman, R. (1989). The structural approach to direct practice in social work. New York: Columbia University Press.